"She's ignoring our crying again. How does she know we haven't got safety pins sticking in us up to the hilt?"
"Mum and me just had a clash of personalities!"
GROWING PAINS

"Oh, I don't mind going to school—it's hanging around there until it's time to come home that gets me!"
"Well, I dunno. I think I'll shop around awhile first before I buy."
"I'm worried about my mind, doctor—I actually catch myself enjoying school every now and then!"
"I want a doll's house like Susie Jones has—one with a cocktail bar in it!"
"And that noise, I suppose that’s the Drone’s Droning?"
GRIN AND BEAR IT!

"I'm at my wit's end with Junior—he's four years old already, and hasn't earned a cent!!"
GROWING PAINS

"I finished it weeks ago, but I am just forgetting to return it."
GROWING PAINS

"I ask for enough food to last our flight—and she brings me one Jelly bean?"
"Why, yeah! I probably licked your son—who's calling, please?"
"Know anything about a book of our cunnin' remarks that mother has been keeping for posterity?"
"We thought we'd start writing to Santa Claus now—because last year we didn't have time for the proper research."
"Good heavens! Imagine being swept into the arms of a Knight dressed like that!"
“All right, Dad—but it's only fair to warn you I've been studying jiu-jitsu!”
"I want something for a brother who doesn't deserve anything."
‘You can come out now, Dad. It ain’t the instalment collector; only a man with a summons.’
"I hope mother keeps him. He's really the nicest father I've ever had."
"With this family reunion of ours getting closer, we've got to do something about the Aunt kissing problem!"
"She's getting to be such a bore—always recounting the 'cute things her parents say'!"
SKIPPY

THE OLD MAN SAYS HE HAS A TASTE FOR MUSIC.
HE MUST BE A MAMMY GOAT.

WELL, THEN, THERE YA ARE SUPPOSE I WAS SENT OUT FOR COLOR, COULD I GO OUT AN GET A BASKET OF SUNSET?

S'YA CAN'T TASTE MUSIC, CAN YA?

CAN YA HEAR A CHOKKLET BELLOK?

NO.
"And please don't give Dad any more little boys until he learns how to treat the ones he has."
“It must be nice to be a problem child, and be able to do just what you darned well please.”
"Daddy's a retiring sort of a person—it's hard to get him out of his shell."
"I wanted to stick to the first chapter, but the horse kept skipping to the one on steeplechasing."
SYDNEY UNIVERSITY
THESIS
M.A., 1939:
BURTON, N.W.

THE CHILD GUIDANCE CLINIC

A CRITICAL SURVEY

N. W. BURTON,
SYDNEY,
2/2/39
FEBRUARY 1939
"The Child Guidance Clinic is an attempt to marshall the resources of the community in behalf of children who are in distress because of unsatisfied inner needs, or are seriously at odds with their environment - children whose development is thrown out of balance by difficulties which reveal themselves in unhealthy traits unacceptable behaviour, or inability to cope with social and scholastic expectations. Its service is rendered through the direct study and treatment of selected children by a team consisting of a psychiatrist, a psychologist, and psychiatric social workers, and also through focusing the attention of physicians, teachers, social workers, and parents on what is commonly called the mental hygiene approach to problems of child behaviour. The essence of this approach is that behaviour is studied objectively, as nearly as possible without prejudice, in the hope of discovering the causes - usually multiple - which produce it, and that an effort is made to modify it by eradicating or abating the causes rather than by precept or the imposition of authority."

SECTION I  ORIGIN AND HISTORICAL DEVELOPMENT OF CHILD GUIDANCE CLINICS

(a) In America
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SECTION II  A CRITICAL SURVEY OF THE CHILD GUIDANCE CLINIC OF THE EDUCATION DEPARTMENT OF NEW SOUTH WALES

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SECTION 1 ORIGIN AND HISTORICAL DEVELOPMENT OF CHILD GUIDANCE CLINICS

(a) IN AMERICA

(b) IN ENGLAND

(c) IN AUSTRALIA
SECTION 1
ORIGIN AND HISTORICAL DEVELOPMENT OF CHILD GUIDANCE CLINICS

In this historical outline a brief summary only will be given of the remarkable growth and development of Child Guidance Clinics in America. An account of this movement has been ably presented in an enlightening and stimulating manner by George S. Stevenson and Geddes Smith in a book entitled "Child Guidance Clinics: A Quarter Century of Development", which is available in Sydney. More attention will be paid to the lesser developments in Child Guidance in England since there is no literature available dealing with the history of the movement there. Particular emphasis will be placed upon the early history of Child Guidance in England, since, in the initial stages, English conditions were more similar to the present situation in Australia than in America.

(a) America

It is true that the term "Child Guidance Clinic" was not coined until 1922, but the essentials of the Clinic scheme were finding their way into practice more than a decade before.

In 1909 Dr. William Healy founded The Chicago Juvenile Psychopathic Institute where concentrated study from medical, psychological and social points of view, upon youthful offenders brought before the Chicago Juvenile Court was undertaken, with the aim of searching out causes of misbehaviour and finding ways of preventing later adult criminality. This was the first Clinic for children in which the psychiatric, psychological and social approaches were combined.
After five years Healy wrote his book entitled, "The Individual Delinquent", which together with the work of the Chicago Institute influenced other communities. The predominant interest of the Institute workers was in delinquency and Court Judges were eager students of its procedure and results.

Judge Harvey Baker after his return from Chicago drew up a statement urging the establishment of a similar Clinic for the Boston Juvenile Court. When he died in 1915 his friends undertook to establish a foundation under his name. By 1917 work was begun at this new Clinic - Healy and his assistant Bronner were called from Chicago to direct it.

Meanwhile Dr. Herman Adler took charge of the Clinic in Chicago which had since 1914 been financed by the Cook County and was now taken over by the State of Illinois. In 1920 it was renamed the Institute of Juvenile Research.

Though the Chicago Clinic recognized the importance of social factors in causation and cure, it had not a regular full-time social worker on its paid staff. But social workers came to be employed by a number of State Mental Hospitals and Clinics in New York and Massachusetts, while in 1912 and 1913 such workers were appointed in two new hospitals - the Boston Psychopathic Hospital and the Henry Phipps Psychiatric Clinic of the John Hopkins Hospital. Dr. Adler going from the Boston Psychopathic Hospital naturally introduced into the Chicago Institute the type of social work with which he was familiar. The Judge Baker Foundation (now the Judge Baker Child Guidance Clinic) also added a social worker to its staff.

The Chicago Institute saw almost exclusively Juvenile Court cases during its early years. The Judge Baker Foundation soon began to serve other agencies as well as the Juvenile Court, while the Boston Psychopathic Hospital and the Phipps Clinic served their communities as a whole without special concentration on juvenile court cases or delinquents.

While thus in the four centres mentioned the foundations of scientific Child Guidance were being laid, related developments were taking place elsewhere in the psychiatric
CHILD WELFARE DEPOT.

Woman’s Complaint.

“DISGUSTING STORIES.”

A charge that a boy of 12 who had been detained at a Child Welfare Departmental depot for a week, had been told disgusting stories by a male attendant, was made yesterday at a meeting of the International Woman’s Society.

Mrs. Nankivell, of Dolphin Street, Randwick, who made the charge, said that she would bring these before industrial officers of the Child Welfare Department, and demand an investigation and a complete overhaul of the methods of handling children in the care of the State.

Mrs. Nankivell was speaking on a suggestion that women inspectors should be appointed to look after the welfare of girl wards of the State, and that the care of boys should be left to men who were able to handle them because of superior knowledge.

“Despite that statement,” said Mrs. Nankivell, “Recently the mother of a boy of 12 who was detained at a departmental depot for a week, told me that when the child returned home he told filthy, disgusting stories at the meal table in front of his sisters and other members of the family.

“TOLD BY ATTENDANT.”

“His mother assured me that the boy, who had been taken to the depot along with five or six other supposed cases of petty theft, had been a rather unphilosophized and innocent lad before his experience, and had been kept apart from other children as much as possible.

“I talked with the boy, and he told me some of the stories. They shocked the coming from such a young child. His parents and I questioned him, and he said that the disgusting stories he had told had been related to him by one of the attendants at the depot,” said Mrs. Nankivell.

Mrs. Nankivell said last night that she was awaiting the return to Sydney of a senior officer of the department, and would then place the facts in her possession before him and demand an investigation.
field. Gradual growth was accelerated by the establishment in 1909 of the National Committee for Mental Hygiene and the necessities of the war period strengthened equipment.

After the war Clinical development was strongly influenced by the demonstrations conducted by the National Committee for Mental Hygiene through the Division on the Prevention of Delinquency which at the end of 1921 adopted a programme designed to cover a five-year period. In 1922 the Division offered, as planned, a demonstration service which would demonstrate Clinical methods and help with the organization of permanent Clinics, provided that there was a certain degree of interest, and permanent local, and, preferably, private support. Several Demonstration Clinics were started mostly in connection with Children's Courts.

The story of the Demonstration Clinics in St. Louis, Norfolk, Dallas, Monmouth, Minnesota, Los Angeles, Cleveland, and Philadelphia, during the five-year period is a fascinating description of an experiment on a large scale, whereby through scientific analysis and comparison the principles were formulated for the most effective practice of Clinical Work in Child Guidance.

In the eight permanent Clinics established as a result of the demonstrations the pattern of Child Guidance took shape. It was found that in the majority of cases the association of Clinics with Juvenile Courts had been a comparative failure, and that social agencies and schools, also more latterly hospitals and university medical schools, were found to be a better medium of approach to the problem. The focus of professional attention shifted from delinquency and the court to the more subtle evidences of maladjustment in home and school. Concrete methods by which the Clinic might be linked more closely with social agencies in the community were revealed. Financial policies were shaped. Details of organization were established. It was found that a staff consisting of a full-time psychiatrist, psychologist, and two or three social workers could handle approximately three hundred cases a year. In order that this
Clinical unit might function as a coordinated team, Case Conferences were evolved. Standards of training of professional personnel were established. Channels through which Clinics might realise educational possibilities were traced.

In 1927 when the Demonstration ended the Commonwealth Fund decided to continue the advisory service which had been established in 1923 to give assistance and advice to new Clinics. Its name was changed from the Division on the Prevention of Delinquency to the Division on Community Clinics. The need for demonstration was over for interest was widespread, and there were well organized Clinics as examples, but there were still many problems and questions to be dealt with in regard to organization and technique.

During the five years Child Guidance had increased four-fold in America. In 1928 the Survey by the National Committee for Mental Hygiene showed 355 Clinics staffed by 529 psychiatrists, 300 psychologists and 344 social workers.

The graph below taken from Stevenson and Smith indicates the growth of Child Guidance Clinic service in America up to 1933. The unit measurement used is the full-time service of a staff consisting of one psychiatrist, one psychologist and two social workers. The curve therefore indicates the volume of service offered more accurately than one based only upon the number of separate Clinics. The data for 1925, 1928 and 1931 are based on nation-wide surveys in these years; those for other years on historical records and on continuous, though necessarily approximate, recording of current developments.
A later statistical analysis of the changes in Child Guidance Clinic Service between 1931 and 1935, by Mary Augusta Clark approximates closely to the amount of reductions in Child Guidance Clinic Service previously estimated by Dr. Stevenson. The aggregate number of Clinical units in 1931 was 77.5; in 1935 was 68.5. Of the 1931 Clinics rating one unit or more in 1935, fifteen maintained their original status; eight were reduced to a point between a half unit and a full unit; two became less than half units and five passed out of the category of Child Guidance Clinics or were discontinued altogether. Four new Clinics appeared in the 1935 listing. As against the loss of 72 Clinics between 1931 and 1935, there were 57 new units created.

It was estimated in July 1937 that the total of the changes that had occurred since 1935 would approximate an addition of ten units and would bring the level of service up to that of 1931. In addition it was thought that in several Clinics the lesser reductions experienced during the depression had been recovered from.

The following graph represents changes estimated by Mary Augusta Clark. The unit of measurement is the same as that used by Dr. Stevenson. The data for 1925, 1928, 1931 and 1935 are based on nation-wide surveys in those years; those for other years on historical records and on continuous recording of current developments.
In a statement dated July 1938 Dr. Stevenson, the Director of the Division on Community Clinics, states that one of the chief difficulties in larger cities at the present time is that Child Guidance Clinic Service has become dispersed in a way that produces a number of weak units. "We have been more inclined to encourage the development of a centralised community service with full time personnel and functional decentralisation of such service to various social and health agencies of the community as needed. ..We have felt that much more important than auspices is the maintenance of standards of personnel."

This emphasis on standards of training and on scientific planning of organization and methods is the key-note of the American ventures. Cooperation, planning and efficiency are manifest throughout. Prior to the establishment of a Clinic due regard is paid to the preparation of a highly qualified and experienced staff and to the preparation of the community which the Clinic is to serve. Quality rather than quantity is stressed. The case load is always limited to permit a high standard of effective work with opportunities for research. Voluntary work is discouraged and it is considered necessary that the staff, preferably full-time, should be adequately remunerated. No students are accepted unless there is a senior on the staff available for training and supervision. All junior and assistant grade workers must be supervised by a senior worker. Despite the fact that financial resources were an essential factor in the successful and comparatively rapid establishment of Child Guidance Clinic Service in America, a scientific approach and the paramount importance of fully-equipped workers has been shown to be of too great a value for any community to neglect when Clinical Work is contemplated.
Child Guidance in England is the direct descendant of the Movement which had its origin in the United States of America, though it owes its actual introduction into England to the energy and enterprise of an Englishwoman (Mrs. St. Loie Strachey). In 1925 she visited the States and saw something of the work of the Child Guidance Clinics in that country. Her interest in the Movement induced her to seek introduction to representatives of the Commonwealth Fund of America, by which many of the Clinics were then being financed.

Before Mrs. Strachey left the country she had already entered into preliminary negotiations with representatives of the Commonwealth Fund. It was agreed that Mrs. Strachey should bring together a group of persons, representing the different types of workers in England, primarily concerned with prevention of delinquency. It was also arranged that if a request were made to the Commonwealth Fund by this group for help in establishing a Demonstration Clinic, the Directors of the Commonwealth Fund would lay the matter before their Committee. In accordance with this arrangement, Mrs. Strachey, on her return, called together certain individuals and representatives of societies for an informal meeting. These included members of

The Central Association for Mental Welfare,
The Howard League for Penal Reform,
The Magistrates' Association,
The National Council for Mental Hygiene.

As a result of this preliminary conference, Miss Scoville, the Executive Assistant of the Commonwealth Fund, was invited to visit England to obtain a first-hand knowledge of the prospects of establishing Child Guidance and with a view to submitting a report to the Commonwealth Fund on her return.

The visit was paid in the Summer of 1926 when the policy of the Commonwealth Fund was defined. It was made clear that the Fund would not consider the establishment of a demonstration Clinic unless it was used as a training centre.
for social workers. The desirability of affiliation with a University was also stressed. It was indicated, too, that the scheme as a whole would not be acceptable to the Commonwealth Fund unless it had the interest of a widely representative group of leaders in the medical, educational and social services.

By October 1928, evidence of this widespread interest was forthcoming as indicated in a letter to the Commonwealth Fund, signed by more than thirty persons, representing a wide field of interests, requesting assistance to be given in the establishment of a Child Guidance Clinic "for training, service and research." In this letter, stress was laid upon the absence of "the psychiatric viewpoint in social work - which, it was felt, the existence of a training centre attached to the demonstration Clinic would do much to remedy. It was also proposed that the Clinic, if established, should not be limited to work with the delinquent child, but should include a service for the dull and backward and neurotic child and provide also for vocational guidance at any rate, as far as vocational maladjustment is likely to be a factor in crime."

The favourable reception of this letter by the Commonwealth Fund led to the presentation of detailed proposals for the promotion of Child Guidance Work in England. These embraced suggestions for general educational propaganda and foreshadowed the scheme, later adopted by the Child Guidance Council, for the loan of psychiatrally-trained workers for Child Guidance Clinics and psychological departments of Hospitals. The Commonwealth Fund also extended invitations to a group of ten persons, representing the different types of social work which the demonstration Clinic would serve, to visit the United States for a period of three months. An offer was also made by the Commonwealth Fund to finance five social workers to undertake a year of training in America in psychiatric social work, in readiness for work with the Clinic when it should open.
These suggestions were warmly adopted by the supporters of the scheme for the establishment of Child Guidance who by this time had formed themselves into "The British Representative Council of the Commonwealth Fund Child Guidance Scheme", consisting of thirty-six members.

During the early months of 1927, the preliminary selections were made of suitable representatives for Observation Visits to the States, and of social workers for a year of training. At the same time, the general outline of future development was slowly being formed. Impetus was given to these various activities by another visit from Miss Scoville, who arrived in March 1927. This gave an opportunity for details of schemes of propaganda to be worked out in preparation for the establishment of the demonstration Clinic. A sub-committee of the Council was appointed for this purpose. Miss Scoville's visit was followed by one from Dr. Barry Smith, the Director of the Commonwealth Fund, who gave his approval of the work in progress.

In readiness for the Clinic's recognition and establishment, negotiations were instituted, at this time, with the University of London, the London County Council, and with numerous social organizations who would later, it was hoped, give the Clinic their active support.

In addition, it was proposed that a psychiatric social worker should be loaned to the psychological department of one or two general hospitals in London, to demonstrate the value of specially experienced social workers in this particular field. This service, which started on a half-time basis in two hospitals, soon proved its value and later led to the appointment of social workers on loan to other hospital Clinics. Since its inception this service has steadily developed and now forms an integral part of the Child Guidance Council's activities. Six social workers are attached to the staff of the Council, whose services can be requisitioned for a loan period of one
year for new Clinics and Hospital Departments.

It is interesting to note the change of opinion in England with regard to the organization of the Clinic, which the early correspondence indicates, e.g., the stress laid upon teaching rather than service, the need for the Clinic to be established - as part of the University Department - and the belief that the function of a Clinic would be the prevention of delinquency rather than the treatment of children presenting every variety of behaviour problem.

By the Autumn of 1927, the Council’s activities had gradually developed in two directions - educational propaganda and the establishment of the demonstration Clinic; and work for the furtherance of both these projects was steadily carried on with the assistance of the now-constituted Child Guidance Council and its Executive Committee.

Up to this time, all expenditure had been borne by the Commonwealth Fund, which had agreed to finance the Council for an unspecified period and to bear the full cost of the Clinic for three years with diminishing assistance for a similar period.

It soon became apparent that the opening of the Clinic would have to be deferred until 1929. Five social workers were already in training in 1927 and plans were being made for a sixth. In addition, another group of six to follow them, as facilities for training in England were not yet available. Meanwhile, the selection of suitable candidates for the posts of Director and Assistant Director of the Clinic, Chief Psychologist and Assistant Psychologist and Chief Social Worker was occupying the minds and energies of the Council and in the Autumn of 1928, those selected were afforded an opportunity of visiting the States for periods varying from three to four months. During this time, efforts were being made to find a suitable home for the Clinic and the difficult decision of locality was made.

Islington was finally selected as a suitable Borough and there the first Child Guidance Clinic (now known as the London Child
Guidance Clinic) organized by the Council, in conjunction with the Commonwealth Fund of America, with a staff consisting of two Psychiatrists, two Psychologists, five Social Workers and Clerical Assistants, was established in July 1929.

The original aim of the Council, which, it will be remembered, gave precedence to training over service, and relegated research to the third place, was somewhat altered in actual practice, service forming at first the most important part of the Clinic's work. This change of emphasis was due partly to demand, but chiefly because the results of service were considered the soundest propaganda.

In spite, however, of this stress on service, fifteen students were given practical experience in Child Guidance work during the first year of the Clinic's life.

Another original plan, the proposed affiliation with the University, did not take place, though the joint training scheme for social workers had been arranged by this time with the social Science Department of the London School of Economics, the Child Guidance Council awarding six scholarships and defraying the whole cost of the training course.

The aim of the Council was "to share in the development of mental hygiene by assisting in the establishment of Child Guidance Clinics and through the diffusion of Knowledge of Child Psychology." (x) It achieved this end by means of publications, lectures, meetings, conference, Inter-Clinic meetings, grants and fellowships, and loan services to new Clinics.

It has been the policy of the Council to demonstrate the value of new methods through direct service on a loan basis for limited periods. This accounts for the presence of a psychologist on the staff of the Council for more than two years concluding in March 1932 and of a group of social workers which is still maintained.

The Council has always advocated the allotment of a certain proportion of Clinic time to teaching. A high standard of professional education and efficiency is demanded. It is considered that "Child Guidance Clinics do not exist only as a clinical service but they form centres for information from which knowledge of Child Guidance is disseminated and in which new workers may obtain instruction." (x)

In the early days the Council encouraged the establishment of Clinics staffed by a medically-directed team of trained workers. As the Clinics grew in number a certain diversity of approach and emphasis manifested itself. Too great a divergence was considered unwise lest it confuse the public. It was considered that only by having a centrally-organized body strongly representative of the Clinics themselves that unity and strength could be given to the movement, while at the same time encouraging individual methods.

In the early stages the Council was assisting in organization and laying down principles, but the function of the Council even as early as 1933 appeared increasingly to be that of maintaining contact among the various Clinics throughout the Country, arranging interchange of information, and discussion, so that the greatest values might be gained from variety of experience, and the standard of work might reach the highest attainable level.

Early reports reveal that during the first years the Council concentrated upon the demonstration of Child Guidance as a new method of studying and treating behaviour problems in children. As the idea of Child Guidance was gradually accepted the Council no longer required to concentrate so much upon publicity and propaganda. Indeed publicity has recently been deliberately curbed to regulate the demand to the supply of trained workers.

Until September 1930, the London Child Guidance Clinic was administered by the Child Guidance Council but after that

(x) Child Guidance Council Report 1933
date, with a view to giving it a professional status, it became an independent body administered by a Committee composed of Medical and Lay Representatives and a Medical Board.

From the outset the London Clinic was designed to serve two functions, the treatment of children and the training of students. In 1933 the Clinic was divided into a Treatment Section and a Training Section, each laying emphasis where it was particularly required. In both sections each case is allotted to a psychiatrist who works in conjunction with a psychologist and two social workers, each group forming a team or unit. "The wisdom of the division of Clinic activity into two sections has been proved by experience as it has increased the efficiency of both aspects of the work."

The Commonwealth Fund of America generously contributed the entire cost of equipment, starting, and maintenance for four years. After March 1933 the Boards of the Clinic agreed to raise half the cost of the Treatment Unit, the Commonwealth Fund agreeing to meet the other half, and in addition the whole cost of the Training Unit for a further period. The Clinic finds the money by means of fees for service, lectures, an annual contribution of £460 by the London County Council, and by the activity of its Appeals Department.

The London Child Guidance Clinic has of course contributed most to the progress of the Child Guidance Movement in England, for besides demonstrating the need for this service, it became the recognized centre for training psychiatrists, psychologists and social workers in clinical work with children. It was really a Central Demonstration Clinic on the American model.

Though it was not possible to proceed to establish, throughout Great Britain, fully-staffed and fully-equipped Clinics as in America, many Clinics gradually grew up in other cities and towns as well as in London itself. In the main these Clinics started as partially-staffed, part-time Clinics, much of the work being done on a voluntary basis. Thus in
some Clinics one finds a medical view-point, in others psychological work finds a prominent place, while in some it is the social aspect of the work that is stressed.

The Clinics which have been established might be classified into three types:

(1) The Voluntary Clinics governed by independent Committees and depending for their support on contributions, donations, and grants;

(2) Hospital Clinics which are attached to out-patient departments;

(3) Clinics organized under Local Education Committees.

In 1935 it was expected that there would be established an increasing number of Clinics under Local Education Committees, for the Board of Education consented in that year to allow the expenditure of the Birmingham Child Guidance Clinic "to rank for grant as part of the provision for school medical service." The principle had been established in the previous year that a Local Education Authority might contribute to voluntary Child Guidance Clinics for "services rendered to children referred by the School Medical Officers."

The 1936 Report of the Child Guidance Council states that experience in many districts shows that the more closely the Clinic is linked with the existing educational and medical services, the more successful is its work.

In 1937 the Council reports that many voluntary Clinics are being taken over by Local Education Committees.

The latest report dated July 1938 from the Secretary of the London Child Guidance Council states that Clinics recognized by the Council now number forty-seven, fourteen of which are wholly financed by public funds and are under the direction of the Local Education Committees, twelve are partially supported by grants from public funds and the remainder are voluntary Clinics. Seventeen Clinics are fully staffed, i.e., have a psychiatrist, psychologist, and psychiatric social worker; eighteen are part staffed, all having a medical
director and either or psychologist or social worker; one has no medical director.

Throughout the history of the movement in England one notices in every Clinic the continual cry for funds and the warning in each annual report that the work is endangered by inadequate financial support. The intense financial struggle cuts out research, and provides little scope for scientific planning and preparation. In so many cases the Clinic starts with less than the essential team and in most cases work is of a voluntary part-time nature. It is only through the generosity of the Commonwealth Fund which made provision for the Council and the Central Clinic for a number of years that there has been possible any organized scientific planning.

(c) Australia

Overseas practice in Child Guidance Clinics had led the more advanced educationalists in Australia to realise the need for the establishment of Child Guidance Clinics, but there is as yet no general public, or even widespread professional understanding of the nature and function of a Child Guidance Clinic.

Though there are vague Clinical projects in the several States it is only in New South Wales that Child Guidance Clinics have been established. There are in Sydney one full-time Clinical Unit within the Education Department; and two part-time partial units, one at the Rachel Forster Hospital and the other at the Royal Alexandra Hospital for Children.
SECTION 11
A CRITICAL SURVEY OF THE CHILD GUIDANCE CLINIC OF THE
EDUCATION DEPARTMENT OF NEW SOUTH WALES

Part A ORGANISATION
Part B STATISTICS
Part C THERAPY
SECTION II

SURVEY OF THE CHILD GUIDANCE CLINIC OF THE DEPARTMENT OF EDUCATION

NEW SOUTH WALES

PART A ORGANIZATION

(1) The Place of the Clinic in the Department of Education

The work and development of the Clinic have been greatly facilitated by its being an integral part of the Education Department. The advantages have been administrative, financial, and professional.

For administrative purposes the Clinic is regarded as a part of the Medical Branch of the Department which has given it a considerable amount of support and prestige.

Financially the organization of the Clinic has been made possible inasmuch as the teaching service has provided the salary of the psychologist, while the Medical Branch has been responsible for the salary of the psychiatrist and for that of the social worker. The clerical work has been undertaken by the staff of the Medical Branch through which also supplies have been obtained from the Stores Branch.

When still more important is the professional effectiveness gained by this attachment to the Department. The Clinical staff is able to work in close contact with school medical officers, school nurses, and the Superintendent of the Special School; there is a useful co-operation with Child Welfare Department Inspectors and Truancy and Probation Officers; there is an effective relationship with school teachers, head masters, inspectors, and administrative officers; and, most important of all, is the vital association with the Research Officer and the School Counsellors. Then too there is occasional assistance from the Statistics Branch, the
Examination Branch, the Library, and the Stores Department. Since all these Departments are housed in the building in which the Clinic has been given a place, immediate and personal contact is possible whenever necessary.

(ii) Clinical Staff

The Clinical team consists of a psychiatrist who is the Director of the Clinic, a psychologist, and one social worker who are full-time officers.

(iii) Student Training

There were repeated requests from the Board of Social Study and Training for the Clinic to receive Social Service Students. The Clinical staff rejected such proposals in view of the fact that there would be no adequate supervision. However, when a social worker was appointed to the Clinic the administrative authorities of the Education Department saw fit to grant permission to the Board to send students. It has since become necessary for the Clinic to stipulate that no student be accepted unless she is a senior student thinking of specialising in Child Guidance Work, and that such a student must be prepared to do practical work for a period of at least six weeks or for two and a half days each week for a period of two University terms.
(iv) Publicity.

No steps were taken to make public the activities of the Clinic. Information was withheld from newspaper reporters.

In some instances requests for addresses on clinical work were acceded to by the psychiatrist and the psychologist but these were very few in number, of an unofficial nature, and usually in connexion with kindred associations whose members were already acquainted with the work of the Clinic.

As it was considered unwise to make public even to all the state schools, the establishment of the Clinic, lest there should be an overflow of cases required, and since at the same time the expenditure of public money upon the Clinic demanded a steady flow of cases, the method of school schedules was adopted. This ensured from the start a steady flow of cases which has since been maintained. These schedules were sent out from time to time to a few selected schools with an accompanying explanatory letter (a copy of which will be found on the next page). The schools then returned the completed schedules from which cases were selected and appointments offered to the parents who were given a date by which, if the appointment was desired, it must be accepted. The number of "schedule cases" varied according to the number of cases referred directly and spontaneously to the Clinic, and "schedule cases" were always given appointments only on certain days, the remainder of the time being reserved for cases referred by agencies outside the Education Department proper. Gradually as teachers, counsellors, doctors, parents and others, became accustomed to using the Clinical service fewer schedules were therefore sent out. After more than a year the schedule-method was almost entirely dropped, the Clinic's existence was gazetted in the official monthly publication of the Education Department, and it then became more and more customary for teachers to refer problem cases as they arose. This has made it possible to reduce considerably the lapse of time between the reporting of a problem to the Clinic and its treatment.
Establishment of Child Guidance Clinic.

Following a practice which has proved very successful in the United Kingdom, America, and many European countries, a Child Guidance Clinic has been established in connection with the School Medical Service of the Education Department.

Experience has shown that special study and treatment of mal-adjusted children by a team consisting of a psychiatrist, psychologist, and social workers serves not only to relieve the child's present difficulties, but has a most valuable influence in preventing delinquency and nervous and mental illnesses in later life.

To quote from Stephenson and Smith - "The Child Guidance Clinic is an attempt to marshal the resources of the community on behalf of children who are in distress because of unsatisfied inner needs, or are seriously at odds with their environment - children whose development is thrown out of balance by difficulties which reveal themselves in unhealthy habits, unacceptable behaviour, or inability to cope with social and scholastic expectations. Its service is rendered through the direct study and treatment of selected children by a team consisting of a psychiatrist, a psychologist and psychiatric social workers, and also through focusing the attention of physicians, teachers, social workers and parents on what is commonly called the mental hygiene approach to problems of child behaviour. The essence of this approach is that behaviour is studied objectively, as nearly as possible without prejudice, in the hope of discovering the causes - usually multiple - which produce it, and that an effort is made to modify it by eradicating or abating the causes rather than by precept or the imposition of authority.

"In adopting the title child guidance, the clinic has, of course, given a restricted meaning to a term of wide applicability: parents and parent substitutes, schools, courts, medical and social agencies of various types have long been engaged in aiding children. Child Guidance Clinics have attempted to provide guidance at those points where the understanding and service which these agencies have mastered to meet a child's need are not sufficient. Such an attempt might be presumptuous except for the fact that the clinics offer not merely one line of attack on these difficult problems, but a synthesis of techniques not often brought together elsewhere, and more effective in combination than they could be singly."

The clinical unit is headed by a physician specially trained for the practice of psychiatry - that is, acquainted with the known range of mental deviations, their origins and therapy, and with the mechanisms of behaviour generally. /Associated with him
Associated with him is a psychologist trained particularly in the technique of measuring, evaluating, and developing specific capacity and achievement, often with special reference to formal education. The team is completed by a psychiatric social worker or social workers trained in the analysis of social situations and the social treatment of emotional and behaviour problems."

The Departmental Child Guidance Clinic is now ready to function, and it is intended to co-operate with teachers in solving problems which have resisted the resources of the school and the home. Head teachers are therefore requested to select suitable children for reference, and their guidance the following categories are mentioned:

1. Those showing nervous symptoms, such as morbid fears, obsessions, habit spasms, sleep disturbances, nervous debility, loss of appetite, speech disorders, etc.

2. Those suffering from personality disorders such as shyness, unsociability, excessive fantasy, stubbornness, disobedience, overactivity, listlessness, supersensitiveness, etc.

3. Those showing behaviour disorders, such as temper-tantrums, fighting, irregular school attendance, truancy, lying, stealing, sex difficulties, etc.

Cases of simple mental backwardness or mental deficiency should not be referred to the Child Guidance Clinic. These are dealt with by the Medical Officers during school medical inspections.

It is therefore requested that you complete the accompanying schedule, and present it to the School Medical Officer during the forthcoming medical inspection of your school. The Medical Officers will review these children and select cases for reference to the Child Guidance Clinic.
<table>
<thead>
<tr>
<th>Character &amp;c.</th>
<th>Remarks on Conduct</th>
<th>Disorder</th>
<th>Nature of Progress</th>
<th>Scholastic Grade</th>
<th>Age</th>
<th>Name</th>
</tr>
</thead>
</table>

**DATE**

**SCHOOL**

**CHILDREN SUITABLE FOR REFERENCE TO CHILD GUIDANCE CLINIC**

**SCHOOL MEDICAL SERVICES**

**DEPARTMENT OF EDUCATION**
(v) Sources of Referral

The Clinic service is primarily intended for children who attend State Schools. These children may be referred to the Clinic by teachers through the Head Master; by school medical officers and nurses; by school inspectors and administrative officers; by school counsellors; by school attendance officers, court probation officers and Child Welfare Department inspectors; by parents on personal application; by doctors, hospital almoners and nurses; and by community agencies (such as the Children's Library and the Children's Playground). The Clinic is also obliged to accept certain children referred by the Children's Court, the Child Welfare Department, the Crippled Children's Society and the Soldiers' Children Education Board.

Many children referred to the Clinic are not accepted for reasons given below under "Selection of Cases". A number of requests for service come from people who are under the impression that the Clinic undertakes purely educational guidance and vocational guidance. Arrangements are made for these applicants to gain the assistance they desire but they are not included in the statistics as having been advised at the Clinic.

The following figures indicate the number of cases accepted for service by the Clinic from the various sources in 1937 and the first six months of 1938:-
<table>
<thead>
<tr>
<th>Source of Referral</th>
<th>1937</th>
<th>1938</th>
<th>1937 &amp; 1938</th>
</tr>
</thead>
<tbody>
<tr>
<td>School (Direct Application)</td>
<td>291</td>
<td>82)</td>
<td>393)</td>
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<tr>
<td>Research Office (Including School Counsellors)</td>
<td>21</td>
<td>24)</td>
<td>45)</td>
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<tr>
<td>School Medical Officers</td>
<td>16 Schools</td>
<td>2 Schools</td>
<td>18 Schools</td>
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<tr>
<td>Internal Miscellaneous</td>
<td>Total</td>
<td>Total</td>
<td>Total</td>
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<tr>
<td>(School Inspectors, Director &amp; Minister of Education, School Attendance Branch, Superintendent of Special School)</td>
<td>408</td>
<td>143</td>
<td>551</td>
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<tr>
<td>Personal Application</td>
<td>30)</td>
<td>5)</td>
<td>17)</td>
</tr>
<tr>
<td>Child Welfare Dept. 180) &quot;Survey &quot;Brush Farm&quot; &amp; &quot;May Villa&quot;</td>
<td>250)</td>
<td>104</td>
<td>354</td>
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<tr>
<td>Children's Court</td>
<td>88</td>
<td>58)</td>
<td>146</td>
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<tr>
<td>Soldiers' Children Education Board</td>
<td>63</td>
<td>32)</td>
<td>95)</td>
</tr>
<tr>
<td>External Miscellaneous (Crippled Children's Society, Private Doctors, Hospitals, Almoners, etc.)</td>
<td>22</td>
<td>6)</td>
<td>28)</td>
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<tr>
<td>TOTAL</td>
<td>831</td>
<td>343</td>
<td>1,174</td>
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</table>

(vi) Selection of Cases

The main principles governing the selection of referred cases have in practice come to be:-

(1) That the child should be in attendance at a state school.

(2) That a child whose guardian is obviously able to pay specialist fees should not be accepted.

(3) That "problem" children in the sense of emotional maladjustment be accepted, a circular being printed for guidance as to the type of problem which is considered suitable for referral.

(4) That no purely educational guidance problems be accepted but be referred to the Research Officer.

(5) That no purely vocational guidance problems be accepted but be referred to the Institute of Vocational Guidance or to the Vocational Guidance Bureau.
(6) That as far as possible mental defectives be not accepted unless shown to be suffering from difficulties susceptible to some adjustment, but be referred to Glenfield Special School, or to other suitable institutions.

(7) That a very few selected "speech" cases be accepted for treatment, the others being referred to the Children's Hospital or to a specialist.

(8) That certain cases referred by the Child Welfare Department, the Children's Court, the Crippled Children's Society and the Soldiers' Children's Education Board be accepted for consultation.

(9) That each case referred by doctors, almoners and other outside agencies be considered on its merits in accordance with the principles outlined above.

The selection of cases (other than those referred by Child Welfare Department, Children's Court, Soldiers' Children's Education Board), is made always by one of the Clinical team, and each case is considered individually, with reference to any special circumstances, with the principles enumerated above, serving as a guide rather than as a rigorous rule.

11) **Clinical Services**

(a) **Study**

The majority of cases accepted by the Clinic are studied from four aspects - physical, social, psychological and psychiatric. There are, however, groups which receive partial study only.

All "school" and "departmental" cases receive physical, psychological and psychiatric study, though it is found that some, for example problems due entirely to mental defect, do not require social study. Only a very few selected cases of those referred by the Court, the Child Welfare Department and the Soldiers' Children's Education Board entail social study by the Clinic, but all receive physical, psychological and psychiatric study.
(b) Types of Service

The extent of service required of the Clinic varies with the type of case and with the agency referring it. For this reason it maintains what might be designated a "Full Treatment Service"; an "Advice or Partial Treatment Service"; a "Consultation or Co-operative Service"; and a "Diagnostic Service". In its early stages it occasionally provided a "Survey Service".

(1) The Full Treatment Service

The full treatment service involves full study and treatment of the case by the Clinic. The extent to which this is offered varies of course with the seriousness of the mal-adjustment together with the community facilities within the scope of the parent's environment.

Most of the full treatment cases are from the schools, though similar service is offered to a very few selected cases from outside agencies such as the Children's Court, the Child Welfare Department and the Soldiers' Children's Education Board.

(2) Advice and Partial Treatment Service

Many cases do not warrant more than one attendance at the Clinic for examination and advice and hence no study is required by the social worker. Children who are problems merely owing to mental defect fall within this group. After physical, psychological and psychiatric study the mother and the school may be given advice; but no further treatment is offered. Similarly with some physical defects; and even with some of the minor emotional problems, it is at times considered that advice to the parent and to the school and a talk with the child during his visit to the Clinic for study will be sufficient to effect adjustment. It may happen too that a case of speech defect, for example, is studied from the physical, psychiatric and psychological points of view and is then advised to seek treatment from some community service outside the Clinic.

The increasing number of cases which, after a single interview, are referred to an agency which would give them more suitable assistance than can be gained from the Clinic, are not included in the statistics of Clinic services.
(3) Consultation or Co-operative Service

Several agencies co-operate with the Clinic staff in the study and treatment of some of the cases they have referred to the Clinic. Many of the Child Welfare Department cases fall into this group, for its inspectors and staff provide the history and the social service aspect of the case. Frequently too, its inspectors and officers are responsible for assisting in carrying out the treatment suggested by the Clinic. A similar arrangement is made when cases are referred by hospital almoners.

The most effective service of this type is that carried out in co-operation with the Research Branch of the Education Department. In these cases the school counsellor, through the Research Officer, submits a report outlining the problem, giving a school record and any available history concerning the case. At the end of each week the counsellor is usually present at a case conference where cases in which he or she is interested are discussed. In addition to this co-operative study of the case there is continued team work in treatment.

(4) Diagnostic Service

With the exception of a very few cases selected for full treatment, and those for whom a co-operative service is arranged, the cases referred by the Children's Court, the Child Welfare Department and the Soldiers' Children's Education Board require diagnosis only. The social history is supplied by the agency concerned, while the Clinic carries out the physical, psychological and psychiatric examinations. The Clinic then supplies the agency with a written report of its findings, together with recommendations as to the future treatment of the case, but the Clinic takes no further responsibility for action on its recommendations. Usually the agency gives a follow-up report on the progress of treatment and if necessary further advice or a re-examination is given.
(5) **Survey Service**

A further type of service, but which has been discontinued, is that of periodic survey work. It was only in the first few months of its existence that the Clinic was able to supply such services. Physical, psychological and psychiatric studies were made of forty-six inmates of "Brush Farm", Home for mentally defective girls, and twenty-four of "May Villa" Home for mentally defective boys.

(viii) **Case Load**

From the above recital of services provided by the Clinic, it will be seen that the total number of cases accepted by the Clinic does not give a true indication of the case load.

(ix) **Clinical Procedures**

The routine procedure adopted at the Clinic is as follows;-

The psychiatrist interviews the parent or guardian who has accompanied the child to the Clinic. He gains from her (usually it is the mother) a statement of the child's difficulty and a full family and case history which supplements the report from the school or agency referring the case. Meanwhile the psychologist interviews the child and administers a Binet intelligence test. The child is then given a physical examination and an interview by the psychiatrist. After a brief consultation between the psychiatrist and the psychologist regarding the advice the parent needs, and as to whether the child requires further treatment, the psychiatrist again interviews the parent. Sometimes it is considered necessary to give a self-administered intelligence test as a check; at other times a non-verbal intelligence test needs to be applied; if an educational difficulty is suspected education tests may be given by the psychologist; or if there is an emotional maladjustment requiring treatment the psychiatrist may begin therapy. If it is considered that further attendance at the Clinic is desirable an appointment is made.
Each morning there is a Case Conference at which the psychiatrist, psychologist and social worker discuss the children who have been examined on the previous day. It is decided what line of treatment shall be adopted and a preliminary report giving diagnosis and treatment is sent to the school. In most cases the social worker is requested to visit the home and the school, and also when necessary, other agencies such as Boy Scouts, Air League and Children's Playground. Even if the child is not expected to attend the Clinic after his first visit the social worker usually tries to visit the school in order to supplement the short written report and to discuss any relevant problems with the teacher. In such cases she may also visit the home in order to assist the mother to effect the changes in home hygiene which have been suggested to her at the Clinic.

Of course, the social worker keeps in touch with cases which attend the Clinic for further treatment. In connexion with these "return cases" there are periodic discussions at Case Conferences after the social worker has gathered more information which throws light on the case, or has become aware of further developments. Similarly the psychiatrist and the psychologist contribute information and reports after the patient has re-visited the Clinic.

Thus by means of these Case Conferences the findings of each member of the team are related and the aspect of treatment, carried out by each individually, is thereby co-ordinated.

In order that the psychiatrist and the psychologist may function effectively without waste of time, the psychiatrist director assumes in the main the responsibility of interviewing parents and of writing reports (which are always signed by the psychologist in addition), while the psychologist attends to records and appointments.
The usual weekly programme for the psychiatrist and the psychologist shapes itself approximately as follows:

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<th>Morning</th>
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<tr>
<td>Monday</td>
<td>Case Conference</td>
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<td>3 new Cases</td>
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<td>Prepare records</td>
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<td>Tuesday</td>
<td>Case Conference</td>
<td>Re-visits of old Cases</td>
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<td>3 new Cases</td>
<td>Reports and Records</td>
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<td>Wednesday</td>
<td>Case Conference</td>
<td>2 new Cases</td>
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<td>3 new Cases</td>
<td>Reports and Records</td>
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<td>Thursday</td>
<td>2-5 Court Cases at</td>
<td>2 new Cases</td>
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<td>Glebe Metropolitan Shelter</td>
<td>Reports</td>
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<td>Friday</td>
<td>Case Conference</td>
<td>Re-visits of old Cases</td>
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<td>Speech Clinic</td>
<td>Case Conference with</td>
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<td>Records and Reports</td>
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(x) Tests

The following is the list of the Psychological Tests used at the Clinic:

**Intelligence Tests**

- Binet = Stanford Revision
- " = Terman and Merrill Form L
- " = Terman and Merrill Form I

**Otis Higher Examination** Form A

**Otis Intermediate Examination** Form B

**Australian Council for Educational Research:**

- Non-Verbal Test of Intelligence
- Seguin Form Board

**Education Tests**

- Australian Council for Educational Research: Reading Tests
  - (i) Word Knowledge
  - (ii) Speed of Reading
  - (iii) Reading for General Significance
  - (iv) Reading to Note Details
  - (v) Reading for Influence

- Australian Council for Educational Research: Individual Reading Test

- Burt: Reading Tests
- Australian Council for Educational Research: Spelling Tests
- Burt: Spelling Tests

- Teachers' College: Arithmetic Tests
Since considered practice has been to use no test which is unstandardised and which is not proven reliable, no tests of temperament, emotion, character, or special aptitudes have been used.

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<tr>
<th>11-6</th>
<th>1V-6</th>
<th>Vlll</th>
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- 27 -
Since considered practice has been to use no test which is unstandardised and which is not proven reliable, no tests of temperament, emotion, character, or special aptitudes have been used.

Since the Terran and Herrill Form L Binet test is the routine test used, an abbreviated score sheet has been worked out for the use of examiners who are well acquainted with, and skilled in the use of, the test. A sample is attached hereto:
MEDICAL EXAMINATION

REferred by......

Surname
(Christian)

Address

Date of Birth
Place of Birth

Height (standing)?
in. : Weight
lbs.

Eye

Visual Acuity— with glasses R.
L.  ; Without R.
L.

Ear

Hearing R.
L.

Dental—Br. Carious P.
T.
: Other Defects

Nose and Throat— Adenoids

: Tonsils R.
L.

Other Defects

Heart

Lungs

Skin

Anemia

Nutrition

Deformity

Gait

Hernia

Genital Urethra

Nervous

Speech

Expression

Stigmata

S.M.S. No. 48.
(Boy)

O.C.G.C. No. 4.

CHILD GUIDANCE CLINIC.

DEPARTMENT OF EDUCATION, N.S.W.

CONFIDENTIAL SCHOOL REPORT in the case of

School.

Class

Position in class.

Enrolment in class.

1. SOCIAL HISTORY AND REACTIONS—Comment on home conditions and neighbourhood; known characteristics; and school records of brothers and sisters:

Whom does he choose for associates?

Does he play with younger, older, or children of his own age?

What are his chief amusements, interests and recreations?

Indicate any definite traits (by underlining), such as—

Fearful

Fear

Teases

Teasing

Obedient

Obeying

Timid

Afraid

Angrily

Easily led

Pugnacious

Fighter

Disobedient

Leader

Passionate

Agitated

Sulky

Shows off

Ill-tempered

Gloomy

Inquisitive

Social

Irritable

Aggressive

Muddlesome

Seclusive

Quarrelsome

Argumentative

Wants all he sees

Over-affectionate

Cruel

Vicious

Hoard

Careless

Destructive

Vandalistic

Eager to learn

Indifferent

Does he lie?

Protectively?

Maliciously?

Imaginatively?

Purposelessly?

[OVER]
Does he steal? What kind of things?
How long since last lapse?
Truants? Or wanders away? How long since last lapse?
What is his own reason for truanting?
Constantly in trouble? What for?
Is he abnormally interested in sexual matters?

**2. SCHOOL HISTORY**
Has he frequently changed school?
What grades has he repeated?
What is his behaviour like in class?
Is he quicker or slower than other children in his class?
Attendance—Days absent Punctuality
Marked aptitudes in school activities

Significant experiences outside school

**3. ANY FURTHER RELEVANT COMMENTS OR REMARKS**

Mental Tests
Chron. age
Test used
Mental age
I.Q.

(Signature of Teacher)
(xi) Record Cards

Three types of record cards are used, samples of which are submitted. The pink card is sent to the school (after the parent's acceptance of the appointment offered by the Clinic) in order that, in addition to the original statement of the problem, the Clinic may have a systematic confidential school report on the child prior to his examination at the Clinic.

The blue card is the type used by the psychiatrist for a boy. The yellow card is that used by the psychologist and the social worker for the girl.

The Clinic favours the view that the pigeon-hole-type of card is inadequate for any other than the physical examination since each case is so individual with varying emphases that formal headings on cards often prove cumbersome and inappropriate. The point stressed is that the headings must be in the mind of the worker himself so that he will carry out a systematic examination and record an adequate and significant presentation of his results.

(xii) Official Reports

A clinical report is sent to the agency referring the case and at times a duplicate is sent to another interested authority. For example, if a child is referred from a school where there is a counsellor, a copy of the report is also sent to the Research Officer.

Included in the report are the results of the physical and mental examinations of the child, together with a brief diagnosis and suggested treatment. This is supplemented by the social worker who visits after the report is sent.
CRITICISM

A criticism of this clinical organization which has been discussed in detail reveals many helpful suggestions which might be considered with advantage when an extension of clinical work is being planned.

Though failures and defects will be stressed in order that they may act as danger signals one must remain aware of the marked success of the work that has been achieved in the face of immense difficulties in a community which is scarcely aware of the concept of child guidance, still less of the principles of clinical work. The distinct advantages of a Clinic organized within the educational system will be discussed later.

(1) Clinical Staff

The main defect of the Clinic is that in the initial stage fully-equipped workers were not secured. The psychologist, though with an adequate academic background, teaching experience, and practice in testing and clinical work as a school counsellor, had had no direct experience in a Child Guidance Clinic. The social worker, although an experienced nurse, was completing the final year of her social-study course at the time of her appointment and had also no previous opportunity of practical work in a Child Guidance Clinic.

This defect seemed inevitable in the pioneer stage since no facilities are available in Australia for the training of the staff of a Child Guidance Clinic, and the Education Department was not at liberty either to "import" expert overseas workers, or to send members of its staff abroad for specialized training.

One might produce arguments for and against the wisdom of establishing a Clinic in the absence of a fully-equipped staff, and though the writer holds the view that in the initial stages of the movement the qualification and experience of the clinical staff are of paramount importance, it may now be argued that the Clinic has by its excellent results justified its establishment. One must admit that its experimental nature
has not been without advantages, for its methods and procedure have been flexible. A keen and studious staff with a background of clinical literature and with the advantage of discussions with overseas workers, has been able through practical experience to devise a system which is applicable to local conditions, so that after two years of increasing practical success it has come to be an established influence in the mental hygiene of the community. Moreover its existence has hastened the development of Child Guidance Clinics by spreading the principles of Child Guidance in the community and by revealing the need for clinical work; by its success it has shown future possibilities for Australian Clinics; and by its failings it is able to sound a note of warning.

(ii) Student Training

It is submitted that the acceptance of students in social work for certain periods of practical experience at the Clinic was a dangerous procedure inasmuch as they had no supervision from their own administrator; moreover the social worker at the Clinic was of their own academic level. Moreover, with a team of only three workers it was impossible to find adequate time to devote to them.

It is a matter for argument whether an Educational Department Clinic should be so organized as to assume teaching work which might well be considered the function of a University, or whether it should concentrate upon dealing with the immediate problems presented by the schools organized within its system. The Clinic has achieved the narrower aim but by its rejection of the wider and more far-sighted policy one feels that the Department missed a tremendous opportunity to make a more lasting and effective contribution to the community, in the nature of a Demonstration Clinic.
(iii) Publicity

The writer believes that the Departmental policy of preventing publicity was, in view of the whole field, a short-sighted one, for where there is a general public demand the need tends to be supplied. Far better to have risked an overflow of cases, and to have had too great a demand for services, thereby showing the urgent need for an extension of the work.

The interest of newspaper reporters should, it is submitted, have been encouraged and abundant but wise information given.

A series of public lectures — lectures to professional groups and lectures to students in training — might well have been given by the clinical staff.

Moreover, the schedule method, by which certain schools were notified of the Clinic’s existence, though it proved of value in maintaining a steady flow of cases in the initial stages, could have been made more effective if there had been some preliminary personal contact between school teachers and the clinical staff. It was originally suggested that the School Medical Officers during their visits to schools should explain the function of the Clinic to the teachers and leave the schedules to be completed; but so often the School Doctor’s own idea of the Clinic was inadequate and the schedule was also frequently confused with the School Medical Officer’s schedule for defective children. There was then a later decision to send schedules to schools which had not had medical inspection for two or more years, as it seemed that such schools were most in need of assistance. This again encouraged a confusion between the mental-defective schedule and the clinical schedule.

It would have been wiser to have had direct contact, either by the clinical staff making a few preliminary visits to schools, or by a few teachers being invited to the Clinic, in order that they might understand the Clinic’s aims and functions, thus enabling them to make a more suitable selection of children to be referred for study and treatment. This defect has gradually eliminated itself, since schools which have sent cases
to the Clinic have come to know, through the medium of the social worker and the school counsellor, with what type of case the Clinic deals.

(iv) "Referral"

An analysis of the referral figures indicates that, despite the fact that the total number of cases accepted is reduced, the agencies external to the schools have maintained an approximately equal number of referrals each year, namely a total of 423 for the whole of 1937 as compared with a total of 200 for the first six months of 1938. The school referrals however decreased in the first half of 1938 by at least one-third of the number referred in 1937, the figures being 408 for 1937 and 143 for January-June 1938. Thus in 1937 there was a 50% referral by schools and by external agencies, the figures being 408 for the former and 423 for the latter; whereas in 1938, 143 (42%) cases were referred by the schools and 200 (58%) were referred by external agencies, giving the latter an increase of 10%.

This tendency for the Clinic to accept more cases from established agencies means a reduction of its direct contact with the schools. This is a natural tendency since, when the clinical staff is too fully occupied with its routine clinical work to allow of time for educational work, it is much easier to accept cases discovered by other agencies than to seek its own cases by a constructive policy of education in the principles of child guidance in the schools. There is a further danger lest this tendency will hinder some of the external agencies from establishing their own Clinics.

Now that the statistics are revealing this tendency, steps can be taken to place greater emphasis upon the more direct contact with the schools which must be the predominant function of a Clinic organized within an educational service. The figures show more than a 50% increase of cases referred by the Research Department. This is indicative of a tendency for a closer and most effective co-operation between what may be termed the Educational Guidance Section and the
Child Guidance Clinic. This is a very pleasing and encouraging development, for it is the beginning of an approach to the ideal condition when each school will be in close contact with a school counsellor (attached to the Research Office) who will by means of systematic surveys and frequent contacts with teachers, select appropriate cases for the more specialized Clinical Child Guidance.

In view of the policy of restricted publicity it is interesting to notice that the number of personal applications have remained stable.

(v) Case Load

A comparison of the 1937 and 1938 figures shows a pleasing reduction in case load. As is not infrequent in the establishment of a Clinic, too many cases were accepted in the initial stages. This was due to various factors, the chief being a temptation to accept too many cases when so many are requiring treatment, and an ignorance of the necessity for a small case load in clinical work on the part of those in administrative control who considered that so few cases do not justify the expenditure of public money. Moreover there was in the Medical Branch (to which the Clinic was attached) a misunderstanding of Binet testing and Clinical psychology.

The case load still tends to be a little too high, though it never exceeds five new cases a day and approximates to an average of 12 to 14 cases a week.

(vi) Clinical Services and Procedures

It has been fortunate that psychological, physical and psychiatric examinations are regarded as a routine service. There is a danger though, that when co-operative agencies can gain this full examination of their cases, they will tend to send so many cases for diagnosis that the Clinic staff will have less time for the more intensive type of work which must always remain the most vital and constructive aspect of any clinical service.
There has been a distinct advantage in the experimental nature of the Clinic in that the workers have been free to develop their own procedures. (x)

(vii) **Case Conferences**

The regular Case Conferences have proved a valuable means of relating the work of each member of the Clinical team. The joint weekly Conferences have also proved effective in combining the work of the school counsellor and the clinical unit. The Case Conferences might even have been further developed to include, on occasions, representatives from interested agencies.

(viii) **Records**

Record cards have proved satisfactory from the point of view of the immediate needs of the Clinical workers in their everyday routine but they are inadequate for statistical and research purposes. It is an extremely difficult and tedious task even for one acquainted with them to extract information for statistics and for follow-up data. As a means of estimating the effectiveness of therapy this is surely a defect. Then, too, the record cards should set out clearly enough to be of value to research workers who wish to gain data for work in the field of Child Guidance.

(ix) **Research**

The Clinic failed to devote any of its time to specific research. Moreover the only official statistics compiled were the number of cases referred by each agency.

It is submitted that statistical analysis, follow-up, and research problems should be a vital element in any clinical work.

(x) This is perhaps of more value than is at present realized. Miss Doris K. Potter in her Report on Year's Work (1935-36) as a Carnegie Fellow in Education, University of London states - "Child Guidance Work in England owes much to America....... It is inevitable that the methods should be largely based on American procedure....... danger of England not developing procedure suitably adapted to local conditions."
(x) **Inter-Clinic Co-operation**

Though a friendly and useful co-operation has been maintained with the Rachel Foster Clinic and with the Children's Hospital Clinic, no regular association has been maintained. Hence there has been no attempt to carry out combined research, and to provide for a uniform system of records, follow-up work and statistical data.
REVEALED NEEDS

Following upon this critical study, several needs which the clinical system as at present established, has as yet failed to supply, might be tabulated.

Personnel of Staff

There is an urgent need in the initial stage of clinical work in Australia to have highly qualified workers in each of the three aspects of the work - psychiatric, psychological, and social. In no field of work is insufficient knowledge more dangerous - not even in medicine, for there, physical symptoms soon reveal lack of skill; but in dealing with psychological maladjustments there can be little immediate check upon the damage done by unskilled treatment. It is so easy to be content with inefficiency when there is no standard of efficiency. At present there are no facilities in Australia for training in psychiatric, psychological or social work in a Child Guidance Clinic. If, therefore, the work is to develop effectively it must be realized that the initial workers in the field must either come from overseas or else must have had adequate overseas experience. This point is emphasised very strongly for the writer is convinced that with a carefully-selected and well-trained staff, the Child Guidance Clinic cannot do other than become a vital and recognized service in the community.

Student Training

Moreover, the initial personnel is of especial importance in that it is upon them that the responsibility for training their successors falls. Though a wider view of work done in other parts of the world must always be of value, it must be realized that Australian Clinical work must attain a certain independence and work out and establish a training system which will best fit in with the existing facilities in the community.
Publicity and Parent Education

If the Australian public is to support Child Guidance it must be led to know its meaning and value.

Moreover, it is the duty of the Clinic, as the most highly specialized form of Child Guidance, to take a leading part in propagating through the community the general and specific principles which may assist parents in bringing up children in such a way that they will be comparatively free from maladjustment.

Thus there is a need for lectures by experts to parents and teachers; for ably-led discussion groups; for the publication of informative pamphlets and special literature; and for wise newspaper publicity.

Need for Definition and Recognition of Principles Involving Selection, Case Load, etc.

Until the community has come to know the meaning while it of Child Guidance and is in the main ignorant of the aims of the Child Guidance Clinic, it is necessary to ensure that the Clinic does not tend to enlarge its scope to the point of reducing its effectiveness, or to attempt to supply the demand for its services to a greater extent than its staff warrants, thereby decreasing its efficiency.

Though keen to have independence, we cannot afford to ignore the experience of hundreds of Clinics in other countries. While we have yet to educate, even the professional classes, in the principles of child guidance, those specializing in this field of work must take care that the fundamental principles of highly specialized team work on a small number of cases of a special type, be adhered to.

This points to the need for a Clinic Committee to deal with general principles. It is advocated too that there should be an association of psychologists, one of the aims of which would be to safeguard the principles of clinical psychology.
Research

The urgency of immediate demands must not blind one to the fact that in the long run research is an essential aspect of Child Guidance work. The American Clinics have assisted England and Australia by their attention to research and statistical data, and the English Clinics are regretting their failure to emphasise this aspect in the earlier stages of their work. They are finding, now, that they require statistics and information which it is very difficult to secure after the lapse of several years. Australia is even now failing in that direction - hence there is a need for some scheme which will ensure that clinical statistics will be kept, up to date in a standardized form, that research into administrative and therapeutic problems shall be encouraged, and that there will be a systematic follow-up to test the adequacy of treatment.

Records

Opinions vary greatly as to the value of respective record cards, but there is a need for a certain standardization. There is a need for the compilation of a record card which will adequately serve practical everyday clinical services without waste of time, and yet will also be of value for statistics and research.

Inter-Clinic Co-Operation

Though each clinic must be free to develop along its own lines, and each clinical worker must have professional freedom, there is an outstanding necessity for systematic co-operation among the several clinics.

There is a demand for an association of professional workers (not just a State Child Guidance Council) which will lead to a combined attack upon the problems of their own work and the Child Guidance problems of the community.
PRACTICAL SUGGESTIONS

Any type of Child Guidance Clinic, provided that it is adequately staffed, might be organized so as to supply the needs enumerated above, but they would best be met by the establishment of a Central Demonstration Clinic more specifically built and designed to train students and to organize clinical activities, thus unifying the whole field of work.

The various types of Clinics which have already sprung up are a healthy sign and each should be allowed to develop spontaneously for each is serving a specific need in the community.

The Hospital Clinic and the Educational Clinic each has its advantages and disadvantages. The Educational Clinic, where it is attached to an educational system, has the disadvantage of being not entirely free in its administration, but it has the tremendous advantages, as already indicated, of effecting adjustment in children through co-operation with the schools and other departmental branches. The Hospital Clinic while suffering from the drawbacks of less assistance from educational authorities derives great benefit from the assistance it receives from hospitals and almoners. It would seem, however, that the hospital tends to get rather special types of children - particularly those with physical defects and low intelligence. It has also the disadvantage of the hospital atmosphere. There is, too, the very real danger that the social work of the Clinic may be regarded as a part of the general social work of the Hospital.

Though it is submitted that the educational rather than the hospital Clinic merits extension, it is considered that the deficiencies in the present system might be met most adequately by the establishment of a Central Demonstration Clinic.

Since the emphasis in such a Clinic should be upon the teaching and training of professional groups, it could make its most effective contribution if attached to the University.
It would be ideal for this Clinic to be part of a University Demonstration Centre in Social Services and Child Guidance. At present, doctors and teachers are not fully conversant with the principles of child guidance, psychological and social work; students in social work are unable to gain adequate training and supervision in the agencies where they do their practical work; there is no supervision or practical facilities for psychological clinical work for students in psychology at the University, with the result that much of the psychological testing required in their course is "faked". No training is available for school counsellors, for welfare workers in various community agencies, and for the staffs of institutions. As has already been pointed out there are also no facilities for the training of the team of workers necessary for a Child Guidance Clinic, including speech therapy and remedial work. Thus it seems that of the existing organizations in the community the University is best suited to meet the needs of the present situation.
CHILD GUIDANCE CLINIC

Suggestions for a Central Demonstration Child Guidance Clinic

1. That the Clinic be attached to the University and that if possible it be part of a University Social Service Centre including at least a Child Guidance Clinic; a Community Playground; a Community Library; and an Open-Air Theatre.

2. Location: That the Clinic be situated in or adjoining the University.

3. Staff: That in the initial stage the Clinic should be staffed with overseas workers or with Australian workers who have had recognized training abroad.

    That a small team of highly-skilled and adequately-remunerated workers be preferred to a larger staff at a lower salary rate. That the initial staff should consist of:

    Director
    Psychiatrist (man)
    Psychologist (woman)

    2 Psychiatric Social Workers (women)
    Part-time Speech Therapist (until there is possibility of a separate Speech Class)
    Remedial Teacher of Psychologist (until there is possibility of special Remedial and Reading Clinic)

    2 School Counsellors (a man and a woman for the Great Public Schools)

    Clerical Staff

4. Student Teaching: That the fundamental aim of the Clinic should be the spreading of the principles of Child Guidance throughout the community, by training and teaching and by demonstrating to professional students, rather than by an extensive clinical connexion.

    This would entail an adequate training scheme for students of various types. Short courses of a practical and theoretical nature should be provided for doctors, teachers and social workers; while intensive courses in Child Guidance should be prepared for those who intend to follow as a profession Child Guidance in its specialized clinical aspect.
5. **Publicity and Parent Education:**

The Demonstration Clinic should undertake to organize series of lectures to both lay and professional groups.

It should also be responsible for publications and pamphlets which might inform the public of the movement for which it stands.

6. **Clinical Information:**

It should also undertake to keep abreast of worldwide clinical experiments and developments and disseminate current information concerning organization and therapy to the several Clinics, thereby increasing the efficiency and saving the time of the clinical workers.

7. **Research Co-ordination:**

Such a Central Clinic should co-ordinate the research work of all the Clinics within the community. This would necessitate the compilation of a standardized record cord, system of statistics and follow-up data. In this way co-operative research would be encouraged and therapy would inevitably become more effective.

8. **Referral:**

A Clinic of this nature should obtain its cases from varying sources and from various social levels in the community in order that students may have a wide experience. For this reason one would suggest that arrangements should be made for a certain number of cases to be referred by the Children's Court, by community agencies such as the Children's Playground, by certain institutions, and perhaps by some near-by public schools.

Since, however, there is a special need in the community for a development of services for what might be termed the Middle Class, the Demonstration Clinic might well show how this need could be met. This could be done most effectively by having on the co-operative staff of the Clinic school counsellors who might work in the non-state schools and select cases worthy of investigation at the Clinic.
9. **Finance**

In view of the fact that a large sum of money is to be spent on improving the parks surrounding the University, the municipal authorities might make some contribution towards a social service project. In this way the cost and upkeep of the grounds for the Clinic might conceivably be met.

There is the possibility that the University might make itself responsible for the salaries of the clinical workers who are engaged in teaching work.

Since Child Guidance Clinics save the State a large expense by preventing delinquency and insanity, it is just that an annual governmental grant might be made. Various community agencies referring would, so it has been stated, be willing to pay fees.

There should be a scale of fees for cases attending the Clinic.

Fees should be required from students attending courses.

There should be requests for private and public subscriptions.

The plan on the next page outlines possible developments in the clinical field:
Red ink indicates present facilities.
A refers to one clinical unit and each side of the A refers to one member of the clinical team.

FUTURE

TRAINING OF CLINICAL WORKERS.

DIRECT COMMUNITY SERVICE.

EDUCATIONAL Child Guidance Clinics.

DEPARTMENT OF EDUCATION.

Research Branch.

Medical Branch.

Research Officer
School Counsellors.

Educational Guidance Clinic.

CENTRAL

Child Guidance Clinic
Social Worker

TRAVELLING

Child Guidance Clinic

GREAT PUBLIC
Schools Child
Guidance Clinic.

NURSERY
Schools Child
Guidance Clinic.

Convent
Schools.

Roman
Catholic Child
Guidance Clinic.
PART B

STATISTICS

In the following statistical presentation there will be found distributions which are descriptive of the total number of cases examined at the Clinic from January 1st. 1937 to June 30th. 1938.

The following groups have been selected for purposes of comparison:-

(1) "Personal Application": This heading includes those cases which are referred to the Clinic by parents or relatives.

(2) "Child Welfare Department": Here are cases referred by the Child Welfare Department, excluding those who are referred for examination prior to employment or boarding out.

(3) "Children's Court": Since the small number of boys referred by the Medical Officer at the Children's Court are of a very special nature, the girls only are presented in the comparative statistics.

(4) "School Direct": These cases are referred directly by the schools, that is, by the class teacher or head master.

(5) Schools Totals: This title includes "Personal Application", Direct School Application, as well as cases referred by the Research Branch and the School Counsellors; by School Medical Officers and Nurses; by the School Attendance Branch; by School Inspectors; the Director; the Minister and other Departmental Officers.
INTELLIGENCE QUOTIENT

Though the Intelligence Quotient distributions are self-explanatory, there are certain definite tendencies which deserve special comment.

It is significant that of the 1,047 cases tested at the Clinic, Intelligence Quotients between 80 and 90 occur most frequently. These "dull" children appear so close to the normal group that few allowances are made for them, whereas in reality their capacity does not enable them to keep pace in the ordinary class at school.

There is a marked coincidence between delinquent behaviour and subnormal intelligence. In the "school" cases where there is only 12% of delinquency the Intelligence Quotient distribution tends to approach the normal curve, there being 47% below Intelligence Quotient 90 and 53% above, 16% of the latter being above Intelligence Quotient 110; while in the Children's Court and Child Welfare Department cases, where 83% of the children are delinquent, 73% are below Intelligence Quotient 90 and only 27% above, 3% only of the latter being above 110 Intelligence Quotient.

The markedly higher level of intelligence of the "personal application" group is interesting since one might expect the more intelligent parent to seek advice of his own accord.
I.Q. DISTRIBUTIONS CHILD GUIDANCE

TOTAL CLINIC CASES.

N. = 1047
Boys: 544
Girls: 503

N. = 530
Boys: 331
Girls: 199

Schools (Total including School direct,
Research Branch, Personal, Internal Miscellaneous)
Personal Application.

Child Welfare Department.

Children's Court.
Schools Total (including Direct school appeal, personal appeal, Research Branch, Internal Miscellaneous)
Child Welfare Department

Children's Court
School Cases (Direct application).

Personal Application.
10. Percentages in Various Groups

- Children's
- School
- Military
- Prisoners
- Total

N = 550

N = 1,041

N = 71

N = 261

N = 89

N = 115
Intelligence and Delinquency.

School Cases
12% Delinquent
Non-delinquent

IQ

Children's Court
and Child Welfare
Cases
85% Delinquent
Non-delinquent

IQ
### I.Q. Distributions

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**Total:**
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- 206
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- 138
- 146
- 284
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- 146
- 313
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### Breakdown by Age

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**Total:**
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### Breakdown by IQ

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**Total:**
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### Breakdown by Gender

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**Total:**
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CHRONOLOGICAL AGE

A cumulative frequency distribution of the Chronological Ages of 1,101 cases examined at the Clinic indicates that the greatest frequency occurs at year 13. This is significant in view of the fact that at that age the majority of children are either transferring to a secondary school or are repeating the last year of the primary school course — both of which situations involve special adjustments.

Non-cumulative distributions of the 586 boys and 515 girls which make up the total number of Clinic cases reveal marked sex differences. These "total case" distributions are not directly comparable in the upper range since they include girls, but not boys, referred by the Children's Court, but the lower range implies that maladjustments appear to occur at an earlier age in boys than in girls.

The "school" cases thus show a marked rise in the frequency of boys cases at 8 years whereas the rise in the curve for the girls comes later towards 10 years. It may be that boys have an earlier freedom than girls and that they tend to show their maladjustments in a more overt and rebellious manner — and of course more boys show delinquent behaviour and truancy — while the girls are perhaps more protected until a later age and show more neurotic symptoms which are not detected and observed until they have become accentuated later.

The "Child Welfare Department girls" distribution, as does the "Children's Court girls" distribution, shows the greatest frequency at 15 years and high frequencies immediately above and below this period. This is indicative of emotional difficulties connected with developmental instability. It is obvious that there is inadequate care, understanding and recreation for girls about 15 years of age.
CHILD GUIDANCE CLINIC

JAN 1st 1931 to JUNE 30th 1938.

Chronological Age.
Schools Total.
Cumulative Distribution
Chronological age: Boys + Girls

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Girls 515
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| Jan 1st - Dec 31 N = | 192,109 | 291 | 10 | 11 | 21 | 412 | 16 | 10 | 2 | 12 | 46 | 22 | 68 | 252 | 106 | 408 | 90 | 50 | 180 | 19 | 69 | 88 | 109 | 159 | 283 | 41 | 22 | 63 | 15 | 7 | 22 | 441 | 344 | 76 | 1 |

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<p>| Jan 1st - Dec 31 N = | 192,109 | 291 | 10 | 11 | 21 | 412 | 16 | 10 | 2 | 12 | 46 | 22 | 68 | 252 | 106 | 408 | 90 | 50 | 180 | 19 | 69 | 88 | 109 | 159 | 283 | 41 | 22 | 63 | 15 | 7 | 22 | 441 | 344 | 76 | 1 |</p>
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| Jan 1st 1937 to June 30th 1938 | 67 | 30 | 97 | 206 | 540 | 146 | 284 | 154 | 372 | 1101
MENTAL AGE

The non-cumulative graphs of mental age show a less marked sex difference but there is still a tendency towards a greater frequency of boys at an earlier age.

It is very significant that both boys and girls, as seen in the "schools" distributions, show the greatest frequency at 8 or 9 mental years. This being very marked in the case of boys. This is the stage at which the child is attempting to adjust himself to the new discipline and atmosphere of the primary school after his transfer from the infants school.

Though the Children's Court group appeared by their chronological age to have reached maturity, the Mental Age distribution shows that few are more advanced in mental level than the child in the primary school.
MENTAL AGE DISTRIBUTIONS

TOTAL CLINIC CASES.
TOTAL CLINIC CASES.

Mental Age:

- Boys: 113 cases
- Girls: 134 cases

Child Welfare Department:

- N = 241 cases

Mental Age:

- Boys: 113 cases
- Girls: 134 cases

Children's Court:

- N = 108 cases
- Girls: 108 cases
## Mental Age Distributions

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### Statistics

- **Total**
  - B: 536
  - G: 478
  - GRAND TOTAL: 1014

- **Year**
  - Jan 1937: 329
  - Dec 1938: 88
Any classification and description of types of behaviour problems must be somewhat arbitrary and superficial. The various types of reaction are not found in an isolated condition but are naturally mixed. For example, the shy withdrawn child usually shows some timidity and may to a certain extent display the characteristics of the over-conscientious child; the over-aggressive child may show the characteristics of the obstinate child; the stammerer may suffer also from enuresis, and so on. For statistical purposes there has been an attempt to select the major difficulty. Thus since the secondary problems are not recorded the statistical tables do not give an accurate indication of the frequency of the various maladjustments.

The following list gives some indication of the types of problems referred to the Clinic:

- Stealing
- Absconding
- Alcoholism
- Damage to Persons & Property
- Lying
- Disobedience
- Temper Tantrums
- Quarrelsome
- Supersensitive
- Shyness
- Over-activity
- Excessive Phantasy
- Inattentive
- Chorea
- Invalidism
- Anxiety States
- Sleep Walking
- Night Terrors
- Unclean Bodily Habits
- Thumb Sucking
- Masturbation
- Stammering
- Cleft Palate
- Poor School Progress
- Backward
- Feebleminded
- Special Disabilities
- Epileptic Fits
- Poor Manual Control
- Left Handedness
- Poor Home Hygiene
- Sexual Misconduct
- Truancy
- Late Hours
- Uncontrollability
- Obscene Language
- Stubbornness
- Fighting
- Unsociable
- Lacking in Confidence
- Restlessness
- Lacking in Concentration
- Day Dreaming
- Habit Spasm
- Morbid Fears
- Refusal to Eat
- Sleep Disturbances
- Nightmares
- Faulty Feeding Habits
- Untidiness
- Nail Biting
- Enuresis
- Lisp
- Ideoglossia
- Psychological Test
- Slow
- Lethargy
- Poor Attendance
- Painting Turns
- Malnutrition
- Defective Hearing
- Defective Vision
FAMILY HISTORY

With reference to family history each case has been regarded as falling within one of four groups.

**Group A** refers to the "broken home" situation where one finds such factors as the mother and father dead or separated; the presence of a step-mother or step-father, foster-parents or guardians.

**Group B** includes definitely vicious factors such as immorality and alcoholism, but also such influences as invalided parents and unemployment.

**Group C** indicates that there is either a family history of the problem for which the child has been referred; or that the father is a returned soldier (without an invalid pension); or that the mother or father are definitely reported as suffering from "nerves".

**Group D** shows cases which are, as far as it known, free from the above factors. It is not implied that the family situation here is satisfactory for cases in this group reveal a defective home hygiene.

This classification too, must inevitably be an arbitrary and artificial one. Moreover each case, though listed under the apparently predominant one of these various environmental factors, is in reality very frequently under the influence of a combination of such factors. The following examples, typical of hundreds of cases, are significant:

Father dead, Mother immoral character and in hospital, step-father dead from drinking;
Father and step-mother alcoholic, Mother dead;
Father and Mother living apart; Father alcoholic; Mother works;
Father dead, Mother deserted, Patient with Guardian;
Mother and Father unknown, Patient illegitimate, adopted and travelling with Circus;
Father deserted, Patient with Mother who has four illegitimate children;
Father dead, Step-mother alcoholic and immoral with two illegitimate children;
Father dead - alcoholic and gambler, Mother works.
An attempt has been made to put into statistical form the relationship between type of family history and type of maladjustment.

It will be seen that the statistics reveal a marked relationship between the "broken" and "vicious" home, and the delinquent child. It cannot, of course, be said that where there is a broken home, delinquent conduct will inevitably result but the statistics show that, almost without exception, in the cases examined the delinquent child is associated with a broken or definitely vicious home situation. It is significant that of the delinquents referred for examination by the Children's Court, 64% come from "broken" homes and 30% from "vicious" homes, giving a total of 94% as opposed to 6% from homes where there are apparently none of these definitely disruptive situations.

Of the delinquents referred by the Child Welfare Department, 83% come from "broken" homes and 17% from "vicious" homes.

Of the delinquents referred by the schools, 58% come from "broken" homes and 35% from "vicious" homes, giving a total of 93%, as opposed to 7% from homes where these defects are apparently not present.
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29 = 13.7% Delinquent
170 = 86.3% Non-Delinquent
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Total: 179 girls, 87% Non-delinquent.
# School Cases: Boys

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39 = 11% Delinquent. 89% non-delinquent.
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| Total | 23 | 51 | 9 | 23 | 4 | 3 | 2 | 115 |

100 % Delinquent
## Child Welfare Department

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<td></td>
</tr>
<tr>
<td>Father returned soldier</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family History apparent for free from above defects</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Family History unknown</td>
<td>2</td>
<td></td>
<td>5</td>
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</tr>
<tr>
<td>TOTAL</td>
<td>88</td>
<td>6 11 8 10 15</td>
<td>60</td>
<td>10 29 25 9 5</td>
</tr>
</tbody>
</table>

- Delinquent: 68% (14% of total) 32% (16% of total)
- Non-Delinquent: 32% (16% of total) 68% (14% of total)

- Delinquent: 52% (10% of total) 48% (9% of total)
- Non-Delinquent: 48% (9% of total) 52% (10% of total)
<table>
<thead>
<tr>
<th>Type of Family History</th>
<th>Delinquent</th>
<th>Non-Delinquent</th>
<th>Total</th>
<th>Delinquent</th>
<th>Non-Delinquent</th>
<th>Child Welfare Department</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A.</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mother dead or unknown</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>10</td>
<td>12</td>
<td>19</td>
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<tr>
<td>Father</td>
<td>6</td>
<td>23</td>
<td>29</td>
<td>11</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Mother + Father</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>8</td>
<td>10</td>
<td>19</td>
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<tr>
<td>Separated or Divorced</td>
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<td>15</td>
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<td>19</td>
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<td>Step Mother</td>
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<td>11</td>
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<td>Step Father</td>
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<td>F. works away from home</td>
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<td>4</td>
<td>8</td>
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<td>2</td>
</tr>
<tr>
<td>Patient away from home</td>
<td>1</td>
<td>1</td>
<td>2</td>
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<tr>
<td><strong>B.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother Immoral character</td>
<td>1</td>
<td>1</td>
<td>2</td>
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<td>2</td>
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<tr>
<td>Father Immoral character</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Father alcoholic</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
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<td>Mother + Father</td>
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<td>5</td>
<td>7</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Mother Invald</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>3</td>
<td>6</td>
<td>9</td>
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<tr>
<td>Father Invald</td>
<td>10</td>
<td>48</td>
<td>58</td>
<td>5</td>
<td>17</td>
<td>22</td>
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<tr>
<td>Mother + Father</td>
<td>1</td>
<td>5</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Unwanted child</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Mother deaf</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Parental differences, acknowledged</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>4</td>
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<tr>
<td>Mother works</td>
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<td>11</td>
<td>13</td>
<td>6</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>Father unemployed</td>
<td>3</td>
<td>24</td>
<td>27</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Father Relief Work</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>C.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father Returned Soldier (no promo)</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Mother &quot;nerves&quot;</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
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<td>2</td>
</tr>
<tr>
<td>Father &quot;nerves&quot;</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Mother + Father &quot;nerves&quot;</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Family history of problem referred</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>D.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family history of problem referred</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Family history unrecorded</td>
<td>66</td>
<td>12%</td>
<td>78%</td>
<td>555</td>
<td>115</td>
<td>100%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>66</td>
<td>12%</td>
<td>555</td>
<td>115</td>
<td>100%</td>
<td>78%</td>
</tr>
</tbody>
</table>
PROBLEMS IN ILLEGITIMATE CHILDREN

The number of illegitimate children figuring in the statistics is too small for any generalization. It is interesting, however, to notice that where illegitimate children are "only" children - which is frequently the case since they tend to be placed with an elderly relative or a guardian with a grown-up or no family - they show behaviour difficulties of the neurotic type. Where they are amongst other children, their behaviour is of a delinquent type. It seems that in some subtle way the child notices a difference in the treatment afforded him even by adults who consciously try to make no discrimination. Or again a child may be taunted by other children by being told that she is a State girl; or when aggravated another member of the family may tease the child about his lack of family relationships.
<table>
<thead>
<tr>
<th>Type of Problem</th>
<th>Illegal</th>
<th>Girls</th>
<th>Boys</th>
<th>Total</th>
<th>Adoptive</th>
<th>Girls</th>
<th>Boys</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lying, Stealing, Absconding</td>
<td>5</td>
<td>6</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Disobedience, stubbornness, Tempe.</td>
<td>2</td>
<td>'Only' child</td>
<td>2</td>
<td>'Only' child</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restlessness, over-activity.</td>
<td>1</td>
<td>'Only' child</td>
<td>2</td>
<td>'Only' child</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shy, unsociable, supersensitive.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Habit spasm.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stammering</td>
<td></td>
<td>'Only'</td>
<td>1</td>
<td>'Only'</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor progress, backward, slow.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Delinquent</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Non-delinquent</td>
<td>4</td>
<td>6</td>
<td>4</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>2</td>
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<tr>
<td>Total</td>
<td>9</td>
<td>12</td>
<td>6</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Percentage Delinquent</td>
<td>56%</td>
<td>50%</td>
<td>53%</td>
<td>33%</td>
<td>0%</td>
<td>16.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage Non-delinquent</td>
<td>44%</td>
<td>50%</td>
<td>47%</td>
<td>67%</td>
<td>100%</td>
<td>83.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage Delinquent excluding 'Only' children</td>
<td>100%</td>
<td>50%</td>
<td>47%</td>
<td>67%</td>
<td>100%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PROBLEMS IN ONLY CHILDREN

The Statistics reveal a marked tendency for "only" children to show maladjustment of the neurotic rather than the delinquent type. Of 69 "only" children, 6% show delinquent behaviour and 94% neurotic behaviour.

This result supports other investigations. Ward compared 100 "only" children in a Child Guidance Clinic and found less lying, stealing and truancy in "only" children and more difficulties of a "neurotic" nature as compared with his control group of Clinic cases from three-children families. Goodenough and Leahy compared 41 "only" children at Minneapolis Child Guidance Clinic with other Clinic cases for a certain period, finding more neurotic tendencies for "only" children.
<table>
<thead>
<tr>
<th>Problem</th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lying, Stealing, Absconding, Truancy</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Temper, disobedience, stubbornness</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Shy, unsociable, supersensitive</td>
<td>8</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>Habit spasms</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Morbid Fears</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Restlessness, over-activity</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Stammering</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Sexual perversion</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>having jobs</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Right hand writing</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Educational Guidance</td>
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<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Poor progress, backward, slow</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Fits, Tumors etc. suspected</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Number</strong></td>
<td><strong>31</strong></td>
<td><strong>34</strong></td>
<td><strong>65</strong></td>
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<tr>
<td><strong>Delinquent</strong></td>
<td><strong>0</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
</tr>
<tr>
<td><strong>Non-delinquent</strong></td>
<td><strong>31</strong></td>
<td><strong>30</strong></td>
<td><strong>61</strong></td>
</tr>
<tr>
<td><strong>Total Number</strong></td>
<td><strong>31</strong></td>
<td><strong>34</strong></td>
<td><strong>65</strong></td>
</tr>
</tbody>
</table>

| Percentage Delinquent                        | 0%   | 10%   | 6%    |
| Percentage Non-delinquent                    | 100% | 90%   | 94%   |
NUMBER AND PLACE IN FAMILY

It must be remembered that a statistical representation of the place of the patient in the family is to some extent misleading since for example, a child may be an "artificial" only child: Take for instance a child aged 7 years 8 months, the third in a family of 3, the others aged 27 and 21.

The figures show, however, a definite tendency for the first child in the family to be the mode, and be the most frequent size of family. The significance of this will be discussed later.
NUMBER in FAMILY.

School Cases. Unit: N = 540
Personal Application. Unit: N = 96
PLACE in FAMILY

School Cases. Unit: N = 541
Personal Applic. Unit: N = 95
PART C  THERAPY
PART C     THERAPY

Though each Child's problems are in a very real sense unique and demand an individual therapy, and though each child usually suffers from a combination of symptoms, there will be an attempt in the following section to show the nature and results of the therapy directed towards some of the more common forms of maladjustment.
DELIQUENCY

Though a large number of delinquents are examined by the Clinic comparatively few are presented for treatment. The majority of the cases referred by the Children's Court are, it is considered, not amenable to adjustment without institutional treatment. Since the aim of the Child Guidance Clinic is prevention it is politic to concentrate on the cases which are commencing a life of delinquency rather than to spend excessive time on hardened cases in which little adjustment can be made. "A girl in late adolescence whose sexual irregularities have already crystallised into a definite pattern of life needs care of a sort which the Clinic can hardly give without limiting its service to many more promising cases which clamor for attention."

Take in illustration such typical court cases as the following:

Girl aged 15 years 8 months with a mental age of 10 years 7 months and an I.Q. of 68 whose first intercourse was at the age of 10 years (when she would have had a mental age of less than 7 years), usually only three times per week until the last 12 months when it became more frequent. "On Saturday night last she went with a number of men to the stables at the rear of the V____ Hotel where 18 men had intercourse with her." Her vocational ambition was to be a barmaid which position she had held temporarily for two days.

30/7/36: Girl aged 14 years 7 months with a mental age of 7 years 5 months and an I.Q. of 51. She is 4½ months pregnant and several men are to be charged with carnal knowledge. The mother and father are said to be mentally defective. Although the patient has reached 5th. class at school she is unable to read or write. Her speech is so indistinct that it is difficult to understand her conversation. Since she had very

\*Stevenson & Smith "Child Guidance Clinics" page 76.1934

little realisation of her position or prospects and was considered incapable of caring for herself it was recommended to the court that she be placed in a mental hospital for care and treatment.

4/8/37: Charged at Children's Court as a neglected child. She had been arrested in a residential in George Street, Sydney and stated that she had come to Sydney from N____ to start work with a lady but this lady did not turn up. Some men had interfered with her at the residential and medical examination showed that she had previously given birth to a child and was about 2½ months pregnant. Evidence was given that the home at N____ was found in a dirty condition and that both parents were mentally defective. The girl was committed to the care of the matron of the Salvation Army Home until 18 years of age. She was however found to be suffering from venereal disease and sent to hospital for treatment. She was later discharged with her baby and was taken back to N____ by her mother. Approval was given by the Court for transfer from Salvation Army Home to mother for the rest of the period of probation.

October 1938 her brother reported to the police that he had found a man in his sister's room. It appears that the girl had been left in the house on her own from morning until late at night. When a strange man selling door mats went to her home he was invited by the girl to go into her room. Intercourse appears to have been prevented by the approach of her brother. It is stated that she visits Park and Show-ground with men and boys. She admits intimacy on various occasions. Again it was recommended that she be placed in an institution.

Boy: Chronological age: 17 years 11 months, I.Q. 95.

8/6/33: Children's Court - uncontrollable. Placed on probation.

7/12/33: Children's Court - uncontrollable. Placed on probation.

9/3/34: Children's Court - Tram-fare - fined
11/4/34: Children's Court - stealing. Committed to Farm Home, Mittagong.

11/4/34: Entered enclosed lands - Farm House, Mittagong.

1/5/35: Breaking, entering and stealing - committed to Farm Home, Gosford.

6/12/35: Transferred to Yanco. Absconded three times.

26/2/36: Decision cancelled to send him to Gosford - recommitted to Yanco.

17/7/36: Absconded.

27/7/36: Stealing in company, three charges. Committed to Riverina Welfare Farm.

12/9/36: Absconded.

15/9/36: Stealing - committed to Farm Home, Gosford.

13/10/37: Approval for release and placement.

9/11/37: Breaking, entering and stealing. Sent to Farm Home Gosford for nine months.

12/11/37: Absconded

On 23/12/37 Court remanded him until 28/1/38.

Had this boy been presented at the Clinic not in 1938 but in 1933 when he was revealing mild behaviour problems owing to the weak discipline of his mother followed by the inconsistent discipline and over-protection of his grandmother, the possibilities of normal adjustment would have been almost assured whereas now they are remote.

The study of cases such as these serves as a valuable stimulus to the efforts of the Clinical workers and lends a perspective which colours their attitude in dealing with pre-court cases. A study of the personalities and histories of the delinquent group provides a wealth of information for the treatment of pre-delinquent cases. It is through the Court cases that one sees most vividly what the Child Guidance Clinic is trying to prevent and through them one sees more clearly the insidious causes which are at work in a lesser degree in less marked cases of maladjustment.
LYING

One of the most common types of delinquent behaviour reported is that of lying.

It is extremely interesting and of great significance to observe the parental attitude towards this behaviour. Most parents do not see in it a reaction to a difficulty which the child has encountered but immediately describe the child as a "wicked" or "naughty" boy who just tells lies for no apparent reason. They seek for no reason but merely punish the child and are then surprised and angered that even though the punishment is increased in severity the lying does not diminish.

Many parents too have one standard for themselves and another for their children. They will, for example, lie quite blatantly to the doctor when they have actually come to see him about a few petty lies that the child has told. They will even lie in front of the child. Many will tell the doctor in the child's hearing that he goes to bed at 8 p.m. and never goes to the pictures though the child knows that this is untrue. One boy, for example, took great delight in saying to the psychiatrist and to the psychologist independently, "Don't tell mother that I told you, but she took me to the pictures last night - she said the doctor mustn't know for he'll think I'm a fine mother taking you out when I promised not to." Or again the mother will at times send the child to tell the social worker who has called to see her, that she is not at home.

Many parents too place so much emphasis on the lie that the child is branded as a "liar" and feeling that he has fallen short of the standard required and is doomed to get "worse" he feels more insecure with the inevitable result that his lying is accentuated.

Thus in dealing with lying it is essential to treat it as a symptom and deal with the underlying cause. To do this one must investigate the whole situation and discover
whether the lying has originated as a self-defensive mechanism which the child hopes will protect him from the painful beatings and parental hostility which he thinks some action (which was probably accidental, e.g. breaking a vase) will provoke; whether it is due to the imitation of adult behaviour; or whether it is a means by which the child hopes to receive attention and bring himself into the limelight.

In the first case treatment must among other things aim at the cultivation of a more reasonable and understanding attitude and less severe punitive measures on the part of the parent. There should be no bribing into confession. Any normally intelligent child will appreciate fairness and accept reasonable punishment imparted calmly and without hostility. In the second case the parent must be brought to realise his inconsistency in demanding truth from the child when the parental pattern of behaviour involves lying. Parents must be careful not to deviate from the truth in the child's presence, and if certain conventional lies seem necessary it is best to explain them to the child. In the third case the child usually adjusts himself if he is given occasional outings and has opportunities to take part in interesting activities with other children. He does not then feel impelled to manufacture adventures about which to tell his friends for he has real interests and associations which enable him to entertain his playmates without boasting and bragging of imaginary adventures.

**STEALING**

Stealing is of course a frequent problem. Unfortunately it is also one in which the behaviour is regarded as having an end in itself rather than as an expression of some underlying difficulty. It must again be stressed that here too there will be varying causes so that each case requires individual handling. Neither will the extent of the stealing be an indication of the severity of the maladjustment. A child who steals odd pennies may be suffering from a far more serious
emotional maladjustment than the dull adolescent who assists in stealing pounds worth of goods.

The child may steal in order to bribe other children to play with him; he may steal because his food is inadequate; he may steal when led by other boys; he may steal because he has not the same pocket money as the other boys with whom he mixes - whatever the outstanding factor the therapist must attempt to remove the underlying insecurity and anxiety.

Thus in cases of this character therapy is usually directed towards such factors as assisting the child to mix on equal terms with other children, assisting him to participate in activities of suitable clubs, adjusting situations at school and at home where perhaps the child is discriminated against, or fails short of the standards required, and is made to feel inadequate and insecure. Wrong parental attitudes must be altered. There is a very serious danger in the way that parents lead the child to think that one offence spells ruin, that because he has taken the downward step he is sure to go to the bottom. Such branding will almost inevitably send him to the bottom. Moreover parents must be consistent. So many guardians take no notice when the child steals small articles or takes pennies from the till, but as soon as larger amounts are involved they immediately regard the child as a thief and take every opportunity to remind him of what is, in their eyes, an inherent weakness. In reality they have taught the child to steal in that they have allowed such habits to be formed. It is significant to notice how frequently stealing occurs in unwanted children and in adopted children who are brought up with foster brothers and sisters.

Some cases of stealing require just a simple interview in which advice is given to the parent after the child has been examined; others require a short or long period of careful and consistent follow-up; while in some cases where it proves impossible to alter the unhealthy home conditions owing to the parental attitudes, a period in an institution is found to be necessary.
TRUANCY

The most interesting, the least sordid, and yet perhaps the most significant and important type of "delinquent" behaviour is that of truancy. Truancy is not the whole difficulty. Its possible results are the real problem.

As with most maladjustments it is difficult as well as misleading to speak of this as a general problem when each case is so individual a reaction to a unique set of circumstances. Innumerable "causes" of such behaviour might be mentioned. The child who is below normal intelligence, or the child who though normal is for some reason backward, may truant because he is unable to do the work that is required. The child of high intelligence may find nothing to interest him in the work of the class in which he finds himself; a child with defective sight or hearing may find the school situation too difficult; a child may fear excessive punishment for something he has done at school; he may be unsociable and fear the situation in which he feels insecure when with other children; he may even fear being teased by them; parental poverty may be responsible as when the child has no boots to wear or feels that his clothes are noticeably shabby as compared with other children; the more intelligent child when concerned with hearing constant discussions and worries over family poverty may try to earn money instead of going to school; the child may have been encouraged by his parents to stay at home for inadequate reasons, or even for personal convenience as for example when the child is kept at home to mind the baby; parents may even give the child a note instead of letting him face the situation at school after he has truanted the first time.

Truancy is not an audacious but a fear reaction. It is significant that the truant is predominantly an unsociable child who has not learnt to mix with his fellows; so many truants go fishing; an amazing number suffer from enuresis; many
are backward in reading which is basic to their school work; many are emotionally immature owing to parental over-protection which has prevented their mixing with other children; many are subjected to parental friction and inconsistencies; some are punished and bribed; probably all are the outcome of a weak parental discipline. The parents of truants are usually irresponsible, weak, ineffectual people whose commands can easily be evaded and who though they may give instructions and nag continually have little idea of what firmness implies. They are weak and inconsistent - hence the child proves wayward.

Therapy is directed towards any such etiological factors which are found to be present. Any physical defects, particularly visual ones, are attended to; after mental examination any necessary educational adjustment is made so that the child will be in a grade where the work will be suited to his ability; opportunities for recreational activities and association with other children are afforded the child; he is given encouragement and praised for his successful efforts by the therapist in whose sincere and constant interest he finds a certain security; an attempt is made to correct faulty parental attitudes and to assist the parents to enforce a firm and consistent discipline.

**ABSCONDING**

"Absconding" from home or from an institution is also a more vicious problem than at first appears for so often it is the prelude to severely delinquent conduct. Stealing frequently follows, but the greatest peril is in the sexual sphere.

The predisposing home situation may range from a minor to a severe one. The child may have come to feel that though he is personally involved in no particular difficulty the unhappy atmosphere of the home is intolerable. Perhaps there are continual parental quarrels, or there may be the brutality of an alcoholic father. On the other hand many children may run away owing to a specific personal difficulty when, for example,
the child is afraid to present a bad school report, or afraid to face the punishment involved in some activity or in some breakage for which he is responsible. The child may feel that he has been treated unjustly, that he has been punished for something of which he was not guilty, or that he is nagged at constantly, or contrasted with other siblings. Again the child may feel that she is debarred from interesting activities as for example was the case of a girl who, having absconded from home and got into difficulties with some sailors, stated as her reason that she had knitted and knitted until she nearly knitted herself.

Therapy is directed towards changing parental attitudes, replacing nagging, criticism and punishment with encouragement, understanding and reward; by relieving the child as far as possible of emotional strains; by socialising him; by providing him with opportunities to mix with other people and participate in interesting activities.

Illustrative Case Histories

Boy: Chronological Age: 12 years 11 months.

Problem: Truancy.

Family History: Father died of suicide twelve years ago. Mother has a widow's pension and suffers from diabetes. Patient has two brothers aged 24 and 16 years and two sisters, one aged 21, and the other 18 years, both married.

Patient passed primary final in the country and then gained a bursary from a city primary school to a metropolitan high school. He attended the high school for two months and got behind in Latin through staying away sick. Teacher used to keep patient in every afternoon to study it up from text-books but did not tell him how to do it and so patient stayed away. The patient stated that all the other boys were always above him so at first he stayed away on Latin days. He bore no ill-will towards the master saying that the boys at the school were all picked boys and it was not the master's job to give extra coaching after patient had been away.
His mother received a note saying that he had been absent for so many days. Upon being questioned the patient complained about Latin and refused to go back to high school. The Child Welfare Department Inspector took the patient to a primary school but he only attended for one day and then refused to go back. A few days later the mother received a note stating that the patient was not going to school. The Inspector then said that he would take the patient to Court but mother heard no more about it. He is now appearing before the Court, not having attended school for six months.

The patient stated that instead of going to school he used to walk round city or use tram and lunch money to go to the pictures or to go to Manly. He did not know about the Public Library at first but since discovering it has spent most of his time there.

His mother stated that he had no mates and never bothers about boys with the exception of two cousins aged 13 and 11 years. He had threatened to run away with cousin at beginning of truancy but was caught by uncle at Central Railway Station. He is not fond of games but goes swimming and in his mother's opinion, reads too much. He does everything he is told at home. He has walked in his sleep on two occasions during the present year. He suffers from bilious attacks and headaches and frequently has styes on his eyes.

Clinical Examination 21/10/37 revealed that though he looked pale and unhealthy he was well-grown and in satisfactory bodily health except that he appeared to suffer from eye-strain. Binet-testing gave a Mental Age of 16 years 10 months and an I.Q. of 130.

Therapy was directed towards the mother who was ill-equipped to understand a boy of superior capacity and was unable to exercise proper parental control. It was arranged that the boy should attend the primary school for the remainder of the current term on the understanding that he enter a suitable secondary school in the following year.
25/10/37: Child had blepharites and septic sore on face which made it undesirable for him to attend school.
1/11/37: Blepharites still present. Boil healing. To attend school tomorrow.
18/11/37: Patient states that he has attended school regularly except for two days which he missed on account of bilious attack. The Inspector states that patient is getting on well at school.
13/11/37: Arrangements have been made for child to return to High School the following year. Good follow-up report for 1938.

Boy: Chronological Age: 7 years 10 months.
Problem: Truancy, theft.
Family History: Father on relief work for a long time. Mother treated by doctor for epilepsy since age of 18 - one of five brothers, was before the Court for receiving stolen goods six months ago.

Patient had been truanting and stealing at school prior to Christmas vacation. One Sunday since then he ran away from home and attended meetings and services at various churches. He was brought home by two members of the Roman Catholic Church.

He had started truanting over six months ago. His mother at the time did not approve of the teacher as she had a harsh way of speaking to the children and she favoured Roman Catholics. Shortly afterwards the patient was transferred to another school but there was no improvement and he also started taking money. He took £1.5.0 and then 10/- from his mother's purse which was under her pillow. He took a mouth organ from Woolworths. He stole two purses from school. He used to go to a Moulding Firm and would come home black and say that he was earning 4/3 per week. He does not squander money but gives it away. His escapades all occur early in the morning. He is the only one who rises early. He suffers from nocturnal enuresis.

Clinical Examination revealed that he was well-grown and of sturdy build but showed stigmata of former rickets. Binet-test-
ing gave a Mental Age of 7 years and an I.Q. of 89. It was obvious that he had been very much exercised regarding money matters by frequent discussions, he had heard, regarding the family poverty.

**Therapy**

15/2/38: Eight out of fourteen (yet beds). No absences from school. He is said to be very restless at school.


**Girl:** Chronological Age: 12 years 11 months.

**Problem:** Summons issued against father on account of child's truancy. Has not attended school for eight months.

**Family History:** Truancy Inspector called to say that child was not attending school. Mother did not know. Child used to play in park or go to visit an aunt who did not inform the parents.

**Clinical Examination** revealed that the child had a Mental Age of 9 years 3 months and an I.Q. of 75. She was very self-conscious and blushed continually. She appeared to be very afraid of making herself ridiculous before her companions in class on account of her ignorance, and lack of capacity. She was unable to read or calculate and manual control was very poor. She stated that although she had tried she was unable to learn at school. She also "had no one to play with as one girl told the others not to play with me, so I used to get the sulks and would not go to school." She did not want to go to the nearby secondary school because "I know a lot of girls there and they might torment me because I'm no good at lessons - no one could be worse than me at lessons - I'd like to/to school because nobody knows me there."

**Therapy:** The child was so maladjusted that it was at first thought that there was no solution other than to recommend that she be committed to an institution. However it was recommended that the Court grant a period of probation while a final effort be made by the Clinic social worker to adjust the child at school.
5/7/38: Case was discussed with head teacher at local secondary school. Teacher stated that patient's sister was absent from school. Mother was found to be unaware of the child's absence. She was very unkempt and seemed incapable of handling the small children. She promised that she would take both girls to school the next day. She added that the aunt was too soft with them. The social worker also visited the aunt who promised to co-operate and send the children on to school.

21/7/38: Teacher reports that both children have attended school regularly. The mother brought them the first day and since then they have come alone. The class teacher has been instructed not to worry patient about her work but to do all that she can to make her happy. Mother stated that the girls go to school willingly every morning and they are now having a competition as to who goes most.

23/8/38: School reports that patient and her sister are attending regularly and giving no trouble.

6/10/38: Both girls attending regularly and giving no trouble.

**Girl:** Chronological Age: 16 years 7 months.

**Problem:** After working in a city store she used a lady's name who had an account, to buy some goods - about £4.10.0 in value.

**Family History:** Father who is now a labourer lost a good position when the buses stopped running six years ago. He had promised the patient that she could go to the University. He thought she might take up teaching, journalism or law.

It then became necessary for patient to leave school at the age of 14, just before sitting for the Intermediate Examination. She worked as a shop assistant and in the office at a large city store. She was cashier for some time and decided to give it up since "there was no imagination in it." She received only 13/4 a week and felt that there was little hope of promotion. After fifteen months she left to better herself and secured a job in an advertising company which tried to establish a newspaper. She did everything there and liked
it very much. Her mother stated that she noticed a change in her while she was there. She used to go to the best city hotel for lunch and do things beyond her means. Her mother took her away and found that she had gone back. After six months the newspaper failed. She then stayed home for six months helping her mother. She then worked for a month as a salesgirl at another leading store but was put off owing to a new award a month ago. She had a good reference. Following that she operated on a lady's account.

About eight months ago patient received a letter from a city store saying that they were opening accounts for business girls. As patient was told that she could not have an account unless she were over twenty-one, she signed her father's name. She ran up about £10 in a week since she wanted an evening frock for a dance. She was paying the money off weekly and in the end her father was responsible for £8.

It was stated that the patient associates a great deal with a maternal aunt who is in a higher social stratum than the patient's family and has an income of about £18 a week. Her mother said that the patient did not go out much at night, was always pleasant and tidy, helpful in the house and had never been any trouble.

Clinical Examination 28/10/37: Binet-testing gave a Mental Age of 17 years 3 months and an I.Q. of 108. This cannot be considered as an indication of the child's level of intelligence since the old Terman revision was used in which there is no scope for a highly intelligent girl of this age. The girl was highly strung and excitable but had an extraordinarily attractive and vivacious manner. She stated that she could not settle down to work without prospects. The only prospect for a salesgirl is to become a buyer and that entails such a long period of waiting for promotion. She regretted that she had been unable to specialise. She said that she had no friends, that she did not "mix in much" and that she did not like the people who lived in the locality. She felt that she was old
for her years and that older girls had boy friends while the younger ones seemed foolish. She spent her spare time reading and swimming by herself. She was quite rightly confident in her ability to sell things.

5/11/37: Placed on probation by Court. Clinic advised job immediately.

9/11/37: Mother states that patient is more humble now - has lost her high ideas - thought she was too good for parents.

23/11/37: Has position as salesgirl. Unnatural in that she will not mix with young company, because parents will not let her have the sort of friends she wants.

12/1/38: Father stated that patient is now well adjusted.

She is doing a great deal of surfing. After the preliminary trial before Christmas at the city store she is now to return as a permanent employee.

Girl: Chronological age: 12 years 9 months.

Problem: Arrested with sister on wharf in company with a sailor at 5 a.m. This was the third occasion they were seen out early in the morning and late at night with sailors. Sexual intercourse has taken place.

Family History: Mother suffers with nerves and is being visited by doctor for nervous headaches and indigestion. The father when seen by the social worker appeared to be an agreeable unassertive little man who seemed to have little part in the home and avoided any discussions of the girl's problem.

The patient had diphtheria at four years of age and this was said to have left a weak heart. She faints if she cuts her finger or gets a shock. She is said to be getting on well at school. She gave no trouble until four months ago when she went to her grandmother at a hotel. She did not come home and police found her talking to a sailor. She stated that about four or five months ago she met a boy after the pictures and walked down to the park. Her elder sister went home and left her.
Clinical Examination 25/8/38 revealed that she was shy and self-conscious, hesitant and lacking in confidence. Binet-testing gave a Mental Age of 13 years 3 months and an I.Q. of 104.

Therapy: Since the school would not have the child back as all the girls knew of her misdemeanours it was arranged for her to attend another Convent school. The previous school reported that the child had been a good worker but was not stable and did not mix with the other girls much. Therapy was discussed with new teacher who appeared to take sympathetic interest.

12/9/38: Teachers reported that child is behaving well at school.
13/9/38: Mother states that patient likes new school and behaviour is satisfactory.
27/9/38: Has taken to new school very well. She is now taking languages. She stays at home and reads books on Saturdays. Plays basket-ball and tennis at school every afternoon.
10/11/38: Child is working very well at school and taking a great interest in school activities.

Girl: Chronological age: 14 years 3 months.

Problem: Arrested on wharf in company with sailor at 5 a.m. Seen previously early in the morning and late at night with sailors. Examination reveals that sexual intercourse has taken place frequently.

Family History: Sister of case given above. At four months patient was taken to hospital for chest trouble and at six months was admitted to hospital for broncho-pneumonia. She suffered from bronchitis on and off for six years. She suffered pyelitis from six years to thirteen years. Least thing seems to knock her up. She has missed a lot of schooling through sickness. She suffers a lot with headaches. She used to wear glasses for headaches but refuses to wear them now because she does not like them. The school reported that she worked hard and had passed her examinations. Her mother stated that she did not have the
energy to want to play basket-ball much. She was obedient and willing at home though she was not asked to do much. She never brought her friends home. About three months ago she started coming home late; she would say that she went to the pictures. She left school about six weeks ago to go to night school. She was working at a factory but she had to stand on concrete and the noise was too much and she got too many head- aches so her mother took her away after three weeks. About seven weeks ago she ran away from home for a fortnight. She went to the pictures with some girls and then stayed talking until just after 12 o'clock. The girls said not to go home and so she went to stay with some girl friends. Her mother said that she had stated that she was frightened to go home. Clinical Examination 25/3/38 revealed that the girl's eyesight was defective. She was very defiant and rebellious, hedged with questions, and attempted to justify her conduct.

She was unrestrained and undisciplined, demonstrative and talkative, careless and impulsive. Her attitude appeared quite irresponsible. During testing she was very co-operative when able to answer but if ignorant became very rebellious and would not be persuaded to exert any effort. She had been behaving in a demonstrative rebellious manner while at the Shelter and had whistled and talked with the tradesmen. Binet-testing gave a Mental Age of 15 years 5 months and an I.Q. of 105.

Therapy: Though it was considered that her influence was a menace to her younger sister it was recommended that she be placed on probation on condition that she attend day school, that she be not allowed to go out at night unless in the company of a responsible person, and that she attend the Clinic periodically. Since there was no business course at the Convent which her sister was attending and the patient did not want to go to the Technical College but wished to take her Intermediate Examination, it was arranged that she go to a Convent where she could take her examination and do business subjects.
15/9/38: It was reported that she was attending school satisfactorily. She seemed to like the new school and was studying until 11 p.m. on the previous night. She had been placed on probation by the Court provided that the conditions recommended above were carried out.

23/9/38: Mother says that patient refused to attend school and ran away to aunt. Father brought her back. Mother thinks now that she will have to get a job.

27/9/38: Patient left home about 7 a.m. today. She did not take anything with her. She said that she did not want to go back to school but wanted to get a position. She said that the teachers had been very nice. She had been doing her home lessons each night with the exception of Friday when her father took her to the pictures. She was still complaining of headaches a good deal.

4/10/38: Child said that she had run away to aunt because she was scared to come to the Clinic since she "thought you might make me go back to school." Mother was advised to find a job for patient as quickly as possible.

10/11/38: Court has concluded the case. Patient is working at the same factory as before in a more congenial job and seems quite contented.
"INVALIDISM"

Faulty Feeding Habits. Sleep Disturbances.

The "invalid" child and the child who suffers from faulty feeding habits are the result of and are maintained by parental mismanagement. The problem occurs not, as is frequently assumed, in neglected but in over-protected children. Thus the majority of cases of this type are "only" or "youngest" children, and all tend to be children who are so accustomed to adult company that they have not learnt to mix with other children amongst whom they are fearful/anxious.

Such children occupy the centre of attention in the home and find that refusal to eat at meal times is an excellent opportunity to gain special notice. The usual adult reaction is to do anything to get the child to eat - admonition, warnings, threats, punishment, bribing, timimg, mechanical force, story-telling, and so on: all of which bring the child more and more into the centre of attention. Frequently special foods are prepared at which the child protests even more vigorously perhaps whining, screaming, fighting, criticising or even vomiting.

Other children, though they may eat what is provided, eat inadequately, or they may not digest what they eat owing to some emotional disturbance. If, instead of attacking the underlying fear and anxiety the parent pays attention to the physical reaction, it becomes accentuated, so that both child and parent really come to believe that the child has some incurable physical illness. Children who suffer, for example, from digestive disturbances owing to fear occasioned by their failure to mix with their fellows at school or by their fear of the scholastic demands made upon them, frequently become so over-protected that they actually become physically unfit and malnourished.

Again children may be trained in invalidism because of some superstitious idea of the mother in regard to inheritance.
or to experiences during pregnancy. She is so anxious lest the expected symptom appear that she makes a hot-house plant of the child.

Many children when in insecure, fear-provoking situations take retreat in illness because they have heard their own minor illnesses, or other people's illnesses, discussed by adults.

In treating such cases, any physical defect revealed by medical examination must be attended to, but if no physical defect is present both mother and child have to be convinced that this is so. Moreover psychiatric interviews must change their pessimistic outlook to a hopeful attitude towards the results of treatment.

Anxieties, such as overpressure at school, and failure to mix with other children must be adjusted. The child must be helped to a certain independence through association with childish companions and participation in childish activities with a minimum of adult society and attention.

Therapy must be directed towards changing the parents' attitude. They must be encouraged to make efforts to do away with emotional upsets in the child's presence; as also with manifestation of over-solicitude, over-protection and over-indulgence. They must appear to disregard the child and on no account to speak of him in his presence or hearing. It must be impressed upon them that coaxing and bribing, forcing and punishing, and even reasoning, endanger the child's emotional growth.

In regard to feeding problems it is advisable to put the food before the child at the regular meal-time and always in the same place. All attention should then apparently be withdrawn. If at the end of the meal the food is not eaten, it should be removed without further comment. On no account should special dishes be provided for the child, and no food should be given between meals. It must be explained to the parent that there is no danger involved if the child misses
several meals, but there is a very real risk of crippling his emotional development if parents show excessive anxiety and over-protection.

In regard to problems of digestive disturbances and such like, the important point is that the parent must be persuaded to show no undue alarm over the symptom and must as far as possible disregard it. At the same time the parent must be encouraged to cooperate with teachers and clinical staff in an effort to assist the child to a greater independence and security.

Sleep disturbances closely resemble feeding difficulties in that they are a bid for attention by the child who has become anxious and fearful. Again it is in the over-protected child that this difficulty usually occurs, as well as in the child upon whom excessive demands have been made. The latter tend to show such symptoms as sleep-walking, nightmares and restless sleep, while the former reveal an unwillingness rather than an inability to get adequate sleep.

Thus it is found frequently that the sleep difficulty is a part-manifestation of the general spoiled or over-protected child reaction, based on faulty parental management. The child who has to be coaxed to eat learns that the act of going to bed is another means of securing attention. The child may refuse to go to bed or may refuse to go unless certain promises are exacted, for example, having a light on, having someone with him, or perhaps being played with or read to. Similarly the child may make up in the night and call for parent until he has been "calmed" or taken into parents’ bed. Again unfortunately adults usually resort to methods such as bribery, coaxing, pleading, reasoning, punishing and so on. Since the parents usually "give in" in the end the bed-time performances are kept up indefinitely.

When these faulty habits have come into existence, sedatives may assist but are of no real importance in therapy.
Restless and insufficient sleep is a sign that there is some disconcerting influence in the patient's environment, which must be removed. An adjustment of parental and scholastic demands in relation to the child's ability together with a more suitable home hygiene will usually reduce the difficulty fairly rapidly.

In cases where there is an unwillingness to go to sleep, treatment includes the establishment of a greater independence, particularly in everyday matters of feeding, dressing and so on. Regularity of retiring is insisted upon. If the child is treated as a baby and sent to bed too early, or treated as an adult and allowed to stay up too late, the time of retiring is adjusted to suit the age of the child. It is stipulated that as far as the child is concerned parental withdrawal must be complete. Neither should adults discuss in front of a child the pleasant activities that they have had after he has retired. It is also extremely unwise to send children to bed for punishment since this impresses on their minds the wrong idea that bed is distasteful.

**ILLUSTRATIVE CASE HISTORIES**

**Girl:** Chronological age: 10 years.

**Problem as stated by aunt:** "Patient is painfully thin though doctor cannot find anything wrong. She gets very morbid and says that she wishes she were dead. She gets into terrible temper tantrums over the least thing, calls you all sorts of names and is sorry afterwards. She complains of pains all over her body and is very restless in sleep. She turns up her nose at everything at meals and wants whatever is not provided - greatest difficulty in the world in feeding her. She makes friends but does not keep them as she finds some fault with them."
Family History and Hygiene: Father dead for two years, was a sailor and had been separated from mother owing to another woman. Patient and mother live with mother's sister and her daughter. Mother who is an office cleaner, crippled with rheumatism, is very nerdy and always a worrier even when things are going right. Mother leaves home before 5 a.m., is home in the afternoon and goes out to work again from 4 to 9 p.m. When she returns she goes into patient's room and says "Are you awake, darling?" Patient complains to mother that aunt has been growling at her in her absence.

It is stated that the child likes to help but is not permitted to "as she is not strong enough". The mother was working very hard up to the patient's birth and was able only partly to nurse the patient who was very difficult to rear and has since been treated as a delicate child.

The two cousins are called for each day at school by the aunt of the patient for fear of traffic or being lured away. The school reports that the aunt fusses too much and comes up to school if the girls are a few minutes late. Though the patient is reported to be very polite and talkative with adults at home, the school reports that she is "shy and retiring". She does well in all her school work coming second in the examination.

The social worker found that when patient was at home with a cold she seemed quite well and the aunt acknowledged that she liked staying home from school.

Clinical Examination - 14/6/38 revealed that the child was in very thin condition yet beyond dental caries no bodily ailments were found. She had obviously been encouraged to regard herself as an invalid and stated that she was "delicate" and "gets shaky" if she stays in bed too long on Sunday. She had become introspective and was taking inadequate meals.

Binet-testing gave a Mental Age of 10 years 2 months and an I.Q. of 102. She was lacking in initiative, timid, and reserved, but polite and old-fashioned as though accustomed to adult society. She was extremely irritated when confronted by
a difficulty and made excuses for any failure. She was very conscientious and appeared to expect far greater achievement than her ability warranted. It seemed that she was attempting to make up for her unsociability with the other children by scholastic success.

Therapy was directed towards (a) reduction of adult company, (b) more emphasis upon recreation and assistance in mixing with other children, with less stress on scholastic work at school, (c) modification of home hygiene: Mother and aunt to show no anxiety; not to fuss over the child or worry if she had no appetite, etc.; to send her to school regularly.

18/7/38 Slight improvement reported.

25/7/38 Aunt reports that patient is much better and is eating quite well. She is still not allowed to come home alone.

Girl: Chronological: 12 years 2 months.

Problem as stated by School Counsellor "Patient is said to have very weak eyes which account for her many absences from school. She admitted, however, that sometimes she is kept at home to help her mother."

Clinical Examination revealed that the child had a mental age of 9 years 4 months, and an I.Q. of 77 in view of which she would inevitably find 4th class work too difficult. Though well-conducted she was extremely babyish and dependent. She was unable to read.

It was learned that at the age of 8 years the mother had been advised by the School Medical Officer to consult an oculist regarding a squint, which appears to have been cured by treatment given. While the child was found to enjoy normal visual activity at the present time, the investigations previously made, much impressed the mother, and provided the child with a pretext with which to cover her poor mental capacity. More recently she has become accustomed to plead that her bad eyesight causes headaches and is learning to evade all difficulties by this means. The "headached" usually occur in the
morning and mother's remedy is to give the child an aspro and put her to bed.

**Therapy.** The mother was reassured regarding the child's eyesight and was advised to disregard the headaches. It was suggested that the child might be encouraged to undertake simple household tasks. The school was requested not to push the child but only to require her to perform tasks within her capacity, and to include as much manual training as possible in her curriculum.

A week later the teacher reports that child is a changed girl now. She is being treated differently at school and is made to carry out easy tasks which she does very well. Her confidence has greatly increased and she seems very much happier. The mother states that the child is helping with the cooking in the evening and does it very well.
ENUREESIS

Though enuresis is generally acknowledged to be a particularly obstinate problem, the psycho-therapy directed against this habit has yielded very satisfactory results.

Treatment, of course, is directed towards the whole child and its environment; and though some kind of physical weakness may perhaps be partly responsible for the habit, it is considered that it is probable that it would not occur in the absence of excessive anxiety. Unfortunately it is found that the measures usually adopted by parents for its relief are more likely to lead to its continuance. Punishment is usually harmful. Over-concern and anxiety on the parent's part is equally dangerous for it rivets the attention of the child on his difficulty and his anxiety and fear which are already an overwhelming burden are increased. It is significant that many children are cured by the removal of all restrictions and precautions. There are occasionally dramatic cures when children are removed from their parents, either through the child going away for a holiday or through the parent being obliged, for instance, to go to hospital. It is significant too that very many stammerers and many truants are enuretic, and as with stammering it is found very much more frequently in boys than in girls. Enuretics tend to be extremely self-conscious, fearful, and restless. They are very heavy sleepers. Many of them are very sluggish, hence it is found that they benefit from doses of thyroid gland.

Cases of enuresis have responded well to a therapy based upon encouragement, suggestion, and regular routine.

In the first place there is an attempt to assure the mother and the child that there is no physical defect and that the difficulty is amenable to treatment. Any excessive demands and anxieties in the child's environment are as far as possible
removed. There is an attempt to build up the child's self-confidence and increase his independence. The parent is urged to show no anxiety and to pay no attention to the difficulty, never to reprimand or punish the child for his weakness but always to praise and show pleasure in the event of any improvement.

An analysis of the cases presented for therapy reveals that enuretics are very heavy sleepers. For this reason the mother is advised to make the child at ten o'clock each night and give him a dose of medicine - actually the mixture is of no physical value but it ensures that the parent rouses the child regularly, and really wakes him, for so often children are disturbed and cut out of bed but are really still asleep. The child is told that if he takes the medicine he will wake up when he wants to go to the lavatory and he is given a diary in which each day he writes "dry" or "wet" against the previous night. The suggestion almost invariably works, though it is sometimes a long period before the cure is complete. It is with secret glee that one hears a patient say "I forgot my medicine on Wednesday night and had an accident", or a mother saying "Jimmie has been all right since he has been taking his medicine again." One very perturbed child came to the psychologist and showing his diary remarked confidentially "I've got a bad report for the doctor this month - but you know it's those pills - they're not the same size as the last ones." It is interesting to notice that quite frequently one finds that if a child is out late there is a recurrence of the difficulty, which appears to be due to the fact that being overtired he is sleeping so heavily that the suggestion does not take effect.

The most severe case of this type has been that of a girl aged 13 years 3 months who, the mother stated, had wet the bed every night since a chill on the kidneys at the age of 2 years, and who "blinks and pokes faces as if she had St. Vitus' Dance." This latter habit had been going on for about 8 years following the prescription of glasses by a doctor.
The mother took the glasses from her and there was some improve-
ment until another doctor prescribed glasses three years ago.
Though these were also taken from her, she "still continually
blinks". The mother added that the child was very highly
strung, gets very confused when scolded, is obedient but not a
willing helper, is always tired and languid and just wants to
sit down and draw all day. The patient eats well now, though
not formerly. She sleeps well in a bed on the verandah with
her brother. She usually goes to bed between 9 and 10 p.m.
and does not go to night pictures. She is a very heavy sleeper
and does not seem to know where she is when roused at night.
She plays cricket with her brothers and is a good mixer but she
has become very depressed because though she has had several
invitations for holidays she cannot go on account of the enuresis.
Her teachers say that she is "brainy but cannot concentrate."

The father, a clerk in the Railways, is a returned
soldier. He is very nervous and gets very upset if he has to
correct the child when he would be unable to take his meal and
would suffer from palpitation. The mother had recently two
miscarriages and is soon to have a gynaecological operation.
There are two brothers.

Clinical Examination revealed no physical defects. Binet-
testing gave a Mental Age of 16.8 and an I.Q. of 126 with which
ability she should have had no difficulty in maintaining a
middle position in her second year High School class. The
habit spasm which took the form of a very frequent blinking of
the eyes was found to be severe. She was extremely self-
conscious, so inert, and so slow in speech that she appeared at
first by her manner and answers to questions to be a person of
low intelligence. She was restless and languid and seemed to
want to stretch, and stated that she felt tired always.

Psychotherapy was initiated during her first visit to
the Clinic. A fortnight later it was reported that though she
had a bad cold there had been only five out of twelve wet beds.
Three weeks later seven out of twenty dry beds were reported and
it was stated that she was very careless in her attention to her room at home. Necessity for joining in games at school was stressed. "After a further three weeks the mother reported that the child "does not pay attention at school and has no inclination to do anything." She cuts out pictures of Shirley Temple and Princess Betty. Six out of twenty-two dry beds were reported and it was stated that she often keeps awake until her mother comes in with her medicine. At the next fortnightly visit the mother said that the patient was much better and seven out of twelve dry beds were reported. Three weeks later, despite an attack of influenza the patient reported fourteen out of twenty-one dry beds. She was persuaded to accept an invitation for the holidays, while the mother went to hospital for an operation. A month later the patient reported that she had had a lovely holiday. There were only two out of twenty-four wet beds while she was away on holiday, but nine out of fourteen wet beds after returning home. A month later, after the mother had been home from hospital for a fortnight, she came to say that she was very pleased with the patient and that there had been only four or five wet beds in the month. During the next three weeks the patient's brother had been taken to hospital with diphtheria and the patient had spent several days at home since she complained of pains, headaches and sore eyes. She has been skating and playing tennis regularly. Fourteen out of twenty-eight dry beds were reported. Three weeks later it was considered that the patient was "much improved". A month later she went for another holiday during which there were no wet beds, though there had been three since her return. The last report was five wet beds in the month. The patient is still in attendance.
Boy: Chronological age: 6 years 1 month

Problem: as stated by mother. Frequently wets bed; has a straw mattress, says that he cannot help it. At first he was running out of school all the time to pass water but not so much lately. If the least thing upsets him he wants to go to the lavatory. He started school at 5 years and is said to be a good boy but is very anxious and self-conscious, for example when teacher told him to come and clean the blackboard he was up and dressed before 6 a.m.

It was elicited from the mother that he did not talk until two years old. He sleeps well but is a very heavy sleeper; he grinds his teeth in his sleep. Bowels are very easily affected, for example by prunes. He is faddy with his food and needs persuasion. He has a happy disposition and plays happily and quietly by himself; he is agreeable with other children but will stand aside. His biggest drawback is his self-consciousness.

Family History: Mother has "nerves of the heart". Father is a returned soldier not pensioned but still has headaches from shell-shock and was in Broughton Hall after the war. Financial difficulties since depression.

Clinical Examination revealed no physical defects. He weighed 49½ pounds and 43½ inches in height, being well grown but thin. Binet-testing gave a Mental Age of 6 years 10 months and an I.Q. of 112 (superior intelligence). He was found to be excessively shy and self-conscious; he appeared very worried when unable to do tasks.

Therapy: The usual psychotherapy with the over-protective mother and the patient was initiated on 6/12/37 and the school was requested to assist particularly by supervising the patient in the playground and if necessary encourage him to join in games with the children in order to ensure that he mix freely with other boys.
21/12/37: Improving - eight out of fifteen wet beds.
4/1/38: Ten out of fifteen wet beds.
18/1/38: Nine out of fourteen wet beds.
6/2/38: Weight 52½ pounds, height 48 inches.
15/3/38: Eight out of fourteen wet beds. Mother reported
that there was some improvement but that though he had the
tablets prescribed he had had no mixture lately. Father is
very irritable and nervous, he has not earned since Christmas. To
continue with medicine.
5/4/38: Much better; nine out of twenty-one dry beds.
in class.
24/5/38: Has not been to school since last visit on account
of eruption on face. Height 49 inches; weight 54½ pounds.
Twelve out of twenty-one dry beds. To discontinue medicine
but to continue with tablets each morning.
9/6/38: Was worse after leaving off medicine but has improved
since mother renewed medicine. Is eating well and playing
better. Height 49½ inches; weight 57½ pounds.
4/10/38: No wet beds for six weeks. Weight 57½; height 50.

Boy: Age: 11 years 10 months.

Problem: Enuresis; hypersensitive; faulty posture. Referred
by the school for very slow progress; nervousness; very reserved.

His mother stated that he wets the bed periodically
and that he had wet the bed every night for the last six weeks.
He goes to bed about 9 p.m. and sleeps well, and is roused by
his mother at about 10:30 p.m. On account of his round
shoulders he had attended a hospital class each Saturday morn-
ing for exercises but it was too tiring and had to be discon-
tinued. He is too nervous; he has to have anaesthetic for
teeth. He is well behaved but needs coaxing. He is not help-
ful; inclined to be solitary, not a good mixer, mostly plays
with smaller brother, but fights a good deal. He is too quiet
and will not speak up at school.

Clinical Examination revealed a severe curve in thoracic spine. His posture was most faulty and his muscles extremely soft and flabby. He showed a dislike for active games and for any form of manual occupation. He had become hypersensitive and solitary and stated that he had not many friends. Binet-testing gave a Mental Age of 9 years 6 months and an I.Q. of 80. The scholastic demands made of him in 6th. class had undermined his confidence to such an extent that he was over-anxious and fearful, explaining frequently before attempting a task that he did not know what to say.

Therapy: The school was requested not to push him in scholastic subjects which he would be unlikely to be able to grasp and which would only accentuate his nervous symptoms but to give systematic training in physical exercises and active games and to stress manual training in preparation for his future vocation.

19/4/37: Postural exercises given
4/5/37: No change
21/5/37: Mother reports that he will not do exercises. The bed-wetting is as bad as ever. He is a very heavy sleeper. Psycho-therapy for enuresis initiated.
14/6/37: Two dry nights
6/7/37: Mother states that he is exercising better and that enuresis has improved. Patient states that he has got himself out of bed a few times at about 1 a.m.
3/8/37: Wet beds about once per week
14/9/37: Two wet beds
12/10/37: No wet beds

Girl: Chronological age: 15 years 1 month

Problem: Said to be mentally retarded, unsuccessful at school, not strong enough to undertake a domestic position. Suffers from enuresis for which a private doctor who reports no improvement has been treating her. She wets the bed every night and has done so all her life. She will never tell that she has wet
the bed nor attempt to dry her own bed and always answers "No Mum" if asked if she has wet bed.

Clinical Examination 6/6/38 revealed no bodily defects. Binet-testing gave a Mental Age of 12 years 4 months and an I.Q. of 92. She was found to be very immature emotionally and obviously far too dependent and seriously lacking in ordinary self-confidence.

Therapy for enuresis was started on 6/6/38. It was suggested that measures should be taken to remedy her character defects by requiring the girl to assume more responsibility, by encouraging her to associate more with other children of her own age and join a suitable Girls' Club such as the Girl Guides. As it was considered that a Domestic Science School would be more suitable to her both from the point of view of character formation and future vocational placement it was arranged to transfer her from the primary school in which she was repeating the final year.

21/6/38: Guardian reports improvement - two wet beds. Plays tennis and rounders on sports' afternoon.

5/7/38: Only two wet beds. Progressing favourably.

26/7/38: No wet beds. Seems to be an improvement in school work.
DISOBEDIENCE, STUBBORNNESS, TEMPER-TANTRUMS

The disobedient, stubborn, pugnacious, or bad-tempered child is frequently an over-protected child who has not learnt to mix with other children and rebels against their codes since he is so accustomed to adult company in which he is the centre of attention.

Such children are most commonly the result of an inconsistent and capricious discipline. Frequently the child is not given the opportunity to find out what is desired and what forbidden since he is scolded on one day for some activities which were tolerated the day before merely because of a change in the mood of the parent. Or again the parent may give an excessive number of commands but not see that the instructions are carried out. Similarly parental discussions may lead to disobedience for divided authority is of course no authority. Excessive leniency may be equally harmful for the "spoiled" child is not taught to obey since he learns that he has only to resort to temper-tantrums and such like to obtain his wants if he does not get them otherwise. In this way the child becomes conditioned to a certain type of response and this response becomes a habit. Excessive sternness with the unreasonable and impossible orders it involves will also cause the child to disobey.

Many children re-act in this way as a defence against the too-great demands made upon them. Thus one frequently finds that the dull and feeble-minded child who is expected to keep pace with his more normal classmates, is reported as a stubborn, bad-tempered or disobedient child.

Treatment will be directed towards socialising the child by assisting him to mix with other children and by demanding of him no more than his ability warrants, but most important perhaps is the insistence upon the parents administering a firm and consistent discipline. As Kanner states "Uniformity and
consistency of discipline with abstinence from extremes and full parental agreement with regard to polices will be advised." (x) Parents must be urged to give reasonable commands only, and no more than are absolutely necessary, but to insist on their fulfilment. Objectionable methods of securing discipline must be discouraged. Bribes and threats should not be employed.

Corporal punishment must be abolished - it is either carried out in anger when the parent who wishes to control the child is not even capable of controlling himself, or is done from a mistaken sense of duty accompanied by such remarks as "It hurts me as much as you" and followed by apologies, regrets, and yielding in the end. Moreover it may make the child afraid of his parents or it may put them in the wrong in his mind and thus lead to feelings of bitterness and revenge, or as is frequently the case it may make the child callous and accustomed to inflicted pain.

It must always be remembered, too, that it is particularly unreasonable to punish the child - especially the very young and the very dull child - for things, the wrongfulness of which he does not comprehend.

After the child has failed to obey, it is in order to deprive him temporarily of some privileges which he enjoys; but it must be ensured that he does not by whining, screaming, or pleading have his just "sentence" reduced or done away with. On the other hand good behaviour should be acknowledged and rewarded.

Thus as Dr. Susan Isaacs says in "The Nursery Years" (x) "In general, then, as regards obedience, we should take care neither to ask the child for more than he can give, and give without undue strain, nor to put into the form of real demands things which we are not in the end justified in insisting upon. It is as important to keep firmly, however gently, to any definite requests that we do make, as it is to make sure that the requests themselves are wise and helpful."

(x) Page 105. Kanner "Child Psychiatry"
Boy: Chronological Age: 7 years 7 months

Problem: The school reported that the child was "source of danger and menace to pupils and teachers." He is subject to outbursts of temper and violence without any apparent reason. He is in the habit of collecting sharp objects, e.g. wires, nails, and using them in a threatening manner. He has proved it too great a risk to allow him to play with other children and he has to be kept under strictest supervision of a teacher all day. He recently kicked a teacher and attempted to bite the same teacher and another." The school had received instructions to exclude the child until examined at the Clinic.

Mother states that the child is restless, interfering and mischievous and that she would like to have him taken care of. He upsets the home on account of mischievousness and bad tempers.

Family History and Hygiene: Father has been out of employment for eight years and is very irritable on account of mental worry.

The maternal grandmother and paternal grandfather are heavy drinkers and maternal uncle in mental home.

The mother who is feebleminded suffers with nerves. She had miscarriages on 2nd. and 4th. pregnancies. She admits that she nags at the children. She states that she cannot control herself on account of her nerves and her own mother is always getting on to her for the same thing. She treats them capriciously with neglect or blows; she is constantly nagging or complaining without any attempt at systematic discipline. She added, too, that the child was very troublesome at school and goes for all sharp instruments, "perhaps because I hit him so much."

Clinical Examination 8/18/37 revealed that the child was undersized and in rather thin condition. At the time he had impetigo on hands and knees. Binet-testing (Terman) gave a Mental Age of 6 years 4 months and an I.Q. of 83. He was
left-handed and when asked to write he wrote in mirror fashion. He was not at all shy, but talkative and very restless and seemed to be wanting an outlet all the time. Throughout the psychological test/interview he kept up an incessant flow of irrelevant chatter for example "Don't like school because teacher sends home notes about me being naughty when kid only because I don't like kids being naughty pushes me so I make up my mind on way to school to be naughty/ to me. I'm a clever boy. I hope I get everything right. I'm the cleverest boy. My mother won't allow me to write with a pen. Tell mummy I want an ink pen."

Treatment: The boy's faulty behaviour was attributed to his unstable home environment. It was recommended that he be excluded from school for a period of three out-of-twelve months when he might be given another trial at school. Advice was given to the mother and grandmother.

Second Clinical Examination 19/5/38: The grandmother states that the mother has no control of herself. She encourages violence in the child - "flies at child and bullies him after spoiling him." The father now has regular work. The family is in a very small home and maternal grandmother has all their furniture in return for board. Mother is very clean and feeds the children well but has not the patience to rear them.

The patient's skin had improved. He stated that "a boy threw a ball and hit me in the stomach. Mother kicked boy in behind and called him a s....."

Binet-testing (Terman and Merrill) gave a Mental Age of 6 years 10 months and an I.Q. of 85. The child still showed very poor manual control. He was very keen to use pen and pencil but very awkward and clumsy. He still wrote in mirror fashion. He was very co-operative and obedient though demanding attention all the time. His association with adults led him to make surprising remarks. When attempting to draw a diamond he said "I must concentrate." He was very eager to do well and extremely pleased with success and praise. He was confident and friendly and there was an incessant flow of
spontaneous conversation. He was eager to go to school—"I think I've been missing a lot of things lately — I haven't been at school. I like school but don't like writing A.B.C."

Treatment: It was decided that he should return to school. The social worker could not prevail upon the meadmistress to give the child a trial until after July 1st, when the kindergarten mistress who was away was expected to return. She was very nervous about having him with the other children and as two teachers were away she felt that she could not give him adequate supervision.

When the social worker visited her the mother stated that the child was improving and that she was trying to be patient with him. He does odd jobs willingly, and can do messages quite well. He had been to Sunday School as suggested for the last two Sundays and has behaved well. He had been allowed to go as a reward for being good. His mother had been letting him practice writing and his grandmother gave him some plasticine with which he makes letters and animals quite well. He does not want to play on the street now. The paternal grandmother stated that the mother was much quieter and more controlled. Now that the father is permanently employed she has less financial worry and is better altogether. The grandmother has had several "straight talks" to her and told her that she must try self-control, or she may lose the child altogether.

The mother's manner to the child was quiet and reasonable and the child seemed obedient but still a bit excitable. The grandmother apparently understands him very well and has pointed out that he would soon show the other boys how sensible he was if he took no notice of their teasing. The mother was asked to take the child back to school on July 1st.

6/7/38: The school reported that patient had returned to school and had been put in class with a very sympathetic teacher. He is very pleased to be back at school and looks much better and happier and so far has behaved very well. The class teacher is very interested and expressed appreciation of Clinic assistance. She said that the mother seemed much
quieter and more sensible.

20/7/38: Teacher gives good report. Patient behaves very well in school and playground. He says he is going "to help mind the other boys." The paternal grandmother who is the cleaner at the school says that the mother is much better though a little excited just now as they are moving next Sunday.

20/7/38: When social worker visited the home the mother was busy preparing for move. She was very excited but "does manage to speak quietly to the children."

4/8/38: New home seems comfortable, clean and fairly neat. Mother is very thrilled with big rooms and big grassy yard. Patient seems well-behaved and happy. He says that he has four girl friends but no boys, wishes he had a boy friend. Obviously he loves the importance of a visitor to see him.

16/9/38: The mother says that the patient is behaving well and that there have been no complaints from school. Mother seems happier and less uncontrolled.

16/9/38: Mistress at school reports that child has settled down well and is no trouble in class or playground.
RESTLESSNESS, OVER-ACTIVITY, EXCITABILITY

Restless, over-active and excitable children usually prove to be children who have inadequate or unsuitable outlets for activity.

This is most commonly due to a failure to mix with other children with the result that the child lacks not only childish companions but is debarred from childish activities and adventures. Inevitably he then spends much of his time with adults where he is so frequently expected to sit still and is almost invariably left with nothing suitable to do and subjected to a capricious discipline governed by adult moods and interests. Else he spends his time alone where again it is very frequently easier to do nothing than to find amusements. Such children will obviously be restless for their energy is indigested and frequently such children will "show off" and become excitable and over-active when amongst adults, while they are fearful amongst children. Many indulge in phantasy and day dreaming.

Behaviour of this type occurs very often in over-protected children, especially in only children and in "artificial" only children.

Cases of over-activity are found frequently amongst bright children who are in a class with children of a much lower mental age and general ability. Such children respond well when placed in a "special class" where they are competing with others of a similar superior ability.

More often, however, the restless and excitable and over-active child is the dull and feebleminded child who cannot possibly keep pace with the work of the school grade in which he finds himself. Such children become restless because they have no tasks to interest them and take up their energy. Frequently too such children become very noisy and demonstrative as compensation for their constant failure. Many find that irrelevant noisy comment and questions distract attention from their failure to reply to questions; others find that they can secure
attention by a demonstrative noisy manner. It is significant that these children settle down very quickly when they are given manual and practical tasks which are within reach of their ability.

Therapy is directed towards modifying any unsatisfactory conditions in the home hygiene, such as late hours; reduction of adult society; assistance in mixing with children; an adjustment of scholastic demands to ability, and ample opportunities for suitable activity and recreation.

**Boy:** Chronological Age: 5 years 8 months.
Mother says:
**Problem:** "Restlessness, distractibility, unmanageable, irritable, babyish, little control over bladder."

Teacher says: "Muscular control poor, dirty, untidy work, restless and heedless, seems a lonely boy - does not join in play with other children."

Patient was running away from school a lot at first and does not seem to mix with other children. On one occasion he went to a friend and was walking about for three hours as mother always took him back if he went home. He plays well at home but he has not many children to play with. He prefers playing with girls at school. He is very untruthful, for example, when he smashed his toy car he told the butcher that his father had smashed it. He romances a great deal. When visiting friends he used to put any little toy he fancied into his pocket. He is very destructive with clothes and toys. He sucks his finger, chews clothes and always gets his clothes very dirty. His sexual organs seem to worry him; he says that they are too big for his pants.

**Family History:** Maternal and paternal grandfathers had nervous breakdown. The father, an officer in the Commonwealth bank, had a great deal of sickness as a child. He had infantile paralysis and bilious attacks every day of his life. The mother was alone a lot during pregnancy as father was doing nightwork at the bank. Mother lost two stone in weight in first five
months looking after patient who cried a lot and wakened a lot at night for several years. From eighteen months to three years he used to have twitching attacks. His face and all limbs would twitch but he would remain conscious and unable to sleep. The patient's brother aged 3½ was the opposite of the patient being a very placid child.

Mother and father studied child psychology and try to follow it. The father was very strictly brought up and thinks stick does no harm. Mother thinks it should be very rare and says half jokingly there will be a divorce if he tries too much beating.

Clinical Examination 27/6/33 Beyond a sallow skin and marked epicanthus no physical defects were revealed. Binet-testing gave a Mental Age of 6 years 4 months and an I.Q. of 112. The child was very co-operative, self-confident, socially assured, and obviously accustomed to adult society, dependent, talkative, desiring further instruction, encouragement and attention. His manual control was very poor and his speech indistinct and babyish.

Therapy: It was considered that the boy's difficulties had arisen from over-protection on the part of his parents, which had caused him to become self-conscious and dependent. For the same reason he had difficulty in mixing with boys of his own age and showed poor motor control. Therefore the mother was advised regarding home management and it was suggested to the school that more progress was likely to be made by playground supervision to encourage him to join in games and group activities with other children than by formal teaching.

18/7/33: Mother states that patient has wandered off from school only once but they decided not to punish him or make a fuss. He seems happier and is doing better work at school though he still does not mix much with other children and prefers to play with his small brother who treats him as a hero. She has heard that at the Private Kindergarten where patient used to go to school at first, the other children would not play with him
because he wanted to run everything. He has apparently no
confidence with children now. He is much more independent and
can dress himself. Mother playing tennis two days weekly and
takes attention off children.

On the same day the school teacher reported that she
was encouraging the patient and getting good results. She had
been giving him jobs in lunch hour to gain his confidence. The
social worker suggested that some responsibility in class would
be better and give him more chance to play with classmates.

15/8/38: Child away from school for a month owing to influenza.
Mother in bed with influenza. Mother states that child has gone
back to old ways of playing with little brother and tiny children.
Social worker advised note to teacher suggesting kindergarten and
Mother agreed to take patient to Moore Park Playground on
Saturday.

7/9/38: Playground supervisor reports patient attended every
day for a week (school holidays) - seemed happy but not joining
in with other children much.

22/9/38: Patient has had tonsillitis. Mother states that he
has a mate whom he goes to school with and plays with after
school. Seems much happier.

Teacher reports that his work has much improved but
he will have to repeat the year. He is playing with other boys
at lunch time now.

Girl: Chronological Age: 3 years 9 months.

Problem: Habit spasm: dough and blinking eyes and screwing up
nose; over-active; imaginative; talks to herself, to dolls,
and to fairies. Is put to bed at 7 p.m. but talks until 9 p.m.
Frequently has mother in room chasing fairies on the window pane
and curtain. Is determined and self-willed and will not stop
until she gets what she wants; she keeps on for hours and
always cries if she does not get her own way. It is difficult
to get her to take her meals.

Family History and Home Hygiene: Mother states that child was
a wonderful baby but has never been the same since she took a
convulsion at age two, and this was followed by measles. She and her only brother idolise one another. She has no other children to play with since the family live on a new estate in a neighbourhood where on one side of the road there are old families with no young children and on the other side there are recently married couples with no children. The mother has blood pressure and heart disease and is a very over-anxious fussy type.

Clinical Examination revealed no physical defects. There was a habit spasm present and the child was extremely talkative and active. Binet-testing gave a Mental Age of four years four months and an I.Q. of 116.

Treatment: The mother was advised to take no notice of the habit spasm; to reduce adult company to a minimum, and to terminate all contact absolutely when the child was put to bed.

It was arranged for the child to attend Kindergarten. The headmistress reported that the child had settled down well, gave no trouble at all and seemed perfectly happy. Teacher takes very little notice of her and no twitching or coughing had been seen.

Boy: Chronological Age: 8 years.

Problem: "Won't learn and refused to go to school; mischievous; highly strung and excitable. Troublesome with food. Mother has to stand over him all the time and make him take meals; he always wants something different from what is provided. He is up before daylight during the week-end but will not get up on school days. He is very dissatisfied, though he has everything he wants, he is always changing his interests and wanting something fresh. He wants all his own way. He gets on with younger children but older ones will not be domineered. Not at all shy with adults - will go straight up to a strange car and talk to occupants.

Family History: Father was an only child and always shut himself
himself away. He expects patient to do the same and will not let him have any companions for fear they tread on the garden. Child then wants to go into other homes. Father is not a child-lover and has refused to have any more children.

Clinical Examination 21/6/38 revealed that the child had a Mental Age of 5 years 11 months and an I.Q. of 74. He was found to be very highly strung and excitable, and at the same time extremely dependent, being able to do little for himself. On account of his babyish ways and old-fashioned conversation he had evidently become the butt for other children at school. He stated that he disliked school because "the boys hit me on the way home and knock me over at school and make my nose bleed. One boy tries to get me into trouble all the time; he caught me and smacked me and I went another way. I'd rather go to boarding school than all these other schools; I'd have more playmates then; all the boys fight with me here but they wouldn't be allowed to fight at boarding school." It was gathered that his difficulties had arisen from his position as an only child who had been unable to escape excessive attention from adults while he had had no opportunity to mix with other children and had indeed become quite unfitted to do so. Moreover as he himself stated "Mother spoils me but daddy doesn't." A visit to the home showed that the boy did as he liked. His toys were about the house. The mother frequently discussed the boy in his presence.

Therapy: was directed towards a more suitable home hygiene and emphasis upon group activity and play at school. It was arranged for the mother to attend a child study group which is held at the school once a month for mothers.

21/7/38: Teacher reported that child was unable to do the work in 2nd. class and became very restless. He was placed in 1st. class two weeks ago and seems much happier. He is slow at learning but is less restless. There has been no trouble in the playground.
21/7/36: Mother very pleased with patient. States that he is happier at home and has a friend with whom he plays on most days. She is very interested in the discussions at the child study group.
HABIT SPASM

In the treatment of habit spasm it is not the tics that must be treated but the patient who has them. The habit spasm itself is but a symptom of some underlying fear or anxiety, it is a danger signal that there is something amiss in the emotional life of the child. It is a matter of common experience that the more the child's attention is directed towards the movements, either in a therapeutic effort or otherwise, the less they are likely to disappear. This is why parental correction in the form of admonition, nagging or warning does not usually result in improvement. This is also why such methods as exercises before the mirror do not have the desired effect. These measures, as well as massage, electro therapy, and even suggestion centring on the tics only, disregard the much larger issues of the etiological basis anchored in the child's personality and environment. Since too, tics are practically always combined with other personality difficulties, it is natural that the therapy is directed towards a better adjustment of the child as a whole rather than towards treating the co-existing tic and other problems as separate things.

Therapy must be preceded by careful examination in order to discover whether there is some local stimulus, and whether the environment is reassuring. The first care must then be the relief of any local irritating conditions. If there are extant any physical factors which originally led to the evolution of the tic they must be remedied, for example, a stray lock of hair, a tight cap, bad lighting, etc.

It must be remembered, however, that no matter how potent the local stimulus the habit would not persist had it not become a channel for the relief of anxiety, the outlet of emotion which has been blocked.

In this connexion it is interesting to notice that it is very often not so much a particular part of the body, as
some function associated with that part which has become ex-
aggerated and detached from its original purpose. The habit
spasm, too, frequently arises in circumstances which appear
to be innocuous.

The next therapeutic step is to correct faulty
notions, and to banish superstitions regarding the habit spasm.
Parents and teachers must be led to know that there is no
organic or nervous disease present. They must realise that
the habit is not something consciously created by the child
just to torment his family. It must be shown that it will not
be broken by scolding and punishment. Reason alone will be
of little avail for it also neglects the intense feeling-life
of the child. It must be realised that if the child's feelings
are wrong he will tend to do the wrong thing. The almost
irresistible "don't-do-that" attitude must be supplanted by a
"do-this". Ignore the habit and reassure the patient.

Therapy must also be directed towards the overcoming of
environmental difficulties. This may involve attention to
the family, where parental friction, fear of an alcoholic father,
chronic invalidism, favouritism or contrasting of children,
excessive parental ambition, parental over-protection and other
such subtle attitudes, may create the need for advice and
guidance. School adjustment may be necessary in some cases.

Just as psychiatric treatment aims at cultivating in
the parent an optimistic outlook, so the psychiatrist tries to
establish self-confidence in the child in regard to the cur-
ability of his movements. He has to remove the notion that
organic illness is responsible. Further than that, a con-
structive hygiene is worked out so that adequate occupation,
play and rest will be ensured for the child. In this way his
attention becomes turned away from the habit spasm and his
energy directed into suitable activity. In this connexion it
is interesting to notice that habit spasms tend to occur in
over-protected and only children. Such children are debarred
from the companionship of other children and from participation in childish activities. With reduction of parental anxiety and over-protection, assisting the patient to mix with children of his own age, and with the provision of suitable occupations, it is amazing how quickly habit spasms clear up.

**Boy:** Chronological Age: 10 years 9 months.

**Problem:** Mother states that he has had a terrible shaking of head for two and twelve months. It has got worse and she cannot bear it a moment longer.

**Family History:** Mother invalid pensioner. Father divorced six years ago and remarried. Drinker. Divorced for desertion though mother now says that she was committing adultery at the time. Lived apart after patient's birth. Mother and patient live with grandmother and four cousins (ages ranging from 15 - 4 years), children of a deceased aunt. Patient's school progress has been handicapped by irregular attendance. Mother worries about patient too much and keeps him away from school even if he has a slight cold. He spends most of his time with his mother, even going away for holidays with her during the school term.

**Clinical Examination 5/4/37** revealed that despite his frequent absences from school owing to "illness" his general health was satisfactory. He was an over-grown lad whose height-weight ratio corresponded to that of an average boy of 14½ years. Binet-testing gave a Mental Age of 11 years 6 months and I.Q. of 107. He suffered from a habit spasm which involved a jerky backward shake of his head. The boy was obviously too accustomed to the company of his mother who was a fussy type and who had treated the habit spasm by saying continually "Don't do that" but at the same time giving the child nothing to do. His hair was worn in long dark curls. He had no boyish interests and was not allowed to play "rough" games like football.
Therapy included participation in games and group activities at school, enrolment in a boy's club, less association with adults. The mother was advised to send the boy to school unless he were really ill in bed in which case she should call in a doctor. If she felt anxious about his health she should bring him to the doctor at the Clinic rather than keep him from school. Above all, the mother was encouraged to pay less attention to the child; to show no anxiety regarding the habit spasm, but to disregard it entirely. It was suggested to the mother that perhaps the habit spasm might go more quickly if the child's curls were cut since the hair must be an irritation. She was very upset at the thought of losing the curls but she at last agreed to think about the suggestion.

20/4/37: Mother states that habit spasm appears at times. No habit spasm observed during visit to the Clinic. Father upsets patient by passing unseemly remarks about mother. Child came home and asked mother what "illegitimate" means. Patient has anxiety dreams.

4/5/37: To have treatment at Dental Hospital. No habit spasm.
25/5/37: Has been in bed with bronchitis.
15/6/37: Habit spasm of shoulder and head not observed but now has habit of licking lips which is excoriated. It was thought that if the habit spasm persisted a permanent scar might be left.
9/7/37: Progressing favourably. Has started to play football with the school team. No habit spasm.
26/7/37: Was kept home from school all last week and today because mother had a cough.
29/7/37: Patient says that he has been home from school 16 days in past month but mother states that it is only six days. His mother does not let him go to school when it rains lest he catch a cold. She rubs his chest and keeps a thick singlet on him. Since it was found that the patient slept with the mother it was stipulated that this must cease. Patient now had a habit spasm of blinking his eyes.
17/8/37: School attendance regular until 15th instant when
mother called in doctor for feverish cold. Patient has been in bed since. Doctor saw him this morning and said not to bring him to Clinic.

24/8/37: Chest and throat clear. Attended school today.
30/9/37: Doctor has certified that mother must be relieved of her wards on account of heart disease and neurasthenia.
5/10/37: School attendance satisfactory. No habit spasm.
9/11/37: School attendance satisfactory except for week's holiday with mother.
7/12/37: Regular school attendance.
21/12/37: Progressing favourably.
25/3/38: Doctor ordered patient to bed for seven days for bronchitis.
17/5/38: Absent one day for cold, another day for digestive disorder. Was away for four days' car trip.
5/7/38: "Bad pains in umbilical region, dry in mouth, heart burn".
12/7/38: Feels well except for heart burn early in morning. To join Boy Scouts.
2/8/38: Feels quite fit.

**PSEUDO-CHOREA**

There have been referred to the Clinic some very interesting cases of pseudo-chorea. Some of these are cases of habit spasms which had actually been diagnosed and treated as chorea by medical practitioners. Now the treatment for habit spasms and the treatment of chorea are diametrically opposed. Chorea is a disease of the nervous system and demands rest and a period in bed, whereas habit spasm is a sign that active outlets are necessary. Hence if habit spasm is treated as chorea it becomes more severe and it is possible that through inactivity the child may become physically unfit.
Boy: Chronological Age: 13 years 4 months.

Problem: School report of 10/6/37 stated that he was "backward mentally and did not appear robust." On 16/10/37 he was placed in custody of a guardian but his conduct called for medical examination and he was thought to be suffering from chorea and early rheumatic carditis. He was placed in Smith Family Recovery Home and intended to remain for six months but was discharged on 12/3/38 for assaulting another inmate. He was reported by the matron to be almost uncontrollable and of a vicious nature. His present guardian reports that he will get into tempers when he punches, hits and says nasty things when the slightest thing is wrong. Has habit of shaking his head or blinking his eyes. He sleeps restlessly and in conversation repeats the same thing over and over again.

Family History: Father died 1930 of pulmonary T.B. The mother died of pneumonia in 1936. The child had apparently had a hard life, and had been short of money and food. Apparently there were two other children and a man, whom children called stepfather living in the home. He would thrash the children who were allowed to run about wild and go to bed at any hour. The man was on relief work and the younger children were apparently illegitimate children of the mother.

Clinical Examination 14/2/38: He was found to be of average height and fairly well nourished. Vision was somewhat defective and tonsils required attention. No signs of chorea were discernible, and the cardiac condition was satisfactory. He was however found to be the subject of a very severe habit spasm affecting facial movements. There was a nervous twitching of the muscles near the eyes, and a mannerism of putting fingers on bridge of nose and partly over eyes especially when confronted with a difficulty. There were other restless movements and his nails were badly bitten and torn. The child looked so pale and sick and these nervous symptoms were so severe that one could understand an observer diagnosing the case as one of chorea yet the doctor and the psychologist felt confident that
the movements were not choreic in nature and that the child appeared and was so unfit owing to wrong treatment.

Binet-testing gave a Mental Age of 10 years 8 months and an I.Q. of 81, but it was considered that his state of severe nervous tension and excessive emotional reaction may have prejudiced the result. Moreover the child looked so ill that the psychological hesitated to press him.

Therapy recommended wise and stable guardianship; constructive interests including a Boys' Club, and plenty of sport and activity; emphasis on manual and technical training at school in view of the fact that he is likely to be fitted only for a routine unskilled occupation.

1/3/38: Guardian states "taking more interest in school." Twitching disappeared. To start swimming.

22/3/38: Has cold and earache. Guardian reports marked improvement. Has been going out with Scouts.

12/4/38: Guardian in bed. Patient has not been able to go swimming on account of cold.

10/5/38: Came fourteen out of thirty-six in 5th. class; 468 marks out of 700. Not allowed by guardian to play football.

7/6/38: Had tonsillectomy last week. Very nervy the previous week.

5/7/38: Did well in half-yearly examination; 530 marks out of 800.

16/8/38: In bed with cold during week-end.

SHYNESS; SUPERSENSITIVENESS; UNSOCIALITY

The shy, supersensitive, unsociable child is of course predominantly the over-protected child who is so accustomed to adult society that he is unable to mix with children. Most of the children referred to the Clinic for maladjustments of this character are not shy but most sociable with the Clinic Staff. Thus it is shown that they are so accustomed to adult society that a strange adult does not make them feel insecure, even though they are markedly unsociable when in the company of their equals.

This difficulty occurs frequently in only children and in the child who is many years younger than the next sibling; as also in children who are kept away from other children because they are living in neighbourhoods where their parents feel that they will be harmed by associating with the other children. Similarly children whose families are isolated frequently reveal these symptoms, for example, children who live in lighthouses, or in outlying suburbs.

Such children, even when of low ability, frequently become over-conscientious at school. They tend to exert themselves so that they may become a "teacher's favourite" in order to make up for their inability to get on with children. They then rise to forms beyond their capacity and are at the same time teased and bullied by other children. These additional strains cause further difficulties such as night terrors, habit spasms, and morbid fears.

One finds this excessive sensitiveness and unsociality even in children of very high intelligence who are "shown off" by their parents and who, though very successful at school, are not accustomed to children's society.

The supersensitive child frequently comes too from the family where there is an air of fussiness and over-scrupulousness and where there is an atmosphere of parental criticism.
Therapy must include forbidding adult company and providing opportunities and assistance in mixing with children. The parents must realise that children should not be models but children. The playground is, in such cases, more important than the classroom. The Supervised Municipal Playgrounds and Children's Libraries are of tremendous assistance in problems of this type.

**Girl:** Chronological Age: 13 years 5 months.

**Problem:** "Nervous, shrinking, manner generally is a direct invitation to be bullied; abnormally sensitive to being teased about her surname or 'cry baby'; will not make any attempt whatever at defending or explaining herself; has no friends of her own age; plays with little children."

**Family History:** Father nervy and irritable, has a way of speaking in a loud bullying voice and upsets patient very much at times. He has no patience at all with children. He used to be alcoholic. He was almost "mental" before patient's birth. Patient's elder sister was delicate as a baby and quarrels with patient. There are two elder stepbrothers (paternal).

Mother had a lot of worry before patient's birth regarding elder sister. It was a difficult birth and Mother was aged forty at the time. Patient's twin sister died shortly after birth and since mother had to nurse father who had had an operation, patient was put on bottle at three months. She was a very cross baby.

At the age of five years patient fractured her right forearm. Mother wanted her to have an anaesthetic but the doctor refused. Patient screamed during the operation and had to be held. It was some time after that that the weeping started and mother blamed that for it.

Patient started school at five years and it was no trouble to go though two years ago she was very unhappy at the primary school as teacher used to hold her up to the class as a cry baby.
Mother states that patient is very fond of little children but does not get on well at all with children of her own age who call her a cry baby. She has no friends. She still likes to play with dolls. She is not shy with adults and gets on well with them, she "talks like an old woman." A maternal aunt lives with the family and patient cannot get on well with her; the aunt wants to direct her all the time.

Clinical Examination 10/10/38 revealed that she was a big girl for her age and in satisfactory bodily health. She had an I.Q. of 121. While the various emotional tensions in the home especially the dominating attitude of the aunt, made it a difficult one, it was considered that the indispensable factor, which had affected the child from birth, had been an anxious and over-solicitous tendency on the mother's part. This had been especially evident from the time that the child had sustained the fractured arm shortly after commencing her school career from which time her mother dated her excessive proneness to tears.

The child herself was found to be painfully aware of her weakness and her valiant efforts to overcome it had been frustrated by the fact that everyone expected her to break down. She was quite ready to confess that she felt extremely lonely on account of the unwillingness of any of her schoolmates to befriend her.

Therapy: It was anticipated that any effort to restore her self-confidence which had been subjected to systematic undermining for so long, would bear fruit. It was explained to the mother and to the teachers that she should never have her attention drawn to her weakness but should be encouraged to regard herself as a perfectly normal girl. It was arranged for her to join the Girl Guides.

1/11/38: Mother reports marked improvement. Patient has just left for Stewart House for a month. She has joined the Girl Guides and went for a "hike" last Saturday and had a very nice time.

13/12/38: Has had six weeks at Stewart House. Much improved.
There was an informal request from one of patient's teachers to know where she had been for assistance since her change of behaviour was a "miracle".

**Girl**: Chronological Age: 9 years 6 months.

**Problem**: Melodramatic. Has periods of emotional intensity. She has at times threatened to kill herself and mother is of the opinion that she is quite capable of it.

**Family History**: Elderly parents. Father is a bottle merchant and mother assists in business. Elder brother aged 27 years was married two years ago. The mother is a disappointed woman who feels that she has missed her vocation as a dramatic artist.

**Clinical Examination** revealed that the child had a Mental Age of 9 years 6 months and an I.Q. of 95. It was found that she was quite at ease with adults with whom she had been too much associated. She had been discouraged from mixing with children of her own age and consequently soon got out of hand and quarrelled when in their company. She is not allowed to have companions at home and thinks that most of the children at school do not like her. They call her names and "sometimes I wish I were dead." "The girls say that if any one else does things I'm jealous. When I'm monitor, if the other girls come out I tell them to go back to their seats."

**Therapy**: 24/1/38 Mother was advised to exclude the child from adult company as far as possible and to foster companionship with children of her own age. It was pointed out to the mother that the child's melodrama and references to suicide were copied from herself. The school was requested to give her a minimum of adult attention and to encourage her to join in games and group activities.

1/3/38: Definitely improved

29/3/38: Improved

2/5/38: Headmistress reports that child is getting better

15/6/38: No further trouble
POOR SCHOLASTIC PROGRESS

Poor progress is most commonly due to low intelligence in which case clinical assistance can go no farther than to examine the child and suggest suitable schools.

Frequently however poor progress is due to remedial factors such as emotional maladjustment (for example, shyness), physical defect (for example, defective sight or hearing), absence from school, poor hygiene, lack of interest, need for educational guidance. In such cases the etiological factor can be remedied adjustment is usually attained fairly rapidly.

Girl: Chronological Age: 12 years 2 months.

Problem: (as stated by school) "Pugnacious, ill-tempered, irritable, quarrelsome, cruel, disobedient, destructive, teases, easily angered, sulky, meddlesome, easily led, shows off, careless, indifferent, excitable, highly strung, tells lies, she is constantly in trouble for roughness in play. She likes spelling and reading and will copy out work contentedly but dislikes anything requiring reasoning or creative work. Her arithmetic is extremely weak and she will not do her work unless forced.

Her parents stated that she was inclined to be boisterous and had always been highly strung. They were concerned that her school progress was poor, especially in arithmetic. Parents and teachers had found the child so unmanageable that she was brought a distance of about fifty miles to the Clinic. Clinical Examination revealed a Mental Age of 7 years 4 months and an I.Q. of 60. She was in 4th. class at school where the average mental age would be about 10 years. Her parents stated that she did not like going to school at six years of age and took a long time to settle down - at that time her mental age would have been only three years seven months. Though she was noisy, boisterous, undisciplined, meddlesome and inquisitive when at first interviewed there was a remarkable change when she was required to do tasks which were within reach of her
ability and she settled down very well in the test situation. Despite the fact that she was causing concern regarding her school progress in accuracy and speed of reading she attained a standard about two years in excess of her mental age. She had obviously been discouraged by the administration of tasks beyond her grasp and it was significant in the test situation that as soon as a task was too difficult she attempted to distract the examiner's attention by innumerable irrelevant questions and noisy excitable behaviour.

The child had the appearance of a normal healthy, even bright, child so that it was not surprising that she had not been regarded and treated as a feeble-minded child.

It was suggested that she would be likely to be capable of filling only some vocation requiring simple mechanical work. Her educational horizon would be limited to moderate competence in reading and writing and calculating money of small denominations. It was recommended that no attempt be made to push her but due encouragement be offered for any small success achieved. Teaching should be made as concrete as possible and as much manual work as is available should be provided.

Boy: Chronological Age: 11 Years.
Problem: Fair progress, shyness, nervousness; can do mental arithmetic but cannot do it on paper. Has a large fund of knowledge but can do no work on paper.
Family History: Father a returned soldier, asthmatical, sleeps badly. Mother suffers with a neurotic skin trouble, for example, her lips and eyes swelled up when she heard of her brother's death and the war. She dreads going among strangers especially womenfolk. There are few companions that parents approve of in the neighbourhood and patient is very nervous of other boys. Patient gets sick in the stomach if he attends a picture show and as soon as he feels everyone around he says "Oh, Mum can I go out?" He likes small toys. He started school at seven years and attended a small private school till eight years. He
now comes well down in class, and is particularly slow at writing anything.

Clinical Examination revealed that he was a big boy for his age. Binet-testing gave a Mental Age of 12 years 1 month and an I.Q. of 110. His reading age was that of an average child of 10 years 4 months and he was much below standard in arithmetic.

It was considered that his timidity and shyness as also his poor showing in school might be attributed to an over-protecting attitude on the part of his parents who had discouraged him from associating with other boys, thus hampering the normal development of initiative and character.

Therapy was directed towards a reduction of parental attention and anxiety. The boy was encouraged to enter actively into school life by joining in sports and organized games. It was arranged for him to join the Boy Scouts.

17/9/37: Has joined Cubs. He received tuition in arithmetic at the Clinic. It was found that his inability was due to dependence rather than to ignorance. He was so accustomed to instruction and oversight even in the matter of homework that he had not even the initiative to write the figures down without advice and instruction of some one else.

15/10/37: Mother notices general improvement.

12/11/37: Mother says that teacher has noticed remarkable improvement in patient's initiative. He obtained nearly 100% in geography and history. Written arithmetic is still behind but he is very good at mental arithmetic. He is very keen on the "Cubs".

17/12/37: Teacher is very pleased and notices that patient is much brighter.

16/3/38: Mother states that patient has improved in every possible way. He was in the Champion Six in the Cubs. He came on well at cricket and smashed two teeth at football. He has shown a remarkable gain in self-confidence, independence and initiative. He succeeded in his determination to gain 100% for arithmetic.
GIRL: **CHRONOLOGICAL AGE:** 9 months 3 years.

**Problem:** "Very poor progress, lethargic, is not mentally deficient - cannot read a word, will not attempt anything."

**Family History:** Maternal grandmother and granduncles could not learn at school and still cannot write their names. Mother could never learn at school.

**Clinical Examination** revealed that the child had a Mental Age of 5 years 8 months and an I.Q. of 61. Though in 3rd. class she had not yet reached the mental level at which a child can profitably commence learning to read. Her inability had been interpreted by the teacher as a refusal to try to learn.

GIRL: Chronological Age: 13 years 9 months.

**Problem:** Can write anything but does not seem to be able to grasp reading. She is all the time wanting to lie down and it is difficult to get her to do anything.

**Family History:** Maternal uncle feeble-minded. Two maternal cousins mentally defective.

**Clinical Examination** revealed that she had a Mental Age of 5 years 4 months and an I.Q. of 39. She was in 6th. class at school where the average mental age would be approximately 12 to 13 years. Her physical development was advanced so that it was even more difficult to picture her as having the mind of a very small child.

GIRL: Chronological Age: 9 years 3 months.

**Problem:** "No progress. This child is quite deaf."

**Family History:** Mother died a year ago

**Clinical Examination** gave a Mental Age of 5 years 10 months and an I.Q. of 63. The opinion was formed that the degree of deafness present should prove only a minor obstacle and that her failure to grasp instructions was mainly due to lack of understanding. Having found that she could not meet the demands made of her she had relied upon "deafness" to alleviate her difficulties. She had no difficulty in hearing in test situation
despite traffic noises, and when she could not answer a question, on being asked "Can you Hear?" she replied "No". She was at present in third class where her complete failure might well have been interpreted as deafness.

Boy: Chronological Age: 13 years 1 month.
Problem: Will not do any work at school; demoted;
Family History: Father is unemployed, having been in and out of work for four or five years. At present he is unable to get any food relief since his two daughters are working. Father states that "patient is touchy because he hasn't the books he should have and won't ask for them"; but father can only just keep family in food without buying books. Mother has to go to work and has no influence over the boy.

The school history revealed that the patient had been normal in 4th. class and was selected for the Special class. He did very well at first but changed teacher after six months and reacted by "passive resistance". He then went into High School where because of his poor progress he was at last demoted from second year to first year where he refused to do any work at all. He was very unpopular with his school fellows, played no sport, seemed to enjoy knocking girls over at combined functions. It was reported that though he was fond of meccano and pulling things to pieces, he did not seem to set his mind on a job and stick to it. He was not lazy. He would do anything about the house if left to himself, but would not do anything if asked to. He was never idle, occupied with household duties, gardening, woodwork, long rambles, and recently with learning to use the typewriter. He was in the habit of going to the pictures every Saturday afternoon and would read anything that he could get hold of. He was in the habit of keeping to himself and would not make any friends. He frequently played all day with his small brother and sister aged 5. His father stated that he was just as reserved and solitary at home as elsewhere.
About a year ago the patient had truanted for two weeks. He would not tell his family what he had been doing though he stated at the Clinic that he had just walked about the streets and did not speak to anyone.

He had nicotine poisoning when at the age of eighteen months from a picked-up cigarette butt. Since then he had gastric attacks every month.

Clinical Examination 7/5/37 revealed that he was in satisfactory bodily health. Binet-testing gave a Mental Age of 14 years 11 months and an I.Q. of 114. On interviewing him he was extremely reserved and almost sullen. He admitted that he mostly keeps to himself. It was gathered that he was bitter about the family's poverty and the necessity of his abandoning any hopes of a University career.

Therapy: In view of the boy's very poor scholastic showing and the family's financial circumstances there seemed no possibility of a University career. The family would endeavour to keep the boy at school for another year or two if he were likely to benefit. It was difficult to see how the boy would profit from his present High School course, whereas it was desirable to fit one of his ability for some vocation superior to that of an unskilled labourer. Hence it was recommended that he should be transferred to a suitable Technical School.

15/10/37: In first year at Junior Technical School Counsellor reported that he was taking much more interest and now doing well.

22/7/38: School reports that "he has made a very satisfactory adjustment. In the half-yearly examination he topped the second year. In contrast to his attitude at High School he now does very satisfactory homework. His teachers have handled him sympathetically and he has regained interest in school work and self-respect. He is practically always finished first in arithmetic and is then allowed to correct and help other boys of the class. His social personality is still unimpressive and he still reacts in a sullen way when crossed. Lately he is beginning to participate in games and fun in the playground, and in class voting on popularity he is always somewhere near top."
REMEDIAL TEACHING

School backwardness is so frequently associated with nervous disorders and truancy (and hence with delinquency) that remedial teaching in reading and arithmetic is an important aspect of therapy.

Owing to the very limited time at the disposal of the psychologist for this type of work, only a very few severe cases have been accepted for treatment. No children suffering from general mental defect are accepted for remedial work.

In cases of backwardness due, not to specific disability, but to absences from school at critical periods, frequent short absences, or failure to keep quite up to the pace of the class, encouragement, praise and understanding are of even more importance in therapy than are the special teaching methods used. Remarkable changes in habits and personality, particularly among truants, are manifest when such assistance and encouragement are given then.

Though in cases where there is some specific disability present, encouragement, praise, and unbounded patience are of vital importance, it is essential too to find suitable methods by which the child may be taught. A child with good auditory imagery will for example usually learn to read more quickly by the phonetic method, whereas a child whose visual imagery is good and whose auditory imagery is defective will find "look-and-see" and picture methods more profitable. Wherever possible the emphasis is placed on phonetics since this seems the more reliable method in the long run. It is significant perhaps, that it is so frequently found that children suffering from backwardness in reading do not attempt to use phonetics but spell the letters of the words over to themselves.

Material from various sources and original material which experience has shown to be satisfactory have been incorporated in the remedial reading programme which is too detailed to present here.
Boy: Chronological Age: 10 years 2 months.

Problem: School reports that "his progress is nil. He takes no interest in his school work. He came 36th. out of 36th. in 4th. class; he truants and steals and is a nuisance in class and is badly conducted. He is constantly in trouble for dis-obedience and untruthfulness. He takes no interest in sport, plays in streets or park and is always in mischief. Pugnacious, cruel, destructive, teases, sulky, wants all he sees. His mother shields him and his parents seem to have no control over him."

Family History: His mother stated that he suffered from enuresis until six months ago. He wants his own way if he can get it. He calls out in sleep at times/he has been excited in day. He started to miss half days when changed to new school a few years ago; missed a whole week this year. Plays about in park with other boys and then would come home and tell mother that he had been to school. Was before Children's Court a month ago for stealing from Coles.

His mother suffers from nerves and his father has been unemployed for five years.

Clinical Examination revealed that he was hard of hearing in the right ear. Binet-testing gave a Mental Age of 9 years 4 months and an I.Q. of 92. His educational age for reading was 8 years 3 months while he was extremely backward in arithmetic. He was unable to say even twice times table and could not subtract, multiply or divide. He disliked school and was frequently kept in. He gave his reason for disliking school the fact that boys hit him and threw things at him. It was found that he went to the pictures on Friday nights and on other nights frequently stayed up until 11 o'clock playing cards with his sisters. He was very unsociable and made it apparent to the examiner that he was doing the tests only because he had to. He was extremely unco-operative, rather aggressively sullen and sulky, and was very displeased and irritated by failure. The general retardation in his school work was attributed to irregular
attendance and lack of interest, rather than to any specific defect.

Therapy was directed towards a more suitable home hygiene with emphasis upon early hours, reduction of feminine society, and encouragement and praise for good conduct. It was arranged for him to attend the Municipal Playground. His teacher at school was asked to notice and express approval at any improvement. He was to attend the Clinic for tuition in arithmetic for a short time one afternoon each week.

In a week his father reported that they had realised that thrashing would do the boy more harm than good, and that he is trying to encourage the boy in every way and feels that he will be all right now. The boy is showing no desire to go out and is proving very willing and helpful. The mother stated that she was sending the patient to bed between 8 and 9 p.m. and that she has no trouble now in getting him up in the morning in time for school though his father still takes him to school.

At the Clinic the patient was brighter and more cooperative but still very unsociable and sulky. He seemed to be liking the playground. Though various dodges had to be used in order to make him interested in his tables, he had worked at them satisfactorily, having learnt 2, 3 and 4 times. He mastered subtraction and understood multiplications in his first lesson.

The next week the mother told the social worker that he was "a changed boy, helpful, and never wanted to go out with the rough crowd now."

By the end of the third lesson he had mastered subtraction, multiplication, and short division. He reported an early mark at school for getting his division sums correct. Gradually he learnt his tables and caught up to the standard of the class since when he has worked hard with interest and has been able to master new sums as they were taught in class. He was very pleased with his teacher's remark "you are trying hard" and was thrilled with praise from the headmaster when he gained nine out of ten in his test.
A month after his first visit to the Clinic his mother
told the social worker that "he is no trouble at all now. We
trust him in every way and let him know that, and he responds.
He goes and comes from school alone and is always punctual."
The school reported improvement within a month. No unfavourable
reports from school and home have been received.

In less than three months he showed a remarkable im-
provement in his attitude at the Clinic. He has become very
co-operative; takes pleasure in spontaneously talking with other
members of the Clinic Staff. Instead of his sulky negativism
he has a happy expression, greets the staff brightly and chatters
happily. He has become so responsive, that as soon as it is
suggested, for example, that he should make neater figures he
immediately takes pleasure in neatness. He has not only lost his
backwardness at school but has gained a new attitude.

Boy: Chronological Age: 10 years.
Problem: School reports that he is very backward, spiteful,
especially to girls whom he punches; conduct mostly fair;
constantly in trouble for fighting; pugnacious, quarrelsome,
cruel, teases, shows off, careless.
Clinical Examination revealed that this boy was of at least aver-
age intelligence. Binet-testing gave a Mental Age of 11 years
7 months and an I.Q. of 116. He was found to be markedly back-
ward in his attainments, his educational age for reading being
that of an average child of 9 years 4 months. In his attempts
at reading he used no phonetic sounds but merely spelt over the
letters of each word. He had obviously an intense feeling of
inferiority where reading and language were involved. His
emotional reactions were excessive and immature. He seemed
abstracted and at a tension and appeared not at all happy.
In his anxiety to show that he could do things he was careless
and hasty in performance.
Therapy. Phonetic Method. He could recognise all the alpha-
betical sounds and simple combinations at the first lesson.
He had great difficulty with non-phonetic words such as "rough" and "light". He progressed steadily and in a month reported that he was noticing a difference in his reading at school. Though still hasty and careless he was much more confident, and happy. After five months he is now reading simple books slowly but accurately and with enjoyment, and comes to the Clinic with a bright happy expression to tell of his activities during the week.

Boy: Chronological Age: 12 years.

Problem: School reports "Poor progress at school but has common-sense; worries about his educational disabilities (a form of congenital word blindness).

Clinical Examination: Binet-testing gave a Mental Age of 11 years and an I.Q. of 91, while a Non-Verbal test gave an I.Q. of 95. His educational age for reading was that of an average child of less than 6 years.

Therapy: Tuition in phonetics was commenced on 26/10/37, and has since continued at first once each week and later once a fortnight. Though the patient found phonetic words easier than non-sound words it was at least three months before he had mastered simple sounds. In five months he could read simple books such as Sinbad the Sailor. He has gradually come to read with greater ease and accuracy, is extremely pleased by his success and shows a marked increase in self-confidence. He is now reading and enjoying "Coral Island" and his teacher reports that he is happy in school and his reading has much improved.
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SPEECH DIFFICULTIES

The most troublesome habits to treat are those concerned with speaking. One of the reasons for this difficulty is that so much attention is concentrated on the symptom itself rather than upon the underlying causes.

Though the remarkable differences rather than the resemblances between individual cases of stammering are at first apparent, one does not find certain characteristics. The typical stammerer is of the unstable nervous type and his habitual approach to any situation is characterised by anxiety tensions. The stammerer finds it difficult and at times impossible to relax. When in a situation in which he feels insecure and ill-at-ease he reacts by a general tension which accentuates the stammer; as the stammer becomes more severe he becomes more and more tense while straining to speak, until at times in severe cases, the stammerer's body, most conspicuously his arms and legs, is stiff as iron. This tension interferes with breathing which instead of being naturally rhythmical is jerky, spasmodic and irregular. It is weeks and even months before some children can acquire regular breathing and even when such habits have been acquired as soon as there is a lapse into stammering breathing immediately becomes extraordinary irregular and spasmodic.

On the whole the stammerer tends to be very restless. His activity seems rather undisciplined and unorganized. There is usually poor muscular control particularly of the tongue and lips. Posture is stooped in a significantly apologetic attitude. Some even after several months, find it difficult to look directly at the therapist and shake hands after a visit to the clinic.

Many stammerers reveal confused thought. They are so accustomed to heightened consciousness of self—obtruding that thought has become indefinite and hesitant. When the stammerer's confidence has been gained he tends to be talkative. Owing to his having been forced because of his disability into withdrawing
a great deal from society he has usually developed interests and hobbies and when he finds the therapist genuinely interested he is anxious to speak of these.

The noticeable onset of stammering is usually apparent on beginning school or on transferring to a more advanced school.

The records indicate that stammering is far more frequent in boys than in girls. There is a marked coincidence between stammering and enuresis. The stammerers tend to be of a comparatively high intelligence.

All of these characteristics show that the normal feeling of security and poise is undermined by lack of confidence which produces anxiety and heightened self-consciousness.

Despite the prevalence of speech disabilities and their severe effects upon the personality of the sufferer very little systematic research has been carried out in this field and there is in Australia scarcely even an awareness of the urgent necessity for providing appropriate clinical services.

Since several cases of lisping, ideoglossia, and severe stammerers for whom no professional treatment was available, were referred to the Clinic it was decided towards the middle of 1937 that one morning a week would be reserved for a speech clinic.

That many satisfactory and some apparently miraculous results have come out of this experiment leads one to stress what is not yet widely realised - that stammering is a psychological disturbance. It is not the speech disorder which must be treated but the child who presents the speech disorder.

For this reason any therapeutic attempts must be preceded by a thorough knowledge of the patient's personality and environment, his physical condition, home management, school situation, mode of onset of stammering, and of any behaviour difficulties which he may have.

Therapy must then be directed towards the correction of any physical ailments. Excessive strain at school must be
removed. The patient and his family must be relieved of the feeling of consternation and hopelessness which often goes with notions of organic origin and inheritance. Habits of pitying the patient and speaking of his difficulty in his presence, interrupting him impatiently, teasing him, reprimanding him or beating him, must be broken. The child must be listened to calmly and with no show of emotion by those who surround him at home and at school. He should be given all the time he needs to say what he wishes to say. He needs to lose some of his excessive consciousness of self and to gain a more objective outlook. Hence it is fruitless to criticise and correct him and turn his attention inwards. Interest in the "self" has already become too intense for the "not-self" should be the normal centre of interest. Thus it seems that it is only by a steady outgoing of the "not-self" that the child can lose his abnormal consciousness of self and attain a feeling of security.

Thus in this experiment the objective has been to adjust the child by establishing self-confidence and a feeling of security with the assumption that the speech difficulty will then right itself. To effect this analytic methods have been entirely neglected.

At first individual method outlined by McAlister in her "Speech Therapy" was followed but gradually there was evolved a combination of the individual and the class method. Throughout the emphasis is placed on individual encouragement and suggestion in an informal friendly atmosphere.

When the patient first visits the Clinic for medical and psychological examination he is shown relaxation and tongue exercises (V. McAlister "Speech Therapy") which he is asked to practice each day so that when he attends the speech Clinic the following week he will be able to join in with the class.

The boys are required to attend the Clinic punctually at 9.30 a.m. each Friday. After saying "Good-morning" - in an informal manner - they put down rugs and cushions on the floor, take off their shoes and lie down in a comfortable position
with one hand alongside and the other resting on the lower abdomen. The therapist counts aloud "In 1, 2, 3, Out 1, 2, 3" while the children breathe rhythmically. The therapist assists various members of the class by placing his hands on the patient's hand which is resting on his abdomen, with slight pressure on the "in" count and lifting of pressure on the "out" count. He then lets the children breathe to their own time. He lifts arms and legs of various children and shows them how relaxed they are. When the children are relaxed the therapist gives them suggestions encouraging them to feel relaxed and at ease. Various phrases are repeated which induce drowsiness and ease. He stresses the fact that they must think of ease, that whenever they are relaxed and think of ease their speech will not be difficult.

Speech situations must then be produced so that the stammerer may practice speaking when at ease. After the relaxation exercises the therapist makes a general request for someone to tell about his last football match, etc. Some children volunteer and gradually others are led into taking a part. They then go on to describe pictures in turn, first in front of them and then with it with the picture/out of sight when they are asked to recall what they have seen. Various games are used, for example, one boy goes out of the room and on his return has to guess what object the others have thought about by asking questions to which nothing other than "yes" or "no" might be given in answer.

The social worker continues the supervision of such games with the group while the psychiatrist and psychologist each take a child for individual work. MoAlister's tongue and lip exercises are given. Much emphasis is placed on reading and informal conversation with the therapist. Reading seems specially important because it is a means of getting a regular rhythmic objective speech which will tend to become antagonistic to the old hesitant habit. Marking the reading material with strokes for pauses is found to be of remarkable value for it develops habits of rhythmic breathing and there is less
anxiety for the stammerer who can master what is ahead step by step. Most of the stammerers read very quickly. They are afraid to pause or go slowly. They have the feeling that once started they must get the words out while they can with the result that they are at a severe tension, get out of breath, are forced to pause in the wrong places and frequently in the midst of a word, and then start to stammer. Actually they read more fluently when they read more slowly and pause rhythmically as pause marks indicate, though for a while they need the security of the therapist reading aloud with them in a calm even voice, at first all the time and then at intervals when the stammer appears. Many of the most obstinate stammerers are good readers.

Various exercises and games are introduced in this individual part of the therapy but perhaps the most valuable aspect of it is the informal conversation with the therapist when the child can find security and ease in the consistent encouraging friendly attitude of the therapist who shows that he is genuinely interested in the child's thoughts and activities. The therapist's attention is directed not so much towards the way the child speaks but towards building up his confidence by en- (ty to feel that the therapist understands his difficouragement and suggestion. The child comes/and gives him the assurance that it can be cured. It is significant that during the period of treatment it is not just the improvement in speech but the change in the whole personality of the child which is conspicuous.

Throughout treatment it is necessary to give tasks which can be accomplished easily enough for the stammerer himself to see signs of improvement. The important factor in the building up of self-confidence is that the child should see his own success in the sphere of speech towards which his heightened self-consciousness has become directed. Hence it is of advantagethe child leaves the clinic each week be one in which the patient feels adequate and at ease so that he can carry away a feeling of confidence.
Too few cases have been treated at the Clinic to warrant any definite statements as to the cause, onset, and therapy of stammering, but the following case histories are significant and suggestive of problems which are worthy of investigation.

**Girl**: Chronological Age: 11 years 4 months; Mental Age 10 years 1 month; I.Q. 90.

**Medical History**: Premature birth; very delicate for six months; scarlet fever followed by rheumatoid pains at six years; Tonsillecτomy at seven years; walked at twenty months; single words at fifteen months and started to talk at twenty-four months.

**Home**: Mother who is undersized, shy, and nervous, states that she herself was a nervous child.

**School reported speech difficulty and fair progress.**

**Speech**: Mother stated that the child gets nervous and stutters, that she has been worse during the past year, though she seemed to start to stammer when she was promoted to the big school.

**Clinical Examination**: Subject was a very small, nervous, shy, timid child with haggard dark-ringed eyes and during most of the psychological and medical examinations she either stammered severely or was unable to get any sound out at all. The more she tried to speak the tenser her muscles became and in most cases when she was required to speak she strained for several minutes with mouth wide open, emitting no sound whatever. Objective tests presented no less difficulty - it was just as though her speech organs became so rigid that they were paralysed. She was the only stammerer examined who was unable to attempt objective tasks like pronouncing letters in sight testing or pronouncing digits in the Binet test. In order to get some estimate of her intelligence the psychologist had to resort to asking her to write down the memorised digits.

**Therapy**: Fourteen visits to Clinic during a period of nine months.
Patient 21/7/37: was shown tongue and breathing exercises. Breathing was found to very irregular and extremely jerky when subject tried to speak. The mother was advised to encourage the child and not to draw attention to her speech and her teachers were asked to excuse her oral work in class for a time, to permit no adverse comment on her defect, and to adopt a hopeful attitude.

After two visits at weekly intervals improvement was reported. At the following visit both mother and patient reported greater ease at home except when strangers were present. Patient also reported less difficulty at school though "I shiver with fright when the teacher yells at me." There was a remarkable improvement at the Clinic where patient read and spoke almost without hesitation.

In view of this knowledge of the school situation the school was given further advice as to how to handle a special case such as this and it was requested that the child should not have undue attention focussed on her, much less be scrutinised by the class teacher.

After an absence, owing to measles, patient visited Clinic towards end of September. She read and spoke without hesitation but reported periodical difficulties. In giving information that she is unable to say "I" or "Iris" she says them perfectly. On the next visit she was eager to report that she could now go messages. She again complained that her teacher hit and shook her when she had mistakes in dictation. The next week the mother reported that the child had no hesitation in going to shops, that she stumbles a little at times through trying to speak too quickly but she never becomes blocked.

As there were no setbacks fortnightly and then monthly visits were made to the Clinic. Though in the new year patient was promoted to sixth class where the work would inevitably be difficult there was no recurrence of the difficulty. A recent report from the school indicated that no further diffi-
culty had occurred during the past year.

Boy: Chronological Age: 13 years 9 months; Mental Age Fourteen years 6 months; I.Q. 105.

Medical History: Defective vision.

Home: Father has poor health. Though patient came thirteenth out of fifty-three in 2nd. year his father was not satisfied and considered that he was spending too much time on sport. The mother complains of forgetfulness and "mind going blank". Older brother who once stammered teases patient.

School reports good progress and severe stammering.

Speech History: Mother states that patient has stammered terribly for the past year. When playing cricket with three other boys patient broke a garage window next door. They decided not to confess and patient lied to mother about it. He was given a hiding and has stuttered ever since. Patient himself states that he started to stammer eighteen months ago when he "got nervous". The incident of the garage window occurred two years ago. He was upset when found out, but does not think that this was the beginning of his stuttering. It is significant that the onset of stammering was at the time of promotion to Secondary School. Patient probably felt too an additional insecurity owing to loss of confidence in him after the garage window incident.

Clinical Examination: Stammer was found to be very severe. It was mainly a repetition of initial consonants. The patient had no specific mannerisms but he blushed very easily, was extremely self-conscious, uncommunicative and reserved. His speech was of a poor quality being both ungrammatical and careless. He seemed to stammer mainly when he felt himself under scrutiny.

Therapy: twenty-three visits over a period of seven months. The school was asked to make every effort to place the boy at his ease since his condition was associated with excessive self-consciousness and too great effort.
No improvement was noticeable in a month. Patient stated that his father and mother, especially his father, pull him up every time he starts to stammer. The next week he reported that he was stammering more at home than at school. His mother was asked to come to the Clinic and she was advised to treat the stammer with apparent neglect.

In the early part of the following month the patient was able to read fluently after relaxation but his repetitive stammer was still very acute. He states that one of his brothers embarrasses him. He had stammered but had now overcome it at the age of 23 and teased patient. The patient states that he often hesitates in order to find synonyms for words which he thinks he cannot say. He reports that he is no better but it is encouraging to the therapist to find that he is speaking better after relaxation exercises. By the end of the month he was progressing so steadily that he was beginning to have confidence. In the following month he reported that he came sixth out of thirty-eight in term examination and stated that he had a few bad days during the week when he felt tired. He was speaking well at the Clinic and spontaneously stated that he could now relax and speak well at the Clinic but could not find the same security elsewhere. In the following month despite examination he maintained his progress. Towards the end of the year the teachers reported a remarkable improvement, and before the end of the school term the patient claimed that he was cured.

After a nine months interval since he last reported to the Clinic, a report was requested from the school. The teacher in whose class he now was, was unaware of the disability.

**Box:** Chronological Age: 11 years 3 months; Mental Age: thirteen years three months; I.Q. 118.

**Medical History:** Mother had bad nerves during pregnancy.
Walked at ten months. Single words at eighteen months. Sentences at two years. Scarlet fever. Severe diarrhoea at
six years. He was ambidextrous; left-handed at first but wrote right-handed naturally. Tonsillectomy at twelve years.

Home: Maternal aunt stuttered and was left-handed. Mother had suffered with "nerves of the stomach" and insomnia for years.

School reported fair progress in 6th. class, nervous debility, stutters, excitable, frequently fighting, shouts out anything that may come to mind.

Speech History: Mother states that he has stuttered since he was badly scalded on the arm at the age of two years - scald was not bad enough to get medical attention but large part of arm was blistered. He was still talking in baby fashion at the time of the accident. He has stuttered badly for a long time but has been worse since going to school.

Clinical Examination: He was a well-grown boy with a round fat face, the most outstanding feature being the dark haggard appearance below his eyes. His stammer was of an explosive type. When about to speak his cheeks were greatly puffed out and his lips tightly closed so that he appeared as though he would blow up at any moment. After maintaining this balloon-like expression for several seconds, when the pressure became too great the air escaped in a violent explosive burst. This held up regular breathing so that the patient became quite puffed and breathless and then had to take a further breath in the middle of the word. For example, if trying to say the word "because" his cheeks blew out and his lips closed tightly and then suddenly the explosive "b" escaped but there was no breath left for the rest of the word and after an effort to obtain more breath the balloon-like effort started over again. There was also a great deal of repetition; the patient would pronounce the first letter of syllable in a plosive manner over and over again. When he did manage to speak a few words his voice was slow, toneless, nasal and drawling. He was very restless and his mother reported that "he will not sit still in a chair."
Therapy: Thirty visits during period of one year.

The school and the mother were continually urged to avoid correction and admonition. The mother accompanied the boy to the Clinic during the first months of treatment and it was difficult to prevent her from discussing the boy in his presence. He repeatedly heard her say that he was "good but spoilt and lazy". He showed intense impatience at times when she spoke about him.

In a month's time improvement was reported; the patient had even gone messages without a note. On the next weekly visit patient reported lapses on some days but greater ease noticed. He seemed to be less haggard; the confidence he now had in his ability to go into shops for messages seemed to have given him some feeling of security. There was still a great deal repetition and explosive speech at the Clinic especially in conversation and in description of pictures which was pitiful to see and to hear. He was reading with greater ease though he still needed the security of reading in unison with the therapist. After two more months he was still stammering badly before relaxation exercises. His mother had to be still/advised to refrain from discussing patient in his hearing.

In the next month it became increasingly apparent that he was steadily gaining in confidence and his appearance was very much brighter. In the new year he started coming to the Clinic on his own and though he still stammered explosively at times with cheeks puffed out he had definitely acquired stability. He continued to progress and lost the haggard dark nervous appearance about his eyes, read without faltering, spoke without tension and reported in a vivacious tone that "he was doing real good now." In the several months since clinical visits were discontinued there has been no recurrence of the difficulty.

Girl: Chronological Age: 11 years 11 months; Mental Age: 11 years 6 months; I.Q. 97.

Medical History: Is always complaining of headaches. Had
suffered from enuresis since babyhood. "Regards bed-wetting as a joke. Brothers call her "sea-weed" but she takes no notice. She is very pleased if bed is not wet but that is only on very rare occasions when she regards it as a rare event." She is a very heavy sleeper. She has a large appetite and is called "dirt-box" at home because she eats all the leavings.

Home: Father is on relief work and mother is suffering from menopausal symptoms and family worries. Patient has three brothers, the eldest of whom is unemployed and had five sisters. Of these the eldest was an invalid pensioner suffering from T.B. and died seven years ago, another died nineteen years ago and a third has been a cripple since the age of three years.

The patient's maternal uncle was left-handed.

School reported that the patient was a severe stammerer.

Speech History: Mother stated that patient had stammered badly for the last two years. She will not go a message unless it is written down. Her little brother and sister mock her and now they are beginning to stutter too. The child herself states that the speech difficulty came on at about the age of six years. She was worse at home than anywhere else and her mother noticed it first. It is perhaps significant that when the child was about six years old, one of her sisters died and another became crippled.

Clinical Examination: She was very self-conscious and conscientious. She stammered all the time. It took the form of a hesitancy rather than a repetition. She started each sentence with "er-er-er" and inserted "er-er! after each word. There was so much "er-er" that her speech was at times unintelligible. She took so long to get it out that she forgot what she wanted to say. During testing her answers were neither concise nor to the point and all explanations were far longer than was necessary. She rarely failed to find an answer and made up a lengthy one even if ignorant of the true one. It seemed that
her long answers which took an interminable time to say and her helpfulness with test material were an attempt to assure the examiner that her failure to respond was not wilful.

Therapy: A most remarkable change was apparent within a week. The child's diary showed a record of five out of six dry beds. Mother and child reported improvement and greater ease in speech. The mother stated that she was a "different child", that she gets up early and runs about, is very bright and has only once complained of a headache. Even the neighbours have remarked that the child is speaking confidently and without stammering. Her brother was amazed that she was so much happier. Her teacher reported that there had been a marked improvement at school, that the patient was volunteering for recitation and taking part in class dramatic work.

The child has been unable to attend the Clinic again owing to dental treatment but the social worker reports that she is still showing a marked improvement both in speech and in general attitude.

Boy: Chronological Age: 13 years 8 months; I.Q. 111.
Medical History: Scarlet fever five years ago. Tonsils removed a year ago. Enuresis until age of eleven years.
Home: Mother suffers with nerves and is left-handed. Father stammered as a boy and suffered with discharging ears after scarlet fever. Sister has infantile paralysis.
School reported that he had done brilliantly and they were particularly anxious that his stammering should not endanger his career.
Speech History: Father states that patient has stammered very badly for eighteen months but has stammered a little since he had scarlet fever five years ago. This affected his ears. The mother states that there was no stammering until eighteen months ago when patient was suffering from discharging ears. The mother added that one teacher at the primary school used to be sarcastic and cause boys to mock the patient who cried and did
not want to go to school. Patient himself says that his speech difficulty occurred in 6th. class (he is now repeating 1st. year at a secondary school) after he had been singing K-K-K-Katie. His mother told him to think before he spoke and the more he thought the more he stuttered. He got over it for a time in the last part of 6th. class but the stuttering returned during the Christmas holidays. He was troubled most with the vowels especially "i". When trying to say "If" patient says I - i - i - i - a f. He used to be frightened to go into a shop and he is still unable to buy a railway ticket. In buying his season ticket he could not say his first name "John" but he could say his surname. He states that he has most difficulty in geometry, e.g. "i - i - i - i - intersecting"lines" and "a - a - a - a - angles".

**Therapy:** In three months patient was showing definite improvement. A month later his mother came to report that there had been a marked improvement in the patient - "every one remarks on how well he is doing. He seems very happy with himself and seems to be getting more confidence generally." Apart from a very slight stammering at the time of examinations he has maintained his progress. Two months ago he came to the Clinic to express his own and his family's gratitude for his recovery and there has been no recurrence of the difficulty since.

**IDEOGLOSSIA**

**Boy:** Chronological Age: 10 years 6 months; Mental Age: 10 years 6 months; I.Q. 100.

**Medical History:** At the age of eighteen months he fell on the asphalt and became unconscious. His forehead was dented and his father drew it out by sucking with his mouth. He had suffered from enuresis. His ears were a-symmetrical. His bottom teeth closed over the top ones and his jaw was noticeably forward.

**Home:** Father suffers with asthma and his mother (now dead) was dying of cancer. His paternal uncle is ambidextrous. The
patient sleeps with his father and twitches in his sleep. He refuses to go into a bedroom even in the daytime unless accompanied.

School reports slow progress; speech defect; troublesome boy in playground.

Speech History: Single words at twelve months; sentences between age of two or three years. His speech is always almost intelligible to strangers.

Clinical Examination: Though medical examination revealed no organic defect it was observed that breath control was poor; that tongue, lips and palate were soft and flabby and extremely clumsy in movements. "Ten" was pronounced as "en"; "22 Bishopsgate Street, Camperdown" was given as "enty oo isho-ate est Amerdun"; "4A" was pronounced "or A". It was not until the psychiatrist and the psychologist had heard his speech for some time and compared it with known things as above that they could interpret what he said. The Principal Medical Officer came in later and was quite unable to understand one word.

Binet-testing presented difficulties but the child was very patient and co-operated well and an I.Q. of 100 was scored. This was verified three months later by an Otis test which gave a score equivalent to I.Q. 98. The child was obviously not unintelligent and had plenty to say.

Therapy: Patient was given McAlister's exercises which he was required to practice at home - relaxation and breathing, lip and tongue exercises and exercises for specific sounds. Gradually he learnt to make each sound and with encouragement of the right sound at the Clinic together with much carefully supervised practice in less than a year he could make all individual sounds quite well though he was apt to lapse in conversation or rapid reading.

After thirty-eight attendances at the Clinic over a period of a year it was arranged that he should cease regular clinical attendance and report progress at intervals. The
school was asked to furnish a report which stated that his
speech was almost normal, and that he had obtained 68% in
a recent reading test, the class average being 68.3%.

When last he reported at the Clinic there were no
difficulties other than the "th" sound which was pronounced
correctly when he spoke slowly and carefully. He had
mastered "th" at the beginning and the end of words but he
still had a struggle to pronounce words like "father" where
the preceding "f" (lips and teeth) interfered with the follow-
ing "th" (tongue and teeth).

He now seems able to make himself understood every-
where. He attends a playground and is making up for the
years when it was difficult to mix with other children. He
had become reserved and reticent and spent most of his leisure
time in reading. It was significant that he was always so
anxious to talk a great deal at the Clinic.
SECTION III

CONSTRUCTIVE THEORY
Implications for the Prevention and Therapy of Mental Illness:

Practical Suggestions for applying the application of these principles of mental hygiene in the community, so that mental illness may decrease.

**Parent Education.**
- Education of professional groups (e.g., teachers) in principles of child guidance by lecturers, discussion groups, psychiatric social workers, newspaper articles, pamphlets, publications.
- Child Guidance Clinics.

**Children's Cube.**
- Children's Cubes.
- Children's Libraries.
- Children's Playgrounds.
- Children's Camps.
- Extension of social activities at school.
- Day nurseries.
- Pre-School Clinics.

**By education of community in principles of mental hygiene.**
- Promotion of educational guidance and character formation.
- Promotion of educational guidance and character formation.
- Promotion of educational guidance and character formation.

**Knowledge of psychological principles of learning and character formation.**
- Dissemination of results of application of this theory in clinical practice.

**Extension of Educational Guidance and School Counseling.**
- Revision of standards of schools.
- Vocational Guidance.
- Efficient teaching.
- Technical and manual education.
- Backward Classes.
- Tall and backward classes.
- Special classes + schools.
- Adequate classified institutions.

**Social Reform.**
- Living conditions.
- Housing.
- Unemployment.

**Regular medical inspection.**
- Systematic physical examination.
- More emphasis on physiology and physical hygiene in the school curriculum.
- Clinical < Hospital.

**Implications for Therapy.**

**Psicotherapy directed towards change in parental attitude.**
- Foster child to meet with children.
- Minimize adult society.

**Establishment of environment through encouragement.**
- Foster environment.
- Minimize adult society.

**Mental Testing.**
- Subsequent adjustment of school or employment without a parental demand in relation to child's capacity.

**Investigation of environmental treatment for any necessary assistance.**
- Psychological examination.

**Physical Examination.**
- Treatment of any defects.
CONSTRUCTIVE THEORY

Despite the extension of community education in mental hygiene there is still a prevalent tendency even in the highly-educated sections of the community to emphasise the dangers of physical illness and poor physical hygiene at the expense of neglecting almost entirely the more insidious dangers of mental illness and inadequate mental hygiene. In the physical sphere the patient is usually not held responsible for his illness, but is regarded as a victim of a disease caused by certain attacking factors or germs in his environment; whereas there is a dangerous tendency to relegate behaviour abnormalities, indicative of ill-health of the mind, to no cause other than innate peculiarities or even studied perverseness in the individual. Thus there is a realisation of cause and effect in the sphere of physical disease where symptoms and causes can readily be seen, while because the causes of the symptoms of mental disease are usually non-physical in nature they are less easily discovered and so rarely related that there is a tendency not to regard the patient suffering from mental maladjustment as a victim to menacing conditions in his environment and make-up.

Thus it must be emphasised that mental illness is just as real to the patient suffering from mental ill-health as is physical illness to the patient suffering from a physical disease. So it must be remembered that the mental life has basic needs just as has the physical life of an individual and the failure to supply these needs will lead to an unhealthy mental life no less readily than will a failure to meet physical needs lead to bodily disease.
PSYCHOLOGICAL SECURITY

The writer is submitting the theory that in the mental life and adjustment of an individual, psychological security is the fundamental need, and that the explanation of emotional maladjustment involving behaviour of the neurotic or delinquent type is to be found in the feeling of psychological insecurity.

It must not be thought that psychological insecurity implies only the psychological counterparts of economic or material insecurity. It is the more subtle forms of insecurity which prove so dangerous - insecurity caused by failure to measure up to academic and social standards, by a failure to mix with children owing to over-protection by adults, insecurity due to friction between parents with resultant inconsistent parental discipline and ultimately that engendered by the broken home.

Adjustment and maladjustment, or balance and imbalance, mental health and mental illness, normality and abnormality - or whatever the terms by which one chooses to name the extremes of the scale of mental life and health - will bear a positive relation to a similar graded measuring scale at the extremes of which are psychological security and psychological insecurity. Thus psychological security will be seen to be necessary for adjustment and normality, and as soon as this psychological security is reduced there is a tendency in the mental life of an individual away from normality, so that we may say conversely that psychological insecurity or loss of security is the major cause of abnormality or maladjustment.

It is necessary to stress the fundamental nature of this need for security. One of the first instinctive reactions in the new-born infant is that of fear occasioned by a physical loss of support. The very nature of the emotion of fear with its conative withdrawal tendency to preserve or safeguard the individual from threatened or apparent danger means that it is
fundamental in the life of the organism.

Just as one may have a feeling of fear due to a real or imagined physical danger, so one may have the same feeling of fear due to a real or imagined psychological danger. Thus a loss of psychological support, or in other words, loss of psychological security, causes a biological reaction of fear. Moreover just as the emotion of fear when occasioned by a physical stimulus is accompanied by an instinctive tendency to withdraw from the fear-exciting stimulus so the emotion of fear when occasioned by the psychological dangers of loss of psychological support, or of psychological insecurity, involves a fundamental tendency or action of withdrawal from the stimulus which threatens the psychological life of the organism.

Hence this psychological insecurity is so much more perilous than a physical danger because it is occasioned by the real or imagined attitudes and feelings of other people towards the individual. For this reason the feeling of psychological insecurity involves a tendency to withdraw from other minds, from other people. In this way a vicious circle is created for though the original stimulus may have been a very slight or even an imagined one, the biological tendency for the individual to withdraw means that he is unconsciously and inevitably increasing the insecurity from which he is trying to escape. It is only through a conscious objective realisation of the situation - and that is usually possible, especially in children, only through the assistance of another mind which has been trained to observe the whole situation objectively - that his vicious circle can be interrupted.

Thus the psychologically insecure individual tends to withdraw from society so that there comes to be almost an identification of “good mixing” or sociability with normality and adjustment, and of “bad mixing” or unsociability with abnormality and maladjustment.

One must remember, too, that the fear-provoking stimulus may be real or imagined. Just as an individual’s mind
and experience will colour his perception of a physical danger so there is always an individual perception, however, dim, which influences an individual's response to a psychological danger. Thus it is not what other people think of the child, or what other people expect of him, that matters so much, as his own idea of other people's attitudes towards him.

It is this potency of an imagined fear-provoking stimulus that increases the danger of a psychological as opposed to a physical stimulus. If a child has an imaginary fear of a physical object there is a tendency on the part of adults to demonstrate in a practical and convincing manner the imaginary aspect of the child's fear so that he may regain security, but since it is more difficult to demonstrate the imaginary character of an imagined psychological fear adults tend to leave the child without assistance.

Moreover where the danger is not imagined, but real, since the physical danger can be readily perceived by the senses, it is more usually and easily removed, but a real psychological danger is a much greater menace because owing to its psychic character it is not capable of sense-perception and is therefore more difficult to become aware of and to deal with, and hence is rarely removed by the ordinary parent.

This failure to perceive the reality of the child's imagined fears - and frequently even those which are grounded on fact is in the main due to the common characteristic of adults to fail to understand and to enter into the child's mind and world. Because the child is living in a world where adult standards prevail he is treated as a "small adult." Every adult, however fully trained in dealing with children, knows that it is far easier, especially in our modern life which is so busy and full of striving, quickly to judge the child by the standards and values of the adult world rather than by his own system of values. Wherever there is this failure to understand and enter into the child's mind and world there must be a resultant insecurity in the child's mind, for his psychological
needs are not being appreciated and supplied.

Thus most parents find it difficult and frequently impossible, to grasp this suggestion that material insecurity is not so devastating as psychological insecurity. To many the very idea of a psychological insecurity is entirely foreign and to some it is incomprehensible. If the parents do come to realise that the child has lacked something that he needs and has a right to have (e.g. consistent treatment; approval; freedom and opportunity to mix with other children, and so on) they sense the implication that it is they, not the child, who are responsible for his misconduct, and their immediate reaction is to attempt to increase his material advantages. This is at time almost an unconscious impulse - they feel that it is thought that they have failed and they react in a compensatory manner, by giving the child more material things. They feel impelled to make up for their lack by giving the child something; but particularly to the dull, giving is regarded as something which must be perceived by the senses. This impulsive reaction in the parent aggravates the child's difficulty for he feels that his parents think that he is not satisfied with the material advantages which they have given him (probably at a sacrifice of which he is aware), that he is ungrateful and wants more, and he realises that they just do not understand his feelings of insecurity. It is psychological, not material support that he is wanting so badly.

If this theory is applied to emotional maladjustments in children one may say that the feeling of fear occasioned by psychological insecurity, with its inevitable withdrawal tendency, may lead to the different types of withdrawal from society. The classification chosen is that which divides maladjustment into the rather artificial groups of

(1) the non-delinquent type which is described as neurotic.

Quite independently the writer has come to the same conclusion as Susan Isaacs that "neurotic difficulties include defiance or stubbornness, failure to respond to training in cleanliness,
thumb-sucking and nail biting, difficulties with regard to food and feeding, aggressiveness, jealousy, shyness, destructiveness, stammering, sleeplessness and inability to bear being alone as well as the more serious phobias or night terrors or excessive masturbation." (x)

(2) the delinquent type whose reactions since they tend to injure others as well as themselves are not approved by society.

The writer considers that one is scarcely justified in a distinct or a too-wide separation of one kind of maladjustment from the other for though upon first being confronted by abnormalities of behaviour one is struck by the individual differences in various children, a wider and more intimate experience reveals the common origin and fundamental similarity in disturbances of emotional development.

Prior to experience in dealing with problem children the writer had expected to find in practice an illustration of the theoretical and popular view that the characteristic of the delinquent child is a rebellious aggressive attitude, while in neurotic children fear and anxiety are very evident. Observation does not support this view and it is considered that the distinction implied is rather superficial one for as Dr. Isaacs suggests aggressiveness is frequently - the writer would say, always - a reaction to fear and anxiety, to insecurity. Levy thinks that at least some, if not all, delinquent children are neurotic. Phyllis Blanchard states that the experience at the Philadelphia Clinic with neurotic and delinquent children bears out the statement as to the relationship between anxiety and aggression. Thus the writer would suggest that all maladjusted children, different as their symptoms are, reveal a fundamental psychological insecurity and show a similar unsociability in that they cannot mix naturally with their fellows. "Crime and delinquency arise from the natural

reaction of a particular temperament to certain difficulties in personal or social life. . . . In the same way, neurotic disorders, prove on analysis to have their origin in reactions, formed along perfectly natural lines though by a somewhat different temperament, to much the same difficulties in much the same sphere, namely the personal and social life of the patient. Both are essentially the result of personal maladjustment. The distinction between the two is largely superficial. . . . In both, the patient's attitude towards other persons and towards society is fundamentally disturbed; but in a neurosis the disturbance usually follows lines which society does not regard as illegal. What is affected is primarily the peace and efficiency of the patient, not the peace and property of other persons." (x)

Moreover just as it is considered that in some respects delinquent and neurotic children are not so fundamentally different from one another as their surface personality and behaviour patterns might indicate, so too it must be borne in mind that they are not so much unlike children who make more successful adjustments. Clinical experience clearly reveals the continuous merging of behaviour difficulties into each other from the mildest "normal" form to the severest mal-sees normal children who have adjustments. One/phases of similar though not so persistent behaviour as that which characterises those who are maladjusted; one sees too the maladjusted child gradually becoming more normal.

If maladjustments may be explained in terms of similar fundamental causes, why are there differing types of abnormal behaviour? This, it will be suggested, in the following discussion, is due to differences in the innate constitution of individuals as well as to differences in the pattern of their respective environmental influences.

Bearing in mind the fundamental similarity of the various forms of maladjustment, by investigating the factors which lead to the differing behaviour patterns in different individuals, one can gain a helpful insight into the nature, causes and therapy of various abnormal behaviour patterns. It must be remembered, however, that though for purposes of discussion these groups are being presented as definite and distinctive types, each group must be regarded not as a clear-cut class into which individuals are divided, but as indicative of tendencies towards particular characteristics.

Taking first what has been termed the non-delinquent or neurotic type one might take a subordinate principle of division which divides the group into two further types, again according to the pattern of their overt actions, their external and observed behaviour - the "introvert" type and the "extravert" type. (x) The fact that in each of these types there is a common tendency to withdraw from normal relations with other people, is rarely recognised. If of the introvert type the maladjusted individual may feel an acute psychological lack but will be afraid to take or even to ask for what he feels he needs with the result that he will withdraw into himself in his failure to find security. In this way his needs are increased while his satisfactions continue to be decreased. Hence the introvert type whose innate organisation of instincts and glands involved in temperament already has more of submission and fear, tends by this withdrawal reaction to accentuate his innate tendencies. Such maladjustments as shyness, unsociability, super-sensitiveness, habit spasm, restlessness, morbid fears, sleep disturbances, masturbation, invalidism, are in this category.

(x) See Appendix - pages 264-267.
The extravert type, when maladjusted, is also unable to mix normally with other children and for this reason has a similar feeling of insecurity and separation from his fellows. Since he has more of anger and assertion in his make-up, he will tend when confronted by psychological insecurity to ask for and try to get something which he feels will satisfy his immediate needs. He tries very hard to convince himself and everyone else that he is adequate to the situation, and the more intensely he feels he is inadequate the harder he tries to make everyone think he is. His behaviour is then the result of insecurity and inefficiency of some sort. He cannot gain satisfaction and security for despite his grasping at momentary needs his abnormal reactions are frowned upon, he is disapproved of, and the gap between himself and others is widened so that with an increase of unsociability and insecurity his abnormal conduct is intensified. Thus one finds in this type of individual such symptoms as temper-tantrums, stubbornness, disobedience, fighting, destructiveness and violence.

Thus the maladjusted extravert and the maladjusted introvert are seen to be working towards an impossible goal. Each is trying to find security which cannot be attained since neither knows his real need. A vicious circle is created for though their real need is satisfying social relationships with those about them, the reactions characteristic of each type widen the gulf between the individual concerned and his fellows.

Turning to the delinquent group one finds that the most outstanding characteristic of the delinquents studied in the preceding survey, are not boldness, aggressiveness, and self-confidence, as is popularly assumed, but timidity, dependence, and lack of confidence. Observation convinces the writer that the main underlying cause of their delinquent behaviour is lack of psychological security. The continual fear which insecurity produces is revealed in the timidity of the delinquent; thus one find in the delinquent a social inadequacy, a lack of adjustment to society, an inner
lack, a feeling of incompleteness as Janet's "Sentiment d'incomplétude" suggests. Typically, the delinquent child is solitary and unsociable and takes a-social substitute satisfactions. Thus he fulfills his social means the wants and impulses of the moment in an unsuccessful attempt to satisfy his feeling of inadequacy. Hence he shares the maladjusted non-delinquent's anxiety owing to his inability to supply his fundamental need for security in his social relations with those about him. These conclusions are supported by the recent research of Healy and Bronner who diagnose the symptom of delinquency as a "reaction of the individual who is attempting to obtain compensatory satisfaction" since he suffers from, what they have summed up as the etiology of delinquency, "special emotional discomforts caused by unsatisfying human relationships." (x)

Though the reaction of the delinquent appears on the surface to be identical with that of the extravert who tries to attack the dangerous situation, in reality the delinquent's reaction is not a positive one. Rather, it is a withdrawal from what has become to him an intolerable situation. It is significant, in this connexion, to notice the number of delinquents who begin as truants or absconders. Healy and Bronner state that 60% of delinquents were truants. Sullenger found that in 90% of cases, truancy was the basis of delinquency. Glueck found that 64% were truants. In the cases studied in this investigation, the real delinquencies such as sexual misconduct and stealing seem to be a later subsequent development. The original reaction is retreat from the situation.

Take, for example, what might be regarded as the typical reaction of each of these three types to an uncomfortable or insecure school situation. The maladjusted introvert will retire within himself, make less contact with children and teachers, and keep facing the situation, worrying but doing nothing about it. The maladjusted extravert will make a

(x) Healy & Bronner "New Light on Delinquency and its Treatment" Page 207.
positive effort to overcome his insecurity, will try to make himself the centre of attention, and in doing so will rebel against teachers and fight with children, thus mixing with others no better than does the introvert. The delinquent will retire from the situation by truancy.

Though in speaking of neurosis and delinquency as symptoms one must beware of speaking of a cause or even causes which result in insecurity since it is a combination of conditions inside and outside the individual which precipitates maladjustment, yet there can be found similar environmental factors in each type of abnormal behaviour even if the "pattern of causes" varies in each group.

Thus, as well as the possible differences which have been suggested in the innate constitution of the delinquent and non-delinquent groups, the main difference seems to be that the delinquent group has a more severe pattern of detrimental environmental influences. The delinquents tend to be confronted by difficulties and insecurities in home, school, and neighbourhood. The "broken Home" factor means that they have usually lacked normal affection, discipline and hence security, at home; the fact that they came usually from the dull or feeble-minded or backward sections of the population means that they have usually to face a further insecurity at school where low intelligence and backwardness frequently make them feel that they cannot meet demands. Added to this they tend to come from poorer neighbourhoods thus having the added though minor factor of economic security. Therefore one feels that though delinquents and neurotics are the same at base in that they are reacting to a similar feeling of insecurity; this, together with their differing outward behaviour, is due to a different pattern of environmental factors operating on different types of human beings.

For this reason, despite the fact that one speaks of tendencies and causes for the behaviour of different groups each case of maladjustment must be treated as the reaction of
a unique individual. One can understand maladjustments of any type only as one can see the special relations between environmental strains and the child's efforts to make adaptations to them, in each separate case.
Since it has been affirmed that the explanation of all forms of maladjustment whether of delinquent or non-delinquent type may be summed up in the phrase - "psychological insecurity" one must attempt to discover the factors which tend to produce this feeling in the mind of the child.
(1) **DEFECTIVE DISCIPLINE**

The first major factor to be discussed may be summed up under the heading, Defective Discipline. This may involve lack of discipline, weak discipline or inconsistent discipline.

This study of maladjusted children points to the same conclusion as did Burt's investigation of delinquency, namely that "The most serious factor of all is undoubtedly a defective home discipline. In some homes there is no discipline at all. In others, the discipline is weak. In others, perhaps the more numerous, it is excessively strict and severe. Worst of all is the spasmodic, alternating, forcible-feeble type of treatment, where the child is first petted and cajoled, and then scolded and whipped." (x)

It is usually acknowledged that the chief source of juvenile delinquency and unhappiness is the "broken home", due either to discord or death. It is frequently realised too that the vicious home where there are such vices as alcoholism and immorality may exercise almost as evil an influence on the child. It is less frequently realised that the child's inner life may be damaged seriously by open contention between parents who continue to live together, while it is scarcely realised at all that differences and disharmonies which the parents think they are successfully concealing are sensed even by very young children with most disturbing results.

Professor J.R. Howser says "No child can develop normally in a family situation surcharged with tensions between parents. Even though the parents do all in their power to conceal their conflicts from their children, minimal expressions, incipient coldness, and reserve belie all attempts to hide the

(x) Burt "The Subnormal Kind" Page 168.
strained relations and, therefore, react upon the child. Often, too, there is . . . lack of concerted discipline . . . Every phase of the emotional life of the child may be affected by domestic discord, depending, of course, upon the form which domestic discord takes." (x)

These conditions are damaging to the child's psyche in that each of them leaves him without "security". In the "broken home" situation there is inevitably a defective discipline, which it can be assumed was equally defective before the home was "broken". It may be that the remaining parent enforces a discipline which is inconsistent with that enforced by the parent who has for some reason left the home, as for example when, after the death or desertion of the mother the father supplants her lax supervision by a strict discipline. Or again the remaining partner may react to the loss of the other in a compensatory manner as for example, is not infrequently the case with widows, and deserted mothers, who pamper their sons; or again discipline may be changed by the advent of a new comer - the step-mother is no fairy-tale difficulty as far as the child is concerned, but a very real one; or again the child may be transferred to another home where he is under the entirely new discipline of a strange guardian. It is significant that such children are usually placed either with elderly relatives, (frequently with their grandmothers), whose discipline is almost invariably unsatisfactory, or else they are placed in foster homes where they are accepted by people who desire to use them for their own ends, and discipline is capricious and discriminatory from the child's point of view; or else they are placed in state institutions, where owing to the presence of untrained officers discipline is frequently defective.

(x) "Mental Hygiene" Vol. XVI; January 1932.
In the vicious home also, it is obvious that a capricious and weak discipline prevails for the child is either neglected, or is subjected to the alternation of excessively harsh and indulgent treatment meted out by alcoholic parents; or is alternately neglected and then nagged at by a mother who is forced at times to go to work. Then again, in the apparently satisfactory home where there is really parental friction the child may be endangered by the inconsistencies between the discipline of each parent. Moreover there is the constant insecurity and tension created by the fact that the child never feels safe from the parental emotional upsets which he knows he cannot control and which may come when he least expects them. Mrs. W.F. Dummer says that "The essential home of the child lies in the attitude of the parents towards each other." (x) There is special significance in Dr. Van Waters claim that "for the welfare of the child it is best to subject it to the influence of only one of the combating parents; two conflicting attitudes are almost certain to produce breakdown in the child, in health, sanity, or morals." (xx)

Weak and inconsistent discipline is found also in homes where there are harmonious parental relationships. Especially does this occur in the case of an only child. The over-anxious parent tends to give excessive direction and instructions and does not make sure that they are carried out so that the child comes to know that he can evade parental authority. So often parents who come to the Clinic with "uncontrollable" children say "I'm at my wit's end, I just don't know what to do with J_____; I've tried everything - kindness and harshness, pampering and beating." One can always reply truthfully, "Yes you have tried everything except consistency."

(x) "Mental Hygiene" XVI; 1932.
(xx) "Youth in Conflict" 1925.
These vagaries of discipline make the child feel insecure because the treatment he receives bears no logical relation to his actions but depends upon the feelings and emotions of those in authority over him; thus approval and disapproval are so capricious that he does not safely know what to expect or when to expect it. Not only does the child feel quite insecure in his relations with his parents since he is never quite sure where he stands, but the inconsistency of the discipline also prevents the establishment of habits of thought, feeling, and action so that the child has also the insecurity of immaturity.

The following clinical statistics are significant in this connexion:-

Of 115 delinquents referred for examination by the Children's Court 64% came from "broken homes" and 30% from "vicious homes". Of 174 delinquents referred by the Child Welfare Department 63% came from "broken homes" and 17% from "vicious homes". Of 66 cases of delinquency referred by the schools 58% came from "broken homes" and 33% from "vicious homes". Thus of 355 delinquents 68% came from "broken homes" and 27% from "vicious homes", giving a combined total of 95%.

Healy and Bronner report that at least 91% of delinquents gave clear evidence of being or of having been extremely disturbed because of emotion provoking relationships with others, mainly with others in the family. Miller states that running away from home by boys takes place at periods when there have been radical changes in family relationships. Of 500 cases 55% of the boys had never experienced stable environment. Most of them had lost one or other parent, the rest of them had divorced or step-parents. "Loveless homes or homes where cruelty or injustice reigned were to be escaped from."
CLINICAL EVIDENCE

Mother Dead

Girl: Chronological Age: 14 years 5 months; Mental Age: 14 years 1 month; I.Q. 98.

Problem: Truancy, stealing, lying.

History: Father who is a Master-Mariner is away from home a good deal. Mother died nine years ago, with "abscess on the brain". She looked healthy but was always complaining. Father married again five years after wife's death. After mother's death he let two daughters (one of whom was the patient) go to her sister in the country. At first he was very pleased with the way they were looked after. They were living privately at first but later had refreshment rooms and just neglected the children who became very careless in their manners. The father now thinks that the aunt kept the children merely for the money which the aunt received from the father. The aunt also spoke ill of the father to the children - she probably resented his second marriage. Before coming to Sydney for a holiday the children stayed with their parental grandmother who said that they were in a disgraceful state. The son who had been living with maternal grandmother and two bachelor uncles (grandmother spoilt son and though father had been living in the home and almost kept the place for three years, grandmother talked about father to son) went to the paternal grandmother's home to collect the children who had been with her for three weeks. The paternal grandparents had a small shop and they did not mind the children helping themselves to sweets but the boy and the girls also took money. The boy had been treated well but not wisely by the maternal grandmother; "he has no principles and was not a good influence on the girls". The three children returned to the father and step-mother and since then there has been four-and-a-half years of misery.

About a fortnight after the children returned to the father the school informed him that the patient had taken
threepence. Since then she has been stealing continually. An old man used to give her pennies. When the father tackled him he gave excuses but patient and the old man gave contradictory statements. About three-and-a-half years ago patient truanted and went to town. She truanted at intervals, shop-lifting in the suburb where her father lived and was well-known. She then began begging. She could not be allowed out without she would ask for two shillings. Frequently she truanted from school and went to another suburb where she knew one of her school friends lived. She would go to the house and say that she knew the girl at school and would then tell a pitiful tale that she wanted two shillings for typing money for school. She would then go along the street from house to house. The father does not know what she did with the money she gained but he seemed to be spending his time paying money back.

She got her friends into trouble at school owing to the following incident. One of her father's friends had an ironmongery shop. Patient took a child's china set (worth fifteen shillings) from the shop without the shopkeeper's knowledge, and brought it home saying that it was for little 3 — the eldest of the present family. The patient explained the purchase by saying that several girls at school had put together and bought it. She had warned the other girls to support her story. At last the father heard of the matter from the school.

After the fuss at school the headmistress preferred the child to leave. Since there was no need for her to secure a job she stayed at home. She did not help in the house as expected and wanted to do such things as weeding the garden. She wanted to go to work and so was allowed to take up a position. Her first job was knitting, her second office work and the third in a factory. Though she was supposed to be working at the latter job and told her step-mother that she was getting twenty-one shillings per week, the Court showed
that she was receiving only fourteen shillings and had been at work only about one third of the time. She had other money which her step-mother spent for her. On the first day her work was praised, on the second day she said that she had an abscess at the back of her eyes and wanted to see a doctor. At last she lost the job and spent her time walking about the town.

One day she went to a city store, where her father and mother were known. She went to a shop-assistant and said "You remember mother buying curtains a short time ago? I've just come from my employers and I've lost two shillings. There will be terrible trouble. Could you lend it to me until tomorrow?" The assistant explained that she could not borrow from the store but she offered to lend her two shillings of her own money. She explained that she was rather short herself and reminded the girl to return the money within a week at the latest. The patient said "Oh, yes, I will bring it tomorrow without fail." Later the shop-assistant rang the patient's step-mother, and the father had to pay the two shillings.

The father had become a nervous wreck through worrying over the child. He has lost three stone in weight and the men on board ask him what he is worrying about. One day the second mate on the ship was laughing over the escapades about which he had heard from friends living near the patient's home. A nurse had been telling him that the patient stopped her in the street and asked for two shillings. When she refused to lend the money the child stopped a man. Again failing to get the money she went to a house to ask for it.

Even with clothes there is a difficulty. The best of clothes are purposely ripped to pieces. The father was arranging to have the children taught the piano but they were going to kick it to pieces.

When taking the other two children (his present wife's children) to be christened, he wished all the children to come but as it was raining he decided to leave them at home. When he
reached the corner of the street he changed his mind and returned to get the children. He found the boy and the girls trying to get into the father's room.

The father states that he is annoyed that the step-mother has been so good to the children and that they treat her as they do. The son is all right with his step-mother when his father is at home, but in his absence he is discourteous. The patient "has been cautioned so often without steps being taken that she thinks it a joke." She lies about her step-mother to her aunt or to her maternal grandmother and then on her return tells tales about the grandmother to her step-mother. The father said that the step-mother would do anything for the children and the patient says that she likes her and gets on well with her.

The father thinks that the "ideas" must have been given to the child by his first wife's people to annoy him. He realises that the child has had inconsistent treatment and regrets that he sent her to her aunt, instead of keeping her in her own home, but at the time of her mother's death it seemed the only course to take.

The child herself stated that she liked being with her aunt "though they don't like her down here. I think she didn't look after us as she should have in the last two years but let us run wild and go out as we liked." She added that her father spoilt them when they were staying with their aunt. They had only to write for things and he would send them immediately. "Then when we came down here he hadn't time or money to go on spoiling us."
Mother Works

Girl: Chronological Age: 16 years 5 months; Mental Age: 12 years 4 months; I.Q. 77.

Problem: Stole from her mother £76.10.0 in notes as well as other odd silver. Bought clothes and went for a cruise to Barrier Reef where she stayed for three weeks on Diamond Island. Since return has been staying (under assumed names) in good hotels, the last being Usher's.

Police have four other charges of stealing against her, large amounts being involved, one of which was furs valued at £100. Sexual intercourse has taken place.

History: Mother divorced from father two years ago. Patient states that parents were happy until about four years ago when her father used to go out with the woman to whom he is now married. Parents separated three years ago. Sister is in a Home and brother is with mother who is in domestic position. Mother states that patient has always wanted her own way, and was spoilt when she was young being the only child for six years. Failed Primary Final at eleven years and did not sit next year on account of "illness". When patient was thirteen-and-a-half years mother had to go to work and had to keep patient at home to mind the baby. Later patient got a job at Web-Proof Hosiery for two or three months but was put off for slackness; then was salesgirl at City Fashions which closed down six weeks later; then shirt factory for two or three months where she was earning eight shillings a week out of which her fares to and from Cronulla where her mother lived, cost seven shillings and sixpence; then had several domestic positions at Cronulla during the holidays. Mother was working at this time at the Hotel Cecil at Cronulla until 9 p.m. Patient did not like staying by herself and would go to a girl friend's place or to pictures and not get home until late. The night that the patient absconded she had "had words" with her mother about patient keeping late hours; mother hit patient who hit mother back. After her mother was
asleep the patient stole the notes and left home. It was from some tourist posters in her mother’s case that the girl conceived the idea of going to the Reef.

**Mother Drunkard**

**Girl:** Chronological Age: 15 years 6 months; Mental Age: 11 years; I.Q. 75.

**Problem:** Absconding, stealing, sexual misconduct.

**History:** Admitted to state control at the age of four years six months. Her father was a seaman and away from home a lot. Her mother was a drunkard and the children roamed the streets until midnight. The mother frequently left home taking the three younger children with her and leaving the other three (her husband’s step-children) to fend for themselves. On the occasion when the patient was admitted to state control the mother had left home taking the patient and two other children with her. She had not arrived home at midnight. Later the father was awakened by hearing one of the girls crying. He got up and saw two of them standing outside. Later on he found his wife in company with two other women lying drunk in a shed. He again saw her at 2.30 a.m. in the same state. At 5.30 a.m. she came home asking for money and then did not return home.

After being charged by the Court as a neglected child the patient was boarded out to a guardian for a number of years. At about the age of twelve years she commenced stealing money from her guardian. The guardian occasionally gave her money for riding of which the child was very fond. The child then commenced truanting and stealing money from her guardian in order that she could hire a horse from the Local Riding School.

She was on this account returned to the Depot from which she absconded. She promised that she would settle down if allowed to return home. When it was explained to her that she could not return to such conditions she promised to settle down
if again boarded out. She was placed out but absconded within a month. She went home (admitting that she had taken a pound from her guardian with her) and found that her mother was in prison. She remained at home "house-keeping" for her "father" first and her "brother". She wrote from there to her guardian. She was then located and brought before the Court again and committed to an Industrial School. Eighteen months later both her mother and her first guardian sought discharge but her father himself agreed that "it would be suicidal to return the girl to her mother."

Approval was given, however, to place the girl in employment. After being in work for a week she was returned to the Depot from which she absconded. She admitted associating with sailors, whilst living in the city after absconding. She was brought before the Court but was allowed to go to a step-sister. She settled down in employment but later found work in another country town. She soon left it and went to the home of a widower where she and the widower's daughter and another girl aged fifteen went "joy riding with youths in motor cars." The girl was again brought before the Court - she expressed a desire to return to the lady who had employed her in the country. Since the report on this home was satisfactory Court action was adjourned for one month, with a view to withdrawal if her record was a satisfactory one in the meantime. When the "adjourned case" was again before the Court the reports on the girl's behaviour proved satisfactory, but her employer was not satisfied with her work. She agreed to keep the girl in her employ for a further three months on trial but would pay no wages, only give board and pocket money. The girl wanted to remain there and the charge was adjourned for three months.

The girl called at the office four days after her appearance at Court and stated that the day after she was before the Court and allowed to go to her former employer she had left the home and gone to a cousin. This woman aged twenty-five was an invalid pensioner and had three children under the age of
seven years. Her husband was on relief work. The girl wanted to remain with this woman and do the housework. The inspector reported that the home consisted of three rooms and a kitchen and four nights prior to his visit the patient had slept at the home of the mother-in-law of the cousin with whom she was living. The cousin was unable to give the girl wages and the inspector recommended that the girl should not remain there.

The girl was then for two months working as a domestic in the country. There were no complaints for about six weeks when the girl started keeping very late hours and told her employer that she and her companions had been drinking and smoking. While in this position she admitted intercourse with no less than six boys. She was again located at the home of her parents. The home was still totally unsuitable and the parents realised that they had no control over her.

When she was admitted to the shelter prior to her latest appearance before the Court she complained of pains in the abdomen. When questioned she said that she had been nearly three months pregnant and about two weeks previously had taken pills which had brought on a miscarriage. After medical examination she was admitted to the Women's Hospital.

At this stage she was referred for the first time to the Clinic.

Inconsistent Elderly Guardian

Boy: Chronological Age: 7 years 10 months; Mental Age: 6 years 10 months; I.Q. 87.

Problem: Has been stealing money since the age of four years in small amounts until recently he has taken larger sums.

History: Patient is illegitimate. Mother and father were brother and sister. Father was then eighteen years and mother seventeen years of age. Grandmother implores secrecy and on
this condition guarantees ten shillings per week. Patient has been with guardian since he was one month old. He was discharged from state control but guardian agreed to keep him on. Guardian has grown-up family of her own. She has lost her husband and has a small business.

Patient never had a good appetite. He stays up until 8 or 9 p.m. listening to wireless with guardian's sons aged eighteen and seventeen years. He sleeps in single bed in guardian's room. Guardian states that he doesn't seem to be able to play and quarrels with other children though he is very popular and well-behaved with adults.

The guardian revealed that when four years of age this boy started to help himself to coppers from the till - this was not regarded seriously, the guardian adding, "I did not mind a few pennies". About eighteen months ago she noticed him hiding some of the change when sent a message. He then spent pennies for milk on toy aeroplanes, etc.; he also used to sell fruit given for his lunch to get pennies. Later he took money from older boys' drawers, taking a ten shilling note about a year ago. He has always had money which his guardian does not know where he obtains though she thinks he used to go to her sister's purse. Her sister lives nearby but has not missed any money. Even after large sums had been missed the guardian's son continued to leave his money about or place it in an unlocked easily-accessible drawer. Last week patient took £2.6.0 from older Boy's drawer of which sixteen shillings was recovered.
Changes of Guardianship

Boy: Chronological Age: 13 years 2 months; Mental Age: 11 years 4 months; I.Q. 87.

Problem: Absconding from institution. Sixteen abscondings in fifteen months.

History: (as stated by patient): Mother put patient on state at age of seven months. He was with Mrs. A until three years ago after which he absconded several times in an attempt to get back to her. He absconded from the Newcastle Shelter and got back to Mrs. F. He was then brought to the Royleston Depot and sent to the Farm Home at Mittagong. He remained there for eighteen months though he did not like it as he had to rise at six a.m. He was boarded out to Mrs. B for six months. Her husband came home "on the booze" and hit patient on the head with a plate. Patient was returned to Royleston after which he was sent to Mrs. C who said that she did not like patient's little ways when he tried to be funny. He was then boarded out to Mrs. D whose husband did not like patient because he thought patient made fun of little boy who was tap-dancing. Patient was then sent to Mrs. F who said that she could not have a delicate child when his nose bled one night. He was then sent to Mrs. F where it was "good-oh" but he was sent back for stealing. Now at Royleston. Was charged at Children's Court for running away sixteen times in fifteen months.

Clinical examination showed him to be childish in manner and speech as well as emotionally immature but he was at the same time very sophisticated suggesting unhealthy adult association earlier in his career. He was proud of his frequent abscondings and regarded himself as a wag, labouring an ambition to become a circus clown.
Invalid Father

Girl: Chronological Age: 14 years 5 months; Mental Age: 14 years 9 months; I.Q. 101.

Problem: Arrested at Central Railway Station after alighting from Melbourne Express. Had "hiked" to Adelaide with four other girls (well-known prostitutes) when American Fleet left.

History: Father is invalid pensioner for "Neurasthenia". He is nervous and irritable and mother could not live with him. She has been living apart for over a year and she herself takes "funny nerve turns". There were four brothers of whom three are dead; and a sister aged six years. One of the father's cousins is said to be in a mental hospital.

Patient left school at the age of fourteen years and obtained a position in a factory for two months when she gave it up without notice. She told her mother that she was not well but she soon brightened up and her mother made no enquiries. A few days later patient was sent a message but she did not return.

The patient stated that she ran away because her father started talking about her, saying that she went to dances every night with young boys and that she would "do anything for five shillings." She denied going to dances but stated that she went to the pictures once a week with her brother. She had arranged with the other girls at Sydney Hospital, the day the ship "Rodney" turned over, to run away to Adelaide in order to see some of the American sailors. She stayed at another girl's home that night and left early next morning. The party of five was away for three weeks and two days. They reached Adelaide having walked only three miles, securing "lifts" for the rest of the way. The patient denied any misconduct but did not keep her appointment for medical examination.

Two months later she again appeared before the Court. She stated that she slept in after her last medical examination and was too late to keep her appointment with the doctor and
psychologist. She had got a job at a cafe but was put off because she arrived at 7.10 a.m. instead of 6 a.m. Instead of returning to her mother she went to a domestic position. She then went to Brisbane with a girl whom she had met in Melbourne. They secured lifts for the greater part of the way, this time the patient taking the lead in requesting cars and lorries to assist them. She told the psychologist that "the women police won't believe us, but they were really nice men that we picked up; we even travelled with a minister and his wife for part of the way." They stayed three days in Brisbane and two days in Gloucester on the way back. They were picked up by the police in a hamburger shop in Sydney. Patient admitted sexual intercourse with a boy in Sydney and also on the road from Brisbane. Intercourse had taken place five times during the past month.

Change of Custody between Mother and Father

Girl: Chronological Age: 15 years 2 months; Mental Age: 11 years 7 months; I.Q. 76.

Problem: Left home and lived in a room with a girl. Admitted going with American sailors. Returned home and father interfered and took her to live with him. She returned to mother and said that "Father belted her".

History: Father left home eleven years ago and went away with another woman. Mother received £2 a week from her husband and 5/- endowment. There is a brother aged eleven and a sister aged thirteen years.

Patient has always been nervy and gets irritated if things don't go her way. Severe burning (boiling water) at two-and-a-half years affected her for several years. Her chest and neck are still extensively scarred. She still suffers from enuresis. She is inclined to be disobedient and likes her own way.
After remaining at home for a few months after leaving school she worked in an upholstery factory which she left after four months on account of her father who also worked there. He would see her at lunch time and nag at her. Last July her father persuaded her mother to give him custody promising to board her with his sister and have her trained, but instead he took her to live with his paramour. Patient then worked at a factory for three weeks but left because she did not like the girls. She then worked at another factory which she left a week before absconding because another girl wanted to direct all the time.

Patient stated that on the Sunday that she absconded she had gone to see a girl and had been ill and was put to bed. She tried to ring her mother without success. Patient had met this girl at the Quay three weeks previously when she had introduced patient to American sailors. As soon as she was well she returned to her mother who said that she had put the matter in the hands of the police. A little later her father came and "smooged" patient round to going to live with him. He took her to live with him and a lady friend who used to run patient's mother down and would say awful things. Her father wanted her to sign a paper and when she refused he flogged her with a belt. She then ran back to her mother again but left when told that her father was coming after her. She then joined twenty girls who were walking to Melbourne. The other girls were following the American Fleet but patient only wanted to get away from her father. She admits sexual intercourse on three occasions, once about four months ago when patient accepted a lift home from a lorry driver; again when she accepted a motor cycle ride two weeks later and the boy threatened to make her walk home if she refused; and again in Melbourne with an American sailor.
Mother Divorced

Girl: Chronological Age: 16 years 7 months; Mental Age: 13 years 5 months; I.Q. 84.

Problem: Stealing from Woolworth's to value of 19/11; also from Coles' Store in company with another girl.

History: Step-mother who appears to be weak and indefinite give little reliable information. It is gathered that the mother was divorced about nine years ago on account of running away with other men all the time. Step-mother married six years ago. Since father and step-mother were in country children (two boys aged twelve and eleven years, a married sister aged twenty-one and a sister aged fifteen years) were with their mother who was with a man with whom she had been living for a good many years.

Patient has been mostly out of employment. She said that she was working but parents found that she was not. She never brought home any money. The patient stated that she did not like her mother who was "nice to your face but talks about you behind your back." She lives with Mr. S____. "We don't take any notice of him at all much - we don't like him."

Patient worked at dressmaking for six months, receiving ten shillings a week. She then had a factory position at 17/9 a week for seven months when she was put off owing to slackness. She had another position for seven months and was again put off for slackness. She was out of employment for five weeks but did not tell her parents. The girl with whom she was found stealing, gave her money for fares, etc. She admitted collecting with a bogus letter at Erskinville in which it was stated that she was one of family of eight children with no mother. The girl claimed that she had good references from her employers and it was found that she has to leave home at 5.15 a.m. and returns at 7.40 p.m. when working, having to row part of the way.
Mother in Mental Hospital

Girl: Chronological Age: 14 years 11 months; Mental Age: 8 years 10 months; I.Q. 59.

Problem: Father has had sexual intercourse with her once a week for past eight months. Patient is said to have run away on account of father's treatment.

History: Father deaf and has lumbago. He is an invalid pensioner aged about forty years. The mother has been in a mental hospital. There are three brothers at home but her three sisters are away, two of them being married.

The patient left school at the age of thirteen years to mind her sister's illegitimate baby whom the patient's father adopted. She had a factory job for a week but left it because she could not do it. Patient and her mother left home the previous year because her father was in gaol for interfering with a girl (so mother told patient). The patient stated that her father came to her room every Saturday night and interfered with her in her sleep. The mother was in a mental hospital until the beginning of this year. She was very suspicious and would accuse patient of immorality when she went to the pictures.

Patient went to her sisters who all live together but her father worried them and so they said that patient would have to go home. The police called at her home and took charge of patient.

Alcoholic Father

Girl: Chronological Age: 15 years 4 months; Mental Age: 16 years 9 months; I.Q. 109.

Problem: Absoceed from home.

History: Father alcoholic and used to knock mother about.

Mother left him thirteen years ago. When a little toddler patient would not pass another child in the street without she would rush up and attack it. When they were living with maternal grandparents about three-and-half years ago mother noticed patient
coming home late from school. If mother spoke to her she would always become very abusive, was always cunning and lied when questioned. She always wanted to be with the boys. Mother moved to another district three years ago in order to get patient away from the environment. She soon started coming home late from school again. When her mother spoke to her about it, patient ran away and was brought home by police at about 2 a.m. Patient left school at the age of fourteen years and went to work. She was in six jobs in a very short time as she could not hold them. She did very well for a while at ambulance work at night but she started coming home with the ambulance boys. About three months ago her mother took her to the doctor who said that she was pregnant. Shortly afterwards she fell downstairs and had a miscarriage. No doctor attended her.

Prior to the last absconding she went to the Harbour Fireworks Display with her sister and other girls but did not return until 5 a.m. Her excuse was that they were unable to get a train owing to the crowds. Her mother forbade her to go out next day but she sneaked out and was not found until five days later. She had been with American sailors.

Mother Divorced - Pattern of Immorality
Girl: Chronological Age: 15 years 10 months; Mental Age: 12 years 10 months; I.Q. 81.

Problem: Vagrancy
History: Mother divorced in 1925. Patient with mother from 1931-1934. After two years patient wrote and said she wanted to come back to father as she was miserable. A little later she was found sleeping in the park with boys. Returned to father in October 1934. She was always eager to be with the boys and would play up on her step-mother. Patient is of
affectionate and demonstrative disposition but neither father nor step-mother are. Her first job in an office lasted only two weeks as she spoke too familiarly with people. She then had a domestic job for one or two months but she was told that she was no good in the house. She then secured a job in a restaurant but was there for only a few weeks since she was "absolutely no good at housework and would throw herself at any man who came into the shop." She then had a domestic job with respectable people in the country but she was there only for a month since they found that she had boys there at night. She cleared out and started to walk forty miles to town alone. She spent two nights on the road, and a man gave her a lift. The police picked her up near the town. The girl admits her inability to control herself where boys are concerned and states that she is like her mother in that respect.

Immorality

Girl: Chronological Age: 14 years 3 months; Mental Age 14 years 4 months; I.Q. 101.

Problem: Charged at Children's Court as a neglected child.

History: Father's address unknown. Mother of loose moral character. Patient was living with mother who has for six years cohabited with S__. Living with them in a hut of iron, wood and bags divided into four compartments are five other children, three of whom are the illegitimate issue of the mother and S___. S____ appeared at Court to answer four charges of unlawfully and carnally knowing the patient but as a prima facie case was not made out the charges were dismissed. There was medical evidence that the child showed all signs of having been interfered with and in her evidence she admitted sexual intercourse with at least one person. The child made a statement to the police that S____ had had connexion with her on four occasions; she retracted this statement in court but it is possible that she did so under pressure of Mother and S____.
Frequent Changes of Discipline

Boy: Chronological Age: 14 years 5 months; Mental Age: 9 years; I.Q. 73.

Problem: Absconding

History: Father addicted to drink. Patient was sent to Scarba Home for six weeks at the age of five years and then to Dalwood Home for a week, after which he was in Baulkham Hills Home for eighteen months and in Kincumber Home for four years. After being home for about a week he was sent to Farm Home, Mittagong. On this occasion two years ago he was picked up by the police for begging in the street. He had left home three times before and stated that he had trouble at school, could not learn his lessons and was chastised. His mother said that his father had beaten him. He absconded twice from Royleston Depot and three times soon after being placed in Mittagong Home. Later he attempted to attack the Matron with a knife and threatened to use an axe on the charge boy. He then broke into a shop and stole cigarettes and chocolates and ice-cream. He absconded twice more, the second time he was clad in pyjamas and overcoat and broke into a kiosk. He was later sent to Farm Home, Gosford where on two occasions he took a knife and stabbed a boy in the arm. He absconded twice and gave himself up to the Metropolitan Boys' Shelter. The next time he absconded he was found by the police after having stolen a motor-cycle at Manly. He absconded again two months later. Subsequently he made elaborate arrangements to set fire to the ward and was found with a ratchet screw-driver in his shirt and a piece of piping 18" long in his bed and a very sharp pocket knife in his mattress. He stated that he intended to stab a fellow inmate.

The boy stated that he did not like homes though they feed him well and are kind to him. He gets mad fits at times when he thinks of his mother who is ill and supposed to die at any time. He then runs away from the home. "They take you back and give you a cane and put you in the cell for a couple of days." The boy made it clear that he was capable of exercising
sufficient self-control but did not make the necessary effort. It was considered that he was not insane but that his instability originally arose from faulty home environment. The success of his repeated abscondings was also calculated to produce in one of his mental calibre an impression that those in authority over him are impotent, and to inspire him to acts of more and more open defiance and violent rebellion. The boy's remarks also left the impression that he had been receiving letters from relatives, couched in injudicious terms, which militated against the efforts to reform him on the part of the institutions.

Step-mother

Girl: Chronological Age: 17 years; Mental Age: 13 years 4 months; I.Q. 83.

Problem: Sexual misconduct and absconding.

History: Eighteen months ago was charged as uncontrollable. Her mother had left her father who was living with another woman. The girl and her two younger brothers lived with her father. They were unhappy in the home. Her father was good to her but "not the other woman who used to belt me." The girl disliked her "step-mother" so much that she left home and stayed out all night which she spent in the park with a boy with whom she had sexual intercourse. She admitted sexual intercourse during the previous year with two boys as well as four or five times during the past two months. She stated that her father was suing her mother for divorce and the girl herself was to give evidence in a charge against a boy at the court during the following week. She was placed in an Industrial Institution.

In a year, during which her mother had died and her father had remarried, she was discharged to the guardian who had had her from the age of eleven to thirteen years. She obtained employment in a Milk Bar and used to come home at all hours of the night. She was said to have been seen at all hours with Chinamen and sailors. She left the milk bar on account of a
row with the "boss". She had been away for two days with influenza and the "boss" doubted she had been ill and the patient threw the milk shaker over him and left. It was found that sexual intercourse had taken place two or three times a week with one boy since she left the Industrial Institution six months ago.

Inconsistency of Discipline between Mother and Father

Girl: Chronological Age: 8 years 2 months; Mental Age: 8 years 2 months; I.Q. 100.

Problem: Shakes arms when reads.

History: Father takes child's part and will not punish her.

Girl: Chronological Age: 11 years 11 months; Mental Age: 10 years 5 months; I.Q. 87.

Problem: Retarded, stubborn, nervous instability.

History: Father always gives in to her. If mother gives instructions patient has only to cry and father will say "Let her have her own way."

Girl: Chronological Age: 9 years 11 months; Mental Age: 11 years 10 months; I.Q. 119.

Problem: Restless and works below capacity

History: Patient lives amongst adults, being thirteen years junior to the next in the family. The mother is suffering from menopausal symptoms and the father is indulgent. He once spoilt the patient and cannot bear to see her corrected.

Girl: Chronological Age: 9 years 2 months; Mental Age: 7 years 4 months; I.Q. 80.

Problem: Nervous symptoms; takes turns; temper.

History: Father takes patient's part against mother and will not allow child to be punished. Mother is under medical treatment
for nerves, having had St. Vitus' Dance as a child.

**Unwanted Child**

Boy: Chronological Age: 14 years 7 months; Mental Age 14 years 2 months; I.Q. 97.

Problem: Stealing

History: Patient was never wanted. His father forced mother to have child because he was annoyed with her for going out. "Father picks on the patient all the time and says that he is lazy". His brother is father's pet. Patient says that he cannot do anything right for parent. In addition to feeling the home situation he has now become solitary at school.

**Mother feels guilty regarding Illegitimate Child**

Girl: Chronological Age: 11 years 4 months; Mental Age 8 years; I.Q. 70.

Problem: Very slow at school, disobedient, lethargic, no interest in work, nervous type; stealing, lying, destructive.

History: Illegitimate. Mother went to work in order to keep patient. Patient was adopted at the age of six months but the guardian did not treat her well so the state took the patient from her. The mother did not hear of this until four years later. The mother took guardianship again when patient was about nine years of age. She was very nice at first but in about three months she started stealing and telling lies. She was in a dreadful state when she first came to her mother, but has improved somewhat. She was very thin and had a lot of sickness if she ate anything rich and was faddy with her food. She suffered from enuresis until a year ago. She was very destructive and marked the furniture with scissors. Other children do not like playing with her because she is disagreeable.
She goes playing with other children though Mother is afraid to let her out of the house. She is very cheeky to her step-father. Her father who was a post office official was a strong healthy man. The mother, who is possessed of finer sentiments, has never been able to reconcile herself to the fact that she has given birth to an illegitimate child. While by no means lacking in maternal affection, the child's presence has acted as a continual reproach to her, until she has lost her appetite and sleep to such an extent that she has dropped over two stone in weight and has become reduced to a state of severe emaciation. The mother's distress of mind and body has had an unfavourable influence on the child whose delinquent tendencies are regarded as reactions to the feelings of insecurity so occasioned. It seemed essential that the child should be separated from her mother at least until the latter could recover her bodily health and peace. Since the child was feebleminded it was recommended that admission to Brush Farm Home would be the best solution.

This recommendation was not carried out and eight months later the step-father stated that the child was playing up dreadfully. She was in a Home twice early in the year but they did not get on with her at all. She truants and will steal anything. The mother has become so worried about it that she takes hysterical fits and the doctor has threatened to put her away. The mother states that the child cannot be trusted at all, and that she has been lying and stealing money frequently. She has done all she can for the child but cannot bear her any longer.
**Unwanted Adoption**

**Girl:** Chronological Age: 15 years 7 months; I.Q. 96.

**Problem:** Stealing and absconding

**History:** Illegitimate. Adoptive father who adopted patient about fourteen years ago is now about to take divorce proceedings against adoptive mother. The girl herself stated that her parents could not afford to keep her and put her on the street at the age of eighteen months. She knows nothing of them. Her foster parents parted about eighteen months ago. The father is a drunkard and uses bad language and accuses both mother and patient of immorality. He would accuse mother of going out with black men and would become very jealous. He would break a piece of lattice over patient. He would come home about 2 or 3 a.m. and wake them up. He never wanted mother to adopt patient and was always jealous of her. The mother was always good to the patient and father treated patient worse after mother left. He would give her a hiding every day. He was never sober and would go to the hotel every night after work. Patient absconded from foster-father with fifteen shillings which a man had given her to pay an instalment on a bicycle. She then stole thirty shillings. She ran away to a lady in the country but did not like it there since she was not allowed to go out anywhere. So she stole money and jewellery and came on to Sydney. She had a position in a milk bar for two weeks but was put off because she was not experienced enough to make up the sundaes. She was charged at the Children’s Court where she alleged that she had turned eighteen years of age. She was then sent to Corelli and a domestic position was secured for her. She stole watch, clothing, money and handbag and absconded from the doctor's home in which she was working. She returned to her mother and was later charged as a neglected child. She stole £14.15.0, jewellery and money, and was about to board the train to Sydney when she was overtaken by the owner of the property. She wandered about the streets and finally went to the Police Station.
Preferential Treatment

Boy: Chronological Age: 8 years 8 months; Mental Age: 8 years 2 months; I.Q. 94.

Problem: Committed as uncontrollable.

History: At the age of seven years child broke into a newsagency and stole money and toys. He admitted committing the offence and had the missing articles in his possession. No action was taken on account of his extreme youth. He again broke into the same shop and stole a bicycle and about a pound in money. No action taken but again reported. He then broke into the Shire Council Chambers by breaking a window, entering and opening a door with a key which he had stolen. Nothing was taken except the key. His mother gave evidence that he had at times played truant from school. He would attend in the morning and leave before school was over. She would know nothing of it until he returned home late at night.

It was found that the household consisted of the boy's grandmother and another family as well as the boy's own family, there being ten persons in the home. The boy was required to sleep with both parents. He claimed that he received preferential treatment over his brothers and sister owing to a severe accident which he had at the age of five. He described himself as his parent's pet. He was frequently encouraged to remain home from school without sufficient reason. He is unable to mix with other children at school. They tease him and treat him as a "sissy". He has to go to school without a cap as the boys would throw it away. He added that he had seen a cinema representation of a man breaking into a shop by smashing the window and that he endeavoured to imitate this man's prowess when he himself broke and entered,
Mother Lies

Girl:  Chronological Age: 11 years; Mental Age: 12 years 9 months; I.Q. 116.

Problem: Lying and stealing

History: Father a thief and at present in gaol and mother died in child-birth. Adoptive mother told patient all sorts of fabrications and lies to prevent patient from knowing her parentage but she knew it all the time. Mother took child for two trips to New Zealand where she was accused of stealing money from teacher's purse (about a pound in small amounts).

Foster-father returns home from work at midnight. He sleeps in lounge while patient sleeps in single bed in mother's room. She and mother go to pictures during day sometimes and go to bed at about 7 or 8 p.m. and listen to the wireless. The guardian says that the child is never away from her, that she is very fond of men and that guardian has "told her everything". The guardian has no children of her own. The child is jealous of girls or children but has plenty of assurance with grown-up people and her companions outside the family are mainly grown men. The child states that she is not allowed to skip or play hop-scotch at school since it wears out her shoes.

The family live on a house-boat. Patient is friendly with boatshed people nearby. When there was a letter missing from the boatshed, guardian point blank denied that the child had anything to do with it when she knew that patient had taken the letter for the stamp. She also made the child swear that she had never seen the letter.

Patient also took lace to the headmistress at school stating that it was a present from her mother. Her mother knew nothing of it.

About three weeks ago the child came home and said that she had been knocked down by a motor bicycle, that the rider of the cycle had given the teacher five shillings which
the doctor at the school had spent on medicine and dressings. The mother accepted the story even though the child had rowed the boat home with her arm in a sling. The child told her mother that the doctor who was giving diphtheria injections told her to put splints on. She showed her mother the pencil lines which she said the doctor had drawn on the pieces of wood so that she would know where to place her arm. The mother displayed such extraordinary credulity that she made no enquiries for three weeks. At the end of that time the patient returned home at 5.45 p.m. and said that the doctor had paid sixpence for tea and soup for her and that she had electric massage. The next morning the mother went to the school but the headmistress seemed to know nothing about the matter. The patient had told the teacher that she was with her mother when the accident occurred. The patient had been wearing her arm in splints for three weeks and when it was investigated at the Clinic, she acknowledged that she put the splint on herself and had drawn the pencil lines in order to convince her mother that the doctor was responsible.

The child was very sophisticated and conversed in a mincing babyish manner suggesting the influence of her home environment. While her mother deprecated the child's dishonesty, she had, on her own showing, enjoined dishonesty on the child, when frankness would have been inconvenient to herself. There was evidence of disingenuousness to questions which would be calculated to have its influence on the child.
Illegitimate Child

Girl: Chronological Age: 14 years 9 months; Mental Age: 12 years 4 months; I.Q. 84.

Problem: Absconding and stealing.

History: Illegitimate. Mother was fourteen years old at time of patient's birth. Patient has been with present guardian since the age of fourteen months. At the age of twelve she started playing truant with other girls. "She did not know that she was a state child until then." Her guardian states that she cannot speak the truth and steals money. If sent a message she give the wrong change and then lies about it. She left school at the age of fourteen and after three months secured a position which she retained for only one day though she pretended that she was going to work for a week while she was really having a good time about town. Later she stayed away all night stating that she went round town all night on a bicycle. She loves to wear boys' clothes and knows all the boys nearby but there have been no sexual difficulties. On two other occasions guardian had to speak to the police as the patient stayed out very late. She did well in a printing firm for three months but was put off for carelessness.

She is lively, pleasure-loving and intolerant of any prolonged application. Though it is claimed for example that ample drawers are provided she leaves her good clothes lying on the floor in the bathroom for her guardian to pick up. She escapes all domestic duties and evades all responsibilities by taking advantage of her guardian's softness and affection. Her chief friends go to colleges, and have much more money to spend than has the patient. She will not persevere with any employment in order to earn for herself and thus she has to supplement her pocket money by dishonest means.

Her latest escapade was to abscond with another girl with whom she stayed away for a week. They lived in an empty house at the seaside where they sold bottles and begged food.
They were found in men's clothes by the police. They had seen some painters' clothes and put them on in the hope of finding some money in the pockets.
11 DEPENDENCE

It is commonly accepted that maladjustments in children are largely due to neglect on the part of the parents - a material neglect or a neglect due to the interests of parents outside the home. People are surprised to be told that the majority of problem cases dealt with at the Clinic are due to the opposite type of situation where the child is hampered by parental over-protection, which is equivalent to "spoiling" the child's chance of successful adjustment in the world where he will feel insecure owing to his excessive dependence at home.

Parents have great difficulty in understanding "spoiling" in terms of keeping the child too dependent; they think of it only in terms of giving material things, not in terms of giving too much attention and assistance. H. Crighton Miller in "The New Psychology and the Parent" says in this connexion "This phrase, (The Call of the Cradle) covers a species of spoiling which often is not recognised as such - a drag back towards dependence as opposed to independence, to irresponsibility as opposed to responsibility, towards the ego as opposed to the herd. We spoil a child every time we make dependence, irresponsibility, self-centredness, unnecessarily easy and attractive. . . . We cannot make the Call of the Cradle too alluring to a child without permanently influencing his character." Dr. Boyd, speaking at the New Education Fellowship Conference in 1934 emphasises this danger: "The less one is conscious of the work of bringing up children the better. The first-born has a hard time; we are far too conscious of his behaviour."

The statistics relating to the place in the family of the children referred to the Clinic bear this out. The
case of the child who is first in the family occurs most frequently. This group includes "only" children but it also includes a large number of eldest children who have for some years at least been "only" children.

It is difficult to define spoiling for it manifests itself in such diversified forms, for example, one child reacts by showing off and smashing things, another weeps and refuses to eat unless coaxed. Yet there is a fundamental likeness, a common error in management. Both types are failing to adjust themselves to a real world where each child is supposed to have certain rights, to recognise the rights of others, and to be capable of a certain measure of self-control and self-direction. Both are behaving like babies, demanding those about them to continue services suited only to infancy.

Though it is stated that the child must have the security of consistent treatment and affection in his home if he is to face the world successfully, it must not be forgotten that the world cannot be faced for him. He cannot remain always in his home and must therefore be prepared for his contact with the outer world. Though parents frequently realise the danger of contact with the world outside the home, they more often fail to realise the necessity for preparing the child for it since it is an inevitable experience. Though the school is the social agency by which the child first comes into contact with the outer world, and its chief advantage is that it takes the child away from the home while still giving it a certain protection, yet the movement away from the protection, dependence, and higher security of the home to the different environment of the school is a hazardous one if it is taken at a leap rather than as a more gradual and secure step. If the child has not been encouraged as he emerges from infancy, to mingle with other children, given the opportunity to handle and learn about things, taught to fight his own battles and encouraged to make his own plans, he will feel the marked insecurity of the sudden bound which he is required to make. If thus unprepared
he may at first even refuse to attempt the jump and cling to the security to which he is accustomed in his home; or if he does reach the new world of the school he feels insecure in this too abrupt change from an adult to a child's world.

Thus one finds in cases of over-protection, over-indulgence, and over-solicitude of parents and adults, the significant factor is that the child feels insecure when in the company of other children since he has been so much in the society of adults and has received so much adult attention that he has been unable to learn to mix with other children and is hence debarred from childish companionship and childish activities, which accentuates the insecurity of his own immaturity. "Thus children who receive the continuous concentrated attention of the adults who surround them are not only being ill-prepared for such seding of the first place in the household as must follow upon the arrival of a brother or sister, and for mingling on equal terms with their peers on playground or in schoolroom, they are also failing to develop their own inner resources."

This condition becomes aggravated since the greater the child's insecurity through inability to mix with children the more the over-protecting parent tends to make up for this failure by affording the child more shelter and protection. Thus the usual vicious circle is created whereby an increasing protection by adults in the home leads to an increasing insecurity in the child's relations with other children.

If then the child is unprepared for his contact with the world he will be so overwhelmed by his feeling of insecurity while in it that he will be unable to make normal adjustments without unusual assistance. Various types of children with varying environmental backgrounds will react to such insecurity in various ways. The introvert type may show abnormal symptoms such as marked shyness, hyper-sensitivity; the extravert type may take refuge in temper-tantrums and bullying; other neurotic symptoms such as habit spasms, morbid fears, night terrors, disobedience and stubbornness may result; similarly
delinquencies may occur as, for example, in the child who steals in order to bribe the other children to befriend her.

It is significant that the most common characteristic in the histories of both neurotic and delinquent children is this inability to mix with other children; and in the neurotic type at least it is almost always associated with excessive adult attention. Moreover, where therapy is directed towards greater independence from adult direction and attention, and towards assistance in enabling the child to mix with other children, the maladjusted child makes a satisfactory adjustment fairly rapidly.

Parental anxiety is therefore very dangerous. Without realising it those who do too much for their children, are full of fear that the child cannot do anything without them. Without knowing it they lack confidence in the child and increase his fears. Moreover the child is deprived of the reassuring pleasure that comes from finding he can do things about which he may be in doubt.

Thus it is a great psychological problem for parents to know how and when they should modify their original cherishing protective behaviour so as to permit the individual to establish secure relations with the world of reality.

The excessive protection is usually on the part of the mother. It seems in general that the father does not understand babyhood but appreciates adolescence, while the mother does not seem to understand adolescence but wants to keep the child a baby. The tender-hearted mother can be a very dangerous person for by loving her children too well she can prevent them from becoming persons. It is interesting, however, to notice that since independence should be a stage-by-stage process and not a bound, the authoritarian attitude of the father, if excessive, can prevent the child from growing up just as does the excessive love characteristic of the mother. In both cases the child is still receiving too much adult attention and direction. If the
father is excessive in his attitude of authority the extravert child will rebel while the introvert will evade authority by subterfuge or lying. He will be just as immature and insecure as is the child who is excessively dependent on his mother. Moreover the father's excessive authority will probably tend to increase the child's dependence on the mother.

Frequently, too, the adult over-protection is associated with children whose grandparents live in the home; as also with those who have devoted single aunts, or again with those who through illegitimacy or some broken home situation are looked after by an elderly guardian or a guardian with a grown-up family; with those who have older step-brothers and step-sisters; while the "only" child and the "artificial" only child are of course the most characteristic examples.

These adult reactions may be due to various causes. It is suggested that one of the major insidious causes of exaggerated parental protection is due to a disappointed love life where unhappy marital relationships lead to parental search for satisfaction in the child. There may be the added emotional drive of seeking satisfaction out of identifying the child with the unsatisfactory marital partner. Take for example, the case of the mother who is devoted to the boy who is "just like herself" while in her eyes everything is wrong with the one who is "just like his father".

There is also the frequent influence of insecurity and anxiety associated with the menopause and with the superstitious ideas of the mother in regard to pregnancy. Associated with these are ideas about heredity which cause the excessive anxiety with which children are often watched from birth, their characteristics noted and referred back to supposed origins, their future forecast. Take for instance the boy who is so like his ne'er-do-well uncle in appearance that after his first minor delinquency his parents hold no hope for him and repeatedly say in his hearing that he is just like his uncle and will of course continue to follow in his footsteps.
Apart from parental defects and maladjustments, the small families common to modern life must accentuate this parental attitude of over-protection.

Though for purposes of exposition, factors such as inconsistent discipline and over-protection have been singled out, in reality these attitudes are frequently interwoven. As Kanner says, "It is interesting to observe for example that most over-indulgent parents, anxious to warn and protect their children against imaginary perils, are at the same time, nagging, scolding, perpetually admonishing parents. Thus an inconsistency in the handling is created, which cannot fail to have its damaging effect on the children." (x)

(x) Kanner, "Child Psychiatry" page 95.
CLINICAL EVIDENCE

Not Allowed to mix with Children

Girl: Chronological Age: 12 years 8 months; Mental Age
9 years 7 months; I.Q. 76.

Problem: Very fair progress; nervous debility; morbid fears;
emotionally immature.

History: Patient sleeps with mother. Father sleeps in another
bed in same room. The mother is from Belfast and does not allow
patient "to mix with bold children of the neighbourhood - Aus-
tralians are too lax." The child had always had excessive adult
attention and the demands made of her exceeded her ability.

Girl: Chronological Age: 10 years 5 months; Mental Age
9 years 8 months; I.Q. 93.

Problem: Supersensitive and shy; sleep disturbances.

History: Father separated. Mother lives with aunt. Mother
is too russy. She always meets child after school and child is
not allowed to play with children of neighbourhood.

Boy: Chronological Age: 7 years 4 months; Mental Age:
6 years 10 months; I.Q. 93.

Problem: Shy; seclusive; lacks confidence.

History: Father is an invalid pensioner. He was always "pick-
ing" on the children. He was in Broughton Hall. He was un-
faithful when mother was in hospital after operation and became
obsessed with the idea that he had venereal disease. He tried
to strangle his elder son. Father is away from home now and
mother will not have him back, having separated about six months
ago. Mother is a worrier and does not like children out of her
sight. She is in poor circumstances and is forced to live in
poor neighbourhood. She forbids the children to have compan-
ions lest they are led astray.
Excessive Adult Company

Girl: Chronological Age: 9 years 11 months; Mental Age: 9 years 7 months; I.Q. 97.

Problem: Masturbation. Reported as "a sexual pervert and capable of ruining local youths." Headmaster states that she practises self-abuse in the classroom. She admitted "that she behaved in a disgusting fashion with a dog in the street and that she was in the habit of interfering with herself in the street."

History: Has been with guardian for seven years. Adopted from a relative of guardian's brother's wife. Has been in hospital twice at the age of three and six years for convulsions. She was noticed to be masturbating at five years after she started to go to school. Her guardian "used to beat her every time but it seemed that she could not help herself." Guardian hears patient groaning in bed at night and calls out to her assuming that she is masturbating. She is a very restless sleeper and talks at times about school. She sleeps in guardian's room.

This girl had grown up in association with adults whom the guardian admitted had more or less made a doll of her. The guardian accompanies her to and from school in order to shield her carefully from any association with other children. Though it is claimed that she has abundance of toys, it is admitted that she is not permitted to share them with any other child. Her environment and mode of life had cut her off from all the normal interests of her age. Moreover her guardian, teachers and inspectors had repeatedly drawn attention to her undesirable habit.
Lack of Childish Companionships and Activities

Girl: Chronological Age: 9 years 9 months; Mental Age: 9 years; I.C. 92.

Problem: Stealing

History: Mother died when patient was a year old. Father has had a good deal of unemployment. Brother aged nineteen years is living away from home and steals father's tools and cutlery and sells them. Sister aged fifteen years is now in Salvation Army Home for absconding and sexual intercourse. Patient visits her sister. The mother's son aged seventeen years (i.e. patient's cousin) lives with the family.

Patient commenced stealing at about the age of six years. Her elder sister had taken her to see Father Christmas and taught her to pick up things from Woolworth's and other city stores. About a year ago patient took about sixteen shillings from a shop till. She then took £2.10.0 from next door neighbour and £3.4.0 the following week from another neighbour. The mother cannot leave any money about at all. Patient never brings the money home and gives away most of the money that she takes. The child herself stated that the girls at school call her names and are cheeky to her and "I have to give the girls money to play with me."

The child's old-fashioned manner and ease in conversing with adults indicated that she had had more association with adults than with her contemporaries. It was admitted that she was taken out visiting in the evening until a late hour, and that she is unable to mix with children who tease her. She herself stated that "my mother does not allow me out but I sit on the wall and watch the children playing."
Grandmother as Guardian

Boy: Chronological Age: 12 years 11 months; Mental Age: 9 years 10 months; I.Q. 76.

Problem: Poor progress, morbid fears, night terrors.

History: Owing to mother's nervous breakdown patient had been with grandmother for five years. He sleeps with grandmother but goes home every afternoon and sometimes stays and sleeps with parents. He is an only child and had always had too much attention from parents and grandparents.

Aunt as Guardian

Boy: Chronological Age: 8 years 7 months; Mental Age: 8 years 6 months; I.Q. 99.

Problem: Fits

History: Fits were found to be not epileptic in nature but just fainting turns due to over-sensitiveness. His father is an invalid pensioner and his mother very nervous. He stays with aunt with whom he sleeps and goes to mother for holidays. He sits up late at night with aunt and is always in the company of adults.

Grown-up Family

Boy: Chronological Age: 8 years 1 month; Mental Age: 7 years 8 months; I.Q. 95.

Problem: Restless, imagination runs riot; lies; enuresis.

History: Mother deserted by husband after he lost job. Mother is an office cleaner. Patient states that "Uncle sleeps with mother in double bed. Patient is always in grown-up company and not at all with boys of his own age.

Grown-up Household

Girl: Chronological Age: 7 years 3 months; Mental Age: 7 years 2 months; I.Q. 98.

Problem: Morbid fears, habit spasms, highly strung, loss of appetite, stubborn, fair progress.

History: Father divorced and a drunkard. Mother suffers with nerves and "walked out" five years ago. Patient lives with grandparents and is the only child in an adult household.
**Adult Family**

**Girl:** Chronological Age: 8 years 9 months; Mental Age 8 years 8 months; I.Q. 99.

**Problem:** Slow progress, nervous

**History:** Illegitimate child of guardian's daughter and born when mother was aged fifteen. Grandfather is unemployed and grandmother works. The child is treated as a doll by a family of adults.

**Blind and Deaf Guardian**

**Girl:** Chronological Age: 6 years 7 months; Mental Age: 7 years; I.Q. 106.

**Problem:** Masturbation

**History:** Mother and father are dead. Patient has been with aunt since before mother's death. The guardian is old and deaf and the child is always with adults.

**Widow Living with Parents**

**Boy:** Chronological Age: 6 years 11 months

**Problem:** Very slow, no concentration, unstable, nervous, inattentive, weeps, lethargic, fearful.

**History:** Mother suffered severely from nerves during pregnancy. Father died in an accident when patient was nine months old. Mother has been especially nervy since father's death and receives a widow's pension. She and the patient live with grandparents. Grandfather spoils patient and grandmother practically reared him. Two uncles also live with them and spoil patient. Patient is an only child and sleeps in mother's room.

**Mother Works**

**Boy:** Chronological Age: 3 years; Mental Age: 7 years 10 months; I.Q. 96.

**Problem:** Quarrelsome and pugnacious

**History:** Mother was living with her sister when patient was born. Everyone was in the habit of picking him up and nursing him. Father deserted when patient was seven months old. He was interested in "girl friends". Mother goes to work and until recently her mother-in-law was living with her. Child has always been accustomed to adult company and has had little association.
with children. When in children's company he chooses to play with children younger than himself or else quarrels with older ones.

Grandmother and Aunts as Guardians

**Girl**: Chronological Age: 10 years 7 months; Mental Age: 10 years 8 months; I.Q. 102.

**Problem**: "Kleptomaniac - has also altered bank-book".

**History**: Illegitimate. Father is in the navy and married a woman who would have nothing to do with him so he lived in Melbourne with patient's mother. Mother now works at a hotel as a cook. She likes taking the children out and buying them things but when it comes to the matter of looking after them she has no interest. This child has been with her grandmother since birth and has been brought up by her grandmother (who is an invalid pensioner) and two maiden aunts. From this state of affairs it has resulted that while the patient is at her ease in adult company, she soon gets into difficulties when she tries to mix with children. Her thieving appears to be a compensation for feelings of inferiority induced by her failure in this direction. Her grandmother states that the child does not seem to be able to make friends and prefers adults. Her teacher says that patient has no friends and the one little girl that she goes with a good deal at school has plenty of money. The patient herself says that when she asks the other girls if she may play games with then they say "No".

The patient has been unable to resist the temptation of taking money ever since she started school. She was first found out about two years ago when neighbour told grandmother that patient was marching up and down the road with eight shillings in her hands. She also took money from her aunt's purse. About a year ago she had threepence in her bank-book and altered it to sixpence. About two months ago she knocked a little girl down in the street and took sixpence. The child was aged six years and the patient bumped her and sixpence fell
out of her hand. It was reported to the Child Welfare Depart-
ment who interviewed the grandmother about it. The grandmother
then made the patient write every afternoon "I knocked a little
girl down and stole her money and blamed someone else." The
child has also become very untruthful lately.

Only Child

Girl: Chronological Age: 6 years 5 months; Mental Age: 6 years;
I.Q. 124.

Problem: Nervous; screams if corrected; will not mix with
other children.

History: Only Child

Girl: Chronological Age: 5 years 10 months; Mental Age:
5 years; I.Q. 85.

Problem: Very little progress, shy and nervous.

History: Patient has elderly parents whose friends have no
small children. Father who is retired is aged seventy and the
mother is forty-two. Patient is an only child upon whom
excessive care is lavished. The mother states that the child
is always with adults and has not mixed with children.

First Child

Girl: Chronological Age: 11 year 2 months; Mental Age:
11 years 3 months; I.Q. 100.

Problem: Lacks concentration, disobedient, wandering, often
late; has ability but not up to standard of class.

History: Father will not make patient do as she is told.
Patient says that she will be good if mother gets rid of foster-
brother.
Youngest Child

**Girl:** Chronological Age: 8 years 6 months; Mental Age: 8 years 6 months; I.Q. 100.

**Problem:** Slow, super-sensitive.

**History:** Father pensioned owing to shell-shock. Child is youngest of eleven children and has always had too much adult attention.

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**Early Illness in Youngest Child**

**Boy:** Chronological Age: 11 years 4 months; Mental Age: 10 years 8 months; I.Q. 94.

**Problem:** Truancy. Father alleges that patient's hatred of school is reason for running away from home. When he absconds to his married sister she does not send him to school.

**History:** Mother died at patient's birth. Step-mother married five years ago. Father is returned soldier on a small pension. Patient has two elder brothers at home.

At the age of six years patient sustained a serious head injury. It was necessary to restrict his activities during convalescence and for years afterwards he was forbidden to join in active games. Being the youngest of a family of eleven children (four of whom were step-siblings) he had always been treated as a baby. As a result of these conditions he was incapable of making friends and became solitary in habit. He complained of teasing and ill-treatment by his school fellows. He told the teachers, who punished the offenders, but this only redoubled his persecution until in desperation he absconded from school. Truancy began about eighteen months ago when he took some chalks from a boy and the teacher demanded them back. His step-mother kept taking him back to school but he would not stay and he has now been truanting for about a year. He often gets away by scaling trams and frequently goes to a married sister who lives in an outlying suburb. About a month ago his step-mother gave him a shilling for a message. He did not come back but ran away to another suburb, spending the money. He has become very untruthful.
"Artificial" only Child

Girl: Chronological Age: 11 years 7 months; Mental Age: 8 years 8 months; I.Q. 75.

Problem: Poor progress, shy, unsociable.

History: Patient has a brother aged twenty-two and two sisters aged twenty-five and seventeen. Mother is a caretaker and does not put patient to bed until 11 p.m. and later when she comes home.

Girl: Chronological Age: 9 years 3 months; Mental Age: 10 years 1 month; I.Q. 109.

Problem: Bad mixer, lacks confidence, nervous.

History: Father has business worries and is irritable. Mother is nervous. The child is always with adults and there is twelve years interval between her and her sister.

Girl: Chronological Age: 12 years 11 months; Mental Age: 14 years 10 months; I.Q. 115.

History: Youngest of three children, the others aged sixteen years and eighteen years; two step-brothers aged twenty-five years and twenty-four years and a step-sister aged twenty-two years.

Only Son

Boy: Chronological Age: 6 years 6 months; Mental Age: 6 years 10 months; I.Q. 105.

Problem: Cries easily, filleting, restlessness.

History: Feminine companionship (five sisters and no brothers). Not allowed to play on street with other boys.

Boy: Chronological Age: 6 years 11 months; Mental Age: 9 years 8 months; I.Q. 140.

Problem: Dreamer

History: He is an only son and accustomed to association with adults. The maternal aunt lives with the family. Since he has difficulty with other children his mother deliberately keeps him away from children of his own age. "He is better on his own."
Boy: Chronological Age: 8 years 5 months; Mental Age: 8 years 10 months; I.Q. 105.

Problem: Cries, super-sensitive, and excessively dependent.

History: "Has never had a playmate". No opportunity of contact with other children. Parents live quietly. Mother is inclined to over-protect him. Father used to be very exacting and expect child to do things as he wanted but mother has now talked him out of this. Children think patient a baby and tease him which causes him to cry and to become more solitary.

Parental Anxieties

Girl: Chronological Age: 13 years 7 months; Mental Age: 13 years 4 months; I.Q. 102.

Problem: Very little progress, disobedient, deceitful.

History: Doctor said that mother would never rear her. As a result she has always been over-protected and in her anxiety mother continually expects and suggests illness.

Boy: Chronological Age: 9 years 4 months; Mental Age: 9 years; I.Q. 96.

Problem: Lying, truant, irregular attendance, behaviour disorder, quarrelsome.

History: Excessive parental anxiety because two older brothers developed epilepsy. Patient was kept home from school on slight pretenses until he learned to avoid situations by the assumption of illness.

Boy: Chronological Age: 9 years 9 months; Mental Age: 9 years 5 months; I.Q. 97.

Problem: Unsociable, dreamer, sensitive as regards making friends.

History: He was the youngest child, his elder brother being fifteen years old. His confidence had always been undermined because since ill-health after his birth his mother had been over-anxious. She had also forbidden his taking part in such activities as the "cubs" on religious grounds.
Parental Superstitions - Expected to be like Mother

**Girl:** Chronological Age: 12 years 3 months; Mental Age 8 years 6 months; I.Q. 70.

**Problem:** Frequent absences from school; stealing and lying; destructive.

**History:** Father and mother dead; with guardian for eight years. The guardian (her aunt) is convinced that child had inevitably inherited lying and stealing propensities from her mother.

Patient stated that she had been kept home from school by her aunt to help in the house but aunt denied this and said that patient had told her that she came home on Friday afternoons because other children were going to sport.

Expected to be like Father

**Girl:** Chronological Age: 12 years 10 months; Mental Age: 11 years 3 months; I.Q. 91.

**Problem:** Stealing

**History:** Mother and father living apart. Mother lives with parents and goes to work. Grandmother and relatives pay excessive attention to the child and are afraid that her delinquencies are "her father's character coming out."

**Girl:** Chronological Age: 9 years 2 months;

**Problem:** Stealing and Stubborn.

**History:** Mother enrolled patient at school at the age of four years as five years old and patient had to live this lie for years. Mother and father separated at time of patient's birth and were divorced three years later. There is a warrant out for father's arrest for stealing a motor car eight years ago. He was a police officer. Patient and her sister and mother live with grandmother and grandfather. Patient's sister who is of shy disposition and cannot make friends is jealous of patient who is natural and makes plenty of friends. Sister sleeps with grandmother and patient
sleeps with mother. Grandfather is a drunkard. There is constant interference by the grandparents and both mother and grandparents anticipated that child who is like her father would show his weaknesses.

**Early Sickness - Morbidly Dependent on Mother**

**Boy:** Chronological Age: 14 years 1 month; Mental Age: 16 years 9 months; I.Q. 112.

**Problem:** Charged at Court with "malicious damage of mother's property." He has broken nine windows in his home.

**History:** Patient is illegitimate child. Father was a ship's steward and deserted the mother about six years ago. He is in England and was always promising to get married. Patient has a brother who is a deaf mute and a married step-sister aged twenty-two who is a legitimate child by the mother's deceased husband. Patient has never seen his father and believes that he is dead of after-effects of war. Mother's deceased sister's husband who is unemployed is also living with the family. A cousin and his wife have also taken a room in the mother's house.

Patient passed Primary Final at eleven years of age and continued at the primary school for a year but refused to go towards the end of the year and has not been to school for about twelve months. He would go to bed at 10.30 or 11 p.m. and would not get up till 11 a.m. or 12 noon. If mother wanted him to go to school or for a message he would scream. If his mother speaks to him now he smashes windows. He seems to be getting worse. He has a habit of rubbing hands down people. He did this to a cousin who replied irritably and patient then went and smashed a window. He says "I'm a big monkey" and walks about the house imitating a monkey. He has never tried to get work. He says that he knows what he wants to work at when he is ready, but he will not say what it is. His mother states that he would never mix with boys. He himself states that he has no friends and never went in for sport much. He spends his time reading, playing the piano, and helping his mother in the house.
He had been excessively protected by his mother from an early age and had become morbidly dependent on her. Even during his eleventh year he was kept home from school so much on the plea of sickness that his teacher became suspicious. Each succeeding year he was kept home more and more until he lost all confidence and refused to go to school at all. He is still encouraged by his mother to believe that he is ill and to experiment with patent medicines. He still needs to sleep in his mother's bedroom. If put into a room by himself he comes into his mother's room in the night and says that he is frightened.
III DISAPPROVAL AND EXCESSIVE CRITICISM

Wrapped up with the two factors which have been discussed above, is what might be called a third mode of treatment which can be a potent influence in the development of psychological insecurity and the resultant maladjustment which may be involved. The atmosphere created is more important than the things done for the child.

Despite a more widespread knowledge of the principles of learning the great majority of parents and teachers still attempt to teach children by the negative method of showing them what is right by disapproving of their wrong responses, rather than showing them what is wrong by approving of their right responses. Frequently, too, of course, the adult is so busy disapproving of the child's wrong responses that he fails to give him any constructive idea as to what is the right response in the situation.

Thus particularly in these days when the adult himself is so involved in the struggle to maintain his own security in the world that he tends to be easily irritated by and to demand much of even small children, there is a dangerous tendency for the parent - and teacher - to nag at and criticise children to excess and to the exclusion of encouragement and understanding. The child's bad conduct is rarely allowed to pass uncriticised or unpunished and yet his good conduct is not similarly praised and rewarded. Thus the child is disheartened instead of heartened.

"There can be no doubt on the part of those of us who have occasion to study many instances of family life that where punishment is the only corrective the most unfortunate delinquent trends and mental attitudes are created." (x)

(x) William Healy and Augusta F. Bronner "Delinquents and Criminals: Their Making and Unmaking."
When one considers that disapproval is withdrawal of support, one realises something of the psychological significance of this method of treatment for it must inevitably increase the child’s feeling of insecurity. Just as excessive protection keeps the child immature and hampers his initiative so that he feels insecure, so excessive criticism may undermine his confidence. It is obvious that the over-protected child who is with adults a great deal will frequently be subjected to excessive criticism of his actions for he is a child living in an adult world and it is very likely that his desires, impulses and actions will clash with those of the superior adult to whom he is required to submit. Still more damaging is it if this excessive criticism is associated as is not infrequently the case with inconsistent discipline where, for instance, the child is perhaps neglected or allowed to do as he pleases one day, and then is continually nagged at the next for what was approved the day before. There may be too an even more acute feeling of bewilderment and insecurity when inconsistency, over-protection, and excessive criticism are associated in the form of treatment which the child receives. This latter is the most common state of affairs.

People are coming to realise that children do not need hitting and beating but they do not yet see that fear of harsh criticism and scolding is just as paralysing. As Susan Isaacs says in "The Nursery Years", "The Child who goes in fear of scoldings and naggings cannot expand freely and happily into social life. He is thrown back on the infant’s mode of gaining love by his helplessness, or driven into the blind protest of rage and tantrums."

It is encouraging to find that institutional treatment and correctional education has largely changed from the concept of punishment to that of adjustment through understanding of individual differences. Newer methods of discipline, of friendliness and goodwill, cheerfulness and hope, not fear and repression are seen in the attempt to arouse the positive and good traits that the child possesses, not to dull him with fear or destroy his will
by brutality and repression.

Thus as Professor Harold Rugg suggests, "Constant reminders of dependence and inability, the undervaluing of opinions, the ridicule of questionings, and other forms of adult behaviour, steadily tend to kill the child's self-confidence." The child has then to resort to self-defensive mechanisms and tries to find security either in a world of fancy where he may take refuge from the real world or by over-compensation in order to try to atone for his deficiencies.

Loss of parental love, since it is but an extreme case of this type, occasions feelings of the same nature as does this less severe loss of parental support. Then parental love is withdrawn entirely one finds, as one would expect, severe mal-adjustment, usually of the delinquent type, in the offspring.

"State" Girl

Girl: Chronological Age: 11 years 5 months; Mental Age: 8 years 3 months; I.Q. 72.

Problem: Poor progress, troublesome, lying.

History: With guardian since the age of two years. Nothing known of relatives. She does not make friends easily and other girls tell her that she is a state girl. Guardian states that "this causes trouble" and that the child "romances and tells awful lies". For example, she told a neighbour that she was never allowed to sit near the wireless.

Mother did not come as expected

Girl: Chronological Age: 14 years 9 months; I.Q. 111.

Problem: Absconding from a Home

History: Was living with mother and father in Melbourne until seven years ago. Patient thinks they parted through another woman. They had lived happily before. Mother left father and secured work in Sydney. Patient and her sister have been backwards and forwards between mother and father ever since. Father's paramour died last year. She and father boarded together and patient used
to board with them.

Recently patient had been at home helping her mother who was a "house-keeper". Previously patient had worked in a milk-bar for a few weeks, had tried dressmaking which she disliked, and had been a shopassistant. She admitted sexual intercourse with a boy aged eighteen years, four months ago.

Mother went to Melbourne ten days ago in order to get a divorce since she wants to marry again. Prospective step-father is "all right" but patient hardly ever speaks to him. Sister is staying with friends but patient states that she herself had to be sent to a Home because she gets angry and "mucks up". Her mother was to have returned on Sunday, after patient had been at the Home for six days. When her mother did not appear patient said that she got angry and "mucked up". Soon after breakfast the next day she absconded with another girl. When she was brought back she was still defiant and refused to remain.

Stole in Order to be Sent to Mother

Girl: Chronological Age: 15 years 1 month; Mental Age: 13 years 6 months; I.Q. 90.

Problem: Stealing

History: Mother left some three years ago to take a trip to England. She was an English woman and would only talk about England. Finally she went home to her mother and nine months later informed family that she did not intend to return. Patient states that she is upset because her mother has left them and she thought that her "father would get sick of me if I stole and would send me away to England to my mother."

The patient had been charged three times previously with stealing. She admitted breaking into a house and stealing eleven shillings and a pair of stockings. Nine months ago, she stole some parcels and eighteen months ago a gold watch. She affirmed that her father gave her money and that she was not in want.
Since leaving school she had two domestic positions one of which lasted for two weeks and the other for three weeks. She was at a factory for twelve weeks and at Swimming Baths for a week but her father did not approve of her remaining there. The patient admitted sexual intercourse about six months ago stating that she was walking home from the pictures with a boy who knocked her down.

**Stealing in Order to go to Father**

**Girl:** Chronological Age: 12 years 7 months; Mental Age: 12 years 3 months; I.Q. 97.

**Problem:** Stealing

**History:** Mother dead. Legally adopted by guardian five years ago. Father remarried and tried unsuccessfully to get the child back. It appeared that the child commenced stealing in order to go to her father.

**Unsympathetic Step-mother**

**Girl:** Chronological Age: 14 years 7 months; Mental Age: 14 years 7 months; I.Q. 100.

**Problem:** Stealing and absconding

**History:** Mother died thirteen years ago. Step-mother has been married to patient's father for ten years. At the age of nine years patient was treated by doctor for "nerve trouble". She was very irritable and would scream for anything she wanted. She and sister packed clothes one night and went to stay with an aunt. After a month patient went to a Home where she stayed from the age of twelve to fourteen years. Patient then returned home to step-mother about five months ago. She remained at home for two months and was competent in the home. She then secured a position in a factory but although she pretended that she was going to work she did not go. Though she had not been to the factory she told her step-mother that the girls laughed at her. Her step-mother stated that the girl had no friends.

The child absconded from home and secured a domestic position. Patient could not get on with her employer who was a
woman of fifty years. "She was all the time fussing and nagging." The child became very homesick and was desirous of going home with the onset of first menses but the mistress forbade it. The child was frightened and begged to go but she was told that she would be all right and was to remain. She then absconded having stolen £2 in money and a cheque valued at £2 both of which were lying on the table.

The child stated that her step-mother had always misunderstood her and that whenever, for example, she was reading and did not obey an instruction promptly her failure to hear was mistaken for disobedience. The step-mother stated that she did not want the patient at home.

**Step-father - Child Unwanted**

**Girl:** Chronological Age: 10 years 10 months; Mental Age; 9 years 4 months; I.Q. 86.

**Problem:** Has left home four times

**History:** Father died ten years ago. Child states "My mother said she divorced him and put him in gaol and he got away and died. My mother got married to a real lot of step-fathers; A___, B___, B___, Mr. J___ (one of my uncles) and H___ (present step-father)." The child admitted stealing her mother's money and explained that she ran away from home because she has to mind the baby all the time. "The baby cries all the time. Mother and father go down the street every day and get drunk and never come home till the 'pub' shuts. They have a fight on Saturday night and break all the crockery. Mother belts me with a strap and stick. Mother doesn't want me."

The mother states "The girl is not too bad in the home. She takes all the money I have about. She has taken thirty shillings in the last four times she has been away. She says she runs away because she wants to be put into a home the same as her brother. Every time the police bring her back I tell her that she must not do this as she will be sent away and she says that that is what she wants. The child slept on the footpath in front of the house on Saturday night and last night
under a tree at Abbotsford. Neither she nor her brother agree with her step-father."

**Unwanted**

**Girl:** Chronological Age: 16 years 8 months; Mental Age: 14 years 7 months; I.Q. 91.

**Problem:** Absconded from her home.

**History:** Patient left school at age of thirteen years and went into domestic work. She was then sent back to school but truanted for three months so "they just let me be." She remained home to assist her mother until she was sixteen years of age when she secured a job as trimmer at the Abattoirs. She loved the work and after three months she was put off for a slack period and was to return later.

She stayed at home where she did most of the work. Her brothers and sisters were allowed to run wild and patient was expected to look after them. At last four weeks ago she left home because she could not agree with her mother. Her mother would go out visiting a great deal and would wear all the clothing which patient had bought. She had even known to wait until patient was away and then wear the patient's new dress. Her father treated her better than her mother. Her aunts and grandmother told the patient that her mother never wanted her.

When patient absconded from home she stayed with a woman who lived a few streets away. She declares that her parents knew about it all the time but it was only when patient secured a job with much difficulty, that her mother issued a warrant.

Patient stated that she had had a "boy friend" for the last three months. He used to take her out on a motor bike as she did not like the pictures. The last time she went out she fell on Bulli Pass and struck her head. She got very sleepy when riding home later, had a cup of tea and became nauseated but was not unconscious. She admitted sexual intercourse on numerous occasions with one boy since she was eleven years old,
with her present "boy friend" and with two others. She had thought of marrying one boy until she heard that he was going with another girl.

Adoption made known

Girl: Chronological Age; 16 years 9 months; Mental Age; 11 years 10 months; I.Q. 74.

Problem: Stealing, absconding, sexual misconduct.

History: Patient states that she was adopted at the age of one year 6 months. She did not know her father. Her mother died ten years ago, owing to alcoholism. The patient visits her grave but has never seen her.

She stated that her foster-mother took her away from school at the age of twelve years because she could not learn; she then went to board in the country for a year. She worked as shopassistant in a big city store for three weeks but was not quick enough. She then washed dishes at another store for a week. While her foster-mother was in Melbourne she was kept at home for a month to look after the house. When her foster-mother returned she was jealous of the patient who, so the neighbours told her, had been going out with her foster-father. The foster-father also claimed that the foster-mother was jealous. When the foster-mother "clouted patient with a feather duster" and taunted her about her mother's alcoholic habits, the patient ran away.

The patient was arrested in a residential in the city where she had booked under an assumed name. She had stolen £7 from her foster-mother. She met a boy of seventeen years in the lounge of the residential after dinner.

They discussed their positions and came to the arrangement that if she lent him some of her money they would go to Melbourne together where he would get a job and they would get married. He came to her room during the night and said "How charming you look in your night attire." They slept together and when she woke next morning the boy and five pounds of her
money were gone.

The girl admitted sexual intercourse on previous occasions during the last year and she had stolen small amounts from home on several occasions. She had never had a girl friend. She was very unstable, was accustomed to biting her nails and calling out in her sleep, tossing and turning so much that it was impossible to keep the clothes on the bed. She stated that she had been very unhappy at home since last year when she was very upset when told by her adopted mother that her own mother used to visit her as a baby. "Until last year I thought my adopted mother was my own mother." The more jealous the foster-mother became of the patient's relations with her foster-father the more she taunted the patient with her own mother's failings.

Unwanted - Parental Cruelty and Lack of Supervision

**Girl:** Chronological Age: 16 years 9 months; Mental Age: 13 years 6 months; I.Q.: 84.

**Problem:** Late hours; sexual misconduct.

**History:** Illegitimate. Grandmother had custody of patient from the age of two years 9 months until nine months ago. Patient then went to see mother and travelled with mother and her paramour in a horse caravan for seven months. As her mother ill-treated her she returned to her grandmother who turned against the patient when her mother returned. Two uncles also lived with the grandmother, one was good to her but the other did not get on well with her and when drunk gave her a black eye and threw an axe at her.

The patient claimed that prior to her going to her mother she had given satisfaction in domestic positions and held good references. She stated that her "mother was so cranky that it was impossible to live with her. She left me fourteen years ago and I saved up enough money and went to her but she said she hated me and belted me with iron pipings so I reported to the police."
IV INTELLECTUAL DISABILITIES

If a child is unable to measure up to the standards demanded of him there will be a tendency towards insecurity. Whatever be the reason: low intelligence, specific disability; backwardness due to varying causes; or an excessive ambition on the part of parents; or too high a standard exacted by teachers - all are equally pregnant with danger in that they threaten the psychological security of the child.

Inability to measure up to family, social, vocational or scholastic demands may be, and is most frequently due to poor innate capacity. It is difficult to get parents to understand the idea of mental age. Each parent seems to regard his own child as the "average" for his age. So many cannot grasp the idea of a capacity limited by its innate quality; the child's failure is interpreted by them as laziness or obstinacy. Teachers as well as parents frequently err in their estimate of a child's ability and in innumerable instances the child's very real "can't" is taken for a "won't", particularly is this true of vivacious bright mannered dull and mentally defective children. It is strange that though heredity is commonly and pessimistically regarded as of major importance in cases where really it is not the influence of heredity but the influence of the parent's idea about heredity that is of significance, for example, superstitions regarding the influence of experiences during pregnancy, and false expectations in regard to the inheritance of acquired characteristics; yet in the sphere of intelligence which is an hereditary characteristic the parent of a child with low intelligence frequently has an optimistic outlook and insists that "he'll improve as he gets older." Meanwhile parent and teacher keep on pushing the child in the light of this misleading ray of hope. Actually the insecurity of the child of lower capacity increases more rapidly as he gets older for though he has experienced the same number of years and appears to have the same physical stature as a normal child of his age, his rate of mental
growth is slower than that of the child of average intelligence. It seems difficult for the lay mind to grasp the fact that mature individuals may never get beyond the mental level of say a child of seven years, of ten years, of twelve years, and so on, and thus in employment situations dull and feebleminded children frequently feel so insecure and fearful in view of what is demanded of them that they cannot resist flight.

Backwardness with its allied feeling of inadequacy in the school situation may be due to such factors as frequent change of school, late enrolment, long or short absences; parental interference with school regulations; poor home hygiene; or unhealthy relations with teachers or classmates.

In view of the frequent short absences, characteristic of the neurotic child, it is interesting to notice that Frank Sandon finds that "There is, in a number of secondary school pupils, a psychological or physical constitution that results in poor progress being associated with frequent absence, so much so that frequent spells of absence are related with educational retardation more than are less frequent longer spells of much greater total duration."

Further, discrepancy between the child's capacity and the standards required may be due to lack of educational guidance so that the pupil comes to be in the wrong grade, or again it may be due to inefficient teaching, or to a failure on the part of the curriculum to supply the child with the type of work which is suited to his intellectual ability and interests.

Parental ambition often makes the child feel that he is falling short of what is expected of him. Since school is the main testing out place it is mainly in educational issues that parental pride is manifest. There are indications that parental ambitions are frequently due to compensation for the parent's early treatment and his or her own lack of satisfaction.

Hence one may hope for an improvement in future parental attitudes in that by enabling the children of the present to have adequate satisfactions, they will in turn treat their children more objectively and not exact from them standards in compensation for their own feelings of inadequacy and insecurity.

If a child's capacity and the demands made of him are not balanced he will not only fail to find security without which he will not be free to attain the goal of self-realisation, but he will continue to move away rather than towards that goal. Owing to his repeated experience of failure he will continually feel more and more inadequate and insecure with the inevitable result that his psychological insecurity will manifest itself in maladjusted behaviour of either a delinquent or non-delinquent type according to the make up of the individual, and the pattern of his environment.

In this connexion it is significant that so many delinquents are of subnormal intelligence, and that many who are of normal intelligence are backward especially in reading which is fundamental in school subjects. Inadequate school adjustment is one of the common causes of truancy which is, in very many cases, the first step towards serious delinquencies.
CLINICAL EVIDENCE

Poor Intelligence

Girl: Chronological Age: 9 years 3 months; Mental Age: 5 years 8 months; I.Q. 61.

Problem: Very poor school progress and cannot read.

History: Maternal grandmother and grandfather and mother could not learn at school. Patient is feebleminded and is in 3rd. class where the average mental age is about nine years.

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Girl: Chronological Age: 11 years 9 months; Mental Age: 6 years 8 months; I.Q. 57.

Problem: Always comes bottom of class - poor results in all subjects. Peculiar way of speaking as if she had no palate. Very well behaved at school, but lazy about doing homework.

History: Child is in 5th. class though her mental age is that of an average child just starting school.

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Girl: Chronological Age: 10 years 11 months; Mental Age: 9 years; I.Q. 82.

Problem: Very slow; nervous and restless.

History: Has bright manner which tends to mask low capacity so that she is expected to keep up to the standard in 4th. class which is beyond reach of her ability.

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Girl: Chronological Age: 13 years 10 months; Mental Age: 10 years 11 months; I.Q. 78.

Problem: "Retarded and unstable; deceitful and stubborn".

History: Throughout her school career more had been expected of her than her low capacity warranted. In order to evade punishment and uncomfortable situations she had acquired the habit of practising deceit.
Girl: Chronological Age: 11 years 10 months; Mental Age: 6 years 6 months; I.Q. 55.

Problem: Supersensitive and shy; nervous; speech difficulty.

History: Mother had nervous breakdown before patient's birth. Father always "flighty". Separated three years ago. Patient over-protected by mother and adults. She was also feebleminded and was in 5th. class while her mental age was less than that of any average child in 1st. class.

Girl: Chronological Age: 10 years 5 months; Mental Age: 6 years 8 months; I.Q. 64.

Problem: Temper; speech difficulty; poor progress.

History: Parents unknown; adopted at the age of one year. The demands made of her had always been beyond her capacity and now in 4th. class she was about four years below the mental level of her class.

Girl: Chronological Age: 12 years 11 months; Mental Age: 10 years 8 months; I.Q. 83.

Problem: Poor progress; sleep-walker; enuresis.

History: Unsuitable to academic pursuits.

Girl: Chronological Age: 13 years 11 months; Mental Age: 10 years 2 months; I.Q. 73.

Problem: Supersensitive; temper; inattentive; fair progress.

History: Mother works; father dead. Owing to her low capacity she had always been teased at school earning the nickname of "ratty".

Girl: Chronological Age: 8 years 9 months; Mental Age: 5 years 6 months; I.Q. 63.

Problem: No progress, stubborn, unsociable.

History: Mother feebleminded. Child though still in 1st. class is unable to cope with the requirements there. She is amongst children three or four years younger than herself.
Girl: Chronological Age: 10 years; Mental Age: 7 years; I.Q. 70.

Problem: Faulty speech, poor progress.

History: Father home at week-ends only. The next oldest in the family is aged twenty-two years. Patient is the oldest child at home, the others being married. Her general immaturity was thus associated with over-protection as well as defective mental development.

Girl: Chronological Age: 13 years 5 months; Mental Age: 8 years 11 months; I.Q. 71.

Problem: Very slow, temper-tantrums.

History: Foster-mother took patient from mother (single girl) at the age of one year four months. Patient sleeps with guardian. While being spoilt at home she was teased at school owing to her low capacity.

Girl: Chronological Age: 16 years 1 month; Mental Age: 11 years; I.Q. 69.

Problem: Absconded

History: Mother died six years ago. Father went away and has not been seen since. Brother and patient were under guardianship of grandparents. Patient was then placed with a guardian but was returned to the Depot after a month for stealing. She absconded from the Depot with another girl with whom she returned to her grandparents. Since her parents had lived a long way from the school she had not been to school until she entered the custody of her grandparents. She stated that she was never good at anything at school. She left school at the age of fourteen years and secured a job in a factory. She had to catch the 7.30 a.m. train and returned at 8.40 p.m. each evening. She remained in the job for six months and then left because her friend wished to leave. After remaining at home for some months she secured a job in a printing office. She was later employed in Woolworth's and lived with another girl. She left after four months and returned home as she started to quarrel with the girl. She then secured another factory job
during which she stayed with a cousin. She states that she has a boy friend in the city but denies interference. Medical examination reveals that sexual intercourse has taken place.

**Disinterested**

**Girl:** Chronological Age: 11 years 2 months; Mental Age: 13 years 5 months; I.Q. 120.

**Problem:** Very fair progress, lethargy.

**History:** Work of class had always been too easy. She needed further stimulus.

**Classmates Brilliant**

**Girl:** Chronological Age: 14 years 5 months; Mental Age: 15 years 4 months; I.Q. 106.

**Problem:** Poor progress.

**History:** Father dead, was a drunkard. Mother in England. Patient has been with aunt since the age of two years. She works too hard but is unable to keep up to the standard at the first rate High School where all her friends are brilliant.
ECONOMIC INSECURITY

Though economic security is readily understood by most people since it is something material and easily observed, it is amazing to find how little the lack of material things really matters to children. They can live on, and be happy with, remarkably few material advantages.

It is the psychological aspect of economic insecurity that is of importance; for example, in cases of unemployment, where a "pretence" is kept up so that the children in the household are at a tension all the time, or where the father has no interest other than nagging at the children, or where the mother becomes irritable and worried and has perhaps to go to work.

Healy and Bronner found that though they may have importance as factors in an individual case, social conditions do not in general distinguish the delinquent from the non-delinquent child.

More important than the factor of extreme poverty is perhaps that of a comparatively low economic level where the child has less material advantages than those in the social group in which he moves.
Father Dead

Boy: Chronological Age: 13 years 4 months; Mental Age: 11 years 5 months; I.Q. 67.

Problem: Truancy

History: Father died two years ago. Mother has widow's pension. Child had to stay home from school because he had no shoes. He was then afraid to go back for fear of "ragging", and lest he be unable to pick up lost ground.

Friends have more money

Girl: Chronological Age: 14 years.

Problem: Stealing

History: The mother of the patient when aged fourteen was boarded out as a state ward to a Jewish family. She stated that the boy in the family was coming to her room at night but no one would take any notice of her. At last she was returned to the Child Welfare Department who sent her to one of the State Depots. When waiting at table one evening she looked pale and said that she had a pain. She was told to go to her room and a glass of water would be brought to her. She was forgotten about until a moan was heard at 2 a.m. A child was found by her apparently dead.

This child was the patient who has been with a guardian for ten years. The guardian spoils her; gives her good clothes which she leaves on the floor of the bathroom for guardian to straighten out and put away. No sexual difficulties have occurred but the child is "all out for pleasure in the company of people with more money than herself, with the result that she steals from her guardian. For example, when the other ward aged twenty brings all home on Friday night, the guardian puts it on the dining-room table and when she goes to pay the baker on Saturday she is unable to find it. On the Monday the patient tells of a job she has in the city, describing it all in detail and giving accounts of conversations during
the day, and even gives her guardian fifteen shillings out of the £1 which she has stolen. At the end of the week the other ward rang up the supposed employers and found that the firm does not employ women.
VI. PHYSICAL STATUS

Like the economic factor this may be of significance in an individual case but it is relatively unimportant. Healy and Bronner found no general distinction between the delinquent and the non-delinquent child in this respect.

Ill-health is detrimental mainly in that it prevents the child from mixing with other children either through lack of opportunity owing to absence from school or more often through excessive adult attention and protection. So frequently minor and major illnesses in early childhood lead to a ridiculously excessive anxiety and protection on the part of the parents with the result that the child becomes invalided without continued physical cause.

Though many cases of malnutrition are reported, almost without exception they are due not to lack of nourishment but to emotional causes. With increased security through the parental application of a more suitable mental and home hygiene such children gradually gain weight and lose their haggard appearance.

Developmental conditions such as the awkwardness of the adolescent, the onset of adolescence, common disaffections such as acne at a time when the individual is most concerned with outward appearances, may all increase his feelings of inadequacy and insecurity.

Precocity in growth is at times of importance. Particularly is this so in the case of mental or near-mental defectives who frequently mature early. Just as creatures lower in the evolutionary scale mature quickly, so individuals of more simple and immature constitution show this atavistic trait.

Children who are crippled, or have physical abnormalities such as cleft palates, webbed fingers, are obviously burdened with special difficulties in their attempts to adjust themselves.
CLINICAL EVIDENCE

Girl: Chronological Age: 12 years; Mental Age: 11 years 1 month; I.Q. 91.

Problem: Temper-tantrums; unreliable.

History: Social ostracism because of skin trouble which is innate and not infective. Father and some of children also have skin trouble.

Girl: Chronological Age: 10 years 8 months; Mental Age: 10 years; I.Q. 93.

Problem: Very poor progress; nervous debility.

History: Living in family of adults. Refuses food. Malnutrition due to emotional maladjustment.
IMPLICATIONS

(a) FOR MENTAL HYGIENE
(b) FOR THERAPY
(a) IMPLICATIONS FOR MENTAL HYGIENE

It has already been pointed out that each of the factors artifically singled out for discussion, namely, inconsistent discipline, dependence, disapproval of wrong responses, intellectual and physical disabilities and economic insecurity are potential dangers to the psychological security of the child. In view of this it is significant that each one of these factors mentioned is a negative one which makes it not surprising logically that they lead to a breaking down of the individual's psyche. It is only by opposing these negative and breaking-down causes of insecurity by positive and up-building factors that security and normality can be ensured.

Despite the effectiveness of therapy in the milder neurotic and delinquent cases the writer would say with Healy and Bronner that "our Research into fundamental causes has left us with the conviction that the checking of the delinquent career once started is no easy matter." The whole problem must be attacked; it is useless to rely upon mere treatment.

What then are the positive building-up factors -- the conditions which are the necessary preliminaries for an effective adjustment -- the basic principles of mental hygiene? And how may the practical application of these principles be fostered in the community?

In general, it is only by education of the community in the principles of mental hygiene, together with assistance in their application where necessary, and by the provision of adequate educational (including recreational) facilities in all spheres that mental health may be improved.

In order to make the suggestions for the extension of community mental hygiene specific and capable of application an attempt will be made to discuss each principle separately.
(though in reality all are subtly interwoven) together with suggestions as to ways in which these principles might be habituated in the community.

1. **Consistent treatment and effective discipline**

   If the child is to feel secure he must know where he stands with his parents and with his teachers. They must treat him consistently and not capriciously. Though there must be no more than a medium degree of discipline there must be a high degree of uniformity of discipline. The child should have few instructions and commands, but these must be enforced. The child must see that the parent means what he says. Thus each parent must be consistent in himself, the two parents must be consistent with each other, and if possible the school and the home must be consistent in their discipline if the child is to feel secure in his relationships with them. It is significant too, that owing to the law of conditioned reflex it is only with consistent treatment that the child may develop habits of thought, feeling and action. If these inner resources are not built into him he cannot feel adequate and secure, but will be a creature of impulse, irritable with no sustained powers, buffeted by circumstance but unable to make a stand.

   "A subjective judgment of the total home situation secured by a consecutive reading of all records for each child leads to conclusion that control of anger in children is best achieved when the child's behaviour is viewed with serenity and tolerance, when the standards set are within the child's ability to achieve, and when these standards are adhered to with sufficient consistency to permit the child to learn through uniformity of experience, without such mechanical adherence to routine that the child's emotional or physical well-being is sacrificed to the demands of an inflexible schedule. However, when departures from the established schedule are made, they should be determined by a recognition of the needs of the child and not simply by the convenience or mood of the adult in charge.
Self-control in the parents is, after all, likely to be the best guarantee of self-control in the child." (x)

The most important influence in providing this stability is a harmonious family life where parental relationships and child relationships and sibling relationships are satisfactory. There must be little tension between parents and between parents and children. As H. Crichton Miller says, "We all realize today that the child has a right above all things to security of environment. Slowly we are coming to understand that sense of security can be engendered more successfully by a normal home than by any other artificial substitute. We now know that if the child is to reach adult years with a sufficient degree of self-confidence, he must have behind him a background of security, or he will be distrustful of his fellow-creatures, antagonistic to those in authority, suspicious where he should be trusting. . . . The central problem of education today is to give the child freedom and inspire him with a sense of social responsibility." (xx)

In the words of George K. Pratt "Mental hygienists are stressing one great point, namely, that in most cases of nervousness, in many cases of delinquency, in some cases of insanity, and in almost all cases of child behaviour or conduct disorders, the trail leads inevitably and directly back to the home and the parents." (xxx)

Thus as Healy and Bronner state the "Single direct attack of greatest value may be through widespread parental education. . . . Parents must gain insights into the fact that their own emotional attitudes, so often unconsciously motivated, as well as the feeling — life of their children are involved in any behaviour problems presented." (xxxx)

(x) Florence Goodenough "Anger in Young Children" 1931.
( xxx) "A Mental Health Primer"by George K. Pratt.
( xxxx) Healy and Bronner "New Light on Delinquency and its Treatment" page 217.
Parental education may be brought about by the establishment of centres for education of parents in child management, by popular lectures, group discussions; visitors to the home from schools and clinics; group meetings with school teachers whereby discipline of home and school may be co-ordinated; by newspaper articles, pamphlets and publications by recognised authorities.

There must also be education of professional groups, particularly those of teachers and doctors, in Child Guidance principles and methods.

Moreover there must be facilities for consultation with and assistance to parents who require help in dealing with their children. This is most effectively achieved by the professional team which has come to be known as a Child Guidance Clinic. Hence adequate Clinical facilities must be made available.

The most insidious and uncontrollable factor must of course always be that of parental friction and separation as evidenced in the vicious home and the broken home. Any influences which militate against this unhealthy state will obviously afford a more satisfactory treatment and discipline for the child. Since in most cases the workers in a Child Guidance Clinic feel that they are adjusting the child by relieving the parent's difficulty, it is considered that there should be Clinical facilities, more in the nature of a matrimonial clinic, for the treatment of the parent's own difficulties. Even more fruitful perhaps than the American attempt to assist satisfactory rating by the administration of psychological tests, is the idea that if children are happily and satisfactorily adjusted there will be less chance of their proving difficult parents. As E. Miller says "It has been said that there are no abnormal children - only abnormal parents. This is exaggerated and unpalatable, but, nevertheless, there is no doubt that the faults in the parents' personalities are mirrored in their children. It follows therefore that every child we allow to
grow up with some gross defect in its personality carries
with it the potentiality of being a parent who will continue
a fault which may do infinite damage to our civilisation. If
this is a depressing thought, we can console ourselves by the
fact that every time we correct a defect in a child we are
not treating that child alone, but an infinite number of
children yet unborn." (x)

Then too, even if it were possible to remove parental
difficulties and vicious homes, there will always be the in-
evitable difficulty of the occasional mental defective or
insane parent; of broken homes due to the death of one or both
parents; or that of the invalided parent with sometimes the
added difficulty that the mother has to go to work. Since
these are entirely uncontrollable situations the community must
provide adequate facilities for the treatment and discipline of
the children in such unfortunate home situations.

(2) Independence

The child must be free from excessive adult protection
and anxiety in order that he may gain the security and stability
of emotional maturity which will give him freedom to express
himself and which will enable him to cultivate initiative. He
must be free to mix with his fellows and free to indulge in
childish adventure. He must have both suitable companionships
and suitable activities.

Much has recently been done in an effort to provide
children with the opportunities for mixing with other children.
There is still a need for a more adequate number of well-run
clubs such as the Boy Scouts and Girl Guides. Kirkman's
reference to the dangers of excessive day-dreaming pays tribute
to the "remarkable success of Boy Scout and Girl Guide movements
which have given boys and girls an excellent opportunity of

(x) "The Growing Child and its Problems" edited by E. Miller,
London, 1937.
sublimating this evil by a spirit of fine adventure. They have converted, in numberless cases, what might otherwise have been aimless day-dreamers into children of action." (x)

The extension of playgrounds and children's libraries and craft centres, with trained workers who may assist the children in learning to mix with other children and in finding recreational interests, is of vital importance.

The value of such social agencies in the community cannot be over-estimated for almost all disturbed children show some degree of retarded social development. Moreover it is miraculous how rapidly many behaviour problems disappear when the child becomes associated with these clubs and playgrounds.

Similarly social and recreational activities must be extended at school where the child must be encouraged to mix with other children and to increase his initiative by the gradual assumption of responsibility.

Pre-school clinics and Day Nursery Schools are perhaps the most urgent need. The Day Nurseries have been responsible for some very interesting research work which is revealing that the children who have attended Day Nurseries are making the most effective adjustment when they go to school.

Apart from the opportunities by which a child may become a sociable and independent being, if he is to be protected from the perils of adult over-protection, there must be adequate provision for adult interests and activities. With the reduction in the size of the family and the increase of labour saving devices in the home, the modern mother requires "outside" interests for otherwise she will have so much time to spend on attending to and directing her children that she will prevent them from growing up. Many clinic cases in which the child has failed to develop initiative and confidence through parental over-protection and anxiety have improved rapidly after the

(x) C.W. Kirmins "Children's Dreams" George Allen & Unwin 1937.
mother has taken up tennis or some other weekly activity.

Parents too must be freed from ignorant superstitions. For example so many women have false ideas in regard to the influences of experiences during pregnancy, on the later life of the child and rarely is there a case in which it is not the conditions of pregnancy but the mother's expectation of difficulty that is significant.

(3) Approval of right responses

It is by wise praise and encouragement, not by criticism and nagging, that the child will acquire acceptable habits and attitudes. The negative "Don't" must be replaced by the more positive "Do". This can come about only by a knowledge of the principles of learning, and through an understanding of the child's mind and values. This is an aspect of adult education and though much can be done by a direct presentation of psychological principles, perhaps the dissemination of the practical results which the application of this principal reveals in clinical practice might be the most impressive form of instruction. The cases cited in the section on "Therapy" amply illustrate the rapidity with which children find security and lose maladjusted behaviour when they receive support, encouragement, and understanding and are enabled thereby to build up within themselves habits of feeling which will lend them increasing support and stability as they grow in independence. Margaret Phillips in "The Education of the Emotions" says significantly that in our dealings with children we should as far as possible "look the way they are looking", rather than "at them". Since the suggestions of others concerning oneself, and the experience of success or failure consequent upon the effort to make oneself acceptable to them, must needs come, attempts should be made to ensure that such suggestions and experience is, in the long run, encouraging. "To this end, the child's first relations with others need to be characterised by harmony and a conviction of acceptability; only from such experience can he
draw the courage and confidence needed for tackling the experiences of disharmony and unacceptability which may be met later. Only so can we ensure that any self-sentiment formed will be such as to reinforce the outgoing impulse rather than to look emotion up in itself."

(4) *Tasks suited to ability*

It is only by activity that the child can grow, and it is only by successful activity that he can attain security and sufficient confidence in order that he may be free to realise his potentialities. The child must be presented with tasks which are within reach of his ability.

In this connexion N. Crighton Miller in his "The New Psychology and the Teacher" states that "Recent educational experiments have proved to how great an extent the system of enforced attention creates its own problems and how the force of spontaneous interest, set free to work on suitable material, encounters its own experience of discipline as it makes its way along the road to achievement. The child cannot be taught self-realisation; he can only reach that goal through achievement. All teaching has only a negative value compared with the positive value of the experience of achievement. The urge to achievement is the progressive side of the striving after power. The regressive side of it is the lure of attracting attention and creating an effect upon people."

Though the adjustment to ability of the demands made upon it is one of the most straightforward and logical principles and perhaps the most easily applied, it is scarcely apparent in practice in Australia owing to a failure to spend adequate money on educational projects. If financial resources were available there are numerous known deficiencies in the educational system which could be remedied so that thousands of children might be in a position to gain the security which is so seriously lacking at present.
First and foremost there must be an extension of Educational Guidance in the form of a Counselling System whereby each school might be visited regularly by a Counsellor - or better still have a psychologist on its permanent staff - so that all children might be tested, graded, and directed into the most suitable type of education.

This should lead, also, to a revision of standards and to an appreciation of individual differences. At present too much is expected of too many children. The school system requires thousands of children to do more than their ability warrants. That in itself, must make them feel insecure; but their feelings of inadequacy are increased by the fact that their "can't" is frequently interpreted as a "won't". Clinical experience shows that "nervous" symptoms result immediately when tasks are demanded beyond the reach of the child's ability.

There must be an extension of vocational guidance, the value of which has fortunately already been recognised in the community.

Efficient teaching is an essential. Professor Hanley goes so far as to say that "Efficient teaching in the early stages of the child's school career, of the fundamentals of reading, writing and arithmetic might well be called the corner-stone of Mental Health."

Varied types of education to suit the varying abilities of different children must be provided. An extension of manual and technical education is particularly needed since a large group of children suited to this kind of work cannot at present find security in the prevalent academic curriculum.

Backward classes must be established for children who, though not dull, feel inadequate and insecure in their school life owing to absences, change of school and other adventitious causes.

Then, too, dull and backward classes must be established for those who feel inadequate and insecure because they cannot
keep pace with the rate of ordinary class instruction.

Special classes and residential schools must be established for those who are feebleminded and need individual treatment and special attention.

There must be, further, a provision of adequate and classified institutions so that children who require supervision may be treated according to their needs and ability.

In order to assist in the prevention of difficulties due to low intelligence there should be a more intense study of genetics and a practical application, by means of wise legislation, of the principles revealed. R.B. Cattell and J. Leslie Wilson give an interesting account of some research done in an attempt to discover reliable means of assessing the probable mental level of offspring and state that "For practical purposes of calculating the probable intelligence of the children (mid-child), knowing that of the parents, we may employ the following regression equation - I. of mid-child = I. of mid-parent x 0.8 + 28.0 the probable error of estimate being 9.1"

(5) Material Security

Though a much less important factor than it is usually considered a certain degree of material advantage is necessary for normality. Beyond the very small minimum requirements of every human being, it is not so much the absolute amount of material advantages that matters so much as the relative amount in comparison with the group in which the individual finds himself.

A comprehensive social programme involving slum clearance, housing, living conditions, etc. should be embarked on in order to supply the physical, if not the psychological needs, of children. There must be adequate standards of housing and nutrition among the people and knowledge and practice of home economics and of family budgeting along sound lines must be spread.

In classes where there is abundance of material wealth the increasing tendency for "social climbing" should be deprecated. A child who feels insecure in a school where others have far greater material assets than she has, has far less chance of making a normal adjustment to life than if she were in a school, of perhaps less social standing, where she was not hampered by a feeling of economic insecurity.

(6) Physical Fitness

It has already been indicated that the child's physical condition is not so important as the attitude of others towards that condition, yet it must surely be that a healthy body must make more possible a healthy mind.

In order to make the child safe from perils in this sphere there is need for regular medical inspection and systematic physical education. Moreover physiology and physical hygiene should be given a more vital place in the school curriculum. The community has already realised the need for dental and hospital clinics and for public hospitals. There must always be adequate provision for children who are crippled, blind, deaf and dumb.
(b) IMPLICATIONS FOR THERAPY

In view of the absence in the community of this state of ideal mental hygiene, owing to ignorance, lack of training and other vicious influences, and through inevitable conditions such as death, invalidism and subnormality of certain parents, one cannot envisage a time when therapeutic measures will not be necessary.

One of the main difficulties in all remedial work along lines of personality comes from the failure of the specialist to treat children soon enough. This is especially conspicuous in cases of delinquency where difficulties of adjustment, though present but less obvious before, are brought into high relief at adolescence, which time little hope can be placed in therapy. One would wish that the theory that a child "will grow out of" its difficulties were less popular than it is - clinical experience is that it more often "grows into" then, or into worse ones, and that valuable time is lost by allowing wrong trends of behaviour to become fixed habits.

When early signs of delinquency or neurotic behaviour are detected, parents, unless they find themselves immediately able to cope with the problem, should be educated to act as they should in a case of impending serious illness, namely voluntarily to seek and carry out the recommendations of professional service in a clinic where behaviour difficulties are studied and expertly treated.

Since it has been shown that maladjustment is due to insecurity which is brought about by negative conditions, and adjustment implies security which is built up from the positive treatment just outlined, therapy must be positive not negative. Since all problems of emotional maladjustment, whether neurotic or delinquent, are due to some of the child's needs not having been met, to his lacking something which makes him feel inadequate and insecure, it is useless to turn his attention inwards,
for that will do more than accentuate the difficulty. He needs to have his attention immediately turned away from himself at the same time to be placed in a situation where he may be supplied with what he is lacking, in order that his inner resources may grow. He must be placed in a sphere where he can receive consistent treatment and understanding, and by means of successful activity establish confidence.

"I believe that the great majority of children referred to Child Guidance Clinics, even though their behaviour is seriously disturbed, are intrinsically quite normal and that the less mental investigation and treatment they are given the better it is for the child. After all, if the child's abnormal behaviour is the result of a distorted environment, the best thing one can do is to leave the child alone and to straighten out the environment as far as this is possible. In treating children it should always be kept in mind that injudicious investigation into their mental workings may be extremely harmful. All those who deal with children understand the great desire for attention which is almost universal amongst them and how this can be fostered by any process tending to single out a child from his fellows. It is also quite possible that, in certain cases, children may be rendered neurotic by directing their attention towards their thought processes. Therefore when it is possible the child should not be given personal treatment, curative efforts should be brought to bear on him through the everyday environment."

Thus an effective therapy will include such essentials as:

(1) an adjustment of physical defects revealed by medical examination;

(2) a provision of an adequate economic environment;

(3) an adjustment of the school or employment situation and parental demands in relation to the child's capacity as revealed by psychological tests, so that he may be engaged in activities

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(x) Child Guidance and the Schools by Dr. William Hoodie reprinted from the "Educational Research" Supplement of the "Head Teachers Review" February 1931.
suited to his ability:

(4) Wise encouragement, with praise for right responses; and an optimistic outlook which suggests hopeful results from treatment:

(5) Assistance to the child in mixing with other children by providing him with opportunities and with help of which he is unaware; and by assisting parents and teachers to give him no undue attention, not to over-protect him but to allow him to grow up gradually by means of increasing responsibility:

(6) Assistance to parents and teachers in an attempt to afford the child consistent and firm but not excessive discipline.

Thus beyond encouragement and suggestion there is little need for direct treatment of the child unless he suffers from some physical defect which must be treated or from some educational disability which requires special tuition. In the main therapy must be directed towards the child's environment, towards parents and teachers whose attitude towards the child must be changed from one which produces in him a feeling of insecurity to one in which he can find security in his relations with them. This makes it apparent that more and more importance is being attached to the social worker. The older idea of minute analysis by the psychiatrist has given way to a more objective attack upon the child's entire, and particularly psychological, environment. Hence objective and positive methods of therapy are favoured.

If maladjustment is due to psychological insecurity it is essential to treat, not just the symptoms, but the whole child in relation to his environment.

It has been shown in the section devoted to therapy, that the application of these principles which have been outlined, does lead to a change from maladjustment to adjustment.

It is not until there is more security and resultant normality and sociability among the individuals of the world that one can hope for a widespread national security and a stable normality which because of its very quality of sociability would make national strife impossible.
APPENDIX TO SECTION 111

PERSEVERATION AND SURGENCY IN MALADJUSTED CHILDREN

[Diagram showing the relationship between surgent temperament and maladjustment]

SURGENT TEMPERAMENT
(Overactive, unstable, impulsive)

Introvert
(Low surgency + High perseveration)

High
Perseveration

Low
Perseveration

Extrovert
(High surgency + Low perseveration)

Delinquent
(Low surgency + Low perseveration)

PREPUGENT TEMPERAMENT
(Shy, easily scared, sensitive, oscillating)

[See R. B. CATTELL 'Your Mind + More']

MALADJUSTMENT

Unacceptable

Delinquent

Extrovert

High
Perseveration + Low surgency

(Withdrawal into self, with no attempt to alter situation)

Introvert

High
Perseveration + High surgency

Non-delinquent

Extrovert

Low
Perseveration + Low surgency

(Withdrawal from situation + impulsive acceptance of social substitute satisfactions)

Introvert

(Shy, easily scared, sensitive, oscillating)
A further analysis of what is termed introversion and extraversion reveals a more subtle mingling of innate and acquired influences. It may be shown that the introvert is a high perseverator which means that the marked lag of nervous processes will prevent his concentrating fully on the task of the moment, and he will be an anxious, worrying type. Moreover coupled with this is his low surgency or desurgent quality which means a falling away of strength, a failure to meet the world and society—thus as has been indicated he will tend by innate organisation to fail to satisfy his needs. Hence his needs will be increased, his insecurity increased and his anxieties and fears increased which latter will in turn increase his already high innate perseveration.

This assumes that perseveration varies with environmental influences, for example, if a person of the introvert type feels secure in a social group he can throw himself into the present with fewer hangovers from the past and with fewer potential hangovers for the future; but if he is in a group where he feels insecure, he withdraws into himself and perseveration is increased. Hence it is suggested that it is possible that a reduction of insecurity may lead to lower perseveration. This agrees with the findings that normal people are medium or low perseverators, and acute mental cases which have yielded somewhat to treatment show a decrease in perseveration.

Conversely it is the high surgent quality of the mal-adjusted extravert which enables him to "fight" the world. Coupled with this he has low perseveration so that he will tend to go on grasping at momentary satisfactions, for he tends to forget the momentary nature of past satisfactions and he is less anxious and worried afterwards by his present activity. Hence he can live more in the moment and act more impulsively than the introvert.

Thus in non-delinquent types of maladjustment there is an introvert type with high perseveration and low surgency which reveals such symptoms as shyness, unsociability, super-sensitive-
ness, habit-spasm, morbid fears, masturbation, invalidism and such like. There is an extravert type with low perseveration and high surgency, which reveals such behaviour as temper-tantrums, disobedience, fighting, destructiveness and violence.

In the delinquent group one finds introvert and extravert types, the introvert type markedly predominating; but it is submitted that the delinquent tends to be a combination of part of the maladjusted introvert and part of the maladjusted extravert characteristics. It is suggested that like the introvert he may have low surgency - a failure to meet the world, unsociability; but like the extravert he may perhaps have a low perseveration which lends him an impulsive character. Yet unlike the extravert he has not the surgent quality which would enable him to be aggressive and to fight people for his wants, with the result that he becomes fearful, solitary, and unsociable and takes a-social substitute satisfactions. Unlike the extravert he retreats from the situation rather than attempting to attack it and unlike the introvert he impulsively lives in the moment without intense unsolved conflict. This would seem to indicate that there is present a low surgency and low perseveration.

In the example quoted on page 174, one can see that the introvert's reaction to the situation is that of a person with high perseveration and low surgency, while the extravert's is that of one with high surgency and low perseveration. It is suggested that the delinquent's reaction might be found to be that of a person with low surgency and low perseveration for he seems to take the path of least resistance by withdrawing from the situation, while his solution is an impulsive one without regard to inevitable consequences.

Perhaps, too, the broken home situation with its lack of training which is associated with delinquency might result in a lower perseveration, while the lower intelligence which is associated with delinquency might result in a lower surgency.
If it were found that delinquents tended to be low surgents and low perseverators the common suggestibility of the delinquent might be further explained.
SECTION IV  SUGGESTIONS FOR RESEARCH AND REFORM
SECTION IV - SUGGESTIONS FOR REFORM AND RESEARCH

A. CLINICAL

The extension of Clinical Work, particularly the establishment of a Central Demonstration Child Guidance Clinic.

B. SOCIAL

(1) Birth Control

(2) Classified Institutions for (a) Dependents (b) Delinquents

(3) Well-run Homes for State-Wards

(4) Hostels for ex State-Wards

(5) Abolition of Pernicious System of Chasing Neglected and Uncontrollable Children

(6) More Truancy Inspectors

(7) Investigation of the Relation between the "General Goodness" or "G.G." of a community and its Problem Children

(8) Extension of Children's Playgrounds

(9) Extension of Children's Libraries

(10) Extension of Children's Clubs


C. EDUCATIONAL

(1) Extension of Educational Guidance by appointment of School Counsellors

(2) Professional and Lay Education in Child Guidance

(3) Backward Classes for Normal Children

(4) Backward Classes for Dull Children

(5) Special Classes and Schools for Mental Defectives

(6) Extension of Manual Curriculum
D. PSYCHOLOGICAL

(1) Standardised Performance Test of Intelligence

(2) Australian Standardisation of Unsuitable Parts of Terman and Merrill Binet Tests Form L and Form M

(3) Standardised Clinical Tests of Verbal Imagery
   Visual
   Kinaesthetic Imagery
   Auditory Imagery

(4) Standardised Clinical Tests of Memory Span

(5) Special Aptitudes Tests

(6) Tests of Emotional Maturity or Emotional Age

(7) Standardisation of Diagnostic Reading Test (Burt)

(8) Remedial Reading Programme

(9) Remedial Reading Material

(10) Investigation of Type of Play Material suitable for Australian Clinics

(11) Relationship between School Backwardness and Emotional Maladjustment

(12) Investigation of the Relationship between Type of Behavioural Problem and (a) Chronological Age; (b) Mental Age;
    (c) Intelligence

(13) Investigation into Relationship between Truancy or Absconding and Delinquency

(14) Investigation of Coincidence of Truancy and Enuresis

(15) Investigation of Relationship between Attendance at Nursery Schools and (a) later school adjustment; and
    (b) delinquency

(16) Investigation of Coincidence of Menstruation and Behaviour Difficulties.

(17) Investigation of Coincidence between Menopause in Mother and Behaviour Problems in Children

(18) Investigation of Coincidence of Mother's fears during Pregnancy and Occurrence of expected Behaviour Problem

(19) Investigation of dreams in Problem Children of various types

(20) Investigation of amount and depth of Sleep in Problem Children of various types.

(21) Investigation of degree of Persistence in Delinquent and Neurotic Types

(22) Investigation of Perseveration and Surgency in Maladjusted Children of (a) Delinquent; (b) Neurotic Extravert Type; (c) Neurotic Introvert Type.

(23) Relationship between Intelligence and (a) Perseveration;
    (b) Surgency
24) Variation of Perseveration and Surgency with the Age of the Individual; e.g. Is the Perseveration Index Highest at Adolescence?

25) Relationship between Perseveration and Amount and Depth of Sleep

26) Comparison of Degree of Perseveration before and after Therapy

27) Relationship between Stammering and Intelligence

28) Relationship between Imagery and Stammering

29) Relationship between Stammering and History of Enuresis

30) Investigation of Auditory Acuity and Perception of Stammerers

31) Investigation of Muscular Co-ordination of Stammerers

32) Investigation of Rhythmic Sensitivity of Stammerers

33) Investigation of Dreams of Stammerers

34) Investigation of Family History of (a) Left-handedness; (b) Squint; (c) Stammering; amongst Stammerers

35) Investigation of Age of Onset of Stammering

36) Investigation of Perseveration of Stammerers.
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