SOME BEHAVIOUR PROBLEMS AND THEIR TREATMENT.

by

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Chapter I.  The development of personality.

Chapter II.  The Child Guidance Clinic and Its Methods.

Chapter III.  Problem cases.

  a. Problem cases which appear among children with undesirable personal habits.

  b. Problem cases which appear among children with undesirable personality traits.

  c. Problem cases which appear among children with delinquent tendencies.

Chapter IV.  Summary.

Appendix.  Additional case studies.
The Development of Personality.

Chapter I.

Psychologically, the term, personality, connotes a person's entire mental make-up - his intellect, his temperament, his skill, his morality, together with his many other attitudes (i.e. his habitual mode of response.) Each individual has developed a personality of his own; and the differences in personality are due both to heredity and to environment.

The marked differences shown by infants at birth - differences in size and in general bodily appearance, in anatomical traits, in the sensitivity of his organs, in the conductivity and modifiability of the nervous system (on which the level of intelligence depends), in the strength of the natural urges or so-called "instincts" - are differences due to heredity; but other differences that depend on the individual's experiences, on the way he learns by experience and the way he learns to adjust to his difficulties and to his successes, are differences due to environment.

Let us look briefly at the way in which an infant develops from birth. He begins, as one psychologist has said, as a bundle of instincts and reflexes. All his behaviour (i.e. his responses to stimulation) is at the automatic, instinctive level. A sudden loud noise will bring a fear response. Restraint will bring the anger response. He has to learn to see, to hear, to taste; and then, through constant responding to stimuli, he gradually learns to perceive what he sees. His experiences gradually develop their feeling tone. His emotional responses are, at first, primitive ones. There are differences in the intensity and duration of these responses, owing to the innate differences already mentioned.

From the time of birth, the child is constantly responding to
stimulation from the environment; but soon he is making new responses, not the universal instinctive ones. He is learning. He is growing mentally - intellectually, socially and emotionally. Whether he will develop into a mentally healthy individual depends both on the stimulation he is receiving from the environment and on the responses he is learning to make to that stimulation. From birth onward, he is meeting obstacles in his environment, thwartings of his fundamental urges, particularly of the urge for mastery or for social approval. Whether he will develop into a well-adjusted, mentally healthy individual depends on the response he learns to make to these inevitable thwartings. He may learn to make mentally unhealthy adjustments. Take, for example, the retiring, non-communicative, daydreaming child who later develops into the schyophienic type of patient, with whom our mental hospitals are crowded. He is not learning to meet his thwartings. He is evading them; and instead of experiencing the feeling that comes from having successfully surmounted obstacles, his urge for mastery has been satisfied, unhealthily, by daydreaming and building castles in the air. We all indulge in daydreaming to some extent; but when this daydreaming, this shrinking from reality becomes our habitual response to any difficulties we are encountering, we shall soon be living entirely a life apart. Our mental hospitals are filled with such individuals - individuals who have learned in their youth to make these unhealthy mental responses to the thwartings of their urges.

If we look around us, we shall find everywhere people who are ill-adjusted, people of the worrying, overanxious type, people who cannot get on with their fellows, people who are anti-social - all types of maladjusted personalities of varying degrees of maladjustment. The
extremely maladjusted individuals are incarcerated in our mental hospitals and penal institutions. From statistics recently available, it is conservatively estimated that the mental health of twenty per cent of the pupils in any average class in any average school will be such as to interfere with their success in adjustment to adult life, and that four per cent of the pupils in the class will finally be committed to mental hospitals. The tragic side of this situation is that from at least two-thirds to three-fourths of these maladjusted individuals could have learned to adjust to their difficulties in healthy ways had their trend been recognized during their early, formative years. Mental ill-health does not develop suddenly. There is generally a long history of gradual development. If the signs of maladjustment were recognized in the early years of development before the unhealthy responses to the thwartings and difficulties had become habitual ones, the outlook for a mentally healthy adult population would be bright.

With this outlook in view, child guidance clinics have been established during the last two or three decades in nearly every country for the purpose of singling out the children who are already beginning to learn to adjust to their difficulties in mentally unhealthy ways, and for the purpose of training them in learning to make socially acceptable adjustments so that they will develop into mentally healthy adults.

This thesis does not purport to give a full psychological treatment of all the causes or of all the kinds of maladjustment. Some types of maladjustments have been briefly discussed.

It is rather an account, particularly from the sociological point of view, of the work that is being done at the Provincial Child Guidance Clinic in Vancouver with children who are already showing signs of faulty
adjustment - "problem cases", as they have been called. Illustrative cases have been taken from the everyday work of the clinic; and the general methods of the clinic have been described. The diagnosis and prognosis for each case, the suggested treatment and, where possible, the results of the treatment, have been given. A brief summary of some of the outstanding factors in the cases has also been appended.
The Child Guidance Clinic and Its Methods.

Chapter II.

The aim of the Child Guidance Clinic has been pointed out in the previous chapter. To help in achieving this aim, the ideal clinic would have a complete historical account of the individual and of his family and connections, and complete medical, psychological and psychiatric account of the individual. There would be, in any case study, the diagnosis of the trouble (the assigning of causes for the maladjustment), the prognosis or the predicted future development of the individual, the treatment, and a record of follow-up work over a period of years.

Financial outlay for such a clinic is heavy. The Provincial Child Guidance Clinic in Vancouver had to start in a small way, without much financial support. It was established by a group of enthusiastic but already heavily-worked government officials, looking to "prevention of mental ill-health rather than cure". It has gradually developed, as a government service, to help private individuals or various welfare agencies.

The routine procedure for the study of any patient entering the clinic is thorough and exhaustive. Roughly, it may be said to fall into three divisions: a study of the person's environment, his mentality and his physical condition.

The study of the person's environment must include a review of home life, conditions of school or place of work with its accompanying social contacts. This information is obtained through the various child welfare agencies or through the social workers.

The child's mentality is studied through mental tests, conversation, and observation of the child at play. The standard mental test at the Vancouver clinic is the Stanford-Binet. This is often supplemented with the Porteus Maze test, various association and achievement tests, and, in the cases of children who are of normal intelligence and yet who are backward in school, with an examination for reading disabilities. Obser-
vation through conversation is accomplished through talks with the psychiatrist himself. Observation of the child at play is generally made by the social worker as the child is waiting in the play-room for his turn to be examined.

The physical examination is made by the psychiatrist and nurse. In special cases, specific tests may be procured through the Vancouver General Hospital.

Finally, the writing of the case history is of great importance. This document must show, in concise form, the complete history of the patient, and must be available before the examination is started.

The case history falls naturally into sections. The first of these is a short, but most important one. It is a concise statement of the main problems presented by the case. The next section covers all the information with regard to the immediate family and to the family history generally. The personal history of the patient, which follows this, is necessarily detailed. It may be divided into four parts.

1. Prenatal conditions.

2. From birth to six years—development including feeding habits, age of walking and talking, age of bowel and bladder control, and a record of any diseases or illnesses.

3. From six years to adolescence—a record of school progress, noting any retardation or acceleration. Social reactions and personality traits may be indicated by such words as "willing, stubborn, secretive, friendly", and illustrated wherever by concrete examples.

4. The period of post-adolescence—an account of further educational progress or of economic and industrial activities.

In this case history, then, the clinic provides the information
necessary before the psychiatrist can make a diagnosis of the trouble and suggest a treatment.
Problem Cases.

Chapter III.

What is a problem case? The term has a wide application. It applies at one extreme, to the child who is the despair of his parents because he refuses to eat the food provided for him; and it applies at the other extreme, to the youth who has taken his share in a bank hold-up. It is used of the boy who is too quiet and shy to take his share in the play of his fellows, as well as of the man who believes that the whole world is against him.

In the following presentation of problem cases, only those cases were chosen where faulty adjustments or habits were due to environmental conditions alone. This excludes all cases where the mental capacity was subnormal. The cases were then, for purposes of discussion, classified under the three types of maladjustment:

(a) cases manifesting undesirable personal habits.

(b) cases manifesting undesirable personality traits.

(c) cases manifesting anti-social (i.e. delinquent) habits.
a. Difficulties of the first group seem to occur more often among young children, and seem to spring more often from a single cause than the others. The most usual are: thumbsucking, nail-biting, enuresis, masturbation, mannerisms, peculiar food fads, disturbances in sleep.

A number of these may be due to physical causes which can frequently be removed. Others are due to mental causes which cannot be changed by physical treatment.

Case 1. A typical problem in enuresis is to be found in the case of a six-year old boy. He was referred to the clinic by the Children's Aid Society because of enuresis, stubbornness and disobedience. The original trouble was at first probably a physical problem. Through unwise treatment, however, both at home and at school, and through focussing the boy's attention upon his difficulty, the trouble had been prolonged several years beyond the point where it should have ceased. The boy, by persisting in his childish habit, was able to hold the attention of the family on himself, to the exclusion of his younger sister.

His mental age was 6; chronological age 6 years 3 months; and I. Q. 95. He was a healthy boy, eating well and sleeping soundly. He bit his nails, however, and suffered from persistent enuresis. His teacher reported that at first he spent his entire school time in day-dreaming, although his attitude was improving. Even at school he lacked sphincter control. The teacher, after consulting with the mother who approved of the method of treatment, threatened him with whipping. He enjoyed farm life, and helped his foster father around the grounds. He played with his young sister, although he thought that she was too young. He was

* See footnote at bottom of Page 10.
stubborn and disobedient, not affectionate himself, but jealous of affection shown to others, suspicious, stolid, untruthful and given to day-dreaming. His father, who was fairly intelligent but lacking in initiative, worked in a lumber mill. The mother had died two years before the boy was brought to the clinic. The first foster parents, who were interested only in the money they would receive for their care of the children, dealt very casually with their charges. They were removed to a foster home of the Children's Aid Society. There was a sister a year and a half younger. She was bright, active, normal, and was indulged and praised. She was fond of the patient. It was suspected that she was held up as an example for the patient to follow. The foster siblings, a girl and a boy in the early twenties, followed the foster mother's lead in this discrimination.

The clinic decided that the enuresis was the principal problem. The foster parents were told that they had emphasized this failing to the boy too much. He was to be given no drink after supper, and not to be admonished for failure, but rather to be rewarded for success. On no account were they to speak of the matter before the patient, nor to use corporal punishment. They were to show no difference of attitude between the two children.

Since the child was not returned to the clinic, the treatment was probably successful.

Case 2. A second case of enuresis was complicated with destructiveness. This case seems to be worth quoting in full, even although one

* Mental age is the term used to indicate in years the mental development of an individual. When this mental age is placed over the chronological age and expressed in the form of a fraction and multiplied by 100, the resulting figure is known as the intelligence quotient (I. Q.) The I. Q. of a person of average intelligence would therefore be 100.
other has been given. Here, though there was a physical weakness to be­
gin with, that weakness was made use of deliberately by an uncomfortable
and unhappy boy.

Both the father and mother were living. The mother however, who
was suffering from tuberculosis, had not had the strength to cope with
the patient and his younger sister. In order that they might receive the
attention that they required, they were placed in an institution by the
parents. The report from the institution stated that the boy was under
weight, and that his sleep was restless. His bed had to be changed every
night even when he was taken up every three hours. On one occasion at
least, this state of the bed seemed to have been planned, because the boy
had pulled up the robber sheet, had tucked it carefully in again, and de­
clared that the bed was dry. He was an untidy, quarrelsome child, and
somewhat of a bully, deliberately destroying the other children's toys.
Since he resented criticism, deliberately lied and took things from the
lockers, he did not get on well with his companions. He had been in the
institution six months when brought to the clinic.

When the boy's living conditions at the institution were investig­
at ed, it was found that he was cold at nights, since he was forced to
sleep on an uncovered rubber sheet. He was given quantities of milk at
all times of the day in an effort to bring his weight up to normal. The
other children, who were told not to play with him because he was a
"dirty" boy, obeyed instructions. The boy was apparently old enough to
realize that his troublesome behaviour was the quickest means of his be­
ing returned home. The clinic recommended that he be sent back to his
mother, who was better and could cope with him. The mother was told not
to mention the enuresis, but to watch his time for drinking. She reported
that there was an improvement.

Case 3. Eating problems, as well as this of enuresis, are very often used as a means of attracting attention, and even of bullying the family into submission to the child's desire. In the case which follows, the child's misbehaviour at table seemed to be the only method of self expression for him, since the normal channels were all blocked by overprotective parents.

The boy was 6 years 5 months chronologically, and 6 years 2 months mentally. The I. Q. was 96. The parents reported that he was hard to manage at any time, but especially so at meal time. He had had no illnesses, and has a good appetite, but plays with his food, talking continually, throwing his hands around and making himself a general nuisance. He sleeps well, but is slow over washing and dressing. He bites his nails and becomes tense at times. His moods shift rapidly from those of a likeable boy to those of a mean one. Many forms of punishment have been tried without any success. Since he has no companions of his own age, he contents himself with his tools and plays alone. He is given no allowance.

The people he lives with adopted him because they both wanted children, but had none. The boy does not know that he is adopted, but they plan to tell him in the future. The father is interested in the child, and reads with him. The mother is excitable and nervous. Although the family was formerly well off financially, it is not so at the present time. The boy, however, lacks for nothing.

It was felt that the boy, with such over-protection, had a protest feeding disability. The family conversation which takes place before him shows that a scene is expected. He enjoys the attention which he
receives and the correction which is attempted. He has no proper playmates, not sufficient play and no group activities. He has no idea of the value of money. He is inclined to be too dependent, and exhibits negativism. The parents were cautioned not to give him so many orders, and not to be too anxious about, but to let the child express himself more. They were advised to see that he had playmates his own age, and group activities.

The follow-up one month later reported that there had been no progress. Meal-time is still a signal to the boy to act his worst. The mother claims that they tried the suggestion of letting the boy alone, but that he got out of hand completely. He still has no allowance and no companions.

One month later, the mother states that an allowance has been given him. The boy bought a cheap train which broke after two or three days. Although the boy says that he will not buy anything so easily broken again, the mother can see no value in the experience and claims that the money was wasted. Following this incident, the boy was deprived of one cent from his weekly allowance every time he was bad. There was no allowance left for him by the end of the week. The boy's reaction is, "I don't care. I was tired of that game anyway." Lessons in tap-dancing were planned to give him group activity, with the promise of gymnasium classes for the following year.

A month later there was further conversation with the mother about the emotional connection between parents and children, for it was believed that the child was still being over-directed. It was shown how some parents try to live their lives through the child, and expect him to go their pace. Once again the desirability of freedom for the child
in non-essentials was stressed. It is thought that there will be no further progress till the parents grasp and act upon these facts.

Case 4. Still another case which seems to fit into this classification is that of a seven and a half year old boy with an I. Q. of 93. Here the undesirable personal habit which manifested itself was described as "fits of some sort". The doctors thought that they were from physical causes which he would outgrow. The root of the matter, however, seemed to be deeper, and the "fits" to be a different sort of reaction against over-protection.

The boy had had convulsions with teething, and later with an attack of measles. The doctor said that the child would soon outgrow such convulsions. The father was dead. The mother, who supported the family, was an ardent churchwoman. The boy was a good sleeper, and the doctors thought that his "fits" were due to diet. Although he was a leader in play, liked active games and had many friends, he was miserable at school. His fits lasted about five minutes, during which time he stiffened out, with his eyes rolled back. During the examination at the clinic, it was noted that the boy had very little confidence in himself, that he looked for someone else to get him out of difficulties. The mother was warned not to do so much for him, but to allow him to act on his own responsibility. A year later the mother reported that she realized how much of this trouble had been due to nerves, and that she had tried to assist him to help himself. He liked his school better, although his progress was still not outstanding. The patient had announced himself cured after prayer, and had had no spells since.

Case 5. Mannerisms, if they have no definite physical cause, are nearly always the result of some inner conflict or tension. This tension
may spring from a desire to hide something, or from a sense of guilt, or
as a reaction from some outside strain which a child may sense without
understanding. Such a case follows. In common with the two previous
cases, this problem was created by an over-anxious mother who tried to
protect her son from all hard exertion.

A boy of 13½ years of age was brought to the clinic because of the
mannerism of eye-blinking. He had had the usual diseases of childhood.
His health habits were good, although he had stuttered and had bitten
his nails when he was younger. His school work was "Good, if he makes up
his mind to it." His mother reported that "it takes a lot out of him
physically if he tries too much". She says of herself, "If I try, I
nearly always get all I want, but at times the goal has not been worth the
effort for what it has taken out of me." Although she was exceedingly
nervous, she had tried to get over the handicap and believed that she had
succeeded. It was thought that the boy's nervous mannerism was caused by
the tension which radiated from the over-anxious mother. She said that
she felt better after the matter had been explained to her, and that she
would have a more steadying influence on the boy. As the tension becomes
less, the boy's trouble should disappear. The case is too recent to show
results yet.
Problem Cases which Appear Among Children of Undesirable Personality:

b. The second group of behaviour problems is a large one, in spite of the fact that such cases are very often not recognized as problems by parents and teachers. The symptoms are: sensitiveness, seclusiveness, secretiveness, overanxiety, inattention, apathy, day-dreaming, fanciful lying, "nervousness" and a tendency to cry easily, moodiness, obstinacy, quarrelsomeness, selfishness, laziness.

The conditions which cause these symptoms to appear very often lie in the home. They may spring from a sense of tension and unhappiness between the adults of the household, or from a feeling of unjust treatment, or from a fear of financial insecurity, or even from imitation of the grown ups. Sometimes they may have their origin in the child's school life, in a sense of inferiority to other children, or in effort which is unrecognized because its results are not so spectacular as those of brighter pupils, or they may spring from lack of proper play outlets.

Cases which very often go unrecognized, or, at least, untreated, are the negative ones—sensitiveness, seclusiveness, excessive day-dreaming, inattention. Since these traits are not actively disturbing to the peace of family or class, they often escape notice. However, some cases have been brought to the clinic for treatment.

Case 6. A typical case, dealing with listlessness and inattention, was referred by parents who were anxious about the boy's school progress. The parents were correct in their estimate of the child's ability. His I. Q. was 115. Although he had made excellent progress up to grade IV, he had then lost interest. He was obedient, but would put forth no effort. His interests were in Meccano toys and airplanes. The father was a submissive type who made no attempt at discipline. The mother was working, and getting a good salary. There was friction between the boy
and his brother, aged three, because the baby lost bolts and parts from the patient's toys. Upon examination, it was found that the boy's attention was easily gained and well retained. There was a considerable gap in his school work due to a change of school. Apparently, the child was not able to overcome this handicap by himself. His mother, who over-directed him in everything that he did, hindered him from developing any initiative. She was cautioned that she should give fewer orders, and was advised that the boy be sent to private school where he would be under the guidance of men teachers.

Case 7. Occasionally a basic trait which might pass unnoticed has a reaction which cannot be overlooked. A good example of this follows.

A ten year old boy of average intelligence was referred to the clinic for his hard manner. The origin of this assumed characteristic was to be found in the attitude of the step father. The child was illegitimate. The financial conditions of the home were good, with the father contributing to the support of the patient. However, the stepfather was jealous of the child, and showed his feelings. The boy had stolen money twice, apparently more from bravado than for the sake of the money. It was from his habit of frequently crying in secret that his extreme sensitivity was discovered. The plan of treatment was for him to join a Scout Troop, and to have a small regular allowance. No further information is available for this case.

Case 8. Sometimes the individual's response to home conditions un-fits him for functioning as one of a group. Such a case is to be found in the instance of a girl whose chronological age was 14 years 10 months, whose mental age was 13 years 3 months, and whose I. Q. was 96. She had run away from a girls' camp, and had never been active in a group.
Since the father's death, the mother, who was a fortune teller and clairvoyant, had supported the family. There were two sisters and one brother, none of whom was unusual. The patient, who had been ill, expected to keep the centre of the family attention on herself. As she grew stronger, and her illness no longer gained this for her, she tried other means of making herself noticed, even though they were not approved by the family. Although she was affectionate, she was very reticent about herself. An example of this characteristic was the fact that she did not tell the camp director why she refused to swim. As she had had trouble with her ears, she could not go into the water. But although she suffered from teasing among the girls, and actual punishment from the instructor, she would give no reason for her refusal. The mother believed that the daughter, like the father, had been born under an "unlucky star". The plan advanced was that the mother keep the child active, and that she was not to stress any sickness.

Case 9. Sometimes the symptoms are so slight that they can be classed under the general heading of "nervousness". This failing may be intensified by temperamental trends which, as we have discussed, are difficult to alter. Nevertheless, in the cases studied, the nervousness has been intensified by strain of some sort in the home. The case quoted in full is a long one, but it is interesting as an example of what may be done with a deep-seated and long-standing nervous condition.

The girl was 16 years 9 months old. Her intelligence was normal. Her difficulty was that she was continually crying and worrying over her homework, her future and social position, her mental condition. Her health was only fair. She was wakeful and unrefreshed in the morning. She ate neither breakfast nor lunch. Since she had weak arches, she wore
special shoes. Her father, a professional man in Europe, contracted sleeping sickness and was refused admittance to this country. The mother is capable, intelligent and upright. There are two brothers, one of whom, like the girl, is over-ambitious. The other is estranged from the family. When the patient was young, she was accustomed to a luxurious home.

The patient was very musical. Although she was fond of swimming, she felt that she had no time for recreation. In her school work, she was anxious to learn. Since she had plodded along over language difficulties, her attainment was below the average. She was so terrified of failing, that she would not help in the house if it meant that she would have to spare time from her studies.

Until two years previously, she was normal and happy. Then she lost the companionship of a friend who had to take care of a sick mother. At the same time, family and financial troubles grew acute. While the young girl had these worries on her mind, she was forced to change her school because the trouble with her arches prevented her from walking.

There were few visitors to the home. Although financial conditions were becoming worse, the family sent the patient to a camp for a summer, hoping that her mental attitude would benefit by the change. However, there was an emotional outbreak following a sleep-walking episode—an outburst of rage at the nurse. Obviously camp was not suitable for a girl of so unstable a temperament. Even there her mind was filled with worries about the health of her mother and brothers, and with fears that she would have to earn her living in a menial position.

The recommendations and follow-up information are as follows. First, it was advised that she be removed from her home and board at
the school she was already attending as a day pupil. During this year she passed her matriculation in two subjects. It was in this summer that the camp episode occurred. After her next visit to the clinic, it was advised that she board at another school, where she would have outdoor recreation among companions of her own age. There was considerable improvement here, although the patient still worried over her mother's health. After the third visit to the clinic, it was found that she did not join in the various exercises and games of the school because she lacked money and equipment. It was then decided that she should live at home and take as many subjects as she could handle comfortably till she finished her education. Her trouble, the clinic realized, was due to her mother's condition. But it was realized that, if the patient were removed from home, she would be further upset, and would gradually shut herself off.

With improvement, her fears left her, her health built up, and her eating and sleeping became more normal. She is now happily married to a man of assured income and good social background. She has moved away from the scene of her former unhappiness and fear.

Case 10. A very interesting case was brought to the clinic by anxious parents who did not realize what the real difficulty was. They requested an examination because their son had no idea of play. It was during discussion of the boy that they mentioned casually that the child was incurably selfish. His mental age was 10 years 4 months, and his chronological age was 9 years 4 months.

The mother was a graduate nurse. The father was interested in his home and children. The sister, aged seven, was a lively child who found no difficulty in keeping herself amused.
Although the boy had had two convulsions when he was a baby, his health was good. His class work at school was satisfactory, but he would not play; he refused to join in any group or team work. If he had to go outside, he would stand at the edge of the playground with his hands in his pockets and with his hat on.

He started swimming lessons, but was afraid of the water. He would not go to Sunday School till his mother took a class in the same department. The family had catered to him because he was "different". He had a typewriter which he left outside when he felt so inclined. He had several printing sets, with which he made a sports paper. He was not much interested, however, even in this. He liked music, and would read everything he could find.

The chief characteristic of the boy was, the parents thought, that he wanted always to be in command of things. Although he was polite, he was usually whining about something, or arguing when his temper was aroused. Then they volunteered the information that he was incurably selfish, and hoarded his money.

The treatment suggested was that the boy be encouraged to swim so that he might get the benefit of the sun. A bat and glove, it was thought, might encourage his playing among the boys. He was to go to League games with his father. It was advised that he join a gymnasium class, so that the competition of games might improve his selfish tendencies. Above all, he was not to be given the centre of the stage at home.

In the follow up, it was found that the patient was taking music and dancing lessons for rhythm, had joined a gymnasium class, and was taking advantage of the back yard which had been fitted up for play.
(This work had been done for him, without any assistance from him.) He was playing better, though still not enthusiastically. His parents were now really concerned about his selfishness.

He would share nothing, even with his little sister. He accepted it in the natural course of events that he should be waited on, hand and foot. The social worker observed that the father had the attitude that his wife was there for the sole purpose of attending to him. It seems likely that the boy, who is imitative of the father even to the way he wears his clothes, classes himself as a male creature who is to be served by the woman members of his household. The original problem, then, has in great part been removed; but the other problem of selfishness is not likely to improve in the atmosphere of his home.

Case 11. Lying may spring from a number of causes. It might occur from an effort to obtain an unfulfilled wish. It might be the result of a fear of punishment, deserved or otherwise. It might be occasioned by hatred, or a desire to do some person harm in the eyes of others. But occasionally there is a case of lying where the causes are so deeply hidden that they are hard to find.

Such a case is to be found in a little girl, 6½ years of age, with an I. Q. of 97. She was reported by her step-mother. Nothing was known of the child's parents. The step-father was dead. There were two step-brothers, aged 18 and 21. The home was a happy one.

The child sought the approval of all her teachers. Because the other children do not like her managing ways, she has no companions of her own age.

She always had some imaginative story to tell as truth to anyone who would listen. One day she reported that the teacher's car had burnt
up. Another day she said that the children at school had stolen her apples. It was later discovered that she had thrown the apples away, and the children had returned them to her. She returned home one day from the school, which was about half a mile away, saying that some boys had molested her. She had even torn her clothes to give colour to her story. Later, she told the teacher that her mother starved her.

Since the child seemed to have no childish outlets, and, apart from school, was always in the company of adults, the suggestion was made that the mother take a foster child or two into the home.

A year later, the child was reported as living happily with two other children, a girl and a boy, who had been taken into the home. The trouble about imaginative lying had disappeared.

Case 12. The cause of stubbornness, too, sometimes lies in the home. Selfishness, in a previous case, was copied from a selfish father. Subbornness in a child is often the result of obstinacy on the part of the parents. By unwise treatment, a child's will may be broken till he becomes apathetic or lacking in initiative, or, it may be hardened into an unreasonable and unreasoning stubbornness. The child who has not had the opportunity for mixing with other children and for having the easy give-and-take of comradship is more likely to prove obstinate than the child who has played much with others. An unsympathetic attitude on the part of parents or brothers and sisters may result in a withdrawal into self and accompanying stubbornness. In at least one case studied here, there seems to be some ground for believing that there might have been some hereditary trait.

This case, complicated by violent fits of temper, was found in the study of an 8 year old girl with a mental age of 7 years 8 months. The
mother was married, at the age of fourteen, to a man who was so cruel and stubborn that she was forced to leave him. There are three sisters besides the patient. The mother's mother and sister both have bad tempers.

The child's moods show in her face. During one of her stubborn moods, she will do no school work, although at other times she works extremely neatly. She will pull her hair, become furious at her pencil, bite her eraser. She will scream if she is corrected. She is so lacking in team spirit that she deliberately tries to keep her team from gaining points. The mother is not stubborn, but loses patience with the children and gives in to them. The older sister has a disposition similar to the patient's, although it is not so pronounced. The younger children are good-natured and easy to handle.

A few months after the original report about the home conditions had been written, information was brought in that the mother ill-treated the patient, whipping her and marking her back. Still later, the city nurse believed that the child should be removed from the home, as the mother did not know how to handle her.

The suggested treatment was that, since the home situation was not good, (the other children called her "goofy") she would be benefitted by being in another home where she would be quieter, and where she would remain for a considerable period.
Problem Cases which Appear Among Children with Delinquent Tendencies.

The third group of problems is to be found among children who are either definitely delinquent, or, at least, acquiring habits which might eventually lead them into conflict with the law. These tendencies are so in conflict with the lives of the people around them that their faults cannot be overlooked so easily as the less spectacular personality trends of the previous group.

In this section are the disobedient children—so seriously disobedient as to be called incorrigible. They are the teasing children who will stop at nothing in order to have their little jokes. They are the children who have temper tantrums. They are the braggarts and defiers of authority. They are the young people who keep late hours and who seek bad companions. They are the children who play truant, lie or steal, who are destructive or cruel to animals or persons, or who indulge in unusual sex activities.

The term disobedience covers a number of these misdemeanours such as keeping late hours, seeking bad companions, and defying authority. Some cases are hard to classify, so numerous are the forms that the disobedience takes.

Case 13. A girl of sixteen, of average intelligence, was referred to the clinic for refusing to stay at home at nights. She would come in at any time after midnight and refuse to tell where she had been. The family were on relief, with the mother earning a little by washing dishes. The three people live in two shabby, ill-kept rooms which they have not attempted to make attractive. The girl is healthy and athletic, being a good swimmer, baseball and basketball player. She has one special friend who, the parents claim, is a bad influence because she does not have to be home early. The patient will not read. Al-
though she failed her grade six work, she was promoted because of her age. Of all her subjects, she enjoyed only Art. Her teachers reported that she would not apply herself.

The clinic suggested that the girl refused to stay home because it was so unattractive. Since she had artistic ability, it was possible that she might feel more interest in the home if she could be persuaded to help make it more inviting. Her ambition was to become a hairdresser. It was recommended that she train in her chosen work as soon as possible.

Case 14. Temper tantrums seem to occur most frequently among children who are overprotected and "spoiled". In some cases, the children may outgrow this method of gaining their own way. In most instances, however, they need help in gaining self-reliance. There is one case of special interest because the tantrums seemed to be the result, not of pampering and indulgence, but of a mental conflict caused by an irregularity in the personal life of the mother.

The problem was found in a teen-aged girl of normal intelligence. The mother had divorced her husband and was living with a common-law husband who would not marry her because of the children. He was a middle aged man with old-fashioned ideas about instant and unquestioning obedience. The girls were resentful—"Why should we mind him?" He suspected them if they were out after dark. That the girls must have known of the relationship is shown in their persistent resentment and failure to obey the man. There were continual quarrels in the house, with the mother undecided, but generally siding with the man. For one week "neither spoke to us kids."

The patient was miserable at home and hated school. She was not
notable at school for either good or bad behaviour. The clinic recom-
manded observation in a foster-home for at least a year. Her re-
actions were normal to the family situation in the home.

Case 15. The truancy cases studied have all had their causes in
the home, or in factors over which the home had control. In one in-
stance it was a dislike of the step-mother intense enough to cause the
child to run away. In two other instances, the children did not have
enough to occupy their time and energy. The fourth case was one in
which the girl had no proper play outlets. The background of this in-
stance was very similar to the ones in cases 3 and 10. In the first, a
feeding disability was the outcome; in the second, imaginative lying;
and in the one quoted, truancy.

The girl was nine years and four months of age, with an I. Q. of
95. She was illegitimate, and had been cared for by people she re-
membered as her own parents. They moved away, leaving her with other
foster-parents, although they took with them a child of their own whom
she believed was her sister. She had Impetigo, but apart from that was
always well. She was an average pupil in her studies, but her conduct
was below average. She was willing to do chores, for which work she
was always paid. She was somewhat of a tomboy and liked rough play.
She had no companions of her own age, but enjoyed the society of the
foster-mother. She liked to talk and to be the centre of the stage.
She would fit her conversation to the listener. To her, there were no
class distinctions. She had a good imagination and a wonderful memory.

Her first truancy from school occurred when her parents urged her
to work harder after she had brought home a note from her teacher. The
second truancy took place when she was coming home from her grand-
mother's. She was picked up by the New Westminster police. The third time she failed to return home, she said that she had left her bag on the street-car and felt that she should not go home without it. She had been taken out of school after the first incident and given tutoring, under which system she made rapid progress.

After examining her, the clinic suggested that she might be suffering from mythomania. She was found to have defective vision. It was decided that she attend Girl Guide camp for the summer, since she was lacking in proper play outlets with children of her own age.

Case 16. One thing essential for the normal development of a child is a feeling of security. In the case which follows, the problem of lying seems to have been caused, partly by fear of punishment, but chiefly by the lack of a sense of security. So deeply has the feeling rooted itself in the child's life that there seems to be little hope that the problem will be corrected.

The boy was nine and a half years old, with an I. Q. of 106. His difficulty was a failure to adjust in his foster home, and an incurable habit of lying. The father, although he was a drunkard and gambler who did not provide for the child, was intelligent and grateful for the care the Children's Aid Society was giving his son. The mother was dead. There was an older brother adopted by an uncle who could not afford to take the two children. A partial list of his foster homes follows. When the father had placed him in someone's care, and deserted, the child fell to the care of the Children's Aid Society. The society placed him in a home where he remained only five months because the foster-mother objected to medical supervision. His stay in the next home lasted for six months, when he was given up because of
food-fussiness and enuresis. He had been in his next home for two years when he was moved to the home of people who wished to adopt him. His prospective parents, however, did not wish a boy who talked baby talk and suffered from enuresis. They also resented supervision, and compared the child unfavorably with their own son. In his next home, where he stayed only two months, he was so unhappy that he was removed. He was seven months in his new home. He had good care and training there along with five other children, three of whom were Children’s Aid Society wards. It was felt, however, that the foster-mother was too strict. He was therefore moved to another home where he so disgraced himself by his untruths that he was removed to the Orphanage after three months. There he was found to be normal, likeable and mischievous. Finally, he was wanted for adoption by a childless couple who were kindly and intelligent.

The boy was underweight, although he sleptsoundly. His enuresis, which had stopped for the last four months, was due to laziness. Although he had shown himself to be a fussy eater in his foster homes, he ate well while in the Orphanage. His progress in school was normal, but he was not ambitious. He did not like strenuous games, but was fond of badminton, reading, music, mechanical toys. His companions were usually younger than himself.

He had lied continually from the age of seven. There was a question as to whether his habit might have originated from a fear of punishment. His foster home at that time was unsatisfactory. He registered no emotion, and seemed unimpressed when scolded. It was possible that his indifference might be due to the number of adjustments that he had had to make. Since he regarded the first adoption home as his own,
he might have been hurt at his abrupt losing of it. He enjoyed attention and affection, was generous and unselfish, but would misbehave behind the guardian's back. In spite of his happy-go-lucky nature, his first reply to a proposition was "no".

The treatment recommended was that he be moved to his new adoption home where he would be the only one in the home, and where he would have understanding foster-parents. Perhaps here he could build up a "centre" for himself. Adoption was not recommended.

The foster-mother took him. Because she was afraid that he would be hurt, she kept him from playing with other boys. A later report stated that he was established in his foster-home. There is no marked improvement, except that he is playing with the boys more.

Case 17. Stealing, whether serious or petty theft, is one of the most common delinquencies. Again, with very few exceptions, the causes of this delinquency lie in the home. Unhappy or antagonistic homes, lack of adequate supervision and training make fertile ground in which this fault may flourish. The unhappiness may spring from an unrewarded attempt to please an unsympathetic and exacting parent. It may be grief for the loss of a mother. It may come from a sense of unfairness. In some cases, so great is the tension that the child commits a theft serious enough to place him in the Industrial School. The following, however, is a typical case in which a foster home was thought to be adequate to remedy the stealing.

A twelve year old girl, of I. Q. 106, was reported for stealing. Her father was a good workman. Her mother was untidy and apt the shriek and nag. She believed that the patient was a "rotten apple", and would never improve. She always expected the worst. There were two
sisters and three brothers, all normal.

The patient's behaviour at school and Brownies was good. At home, however, money was always missing. The patient was remarkably generous. She was the cause of contention in an otherwise peaceful home.

The clinic believed that she would be better off in another home, as the unsympathetic attitude in her own would probably hold her back. However, since she had been improving a little, if the parents so desired, she might be given a further trial where she was. When the difficulty first arose, the family finances were low; now they were more adequate.

Case 18. One case of stealing which was brought forward was due, not to faulty home condition, but to a reading disability. Because it exemplifies the occasional physical background of delinquency, it is worth quoting in full.

A boy 7 years 8 months of age, and I.Q. 91, was brought to the clinic for stealing. His health was only fair. His schooling had suffered because he had lost several months on account of his poor physical condition. His teacher reported that he had to be encouraged, or that he would fall behind. Some days he seemed alert; others, he could not concentrate. He was fond of animals and books. He was popular, and played with well-mannered boys of his own age.

He had taken pennies, which he said were given to him. Later, he took a knife, and then various amounts of money with which to buy things that he wanted. The store-keeper was warned not to sell anything to him. He was sensitive, dependable and fond of company; he neither held a grudge nor showed off, although he was inclined to day-dream.

The mother was at that time unable to have the boy with her. His
home was a Children's Aid Society foster-home where he was comfortable and well cared for, along with three other wards of that Society.

The clinical diagnosis of the case was that the boy was suffering from a serious reading disability, and that he needed special instruction. The stealing was a substitute for his complex concerning his schooling.

Case 19. The cases of stealing which pass through the Juvenile Court and Industrial Schools are very numerous. As typical instances, the following are appended.

A boy was sent to the clinic by the Children's Aid Society because he stole, lied and was generally unreliable in foster homes. He was transferred to the School. He was given every help, and stayed longer than necessary in order to finish his grade eight work. He then went to his father who was working some distance away from any city. The boy did well there, until the father became so exacting that he drove his son away. The latter went to the towns looking for work. He met some men who gave him some stolen clothes. All innocently, he wore them down the main street, and was taken in charge by the police. He was sent for ten days to Okalla, and then sent back to the School. When he left there, he found work in the lumber camps. He still writes to the School, and seems to be doing well.

Case 20. Another boy, whose mother had died, at the age of seven stated his intention of becoming a bold, bad bandit. Since he did not have the courage to fulfil his ambition himself, he contented himself with encouraging others to do what he wanted to do. He was not popular with the other boys. Since the School found plenty of work for him to do, he finally pretended that he was crazy. So successful was his pretense that he was sent to a mental hospital for observation. When the
fraud was discovered, he was then sent back to the school, where he made a general nuisance of himself. He was out for two years, and then was returned for questioning. Although he is still blustering, the authorities have not been able to connect anything definite with him. He has now come to the point where his great need is to build up his self-confidence, so that he can transform his high-sounding phrases into concrete and acceptable action.

Case 21. A third boy who was sent to the school for stealing found it very hard to settle down and become a reasonable citizen. When he left the School, he joined his father in the interior. It is unknown whether his father was too strict with him or not, but, at any rate, the boy ran back to the School. He was then sent to his mother, who kept him a public school for six weeks till the police sent him back to the School. The supervisor reports that, although they cannot build him up physically, he is more stable than when he came.

Case 22. Still another boy was a Juvenile Court case. He had been charged with petty pilfering twelve different times, and also with the theft of a car. He was physically perfect, and would do nothing to abuse his body. He ran away from the School in a "borrowed" speed boat. He was then kept under close supervision till he settled down, worked with the others and became reasonably contented. When he could not find work on his dismissal, he helped himself to a car so that he could try his luck inland. He was returned to the School, where he again proved himself a natural leader, both in the gymnasium and in the class and shop. The second time he was released he went home, where, his family report, he has completely changed. He is now in a Forestry camp, where he is constructing, in his spare time, a wrestling
ring for the amusement of the men.

Case 23. The last case is of a boy, 9 years and 3 months old, who had a penchant for taking other boys' bicycles. After he had "borrowed" six in one week, and had failed to return two of them, leaving them where he had finished with them, he was sent to the School. His father, who had worked steadily till his wife's death, was drinking heavily, correcting his two boys spasmodically and indifferently. The older brother who was better behaved at this time, was ashamed of the nine year old. The two boys prepared their own meals whenever they felt hungry, went to bed when they were ready, and allowed their two roomed shack, that had been clean while their mother lived, become filthy. The young boy became the favorite with the boys at the School, during his eighteen months there. On his release he was placed in a foster home in a farming district. Twice he ran away back to the School so that he could be with the boys. Following this, he bought a bicycle, did well for a time, and then went wild again. The foster home was too quiet for him after the companionship of fifty other boys. However, he has settled down fairly well now, and should do well.

Some of these cases could have been handled successfully outside of the Industrial School altogether. In the case just quoted, the older brother, who became a problem after the younger brother had left, was dealt with satisfactorily in a foster home. Although that home is still not far enough away from the father's influence, the boy had greatly improved. The brother, on the other hand, whose desire for a bicycle was so strong that he would go any lengths to fulfill it, became in institutionalized case who found it difficult to settle back into normal life.

It would seem, then, that the removal of strain and tension in the
lives of these potential delinquents may be the remedy. For the simpler cases, a foster home under wise supervision is sufficient to resolve the problem. For other cases of long standing which need constant training and supervision, the Industrial School offers the best training.
Summary from Case Studies.

The cases fully outlined and discussed in the foregoing chapter were chosen as illustrative cases from three hundred that had been carefully studied. All the children were so-called "problem cases" - children who were not adjusting healthily and acceptably either to their own limitations or short comings or to the thwartings and obstacles in their environment - children who would, in later life, be expected to be more seriously maladjusted. Their habits in responding in socially unacceptable ways were already being formed.

What were the limitations or thwartings with which they were faced? In the first group of cases, we find that some of the children had physical difficulties; and because the urge for social approval was being thwarted by these difficulties, the children were compensating for their feelings of inferiority by responding (behaving) in unacceptable ways. In all the other cases in this group, we find that the difficulties or obstacles lay in the home relations - tension on the part of the parents, over direction and over-anxiety by adult members of the family. In one case, a child had formerly been the centre of attention in the family because of ill-health, was now well and, consequently, no longer the centre of attention. Since his urge for social approval was no longer being satisfied, he was gaining attention by responding in undesirable ways - undesirable as far as his future development was concerned.

In the second group of cases we find that, although the difficulties and obstacles that the children are facing are practically the same, these children are responding in ways different, but equally undesirable. They are developing such habits as selfishness and lying rather than personal habits such as nailbiting, mannerisms, feeding disabilities.
In the third group of cases, we still find difficulties in the home, as in the other two groups, but we also find other difficulties, though here again it is the urge for self-approval or mastery that is being thwarted. Take, for example, the boy with the reading disability. Since the urge for mastery was thwarted, he satisfied it by stealing and other anti-social activities.

From this brief summary of cases, it may be seen how it is that children learn to respond to the difficulties which they are constantly encountering. The child who is not a problem case is one who is learning to adjust in a mentally healthy way. Our problem case children are learning to respond in so-called "unhealthy" ways. The discussion of our cases shows that this latter group can be trained to develop habits of adjustment that will help them to be successful in adult life. Only by detecting signs of maladjustment in the early formative years can we hope to develop a well adjusted race of adults capable of functioning up to the full extent of their inherited capacities. Our Child Guidance Clinics are helping towards this goal.
Appendix.

Additional Case Histories.

Case 24.

Problem—lack of initiative.

I.Q. 96. Chronological age 6 years 7 months.

Health-- Spinal meningitis makes her feet droop as she walks. She had a poor appetite.

Habits. Will not sleep by herself--Cannot dress herself, although she helps a little. Has no interest in school, and cannot be taught punctuality. Is taken to school by parent. The teacher has to see that she eats lunch. Does not make friends on own initiative, but only if they go to her. No tantrums, and no deliberate disobedience, but simply lack of obedience. Is dependent rather than affectionate.

Family-- One brother, aged three, referred at the same time for temper tantrums.

Treatment--Both children badly over-protected. The girl demands too much of parents' attention and help. They were cautioned to let her do more on her own—gradually to shorten the distance they took her to school, and the time spent with her at night.

Case 25.

Problem—Completely negative personality, and the physical trouble of enuresis.

Cronological age—7 years 6 months. Mental age 6 years 6 months. (The boy's mental age would ordinarily leave him outside the restricted group used for this study. However, the person giving the test made a note that the rating was not valid because the patient was frightened.)

History--The father had deserted.
The mother drinks and smokes heavily.
Two brothers and two sisters, one subnormal.

Home conditions—Very little known, except that there is poverty.

Habits-- Enuresis apparently hopeless. There is no attempt made at school work. Patient is still in grade 1. Has never been heard to form a complete sentence.

Plan-- Foster-home.
Case 26.

**Problem**—Fear and nervousness; fear of the dark, fear of being alone, fear of anything new.

**History**—Father no longer able to work.

The mother fights all the boy's battles, threatening the playmates with the police "if they don't treat my boy right."

**Habits**—Eats what he likes, and vomits what he dislikes. Can not be trusted to stay in bed, but weeps and whines. Is up ten or twelve times in the night. He needs constant prodding to accomplish anything. Can play only as a much younger child would. Cries when anything happens to him, and complains that he is picked on. He is at a sanatorium, and is noticeably worse after a visit from his mother.

**Treatment**—The boy is badly over-protected, and uses his fears to hold the centre of the stage. If he should be kept where he is, the mother should not visit him.

Case 27.

**Problem**—A girl with nervous fears.

**History**—Father of uncertain temper—had deserted.

Mother bright and attractive.

Two older brothers, both normal, and one brother referred at the same time for being nervous and irritable and hard to manage.

**Habits**—She was nervous about school, and wakened early for fear that she would be late. She would not eat with strangers. Mother thought that she would help the situation by sending the child to the Fresh Air Camp, but patient had to be sent home because she refused to eat.

**Treatment**—The boy's school should be changed, since he was backward, and regarded as a nuisance where he was. The girl should be given normal outlets, and play with children of her own age.

Case 28:

**Problem**—Boy referred for crying and nervousness.

**Age** 12 years; I. Q. 109.

**History**—Father was worried about the boy because several of the maternal family had committed suicide. Father often makes fun of son for being a cry-baby.
School— Private school. On one occasion, was to take part in a play, but came home before it started. When asked for explanation, he rationalized his actions. Was told that, as eldest of the family, he had responsibility. He went and enjoyed the play.

Treatment—The boy should be encouraged in sports and other accomplishments so that he will compensate will and feel at home in the presence of others.

Follow-up—A report that the father has stopped jeering, and that the boy should do well with the co-operation of his parents.

Case 29.

Problem— Two brothers referred for nervousness.

Chronological age; 12 years, I. Q. 123. He was over-anxious to co-operate in the psychometric test, and became flustered when he could not understand what was wanted of him.

Habits— Sleeps well— is mechanically minded— is dependable. His brother, although younger, is taller, and the older brother feels inferior.

Chronological age of brother, 9 years 3 months; I. Q. 126.

Habits— Cries too easily; Day enuresis for a while, but trouble has cleared up now. He has many friends. He is mechanical and neat, where the brother is not. He is the youngest, and trades on that fact.

Treatments—The two should be encouraged in group play and in the learning of different games. They should join Cub or Scout movements. Academically, their future will present no problems, but they should be encouraged in physical exercise to even up their personalities.

Case 30.

Problem— Boy referred for nervousness and irritability.

Chronological age 12 years 3 months; I. Q. 109.

Health— Never good. The only time his mother spanked him he fainted. He is easily upset. One day when a boy in his class had fought with the teacher about taking the strap, the patient had come home so excited he could not eat. He walks in his sleep.

Companions— Boys and girls of his own age.
Character— For the last year, irritable and unstable emotionally. Has been spanked for tantrums, with result noted above; has not been touched since. Is fond of children, but is suspicious. He will hold a grudge, and brood.

History— Father had died. The mother had threatened suicide at that time. She is nervous and easily upset. The home conditions are good.

Treatment— Since the mother is of a fearful and anticipatory type, and has radiated this tendency to the boy, she is advised not to overprotect him, but to encourage him to do things for himself and to lead him into group sports.

Case 31.

Problem— Boy of sixteen who was incorrigible.

Intelligence Quotient— 93.

History— The case seems to be complicated with poor family heredity, although there is no specific weakness in the boy. Father had dementia praecox with paranoidal tendencies. The mother had died when the patient was a child. There are two brothers and one sister, none of high mental grading.

Home— The standards of the Step-mother's home are high but exacting, and the atmosphere was antagonistic.

Habits— The boy sleeps well, although he masturbates, smokes heavily, and has been intoxicated. He is dirty in appearance. He is lazy, insolent, quarrelsome, conceited and selfish.

Treatment— It is recommended that he be deported to his father's country where influential relatives might procure him what he wants—a position as a sailor.

Case 32.

Problem— Girl, incorrigible, who has committed one theft.

History— The father a man of college education who deserted the mother. The mother an unstable woman who tries to shift her responsibilities onto others.

Habits— The patient is out every evening, sometimes till twelve. (She has not been encouraged to bring her friends home, because her mother was ashamed of the
basement rooms in which they live.) According to the mother's report, the girl will not bathe frequently enough. (The suggestion was raised that this refusal may be due to insufficient privacy. There is no bathroom.) On one occasion she had taken twenty dollars of her mother's money which she spent on shows and gave to friends. (Since the stealing was only a specific instance, it may be considered an outcrop of her general attitude.) She constantly uses profane language. She is untruthful, quarrelsome, stubborn, and suspicious of her sister.

Treatment— It is recommended that she be placed in a foster home for at least six months, because of her need for training and management. Since she needs the closest supervision, if she cannot get this adequately in a foster home, she should be placed in the Girl's Industrial School. The stealing will disappear as the irritation caused by the home grows less. It is suggested that there be work done in the home to prepare for the patient's re-establishment should she improve.

Case 33.

Problem— Boy with temper tantrums.

Age 3 years. Psychometric test not taken because of his age. He comes from a normal family and seems to be bright.

History— Has a sister who is a problem because she lacks initiative. The parents are in ordinary circumstances.

Health— Good.

Habits— Temper tantrums at least once a day when he cannot have what he wants. He stamps and kicks, and then shakes all over. It is hard to divert his attention from one object of interest to another. He is said not to understand very well what is said to him.

Treatment— Both children are overprotected. The boy can manage his mother as he wishes. The parents are advised to let the children do more on their own initiative.

Case 34.

Problem— Boy with temper tantrums.

Chronological age 3 years 4 months; mental age 3 years 2 months.

History— Mother was ill during most of the pregnancy. The child had had nurse-maid care, but had tired out two nurses. There had been a long succession of physical
illnesses. He comes from a family outstanding in literary endeavor.

Health-- Wakens easily and stays awake. Will not eat when crossed in anything—is never hungry. Cannot hold pencil, nor use his hands. Cannot repeat any nursery rhymes. Has no playmates.

Treatment-- His illnesses have left him the centre of attention. He should be taught to do things for himself, should have definite times for play and should not be interfered with at that time. He should attend kindergarten for the play with other children. He is over-directed and supervised, and not taught a sufficient amount of accurate and completed fact. (Stories should be read repeatedly). With more outlet for his energies, he will eat and sleep better.

Follow-up-- He greatly enjoys Nursery School. He sleeps better, is less irritable, and is improving in every way.

Case 35.

Problem-- Girl so unhappy because of dislike for step-mother that she runs away.

Health-- Thin and wiry build. She is highly strung.

Habits-- Until her father's remarriage, she was very dirty. Now she is clean, with enuresis checked.

Companions-- No special friends, but plays with class mates at school and with step-sisters at home. She is not encouraged to bring friends home.

Personality-- She is agreeable, and untruthful only in matters concerning the step-mother, whom she has disliked since her father's marriage. Her dislike may be caused by objections advanced by some old friends of the father. On one occasion, she ran away to her grandmother. She was sent home, scolded, but not punished. Later, she ran away, but returned to school so as not to miss any new work. There are marks on her body which she says were inflicted by the step-mother. They are believed, however, to be self-inflicted.

Family-- The father is a thin, harried man, much disturbed by the situation. The mother neglected the child and husband. The step-mother has a child from a previous marriage. The union is satisfactory, with no bickering. The parents are afraid of what step the patient may take next. She has threatened the father.
Treatment— It is advisable to remove the patient from the home to see if her attitude toward the step-mother may improve. The patient is not truly revealing herself in the home. She should be encouraged to speak of her feelings freely to the mother, while the woman remains as silent as possible.

Case 36.

Problem— Boy who has had contact with the Juvenile Court for stealing. Referred for running away.

Chronological age 15 years, mental age 14 years 6 months.

Health— Normal. There are marks of old wounds.

Habits— Sleep irregular, bed-time at 11 or 1 A.M. He had no night terrors. Fortnightly sleeps away from home in a barn. He smokes heavily. He has failed twice in school because of lack of effort. He left school several months ago, and has since been "just hanging around". He felt that most of the teachers "had it in for me."

Interests— Boxing. He has a gang who sneak into shows, pick up scrap-iron for the junk dealer. He belongs to no public club or organization, but appears to be the leader of his own gang.

Personality— He is easy to approach, but resentful of criticism that he feels is unjust. He is quick-tempered, self-confident, loyal to his friends. He is not spiteful, nor does he hold a grudge.

History— His parents are immigrants, now on relief. There are ten children. The home conditions are clean and tidy. The family is musical.

Treatment— He wishes to attend Barber College. The difficulty lies in the boy's not having enough to do. He should be kept busy. His interest in boxing might be diverted to gymnasium work under supervision. The boy admits his difficulties, and realizes where they will lead if they are continued. He should remain at home under the friendly supervision of the court.

Case 37.

Problem— A girl who runs away.

History— Father had fair health. He was nervous and restless, and disappeared some ten years ago. The mother is doing domestic work. There is one brother, who is normal and bright.
Home— The house is neat. The mother has roomers, although the patient does not help her much. The patient would rather do anything than housework.

Companions— She has many who undermine the mother's control and keep the girl out at nights.

Work— She has had three housework positions which she left after a short time because, she said, they were too hard.

Interests— Swimming, bicycling and reading "trash".

Treatment— She should take any opportunity for factory work, and join the Y.W.C.A. for group instruction, so that she will have her time more fully occupied.

Case 38.

Problem— A girl reported for stealing, lying, hurting companions and destroying property.

Chronological age 11 years 4 months; I. Q. 99.

History— The father is a steady worker, although at the present time he is working at whatever he can get. The mother, who is dead, was not a clean housekeeper, and was only an indifferent mother.

Habits— The girl is always hungry. At night she is always wide awake rather than drowsy. He had bad sex habits.

School— She is in grade six, and not doing her best work.

Treatment— She must be moved from her present situation. The father and grandmother, with whom she is staying, are willing for this to be done. Since she was untrained and neglected when taken by the grandmother, she needed more supervision than the old woman could give her.

Case 39.

Problem. A girl with kleptomaniac tendencies.

Age 13 years 3 months; I. Q. 94.

History— The father is on pension because of disability. The mother is always in an extremely nervous condition. There are three brothers and two sisters who are all excitable and irresponsible.

Character and habits. She is inclined to be quarrelsome. Al-
though she is obedient and friendly, she is egotistical, quick-tempered and impulsive. Her first known theft was the sum of eleven dollars. She has been caught silvering copper coins. She has stolen a dinghy and a bicycle. She was accused of breaking, entering and stealing two rifles, money and keys.

Treatment— It is no use to try leaving her at home, as there is no support there, only constant checking and nagging by the mother. There will be only difficulties if there is an attempt to place her in a foster home. The best solution is the Industrial School.