A Follow-Up Study of Pre-Psychotic and Psychotic Children Seen at the Institute for Juvenile Research

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A FOLLOW-UP STUDY OF PRE-PsyCHOTIC AND

PSYCHOTIC CHILDREN SEEN AT THE

INSTITUTE FOR JUVENILE RESEARCH

by

Louise Rose Amati

A Thesis Submitted to the Faculty of the School of Social Work

of Loyola University in Partial Fulfillment of the

Requirements for the Degree of

Master of Social Work

February

1963
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CHAPTER I

INTRODUCTION

STATEMENT OF THE PURPOSE

This follow-up study constitutes an attempt to determine the type of adjustment the prepsychotic and psychotic children have made since they were seen at the Institute for Juvenile Research for psychological evaluation. These children had not been accepted for treatment by the Clinic because they were too disturbed to be seen on an outpatient basis. They needed to be treated in a more controlled environment such as an institution.

This study arose as a result of a discussion that occurred at a training staff held at the Institute for Juvenile Research concerning resources for placement of a near psychotic child. The resources were considered close to non-existent except for the more expensive private institutions. During the course of this meeting the moderator suggested a follow-up study of prepsychotic and psychotic children and those present expressed interest in it. In the light of this, the study was begun at the suggestion of one of the psychiatrists, Dr. Devlin, with the purpose of determining by means of the interviews with the parent and the child, whether or not the adjustment of the child had been a favorable one, or if the child had become progressively worse or remained essentially the same.
Some of the more significant questions that this study endeavors to answer include:

1) What was the home situation of the child at the time of the referral?
2) What were some of the problems displayed by these disturbed children at the time of the first examination and how did these differ at the time of the follow-up?
3) What type of interpersonal relationships were these children able to form?
4) How did the psychiatrist's report of the child's adjustment compare with mother's statements concerning the adjustment of the child?
5) How well were the recommendations of the clinic utilized by the parent, and what other methods were sought as a way of handling their problem?

SCOPE OF THE STUDY

The study is limited to those children who were diagnosed as psychotic or prepsychotic as a result of the psychiatric examination at the diagnostic level, and were not accepted for treatment. There were six girls diagnosed as psychotic and sixteen boys, nine of which were psychotic and seven were prepsychotic. The youngest child studied is two years six months old and the oldest is seventeen years six months old. Both negro and white children are included in the study. The records covered the period from 1946 to 1961, in order that there might be about a year elapsing between the first admission and the follow-up interview.
METHOD OF PROCEDURE

The data for the study was obtained through the analysis of records and the follow-up interviews. Three schedules were used, the first two were filled in from the records of the Institute for Juvenile Research and the last one was used to obtain information in the follow-up interview. The information obtained from the records included the material taken from the social history, psychological, and psychiatric interviews on the diagnostic level. In those few cases where one of the three disciplines was missing the same type of information that was needed, was taken from other sources such as the school reports, medical reports, or various reporting letters from other agencies. A review of the schedules show that the first one included the identifying information concerning the child and the parents. The second schedule was concerned with the problems manifested by the child and the relationships of the child toward the parents, siblings, and other children, as described by the parent to the social worker or psychiatrist. It also included the psychiatric report of the child. The third schedule was used for the follow-up interview; the information sought was identical to that of the second schedule since the symptoms shown at the diagnostic level were followed through in order to determine the type of adjustment made by the child. A copy of the schedules used in the study are contained in the Appendix.

There were a total of fifty cases diagnosed as prot psychotie and psychotic between the periods of 1948 to 1951. Thirty-nine of those cases were psychotic and eleven of them were prot psychotie. There were seventeen girls and twenty-three boys. However, out of the total of fifty cases only
twenty-two cases were able to be contacted. Due to the difficulties involved in contacting these persons it took the writer approximately three months to obtain the necessary information.

Part of the difficulty arose because the writer initiated the contact and interpreted the reason for the contact with the patient. Ordinarily, the patient initiates the contact with the agency and brings with him the problems for which he seeks a solution. In a follow-up study, the patient and the parent are asked to give of their time in order to discuss the adjustment of the patient. The usual incentive of offering service or treatment is lacking. The situation is made more difficult since these persons had never been accepted for treatment by the clinic.

The parents were contacted for the interviews by phone if one was listed in the record, but in most cases it was necessary to write a letter for an appointment. The personal contact afforded through the use of the phone merited more results since out of the fifty cases, twenty-one were able to be contacted by phone and sixteen agreed to come in for an appointment. The remaining twenty-nine were sent various types of letters and only six responded. The phone calls were used to introduce the writer and served as a more personal gesture and facilitated the person's participation. Permission was received to use letter-head stationery of the Institute for Juvenile Research to write the letters. There were four types of letters sent out; the first type included those in which appointments were scheduled with the mother and child to be interviewed by the writer and Dr. Devlin. The second type of letter used was for the cases which indicated that the child had been committed to an institution.
In those cases permission slips were sent out with the letter in order that the writer could contact the institution for the necessary information with the permission of the parents. An alternative was mentioned for those children who remained in the home rather than being institutionalized. Arrangements were suggested for an appointment to see them. The third type of letter was used as a follow-up letter to those parents who did not respond either to the appointment letter or to the second letter with the permission letter. Arrangements for a home visit was again suggested and another permission slip was enclosed to provide for the institutional cases. A fourth type of letter was sent to the institutions in order to obtain information regarding the child's adjustment. The questionnaire and the permission slip signed by the parents was enclosed in this letter. The Appendix contains copies of these letters and the questionnaire.

The interviews were scheduled primarily within the agency setting in order that the child could be seen by Dr. Devlin and the parent could simultaneously be seen by the writer. The appointments for both the mother and child could only be scheduled on the first Monday and Tuesday of each month, which included the months of June, July, August, and September. There was an exception of four cases that had been scheduled during April and May.

The following table illustrates how the writer obtained the material for the follow up interviews.
TABLE I

SOURCES OF FOLLOW-UP DATA

<table>
<thead>
<tr>
<th>Source</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Visit</td>
<td>7</td>
</tr>
<tr>
<td>Questionnaires Sent to Institutions</td>
<td>2</td>
</tr>
<tr>
<td>Patient Interviewed By Writer In Clinic</td>
<td>1</td>
</tr>
<tr>
<td>Parent Interview Alone By Writer In Clinic</td>
<td>1</td>
</tr>
<tr>
<td>Patient and Parent Interviewed Simultaneously By</td>
<td></td>
</tr>
<tr>
<td>The Psychiatrist and Writer In The Clinic</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
</tr>
</tbody>
</table>

The interviews were scheduled predominantly in the agency setting. The writer interviewed nineteen parents and one patient. The psychiatrist interviewed eleven patients. Two reports were received from institutions and these were geared to obtain the same type of information as would have been acquired had the mother and the child been seen by the writer and the psychiatrist. The writer found that fourteen children were in the home while eight children were in institutions at the time of the follow-up study.

Twenty-eight cases were not able to be seen for the follow-up interviews at the Clinic. It was interesting to note that in most of the cases, the children came from disturbed family backgrounds which included problems in broken homes, cruelty, promiscuity, psychotic parents, multiplicity of foster homes, and problems involved in adoption. There were eleven girls diagnosed as psychotic with the recommendations of institutionalization. There were thirteen boys diagnosed as psychotic and four as pre-psychotic with the recommendations of fifteen
institutionalization, one for Family Service, and one was unknown. The following table shows the disposition of these cases:

**TABLE II**

**DISPOSITION OF CASES NOT USED FOR THE STUDY**

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Treatment</td>
<td>1</td>
</tr>
<tr>
<td>Institutionalization</td>
<td>9</td>
</tr>
<tr>
<td>Unknown</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28</strong></td>
</tr>
</tbody>
</table>

There were several reasons why these cases were not available for the study as seen in the following table.

**TABLE III**

**REASON THE CASES WERE NOT USED FOR THE STUDY**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case In The Region*</td>
<td>1</td>
</tr>
<tr>
<td>Institution failed to return report</td>
<td>1</td>
</tr>
<tr>
<td>Refusal Of Parents</td>
<td>5</td>
</tr>
<tr>
<td>Families Have Moved</td>
<td>8</td>
</tr>
<tr>
<td>Letters Unanswered</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28</strong></td>
</tr>
</tbody>
</table>

*The case was sent to one of the six regional clinics for consideration.*
THE ADJUSTMENT OF THE PATIENT

The adjustment of the patient in the three areas of behavior problems, interpersonal relationships, and psychiatric report was measured according to four gradations. In order to get a better understanding of the child's adjustment in the Behavior Problems, these are divided into Socially Unacceptable Acts, Sex Problems, Learning Defects, Personality Difficulties, and Somatic Dysfunction. These classifications are set up by the agency for its own use in recording data statistically. Under each one of these categories many problems are included and these are followed through to determine the child's adjustment in this area. This explains why some of the categories had two types of adjustment checked. Some problems were alleviated while others became worse or remained the same. The interpersonal relationships of the child toward the parents, siblings, and other children are also studied to determine the child's adjustment. The last area that is studied is the report of the psychiatrist in which he gives his impression of the child's progress under the divisions of Appearance, Behavior, Relationship, Prognosis, and Diagnosis.

As mentioned above the adjustment of the patient in those areas was measured according to the following four gradations:

1) Same means that the child has not shown any improvement, that is, the problem continues to exist as before or has become somewhat worse.

2) Slight improvement indicates that there has been a partial correction of the problem, with an occasional reoccurrence of it.
3) **Remarkable improvement** indicates that there had been a correction of the symptomatic problems presented at the time of the follow-up interview.

4) **Worse** indicates that the problem has become more pronounced or new problems have arisen.

The four gradations of adjustment were applied specifically to the three areas studied. However, the overall adjustment of the child was judged according to the mechanical device of counting the checks determined the adjustment made by the patient. However, the other types of adjustment were also present in each case but in a lesser degree.

THE INSTITUTE FOR JUVENILE RESEARCH

This thesis was done at the Institute for Juvenile Research which is the oldest child guidance clinic in the United States. It was established under private auspices in 1909 as the Chicago Juvenile Psychopathic Institute under Dr. William Healy, the Director, who served in this capacity until 1917. At that time it came under the jurisdiction of the Department of Welfare of the State of Illinois.

At the present time the main headquarters and administrative center of the Clinic is in Chicago. However, diagnosis and treatment are offered on a state wide basis, since there are seven regional clinics. Some of the services offered by the Institute for Juvenile Research include the examination and treatment of both parents and children if treatment is advisable, and consultive and teaching services for other agencies, schools, and any groups that may be interested in the children. There
are no charges made to individuals, for any of the services rendered by the Clinic, for it is a tax supported agency. Research has an important place in the agency's program although service to the community is the primary goal. Part of the staff are students in training since teaching is another major function of the agency.

Any child under the age of eighteen presenting behavior or emotional problems is eligible for service at the Institute providing his parents are residents of the State of Illinois. The reasons for referring a child to the Institute are numerous and may cover a wide variety of psychological difficulties. This may include children who are revealing problems of disobedience, truancy, temper tantrums, destructiveness, fire-setting, stealing, lying, retardation in learning, failure to adjust in school, sex problems, shyness, daydreaming and any other problem manifested by the child that is causing concern to the parents, relatives, or the community. The sources of referral can include those coming from other agencies, however, the parental referral is the preferred method advocated by the agency. There is usually a several weeks waiting period between the time of application and the appointment time due to the long number of applications and the open intake policy.

The examination on the diagnostic level is conducted by the professional team consisting of the three disciplines, the psychiatrist, psychologist, and psychiatric social worker. The parent, guardian, or other responsible adult is seen first by the psychiatric social worker. The worker endeavors to learn more about the problem that brought the parent to the clinic, the interpersonal relationships of the family members and the current home situation. In addition to this the discussion often
includes the developmental history of the child and the background of the parents. In the meantime, the child is examined by a psychologist who administers various psychological tests which may include an evaluation of intelligence or projective tests. This not only determines the intelligence and aptitude of the child, but also gives the psychologist the opportunity to observe the child's responses in the testing situation. Usually about a week or two later, the psychiatrist sees the parents and observes the child in the play situation. He sees them separately in order he might gain some knowledge into the feelings and attitudes of the parents and the patient. After the diagnostic examinations are completed, the members of this team and other members of the staff under the direction of the moderator, a senior staff psychiatrist, meet to discuss the material obtained, and thus formulate a diagnosis and discuss plans for either treating the child and the parent or refer them to some other agency, or else makes other recommendations that might aid the child's adjustment. The parents are given the results of the examination and the recommendations in a completion interview. If regular continuing interviews are recommended, the child or parent or both are then placed on the waiting file to be assigned a therapist.

Treatment of the patient is carried on through psycho-therapeutic interviews and may extend over a long or short period of time depending upon various factors. There are times when the individual child or the parent are brought in for treatment alone. However, in collaborative treatment the parent and the child are assigned different therapists, and while the parent is being interviewed the child is seen in play therapy.
The therapist must know the psycho-dynamics of the personality in order to understand the problems and feelings of the patient and in doing so, assists the patient to self understanding and the gaining of insight into his own situation. One of its aims is to mobilize the person's capacities so that he is capable of making better use of his faculties. It also endeavors to strengthen a patient's ego in order that he may be able to deal with his own life situations and meet his own basic needs. Very often the anxiety of the patient is alleviated thereby, leaving the person free to lead a more satisfying life. Therapy with children is especially important because the child is still in the process of growth and in many cases much can be done to help him.

During the treatment period of either the mother or the child, arrangements are sometimes made for conferences with an agency which is working with the family, thus helping both agencies to arrive at a better understanding of the family. Collaboration among agencies is very important in the treatment process of a parent or child.
The study of the schizophrenic person has been a source of much attention and research on the part of many psychiatrists, psychologists, and the public in general for the past fifty or sixty years. The literature on schizophrenia was divided into three periods by Bradley, the characteristics of each being determined by the existing attitudes regarding schizophrenia.

In 1896, the concept of Dementia Praecox was introduced by Kraepelin. He was responsible mainly for the classifications and descriptions of the symptoms. He declared, "Dementia Praecox to be a pathological unit, a circumscribed disease entity with a uniform etiology, organic pathology, and a common and inevitable course. The term, "Dementia" was to indicate an irresistible and incorrigible trend towards progressive mental deterioration; the adjective "Praecox" alluded to the early onset during the years of adolescence." He mentioned children very briefly in his discussions of schizophrenia. He felt that there were certain types of children that were predisposed to that condition.

The ideas of Kraepelin influenced the literature from 1900 to 1925 which was the second period discussed. At that time the symptoms of the disease and the characteristic course were considered the same for both the children and adults. Emphasis was placed on the disease rather than the patient.

The third period was concerned with the contributions of Bleuler and Meyer, the psychoanalysts. In 1911, Bleuler introduced the designation of schizophrenia, or the splitting of the mental processes. He stated that "the disturbance may come to a standstill at any stage and some of its symptoms may clear up to a large extent or altogether, but if it does progress, it leads to a dementia of a specific type. His designation also does not hinge on a "precocious onset; numerous cases, indeed, do not display the characteristic features of the disorder until after maturity has been reached." It was with these persons and others following them, that the focus of attention shifted from the study of the disease to a study of the personal characteristics of the patient who was ill. Meyer stressed the "significance of the constitutional factors and life experiences leading to the development of the personality disintegration." Schizophrenia in children was now found to differ in many respects from the same disorder as it occurred in adults. Lutz and other authors "stress the necessity of considering childhood and its disorders distinctly apart from adolescence and the adult life." 

Psychosis in childhood was not very common and often it was difficult to make a diagnosis because it resembled other types of disturbances. The symptoms shown by the child are different than those

2 Ibid.
3 Ibid., 485
demonstrated by the adults; moreover, some psychosis of adults such as psychosis of adults such as paranoia and true depression do not occur at all in children. Margaret S. Mahler, in her article on "Clinical Studies in Benign and Malignant Cases of Childhood Psychosis" describes the differences between adults and child psychosis in the following excerpt taken from the article.

According to psycho-analytic concepts, the ego system forms an insulating and mediating layer between instinctual need impulses and the requirements of external reality. Psychosis in adults as well as in children implies a functional failure of the ego system in this task of reality testing. In adolescent and adult schizophrenics, the psychotic process acts upon a mental apparatus in which the three essential, structurally differentiated components of the personality, the ego, the super ego, and the id have been fully developed. But in a child psychosis the organization of these structures is still in the process of growth. Therefore, the essential differences in the syndrome of the psychotic child and that of the adult schizophrenic would seem to be due to this difference in structural development.5

The actual cause of schizophrenia is unknown. There are a number of factors which may have some bearing upon the appearance of the disorder but these are merely possibilities. In order to understand the child he must be studied and evaluated as a total personality composed of a body and soul. The eternal question of which is more important, nature or nurture, cannot be answered by placing the emphasis of importance upon one or the other, but rather both must be considered together. Heredity is nature's way of passing on to the child the actual and potential characteristics of the parents. Some authors have reported a hereditary predisposition in some of the schizophrenic children studied, but in general the significance of hereditary factors in this disorder seems to be

rather indefinite. Bradley like other authors has pointed to the influence of environmental factors on the genesis of childhood schizophrenia. Within that environment the home and parental influences are the most important, although other forces contribute to a greater or lesser degree to character formation. J. Louise Despert discussed the parents of the schizophrenic child in her article on the "Prophylactic Aspect of Schizophrenia in Childhood." She said that "the parents of the schizophrenic children, especially the mothers, presented a definite personality characteristics. The mothers were aggressive, over anxious, over solicitous, and exhibited a marked ambivalence to these children. The profound and complete rejection on the part of mothers in these schizophrenic children was a conspicuous factor." The results of this follow-up study seem to substantiate this for in most of the cases the mothers were found to have been rejecting of the child. Other environmental factors which weld an influence on the child were discussed by Charles Bradley when he said;

Since schizophrenic behavior expresses a total inefficiency of the entire individual, its origins are to be sought among numerous facets which combine in influencing the personality to adopt its characteristic pattern of response. Theoretically, the child who has come to substitute a life of phantasy for one of fact has either found the outer world so painful and repulsive that he has withdrawn to his inner world of thought in self defense, or his dreams and illusions have always been so vivid and attractive that he has become captivated by them to the exclusion of serious interest in his surroundings. Obviously, a multitude of environmental, emotional, intellectual, physical and physiological factors may have contributed to either of these reactions, thus becoming involved in the etiology of childhood schizophrenia.

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7 Bradley, Schizophrenia in Childhood, 125.
It is important to know some of the symptoms of the psychosis of childhood. Bradley and Bowen did a recent study in which they suggested and defined eight separate characteristics of behavior which they found prominent in the schizophrenic child. These traits were, "seclusiveness, irritability when seclusiveness is interrupted, daydreaming, bizarre behavior, diminution in number of personal interests, regressive nature of personal interests, sensitivity to comment and criticism, and physical inactivity." In addition to influencing the behavior of the child, the psychosis also affects the physical development of the child. According to Lauretta Bender's definition, "childhood schizophrenia has been a clinical entity occurring in childhood before the age of eleven years, which reveals pathology in behavior at every level and in every area of integration or patterning within the functioning of the central nervous system, be it, vegetative, motor, perceptual, intellectual, emotional or social. Furthermore, this behavior pathology disturbs the pattern of every functioning field in a characteristic way." However, every child disturbed by a psychosis reacts to the psychosis in a way determined by his own total personality including the infantile experiences and the level of maturation of the personality.

Although there are four classical types of schizophrenia noted for the adult, these can rarely be found in the child. It is best to classify the type of psychoses according to the onset. The acute onset

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8 Ibid., 33

is supposedly characterized "by abrupt stormy onset and subsequent exacerbations and remissions of psychotic behavior." The second type of schizophrenic onset is said to be chronic in nature and this makes it difficult to set a date of onset. The entire development of this type of illness "is slow and insidious, and often lacks dramatic details." Nevertheless, the prognosis for both is usually poor. As mentioned previously the establishment of a diagnosis of schizophrenia in childhood is often very difficult because it depends upon the total picture of the child. The symptoms cannot be isolated but must be considered in the light of the past history of the child.

The treatment of the schizophrenic child has been very difficult for in many cases the child has failed to respond to any form of treatment. Bradley said that, "except in rare cases therapy appears to benefit isolated symptoms only. Personal psychotherapy is usually ineffectual because of the difficulty of establishing satisfactory rapport with a schizophrenic child." Good institutional treatment can bring about some adjustment in the child but this is usually minimal. At the present time there are very few institutions that are equipped to take care of these disturbed children. Benzedrine has been used with some limited success but again the improvement is on a more superficial level. Shock treatment has been used successfully in many of the adult cases of Schizophrenia but as yet the use of this type of treatment has been limited in regard to the schizophrenic child.

10 Bradley, Schizophrenia in Childhood, 130
11 Ibid., 131
12 Ibid., 132
CHAPTER 11

CASES THAT REMAINED THE "SAME"

The purpose of this follow-up study is to determine the type of adjustment which twenty-two pre-psychotic and psychotic children made since they were seen at the Institute for Juvenile Research for diagnostic evaluation of their emotional problems. These children had not been accepted for treatment because their disturbances were so severe, that treatment on an outpatient basis would not be sufficiently adequate to meet the needs of the child. In most cases, the prognosis was considered poor and institutionalization was recommended for the majority of the group.

Of these twenty-two children fifteen were classified under the category of "same", that is, the child's problem continued to exist or became worse. These cases will be discussed in this chapter. As was described in the introductory chapter, there were four types of adjustment possible, same, slight improvement, remarkable improvement, and worse. The first procedure had been to determine the adjustment of the child in the three areas studied, the behavior problems, the interpersonal relationships and the psychiatric report of the child. Then, the over all adjustment of the child was determined by the device of counting the checks under each type of adjustment. The number of checks that
predominated represented the adjustment of the child. As a result of this, no one case could be considered a "pure" case of an adjustment that had remained the "same" for in all of the cases, the other types of adjustment were also present in a minor way. One has to remember the children studied were human beings, who were subject daily to environmental influences and were undergoing physical, mental, emotional, social, and psychological changes. Therefore, one cannot expect to categorize an individual's adjustment into any rigid setting.

The names used in the thesis are fictitious, chosen to conceal the identity of the child. In general, the information included in the reports about each child was the age, sex, race, ordinal position, date of admission, and follow up, source of referral, number of siblings, the nationality, religion, and economic status of the parents, as well as the home situation and the attitudes of the parents toward the child. The I.Q. and grade placement were also considered important.

The Behavior Problems were divided into classifications that were adopted by the Institute. These classifications were set up by the agency for its own use in recording data statistically. The types of behavior included in each classification can be described briefly as follows:

Socially Unacceptable Acts—acts which seemingly result from deprivation for which the child must compensate and retaliate. These include such acts as temper tantrums, stealing, truancy, lying, and disobedience.

Sex Problems—acts which result in excessive sexual interest, promiscuity, homosexuality, masturbation, and obscenity.
Learning defects—retardation or unsatisfactory progress in school.

Personality Difficulties—it can be an emotional affect which is not appropriate to or is out of proportion to the stimulus that precipitated it. Some examples of these are nervousness, depression, and excitability. It can also be acts which are prompted by anxiety or fear, such as nightmares, nail biting, shyness and chronic anxiety. It may also result in irrational behavior such as peculiar actions, delusions and hallucinations.

Somatic Dysfunction—behavior which has some physical involvement and in which the physical disorder is on a somatic or functional, rather than an organic basis. This includes such disturbances as vomiting, enuresis, speech defect and the glandular syndrome.

The interpersonal relationship included the child's relationships to his parents, siblings, and the other children. Disturbances were noted in this area also. The third area was the psychiatric report and this included the appearance, behavior of the child during the interview, the relationship to the psychiatrist, the prognosis, and the diagnosis.

The following cases are those that were diagnosed as psychotic by the psychiatrist at the diagnostic level.

CASE 1

Carl, a negro child, aged two years nine months, was referred by a councilman to the Institute for Juvenile Research in April of 1950.

The patient's parents were of mixed religion, Catholic and Protestant. At the time of the social history the parents were separated and mother was receiving Aid to Dependent Children and had intentions of obtaining a divorce. The mother described the father as a seriously disturbed person who seemed to have spells at the change of the moon and would shake all over. He had periods of extreme depression in which he would writhe on the floor, tear his clothes and beg to die and at other
times would be extremely happy and gay. Carl was a premature baby of seven months and didn't walk until he was two years old. No psychological was administered to the child when he was examined at the clinic.

The following table illustrates the type of adjustment the patient made since being seen at the Clinic.

**TABLE IV**

**ADJUSTMENT OF THE PATIENT**

<table>
<thead>
<tr>
<th>Area Studied</th>
<th>Non Given</th>
<th>Same</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavior Problems</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socially Unacceptable Acts</td>
<td>X</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex Problems</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Defects</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Personality Difficulties</td>
<td></td>
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<tr>
<td>Somatic Dysfunction</td>
<td></td>
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</tr>
<tr>
<td><strong>Interpersonal Relationships</strong></td>
<td></td>
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</tr>
<tr>
<td>To Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>To Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>To Sibling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>To Other Children</td>
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</tbody>
</table>

The child's adjustment seemed to have remained the same in both his behavior problems and interpersonal relationships.

The mother was contacted for the follow up interview in April of 1962, two years after the first admission. Carl was then four years nine months old. The mother was unable to determine the age of the onset of the symptoms and was not able to speculate as to the cause of her son's condition.

The following report illustrates the behavior problems and the
interpersonal relationships of the boy as it was discussed by the mother at the first admission and also at the follow-up interview. The latter part of the report will include the psychiatric interview at the diagnostic level. No follow up was possible by the psychiatrist because the child had been institutionalized.

**BEHAVIOR PROBLEMS**

<table>
<thead>
<tr>
<th>First Admission</th>
<th>Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Learning Defects</strong></td>
<td><strong>Learning Defects</strong></td>
</tr>
<tr>
<td>He was mentally retarded.</td>
<td>He continued to be mentally retarded.</td>
</tr>
<tr>
<td><strong>Personality Difficulties</strong></td>
<td><strong>Personality Difficulties</strong></td>
</tr>
<tr>
<td>When the worker went to the reception room, mother was changing the patient's diaper and he was lying flat on the floor, nursing a bottle. He does not talk, has never talked, and cannot eat or dress himself. He does not seem to be aware of his surroundings, does not recognize mother, and only drinks milk unless forced to eat baby foods. He has certain ritualistic mannerisms such as twirling his right hand, hitting himself on the head and others. He needs constant watching. On one occasion he stuck a nail through the sole of his shoe while out of doors and mother discovered it after one hour when she noticed him limping. He did not cry when the nail was removed and nothing seemed to hurt him. He seldom laughed, cried, or became angry or hungry. The mother fed him a out every three hours. He banged his head against the wall.</td>
<td>The mother felt that his condition had remained the same. He still wore a diaper, had peculiar mannerism, laid on the floor, and had refused solid foods. He continued to look off into space and hit his head with his fist. He was able to walk and hear well but could not comprehend what was said by mother. The mother felt that the only good it has done to place him in an institution was that he was receiving medicine to make him rest. The mother did not know if the child felt pain.</td>
</tr>
<tr>
<td>The mother said that he still did not show any emotions as laughing, or crying.</td>
<td></td>
</tr>
</tbody>
</table>
# Behavior Problems

<table>
<thead>
<tr>
<th>First Interview</th>
<th>Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Somatic Dysfunction</strong></td>
<td><strong>Somatic Dysfunction</strong></td>
</tr>
<tr>
<td>He has no control of his bowel movements.</td>
<td>This condition has remained the same.</td>
</tr>
</tbody>
</table>

## Interpersonal Relationships

### To Mother

The child did not recognize his mother and their relationship was never close, institution he did not recognize her.

### To Father

There was none recorded.

### To Sibling

The mother expressed the fear that the child would harm the baby.

### To Other Children

The neighborhood children refused to play with him because he always injured them in some way.

## Psychiatric Report at Diagnostic Level

### Relationship to Psychiatrist:

There was nothing recorded concerning the appearance and the behavior of the child, but the psychiatrist did mention the impossibility of establishing a relationship with the child.

### Prognosis:

The prognosis was considered poor.

### Diagnosis:

He was found to be almost out of contact. There was certain features
PSYCHIATRIC REPORT AT DIAGNOSTIC LEVEL

Diagnosis:

that suggested a diagnosis of schizophrenia. He was functioning at a mentally defective level.

Recommendations:

He should be hospitalized immediately at any one of the state schools for the feebleminded.

The recommendations of the psychiatrist were accepted by the mother, for in May of 1950 the child was placed at the Lincoln State Hospital and has remained there since. Although, the mother did not feel the child had improved since being at the institution, she was aware of her own inadequacy in being able to take care of him.

CASE II

Jonothan, aged five years two months was referred by the University of Illinois Hospital to the Institute for Juvenile Research, for a psychological test and an evaluation of his mental capacities. He was seen at the Clinic in February of 1949.

The patient's parents were married in their early twenties and lived with the paternal grandparents for ten years. The parents were both Catholic and received an income sufficient to meet their daily needs. Jonothan was the middle child and had two other brothers. When the examiner interviewed mother, he noticed that mother frequently ordered the child about and physically handled him roughly. As a result he flinched and cringed when she made any motion toward him.

A Stanford Binet Form L test was administered to the child but no
reliable findings could be reported. He was classified as a low grade mental defective because of his psychotic inability to relate. He did not attend kindergarten.

The following table will illustrate the type of adjustment the patient made since being seen at the Institute for Juvenile Research.

### TABLE V

**ADJUSTMENT OF THE PATIENT**

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>Non Given</th>
<th>Same</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavior Problems</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socially Unacceptable Acts</td>
<td>X</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Sex Problems</td>
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<tr>
<td>Learning Defects</td>
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<tr>
<td>Personality Difficulties</td>
<td>xa</td>
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<td>xb</td>
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<td></td>
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<tr>
<td>Somatic Dysfunction</td>
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</tr>
<tr>
<td><strong>Interpersonal Relationships</strong></td>
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</tr>
<tr>
<td>To Mother</td>
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<tr>
<td>To Father</td>
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</tr>
<tr>
<td>To Siblings</td>
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<tr>
<td>To Other Children</td>
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</tr>
<tr>
<td><strong>Psychiatric Interview</strong></td>
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<tr>
<td>Appearance</td>
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<td></td>
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<tr>
<td>Behavior</td>
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<td></td>
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<tr>
<td>Relationship</td>
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<tr>
<td>Prognosis</td>
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</tr>
<tr>
<td>Diagnosis</td>
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</tr>
</tbody>
</table>

\(xa\)--The child's fear of loud noises or sudden movement prevailed.

\(xb\)--The child made a slight improvement in that he seemed to be more quiet, more obedient, and more attentive.

The patient's adjustment was not too successful, although, some slight improvements were made in the Behavior Problems. Two categories
were checked for Personality Difficulties because part of the problem still prevailed, whereas, a slight improvement was shown in another problem manifested by the child. There was no noticeable change in the interpersonal relationships of the child, and the examining psychiatrist at the follow up interview felt that the child had made very little improvement, with the exception that he had appeared to be somewhat calmer.

The mother and child were seen at the clinic for the follow up interview in April of 1962, three years and two months after the first admission. At that time, Jonathan was eight years four months old. The mother felt that the boy's problems were first noticed when he was around two years of age, but mother was not certain as to what might have prompted his strange behavior. However, she did recall that he had had the measles at that time and had a rather high fever.

The following report illustrates the behavior problems and the interpersonal relationships of the boy as discussed by the mother at the time of the first admission. The latter part of the report will include the psychiatric interviews of the child at the diagnostic level and also at the follow-up.

**BEHAVIOR PROBLEMS**

<table>
<thead>
<tr>
<th>FIRST ADMISSION</th>
<th>FOLLOW UP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sociably Unacceptable Acts</strong></td>
<td><strong>Sociably Unacceptable Acts</strong></td>
</tr>
<tr>
<td>He frequently went into a fit in which he threw everything on the floor, broke glasses or windows, or just threw things in general.</td>
<td>The mother said that he continued to holler, yell, and throw things, and didn't know what stimulated these outbursts.</td>
</tr>
<tr>
<td>BEHAVIOR PROBLEMS</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td><strong>FIRST ADMISSION</strong></td>
<td></td>
</tr>
<tr>
<td>Learning Defects</td>
<td></td>
</tr>
<tr>
<td>The child was mentally retarded.</td>
<td></td>
</tr>
<tr>
<td>Personality Difficulties</td>
<td></td>
</tr>
<tr>
<td>The mother felt that the child began doing strange things when he was about two years old such as eating off the floor or from the garbage in the alley. He was not dependable and must be watched carefully to prevent his wandering in the streets. He shuddered at any sudden movements as though he was going to be struck. Street cars, fire trucks, and vacuum cleaners threw him into a panic in which he screamed at the top of his lungs. He wasn't able to feed himself.</td>
<td></td>
</tr>
<tr>
<td>Somatic Dysfunction</td>
<td></td>
</tr>
<tr>
<td>The child hid to wet or soil himself and then told mother. He had no control over his bodily functions. The boy's speech was more like baby talk.</td>
<td></td>
</tr>
<tr>
<td><strong>FOLLOW-UP</strong></td>
<td></td>
</tr>
<tr>
<td>Learning Defects</td>
<td></td>
</tr>
<tr>
<td>Although the child continued to be retarded, he had improved a little because he could recognize the TV programs and seemed to be able to remember many things that had happened in the past. He can also distinguish certain objects.</td>
<td></td>
</tr>
<tr>
<td>Personality Difficulties</td>
<td></td>
</tr>
<tr>
<td>The child stopped eating off the floor.</td>
<td></td>
</tr>
<tr>
<td>Somatic Dysfunction</td>
<td></td>
</tr>
<tr>
<td>He was improved in that he seemed to be more quiet, obedient, and more attentive, and better able to take care of himself. The child continued to be frightened at the loud noises. He chewed his hand when he got excited. He was able to do little things like picking up his clothes, feeding himself and washing himself. He recognized family members.</td>
<td></td>
</tr>
<tr>
<td><strong>INTERPERSONAL RELATIONSHIPS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TO Mother</strong></td>
<td></td>
</tr>
<tr>
<td>Nothing was reported in the record.</td>
<td></td>
</tr>
<tr>
<td><strong>TO Mother</strong></td>
<td></td>
</tr>
<tr>
<td>The mother felt that the boy had always tried to stay fairly close to her.</td>
<td></td>
</tr>
</tbody>
</table>
INTERPERSONAL RELATIONSHIPS

FIRST ADMISSION

To Father

Nothing was reported in the record.

To Siblings

Nothing was reported in the record.

To Other Children

It was difficult for him to play with the other children because of his retarded condition and his aggressive behavior, such as throwing rocks. They always made fun of him. He played by himself more.

FOLLOW-UP

To Father

The mother felt that the boy and father got along fine.

To Siblings

The writer failed to obtain the information concerning this area.

To Other Children

The other children usually did not play with him. He played in the house by himself or mother read to him. He liked to ride a bicycle. There were some children that would play with him.

PSYCHIATRIC INTERVIEW

Appearance

The child seemed to have a markedly deformed cranial in which it appeared as if the right frontal area had been compressed.

Behavior

The child seemed to have a great need to be destructive. He was apparently under much internal pressure toward constant activity. The play and fantasy was poorly organized. He had trouble separating from his mother.

Appearance

He was a thin set, funny kid with a bland expression on his face. He appeared fairly well dressed but seemed quite immature.

Behavior

The boy was sitting along side of mother in the reception room, laughing in a silly manner but for the most part holding his hand over his mouth. He took a gun and aimed at my eyes. His behavior became worse and more excited as he was stimulated by his play things. Every time he spoke his hand went to his mouth. It seemed on several occasions that he was hallucinating since he was pointing out objects on the roof that weren't there. He never responded directly to my questions and his speech was indistinct. He
Behavior

excused himself to go to the bathroom, but a few minutes later I found him in the playroom destroying a puzzle that two girls had been working on. In his contact with the children he evidenced inability to play with them. He made several remarks about the hospital and the boy and girl he saw playing on the roof which of course weren’t there.

Behavior

Relationship

There was very little relationship established between the child and the psychiatrist since the child didn’t respond to anything.

Relationship

There formed no relationship to me at all and interest centered on one or the other object which drew his attention.

Prognosis

This was considered poor.

Prognosis

The prognosis continued to be poor.

Diagnosis

The boy was an exceedingly disturbed youngster who gave the impression of being psychotic. It might be an organic psychosis although there was nothing to indicate it.

Diagnosis

As far as a definite diagnosis of psychosis is concerned, I don’t think it can be made. The most we can conclude is that his behavior proceeds from the organic side.

Recommendations

There was nothing reported in the record.

Although, the recommendations were not included in the record, the boy received some medical treatment. Following, the first admission the child was given dilantin for two years and four months. The mother felt that as a result of this the child had improved in some areas but the progress had been very slow and minimal. It also was not the progress that had been anticipated by the doctor. At the time of the follow up interview,
mother was attempting to make arrangements to send the child to St. Collota's but was afraid that he might not be admitted because of his low I. Q.

CASE III

Peter, aged six years eleven months, was referred by the University of Illinois Hospital to the Institute for Juvenile Research on March of 1950. The patient's parents were both Catholic, and of Russian Irish descent. The family was receiving Aid to Dependent Children due to father's inability to work. Frequent separations have occurred between the parents and the father has been committed to state institutions on three different occasions. During one period of father's hospitalization mother had an illegitimate child who was later placed by an agency. Both parents were in the home at the time of the referral. The patient was the oldest of four children, having two sisters and a brother. The psychiatrist felt that the father was very attached to the child, but the mother was considered inef fectual, dependent, and possibly feebleminded.

A Stanford Binet test was administered to the child at the clinic but the findings were considered incomplete. He was classified as borderline mental defective. During the testing he was extremely distractible, had speech that was incoherent and his play wasn't goal directed. The child had not yet attended school.
TABLE VI
ADJUSTMENT OF THE PATIENT

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>Non Given</th>
<th>Same</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socially Unacceptable Acts</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Sex Problems</td>
<td>X</td>
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</tr>
<tr>
<td>Learning Defects</td>
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</tr>
<tr>
<td>Personality Difficulties</td>
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</tr>
<tr>
<td>Somatic Dysfunction</td>
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<tr>
<td>Interpersonal Relationships</td>
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<tr>
<td>To Mother</td>
<td>X</td>
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<tr>
<td>To Father</td>
<td></td>
<td>X</td>
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</tr>
<tr>
<td>To Siblings</td>
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<tr>
<td>To Other Children</td>
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<tr>
<td>Psychiatric Report</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Appearance</td>
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<td>X</td>
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<tr>
<td>Behavior</td>
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<td>X</td>
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<tr>
<td>Relationships</td>
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<tr>
<td>Prognosis</td>
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<td>X</td>
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<tr>
<td>Diagnosis</td>
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<td>X</td>
</tr>
</tbody>
</table>

The patient's adjustment had not progressed too successfully, for the Behavior Problems had remained predominantly the same, with the exception of the Personality Difficulties which had become worse. The relationship of the child toward other children had also become worse for he was completely withdrawing from them. The psychiatric report also revealed that the child had become worse in Appearance and Behavior since he had been seen at the clinic for the first time.

The follow up interview with the mother and child occurred in June of 1952, two years and three months after the first admission. This was one
of the cases that had been scheduled for an official clinic follow up by one of the members of the staff, and Peter was then nine years two months old. The mother felt that the child had begun to reveal some of his problems when he was about a year old, following a separation of the parents for a seven month period.

The material for the diagnostic report was taken from the Illinois Research record on the child. The mother was interviewed for the follow-up material.

**BEHAVIOR PROBLEMS**

<table>
<thead>
<tr>
<th><strong>FIRST ADMISSION</strong></th>
<th><strong>FOLLOW UP</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Socially Unacceptable Acts</strong></td>
<td><strong>Socially Unacceptable Acts</strong></td>
</tr>
<tr>
<td>He threw temper tantrums.</td>
<td>He had a very bad temper and instead of talking back he threw things or screamed.</td>
</tr>
<tr>
<td><strong>Learning Defects</strong></td>
<td><strong>Learning Defects</strong></td>
</tr>
<tr>
<td>He was very slow in learning.</td>
<td>He continued to be slow in learning, and had no concern for his appearance.</td>
</tr>
<tr>
<td><strong>Personality Difficulties</strong></td>
<td><strong>Personality Difficulties</strong></td>
</tr>
<tr>
<td>The child was nervous and irritable with some obsessive compulsive behavior for he insisted on everything being &quot;just so&quot;.</td>
<td>In addition to being nervous and irritable, mother had to dress and feed him or he would go without his clothing. Occasionally, while on the street he trembled all over and seemed fearful of something.</td>
</tr>
<tr>
<td><strong>Somatic Dysfunction</strong></td>
<td><strong>Somatic Dysfunction</strong></td>
</tr>
<tr>
<td>He did not talk intelligibly and it was a type of echolalia with extensive sound substitutions. The child was enuretic at night. He used his hands clumsily as if they were too heavy for him, and he walked strangely as if he were</td>
<td>He still did not speak intelligibly. He was still enuretic.</td>
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</tbody>
</table>
Somatic Dysfunction

going to fall over.

The child had many eating idiosyncrasies, for he would not eat solid food and insisted that all his food be mashed. He fed himself with a spoon but did not allow the spoon to come into contact with his lower jaw or lips. He would not drink from a cup or glass but would pour the fluid into a spoon. Swallowing was performed in an unusual manner by dropping water into the protruded lower mouth.

INTERPERSONAL RELATIONSHIPS

TO Father

Nothing was reported in the record.

To Father

The mother described the boy as a very sensitive child who had never had a close relationship with anyone except his father and he had tried to do everything for the child.

To Siblings

He didn't play with his siblings too well, for if he did not have his own way or was irritated by them he would call for his mother.

To Siblings

He does not have anything to do with his siblings now.

To Other Children

He seemed to prefer the company of children older than himself and was usually very passive in his play, permitting his playmates to take his toys away from him.

To Other Children

He had changed since the first interview for now he was content to play alone and often rode his bicycle to a secluded spot where he was not bothered by any children. If children did molest him he became angry and threw things at him.
PSYCHIATRIC REPORT

FIRST ADMISSION

Appearance
Peter was a white male, who was average sized, not unusual in appearance, who came passively with the examiner with a sort of gliding gait.

Behavior
He had a somewhat detached air and betrayed a peculiar awkwardness of his lower limbs when at play or when emotionally stimulated. The awkwardness was not organic in nature. His first speaking attempts were purely scholastic in regard to certain stimulus words like 'play' and 'toy'. His enunciation resembled that of an eighteen month old child. He showed a tremendous apprehension about getting dirty and appeared as a clean child. It was felt that he understood questions asked of him but was too detached to answer. His behavior was bizarre and autistic but there was nothing in the case to indicate that a regression had occurred and he was functioning at a dull level.

Relationship
He was unable to relate at all.

Prognosis
The prognosis was considered poor.

FOLLOW UP

Appearance
The child seemed to have become worse in many respects. He was an extremely thin and almost emaciated boy whose hair was just brushed out of his eyes and whose clothes were several sizes too large for him and dirty.

Behavior
The child was reluctant to come with me upon reassurance from the parents, he came, bringing four road maps. He shook hands limply and smiled winsomely. He had extremely fine features and appeared as a pretty and fragile boy. Without showing any signs of recognition of the examiner or being aware of him he went to the sand pile and spent most of the time putting sand into the bucket. I tried to engage him in conversation but most of the time he didn't respond. His speech was indistinct and sounded like a mumble, and his voice had a distinct nasal tone to it. The only time he showed any affect or interest was when I talked to him about his maps.

Relationship
He related very poorly and nearly the entire interview was on a non-verbal level.

Prognosis
It continued to remain poor.
PSYCHIATRIC REPORT

FIRST ADMISSION

Diagnosis

The child was psychotic, but it was difficult to know if the retardation was primary or was the result of a psychotic process, although it was the examiner's feeling that both pertain. He was like a vegetable.

Recommendations

The child will eventually have to be institutionalized.

FOLLOW-UP

Diagnosis

In some areas the child was functioning as an eighteen month or two year old child while in other areas as a six or eight year old child. He was schizophrenic. He was negativistic and related to people in a bizarre way.

Recommendations

Application has been made to the Grace Abbott Treatment center for the child. He seemed to have become worse since the first interview.

In this case the findings of the psychiatrist substantiated mother's awareness of her son's more disorganized and regressive state.

Since this was one of the cases that had already been scheduled for an official clinic follow-up by the staff, a psychological was given to Peter. Although, no psychologicals were able to be given for the follow-up study itself, the writer thought it interesting to take note of the result of the psychological. A Wechsler Intelligence Performance Scale Test was given to Peter. Although, no valid results could be obtained, the psychologist felt that he was of potentially high average to superior intelligence as a result of his responses to three of the sub tests. He was functioning at a mentally defective range but there was no real evidence for mental deficiency or organic involvement.
CASE IV

Dorn, aged seven years eight months was referred by the parents to the Clinic in April of 1948.

The patient's parents were both Catholic and of Irish-Polish descent. The economic status was unknown. He was the middle child and had three other brothers. The patient's home life was a very disturbed one. During the early years of their marriage, the parents frequented many bars. The mother continued to drink and became progressively worse. During one of the arguments the mother told father that she no longer loved him. The father left home in 1947 for a period of six months because of mother's increased drinking and mismanagement of the home. He tried to effect a reconciliation several times after hearing a report that the children were being neglected and mistreated by an elderly woman who cared for them while the mother worked as a waitress. The mother refused a reconciliation and left the home in 1948. Later a divorce was gotten by the parents. The paternal grandmother came into the home and cared for the children, but she had a marked preference for Dorn's twin brother. The psychiatrist felt that the father was interested in the boy on a unconscious level, but seemed to reject the boy on an unconscious level.

The boy's I. Q. was 98 as judged by the Stanford Binet Form L test administered to the child at the Clinic. He was classified as having an average I.Q. He was not attending school at the time of the first admission, although he had gone to school at one time. The psychologist reported that Dorn exhibited extremely atypical behavior during the testing
and it was severe enough to be psychotic.

The information for the follow-up on this boy was secured from Dixon State Hospital through a questionnaire. As a result, not all of the sections in the questionnaire were answered fully, and this made it difficult to compare the material from the diagnostic level with the information received from the follow-up.

**TABLE VII**

**ADJUSTMENT OF THE PATIENT**

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<tr>
<th>Area Studied</th>
<th>Non Given</th>
<th>Same</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Same</th>
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<td><strong>Interpersonal Relationships</strong></td>
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<td>To Other Children</td>
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<td>Diagnosis</td>
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X\(a\)—The report did not mention if the child had manifested any problems in the stealing area or if he was disobedient to rules.

X\(b\)—The temper tantrums continued to exist at the follow-up.

X\(c\)—The child's disturbed behavior in school continued in the institution.

X\(d\)—The child was self-mutilating. This type of behavior was new.
The child's symptoms had remained predominantly the same, with the exception of a worse condition developing in the Personality Difficulties and in his relationship to other children. A slight improvement was noted in his relationship to his siblings but this was not a certainty because the actual relationship between Dorn and his siblings was never observed.

There was no follow up interview with the parent and the child on this case because the child had been institutionalized at Dixon State Hospital. The father was unable to come in, but a letter and a permission slip enabling the writer to contact the institution, was sent to Dorn's father, and he returned the permission slip shortly afterwards with his signature. In August of 1952 a questionnaire and the permission slip was sent to the institution requesting current information on Dorn. In the latter part of September in 1952, the writer received the reply from Dixon. This occurred four years and five months after the first interview with the child on the diagnostic level. The institution reported that there was no overall great improvement in the child. Most of his overt difficulties were periodic. He was capable of giving attention, had a fabulous memory but the interpersonal difficulties were intense. There had been some slight improvement in habit training and personal cleanliness but this was far below normal expectation.

The information on the diagnostic level was taken from the father's discussion at the time of the first admission. The report from the institution provided the follow-up for the three areas studied.
**First Admission**

**Socially Unacceptable Acts**

He was disobedient and would not pay any attention to any rules or regulations within the home. He had been known to do some minor stealing such as milk bottles and then get his brother blamed for it. He had temper tantrums.

**Sex Problems**

He has been found undressing other boys and fingering their genitalia. He licked his brother's penis, rubbed his anus and then put the material in his mouth.

**Learning Defects**

When the child had been in school he had been doing unsatisfactory work.

**Personality Difficulties**

When the father came in the first time he spoke of the child's behavior in school, in which he managed to disrupt the class. When he stood in line he had to be led through the hall from one school room to another, and would suddenly burst into a scream, or else he would climb on a wash basin and scream. Father spoke of lapses which the boy seemed to be having and he gave several examples of this such as; father took him to a store shopping. He seemed to go into a trance like state with a blank expression on his face. He took a package of a woman standing next to him and when father asked him to give it back he didn't.

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**Follow Up**

**Socially Unacceptable Acts**

Nothing was reported by the institution concerning his attitude toward the rules. Nothing was reported concerning the problem of stealing.

He had periodic intense temper tantrums and invited aggression from other boys by provocative acts.

**Sex Problems**

He has been a passive homosexual problem in the institution.

**Learning Defects**

The school progress of the boy remained poor, and was below fourth grade level.

**Personality Difficulties**

He continued to create a disturbance in school and provoked aggression from the children.

The lapses which father spoke of at the first admission were not mentioned as such in the report from the institution. However, since these lapses were later discovered to be epileptic fits, the institution reported that the child continued to have them.
FIRST ADMISSION

Personality Difficulties

hear him. He finally dropped the package and later had no recollection of what he had done. He has had this type of behavior several times before and he thought that the boy was out of contact during these periods. This type of behavior was not manifested by the boy at the time of the first admission.

Somatic Dysfunction

In a later report in the record the writer found that the boy had been observed for two weeks in 1950 at the Illinois Neurological Institute and they found that he had epileptic seizures. They were described by father as trances but he had not realized what they were at the time. The report from the hospital stated that the "seizures would last for three or four minutes. During this period the child had a staring gaze, stiffening of the body, and sometimes groping movements of the hands, gutteral noises from the throat and smacking of the lips. There were about three or four seizures a week.

FOLLOW-UP

Personality Difficulties

The boy's behavior became worse because he has shown self-mutilating behavior such as picking at sores, creating skin lesions and other similar actions.

Somatic Dysfunction

Dorn had twenty-four seizures in 1950. This was a minimum number and probably does not include petit mal and some mild psychomotor attacks.

INTERPERSONAL RELATIONSHIPS

To Mother

Nothing was recorded in the record.

To Father

Nothing was recorded in the record.

To Mother

Dorn's expressed sentiments were very affectionate toward stepmother, father, and actual mother. He was visited regularly and received mail and gifts.

To Father

The boy has expressed affection toward the father.
INTERPERSONAL RELATIONSHIPS

To Siblings

Dorn and the oldest boy always had fights because the other boy wouldn't let Dorn touch his things. He was friendly with younger children.

To Other Children

Dorn seemed to be friendly with small children but got into trouble with children his own age. On one occasion when he was in school he had jumped up from his seat without any warning and grabbed the hand of a boy and bit it on the back.

To Other Adults

This information was not available in the record.

To Siblings

He seemed affectionate toward all the siblings. No actual face-to-face relationship was observed.

To Other Children

He was somewhat isolated socially except for aggressive interchange with Dorn receiving the aggression. His explosive outbursts were uncontrolled and violent. The interpersonal relationships with his cottage of young schoolboys was one of rough and tumble and he couldn't join in this without becoming disturbed. This does not necessarily reflect a change in the patient. He was typically withdrawn or aggressive. The only friend he can name is another lad with passive aggressive alternations.

To Other Adults

This information was requested to obtain a clearer conception of the boy's behavior. He overtly conformed and sought attention, conversation, and favors. He was extremely courteous on the surface but could not maintain a friendly relationship. Overall, his relationships with adults are better than with children but probably only because his aggressiveness is more controlled.

PSYCHIATRIC INTERVIEW

Appearance

Dorn was a well built, red haired boy who was quite provocative throughout the interview.

Appearance

He was a tall, thin, frockled boy with a flattened occiput.
PSYCHIATRIC INTERVIEW

FIRST ADMISSION

Behavior
His chief pattern displayed throughout the interview was one of caricaturing attitudes and feelings. It appeared as if little significant affect was displayed actually. It was difficult to understand him because of somewhat slurred speech. He thought he was here because some people said he was crazy. While he was talking to the examiner he tilted the chair forward and slid from it to the floor. He acted as if her were severely hurt and whimpered. The examiner who had observed the action very closely, was certain the boy was not hurt, and stated so in a firm kind manner. He admitted doing this type of thing frequently. He wanted to be a person who out fires when he grew up. He spun about like a top when the examiner rotated his head by one hand, and continued to rotate after the examiner had stopped spinning him. He protested this procedure in a whimpering manner but nevertheless continued to rotate until stopped by the examiner.

Relationship
He related superficially well to the examiner and seemed quite provocative throughout the interview.

Prognosis
The prognosis was considered to be poor.

Diagnosis
The patient appeared to be psychotic. His home cannot give him the proper supervision and his difficulties would probably increase if he remained in the home.

FOLLOW-UP

Behavior
During an interview he did not display unusual grimaces or gestures but there have been observed during autistic play which was often indulged in. Although superficially courteous and attentive, Dorn remained essentially autistic in his attention. His main interest in an interview is the possibility of asking for favors and gifts. He still demonstrated the spinning mentioned in earlier reports and if encouraged will spin rapidly for many minutes.

Relationship
The child exhibited a similar type of relationship to the psychiatrist.

Prognosis
The prognosis continued to be poor for this boy.

Diagnosis
The diagnosis was chronic Brain Syndrome with Convulsive Disorders with Mental Deficiency and Moderate Schizoid Personality.
Recommendations:

The child should be committed either to Ridge Farm Preventorium or else a public institution.

Following the psychiatric interview at the first admission, attempts were made to place the child at the Ridge Farm Preventorium, but the child was not accepted. The record included reports from later contacts with father, so additional information was available concerning the child between the time of the first admission and the follow-up of the case. In 1949, the father married his housekeeper who had been caring for the boys. She had two small children of her own from a former marriage. Not too long after the marriage, she threatened to leave the father. She did not like Dorn and always referred to him as being "crazy". The boy was placed in the Guardian Angel Boarding school from November in 1948 to January of 1949. He was removed because of his behavior. The writer also found that the child was given pheno-barbital and dilantin periodically from 1948 to 1950. The exact date of the child's placement at Dorn was not known since it was not included in the report from the institution.

CASE V

Carol, aged nine years two months was referred by a social agency to the Clinic in September of 1950.

The patient's parents were Lutheran of German-Lithuanian descent. Within the home lived the parents, Carol, an older sister, her husband and nine month old baby. Carol, the youngest child, had congenital pseudo-
glioma and only light perception in her left eye. She also wore special
built shoes for her feet. In 1947, Carol was placed at Jacksonville
State School for the blind. She was sent home because she was unable to
adjust. The psychiatrist described the mother of Carol, as one who had
a very deep intense hostility toward the child and also tremendous guilt
feelings concerning the child. The economic status of the family was
unknown.

It was impossible to administer a test to Carol because there was
no way of communicating with her. She was thought to be a low grade
mental defective. She was not able to attend any school.
TABLE VIII
ADJUSTMENT OF THE PATIENT

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>Non Given</th>
<th>Same</th>
<th>Improvement</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
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X^a—The child's fear and infantile and bizarre behavior remained the same.

X^b—The child made a slight improvement in that she appeared to be more calm.

X^c—The child's speech difficulty and thumbsucking continued to exist.

X^d—The child made a slight improvement in the feeding problem and enuresis.

X^e—The behavior of the child in the psychiatric interview remained predominantly the same.

X^f—The behavior was slightly improved because she seemed to be more quiet and didn't scream.

The patient's adjustment could not be considered too successful.
since very little improvement was shown in all three of the areas studied. 
Two categories were checked in the Personality Difficulties and Somatic 
Somatic Dysfunction because many of the problems remained the same, while 
in others a slight improvement was noted. The interpersonal relationships 
of the child have remained the same. However, the psychiatrist felt a 
slight improvement was perceptible during the interview with the child, 
although the child's condition remained predominantly the same.

The mother and the child were seen at the clinic for the follow 
up interview with the writer and psychiatrist in June of 1962, exactly 
one year and nine after the first admission. Carol was going to be 
eleven years old in the following month. The child remained with the mother 
throughout the interview because she refused to be separated from her. She 
was quite a distraction, since she shook her head back and forth, waved 
her arms around, gouged at her eyes, hummed, talked repetitiously, climbed 
all over the mother and clung to her. Every few minutes mother said, "see 
what I have to go through all the time." The mother stated that the child 
had been blind since she was five months old, but the peculiar actions and 
behavior were not noticed until she was about two years old. Following, 
the first interview mother had placed the child at Dixon, but removed 
her later for reasons which will be discussed later in the chapter.

The material from the first admission was taken partly from the 
interview with the mother and from the report by the Department of Public 
Welfare.
FIRST ADMISSION

Socially Unacceptable Acts

Carol seemed to be hostile because she engaged in excessive violent physical attacks on others and herself. Upon the least provocation she resorted to violent temper tantrums with much screaming and throwing of things. When angry she would hit or bite herself. This behavior occurred when she wanted something.

Learning Defects

The child was mentally retarded.

Personality Difficulties

She had extremely infantile behavior and also had some habits common to blind children, such as gouging at her eyes, rocking and shaking her head. She was restless, excitable, withdrawn, and daydreamed frequently. She cannot dress herself, or put her shoes on.

Somatic Dysfunction

She could not speak until she was five. She could say words but not sentences. The speech was relatively undeveloped, as independent speech was frustrated by mother who always told her what to say. She was a feeding problem because she had many food dislikes and meals were an occasion of many fights. She sucked her thumb.

FOLLOW UP

Socially Unacceptable Acts

Although, she still has some violent reactions to others, it does not seem to be as pronounced as it was. The temper tantrums continued to be prevalent.

Learning Defects

She was still mentally retarded.

Personality Difficulties

Carol had remained the same in certain actions. She seemed to have a fear of something, but mother couldn't decide what it was. She still rocked her head back and forth, cried, bit her hand and face, gouged at her eyes and was interested in smells of all kinds. She was not able to feed herself except when she ate ice cream. She waved her hand constantly and repeated things but couldn't carry on a conversation. The child seemed to have improved a little in that she had quieted down.

Somatic Dysfunction

She couldn't carry on a conversation but her speech had developed in that she could say more words and would sit and talk to herself for hours, repeating phrases and words that have been said to her. Carol did not fuss about her food as she had previously. She ate more with less fights. She still sucked her thumb.
**FIRST ADMISSION**

**Somatic Dysfunction**

Toilet training was incompletely established and mother tried to handle the problem by forcing the child to go to the bathroom three or four times an hour.

**FOLLOW UP**

**Somatic Dysfunction**

The child did not wet or soil herself and was able to go to the bathroom by herself. She occasionally had a mishap.

### INTERPERSONAL RELATIONSHIPS

**To Mother**

She was very dependent on her. She resisted attempts of her parents to train her to independence.

**To Father**

Father waited on the child "hand and foot" and gave her everything she wanted.

**To Sibling**

There was nothing reported in the record.

**To Other Children**

The play with other children consisted of banging things together, pretending to feed herself, talking unintelligibly to herself, much physical motion, such as rocking, jumping, and shaking her head and snorting. She had never learned to relate to other people.

**To Mother**

The child was still dependent on her. When she was in a strange situation, she would not move from the mother's side and usually sat on her lap and held her mother's hand.

**To Father**

Father continued to treat the child in the same way, but the child was still closer to the mother.

**To Sibling**

The mother thought that she and her older sister got along alright.

**To Other Children**

It was the same type of relationship, because she seldom played with other children because they wouldn't play with her. She got along fine with her sister's little girl, although, they have fought on occasions. She can't comprehend rules of games. She did like to play records and has recognized many of them.
### PSYCHIATRIC INTERVIEW

**Appearance**

Carol was an average sized girl, who during the interview related only with her mother and this was in a very dependent clinging manner.

**Behavior**

She was an anxious fearful child who seemed to be sensitive to any possible injury and loss of support by mother, and her behavior was finely manifested bizarre behavior. Her contact with reality was very poor. She elbowed her hands, mumbled to herself and screamed very loudly when brought into the playroom. Her facial expression was one of fear and staring in the distance. She tended to repeat only what her mother said. Throughout the interview she tended to either keep her thumb in her mouth or picked her nose or stuck her finger in her eye. She kept her eyes rolled up as though looking at the ceiling. Her mood changed very rapidly without any apparent provocation. She walked holding onto her mother. She made certain simple, short verbal requests such as "get a drink". She examined strange things by putting them into her mouth. She became frightened at anything strange and screamed and cried.

**Relationship**

She seemed to be completely oblivious of the examiner's presence even though attempts were made to talk to her.

**Prognosis**

It was considered poor.

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**Appearance**

The appearance and relationship to mother was exactly the same as previously noted by the psychiatrist.

**Behavior**

The behavior was almost the same, and when she heard my voice she became extremely frightened, would hyperventilate, growl, bark like a dog, pet her hands, scratch her buttocks and gouge her right eye with her finger. Her movements were stereotyped and repetitive and there was great need for frequent reassurance from the mother in order to quiet the patient. Her only response to any question of mine was to become very excited and to reach out to touch her mother. The behavior of the child was still within the two and one half or three year age range. The child seemed a little bit more quiet and did not scream as she did previously.

**Relationship**

The child was not able to relate to the psychiatrist at all.

**Prognosis**

It was still considered poor.
FIRST ADMISSION

Diagnosis

The child was considered to be psychotic. As to whether the psychosis was the result of poor environmental factors or due to organic factors is a difficult question to answer.

Recommendation

The child should be committed to a state school where they might be able to provide her with some more regulated and systematic training than she was able to get at home.

The recommendations of the psychiatrist were accepted by the parents for in April of 1961, the child was admitted to Dixon. However, a couple of months later the child was removed because the parents felt she was not receiving the proper care and her health had become worse. During the short time she was there she contracted pneumonia and lost thirty pounds. Following, the child's return home from Dixon, her behavior was worse for she soiled herself and was emaciated. However, she gradually improved a little and some of the disturbed behavior subsided. Although the progress was minimal, mother felt that Carol had made a slight improvement. The mother felt that this was the result of her perseverance as well as the presence of the sister's two year old daughter in the home. Carol tried to imitate the smaller child's singing and playing and even her talking and seemed to be going through the same stage of development as the two year old child.
Case VI

Margie, aged nine years eight months, was referred by the school to the Institute for Juvenile Research in June of 1949.

The patient's parents were Protestant and of French-Irish descent. The parents were married because mother was illegitimately pregnant with their first child. Margie was born during the depression and was not wanted by either of the parents. The mother went to work when Margie was two years old and placed her in the kindergarten. The parents have never spent a great deal of time with their children. They had little understanding of or interest in the needs of the children other than the material needs. The parents were not too well educated and appeared unsound and rude in manner. The economic status of the parents was unknown. It was thought that the child was reacting to the rejection and rigidity of the parents and the present emotional atmosphere in the home.

Margie was the middle child with three other siblings.

The girl's I.Q. was 53 as judged by the Stanford Binet Form L test that was given to her at the clinic. She was classified as a dull normal. She was in the third grade at the time of the first admission. The psychologist reported that she was overactive, distractible and shattered constantly with many bizarre associations. This test did not show the full measure of her ability.
### TABLE IX

**ADJUSTMENT OF THE PATIENT**

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<tr>
<th>Areas Studied</th>
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<td>Learning Defects</td>
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<td>Personality Difficulties</td>
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<td>Somatic Dysfunction</td>
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<td><strong>Interpersonal Relationships</strong></td>
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The patient's symptoms seemed to have remained about the same with a few exceptions. A remarkable improvement was noted under Somatic Dysfunction because father had said that Mangie's speech defect was no longer a problem. Her relationships to the persons closest to her remained about the same, while a slight improvement was noted in her relationship to other children. Although, the psychiatrist reported that a slight improvement had occurred during the follow-up interview with her, it was still not sufficient improvement to change the diagnosis of schizophrenia.
The father and daughter were seen at the clinic for the follow-up interview in August of 1952, three years and two months after the first interview. Margie was twelve years ten months old. Previous to the writer's contact with the parents, the school had been urging the parents to contact the Clinic for re-examination and possible treatment because the child was showing problems at school. The parents had neglected to follow the advice of the school, but in the meantime, the school had contacted the Clinic to inform them of the child's problems. It was therefore a surprise to the writer when the father consented to come in for the follow-up interview. The father inquired about the procedure of re-applying but he made no attempt to speak to anyone on the staff about the child after the follow-up interview was completed. He appeared unkempt and was resistive to any questions that were asked of him. Most of his replies were very short with little information imparted. He was not certain of the age of onset of the symptoms but thought that it might have been when she was around seven years of age.

The mother was interviewed at the first admission and the father at the follow-up interview.

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<th>BEHAVIOR PROBLEMS</th>
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<td><strong>FIRST ADMISSION</strong></td>
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<tr>
<td>Learning Defects</td>
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She was slow in learning but it was felt that it was due to her emotional disturbance. She could be considered a first grade level in all her subjects except art. She had a good sense of arrangement which was the great median through which she gained some worth. (Taken from the school report)

Although, she was in sixth grade she was still behind in her work and had trouble with the school work. She still enjoyed art and does very well at it. A special teacher worked with her privately at school and did seem to help her a little.
FIRST ADMISSION

Personality Difficulties

The mother thought that the child was nervous because she "shook all over" at certain times especially if she were scolded. She was excitable. She was very shy and withdrawn. She was quiet and helpful at home. She was difficult to work with in a classroom situation because of her emotional tenseness. She didn't have any confidence in herself.

Somatic Dysfunction

The child had a speech defect which was lisping and stuttering.

FOLLOW UP

Personality Difficulties

The child still became nervous and excitable when scolded. She continued to shake all over. She has continued to be shy and excitable.

Somatic Dysfunction

The speech teacher helped Margie with her speech and now the speech defect has disappeared.

INTERPERSONAL RELATIONSHIPS

To Mother

The mother said, "Of course she loves me." However, the child once told the teacher she hated her mother.

To Father

"They love him as he loves them."

To Siblings

The mother denied any sibling rivalry. There was just the "ordinary" amount of rowdism between them. On one occasion Margie had been caught twisting her sister's arm because she had refused to wear a pair of gloves. She got along fine with the oldest girl because the older one understands her.
INTERPERSONAL RELATIONSHIPS

FIRST ADMISSION

TO OTHER CHILDREN

She had no friends and the children actually did not like her and made fun of her. She can't play with anyone in the neighborhood because they were all Negro.

FOLLOW-UP

TO OTHER CHILDREN

She liked to play with other children of both sexes. They fight occasionally. She had boy friends in school but she was too young to date.

PSYCHIATRIC INTERVIEW

APPEARANCE

The patient was a pretty, well built girl who came to the interviewing room readily. She was quiet, subdued, and had an enigmatic expression.

APPEARANCE

Margie was a well developed girl of twelve years of age who was also pretty. She was neatly dressed and had a charming way of acting. She greeterd me with a smile and held my hand strongly on the way to the room.

BEHAVIOR

Her speech had a flat, expressionless quality. She frowned when she doubted her success in comprehending what I said. She would make long careful answers almost in the form of a dictionary answer. There was a tendency to perseveration and there was some bizarre associations. She was enthusiastic about drawing and one of the drawings showed a red pool of water and a girl with red spots all over her dress. This might tie in with her first menstrual period. She talked about failing two grades and now was in the 8th grade. When asked how she got to be in the 8th grade, she replied there was an eight on the door. She spoke of her parents as being "nice. "Mother is a kitten in my pictures because she takes care of us like kittens. Father is a dog because he barks at us if we don't come home."

BEHAVIOR

She appeared to be a little nervous and tense in the interview but otherwise showed no erotic behavior. She presented a quite charming and simple external manner. She was a likeable little girl, somewhat withdrawn, yet not delusional nor hallucinatory. Her speech was relevant but some of her reflections were simple and child like. She did not show the bizarness that had been mentioned in the previous interview. There was not too much affect displayed and both serious as well as minor events were reported in about the same tone.
PSYCHIATRIC INTERVIEW

FIRST ADMISSION

Relationship
There was no relationship established between the girl and psychiatrist.

Prognosis
It was considered to be fairly good.

Diagnosis
The patient's flatness of affect, her bizarre associations and perseveration suggest strong schizophrenic trends.

Recommendations
Margie's situation was desperate but the absolute resistance and defiance of the parent's preclude any effort on our part to alter the situation through therapy. The family would not consider placement of the child either.

Although the psychiatrist anticipated the parents had not been receptive to the idea of treatment or placement of the child, so she remained at home. The father didn't think that there was anything seriously wrong with his daughter, and he felt she had improved since she was seen at the Clinic. It was difficult to receive any adequate answers from him all through the interview.

FOLLOW-UP

Relationship
Although she made an effort to relate she still kept me at a distance.

Prognosis
The prognosis should be good providing she receives treatment.

Diagnosis
Although, there has been some slight improvement there still was the schizophrenic process present.
CASE VII

Lee, a negro girl, aged ten years two months, was referred by a social agency to the Institute for Juvenile Research in September of 1940.

The patient's home life was a disturbed one since the father worked irregularly, gambled, and refused to support the family. The parents were protestant. The oldest child was born before the marriage took place. The patient was only five when the father deserted the family and later he was reported dead. The family had received financial assistance since the death of the father. The patient was the middle child with two other sisters. The child needed glasses because she had a persistent nystagmus on the left lateral gaze. She had very poor vision. The mother felt that she had given a normal amount of affection and love to the children, however, the psychiatrist questioned this after interviewing the mother.

The girl's I.Q. was 59 as judged by the Arthur Point Scale given her at the Clinic. She was attending second grade at the time. She was classified as a high grade mental defective. The psychologist reported that the child was shy, quiet, cooperative and generally dull.

The adjustment of this child is shown in the following table.
### TABLE X

**ADJUSTMENT OF THE PATIENT**

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>Non Given</th>
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<td>Sex Problems</td>
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<td>Learning Defects</td>
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<td>Personality Difficulties</td>
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<td>Somatic Dysfunction</td>
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X<sup>a</sup>—The child continued to be a feeding problem and had difficulty sleeping at night.

X<sup>b</sup>—The child's emesis had stopped temporarily.

The patient's adjustment had not progressed too successfully, for the Behavior Problems had remained predominantly the same, with the exception of the slight improvement in Somatic Dysfunction, and a worse condition developing in Socially Unacceptable Acts. The interpersonal relationships of the child have also remained the same, and these had been rather disturbed relationships at both interviews. The psychiatrist reported a slight improvement in the child and also felt that she was more of an
immature type of person rather than a psychotic mental deficient. In the light of the above table, it would seem that the child's condition had remained the same with a few exceptions of improvement shown in the areas followed-up.

The mother and daughter were seen at the Clinic for the follow-up interview, in August of 1952, almost three years after the first interview. Lee was then thirteen years old. They arrived for the interview almost three hours late. The mother thought that the child's symptoms began about the age of two years, but the mother did not know what might have prompted the girl's behavior.

The information on the diagnostic level was secured from the mother in an interview. No other reports were used.

<table>
<thead>
<tr>
<th>Behavior Problems</th>
<th>First Admission</th>
<th>Follow Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Socially Unacceptable Acts</td>
<td>Nothing was reported in the record.</td>
<td>Lee was caught stealing money from her mother's purse. She told lies to mother. She destroyed many things including clothes. She tore them in half.</td>
</tr>
<tr>
<td>Learning Defects</td>
<td>The child was retarded.</td>
<td>She was still retarded. She wasn't able to concentrate in school. She was in an ungraded room.</td>
</tr>
<tr>
<td>Personality Difficulties</td>
<td>The child was nervous and shook all over when frightened. She was restless, excitable and daydreamed quite often. She was also shy and withdrawn.</td>
<td>The child continued to be nervous, restless, and excitable. She was frightened of ears. She often sat and talked and laughed to herself as if someone were with her. The mother felt the child was too submissive and might be sexually attacked some day.</td>
</tr>
</tbody>
</table>
BEHAVIOR PROBLEMS

FIRST ADMISSION

Somatic Dysfunction

She always had digestive trouble and had been fussy about her food. The patient had regressed and wet the bed occasionally.

Lee had trouble sleeping at night. She slept with her sister and often awakened her with her laughing or tossing of her head on the pillow. Lee said she laughed at the shadows on the wall. She never laughed during the day time but only at night.

The mother also felt that the child was uncoordinated. She thought Lee's arms were too soft and weak.

FOLLOW-UP

Somatic Dysfunction

This condition had remained the same and she had lost weight as a result of it. She stopped wetting the bed because mother made her get up and change the bed but not her pajamas. She has continued to wake up at night and laugh and talk to herself. She cried trembled and rolled around the bed.

INTERNATIONAL RELATIONSHIPS

To Mother

Lee clung to her mother constantly.

Lee had always gotten along fine with the mother. She followed mother around and always wanted to be with her.

To Sibling

When the sister was a baby, Lee was afraid of her, but now that she has grown up Lee likes her.

To Sibling

The sister takes care of Lee. Mother told Lee one day, "If I were you, I would be ashamed to have my baby sister take care of me."
INTERPERSONAL RELATIONSHIPS

FIRST ADMISSION
To Other Children

She was withdrawn from other children who teased her. She cried easily and refused to defend herself. If the games were rough she would not play.

PSYCHIATRIC INTERVIEW

FIRST ADMISSION
Appearance

She was a tall, slim, but well developed negro girl who appeared roughly as old as her stated age of ten years.

Behavior

She was sitting next to mother in the reception room, but when the mother gave her the signal she came readily with me. She kept looking at me intermittently throughout the interview. She took out all the items in the box and examined each one thoroughly. There was nothing too significant about her play, except that she played with the sister doll predominantly and later with the father. Her entire behavior was shy, bashful, withdrawn. Her mannerism involved many stereotyped movements of her body and limbs while walking up and down. Much of it seemed unconnected and uncoordinated. She looked at the transom and appeared to be autistically involved. It was my impression that the girl was dull.

FOLLOW-UP
To Other Children

She seldom played with the children and if she did they were usually younger than she. She seemed to get along better with males than females.

FOLLOW-UP
Appearance

She was quite a tall girl for her age, with a significant moon shaped appearance of the face, along with a rather flattened nose. A profile view of her presented a rather attractive girl but her head on facial appearance was rather disconcerting. She was thin and had long limbs.

Behavior

Through out the interview the patient was a smiling, shy, wiggling gingly girl who most of the times throughout the interview would respond, yes sir, no sir, and at other times would go into great details as when she related the friendship between herself and Roger. Speech was relevant, coherent, and spontaneous only when she spoke of him, and that was in terms of how much she loved him and loved to kiss him. She said she was not as fearful as she had been the last time. There was not any evidence of hallucination or delusion, but she was quite fearful. Her affect was minimal and shown in a shy bashful way.
PSYCHIATRIC INTERVIEW

FIRST ADMISSION

Relationship
She was shy and withdrawn.

Prognosis
The child's condition would probably not improve very much.

Diagnosis
In view of the possibility of syphilis in a negro woman of this socio-economic level and in view of the doubtful ophthalmologic findings the possibility of Juvenile Paralysis has to be entertained. Whether the bizarre psychotic type evidence and the apparently mental deficiency are results of this, remains to be seen.

Recommendations
The child should be referred to the neurology clinic for further neurological ophthalmology, and syphilology evaluation. If organic disease is found treatment could be received through us or an institution.

The recommendations given at the diagnostic level by the psychiatrist were not followed through by the mother. She felt that the child had not improved since she was first seen at the Clinic and was considering the possibility of placing the child. The mother was not spontaneous in the giving of information and as a result it was difficult to receive any adequate answers from her.

FOLLOW UP

Relationship
She formed an immature childish relationship as evidenced by her nervous shy, timid way of responding.

Prognosis
It was considered poor, unless she received some treatment.

Diagnosis
The child was more of an immature person emotionally rather than a psychotic mental deficient.
CASE VIII

Donald, aged ten years ten months, was referred by a neighbor to the Institute for Juvenile Research in April of 1951. He was the oldest boy and had two other brothers.

The patient's parents were both Jewish and of Polish descent. The father was a jeweler and had a good income. Following the marriage of the parents they lived with the maternal grandfather, who was quite a domineering person and interfered with mother's handling of the child. They had lived in a congested area and mother kept the boy occupied at home with little contact made outside the home, because she feared he might be killed. The mother came to the clinic because she had been hearing complaints from school about him, and she couldn't understand what had happened to the child. As a boy of two years he could read and write English and Hebrew and could figure out dates. Between the ages of two and three he read the medical books in the doctor's office. At the age of four, the mother bought the patient an encyclopedia set and at four and a half he knew all the main streets in Chicago. His main occupations at the time were reading, writing, and typing. The patient thought kindergarten was a foolish experience because the child did nothing there but play with toys, and patient had never played with a toy in his life. Now he was not interested in school and wouldn't read at all.

When the psychiatrist saw the mother, he described her as a rather rigid, fairly dominating person who had a great deal of insecurity in her own childhood. She had no insight into her own relationship with the patient's problems. The father was described as a rigid man who was much
warmer than the mother but did not care to become involved in the boy's problems. He was a more passive type of individual with an ulcer condition.

The boy's I. Q. was 113 as judged by the Stanford Binet Form L test, which gave him a high average classification. He was in 6A at the time of the first admission. There was much discord in his responses for the mature responses appeared in the same context as the immature responses. A Rorschach was also administered to the boy. The psychologist reported that it gave him a diagnosis of latent schizophrenia with a poor prognosis. The thought disorders and the largely unsocialized unsublimated affect of schizophrenia was present. Insight was totally lacking and the boy was living in a world of ego centric narcissism. His compulsive, intellectual, defenses served to hide his anxiety and gave him some semblance of morality.

The adjustment of the child will be shown in the following table:
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</table>

The patient's symptoms remained about the same, with a few exceptions noted. The Personality Difficulties became more pronounced and a slight improvement had occurred in the sexual problems. The type of adjustment made by the patient was based upon the statements made by the father at the follow-up interview.

The parents did not feel that it was necessary to come to the clinic for the psychiatric interview because they knew the child has not improved and at that time were trying to have the Jewish Charity Bureau place him. Therefore, a home visit was made in July of 1968, one year and three months after the first admission. Donald was twelve years and one month old. The father was not aware of the age of onset of the symptoms, however, he felt that the boy's intelligence had been exploited when he was very young because mother made him perform in front of her friends. The father was a quiet type of person who seemed quite anxious about the
boy's condition. Although the father believed that the boy's behavior had remained the same, he commented on the boy's ability to carry on a good intelligent conversation with adults. He realized the boy was unhappy. Throughout the interview, Donald came into the room and eyed the writer suspiciously and inquired as to her identity and purpose of the visit. Each time the father would tell him to go outside, but the boy would reappear every few minutes.

The material for the first admission was secured from the mother in an interview. The follow-up interview was with the father.

**BEHAVIOR PROBLEMS**

**FIRST ADMISSION**

**Socially Unacceptable Acts**

He usually threw a temper tantrum if he did not get his way.

**Sex Problems**

Whenever, he "makes dirty", he was very thrilled and said ah-ah. He also touched his behind and liked to touch his brother there. He said to them, "I would just love to take all your bandles and smell it." The mother did not think he acted sexy because he was very modest about himself and covered up when the mother was around. He would not undress in front of his parents or siblings but removed his shorts rapidly and jumped into the bath tub. The mother still bathed him and while doing this he would remark that his penis was pumped (erect). The boy has jumped into the bed of one of his brothers and said something about pumping the penis, also.

**FOLLOW UP**

**Socially Unacceptable Acts**

He continued to throw temper tantrums.

**Sex Problems**

He had improved a little in this area because he no longer seemed preoccupied with his bowel movements as he had been before. He also has started to take showers and baths by himself now.
FIRST ADMISSION

Learning Defects
He was doing poorly in his school work although he was capable of doing much better. He was inattentive, oversensitive, overly serious or sad, and daydreamed in classes. (Taken from the school report.)

Personality Difficulties
The patient seemed lonely and unhappy. He was withdrawn and wouldn't answer questions in school. He smelled his food and stuck it up his nose. He has had sneezing spells and this would cause him to tear at his hair. There were times when he seemed to be in another world, especially when he became angry and tore his hair. "He is just not in his right mind at those times and has a lot of hate inside." The Patient was a poor sport for if he lost a game he would be angry and screamed.

Somatic Dysfunction
He was allergic to various things.

FOLLOW UP

Learning Defects
He was still doing poorly in school. He did not show any initiative in his work at all. However, if he does do something he wants it done perfectly. If Donald became preoccupied with some insignificant thing in school, he would work on it until it was perfect, and in the meantime would fail to listen to his teacher.

Personality Difficulties
The father felt that the patient had not progressed at all. He was still showing strange behavior and recently began to place his head down while riding on a bus. They brought him to the doctor to find out why he had done this and he thought it was because the boy had dizzy spells. The smelling of his food had subsided a little but he continued to tear at his hair. The boy was extremely restless and always asked, "What shall I do?" However, if anyone suggested something for him to do he would refuse to do it. He still hollered around the house whenever he was told he couldn't do something he wanted to do.

Although he has dressed himself for some time his appearance is unkempt. His behavior had become worse in many instances for now Donald locked himself in the bathroom and won't let any one in. He has slashed his fingers with a razor blade while in this mood. The boy had no confidence in himself and felt he was no good. He remarked that no one loved him.

Somatic Dysfunction
This allergy was still present.
**INTERPERSONAL RELATIONSHIPS**

**FIRST ADMISSION**

<table>
<thead>
<tr>
<th>To Mother</th>
<th>To Father</th>
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</thead>
<tbody>
<tr>
<td>Donald frequently hit his mother but many times it was the mother's fault because she forced him to do things such as eating faster.</td>
<td>There was nothing recorded concerning their relationship.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To Siblings</th>
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</thead>
<tbody>
<tr>
<td>The mother said that the patient had been terribly jealous of the second child. She had given him almost her complete attention until he was about four years of age, and he resented anything the mother did for the baby. She dared not leave the two boys alone as she was afraid Donald would hit him or try to do him harm. His attitude changed completely in relation to the second baby, for he seemed to love this little boy and liked to take care of him but he always wished he was an only child. The two brothers stick together but seldom played with Donald.</td>
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</table>

<table>
<thead>
<tr>
<th>To Other Children</th>
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</thead>
<tbody>
<tr>
<td>The child was not allowed to play with other children until he was about six. He has made no effort to play with children and snapped at them when they came around. He asked the mother, &quot;why do you want me to have friends?&quot; He hated girls and felt the only advantage in being one was that &quot;You don't have to marry one.&quot; The smaller children in the neighborhood have accepted him but no other children will have anything to do with him.</td>
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</tbody>
</table>

**FOLLOW UP**

<table>
<thead>
<tr>
<th>To Mother</th>
<th>To Father</th>
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</thead>
<tbody>
<tr>
<td>The boy was resentful of the mother because she was too strict and was always &quot;showing off her son&quot; when he was little.</td>
<td>The father felt that the child had always gotten along better with him than with the mother, although he had been disobedient to both of them.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>To Siblings</th>
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</thead>
<tbody>
<tr>
<td>He did not get along with his brothers at all. He fought with them constantly and usually they did not want to play with him. Father tried to encourage the middle child to play with Donald and go to miniature golf with him, but he didn't do it with a happy feeling.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To Other Children</th>
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</thead>
<tbody>
<tr>
<td>The boy still did not play with the other children. There was always a battle when he did, because he wanted everything his own way. The children thought he was crazy or dumb. There was much screaming and yelling while the writer was in the home.</td>
</tr>
</tbody>
</table>
Appearance:
He was a mostly dressed attractive boy of esthenic build and under-sized for his age.

Behavior:
He played with the toys in the box. After the psychiatrist opened the window, he immediately closed it. During the interview, questions had to be frequently repeated, the patient was paying no attention, seemingly absorbed in his own thought. On occasions he would lean back in his chair, audibly hyperventilate a few times and let out a little yell. He told me he was just bored. On one occasion he rested his forehead on the table, looked down at the floor and then smeared a piece of green modeling clay on the table. On occasions he would just walk aimlessly around the room.

Relationship:
Instead of relating to me he "played" with me.

Prognosis:
It was considered poor.

Diagnosis:
The boy was in contact, so perhaps he can be helped. The patient was indifferent, supercilious, self sufficient, highly ego centric, and bored. He was entirely wrapped up in his own thoughts and phantasies. He was quite asocial, had no desire to become friendly with any children. His behavior was immature, infantile, bizarre at times. He was quite schizoid, if not definately schizophrenic and was in need of treatment.

Recommendations:
Refer the child to the Institute for Psychoanalysis or to the Jewish Charity Bureau.

The child was not accepted by the Institute for Psychoanalysis for treatment, but the parents have attempted to have the child placed through the Jewish Charity Bureau. Since no definite plans were forthcoming from the agency, the parents made arrangements to send the child
to a day camp. A neighbor, who supervised the group, drove the children into camp in the morning and returned with them in the evening.

The difficulties that arose as a result of trying to place this child was responsible for the origin of this follow-up study.

CASE IX

Lana, aged eleven years ten months, was referred by the parents to the Institute for Juvenile Research on August of 1950.

The patient's parents were both Jewish and of Hungarian descent. The father was a maintenance machinist. The economic status was unknown. Lana was the middle child with one brother and one sister. The home situation was a disturbed one since the mother and the father both admitted that the child had been neglected during her childhood, not having had the proper foods nor the normal amount of attention and love. Father was not a tolerant or understanding type of person and the psychiatrist felt that the mother was a paranoid schizophrenic who had rejected her child and was in need of institutionalization.

A Wechsler Intelligence Scale for Children was given to Lana but her I.Q. was unclassifiable, because her answers were irrelevant and her attention span was minimal. The child was not attending school at the time of the first admission.

The adjustment of the child will be shown in the following table.
TABLE XII

ADJUSTMENT OF THE PATIENT

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>None Given</th>
<th>Same</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavior Problems</strong></td>
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</tr>
<tr>
<td>Socially Unacceptable Acts</td>
<td>X</td>
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<tr>
<td>Sex Problems</td>
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<tr>
<td>Learning Defects</td>
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<tr>
<td>Personality Difficulties</td>
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<tr>
<td>Somatic Dysfunction</td>
<td>X</td>
<td>Xa</td>
<td></td>
<td>X</td>
<td>Xc</td>
</tr>
<tr>
<td><strong>Interpersonal Relationships</strong></td>
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<tr>
<td>To Mother</td>
<td>X</td>
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<tr>
<td>To Father</td>
<td>X</td>
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<tr>
<td>To Siblings</td>
<td>X</td>
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<tr>
<td>To Other Children</td>
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</tbody>
</table>

Xa—The speech defect continued to exist.  
Xb—The convulsions had temporarily subsided.  
Xc—The enuresis had become worse.

The patient's adjustment in the Behavior Problems seemed to have become worse, with the exception of the remarkable improvement occurring in the Socially Unacceptable Acts, and the slight improvement in Somatic Dysfunction. There were three areas checked under Somatic Dysfunction because part of the problems remained same, another was slightly improved yet another worse as was explained above. No change was evident in the interpersonal relationships.

The follow up interview with the mother occurred in July of 1952, one year and eleven months after the first admission. Lana was then thirteen years nine months old. The mother felt that the marital
difficulties, starvation diets and the latter's affection on her pregnancy
might have contributed to the child's condition.

The following report illustrates the problems and the inter-
personal relationships of the girl as discussed by the mother at the
first admission and also at the follow up with the writer. The latter
part of the report will include the psychiatric interview at the diagnostic
level. No follow up was done by a psychiatrist because the child had been
placed in an institution.

BEHAVIOR PROBLEMS

FIRST ADMISSION

Socially Unacceptable Acts
She tried to cut herself with a razor
several times.
She was destructive and tore up
clothing.
She had severe temper tantrums.

Learning Defects
The patient was bright and keen
about many things, although she
was in an ungraded room. One
day the teacher "picked" on the
child and then Lana began to write
backwards.

Personality Difficulties
The child talked to herself and often
said, "Lana, you're going crazy."
She was terrified of wearing dresses
with snug collars.
She sat for a long time and had a
"trick" of sitting there like a
defective and daydream.

FOLLOW UP

Socially Unacceptable Acts
Mother did not know if she had
attempted anything like that in the
Institution.
The destruction stopped after she had
been in the institution for awhile.
The temper tantrums have subsided.

Learning Defects
The child was worse because she had
forgotten everything she knew. She
had the look of an "institution"
about her, that is stupid.

Personality Difficulties
She hardly spoke at all and seemed
to be in a world of her own.
No information was available on this.
The child continued to daydream but
now it was a constant occurrence and
seemed to be much worse.
FIRST ADMISSION

**Somatic Dysfunction**

The patient began menstruating when she was born and she also had convulsions and bit her tongue and moaned like an animal. She was emaciated. She had a speech defect and sucked her thumb.

---

FOLLOW UP

**Somatic Dysfunction**

The child did not have convulsions while in the institution. However, her health did not seem to be good for she was much thinner now. The enuresis has become worse. The speech defect was still noticeable but mother was uncertain as to whether the child still sucked her thumb.

---

**INTERPERSONAL RELATIONSHIPS**

**To Mother**

The child had a grudge against her because she didn't take care of her during her childhood.

**To Father**

She had never been close to him.

**To Siblings**

She did not get along with her sister. They fought constantly.

**To Other Children**

She was a social failure because she didn't know how to play with other children and they wouldn't play with her.

---

**To Mother**

The child seemed to maintain the same attitude toward the mother.

**To Father**

She had a fear of men and this seemed to carry over to her father.

**To Siblings**

She had a deep resentment toward the sister but adored her little brother.

**To Other Children**

The mother did not know how Lena reacted to the children in the institution but she did not think she played with them.

---

**PSYCHIATRIC INTERVIEW AT DIAGNOSTIC LEVEL**

**Appearance:**

The patient looked exactly like a chronic schizophrenic at a state hospital. Her hair was disheveled, she was wild-eyed, tended to pass into a reverie when her attention was not held. She was in contact,
answered relevantly and coherently for the most part. When observed
by herself in the sitting room, she appeared to be a mute catatonic.

PSYCHIATRIC REPORT AT DIAGNOSTIC LEVEL

Behavior:

She complained that her main difficulty was that they ignored her and
kissed her brother. She would like to leave home and go to school.
All day long she thinks of "composition, records, speed, and music."
She sat there picking her nose and her fingers and exhibited many
strange mannerisms. She appeared to be hallucinating and said that
she had been hearing voices for three years. She dreams about her-
self at night. Two things frightened her and that was her mother and
the men wrestling on television. It was her mother's fault that she
was ill, the child said several times.

Relationship:

The child did not relate to the psychiatrist because of her rather
bizarre behavior.

Prognosis:

There was a remote possibility that physical therapy coupled with a
change of environment might permit a remission.

Diagnosis:

This schizophrenic mother rejected the patient and deprived her of the
gratification of every necessary impulse and destroyed her child. The
patient was definitely psychotic and in appearance, manner, and mental
content was like the regressed, disintegrated schizophrenic of the
chronic wards of the state hospital, whether she was mentally defective
or whether her retardation was due to lack of training was
difficult to determine.

Recommendations:

She should go to a state hospital rather than Dixon or Lincoln as
there was still a remote possibility of remission.

The mother felt that the child's behavior had become worse since
being institutionalized, but she said she realized that there was a lack
of personnel and a "Lot of strange people in the hospital." As
recommended by the psychiatrist, Lena was admitted to Elgin in 1950 and
remained there for six months. The mother removed her because the hospital refused to give the shock treatment because of her epilepsy. In 1951, the mother had Lena admitted to Dixon and she has remained there up to the present time. The mother expressed guilt feelings over her treatment of the child and realized how much influence the home situation had on the child when she returned for a visit and had a recurrence of her convulsions. The convulsions had completely subsided in the institution but returned each time that the child came home.

Case X

Robin, aged twelve years, was referred by the Chicago Care Society to the Institute for Juvenile Research in October of 1960, for the purpose of evaluating his adjustment and making plans for his future.

The patient's parents were Lutheran and of German descent. The father was an irresponsible alcoholic who could not hold a job or support a family. The parents separated when the mother was three months pregnant with Robin. She tried to have an abortion several times with no success. She was as rejecting of the child before birth as after birth. She went to work when the child was ten weeks old, leaving him with the fourteen year old sister. In 1942, the Institute for Juvenile Research had recommended institutionalization with plans for foster home. In 1943, guardianship of the child was awarded to the Juvenile Court and that same day he was placed in the Chicago Nursery and Half Orphan Asylum where he remained until 1951. The boy was the youngest of four children. The family was receiving financial assistance.
The boy's I.Q. was 85 as judged by the Grace Arthur Non Verbal test. He was classified as dull. He was in the fifth grade at the time. The psychologist reported that the child showed lack of affect, extreme withdrawal and mutism.

The adjustment of this child is shown in the following table:

**TABLE XIII**

**ADJUSTMENT OF THE PATIENT**

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>None</th>
<th>Given</th>
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<tr>
<td>Socially Unacceptable Acts</td>
<td>X</td>
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<tr>
<td>Sex Problems</td>
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<tr>
<td>Learning Defects</td>
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<tr>
<td>Personality Difficulties</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Somatic Dysfunction</td>
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<tr>
<td><strong>Interpersonal Relationships</strong></td>
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<tr>
<td>To Mother</td>
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<td>X</td>
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<tr>
<td>To Siblings</td>
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<td>X</td>
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<td>To Other Children</td>
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<tr>
<td><strong>Psychiatric Interview</strong></td>
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<tr>
<td>Appearance</td>
<td>X</td>
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<tr>
<td>Behavior</td>
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<td>X</td>
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<tr>
<td>Relationship</td>
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<td>X</td>
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<tr>
<td>Prognosis</td>
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<td>X</td>
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<tr>
<td>Diagnosis</td>
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</table>

It would seem that the child had shown improvement not only in the Behavior Problems but also in the interpersonal relationships. No improvement was noted in the Socially Unacceptable Acts. Two categories were checked under Personality Difficulties because part of the problems had remained the same while another problem was completely
alleviated. However, the psychiatrist felt that the child had become worse and that was the reason this case was included in this chapter. There was a marked discrepancy between the mother's report of the boy's progress and the psychiatric report.

The mother and the child were seen at the clinic for the follow-up interview in September of 1952, almost two years after the first admission. The boy was then thirteen years ten months old. A psychiatric appointment for the boy had already been scheduled by a staff member, so the writer had the opportunity to interview the mother. She thought that the boy had improved "one hundred percent" and he hadn't done anything really bad for quite some time. She felt that his problems had begun at the age of three years, but was unaware of her own involvement in his problems.

The material for the first admission was secured from a report by the Chicago Nursery & Half Orphan Asylum.

---

**BEHAVIOR PROBLEMS**

**FIRST ADMISSION**

**Socially Unacceptable Acts**

- He recently piled branches and leaves against a car and then set them afire. He set a fire in the mother's basement and also in the worker's car. It usually occurred when the boy was upset.
- He enjoyed being cruel to animals. He pulled bees apart and beat the dogs.

---

**FOLLOW-UP**

**Socially Unacceptable Acts**

- The mother doesn't believe that the boy built any fires outside, but still watched him carefully inside the home. He spit upon the grill when the mother lighted it and carried a lighted string around the house. He hasn't set any fires yet. He was extremely mean to animals. He put a string around a pigeon's neck and kept pulling it until it died. He placed a dog in a cage and threw rocks at it.
BEHAVIOR PROBLEMS

FIRST ADMISSION

Socially Unacceptable Acts
The boy had terrible temper tantrums. When he visited the mother, he would throw dishes, pans, knives, and food at her and the children. He used obscene language and called one of the workers a bitch.

Sex Problems
The boy masturbated.

Learning Defects
The boy was dull.

Personality Difficulties
He had a lot of outward expression of hostility. The boy has thrown excreta and urine from the pots kept under the beds for use at night over the children themselves.
He had nightmares when visiting home during which he would scream and cry "Don't lock me in, don't hit me." When awakened he never knew what was the matter but kept crying and sobbing with his knees drawn up to his chest in a ball.

Somatic Dysfunction
There were times when he was almost mute, and he would speak in incomplete sentences or stammered when he was upset. He revealed moods and feelings by facial expression. He occasionally soiled and was enuretic while in bed or if he was upset he tried to urinate on people.

FOLLOW UP

Socially Unacceptable Acts
No information was available on this.

Sex Problems
The boy has stopped masturbating although, there were a few recurrences of it.

Learning Defects
The mother thought he was either in sixth or seventh grade and he was doing fine. He received good grades.

Personality Difficulties
He never illustrated this type of behavior at home.

Somatic Dysfunction
He was unable to speak in sentences now.

He has stopped wetting and soiling.
INTERPERSONAL RELATIONSHIPS

FIRST ADMISSION

To Mother
His relationship was not a good one to the mother. His behavior became worse everytime he came home.

To Siblings
He and his brother never got along with each other. He liked his sister.

To Other Children
He was cruel and sadistic toward the other children, being delighted when he stoned them and heard them cry or when they were stung by bees, which brought and let loose in the school room.

FOLLOW UP

To Mother
They got along fairly well, the mother said. He has called her names and has disobeyed her occasionally but nothing serious.

To Siblings
He and his brother now get along fine. The oldest brother takes him all over Chicago to show him things.

To Other Children
He stopped fighting with children. He played with children yougar than he, preferably around seven or eight.

PSYCHIATRIC INTERVIEW

FIRST ADMISSION

Appearance
Robin was a small, very thin bespectacled boy.

Behavior
While in the waiting room he spoke to no one and gazed apathetically at the floor, but responded docilely to an invitation to come to the playroom. On entering the room he stopped suddenly and remained immobile and expressionless until someone several times to look about and see if anything interested him. He sat down, maintained a

FOLLOW UP

Appearance
He was a thin gaunt boy who appeared to be preoccupied and curious with a mask like expression. He was neatly though not well dressed.

Behavior
He promptly accepted my introduction and came with me quickly. He exchanged a few words with me on the way to the interview room but these were the last words he spoke to me. There was no spontaneous production at all and he said quietly in the chair looking into space and appeared as if he did not hear me. I had to resort to direct questioning.
PSYCHIATRIC INTERVIEW

FIRST ADMISSION

Behavior

straight, rigid posture and looking
at the floor or out of the window.
His facial expression was a mixture
of apathy, withdrawal, and
resentment. He was totally
uncommunicative and negativistic.
He ignored or failed to respond
to most questions. He rebuffed
the examiner’s friendly overtures.
He did not give any gross evidence
of hallucinatory or delusional
preoccupation, but his withdrawn
and inhibited behavior would make
it difficult to detect such
phenomena. He lived in a phantasy
world.

Relationship

He was not able to relate to him
at all.

Prognosis

It was considered poor by the
psychiatrist.

Diagnosis

The severe isolation, pervasive
fear of adults, negativism and
impulsive aggressive behavior toward
others shows a disturbance of
psychotic proportions in this boy who
was rejected by the mother.

Recommendations

A residential treatment center
such as Dr. Bettleheim
Orthogenic School might help
this boy, but only after many
years, or early transfer to a
custodial institution.

FOLLOW UP

Behavior

did respond monosyllabically and did
so only after my almost demanding
an answer. I detected no affect at
all except when I took him into the
playroom when he appeared to be a
little frightened. I finally
learned from him that he was
attending Montefiore School which he
said was a school for bad boys.

Relationship

There was absolutely no relationship
established between us.

Prognosis

It was still considered very poor.

Diagnosis

The patient was a psychotic child with
no ego organization and was subject
to a wild blow up at any time which
might be dangerous to those in his
environment. He has not improved
at all.

Recommendations

I am going to recommend commitment
for the boy.
Although, the recommendation at the first admission was to send the child to a treatment center, this was not carried through for he wanted to live with his mother in May of 1951 and has remained there since that time.

It was interesting to note the discrepancy between the mother's report of the boy's improvement and the psychiatrist's report that the boy had not only shown no improvement but could be considered a potential danger to anyone around him. The mother had rejected the child since he was born, and during the past year her treatment of him seemed punitive rather than one of encouragement or love. He had never known a parent's love or attention. The mother was unwilling to admit the very disturbed condition of her son, and following the interview with her, the writer had the impression that the child was doing very well. However, after speaking with the psychiatrist, the writer was made aware of the mother's inability to face her child's psychosis. This type of mother was described by Lauretta Bender in her article on schizophrenic children. She said, "the mother bears an intolerable burden of anxiety and guilt and is more bewildered than the child. She will try every mechanism for denying, evading, displacing, or absolving the child's psychosis."

CASE XI

Jerry, aged seventeen years six months, was brought to the clinic

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1 Bender, "Childhood Schizophrenia", American Journal of Orthopsychiatry, XVII, 50.
by the parents in July of 1949, because they wanted an evaluation done of the boy to determine his progress.

The patient's parents were of Swedish descent and they received an adequate income since both of the parents were working. He was an only child. The father was not a particularly successful business man and this was a great disappointment for him because his family had been wealthy at one time. On the other hand, the mother was a successful social worker and was executive director of a large fund in Chicago. During Jerry's babyhood, he was cared for by a rigid nurse and had little contact with either of his parents. The boy was brought to the Institute for Juvenile Research for the first time in 1936 because of his seclusiveness, failure to adjust, sleep disturbances and his kicking and biting. He was later seen in 1938 and the mother had contact with the agency periodically throughout the years and later was seen in 1949. The interview in 1949 was important because that was the first time the child had been diagnosed as psychotic. The child has been in and out of several different schools, but was removed because they were not equipped to handle his type of problem. The child was placed in Vineland Training School for Boys in May of 1946 and remained there until November of 1946. The mother felt that they had not been sufficiently interested in him and that was why he had not progressed too well. He was enrolled in Manor School for Boys in November of 1946 and has remained there to this time. Every summer he was allowed to come home for five weeks and that was how the child was able to see at the clinic for the follow up interview.

Following the psychiatric interview with the mother in 1949, the psychiatrist reported that the mother had pure hostility toward the boy.
The father, on the other hand, was unable to face the problem and still spoke of his son as, "my son is doing well in military school." He refused to recognize the boy's disturbance and made certain demands upon the boy, knowing that he couldn't possibly perform them.

The boy's I.Q. was 51 as judged by a test given to Jerry by the Board of Education in 1944. There was no report of a more recent test given to him. The Institute did not administer a psychological because the boy was out of contact, was incoherent in his thoughts and speech and he was hallucinating.

The adjustment of this child is shown in the following table:

**TABLE XIV**

**ADJUSTMENT OF THE PATIENT**

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>None Given</th>
<th>Same</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavior Problems</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Socially Unacceptable Acts</td>
<td>X</td>
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<td></td>
<td>X</td>
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<tr>
<td>Sex Problems</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Learning Defects</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>Personality Difficulties</td>
<td>X</td>
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<td></td>
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<tr>
<td>Somatic Dysfunction</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td><strong>Interpersonal Relationships</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>To Mother</td>
<td>X</td>
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<tr>
<td>To Father</td>
<td>X</td>
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<tr>
<td>To Other Children</td>
<td>X</td>
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<tr>
<td><strong>Psychiatric Report</strong></td>
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<tr>
<td>Appearance</td>
<td>X</td>
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<tr>
<td>Behavior</td>
<td>X</td>
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<tr>
<td>Relationship</td>
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<tr>
<td>Prognosis</td>
<td>X</td>
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<td></td>
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<tr>
<td>Diagnosis</td>
<td>X</td>
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</tbody>
</table>
The patient's symptoms seemed to have remained about the same. There was a slight improvement noted in the Socially Unacceptable Acts and a worse condition was found in the Sex Problems. The psychiatrist felt that the boy had shown no improvement at all and in some instances might have become worse.

The mother and the son were seen at the clinic for the follow-up interviews in August of 1952, three years and one month since their previous interview. Jerry was then twenty years seven months old. The age of the onset of symptoms was thought to be between the ages of three and four. The mother felt that it was the result of high fever that the child had when he was that age. The mother felt that in general the child had not shown any noticeable improvement. Although, she felt that the child was completely competent from the standpoint of safety. He knew what he was capable of doing, and did just that and no more. When he went to Riverview he knew exactly what rides were good for him and what rides would make him sick. He was very helpful to the mother around the house because he was capable of mowing the lawn, raking the leaves, washing the dishes and making the beds. While he was at school, they gave him the responsibility of setting the dining tables and cleaning them. He seemed to be cooperative in his work. The mother felt that he was a perfectionist at whatever he was capable of doing, which of course, was limited.

The following report illustrates the behavior problems and the interpersonal relationships of Jerry as it was discussed by the mother at the time of the previous interview. Part of the information was also taken from a Vineland School Report concerning the child. The follow-up interview was also with the mother. The latter part of the report will
include the psychiatric interview at the diagnostic level and also at
the follow up interview.

**Behavior Problems**

**First Admission**

**Socially Unacceptable Acts**

He was a pleasant boy to work with, and yet he was not obedient nor
was he cooperative only as he felt
inclined to be. He was not stubborn
and at times was suggestible for
short periods of time.

**Sex Problems**

The mother was concerned about his
masturbating. She found him with an
errection and then he rolled over on
his tummy. She wondered if he should
be sterilized.

**Learning Defects**

The boy was mentally retarded. The
mother felt that he did not show
any interest in academic schooling
but could read first, second and
some third grade reading, memorize
the spelling of ten new simple
words a night. He was able to
travel street cars and transferred
on busy intersections without
difficulty. He was orderly and
abnormally observant and retained
his memory of places and persons.
His span of attention was very
limited. He would not be able to
reason out even simple situations
for himself.

**Follow Up**

**Socially Unacceptable Acts**

The mother said that the boy was
extremely obedient, and cooperative.
There were a few times when he might
not do something but these were few
and far between.

**Sex Problems**

The boy continued to masturbate.
He seemed to be more interested in
the difference in sexes. When he
came with the mother to the clinic
he kept going into the woman's
bathroom and someone had to go in
after him. He said continually,
"I won't peek".

**Learning Defects**

The boy continued to be mentally
retarded. He had a tremendous
memory and never forgot anything.
BEHAVIOR PROBLEMS

FIRST ADMISSION

Personality Difficulties

He day dreamed quite a bit and found a lack of satisfaction therein and therefore does not hear anyone. He scattered whenever possible. He had no speech impediment but spoke rapidly and always on subject which were important to him alone. If he were asked a question he might reply with something absolutely foreign to the subject under consideration. He speaks distinctly.

Somatic Dysfunction

There was nothing recorded in the record.

To Mother

There was nothing recorded in the record.

To Father

The father was somewhat afraid of him because he was much bigger than his father. However, they seemed to get along alright.

To Other Young People

Although he was extremely sociable he did not associate with any one individual because no one was sufficiently like him to appreciate and accept his differences. His play was entirely individualistic.

FOLLOW-UP

Personality Difficulties

He continued to daydream and talked to himself constantly. The boy had no inhibitions for he would go up to a person and say, "I like you," when he never said them before. He would stop people on the street and ask them all sorts of questions. It was difficult to get him to conform while they were out in public. When he hears loud noises he puts his hands over his ears.

Somatic Dysfunction

The child was hyperactive but mother said that he has been this way all the time.

To Mother

The boy has always had a good relationship with the mother.

To Father

The child has an excellent relationship with the father. However, father has never been able to introduce him to his friends.

To Other Young People

He was not accepted socially. He was ego centric. He didn't participate in any sports but always remained alone.
PSYCHIATRIC INTERVIEW

FIRST ADMISSION

Appearance
He was a tall, blond, blue-eyed youth who was somewhat uneasy.

Behavior
He was roaming around the room and after a floppy hand shake came willingly to the interview room. From that point on he was completely scattered, autistic, ruminative and displayed much echolalic and stereotyped movements. He was thoroughly disorganized and disoriented and frequently smiled inappropriately. There was impoverishment of affect and I feel that he was hallucinating during that time. There was never any coherence or logic to his words, which were always incomplete. Most of his gestures are in the form of shivering of his shoulders and shaking of his head together with stroking of his legs. Occasionally, he would nod back and forth with his whole body.

FOLLOW-UP

Appearance
He was a tall boy now, about 6'2" with closely cropped blond hair and well developed body.

Behavior
When we got into the interviewing room he looked at the fire escape and asked, "Who jumps down the fire escape?" Most of the conversation was stereotyped and confined to an innumerable number of silly questions, about the automobiles in the next lot. "Did they take the red lights and license plates off of the cars and bring them in, or why do they have window shades over cars, or was that a blue car or a dirty car. I tried on a few occasions to break through this endless repetitive questioning about automobiles, but he usually repeated the questions and then answered in an infantile form of speech. Whenever I would look at him directly he would seem to evanesce into ethereal space. He would move away when I got close to him and was almost masturbating while with me. Occasionally, he would lapse off into humming some sort of a tune. He was silly and manneristic in behavior as well as in speech. He was preoccupied with himself. Echolalic was present but I did not see any signs of echopraxis. He expressed no affect. It was difficult to say that this type of behavior had proceeded solely from a basis of a suspect encephalitic condition at the age of three and a half. There seems through the years to be a strong emotional element present and after briefly seeing the mother this morning one wonders just
### PSYCHIATRIC INTERVIEW

#### FIRST ADMISSION

**Behavior**

How much she had contributed to the present status of her son. She was a dominating woman but did not evidence much real warmth toward the boy which was the same picture that we saw in her sixteen years ago when she first referred the boy to the clinic.

**Relationship**

At no time was any contact established with him.

**Prognosis**

It was considered poor.

**Diagnosis**

The patient was psychotic and the clinical picture was very much that of a hebephrenic schizophrenia.

#### FOLLOW-UP

**Behavior**

He did not relate to me at all.

**Relationship**

He did not relate to me at all.

**Prognosis**

The patient did not show any progress at all despite help received from several schools. It was a poor prognosis for this child.

**Diagnosis**

It was quite interesting after having reviewed the sixteen year history of this boy and his relationship with the Clinic to see the end result at the age of twenty and this boy presenting problems and symptoms of schizophrenia, probably of the hebephrenic type. He was slowly progressing toward the quite deteriorated and stage of schizophrenia a process which was never countermanded or counter acted throughout the years.

#### Recommendations

It would be best that this patient be committed to one of the state hospitals.

The boy remained at the Manor School for Boys, but the mother did not know how long they would keep him. She was reluctant to send him to a
state institution but felt that this would eventually have to be done.

The following four cases were those that were diagnosed as pre-psychotic by the psychiatrist at the diagnostic level. This type of personality was mentioned by Charles Bradley as being one of the phases preceding a psychosis. The following excerpt was taken from Bradley's book on Childhood Schizophrenia.

Presumably clear-cut childhood schizophrenia represents an extreme turning of the personality which has gradually developed through various so-called "prepsychotic" or "schizoid" phases until the clinical picture has become severe enough to be considered a psychosis. 2

CASE XII

Mark, aged eleven years eight months was referred by a medical agency to the Institute for Juvenile Research in November of 1950.

The patient's parents were Lutherans and of German descent. German was always spoken within the home. After the mother and father had been married for eight years they decided to adopt a child. Although, mother preferred to have a girl, a seven month old boy was adopted instead, and this was Mark. He was an only child and did not have contact with other children until he went to kindergarten. The father was quite close to the boy and it was a shock to the child when the father died in 1947 after slipping off a mole which caused infection. The mother remarried in 1950. The social worker felt that the mother was a rigid moralistic woman whose behavior seemed to be a reaction formation to strong feelings

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2 Bradley, W. C., Schizophrenia in Childhood, 126.
of hostility and destructive impulses. She seemed hostile to the boy. The adoptive father was kind and indulgent toward the patient but the stepfather was a more strict person.

The boy's I. Q. was 110 as judged by the Stanford Binet Form L test administered to him at the clinic. He was classified as high average. He was in the sixth grade at the time. The psychologist reported that he seemed to have an inordinate need to succeed and revealed a great deal of anxiety. A Rorschach and TAT was also given to the boy at the clinic. The psychologist reported that the boy seemed to be headed in the direction of repression, passivity, and intellectualism. The boy seemed overwhelmed by his own hostile feelings most of that aggression was directed toward mother. There was a healthy turning toward men but it could end in homosexuality. He appeared to have guilt feelings and felt inadequate to solve his own problems and was distrustful of people and the world.

The following table will illustrate the type of adjustment the patient made since being seen at the Clinic.
TABLE XV
ADJUSTMENT OF THE PATIENT

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>Home Given</th>
<th>Slight Same Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Problems</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Socially Unacceptable Acts</td>
<td>X</td>
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<td></td>
</tr>
<tr>
<td>Sex Problems</td>
<td>X</td>
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<tr>
<td>Learning Defects</td>
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<tr>
<td>Personality Difficulties</td>
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<td>X</td>
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<tr>
<td>Somatic Dysfunction</td>
<td>X</td>
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</tr>
<tr>
<td>Interpersonal Relationships</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>To Mother</td>
<td>X</td>
<td></td>
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<tr>
<td>To Stepmother</td>
<td>X</td>
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<tr>
<td>To Other Children</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>Psychiatric Interview</td>
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<tr>
<td>Appearance</td>
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<td>Behavior</td>
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<td>Relationship</td>
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</tr>
<tr>
<td>Prognosis</td>
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<td></td>
</tr>
<tr>
<td>Diagnosis</td>
<td>X</td>
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</tr>
</tbody>
</table>

The patient had made no improvement at all since the first time he was seen at the clinic. The problems under the Socially Unacceptable Acts and Personality Difficulties became more pronounced. There was no noticeable change in the disturbed type of relationships the child had toward others, and the psychiatrist reported no improvement in the boy's behavior at the time of the follow-up interview.

The mother and the boy were seen at the clinic for the follow-up interview in July of 1952, one year and eight months after the first admission. Mark was thirteen years four months old at the time. The mother felt that the boy's problems began about the age of eight years,
however, they became more pronounced following the father's death.

The material for the first admission was taken from the record following the interview with the mother.

**BEHAVIOR PROBLEMS**

<table>
<thead>
<tr>
<th>FIRST ADMISSION</th>
<th>FOLLOW UP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Socially Unacceptable Acts</strong></td>
<td><strong>Socially Unacceptable Acts</strong></td>
</tr>
<tr>
<td>He had become defiant and if he didn't</td>
<td>This condition has remained the</td>
</tr>
<tr>
<td>get his way, he would lie down on the</td>
<td>same. He was never satisfied with</td>
</tr>
<tr>
<td>floor and scream, just as he did this</td>
<td>what he had, but complained that</td>
</tr>
<tr>
<td>morning when we came down here. He was</td>
<td>he wanted the best of everything.</td>
</tr>
<tr>
<td>disobedient.</td>
<td>He continued to lie.</td>
</tr>
</tbody>
</table>

**Personality Difficulties**

The mother complained of Mark's poor behavior in public. He disturbed classes in school and in Sunday School. He was saucy to "church ladies." He won't wash, brush his teeth or comb his hair and mother had to do everything for him including giving him a bath. He shaked his head while sleeping.

The boy has become worse because he now enjoyed torturing small animals. There was no peace at home and he needed the mother constantly. He complained of having no freedom. While he is angry he grunted and clenched his fist and the mother felt they might all be murdered in their beds. "He might turn out to be another Heirons boy."
The mother has also found him talking to himself as if in a conversation.
INTERPERSONAL RELATIONSHIPS

FIRST ADMISSION

To Mother

He had been belligerent toward the mother. He also seemed to be jealous of the mother for is she talked to the dog he would torment it and the mother finally gave it away.

To Stepfather

The boy paid no attention to him. Before their marriage, the boy told him that he didn't want his name.

To Other Children

He always fought with children. If he was beaten he never cried about it. He teased them and interfered with their activities.

PSYCHIATRIC INTERVIEW

FIRST ADMISSION

Appearance

He was a tall thin boy who moved about frequently. He had a far away look in his eyes.

Behavior

He investigated the playbox and decided it was for girls. He liked to make tools and bows and arrows so they could use them to attack the kids. He told of boys way laying him on the way home from school and torturing him. He also told of a torture stake in the yard.

FOLLOW UP

To Mother

He had never shown any affection for the mother. He called her names and recently referred to her as "an old fashioned German mama."

To Stepfather

Mark did not like the stepfather and laughed at him when he got a chance.

To Other Children

He still fought with children and on several occasions the mother heard him say, "I'll kill that guy."

FOLLOW UP

Appearance

He was a tall gangly youth with a huge crop of auburn hair cut in crew style. He walked in a limping way.

Behavior

Throughout most of the interview, the boy's head and eyes were down. He occasionally looked at me slowly and showed his nervousness by the shifting of his limbs. His affect was dull and flat, coming to life only when he expressed hostility toward his parents. They maintain a
PSYCHIATRIC INTERVIEW

FIRST ADMISSION

Behavior

of one of his friends which they used in tying up a little boy and torturing him. It was difficult for the boy to express hostility toward his parents. He spoke of nightmares that he had when he was younger of prehistoric monsters chasing him.

Relationship

It was reported in the record.

Prognosis

The prognosis was considered poor.

Diagnosis

The boy was a pre-psychotic and too disorganized to be treated on an outpatient basis. He may eventually become psychotic.

Recommendations

It was decided to recommend placement in a boarding school and for his adjustment to be observed. It was considered better to have the child out of the home.

FOLLOW UP

Behavior

strict rigid control of him. Once a topic was introduced he would speak spontaneously about it but not always coherently. His reflections were infantile and sometimes directed by a strong narcissistic component, yet his language was selective. I did not feel that his expression of hostility towards his parents was more open.

Relationship

The relationship was not a warm one. He showed a dull affect.

Prognosis

The prognosis was poor unless placement could be arranged for this boy out of the home.

Diagnosis

The boy revealed flattened affect, strange associations strongly self-centered attitudes and because of this he was a pre-psychotic boy.

The recommendations of the psychiatrist were not utilized by the parents since the child remained in the home following the diagnostic interview at the clinic. Plans had already been formulated by the placement
Agency to place the child, but the mother refused to go through with it. The child had become worse since the previous interview, but the mother was unable to realize her own involvement in the boy's problems. She felt that perhaps the boy was displaying such behavior because he disliked the stepfather, and wondered why she had to suffer after she had done so much for him.

CASE XIII

Gordon, aged eleven years ten months, was referred by a social agency to the Institute for Juvenile Research in August of 1949. He was the oldest of two brothers and two sisters.

The patient's parents were Catholic and of Irish-German descent. The family was receiving assistance, since father deserted shortly after the birth of Gordon and started drinking and gambling. He returned periodically and became reconciled with the mother but deserted shortly after the birth of another child. At the time of the follow-up the parents were separated. The psychiatrist felt that the mother was a warm person and interested in her children but was quite inconsistent in her demands of her children.

The boy's I.Q. was 74 as judged by a test administered to him by the Chicago Board of Education. He was classified as a borderline mental defective. He was in an ungraded room. A Rorschach was given by the Clinic. The psychologist reported that a severe and prolonged anxiety neurosis was present in which it seemed probable that the inhibitions of sexual curiosity was the important determinant. He was an over-controlled
over-conforming boy who set up compulsive defenses to protect himself. appeared to be accessible to treatment which would seem necessary to prevent withdrawal or exaggeration of the defenses into a paranoid pattern.

The adjustment of this child is shown in the following table:

TABLE XVI
ADJUSTMENT OF THE PATIENT

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>None</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
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</thead>
<tbody>
<tr>
<td>Behavior Problems</td>
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<tr>
<td>Socially Unacceptable Acts</td>
<td>X</td>
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<tr>
<td>Sex Problems</td>
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<tr>
<td>Learning Defects</td>
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<tr>
<td>Personality Difficulties</td>
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<tr>
<td>Somatic Dysfunction</td>
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<tr>
<td>Interpersonal Relationships</td>
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<tr>
<td>To Mother</td>
<td>X</td>
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<tr>
<td>To Sibling</td>
<td>X</td>
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<tr>
<td>To Other Children</td>
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</table>

The patient's problems seemed to have become better, for a slight improvement was noted in the Learning Defects, and a remarkable improvement had been made in the Personality Difficulties and Somatic Dysfunction. The interpersonal relationships of the child have remained the same.

The follow-up interview with the mother was conducted within the home setting in July of 1952, two years and eleven months after the first admission. Gordon was then fourteen years nine months old. The mother believed that the boy's problems began at the age of eleven years, following a story that the teacher had told in class concerning the poisoning of a person by another man. Subsequently, the second person died. Later,
Gordon refused to eat and more problems ensued.

The following report illustrates the behavior problems and the interpersonal relationships of the boy as discussed by the mother at the time of the first admission and as taken from the report of the Cook County Bureau of Public Welfare. The latter part of the report will include the psychiatric report at the diagnostic level. No follow-up by a psychiatrist was possible because the child had gone to the lake for a vacation.

Behavior Problems

FIRST ADMISSION

Socially Unacceptable Acts
Gordon had temper tantrums and cried easily.

Learning Defects
Both the Bureau of Child Study and the Loyola Child Guidance found him to be retarded. He wrote his name incorrectly and couldn't read very well.

Personality Difficulties
He appeared to be a little nervous and shy. Gordon was depressed and spoke excessively about death and believed he would die soon.

Somatic Dysfunction
He was feeding problem because he believed he was going to be poisoned. If he ate at some relatives home he would question the source of the purchases and if the reply was not satisfactory he refused to eat.

FOLLOW-UP

Socially Unacceptable Acts
He continued to have temper tantrums but these were infrequent.

Learning Defects
The boy was still retarded but he was getting along better in school than previously. Even the principal mentioned the improvement.

Personality Difficulties
The mother felt that this had subsided a little. He had no longer spoke of death, although, he was still quite fervent about his religion.

Somatic Dysfunction
Gordon has improved in that he no longer has a fear of eating poisoned foods. This fear lasted for about two months and then disappeared, however, he lost a great deal of weight during that period. He eats everything now.
INTERPERSONAL RELATIONSHIPS

FIRST ADMISSION

To Mother

There was nothing recorded in the record.

To Siblings

Gordon fought with his brother. He had to change schools because they couldn't get along in the

To Other Children

He had some friends but preferred to remain in the house.

FOLLOW-UP

To Mother

The mother felt that he was "such a good boy" and that he had always been good to her.

To Siblings

He seemed to get along fairly well with his sisters and brothers. He still fought with the one brother frequently.

To Other Children

He seemed to have more fun now with his friends. He talked to girls but didn't date them. He occasionally got into fights.

PSYCHIATRIC REPORT AT DIAGNOSTIC LEVEL

Appearance

Gordon was a rather poorly but cleanly dressed boy with a shock of blond hair and a rather odd and unusually mature appearance. He was of average height, thin and pallid.

Behavior

I saw him in a playroom because no interview room was available and he looked around but made no attempt to examine the room and sat down at my invitation. He looked rather suspicious and rarely looked at me but sat making whistling noises through very obviously curious teeth. He made no spontaneous conversation and tended to answer, "yeah and no" whenever possible and sighed frequently. He admitted chasing dreams. He started to model in clay and was compulsive in his work with the rabbit, remolding his arms and legs several times and being quite disturbed that he couldn't get the legs the same length. Although, his general manner was withdrawn and suspicious he did occasionally smile shyly.
Relationship:

He was suspicious of the psychiatrist and was not too communicative.

Prognosis:

The prognosis was considered to be poor.

Diagnosis:

He may develop into a paranoid psychotic if his defenses fail him. It was felt that he was an extremely disturbed boy who was using strong obsessive compulsive defenses.

Recommendations:

He would be an extremely difficult boy to treat because of the marked disturbance in the home situation and it would not be practical. He should be encouraged to enter into activities as would allow him to use his hands and gain encouragement in that way. Relationships with male figures should also be encouraged.

The recommendations of the psychiatrist were not followed through; nevertheless, the boy seemed to have improved a little. Throughout the interview mother seemed to be trying to convince the writer that everything was fine and that the boy no longer had any problems. There was only one thing that bothered the boy and that was that all his teeth have been removed and he was waiting to receive his plate. The mother was not able to determine what made the boy change so rapidly, except that his relatives spoke to him frequently and he apparently overcame his problems. The boy has always remained at home, except for the few times when he has gone to the lake.
Ronald, aged thirteen years five months, was referred by a social agency to the Institute for Juvenile Research in January of 1951. He was the middle child and has one brother, one sister, and one stepbrother.

The patient's parents were Catholic and Lutheran and of Irish descent. The patient's mother was married young, but her first child was illegitimate. The parents quarreled frequently and the father dated other women. Father enjoyed teasing and tormenting Ronald and mother always tried to defend the child. The father eventually deserted and mother received a divorce and later remarried a divorced man with three children, one of which lived with them. The stepfather received an adequate income, but he still had to maintain his first wife and two children. There was much discord in the home, because the maternal grandmother lived there, and she and mother was always quarrelling. The examiner felt that mother was over-protective of the child, lest he be injured while riding his bicycle or have an epileptic fit while swimming. She constantly checked on his whereabouts. She kept him in the house so nothing could happen to him. He was essentially rejected and unwanted by mother.

The boy's I. Q. was 118 as judged by the Stanford Binet Form L test that was administered to him at the clinic. Throughout the test he seemed frightened, tense, and responded very slowly. He was in the seventh grade at the time of the first admission. A Rorschach was also
given to Ronald at the clinic. The psychologist felt that he was a bright boy but very constricted. He presented the picture of a very disturbed child who was depressed and unhappy. His severe control checked out almost all affective responses to his environment. He did respond to his own impulses and had a relatively rich phantasy life which served as an outlet. At present, his contact with reality was excellent and probably served as a protection for an ego that was not sufficiently strong.

TABLE XVII
ADJUSTMENT OF THE PATIENT

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>Non Given</th>
<th>Same Improvement</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavior Problems</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socially Unacceptable Acts</td>
<td>x^a</td>
<td></td>
<td></td>
<td></td>
<td>x^b</td>
</tr>
<tr>
<td>Learning Defects</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality Difficulties</td>
<td>x^c</td>
<td></td>
<td></td>
<td></td>
<td>x^d</td>
</tr>
<tr>
<td>Somatic Dysfunction</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interpersonal Relationships</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>To Mother</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To Stepfather</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To Siblings</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To Other Children</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Psychiatric Interview</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Appearance</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavior</td>
<td>x</td>
<td></td>
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</tr>
<tr>
<td>Relationship</td>
<td>x</td>
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<td></td>
</tr>
<tr>
<td>Prognosis</td>
<td>x</td>
<td></td>
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</tr>
<tr>
<td>Diagnosis</td>
<td>x</td>
<td></td>
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</tr>
</tbody>
</table>

x^a--The stealing has subsided and so have the temper tantrums.

x^b--The boy's lying has become worse.

x^c--The boy was enuretic occasionally.

x^d--The feeding problem was better.
The patient's adjustment was not too successful since very little improvement was shown in all three of the areas studied. Two categories were checked in the Socially Unacceptable Acts because there was a slight improvement in some problems while others had become much worse. The Learning Defects and the Personality Difficulties had remained the same but two categories were again checked under Somatic Dysfunction because the enuresis still prevailed while other problems were improved. The psychiatric report also showed that the child has not improved since the first admission.

The mother and the patient were both seen in a follow up interview in April of 1952, one year and three months later. Ronald was fourteen years and eight months old. The mother felt that Ronald's problems began around the age of eleven years and were the result of "having too many bosses" telling him what to do. The maternal grandmother also gave the child too much and spoiled him. The mother said that the child preferred to go out rather than remain at home. She was worried about him because he did not seem to have any ambition, although, she admitted that he was working part time on a milk truck.

**BEHAVIOR PROBLEMS**

<table>
<thead>
<tr>
<th>FIRST ADMISSION</th>
<th>FOLLOW UP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Socially Unacceptable Acts</strong></td>
<td><strong>Socially Unacceptable Acts</strong></td>
</tr>
<tr>
<td>The mother was concerned about his stealing because he had come home with a stop and go light from a toy train, candy, two bicycle frames, a headlight, and radio. He claimed to have purchased these things and later two boys came and claimed them. He has had temper tantrums for the past three years and these consisted</td>
<td>Since, the boy had been involved with a group of boys that had stolen a jeep and was brought into the Juvenile Court, he has not stolen anything else. She felt that he had stopped for good. The temper tantrums have become few and far between.</td>
</tr>
</tbody>
</table>
of throwing things and crying.

BEHAVIOR PROBLEMS

FIRST ADMISSION

Socially Unacceptable Acts

The boy frequently lied.

He was disobedient to his parents. He has truanted from school several times.

Learning Defects

He was not working up to mental capacity and was failing in several of his classes.

Personality Difficulties

The mother felt that he had always been a mischief maker and had been restless, excitable and depressed for some time.

Somatic Dysfunction

Ronald has been a feeding problem. The meal times has become a struggle off and on throughout the years with Ronald eating only if mother stood over him with a "club". Ronald wet the bed on the average of two nights a week until he was nine when he just stopped.

FOLLOW UP

Socially Unacceptable Acts

He continued to lie especially about school. He would tell mother that the teacher sent him home and she had not told him this, at all. This has become worse.

He continued to do this even more frequently. He was picked up by the police and they gave him one more chance. This occurred recently.

Learning Defects

This has remained the same for he has not received good grades. He wanted to change schools.

Personality Difficulties

This condition has remained the same.

Somatic Dysfunction

Ronald has not been a feeding problem for some time.

He continued to wet the bed occasionally.
INTERPERSONAL RELATIONSHIPS

FIRST ADMISSION

To Mother
He was hostile to mother.

To Stepfather
He and the boy seemed to get along alright, although he couldn't take an interest in Ronald because he was hard to play with.

To Siblings
Ronald was very hostile toward the half brother and on one occasion he threw an ice pick and barely missed him.

To Other Children
He had many acquaintances in the neighborhood. He was well liked by all the school children.

FOLLOW UP

To Mother
The mother felt that the boy was still hostile toward her.

To Stepfather
The boy was belligerent in attitude toward the stepfather. On one occasion when the stepfather reprimanded him, he said "who does he think he is, just wait till I'm twenty-one and then he'll see who is boss."

To Siblings
He fought with his sisters and brothers frequently.

To Other Children
He would rather be with other children his own age rather than be at home.

PSYCHIATRIC INTERVIEW

Appearance
The patient was a small, thin, timid appearing young man who was well dressed in blue jeans, shirt, and tie with bright yellow green shoe laces.

Appearance
He was tall thin set person, who walked in a slouching way. He showed no enthusiasm in seeing me. He seemed quite hostile and angry.
PSYCHIATRIC INTERVIEW

FIRST ADMISSION

Behavior
At least half of the interview consisted of silence or questions such as "what do you mean?" He displayed some peculiar actions during the interview.

Relationship
He had trouble relating to the psychiatrist. He was suspicious.

Prognosis
There was none reported.

FOLLOW UP

Behavior
During the initial part of the interview there were frequent hostile glances turned in my direction. His head was down during most of the interview. He was still quite rigidly controlled and it was difficult for him to relate to people. One had the impression that the boy was using most of his energy to foster this rigid controlled action. His conversation was never spontaneous and his responses were confined to single word responses as "yep" or nope. He didn't feel his mother had changed in attitude toward him. He was disgruntled over the fact that he had to come down to the clinic and did not feel he had problems.

Relationship
He hardly looked at the psychiatrist and his responses were hostile.

Prognosis
The prognosis was guarded and apparently poor, since all the boy's energy was forced into maintenance of rigidly controlled behavior. He was tremendously hostile underneath.
The boy was pre-psychotic and occupied himself in phantasy. He was showing some withdrawal symptoms.

Recommendations

He recommended placement at the Lutheran Institution in addition to consideration of foster home placement.

The writer neglected to mention that the information received on the diagnostic level was from the mother's report to the social worker at the first admission. The psychiatric report on the diagnostic level had been very concise; consequently, it was difficult to obtain a clear idea of the boy's behavior at that time. However, the recommendations that were suggested by the psychiatrist were not utilized by mother for the child remained within the home. The mother felt that the boy had not improved and she was convinced that he would "follow in his father's footsteps", for when he was younger he had been sent to St. Charles. They were considering sending Ronald to Montefiore because of his actions. The mother was not aware of her own involvement in Ronald's problems, but chose to place the blame upon the maternal grandmother and also the others that were living with them in the home. However, this situation was recently changed when the maternal grandmother, the brother and his family moved from the home. The mother hoped that this would alleviate some of the problems that had arisen as a result of their residency in the home.
CASE XV

Harry, aged fifteen years eight months, was referred by the school to the Institute for Juvenile Research in May of 1949.

He had one older brother. The patient's parents were Jewish and of Russian Lithuanian descent of good economic status. Both parents were originally born in Europe. Ever since the parents have been married there has been a long standing pattern of marital difficulty. They operated a candy store and both spent most of their time in it. The child has endured emotional deprivation because of the parent's long hours of work. Both parents have been rejecting of the boy. Mother had seemingly covered her rejection by over protection and father seemed to ignore him completely. Mother waited on the boy constantly and bathed and dressed him until he was ten years old. The mother had described the father as a course insensitive individual who was indifferent to the welfare of his wife and children.

The boy's I. Q. was 83 as judged by the Wechsler Bellevue Intelligence Scale. He was classified as dull normal. The psychologist reported that Harry probably had an average intelligence but was not functioning at that level. He was a freshman in high school at that time.

The adjustment of the child is shown in the following paragraph.
TABLE XVII

ADJUSTMENT OF THE PATIENT

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>Non Given</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socially Unacceptable Acts</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex Problems</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Defects</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality Difficulties</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somato Dysfunction</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal Relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To Mother</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To Father</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To Siblings</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To Other Children</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The patient's adjustment was not too successful, since in most instances the problems and relationships remained the same. The exceptions to this were the slight improvement in the Socially Unacceptable Acts and in his relationship to other young persons. However, the boy's main problem centered around the personality difficulties and in the follow up this appeared to be more pronounced. The learning defects in school were mentioned in the first admission, but mother did not know if he still had difficulties in this area at the time of the follow up interview.

The follow up interview with the mother occurred in July of 1952, three years and two months after the first admission. Harry was then eighteen years ten months old. The mother expressed the belief
that the boy's problem began at the age of eleven years but did not
know what might have caused them. She was not aware of her own
involvement in the boy's problems.

The following report illustrates specifically the behavior
problems and the interpersonal relationship of the boy as discussed
by the mother at the time of the first admission and also at the follow
up interview. The latter part of the report will include the psychiatric
interview at the diagnostic level. No follow up by a psychiatrist was
possible since the boy had been sent to Vaughn Hospital by the Air Force.
The mother would not grant the writer permission to contact the hospital
for further information.

### BEHAVIOR PROBLEMS

#### FIRST ADMISSION

**Socially Unacceptable Acts**

- He was disobedient to both parents.
- He became involved in a minor stealing episode with other boys.
- He has thrown many temper tantrums.

**Learning Defects**

- He lacked the ability to make the necessary adjustment in high school.
- He was restless, inattentive, and daydreamed in classes. He was
  unkempt and dirty in school.
  *(Taken from the school report)*

#### FOLLOW UP

**Socially Unacceptable Acts**

- He has not been in the home so mother does not know the outcome
described. The mother did not believe he was involved in any
further stealing episodes.
- He still had temper tantrums but these were infrequent.

**Learning Defects**

- The mother did not know if the boy had learning difficulties while he
  was in the service.
FIRST ADMISSION

Personality Difficulties

The boy was extremely nervous and stubborn and also restless. He was extremely lazy and had an unkept appearance. Mother had to give him a bath and dress him sometimes. He acted peculiar at times. It bothered the boy if the mother went into a closet. He would wait until she would close the door before he left her.

Somatic Dysfunction

The boy was extremely obese. He had one atrophy testicle and one intra-abdominal testicle which may not function. He had serious migraine headaches and refused to eat many foods.

FOLLOW UP

Personality Difficulties

Although, mother only saw him for visits, she believed that he still had these difficulties. His appearance had remained the same since he continued to be as sloppy as ever. While in the Air Force the boy had a nervous breakdown, but mother did not know the full facts concerning this, nor the particular symptoms that he showed at that time.

Somatic Dysfunction

He has gained more weight than ever. This condition has remained the same. The mother did not know if the headaches prevailed, nor was she certain of his eating idiosyncrasies.

INTERPERSONAL RELATIONSHIPS

To Mother

The boy was disobedient to her and the relationship wasn't what it should be.

To Father

There was nothing reported in the record.

To Siblings

There was nothing reported in the record.

To Mother

The mother felt that their relationship had always been good, and refused to comment any further.

To Father

The mother felt that the boy's relationship to his father was also good.

To Siblings

Harry and his brother always got along fine. The mother wished that Harry was more like his brother since he was quite intelligent.
Appearance:

Harry was a tall, blonde boy who was very markedly obese, especially around the abdomen and the buttocks.

Behavior:

Harry seemed to be somewhat sullen and resentful about being in the clinic and wasn't pleased at the prospect of being examined. He was distracted during the interview and seemed quite anxious about it. When asked questions about his father, he had a tendency to interpret my questions very literally by asking me whether I want a description of his physical appearance. He said his father was a nice man practically all of the time, but as for his mother, he said she nothing much to talk about. He was unable to express any hostility in a verbal fashion toward anybody that was close to him. He stated his disinterest in school and felt that he was bad because he didn't get along with the teacher.

Relationship:

The relationship was not too good since he frequently gazed out the window in a sort of resigned fashion and said that he was here for an examination but didn't care if he came or not.

Prognosis:

The prognosis was not given.

Diagnosis:

It revealed him to be markedly anxious and having a severe problem of expressing his anger and hostility toward parents. The patient's tendency to sloppiness recently was suggestive of a regression and perhaps some disintegration of his personality adjustments which were being taxed by his physical condition and his emotional problems at home.

Recommendations:

The only way to help him would be to place him away from home but the possibility of mother allowing such a placement was very slight.
As was anticipated by the psychiatrist, the mother was not very receptive to the recommendation of placing him away from home. He remained at home until he joined the Air Force in June of 1951. The mother felt the boy's condition became worse following the enlistment. He had wanted to go into the Army, but mother dissuaded him from it, thinking that it would be too much for him. However, while doing basic training in the Air Force, he had a nervous breakdown under the strain and pressure of it. The breakdown was also facilitated by the attitudes of the other boys in his outfit for they disliked him and teased him, and on several occasions placed him under a cold shower for a long period of time. When they released him, his bottom lip was quivering and this continued for some time afterward. He was admitted to a hospital in New York and later released and sent back for basic training. He had a recurrence of the breakdown and was sent to Vaughn Hospital in November of 1951. He has remained there since that time. The mother felt that he was making a better adjustment within the hospital setting.

The following table illustrated the adjustment of the group as a whole showing the predominance of the adjustment "same" with the other types of adjustment also present in a more minor way.
TABLE XI

ADJUSTMENT OF THE GROUP

<table>
<thead>
<tr>
<th>NAME</th>
<th>Same</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carl</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>jonathan</td>
<td>10</td>
<td>3</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Peter</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Carol</td>
<td>12</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lee</td>
<td>9</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Dorn</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Margie</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Donald</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lena</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Robin</td>
<td>6</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Jerry</td>
<td>11</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Mark</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>2</td>
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<tr>
<td>Gordon</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Ronald</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>harry</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

In addition to the predominance of the adjustment "same" of those cases shown in the table, there was twelve cases that had also shown a slight improvement, while only three cases revealed a remarkable improvement and ten of the cases had some of the problems becoming more pronounced.

Out of the twenty-one cases that were followed up, there were fifteen cases classified under the category, "same". There were eleven boys and four girls, two of which were negro. The age of the group ranged from two years nine months to seventeen years six months. Six of the children has been referred by social agencies, two were medical referrals, two were school referrals, two referrals were made by the parents, one was made by a councilman, another one was made by a neighbor and one was unknown. There were four children that came from Catholic families.
three came from Lutheran Families, two from Protestant families, three
came from Jewish families and three others were of a mixed religion.
The home situation of all these children were disturbed in one way or
another because of divorce, separation, desertion, psychotic parents,
drinking, and death. In a majority of the cases the factor of rejection
of the child was noticed on the part of one or the other of the parent
or both. In some of the cases the rejection was on an unconscious level
while in other cases it was overt. There were four families receiving
financial assistance, five others had an adequate income, that is, one
that was sufficiently large for daily living, and five others were
unknown.

The children was a whole had a very low I. Q. with three of
them considered unclassifiable, two were low grade mental defective,
one was a high grade mental defective, two were borderline mental
defectives, three were classified as dui normal, one was average and
three were high average. In several of the cases the psychologist felt
that some of the children would have been placed in higher classifications,
except that their disturbances interfered with their mental processes.
Only eight of the children were attending school and one was in an
ungraded room.

In all of the cases the children had shown disturbances in the
various categories of problems and also in the interpersonal
relationships.
In fourteen of the cases, one of the parents was seen by the writer for the follow up interview, and in nine cases the child was seen by the psychiatrist for the follow up interview. The fifteenth case was the report from the institution concerning the child. A psychiatric interview was also included in this report. Out of those ten cases seen by the psychiatrist at the follow up, seven of the diagnosis remained the same, while three others were changed. The recommendations made by the psychiatrist at the diagnostic level were followed through in five cases only; one recommendation was unknown, and nine others preferred to make their own plans.
CHAPTER III

CASES THAT REVEALED IMPROVEMENT
OR BECAME WORSE

There were twenty-two cases of psychotic and pre-psychotic children contacted for the follow-up interview. Fifteen of those cases were discussed in the previous chapter because their adjustment had remained the same. There were only seven cases remaining. Two of the cases made a slight improvement, three cases made a remarkable improvement and two other cases became worse.

The first two cases to be discussed will be those that revealed a slight improvement. As was discussed in the introductory chapter, a slight improvement indicated that there had been a partial correction of the problem with an occasional re-occurrence of it.

The first case to be discussed under this category was the child that had been institutionalized at Beverly Farms. A questionnaire had been sent to the institution and the information for the follow-up of the case was secured from this.
CASE XVI

Rory, aged twelve years ten months was referred by a medical source to the Institute for Juvenile Research in September of 1950.

The patient's parents were of mixed religion, Lutheran and Episcopal. The father was of Dutch-German descent and the mother was of English Irish descent. They received an adequate income since father was a superintendent in a manufacturing plant. Rory was the younger boy and had only one brother. Both the mother and the father had been married previously. The mother was divorced from her first husband and had one child from that marriage. The father's wife died in childbirth. The child had little attention from his mother during the first five years of life because she was working and continued to work until 1947. At that time mother went through a period of depression. The father was a quiet passive man who had cerebral thrombosis, and had to be very careful of the activities he engaged in. The mother's eldest sister was schizophrenic and had been committed to Elgin. The psychiatrist felt that the child had been rejected by the parents. The mother was extremely hostile, and over protective. The child was fearful of father and the patient had tremendous hostility toward his parents which was the reason he was so destructive.

The I. Q. of the child was unknown. It was an emergency case and no I. Q. Test was administered. However, he was supposed to be an exceptionally bright child. He was in the eight grade at the time of the
first admission. A Rorschach was administered to the child at the clinic. The psychologist reported that the boy showed many signs of hostility and aggressive feelings, together with a propensity for emotional outbursts. Other personality characteristics suggested by the test were a withdrawal from human relationships, a tendency for stypical thinking, and a minimal recognition or awareness of society's standards. He demonstrated a starvation for affection and some signs which indicated he might have rather marked swings.
TABLE XX
ADJUSTMENT OF THE PATIENT

<table>
<thead>
<tr>
<th>Area Studied</th>
<th>Non Given</th>
<th>Same</th>
<th>Slight Improvement</th>
<th>Remarkable Improvements</th>
<th>Worse</th>
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<tr>
<td>Behavior Problems</td>
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<td>Socially Unacceptable Acts</td>
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<td>Sex Problems</td>
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<tr>
<td>Learning Defects</td>
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<td>x(^a)</td>
<td>x(^b)</td>
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<tr>
<td>Personality Difficulties</td>
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<td>Somatic Dysfunction</td>
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<tr>
<td>Interpersonal Relationships</td>
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<tr>
<td>To Mother</td>
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<td>x(^b)</td>
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<td>To Father</td>
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<td>To Siblings</td>
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<td>To Other Children</td>
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<td>Psychiatric Interview</td>
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<td>Prognosis</td>
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<tr>
<td>Diagnosis</td>
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</table>

X\(^a\)--The child still saves everything.

X\(^b\)--He has improved because he is not antagonistic as he was previously.

The child's symptoms seemed to have become somewhat improved, with the exception of some of the problems remaining the same under Personality Difficulties. The information for the follow up on this boy was secured from Beverly Farms through a questionnaire. As a result, not all of the sections in the questionnaire were answered fully, and this made it difficult
to compare the material from the diagnostic level with the information received for the follow up. There was no actual psychiatric interview included but some of the categories were mentioned briefly.

There was no follow up interview with the parent and the child on this case because the child had been institutionalized at Beverly Farms in 1950 and still remained there. The parents were unable to come in, but a letter and a permission slip, enabling the writer to contact the institution, was sent to Rory's parents, and they returned the permission slip shortly afterwards with their signature. In August of 1952 a questionnaire and the permission slip was sent to the institution requesting current information on Rory. A few days later the writer received the reply from Beverly Farms. This occurred two years after the first interview with the child on the diagnostic level. The institution reported that in the beginning he was extremely overbearing, attempted to dominate all the other children and to play one of the employees against the other to his own advantage. He was, to say the least, scheming, not afraid of anyone, very demanding, and hypercritical of everything and everybody. He resented the institutions attempts to continue his school work although he showed unusual ability in the manual arts and did have the ability to do certain projects such as printing the school paper. He resented criticism and was critical of his parents as a result of underlying conflicts, and he felt rejected by them. However, all this type of behavior gradually changed and the boy has been making a very good readjustment.

The material for the first admission was received from the mother.
BSH.;,Vl ()R PROBLEMS

FIRST ADMISSION

Socially Unacceptable Acts

Rory placed a home made bomb in the home of a high school friend. He had arranged it that while the family was looking at TV he would go downstairs to the basement on the pretense of fixing the bicycle and instead placed the bomb in the other house. He stated that the people in the house were manufacturing guns to use against him. The mother discovered that the boy was stealing, because she found many things in his room.

He was destructive with his toys. He has shown many hostile and aggressive acts. He has been known to slash people.

Personality Difficulties

The mother described the patient as a child of "conflict", and said he had intense feelings of love or hate since he was a small child. He constantly antagonizes people and turns them against him.

He has never been afraid of anything. Patient was always very secretive and would hoard things.

FOLLOW UP

Socially Unacceptable Acts

This type of behavior was not mentioned in the report from the institution.

The stealing was not mentioned in the report from the institution so perhaps one may assume that this has stopped.

This was mentioned in the report.

This was not mentioned in the report.

This has not occurred in the institution.

Personality Difficulties

This was mentioned in the report.

It is remarkable how he has been willing to meet out adult employees on a satisfactory level and no longer antagonizes them or has a feeling or frustration. This type of behavior prevailed.

There was still a childish pattern of saving things and saved everything until his room was a fire hazard. It eventually became necessary for the room to be cleaned out. We compromised and let him go over every piece and just keep those things which were more important. This was a remarkable change for the boy and showed emotional growth for when he came he would probably have burned the house down or blown it up.

There has been a gradual readjustment and shuffling in the degree of emotional tension and there has been a remarkable stabilization take place in the boy for now he will accent criticism.
BEHAVIOR PROBLEMS

FIRST ADMISSION

Sex Problems
There was nothing recorded.

Somatic Dysfunction
The boy spoke with a lisp.

FOLLOW UP

Sex Problems
The music teacher was found to be a homosexual and Rory being aware of this carried a pipe around in his music case. He said that if this man had made a pass at him he would hit him. He showed not only an aggressive spirit but a well defined idea and attitude toward homosexuality.

Somatic Dysfunction
No mention was made in the report.

INTERPERSONAL RELATIONSHIPS

To Mother
He turned on mother and was insolvent to her. Once he put his arms around her and she felt was going to choke her. Patient frequently commented that no one loved him.

To Father
The father scolded loudly but spanked softly. Father has always played with Rory.

To Siblings
Rory's relationship to his brother was very good.

To Mother
He shows practically a normal relationship with his mother. The parents have taken him on vacation trips and he has enjoyed them.

To Father
He spoke very highly of his father.

To Siblings
This was not discussed in the record.
First Admission

To Other Children

Patient did not have many friends although parents have encouraged him to bring them home. He was arrogant and bossy with them. He makes a distinction between a real friend from others by the fact that the other doesn't do what he wants them to do.

Follow Up

To Other Children

He had made some friends in the institution and was not as antagonistic as he had been before.

Psychiatric Interview

Appearance

He was a rather pale, well built boy with rather full lips who spoke in a kind of lisping and somewhat out of the side of his mouth. His tone of voice was one of resentment. He was dressed in a blue suit of rough texture with a rather loosely knotted tie.

Appearance

No description was given of the boy.
PSYCHIATRIC INTERVIEW

FIRST ADMISSION

Behavior

He appeared to be willful, provocative and took no pains to hide his hostility. He talked about having one friend but later said that actually they did not like to do the same things so they were seldom together. The rest of the kids taunt him and call him baby. There are big boys in his class. He felt that he couldn't protect himself against them. He expressed hostility against his mother and resentment for her limiting some of his actions. He withdrew and said that he wanted to forget his problems. He spoke of the nightmares he had in which gorillas chased him. He tried to provoke the examiner and when it failed he made a gesture of friendship. He was unable to tolerate this positive feeling for more than a minute and immediately became hostile. He was extremely surly hostile, vituperative in the interview and openly expressed his antagonism against the race.

Relationship

He was rather pedantically hostile during the entire interview and kept his head turned away from me.

Prognosis

Even with extensive psychotherapy the prognosis was not good.

FOLLOW UP

Behavior

There is normal affect tone, there is much less misinterpretation of the attitudes of others and there has been a growing willingness to assume responsibility for the things he has done. He has worked well with those whom he respects and likes but he still is extremely critical of those whom he feels do not measure up to his needs and at times can be openly antagonistic. It is our feeling that at this time he is still emotionally immature, although he is interested in continuing school and is anxious to return home and get some type of vocational training.

Relationship

There was nothing mentioned in the record.

Prognosis

The prognosis was guarded although the family and ourselves have been happy in the progress that he has made.
I think that Rory is pre-psychotic. He has many paranoid tendencies. He has claimed the room was wired and the boys against him. It was the opinion of the staff that Rory was a danger to the community that he should be kept in a restricted environment. He is close to having a psychotic break.

Recomendations

A state institution was suggested if private treatment was unavailable.

The recommendation of the psychiatrist had been followed up because the child has been placed in an institution. The psychiatrist felt that the boy still had some years of stabilization ahead of him and that there was the possibility that during his further adolescence he may generate antisocial patterns but not in a restricted environment where he is given an opportunity to express himself along constructive channels. As long as he is not allowed to dominate a situation and he realized that the institution is still observing him and directing his discipline, he does well. The institution felt that the incentive of returning back to the community has been brightened by the fact that he has made a very fine adjustment since his most recent trip home. Any return back to the community would have to be on the basis of a parole procedure in which he would feel that any let down on his part would immediately lead to a denial of the privilege and a return back to an institution.
CASE XVII

Larry, aged sixteen years four months, was referred by the Aid to Dependent Children to the Institute for Juvenile Research on October of 1930. Little was known about the patient's father, but the mother was of Irish descent and a Catholic. At the time of the first admission the father was not in the home and the family was receiving assistance. The mother had a long history of mental illness, having been committed three times to various state institutions with a diagnosis of Dementia Paseox. The father deserted mother in 1937 and later divorced her in absentia. The maternal grandmother was living with them at the time and has continued to live there and has assumed the dominant role in the household. The mother has remained in bed almost the entire time for no organic reason, although she complained of arthritis. She has given the children love and affection, but the maternal grandmother has resented the responsibility of the children. The patient was the middle child with a sister and a brother.

The boy's I. Q. was 69 as judged by the Wechsler Bellevue test and he was classified as a borderline mental defective. The psychologist felt that the emotional problems interfered with the results of the test and the boy also had difficulty in verbal communication. He was in seventh grade, but had a disturbed school history due to several transfers to various schools including the St. Mary's Training School from which he later ran away.
The following table illustrates the type of adjustment the patient made since being seen at the Institute for Juvenile Research.

**TABLE XXI**

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>Not</th>
<th>Slight</th>
<th>Remarkable</th>
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<tbody>
<tr>
<td><strong>Behavior Problems</strong></td>
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<tr>
<td>Socially Unacceptable Acts</td>
<td>X</td>
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<tr>
<td>Sex Problems</td>
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<tr>
<td>Learning Defects</td>
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<tr>
<td>Personality Difficulties</td>
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<tr>
<td>Somatic Dysfunction</td>
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<tr>
<td><strong>Interpersonal Relationships</strong></td>
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<tr>
<td>To Mother</td>
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<td>X</td>
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<tr>
<td>To Siblings</td>
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<tr>
<td>To Other Children</td>
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</tbody>
</table>

The patient seemed to have made a favorable adjustment. A slight improvement was noted in three of the problem areas and a remarkable improvement noted in Somatic Dysfunction. The two interpersonal relationships have remained the same but these had not been too disturbed at the time of the first admission.

The mother was seen in a follow up interview in August of 1950, one year and ten months later. Larry was eighteen years two months old. The mother felt that the boy had improved a great deal since being seen at the clinic. The age of onset of the symptoms was unknown.
The following report illustrates the behavior problems and the interpersonal relationships of the boy when they were discussed by the grandmother at the time of the first admission and by the mother at the follow up with the writer. No follow up was done by a psychiatrist because the child was not in the home.

**BEHAVIOR PROBLEMS**

**FIRST ADMISSION**

**Socially Unacceptable Acts**
- He was difficult to manage at home.
- He truanted from school frequently.
- He throw things when he was angry, and laid on the floor.

**Learning Defects**
- He had trouble in reading and writing.

**Personality Difficulties**
- He was a shy withdrawn child.

**Somatic Dysfunction**
- He had an upset stomach, nausea and anorexia.

**FOLLOW UP**

**Socially Unacceptable Acts**
- He was more obedient.
- He no longer attended school now.
- His temper tantrums have subsided.

**Learning Defects**
- This was no longer a problem since he did not attend school any more.

**Personality Difficulties**
- There was some improvement in this area.

**Somatic Dysfunction**
- He ate and slept well now.

**INTERPERSONAL RELATIONSHIPS**

**To Mother**
- His mother was "nice" and he got along alright with her.
- She felt their relationship had always been good and he helped her.
INTERPERSONAL RELATIONSHIPS

FIRST ADMISSION

To Siblings

He fought with both of his siblings and his sister considered him rowdy.

To Other Children

He had many friends and enjoyed playing football with them.

FOLLOW UP

To Siblings

This has improved since he seemed to get along fine now.

To Other Children

If the children are good he will play with them, if not he won't be bothered. They have to be the "right kind of friends."

PSYCHIATRIC REPORT AT DIAGNOSTIC LEVEL

Appearance:

Larry was a rather pleasant looking open faced boy with acne on his face. He was dressed in levis and very thick heavy woolen lined flight jacket.

Behavior:

Throughout the interview, however, he was very reticent giving no information spontaneously and answering questions only briefly and frequently after a thirty or forty-five second pause. He spoke in generalities and frequently used the term, "I don't know" or "I don't remember". Toward the end of the interview it was noted that he was extremely tense as demonstrated by his tightly clenched hands. He felt rather badly because he was not in school and stated that the reason he was not going was because they transferred him to a different one and he doesn't want to go there. He was shy tense, and withdrawn and did not relate well to the psychiatrist.

Relationship:

No relationship was established between the boy and the psychiatrist.

Prognosis:

The prognosis was not considered to be very good.
Diagnosis:

This boy was pre-psychotic. He was in touch with reality at the time but he was evidently becoming more and more withdrawn and mute. He would eventually become schizophrenic but would not be accepted for commitment yet.

Recommendations:

The boy should be placed at the Glenwood Training School for Boys.

Although the prognosis for this child was not too favorable, the mother felt that he had improved somewhat since the first interview. It was difficult to obtain many clear statements from the mother because of her disturbed condition and she was quite repetitive throughout the interview. The recommendation of the psychiatrist was not followed through by the mother. He has remained at home and has never worked because he couldn't find anything to do. At the time of the follow up, he was in Florida with some friends helping them with their resort hotel.

The three following cases are those that made a remarkable improvement. A remarkable improvement was an indication that there has been a correction of the symptomatic problems presented at the time of the follow up interview.
CASE XVIII

Jamie, aged five years six months, was referred by the Juvenile Court to the Institute for Juvenile Research in April of 1950.

The patient's mother was Protestant and of Swedish descent. Jamie and his sister were illegitimate twins who were born prematurely. They remained in the hospital for five months. The children were taken from the mother in May of 1948 when she was arrested for excessive drinking and neglect of the children. The children were placed in the Juvenile Court temporary home until the Lutheran Home Finding placed them in a foster home in September of 1948. They have remained there since that time. The boy had a marked strabismus of the eye. The foster mother was described as a warm maternal woman who was very strongly attached to the patient. The foster father also loved them very much.

The boy's I. Q. was 54 as judged by the Stanford Binet Form L test that was administered to him. He was classified as a high grade mental defective. The psychologist reported that his was not one of typical retardation but one of intellectual confusion. He kept up a continual monologue in a loud voice.
TABLE XXII

ADJUSTMENT OF THE PATIENT

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>Non Given</th>
<th>Same</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
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<tbody>
<tr>
<td><strong>Behavior Problems</strong></td>
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<tr>
<td>Socially Unacceptable Acts</td>
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<tr>
<td>Sex Problems</td>
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<td>Learning Defects</td>
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<td>Personality Difficulties</td>
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<td>Somatic Dysfunction</td>
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<td><strong>Interpersonal Relationships</strong></td>
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<td>To Foster Mother</td>
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<td>To Father</td>
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<td>To Siblings</td>
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<tr>
<td>To Other Children</td>
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<tr>
<td><strong>Psychiatric Interview</strong></td>
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<td>Appearance</td>
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<td>Behavior</td>
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<td>Relationship</td>
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<td>Prognosis</td>
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<td>Diagnosis</td>
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The patient's adjustment was considered moderately successful, although by no means were the problems completely eliminated. The boy made a slight improvement in two of the behavior problems, a remarkable improvement in sex problems and learning defects and the socially unacceptable acts remained the same. A remarkable improvement was also noted in his relationship to other children, and this had been quite disturbed previously. The psychiatrist felt that a remarkable change had occurred in the child and it was sufficient to change the boy's diagnosis.
of psychosis. He was considered to be in full contact with reality and adjusting well.

The foster mother and Jamie, accompanied by his twin sister and a worker from Lutheran Home Finding, came to the clinic for the follow-up interview in August of 1952, two years and four months after the diagnostic interview. Jamie was seven years and ten months old. The foster mother was a warm, pleasant woman who loved the twins and exhibited much interest in their progress. She felt that both of the children had made a great deal of progress since they had been placed at their home, because on arrival they were "just like two wild Indians." She was especially proud of the fact that Jamie was attending school. The clinic had advised her that he could not attend school and that it would be futile to start him when he was old enough to attend. However, the boy was doing very well in his school work.

The following report illustrates the behavior problems and the interpersonal relationship of the boy as discussed by the foster mother at the first admission and also at the follow-up interview.

<table>
<thead>
<tr>
<th>BEHAVIOR PROBLEMS</th>
<th>FIRST ADMISSION</th>
<th>FOLLOW UP</th>
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<tbody>
<tr>
<td>Socially Unacceptable Acts</td>
<td>He threw temper tantrums.</td>
<td>He still threw temper tantrums. He shuts up his fist and stamps his feet.</td>
</tr>
</tbody>
</table>
BEHAVIOR PROBLEMS

FIRST ADMISSION

Sex Problems

The only thing that he did was to lie on the floor and look under women's dresses. He masturbated occasionally.

Learning Defects

Although the boy was mentally retarded the foster mother was able to get his attention and made him listen to her. He knew his prayer now and has started to converse with her a little. He tended to stumble his words and when excited was somewhat incoherent.

Personality Difficulties

The boy was never quiet and on the go. He did not seem to be able to register pain when hurt. He had fallen often, would walk into walls, and if an obstacle is in the way, he would walk through it or over it instead of around it. He also had nightmares often of animals chasing him.

FOLLOW UP

Sex Problems

He has stopped looking under women's dresses. He does not masturbate any more.

Learning Defects

The boy was attending first grade and was going into the second grade. He was able to write some words and his memory seemed to be excellent. He was one of the best readers in his class and he understood what he read. He was a curious child and wanted to know about everything. One can carry on a conversation with him. It made it more difficult for the child to be in school because he was hard of hearing and his eyesight was very bad.

Personality Difficulties

Although he was still excitable he calmed down quite a bit. Now she could bring him down to different places and knows he would not be rowdy. He did register pain now when hurt. He was not shy but seemed to be more friendly now. However, sometimes when the boy was speaking she noticed that he would go off on a tangent as if talking to someone else. He no longer had nightmares. He wanted everyone to notice him and even while in class he would do something to make the children laugh.
INTERPERSONAL RELATIONSHIPS

To Foster Mother
They loved the child and he liked to be loved by them.

To Foster Father
The boy was very fond of him and watched him to do things and then imitated him.

To Siblings
He seemed to be getting along fine with his sister, but had been very aggressive toward her.

To Other Children
He played wildly with other children and hollered a great deal, but he seemed to be accepted by the children.
He became rough and shaked them and screamed at them and threw things.

To Foster Mother
He has said, "you're the best mommy and daddy in the world."

To Foster Father
The relationship continued to be a very good one.

To Siblings
Their relationship continued to be a very good one.

To Other Children
Now he can play with the children without becoming excited. He picked out the quiet ones to play with.
He doesn't fight with them but just argues with them. He shares his toys now.
PSYCHIATRIC INTERVIEW

FIRST ADMISSION

Appearance

He was a small, hyperactive, excitable child. He maintained a happy jubilant expression on his face during most of the interview.

Behavior

He came readily with the examiner. He spoke plainly when giving words but when talking in phrases or sentences his vocabulary was not clear. He was conscious of the presence of the examiner. He acted out viciously against the environment. He became overwhelmed in his play and was carried away in his activities. He behaved like a child of two or three years of age. He fell over frequently while running. He became so active he hit himself on the head with a gun. He forced the examiner at gunpoint to stand in the corner. He was unable to understand even simple questions. One had to repeat them.

Relationship

He seemed hostile to the psychiatrist.

Prognosis

There was none recorded.

FOLLOW UP

Appearance

He was a neatly dressed, slightly built boy of seven years who wore rather heavy glasses.

Behavior

There has been a remarkable change in this boy since his last examination. He showed more control and was much more stable than he proved himself before. In the beginning of the interview his play was a little disorganized as he stayed for a greater length of time for each project which he carried through in a normal way. There was no nervousness or hyperactivity displayed throughout the interview. Aside from two or three irrelevant responses he responded well to my questions. His speech was understandable, verbalization relevant and he was quite adept at naming the various objects in the room.

Relationship

He definitely related to me and was quite at home in the relationship.

Prognosis

It was quite good and was a lasting testimonial to the good work done by the foster parents.
The behavior of the child was psychotic in nature. However, whether this was due to an organic trauma, or functional condition as a result of the traumatic experience of his early environment and interpersonal conditions cannot be determined.

Recommendations

The child should be allowed to remain in the home of the foster mother since she was doing so well. She was advised against sending him to school since they did not think he would be able to manage at school, due to his limited potentialities as a student and his general aggressive behavior with children.

The child remained with the foster mother and father, but contrary to the psychiatrist's recommendation of not sending him to school, the foster parents did send him when they felt he was capable of doing the work. He progressed favorably at school as well as within the home. He had become extremely neat and his room always looked tidy. The foster mother felt that the child was reacting favorably to the love and affection that they gave him and also through the combined efforts of the pastor of their church and the teacher in school. They have given the child some religious teaching and now "he won't do anything bad if he thinks God doesn't like it."
Mary, aged twelve years eleven months was referred by the school
to the Institute for Juvenile Research in April of 1950. She was an only
child.

The patient's parents were both Lutheran and were born in
Germany but were married in the United States. The maternal grandfather
had had mental breakdowns and was institutionalized several times. The
father was described by mother as a dictatorial, domineering, suspicious,
jealous, and arrogant man. The father divorced mother on a charge of
adultery when Mary was only a year old, and gained custody of the child.
The mother had a nervous breakdown following one of the court battles over
the custody of the child. She finally gained custody of Mary when she
remarried. The stepfather was described as a nice person easy to get along
with, who liked Mary and tried to please her. Mary has visited the
natural father and stepmother periodically and has remained confused
about family relationships and loyalties. On her visits to her natural
father, Mary has spoken of the seductive actions of the father toward her.

The girl's I. Q. was 86 as judged by the Kuhlman Anderson test
administered to her at school. She was in 8A at the time of the first
admission. A rohrshach was given to the girl by the clinic. The
psychologist felt that the child's ideation had become so estranged from
that of most people that she was living in a world of her own. She
was unable to exercise control even in a situation which made relatively
small demands upon her. She was almost completely driven by her motions and these fluctuated easily. She could be classified as a schizophrenic and would most likely develop into a hebephrenic type. The prognosis was considered poor.

The adjustment of the child shown on the following table.

TABLE XXIII

ADJUSTMENT OF THE PATIENT

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>Non Given</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior Problems</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Socially Unacceptable Acts</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Defects</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality Difficulties</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatic Dysfunction</td>
<td></td>
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</tr>
<tr>
<td>Interpersonal Relationships</td>
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<tr>
<td>To Mother</td>
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<tr>
<td>To Father</td>
<td>X</td>
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</tr>
<tr>
<td>To Stepfather</td>
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</tr>
<tr>
<td>To Other Children</td>
<td>X</td>
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</tbody>
</table>

The patient's adjustment was considered very successful, since there has been a remarkable improvement in almost all of the categories of problems. Two of the relationships remained the same, but these had not been too disturbed at the time of the first admission. The other two types of relationships were disturbed but appeared to be improved at the time of the follow-up interview. The type of
adjustment made by the patient was based upon the statements made by
the mother at the follow up interview.

A home visit was made to interview the mother in July of 1952,
two years and three months after the diagnostic interview. Mary was
fifteen years two months old at the time. The mother said that the
symptoms began at the age of twelve or perhaps earlier when she was
eleven. They appeared about the time of her beginning menstruation
period and became more pronounced following the visit to her father
and stepmother in Florida in 1949.

The following report illustrates the behavior problems and
the interpersonal relationships of the boy as discussed by the mother at
the time of the first admission and also at the follow up interview.
The latter part of the report will include the psychiatric interview
at the diagnostic level. Since Mary had improved so remarkably
the mother did not feel a psychiatric interview was necessary and she
refused to come to the clinic.

**BEHAVIOR PROBLEMS**

<table>
<thead>
<tr>
<th>FIRST ADMISSION</th>
<th>FOLLOW UP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Socially Unacceptable Acts</strong></td>
<td><strong>Socially Unacceptable Acts</strong></td>
</tr>
</tbody>
</table>
| She had become quite impudent and
defiant to teachers in school,
which was opposite to her previous
behavior of being polite and
agreeable. She was indifferent to
school regulations.
Mary ran away from home one night
and was brought back by a strange
couple who had picked her up. She
was on her way to the North Woods. | Now, Mary has a tendency to be
quiet and has been considered a very
nice and cooperative girl in school.
She has never run away from home
since. Mary said, "I merely ran
away because I was carrying out
what every child wants to do, that's
all. Now I wouldn't have the courage
or ambition to do so." |
### BEHAVIOR PROBLEMS

<table>
<thead>
<tr>
<th>FIRST ADMISSION</th>
<th>FOLLOW UP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex Problems</strong></td>
<td><strong>Sex Problems</strong></td>
</tr>
<tr>
<td>She had become quite aggressive toward the boys and talked of their &quot;feeling her up&quot; when she went to the movies. She has told many tales of her father sleeping with her and making seductive advances to her. The receptionist had reported that Mary had cornered a negro boy in the clinic and made seductive advances to him.</td>
<td>The mother felt that Mary was no longer having problems in this area. It seemed to be a temporary thing. She wasn't quite sure that Mary had been telling the truth about those sexual episodes.</td>
</tr>
<tr>
<td><strong>Learning Defects</strong></td>
<td><strong>Learning Defects</strong></td>
</tr>
<tr>
<td>She had maintained an excellent school record until recently, now she was failing her classes due to lack of concentration.</td>
<td>She was getting very good grades in high school. She was worried about her marks and about tests but mother believed this to be natural reaction.</td>
</tr>
</tbody>
</table>


**First Admission**

**Personality Difficulties**

The patient had had a change of personality within the past year which began menstruation time. Several days prior to menstruation she would become hyperactive, restless, noisy, impulsive, melodramatic, and did not eat or sleep well. After the menstruation period she changed to being quiet, even to the point of being withdrawn and lacking interest in friends. This was more her natural manner. Such swings of mood continued to follow her menstrual periods but they were not regular. During these period she complained of headaches, sore throat, sore neck muscles, eye strain, nausea, ringing of the ears. She seemed to have a persecution complex because she cried, threatened suicide felt unwanted, misunderstood, constantly past pleasant experiences which were distorted. She was confused about love and hate. On several occasions she became hysterical and sobbed at something that was funny. These hysterical periods lasted about two weeks and then she quieted down and slept all the time. For a long time she had a phobia about germs and cleanliness. She washed her hands constantly and even refused to touch anything with the palm of her hand. She used gloves. When she sat on a chair she would not let her skin touch it. She took three baths a day during this period. She talked irrationally.

**Follow Up**

**Personality Difficulties**

The mother felt that Mary had made a remarkable improvement since she no longer had the symptoms she showed in the previous interview. Her swings of mood during her menstrual period has completely subsided. It lasted for almost a year but now has not trouble during the period. The pains that she complained of during that period also subsided. She has not threatened suicide lately and does not mention any confusion she might have about her family relationships. Her behavior in school has also been good. She has a tendency to be quiet but mother did not feel this to be bad.

The phobias have also stopped completely.

She no longer talks irrationally.
SOMATIC DYSFUNCTION

She has sleep disturbances during which she talked all night and sometimes sings. Much of her conversation is irrational, almost to the point of being incoherent. She has Asthma attacks. It has become increasingly difficult for her to eat at certain times.

INTERPERSONAL RELATIONSHIPS

To Mother

The mother felt that their relationship was good although she was sometimes confused by her father. Her father had told her to hate her mother.

To Father

She expressed the thought that sometimes she loved her father and sometimes she hated him.

To Stepfather

He has always had a nice relationship with Mary, although he has never tried to supplant her own father. Mary has expressed the fact that sometimes she "like her stepfather more than her father, because he gives her everything that she wants."

FOLLOW UP

SOMATIC DYSFUNCTION

She slept well now with a few exceptions of nightmares.

The Asthma attacks occur infrequently. She has a good appetite now.

To Mother

Mary and her mother were very close. The confusion of whom to be loyal to was finally settled in her mind.

To Father

Mary stated that she has love and respect for her father, but does not feel comfortable in his home. She felt that this was her home with her mother.

To Stepfather

Mary said, "I get along with my stepfather wonderfully."
INTERPERSONAL RELATIONSHIP

FIRST ADMISSION

To Other Children

After her period Mary was very quiet and lacked interest in her friends. Sometimes she hated her girlfriends. She was aggressive towards the boys.

FOLLOW UP

To Other Children

The mother did not think that Mary had trouble making friends, now. She was active in high school doings and seemed to be getting along fine.

PSYCHIATRIC REPORT AT DIAGNOSTIC LEVEL

Appearance:

Mary was a small rather thin girl who was sitting in the waiting room reading a magazine when I went to get her. She came very readily with me.

Behavior:

Some of her statements suggest the possibility of her having delusions. When she described her stiff neck and her headaches she states that it seemed as if her head was growing bigger. She spoke in a rapid flow of speech, and displayed much anxiety. There was a little change of affect during her recital. During a discussion of her father, it was impossible to tell which time she was talking about her stepfather and when she was talking about her natural father. She told of her singing while in class and that she did this frequently. She discussed confusion over her parents divorce. She wanted to be missionary. She asked several times if she were crazy or if those about her were crazy. The entire interview was marked with a flood of ideas.

Prognosis:

It was considered to be poor.

Diagnosis:

In the original diagnosis the psychiatrist was unable to decide whether Mary's difficulties are on a hysterical or schizophrenia basis. Later on in another interview the girl was thought to be psychotic.

Recommendations:

Immediate hospitalization was suggested for the girl since they feared she might harm herself.
The recommendations of the psychiatrist were not utilized since the child remained in the home following the diagnostic interviews at the clinic. The parents were reluctant about institutionalizing the child so they decided to turn to their minister for help. The minister of their church spoke to Mary many times and whenever Mary felt she needed to speak to someone, that was the person she consulted. The mother believed that Mary had kept everything "bottled up" before and that was why she was having so much trouble. After she had the opportunity to express herself, everything seemed to turn out fine. Mary had also attended camp both summers and she thought this was an aid to her.

Mary was present throughout the interview. She answered many questions briefly, but appeared quite anxious about the writer's inquiries. The writer had to reassure the girl several times that the name remained confidential for the study. She was quite attractive in appearance, rather quiet in manner, but seemed intelligent and well organized.
CASE XX

Marion, a negro child, aged thirteen years and ten months, was referred by the Probation officer to the Institute for Juvenile Research in August of 1949.

The patient's parents were protestant and their nationality was unknown. The mother had had a deprived childhood and at the age of fourteen became illegitimately pregnant with Marion. The mother blamed the maternal grandmother because no sex information had been given to her. Following the patient's birth, the mother went to Tennessee to work and left the child with the maternal grandmother until 1948. In the meantime, mother had remarried twice, because the first husband had died. Marion returned to mother in 1948 and was the oldest child with two brothers and two sisters. The psychiatrist who interview mother felt that she was extremely disturbed woman who was functional at a mental defective level.

The girl's I. Q. was 76 as judged by the Wechsler Bellevue test that was administered to her at the clinic. She was classified as borderline to dull normal. She was in 6A in school. A Rohrshach was given to the girl at the clinic. The psychologist felt that it gave a general picture of an intellectually impoverished individual who was moody, apathetic, and infantile. The patient's weak ego control made her affective live unstable. She seemed to have strong negativistic attitudes that kept people at a distance. There was evidence of psychotic process.
The following table will illustrate the type of adjustment the patient made since being seen at the Institute for Juvenile Research on the diagnostic level.

**TABLE XXIV**

**ADJUSTMENT OF THE PATIENT**

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>Non Given</th>
<th>Same</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
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<tbody>
<tr>
<td><strong>Behavior Problems</strong></td>
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<tr>
<td>Socially Unacceptable Acts</td>
<td>x^a</td>
<td></td>
<td></td>
<td>x^b</td>
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<tr>
<td>Sex Problems</td>
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<tr>
<td>Learning Defects</td>
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<tr>
<td>Personality Difficulties</td>
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<tr>
<td>Somatic Dysfunction</td>
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<tr>
<td><strong>Interpersonal Relationships</strong></td>
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<tr>
<td>To Mother</td>
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<tr>
<td>To Father</td>
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<td></td>
<td>x</td>
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<tr>
<td>To Siblings</td>
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<td>x</td>
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<tr>
<td>To Other Children</td>
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<tr>
<td><strong>Psychiatric Interview</strong></td>
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<tr>
<td>Appearance</td>
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<td></td>
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<td>x</td>
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<tr>
<td>Behavior</td>
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<td></td>
<td>x</td>
</tr>
<tr>
<td>Relationship</td>
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<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Prognosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
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<tr>
<td>Diagnosis</td>
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<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>

x^a — The lying has continued.

x^b — The destructiveness, disobedience, truancy, and stealing has stopped.
The patient made a remarkable improvement, in most of the interviews. Two categories were checked under Socially Unacceptable Acts because the problem of lying prevailed, while others problems were no longer present. A definite improvement was also noted in the rest of the problems that the child had presented. The same type of adjustment occurred in the interpersonal relationships and the psychiatrist also reported that he felt the girl was now showing a normal pattern of behavior.

The mother and the child were seen at the clinic for the follow up interview in May of 1952, two years and nine months after the first admission. Marion was sixteen years seven months old. The mother felt that the girl's behavior had been disturbed because the child had come to her home to live, after having spent her whole childhood with the maternal grandmother, who was more lenient with her. Marion was probably reacting to the change of environment.

The following report illustrates the behavior problems and the interpersonal relationship of the girl as discussed by the mother at the time of the first admission and also at the follow up.
## BEHAVIOR PROBLEMS

### FIRST ADMISSION

**Socially Unacceptable Acts**

On some occasions she had thrown dishes out of the window and had taken clothes from her home in order to sell them. She did mean little things like destroying a dinner after her mother had completed it. She was very disobedient and said that her mind told her to do these things. She ran away from home on several occasions. The mother was concerned about her lying and stealing.

### FOLLOW UP

**Socially Unacceptable Acts**

The mother said that she had not thrown things lately and seemed to have quieted down. When she was mad she would cry.

She became more obedient since the previous interview. She would no longer consider running away from home.

When Marion had heard the voices she stole things from the house but since she no longer hears them the stealing has stopped.

### Learning Defects

Marion seemed to be progressing very well because now she got good grades and expected to graduate in June from the eighth grade.

### Sex Problems

She would go out all night and never return until late in the morning. The mother wondered if she was with some boy, although this was pure speculation.

She has stopped going out nights, that is, at a late hour. She participated in community affairs but still had certain hours that she kept.
BEHAVIOR PROBLEMS

FIRST ADMISSION

Personality Difficulties

Marion spoke of voices that she heard constantly and said that she could not control her actions when she received directions from the voices, even though she knew she was wrong. She has been seen to get up at night, walk to a cupboard, help herself to some matches, and then return to bed.

In school, the other children seemed to be able to aggravate her into foolish reactions that caused much more trouble than was appropriate to the irritation (taken from school report).

INTERPERSONAL RELATIONSHIPS

To Mother

She was belligerent toward the mother.

To Stepfather

She got along well with stepfather because he paid her for doing chores.

To Siblings

She quarreled frequently with them.

FOLLOW UP

Personality Difficulties

The mother said the child had greatly improved because she no longer heard the voices.

INTERPERSONAL RELATIONSHIPS

To Mother

The mother felt that Marion was getting along much better with her since she had been with her for awhile.

To Stepfather

Their relationship continued to be good.

To Siblings

Now she liked to take care of the children and no longer quarreled with them.
To Other Children

She seemed to have lots of friends and enjoyed herself with them.

FOLLOW UP

She still had many friends and attended dances and went to roller rinks.

PSYCHIATRIC INTERVIEW

Appearance

Marion was a very colorless, affectless negro girl. At first she seemed frightened but later she was completely unconcerned.

Appearance

She was a well dressed attractive looking girl who smiled pleasantly and appeared well developed.

Behavior

She said she had been hearing voices since the first of the year. It was like someone talking to her but nobody was there. They told her to do many bad things, like the time they told her to spray DDT all over the box next door, or when they told her to break dishes. At first it was a man's voice, and later a woman's voice. Sometimes her side hurt when she stretched and also the front of her head. Her eyes sometimes "go funny" and everything goes together bright and dark.

Behavior

She was well orientated, with warm affect and was quite happy in outlook. She showed no hallucinatory activity and had definite goals in her life. After she graduated she intended to go to Manley to be a beautician. She has not heard the voices for some time and felt that these voices were really her imagination. She no longer thought about them. Her conversation was to a great degree spontaneous. She said she had many friends and participates in many community activities. She felt quite happy and fine and didn't know what had brought about this change. She had no longer had the pains she complained of previously.
PSYCHIATRIC INTERVIEW

FIRST ADMISSION

Relationship
There was very little of a relationship established with the male examiner. She looked out of the window most of the time and verbalized very little.

Prognosis
It was considered poor.

Diagnosis
The patient seemed to be psychotic.

Recommendations
The girl should be taken to a state hospital but if the mother preferred to keep her home, there was nothing in the immediate situation to counter indicate this.

FOLLOW UP

Relationship
She related quite well to the psychiatrist and was spontaneous in conversation.

Prognosis
Since Marion had such a practical outlook on life and had such definite goals for herself, the prognosis was considered to be very good.

Diagnosis
Marion showed a normal pattern of behavior. She seemed to be a well adjusted individual.

The psychiatrist recommended institutionalization of the child, but also told her it was not an immediate necessity. As a result the child remained in the home. The mother did not know why or how Marion had improved so remarkably. The only thing she could say that might have changed the first was the fact that she was afraid she would be sent to a mental hospital. There has been no change in the home situation.
and she had not received any treatment from anyone. The mother appeared to be lacking in intelligence and it was difficult to receive an adequate answer from her.

The two following cases were those that became worse in adjustment. The adjustment worse indicated that the problem had become more pronounced or new problems had arisen.
CASE XXI

Dan, a negro child, aged fifteen years nine months was referred by the school to the Institute for Juvenile Research in November of 1949.

Little was known about the patient's father since the parents were separated shortly after the birth of the child and the father eventually got a divorce. The mother was a Baptist and of marginal income status. The patient was an only child. They lived in a large space in the rear of a second hand store, where the sanitary conditions were very bad.

The boy's I. Q. was 87 as judged by the Stanford Binet, Form L test and he was classified as a dull normal. The psychologist felt that he was an effeminate, passive, superficial type of person who was grossly impaired in the thinking processes. The grade placement at the time of the first admission was 10-B. The school report mentioned that he had been doing well in school previously he failed.

The adjustment of the child is shown in the following table.
### TABLE XXV

**ADJUSTMENT OF THE PATIENT**

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>Non Given</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
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<tr>
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<td>X</td>
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<tr>
<td>Sex Problems</td>
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<tr>
<td>Learning Defects</td>
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<tr>
<td>Personality Difficulties</td>
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<tr>
<td>Somatic Dysfunction</td>
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<tr>
<td><strong>Interpersonal Relationships</strong></td>
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<tr>
<td>To Mother</td>
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<td>X</td>
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<tr>
<td>To Father</td>
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<tr>
<td>To Other Children</td>
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<td>X</td>
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</tbody>
</table>

The patient's adjustment was not very successful since most of the problems became worse rather than being alleviated. The basis for judging the adjustment of the boy was the statements that were made in the follow up with the patient himself.

The mother was contacted by phone for a follow up interview, but no appointment could be scheduled because she was working. The following day, Dan came to the clinic unexpectedly and was then interviewed by the writer. No psychiatric follow up interview was possible due to the unexpectedness of his arrival. The follow up interview occurred in September of 1952, two years and ten months later. Dan was eighteen years seven months old. He was a neatly dressed, rather tall, thin and effeminate type of person. Throughout the interview he kept his eyes downcast and spoke very softly.
The mother was interviewed at the time of the first admission but the patient was interviewed for the follow up interview.

<table>
<thead>
<tr>
<th>BEHAVIOR PROBLEM</th>
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<tbody>
<tr>
<td><strong>FIRST ADMISSION</strong></td>
</tr>
<tr>
<td><strong>Socially Unacceptable Acts</strong></td>
</tr>
<tr>
<td>He truanted from school.</td>
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<tr>
<td><strong>Sex Problems</strong></td>
</tr>
<tr>
<td>He masturbated.</td>
</tr>
<tr>
<td><strong>Personality Difficulties</strong></td>
</tr>
<tr>
<td>The only thing that bothered mother that &quot;sometimes he was in a deep study, like he worried.&quot; He was hardheaded and tried to have his own way all the time.</td>
</tr>
<tr>
<td><strong>Somatic Dysfunction</strong></td>
</tr>
<tr>
<td>There was nothing recorded.</td>
</tr>
</tbody>
</table>
INTERPERSONAL RELATIONSHIPS

FIRST ADMISSION

To Mother

Patient was not affectionate, nor was he the kind of boy who confided in her readily.

To Father

The boy located father in 1948 and they seemed to get along alright.

To Other Children

Mother did not know any of patient's friends or whether he had any. He had never been a child to do much visiting. He isolated himself from school children and tattled on them in school. (taken from school report).

FOLLOW UP

To Mother

He doesn't get along with mother. She doesn't give him love or affection. They are like two strangers.

To Father

They get along alright. "He's no benefit to me now because it is a waste of time and energy to go see him because he can't help me."

To Other Children

I never got along with girls because they never did like me anyway. The boys don't like him because he complained continuously.
The patient was a rather small, very effeminate boy who was passive in manner.

Behavior and Relationship:

He seemed to be older as he started talking, because of his highly intellectualized way of handling things. He was extremely circumstantial, fast talking but affectless. He was not able to handle any aggressive feelings. No evidence was elicited of grossly delusional or psychotic behavior. He revealed very intense seeking of his father in which he had involved the school, the court, the pastor, friends, and mother. There was much confusion in the way he frantically sought out the contact. He play the father against the mother. He had no friends because he couldn't trust them. He went into elaborate explanation of how he had been cheated by his friends. He dreamed about murders and dead bodies. In his verbalization there was frequent misuse of large words and he used words without any meaning. In his relationship, he seemed to be reaching out toward some masculine person.

Diagnosis:

The diagnosis was that the boy was a pre-psychotic personality and there was a danger of his acting out in a homicidal or suicidal manner if placed under sufficient stress.

Recommendations:

A future commitment was suggested and also the school should be contacted to support him in his academic activities.
For the past two years Dan has remained in the home, worked at odd jobs, and attempted to find an agency to take an interest in him. He felt his condition had become worse and wanted to be committed to a mental hospital. He had gone to four different types of hospitals and agencies for treatment and they have not helped him. The entire interview centered around his paranoid ideas of reflection by everyone.
CASE XXII

Erwin, aged sixteen years four months, was referred by an aunt to the Institute for Juvenile Research in September of 1949.

He was the oldest of four boys. The patient's parents were Protestants and of Swedish descent. Both of the parents were working. Very little was known about the home situation, except that in 1947 mother went to Minnesota with the children and left her husband at home. They returned home recently and father noticed the behavior of the child. At the time of the first admission the boy was living with a maternal grandmother. It was the opinion of the psychiatrist that mother had been quite seductive with the boy and had kept him closely bound to her. His grasp on reality was thin and she appeared vague and ineffectual. The father was a weak, defensive, evasive type of person and verbalized little insight into the nature of the boy's difficulties.

The boy's I. Q. was 119 as judged by the Kuhlman Anderson test administered to him at school. No tests were given at the clinic. His grade placement at the time of the first admission was in Junior High School.

The adjustment of the child is shown in the following table.
TABLE XXVI

ADJUSTMENT OF THE PATIENT

<table>
<thead>
<tr>
<th>Areas Studied</th>
<th>Non Given</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socially Unacceptable Acts</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex Problems</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Defects</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Personality Difficulties</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Somatic Dysfunction</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Interpersonal Relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To Mother</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>To Father</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To Siblings</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>To Other Children</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

The patient's adjustment was not very successful since in most instances the problems either remained the same or became more prominent. The type of adjustment made by the patient was based upon the statements made by the father at the follow up interview.

Several letters had been sent to father and arrangements were finally made for the follow up interview in August of 1952, two years and eleven months after the first interview. Erwin was now nineteen years three months old. The father expressed the belief that the boy's problems had begun at the age of fourteen or fifteen years old when the mother had brought the children to Minnesota for two years. Previous to their leaving the boy seemed quite normal and has participated in many school activities but when the family returned, the child appeared as a
changed person. Father had tears in his eyes when he referred to the boy’s commitment to Chicago State Hospital in September of 1949. Erwin has remained there since that time and the father believed that the boy has become worse during this period.

The following report illustrates the behavior problems and the interpersonal relationships of the boy as discussed by the parents at the time of the first admission and also at the follow up of these same areas as discussed by the father.

<table>
<thead>
<tr>
<th>BEHAVIOR PROBLEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FIRST ADMISSION</strong></td>
</tr>
<tr>
<td><strong>Sex Problems</strong></td>
</tr>
<tr>
<td>He masturbated.</td>
</tr>
<tr>
<td><strong>Learning Defects</strong></td>
</tr>
<tr>
<td>No learning difficulties were recorded.</td>
</tr>
<tr>
<td><strong>Personality Difficulties</strong></td>
</tr>
<tr>
<td>When the patient came home from Minnesota two weeks ago he was depressed moody and extremely worried about his health. He seemed to be in a dream world and complained to being tired. He seemed bewildered and had difficulty finding his classrooms.</td>
</tr>
</tbody>
</table>
**FIRST ADMISSION**

**Somatic Dysfunction**

He has failed in school and expressed the feeling that he had only a short time to live. He complained of a short time to live.

**FOLLOW UP**

**Somatic Dysfunction**

His health seemed to be good and his appearance wasn’t change much except that he has gotten heavier.

There was a period following shock treatment when he was unable to feed himself, dress himself or take care of his bodily functions. He fluctuates from good to bad while in the hospital.

**INTERPERSONAL RELATIONSHIPS**

**To Mother**

She and the patient were inseparable until the siblings were born. Patient used to dry dishes just to be near her.

**To Father**

Father was a healthy friendly person with whom he got along fine.

**To Siblings**

He and his brothers didn’t get along because they were constantly fighting.

**To Other Children**

He has never had any friends.

**To Mother**

The father felt that the boy hated the mother. She was inconsistent with him and the boy never knew what to expect from because she flew off the handle.

**To Father**

He has always had a good relationship with him.

**To Siblings**

He still doesn’t get along well with his brother.

**To Other Children**

At times he fights with the other patients, but usually he prefers to remain by himself.
Appearance:

Erwin was a shy, fearful, immature looking blond boy who was very careless in appearance.

Behavior:

He was restless, autistically touched the top of his head, showed poor attention and had a dreamy attitude and asked me frequently to repeat questions. He showed increased in respiration which was rather bizarre. He spoke of aches and pains. He liked to sleep all the time. During the interview he smiled autistically and had a preoccupied gaze into the distance which impressed me as being hebephrenic. There was considerable eye blinking and deep breathing of a bizarre nature. He was under oral tension. At the end he admitted again being uncomfortable and also that he felt he was going to die and he had guilt feelings about masturbating. During one period in the interview he attacked me verbally in a paranoid trend.

Diagnosis:

He gave me the impression of being a hebephrenic with marked paranoid tendencies.

Recommendations:

The boy needs immediate hospitalization and will probably have to go to a state hospital unless arrangements can be made to get him at Illinois Neuwa Psychiatric Institute.
The recommendations of the psychiatrist were followed through by the parents and the boy was hospitalized immediately at Chicago State Hospital. Although, the boy's condition seemed to be worse, father did not have resentment for the hospital, for he felt that they had done the best possible. He felt that the child did not have sufficient interest to keep him busy and that contributed to his mental deterioration. The home situation has changed considerably, since the first admission for father recently obtained a divorce and also received custody of the children. However, father was unable to support them and now the children are scattered around the United States.
The following table illustrates the adjustment of the group as a whole showing the predominance of "slight improvement", in two of the cases, "remarkable improvement" in three of the cases and a "worse" condition in two other cases.

**TABLE XXVII**

**ADJUSTMENT OF THE GROUP**

<table>
<thead>
<tr>
<th>Names</th>
<th>Same</th>
<th>Slight Improvement</th>
<th>Remarkable Improvement</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rory</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Larry</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Jamie</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Mary</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Marion</td>
<td>3</td>
<td>3</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Dan</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Erwin</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

In addition to the predominance of the three adjustment areas, the other types of adjustment are also present but in a lesser degree. It was interesting to note that those who were predominantly improved in either in the slight or remarkable improvement did not have and symptoms that had become worse.

This chapter dealt with the remaining seven cases, two of which had shown slight improvement, three had become remarkably improved and two had become worse. There were five boys, one of which was negro, and two girls, one of which was negro. The age of group ranged from five years six months to sixteen years four months. Two of the children had been referred by the school, three from social
agencies, one was a medical referral, another came from a relative, and the last one was made through the probation officer. As for the religious status, four of the children came from Protestant families, one from a Lutheran family, one was Catholic and the last one was of mixed religion. There were only two cases in which both parents were present in the home and the mother was the only natural parent present in the rest of the cases. These homes had been broken by divorce, desertion and separation. The factors of rejection, hostility, and over protection were found in the attitudes of the parents toward the children. Out of this group there was only one family receiving financial assistance, two were receiving an adequate income, one was a marginal income, and in three others no information was available.

The I. Q. of the children were comparatively low, one child was a high grade mental defective, two were borderline mental defective and two were dull and only one was average, and one was unknown. All were attending school except one and he was a pre-school child. There were only three Rorschach tests administered.

Three of this group were pre-psychotic and four were psychotic. The writer interview six of the parents and one was an institutional case. Three of the children were seen by the psychiatrist and in all three of the cases the diagnosis was changed. There were only two cases in which the recommendations of the psychiatrist had been followed through.
CHAPTER IV

SUMMARY AND CONCLUSIONS

This follow-up study was an attempt to determine the type of adjustment made by the pre-psychotic and psychotic children who were seen at the Institute for Juvenile Research for diagnostic evaluation but were not accepted for treatment. The questions which this study endeavored to answer are: (1) what was the general social data and home situation of the child at the time of the referral; (2) what were the problems displayed by these disturbed children at the time of the first examination and how did they differ at the time of the follow-up; (3) what type of interpersonal relationships were these children able to form; (4) how did the psychiatrist's report of the child's adjustment compare with the mother's statements concerning the adjustment of the child; (5) how well were the recommendations of the psychiatrist utilized by the parent, and what methods were sought as a way of handling their problems.

Summaries of the material contained in the body of the thesis are presented in this chapter in answering the above five questions.

(1) The general social data and home situation of the twenty-two cases is presented in the following general summary.

There were twenty-two cases contacted for the follow-up study. Sixteen of these children were boys and six were girls. There were only two negro boys and two negro girls. Out of this group, the most referrals occurred in 1950 during which there were ten seen for diagnostic evaluation.
seven of whom were boys and three were girls. There was one boy seen in 1948, six boys and three girls seen in 1949 and two boys were seen in 1951. The youngest child in the group was two years nine months old and the oldest was seventeen years six months old. The median age for the group was eleven years ten months old.

There were various sources of referral, four of which came from schools, four others came from medical sources, eight were referred by social agencies, and the others were referred by a parent, neighbor, or relative. In keeping with the agency policy the responsibility for application was assumed by the parents with the exception of four cases in which application was made by the social agency.

There were ten cases in which both parents were in the home. The remainder of the cases were broken homes due to divorce, desertion, separation, alcoholics, psychotic parents or illegitimacy. One boy had been adopted and another boy was with foster parents. All the homes were disturbed in one way or another. In a majority of the cases the factor of rejection of the child was noticed in one or the other of the parents or both of them. Some of the cases of rejection was on an unconscious level while in other cases it was overt.

There were five children that came from Catholic families, three came from Jewish families, six from Protestant families, five from Lutheran families and the remaining three came from families of mixed religion. The principal wage earner of the family was the father; however, in two cases the mothers were supporting the families, and in three other cases the mothers were helping to support the family. There were five
families receiving financial assistance because the father was not in the home. At the time of the follow-up these same families were still receiving assistance. The writer was unable to find any direct information about the economic status of eight of the families, seven of the families had an adequate income and two other families had a marginal income. These had continued to remain the same at the time of the follow-up interviews.

It was interesting to note the number of siblings in a family and the ordinal position of the patient. There were four "only" children in the group. In five of the families there was one child beside the patient, in five others there were two other children in the home, in four cases there were three other children, and in the remaining four cases there were four siblings. In regard to the ordinal position, four children were the youngest, seven were in the middle position and seven others were the oldest children in the family. It was interesting to note that those children who were the "only" children or who were the youngest in the family were in the minority, whereas, there was a larger number of children who were the oldest in the family, followed closely by those in the middle position. There were only two children who were illegitimate in the study, Jamie and Marion.

The intelligence quotients of the children varied from the lowest which was 54 to 118 which was the highest, with the lower degree of intelligence assuming the more prominent place. In seven of the cases no I.Q.'s were obtainable due to various reasons. In three of the seven cases no psychologicals were given because the children's behavior was too disturbed. There were two children classified as low grade mental defectives, two were high grade mental defectives, three were borderline
mental defectives, five were dull normal, one was average, and four were high average. In many of these cases the psychologist felt that some of the children would have been placed in a higher classification, except that their disturbances interfered with their mental processes.

Fourteen of the children were attending school, one was in an ungraded room and two others were pre-school children at the time of the first admission. Out of the fourteen attending school, there were only six children who were in the actual grade they were supposed to be in for their age group. Three of them were classified as high average, one was known to be exceptionally bright and the other two were functioning at the dull level.

As was discussed in the introductory chapter, the psychosis not only affects the behavior of the child but in many cases also affects the physical disorders of the child. In sixteen cases physical disorders were mentioned in the record. Speech defect was found in five of the cases and some disorder of the eyes including blindness was found in four cases. Some of the other physical disorders mentioned were: allergies, motor incoordination, enemia, heart murmur, epilepsy, malnourishment, glandular trouble and rheumatic fever. Since there were only four cases that had been referred through a medical source, it would seem that these physical disorders did not assume a prominent place in the way of a problem.

(2) The problems displayed by these disturbed children at the time of the first admission and at the follow-up is presented in the following general summary.

In general most of the children presented problems in the
areas of Socially Unacceptable Acts, Sex Problems, Learning Defects, Personality Difficulties, and Somatic Dysfunction. The problems under Socially Unacceptable Acts, Learning Defects, and Personality Difficulties seemed to be the most prominent both at the time of the first admission and at the follow-up. Temper tantrums, disobedience, retardation, restlessness and excitability, and peculiar actions seemed to be the most frequent problems presented. In the general areas of problems mentioned above, the adjustment "same" predominated in all of the categories except Sex Problems and a slight improvement was noted as the more predominant factor. In the remaining problems under the general areas studied, the other types of adjustment were present but in a lesser degree.

(3) The interpersonal relationships formed by these children is presented in the following general summary.

A majority of the children had disturbed relationships toward other children and this fluctuated between being overly aggressive and antagonistic or being shy, withdrawn, and too submissive. The follow-up of these same relationships showed that most of these same relationships continued to remain disturbed with a few exceptions. The child's disturbed relationship to the mother and siblings was noted as next in line for a little over half of the children did not get along with either the parent or the siblings. It is understandable that the child did not have a good relationship with the mother, since many of the children had been rejected by them. There were a few cases in which a child was recorded as having a disturbed relationship with the father. Of course, there were only ten cases in which the natural father was present in the
home at the time of the first admission so this may account for the low number of disturbed relationships mentioned.

(4) The psychiatrist's report of the child's adjustment as compared with the mother's statements concerning the adjustment are presented in the following general summary.

Twenty-two cases were seen for the follow-up interviews. Of these, the psychiatrist was able to interview eleven children and two others were institutional cases. The writer interviewed nineteen of the parents and one patient for the study. The youngest child in the group for the follow-up was four years nine months old and the oldest was twenty years seven months old. The median age for the group was approximately thirteen years nine months old. The least amount of years that have elapsed since the first admission was one year three months while the longest lapse of time from the first admission was four years five months. Most of the follow-up interviews occurred approximately two years after the first admission.

The adjustment of the patient was determined by following up the Behavior Problems manifested by him and also the interpersonal relationships, and the psychiatric report. The adjustment of the children was based upon the statements made by the parents and wherever possible the psychiatric statement concerning the child's adjustment. Fifteen of the cases had remained the same, with other types of adjustment present in a minor way, two of the cases had made a slight improvement, three made a remarkable improvement, and two became worse. In most of the cases the parents were well aware of the disturbed condition of their children and their opinion
coincided fairly well with that of the psychiatrist. There were only two cases in which there was a marked discrepancy between the psychiatrist's opinion and the parent's statement concerning the adjustment of the child. In both cases the parent reported satisfactory progress of the child and at the same time the psychiatrist reported how disturbed the child appeared. One of the cases need immediate institutionalization.

(5) The utilization of the recommendations made by the psychiatrist and the methods sought as a way of handling their problems is presented in the following general summary.

Out of the eleven cases seen by the psychiatrist seven of the diagnosis made in the previous interview remained the same while four others were changed. The recommendations made by the psychiatrist at the diagnostic level were followed by eight of the cases. However, one of these cases had accepted institutionalization at the time of the first admission, but was later removed and returned home. One of the recommendations was unknown, three others recommended institutionalization at a later date, and the children remained at home as a result. Ten of the cases did not utilise the recommendations made by the psychiatrist and followed their own plan for the child.

At the time of the follow-up study, seven of the children were in institutions of one sort or another, and another one was in a V.A. mental hospital. Two of the children had been given dilantin for treatment and one of these was in an institution. The remaining thirteen children had remained at home. There was only one boy who had received treatment by some type of therapist. Another girl attributed her remarkable improvement to her minister. Other than these two cases no other methods were used by the parents to handle their problems with the children.
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Kanner, Leo, M. D., Child Psychiatry, Springfield, Illinois, 1938


II. ARTICLES


Despert, Louise J., "Prophylactic Aspect of Schizophrenia in Childhood", The Nervous Child, 23, Spring, 1942

## APPENDIX I

### SCHEDULE

### I. Identifying Information

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Code Name</td>
<td>2. Record Number</td>
</tr>
<tr>
<td>3. Birth date</td>
<td>4. Age at first admission</td>
</tr>
<tr>
<td>5. Date of admission</td>
<td>6. Age at second interview</td>
</tr>
<tr>
<td>7. Date of follow up</td>
<td>8. Sex</td>
</tr>
<tr>
<td>9. Race</td>
<td>10. Number of siblings</td>
</tr>
<tr>
<td>11. Ordinal Position; oldest youngest middle with brothers and sisters (s) middle with siblings same sex only boy with sister(s) only girl with brother(s)</td>
<td></td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Statement concerning home situation</td>
<td></td>
</tr>
<tr>
<td>13. Statement concerning attitude of parents toward child</td>
<td></td>
</tr>
<tr>
<td>14. Adoptive home foster home institution or boarding school</td>
<td></td>
</tr>
<tr>
<td>15. Referred by Responsibility for application</td>
<td></td>
</tr>
<tr>
<td>16. Religion of father mother</td>
<td></td>
</tr>
<tr>
<td>17. Nationality of father mother</td>
<td></td>
</tr>
<tr>
<td>18. Occupation of principal wage earner</td>
<td></td>
</tr>
<tr>
<td>19. Economic status</td>
<td></td>
</tr>
</tbody>
</table>
SCHEDULE

20. I. Q. of child

21. Grade placement at first interview

22. Classification of child

23. Result of I. Q. test

24. Results of Rohrshach

25. Results of T. & T.

26. Electroencephalogram yes no result

27. Any other member in mental institution:
   Yes no who

28. Age of onset of symptoms

29. Circumstances surrounding onset

30. Health of child
APPENDIX II

SCHEDULE

THE CHILD SEEN ON THE DIAGNOSTIC LEVEL

1. Description of child as seen by the parent concerning:

A. Behavior Problems:
   1. Socially Unacceptable Acts
   2. Sex Problems
   3. Learning Defects
   4. Personality Difficulties
   5. Somatic Dysfunction

B. Interpersonal Relationships of the child
   1. Relationship of child to mother or stepmother
   2. Relationship of child to father or stepfather
   3. Relationship of child to siblings
   4. Relationship of child to other children

2. Problems of child as seen by the school

3. Description of child as seen by the psychiatrist:
   1. Appearance of child
   2. Behavior of child
   3. Relationship of child to the psychiatrist
SCHEDULE

4. Prognosis of child
5. Diagnosis given by psychiatrist
6. Functional or organic? (if given)
7. Recommendations given by psychiatrist
APPENDIX III

SCHEDULE

III. Follow Up Interview

1. Child at home: yes _____ no _____
2. Child in institution: yes _____ no _____
3. Date of admission to institution ____________
4. Age of child
5. Name of Institution ________________________
6. Date of removal ___________________________
7. Reason for removal _________________________
8. Grade placement of child at this time ____________

III. Follow Up Interview With Parent

(1) Description of child as seen by the mother (described according to the same behavior, shown improvement, or if it has become worse)

A. Behavior Problems:
   a. Socially Unacceptable acts (same, improvement, worse)
   b. Sex Problems (same, improvement, worse)
   c. Learning Defects (same, improvement, worse)
   d. Personality Difficulties (same, improvement, worse)
   e. Somatic Dysfunction (same, improvement, worse)
III. B. Interpersonal Relationships of the child

   a. Relationship of child to mother or (stepmother)  
      (same, improvement, worse)

   b. Relationship of child to father or (stepfather)  
      (same, improvement, worse)

   c. Relationship of child to sibling  
      (same, improvement, worse)

   d. Relationship of child to other children  
      (same, improvement, worse)

C. Contributing factors for the improvement or non improvement of the child as discussed by the parent

2. Description of child as seen by the Psychiatrist

   a. Appearance (same, improvement, worse)

   b. Behavior of the child (same, improvement, worse)

   c. Relationship of child to psychiatrist (same  
      improvement, worse)

   d. Prognosis (same, improvement, worse)

   e. Diagnosis (same, improvement, worse)
APPENDIX IV

QUESTIONNAIRE SENT TO INSTITUTION

I. Date of Admission __________________________ Age __________

II. Behavior of the child as seen by the parent.

A. These were some of the behavior problems manifested by the child as discussed by the parent when seen here at the diagnostic level.

a. Socially Unacceptable Acts

b. Personality Difficulties

c. Sex Problems

d. Learning Defects

e. Somatic Dysfunction
QUESTIONNAIRE

(1) Has this type of behavior remained the same while the child has been at the institution? Please discuss. Write on back if space is insufficient.

(2) Has the child improved and in what way? Can you account for the reason for improvement? Please discuss. Write on back if space is insufficient.

(3) Has the child become worse and in what way? Can you account for the reason for the worse condition? Please discuss. (Write on back if space insufficient)

(B) What type of relationship does the child have toward:
   a. other children within the institution?

   b. other adults within the institution?

   c. toward the mother and father?
QUESTIONNAIRE

d. toward the siblings?

III.  Behavior of the child as seen by the psychiatrist.

A. Described the appearance of the child at the present time.
   (Include any physical abnormalities or strange facial expression)

B. The following is taken from the psychiatric report following the interview of the child by the psychiatrist.

C. The relationship of the child to the psychiatrist during the interview was:

(I) Has this type of behavior remained the same during his stay at the institution? Does the child maintain the same type of relationship to those who are working with him such as a psychiatrist?
QUESTIONNAIRE

(2) Has the child's behavior and relationship improved since he has been at the institution? Can you account for the reason for the improvement? Please discuss.


(3) Has the child's behavior and relationship to those who work with him become worse since being at the institution? Please discuss the manner in which it has become worse and the reason for the for, if possible.


D. What is your diagnosis of the case at the present time?


E. What is your prognosis of the case?


F. If there are any additional comments, please discuss in the following paragraph.


Dear

We are conducting a research project here at the Institute for Juvenile Research, the purpose of which is to determine what has happened to the children that were seen at the clinic and were not able to be taken on for treatment at that time.

The study is limited in that the children that we are referring to are those that are presenting the same type of problem that your own child presented upon being seen here. We realize that the community has limited facilities for these children and therefore are interested in knowing how the child has progressed.

Since we were unable to contact you by phone, we would like to know if you would be willing to bring your child in for an appointment to be seen by Dr. Devlin, and simultaneously you shall be seen by Miss Amati.

Since there is some limitation on the time available for this research project, we would appreciate knowing if you would be interested in coming in for an appointment on

If for some reason you will be unable to come in on that particular day, you may contact either Dr. Devlin or Miss Amati by phone (So 8-4070) or letter, and perhaps other arrangements can be made that would be more convienent for you. Thank you.

Very truly yours,

(Miss) Louise Amati
Social Worker

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APPENDIX VI

LETTER SENT WITH
PERMISSION SLIP ENCLOSED


Dear

We are conducting a research project here at the Institute for Juvenile Research, the purpose of which is to determine, what has happened to the children that were seen at the clinic and were not able to be accepted for treatment at that time.

The study is limited in that the children that we are referring to are those that are presenting the same type of problem that your own child presented upon being seen here. We realize that the community has limited facilities for these children and therefore are interested in knowing how the child has progressed.

The study is being conducted on an interviewing basis, the child being seen by Dr. Devlin, and the parent simultaneously being seen by Miss Aneti. We are sending permission slips to those parents of children we believe have been committed to an institution, in order that we may obtain the necessary information from the institution. However, if your child is now in the home, we would appreciate knowing this and would also like to make arrangements with you to schedule an appointment.

Since there is some limitation on the time available for this research project we would appreciate an immediate return of the permission slip if the child has been institutionalized. If the child is now in the home, contact either Dr. Devlin or Miss Amati by phone (68-4070) or letter, if you are interested in coming in for an appointment.

Thank you.

Very truly yours,

(Miss) Louise Amati

Social Worker

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APPENDIX VII

LETTER SENT FOR HOME VISIT

Dear

We are conducting a research project here at the Institute for Juvenile Research, the purpose of which is to determine what has happened to the children that were seen at the clinic and were not able to be taken on for treatment at that time.

The study is limited in that the children that we are referring to are those that are presenting the same type of problem that your own child presented upon being seen here. We realize that the community has limited facilities for these children and therefore are interested in knowing how the child has progressed.

We sent you a letter for an appointment on for you and your , but as yet we have received no reply to it. We would prefer to have you and your come to the clinic to see Dr. Devlin and I, but if this seems impossible, I could arrange to make a home visit if this would be more satisfactory for you. I would appreciate knowing as soon as possible if you would prefer this arrangement and if you do, state the date and time you would be available.

If the child has been committed please fill out the permission slip and return that immediately in order that I may contact the Institution for the necessary information.

Please contact either Dr. Devlin or Miss Amati by phone (Se 8-4070) or letter, if you wish to have a home visit arranged or if you would prefer to come into the clinic. Thank you.

Very truly yours,

(Miss) Louise Amati
Social Worker
APPENDIX VII

LETTER THAT WAS SENT TO THE INSTITUTION

Res
Birthdate:
Parents:
Address:

Dear

We are conducting a follow up study here at the Institute for Juvenile Research, the purpose of which is to determine, what has happened to the pre-psychotic and psychotic children that were seen here at the clinic but were not accepted for treatment. We are endeavoring to find out how the child has progressed since the diagnostic interviews at the clinic, that is, if his condition has remained the same, become worse, or improved.

The study is primarily being conducted on an interviewing basis, the child being seen by me, and the parent being seen by Miss Amati. However, some of the children have been committed to institutions and this renders the above procedure impossible. In those cases where the child is institutionalized, permission slips are sent out to the parents in order that we can secure the information by contacting the institution. The study is concerned with the behavior problems of the child as manifested at the time of examination and also the relationships that the child is able to form. In order to facilitate your report, we have included in the questionnaire some symptoms shown by the child as discussed by the parent with the worker and also the report of the psychiatrist.

Enclosed you will find the permission slip and the questionnaire. Since there is some limitation on the time available for this research project, we would appreciate the return of the questionnaire as soon as it is conveniently possible. Your cooperation in this matter will be greatly appreciated. Thank you.

Very truly yours,

William J. Devlin, M.D.

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