PSYCHIATRY AND THE MODERN CHILD

BY

PAUL L. SCHROEDER, M. D.

Institute for Juvenile Research, Chicago, Illinois

The introduction of psychiatry in the study of children grew out of two movements, mental hygiene on the one hand and the Juvenile Court on the other.

With the contribution of Mr. Clifford Beers in his book, *The Mind that Found Itself*, the organization of a mental hygiene society came first in Connecticut about forty years ago, and subsequently in many other states in this country, and found its culmination in the organization of the National Committee for Mental Hygiene. This movement carried with it a greater understanding of the problems of the mentally ill and more particularly a realization that most mental diseases have their onset in childhood.

Following the beginning of this movement the Juvenile Court came, established first in Chicago. This was the outgrowth of the thinking of men and women concerned with the problems of children. This group believed that delinquent children were not inherently pathological but that their delinquency was in response to unfavorable influences about them combined with physical or mental difficulties. Ten years after the establishment of the Juvenile Court, in 1909, psychiatry entered the picture through the organization of the first Juvenile Psychopathic Institute in connection with the court in Chicago. Dr. William Healy, the first director, together with a staff of psychologists and social workers, pioneered the field, working with children brought to the Juvenile Court. The results of these studies appear in *The Individual Delinquent* and *Mental Conflict and Misconduct* by Dr. William Healy. This was followed by the establishment of similar clinics, notably the Judge Baker Foundation in Boston. In 1917 this service was extended in Chicago to include children with minor behavior difficulties such as truancy, school retardation and, in the younger group, with temper tantrums and minor incorrigibilities. At a later date there were included behavior difficulties such as stammering, bed wetting, feeding problems and shyness. In 1921 the National Committee for Mental Hygiene began to establish local community clinics in large cities throughout the United States and Europe, operated on the same basis as the clinics in Chicago and Boston, connected not only with the juvenile courts but more commonly with children's agencies, public schools, and as separate organizations, totalling approximately 225 clinics in as many cities.

In Illinois, as in several other states, this movement has been extended as the Institute for Juvenile Research and has local community clinics in those cities prepared for and desiring it. Ten Illinois cities are now carrying on a local community clinic in which the professional staff of the Institute serves as examiners and consultants. These clinics operate in the following manner.

The local organizations—including public schools, social agencies and medical societies—co-operate in sponsoring the clinic and inviting the Institute to serve as consultant. They are required to select cases, to provide facilities for the examinations, to provide stenographic service, and to defray the extra expenses of travel of the Institute staff. The functions of the clinic are education and demonstration. Selection is therefore made with a view to including cases which not only are remedial but which will be useful as an educational medium for the public school teachers, the social workers, physicians, parents and other persons properly concerned with the control and direction of the child.

One of the sponsoring organizations in the community must agree to assume responsibility for the organization, supervision and follow-up of the clinic. Of the ten clinics in Illinois, four are carried by the public schools, four by social agencies, one by the Juvenile Court and one by a health agency.

The clinic functions through investigation of the social factors involved, measurement of intelligence, physical examination and psychiatric study. Each of these examinations is conducted by a person especially trained in these fields.

The type of service offered to the child and the community is illustrated in the following case:

A child of twelve was referred for incorrigibility and truancy from home and school. The social investigation revealed a home situation with marked instability and disorganization and an evident lack of academic development in other members of the family, a neighborhood which was run down and in which other delinquent children live. The school reported that the child was failing in the fourth grade.

The physical examination showed a well-nourished, well-developed boy with minor disabilities such as local focal infections limited largely to the tonsils, adenoids and nasal passages.

Intelligence tests revealed this twelve-year-old child to have a mental age of eleven years eight months with an intelligence quotient of .97, and therefore, classifiable in the group of average children, with an educational ability of sixth grade. Because of the discrepancy between the actual grade work and the educational age, educational achievement tests were given which showed that he had a marked reading disability of second grade level with arithmetic of the fifth grade level. Other subjects placed him in the fourth grade.

In response to personal interview with the psychiatrist the child indicated a marked antagonism toward school and a self-evaluation as a stupid child. He rebelled at the academic demands made upon him, and stated that he was biding only the time until he could go to work. His association with delinquent companies was already advanced and admiration for the daring of the older boys was clearly evident.

In this child we found we were dealing not only with the limitations in his social situation which contributed to his disinterest in school, but more particularly with a significant reading disability. His obvious good intelligence was a hindrance rather than an aid in the school room. Because he evidently could do better work his teacher demanded more of him without realizing that until his reading disability was overcome he could not be expected to respond at a level in keeping with his abilities. Thus antagonism had already been established in his relationship with his teacher and had grown with each successive change in teachers. It had reached a point at which he was reacting to the intolerable situation at school by escaping in truancy. This in turn threw him into the company of associates who were experienced in truancy, challenging him and stimulating him far beyond the point which he found in the school room.

Recommendations included social work with the family, treatment of the minor physical disturbances, special instruction directed to overcoming the reading disability and stimulation of his interest in school through a larger participation in the school activities which did not demand academic qualification. It was recommended further that special interest on the part of the teacher or some other person be directed towards giving him the confidence indirectly aimed at changing his point of view towards school.

This represents one of the great variety of behavior problems in children for each of which different causative factors may be found. Individual study becomes necessary and treatment directed towards underlying causative factors.