in the world today no social problem is causing graver concern than the anti-social acts committed by children from the ages of 6 to 18 who constitute our juvenile delinquents and problem children.1

Juvenile delinquency is a ‘deficiency’ disease but not of the familiar A, B, C variety. It is not a deficiency of the soma or body but of the psyche. These children suffer acutely from ‘moral and spiritual avitaminois.’

Juvenile delinquency is primarily parental delinquency. A problem parent often breeds a problem child, and most parents of problem children are unhappily married. Wretched home conditions, bad environment and poverty are the commonest causal factors. It is not so much the broken home as the disorganized home that is at fault. The broken home may be brought about by divorce or the loss of a parent or both parents. It is not so much the physical absence of one or both parents as faulty human relationship which causes the numerous inimical anti-social acts committed by juveniles. In the disorganized home we find one or more of the following factors having a trigger action: criminal parents, mental instability in one or both parents, over-severity, neglect, jealousy, favouritism, domination, or parental maladjustment due to race or religion.

The delinquent suffers from an inferiority complex which is manifested in bullying, shouting, lying, vandalism, sadism, vagrancy and bizarre sexual offences. A particularly common form is truancy from school, which has been labelled the ‘kindergarten of crime.’

The juvenile delinquent and problem child appears on the surface as a cold, callous and predatory person. He seems to be devoid of remorse or a sense of guilt when faced with his misdeeds. This is only a mask. He is ‘putting on an act’, for basically he is jittery, anxious, uncertain and insecure.

The problem child has a constant struggle between repression and expression. There is far too much repression but little chance for expression, which must find an outlet. Alcoholics, drug addicts, sex pervers and criminals can often trace to early childhood their subjection to severe emotional stress and strain.

1 Presented at the South African Medical Congress, Durban, September 1957.
corrupt and social outcasts. Such dreadful discovery deflates his ego and is soul-destroying.

Sex delinquency is often traceable to parental incompetence in dealing with the question. Proper enlightenment is the best prophylactic against early sexual maladjustment. Adequate sex education requires a full measure of frankness, tact, and sound common sense. Many parents look shocked or grin or mumble something incoherent when questioned innocently by their child on sex matters. They pretend to be horrified at a natural and correct question on a vital matter which is perfectly physiological and essential for the average normal child to understand. Such parents goad their enquiring intelligent child to obtain information from most harmful channels, where sex is presented in a distorted, melodramatic and obscene form—with grave results.

Prognosis. What does the future hold for the delinquent and problem child? A natural orthotendency tends to produce adjustment. Despite the fact that thousands of boys and girls get into trouble every year, most of them grow into good citizens, but some continue their delinquent careers and are the professional criminals of tomorrow. It is truly amazing how many problem children become fairly well adjusted in later life. Indeed most delinquent children can be reclaimed. This demands continuity of treatment of each child as an individual.

Treatment

How should one treat these deviated children? It is a difficult task because it is complex. There are many facets in the child's make-up, and each facet must be scrutinized. Team-work is essential. The personnel should consist of the general practitioner, the school teacher, pastor, the scout master, the nurse, and the social worker. Such a team will approach the problem child with tact, understanding, and a knowledge of child psychology.

In order to correct character deviations in children we must penetrate the basic layers of character growth and development. If that can be done our next task is to resurrect the natural qualities of anxiety and guilt which were buried at an early age. Find the causal factors and, if possible, eradicate them. It is painful to face the grim fact that despite all our efforts we are often driven to remove a child from a disastrous domestic environment. These unfortunate deviated children need sympathy and understanding, and to provide that we must go down to their level and avoid undue criticism and moralizing. The child must be treated as a whole; he is a unit in himself as well as a unit in his home and in society.

Ira S. Wile, a leading American authority on behaviourism, advises us, when treating a problem child, to think of a cart wheel. Consider the child as the hub; his home, schoolmates and companions are the spokes, and his economic, social and creative opportunities as the circumference of the therapeutic wheel. The careful and cautious turning of the wheel will guide the development of a sound character, a healthy mind in a healthy body, from childhood into adolescence.

The child must be examined physically to determine that organically he is sound. Any physical defects must be corrected and his level of intelligence measured. Readjustments in the home and school will awaken interests and responsibilities which will guide the child into paths of correct social conduct depending on his capabilities.

Prevention. Medicine in the future will concern itself mainly with prophylaxis. Social service will focus its attention sharply upon undesirable environmental conditions which adversely affect the health and welfare of the community. For the prevention of juvenile delinquency a well organized happy home is the great objective. When that is achieved, the problem child will become a rarity.

REFERENCES


TRAUMATIC INTUSSUSCEPTION


Victoria Hospital, Wynberg, Cape

Records show that there were 20 emergency cases treated at this hospital on 31 December 1957. The first, and most interesting was a stab wound.

CASE REPORT

A 26-year-old native male had been stabbed at a party at about 1 a.m. on New Year's Eve, and was brought to this hospital by ambulance. He was seen by one of us (L.H.); he was presented with a vertical stab wound in the left flank, 1 inch long and 1 inch below the costal margin, through which prolapsed a wedge of omentum. His pulse rate was 66 per minute, his blood pressure was 140 / 90 mm. Hg, and his abdominal wall was soft. There was no suggestion of free fluid in the abdominal cavity.

He was admitted to the non-European male ward, given antitetanic serum, 1 million units of penicillin and 1 g. of streptomycin, and was prepared for operation.

Operation (J.R.). A left paramedian incision revealed no perforation of any viscus. The unusual finding was an intussusception 3 inches long at about the mid-point of the small bowel directly opposite the stab wound. This was reduced without difficulty, and careful palpation disclosed no polyp or other abnormality to account for it. The exposed omentum was excised, the incision closed, and a drain inserted through the stab wound.

Antibiotics being continued, the patient was kept on intravenous fluids for the first day, and on the second day he was given fluid by mouth. He made an uneventful recovery.

After the man had recovered from the effects of the party he said he had been in the best of health before he attended it.

Thanks are due to Mr. R. D. H. Baigrie, the Surgeon in charge of the case, and Dr. K. Field, Superintendent, Victoria Hospital, Wynberg, for permission to publish details of this case.