DEVELOPMENT OF PSYCHIATRY AND ITS PART IN THE PUBLIC HEALTH FIELD

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Let us call to our minds for a moment a few pictures with which we are all familiar. One is the child of our neighbor, who, at the slightest provocation, throws himself on the floor and kicks and screams in a most terrifying manner. Johnny Smith, another child, is failing in school. He does not mix well with other children and has a sullen, uncooperative way about him. And have we not all heard the remark of one neighbor to another "Poor Mrs. Smith. Her little Johnny isn't bright"? Then there is the neighborhood"good-for-nothing"and the delinquent children and adolescents definitely on the road to crime, about whom, it seems, nothing can be done except take the case to court when some illegal act is performed. The criminals so developed we put behind bars and Society has taken the "better than thou" or the "serves you right" attitude. Sentiment dispenses gifts of material things with the idea of cheering the criminal along his dreary, useless way and sponsors religious services for his comfort and solace and perhaps,reform.

Also, we have all known the adult who is continually worried about this and that, who is generally thought of as "queer" because of variable moods and emotional states. We know the man who is apparently unattached to any living thing, whose sole purpose in life seems to be to travel from one coast to the other. We give him a sandwich and some change for putting in our wood and he goes on his way, out of our thoughts as well as out of our yards. We know the person who is continually ill, with nothing wrong physically, as far as anyone can tell, and we are familiar with the tragedy and the distress and shame suffered by a family when one of its members is adjudged "insane" or is taken to an

institution for the mentally ill.

We have been fairly well able to cope with physical disabilities and illnesses but the mental field has been left strictly alone. It has seemed beyond our ken, in the realm of the supernatural, and sometimes not even sympathy was offered to those so sadly in need of help.

Fortunately, within the last few years a new picture has been started. The mental field has been coming into its own. We are realizing more and more that mental ills can oftentimes be cured, and that they can practically always be prevented if the right treatment is applied in time. Also, we are realizing the wideness of the mental field. We did not used to think of our so-called "problem children" as having mental difficulties -- they were just naturally "contrary" or "ornory" and had to be controlled by force. And if little Johnny could not do his school work he would have to fail. This, in the face of the fact that up until a year ago Johnny may have been doing average or above average work.

We now are realizing that much and probably most of our juvenile delinquency and crime is the fault of our own society. The gifts of material things are all right and the religious services are fine if they are of the constructive sort, as are all the other attentions and care that we give. But the tragedy of the whole system is that this care was not given in time. With individual help and understanding in the childhood days and adolescent days and at any time when help was needed, how much we could have prevented and how much greater would the work have been!

We now know that conditions in our environment as well as

our own innate make-up are responsible for making us what we are. That the "queer" person is so through no fault of his own and that he may be suffering tortures because of his unstable, insecure, and undecided mental condition. That the wanderer, with a different childhood environment and more understanding from society, might have become one of that society's progressive or at least stable and dependable members. To the family with a member in an institution for the mentally ill, we can now say that there are many chances for recovery and that there is no more disgrace than there is with a physical difficulty.

The steps by which we are reaching this attitude of prevention and cure form a very interesting chapter in the psychiatric and mental hygiene fields.

Reaching far back in history we find that mental disorders have been known almost since the beginning of time. They were thought by most people to be entirely in the field of the supernatural. The methods of treatment used were not scientific and form no part of the structure of modern day psychiatry or psychology. Hippocrates, however, was ahead of his fellows in this field as elsewhere. He believed that epilepsy, at least, had a natural cause just as any other affection. Treatment in ancient times was both sensible and ridiculous. Drugs were used for their quieting effect, and patients were starved, chained and beaten. Yet we find Democrites making a far sighted statement that has stood the test of centuries," It is meet for men to take

account of the soul rather than of the body, for perfection of the soul corrects wretchedness of the body tabernacle, but bodily strength without reasoning makes the soul not a whit better".

Caelius Aurelianus was responsible for treatment that was far ahead of his time. His patients were kept under favorable conditions of heat, light, and quiet. His attendants were taught to be tactful, not to antagonize the patients, and to use physical restraint sparingly and cautiously.

Medieval times brought a decline in this field. Priests were responsible for most of the treatment. Witchcraft was common and certain wells were thought to have a healing effect.

In England, in 1320, under the reign of Edward III, lunacy legislation was first begun. The property of lunatics was vested in the Crown. Bethlem, in London, was the first institution for care of insane patients.

In the seventeenth century there was no great change in the treatment of mental patients. Bleeding was common.

In the eighteenth century, in the latter part of the reign of George III, much attention was paid to insanity, due to the fact that the King himself suffered from attacks of mania. Volumes of literature were published, some of it, seemingly, quite modern. Treatment was based on the antiphlogistic theory. Dr. Joseph Mason Cox recommended inoculation with smallpox or itch. In 1804, he published his "Practical

Observations on Insanity", in which he made the statement " Certain it is that if any considerable commotion, and violent new action, can be excited in maniacal complaints, by whatever means, the mental derangement is often permanently improved". An interesting device for attaining the " violent action" was a circular swing invented by Dr. Erasmus Darwin. The patient was strapped to a chair or bed and rotated at any desired speed. Dr. Cox gives impressive instances of marvellous cures by this method. This swing was advised to be made part of the regular equipment of institutions for the insane. Yet it is interesting to note that the ideal of care for these patients in those days, as now, was " a more humane and successful method of cure".

Acute insanity was thought to be the result of an inflammation of the brain and its membranes. Treatment, to be successful, had to reduce the blood supply to the brain. So, blistering and bleeding were favorite forms of treatment. In 1811, Dr. Crowther, surgeon to Bethlem, boasted of having bled one hundred fifty patients at once.

Emetics, also, were highly recommended and used.

Later in the eighteenth century, came a striking change in treatment. This my be traced to three causes, 1. The great humanitarian movement which awakened sympathy with all human suffering, 2 The gospel of liberty, equality, and fraternity, preached in France, which reached even to the prison asylums of Paris, 3, The gradual enlightenment of medical opinion. To Italy belongs the priorty for asylum

reform, where, between 1774 and 1778, Vincenzo Chiarugi, assisted by Daquin of Chambery, introduced new methods in Florence. But the greatest place in reform belongs to Phillippe Pinel, who in 1792, transformed conditions at the Bicetre and Saltpetriere in Paris. He also convinced the world by his writings that the old methods were futile and wrong. His work on "Mental Alienation" stimulated to fresh effort. To him goes even more credit because his reforms were carried out during the darkest hours of the French Revolution. His reply made to the terrorist, Couthon, stands the test of time, "Citizens, I have a conviction that the insane are only intractable because they are deprived of air and liberty!" That same day he removed the chains from fifty of his patients.

Esquirol was the first to lecture on psychiatry.

England, too, was progressing. In 1796, before Pinel's work was known there, the York Retreat was established by the united efforts of William Tuke and Lindley Murray, members of the Society of Friends. Much credit is due the strong minded William Tuke for his untiring energy which enabled him to carry through his plan at the age of sixty. He met with much opposition and misunderstanding. Even his wife is reported to have said,"Thou hast had many children of thy brain, William, but this last one will be an idiot". The Retreat was fortunate in having as its first physician Dr. Thomas Fowler. He was a man of keen scientific spirit, and was devoted to research. He intriduced the arsenic solution known as Fowler's Solution. During his period of service

he kept records of six thousand cases that were very complete and without bias, relating failures as well as successes. In his research on drugs and therapeutics he was rather unsuccessful as we may well imagine. According to Samuel Tuke's description, "he was led to the painful conclusion, painful alike, to our pride and our humanity, that medicine as yet possesses very inadequate means to relieve the most grievous of human diseases". To our sorrow, this conclusion still holds good.

There wereother institutions in England, also, which were conducted on humane and enlightened principles. Among these were Laverstock House, Salisbury, and Brislington House, Bristol.

Both Pinel and Tuke stood for the socalled "moral treatment". They believed that the psychical environment was just as important as the physical condition, that nothing could be accomplished by drugs and discipline, and stood for complete abandonment of brutal methods of coercion.

In 1793, Fricke introduced humane treatment and reduced physical restraint in Germany.

In the eighteenth century also, another type of reform in the humanitarian field was being carried out, namely, prison reform. John Howard and Elizabeth Frye were two outstanding leaders in this field. John Howard was born in 1726. He became much interested in prisons as a result of his own experience as a prisoner in France. On becoming sheriff of

Bedford in 1773, he immediately set to work improving prison conditions. He found that persons who had been imprisoned and against whom the grand jury had not returned an indictment, were held because of their inability to pay the fee for release. As a result of his work, all prisoners against whom the jury had failed to find a true bill were released, free of all charges. He also worked on sanitary conditions of pri sons in England. In 1775, he traveled in France, Germany, and the Low Countries and made studies of prison conditions. As a result he published his book, "The State of Prisons in England and Wales", in which he makes the statement "If it were the wish and aim of magistrates to effect the destruction present and future of young delinquents, they could not devise a more effectual method, than to confine them so long in our prisons, those seats and seminaries ..... of idleness and every vice". The purpose of the penitentiary law which he succeeded in making is as stated, "to be by sobriety, cleanliness, and medical assistance, by a regular series of labor, by solitary confinement during the intervals of work, and by due religious instruction to preserve and amend the health of unhappy offenders, to inure them to habits of industry, to guard them from pernicious company, to accustom them to serious reflection and to teach them both the principles and practice of every Christian and moral duty".

Elizabeth Fry was born in 1790. In 1811, she became a minister in the Quaker Church. In 1813, she was asked to take

part in allaying the sufferings of the prisoners in Newgate Jail. Through her activities here, she became deeply interested in this field of work and instituted an educational system for the prisoners. News of her work spread and the system of her transformed prison was adopted in London. She was responsible for a movement for the benefit of discharged prisoners, and for the children of criminals and the poor. She contributed much to the reformation of offenders through education.

England, in 1828, passed a Bill for inspection of homes for the insane. All patients had a medical certificate for entrance, and all admissions, removals, and deaths were reported to the Commissioners.

The physicians most active in America were Drs. Bond, Kirkbride, and Rush. The first hospital with a part of it set apart for the insane was established in Pennsylvania in 1752. The first institution designed and used exclusively for the insane was at Williamsburg, Virginia. The first patients were admitted in 1773. The act of incorporation designated it as a "Public Hospital for Persons of Insane and Disordered Minds". It authorized the appointment of physicians and nurses and it was designated as a hospital and not as an asylum. State hospitals were established at Maryland in 1797, New York in 1808, Massachusetts in 1818, Connecticut and Kentucky in 1824, North Carolina in 1828, Ohio in 1838, and Maine in 1840. Dorothea Lynde Dix was responsible more than any one else for

this policy of state care. She began her investigation of paupers, lunatics and prisoners in 1837 around Boston. Her work grew until she had improved the conditions of existing hospitals and founded approximately thirty two additional institutions. From America she went to Scotland and started investigations which resulted in improved conditions there. In Scotland, also, she instituted parochial care for patients.

In Belgium, France, and a few other countries, the system of colony care arose. Under this system the patient was first sent to a central observation hospital and from there, to a family for care. By this means patients were allowed their freedom and stood a better chance for recovery in a normal environment.

Scotland instituted a similar system. The patients were "boarded out" in homes scattered over the country and were not confined to a colony.

By 1870, still the actual care and treatment of those afflicted with mental disease was no farther than the initial stage. All types of mentally deranged patients were thrown together indiscriminately in the state hospitals. Psychopathic hospitals were unknown. Medical students graduated with no knowledge whatever of mental diseases, many of them having never seen a case. Psychiatry was not taught. Psychology was not given in the medical course. That was a subject for philosophers and divines. Research in psychiatry was progressing

in Europe but in America the time had apparently not come for it. Such work as was put out in this country was severely criticized by European scientists. The medical superintendents of institutions for the insane were engaged in executive duties. The institutions did not have suitable equipment or laboratories and there were no internes. Each attendant had several hundred patients under his care. The nursing staffs were also inadequate.

Dr. J.S. Jewell was responsible for starting the "Journal of Nervous and mental Diseases. Through the medium of this Journal he complained of "too little zeal shown by American alienists (the term "psychiatry" had not come into use yet), and thought that"asylums would not bear close scrutiny".

Following the Civil War there was a great increase in mental disease as nothing had been done to prevent its development during the strain of the war period. The presence of these mentally disturbed patients in their homes and in the communities brought the need for their care to the eyes of the public. Thus, an agitation was started for something, some form of treatment to take care of this need. In the care of patients at the general hospitals it was soon found that mental patients needed a different type of treatment. They were helpless, they needed every moment of their day supervised. The attendants and nurses needed special training to care for these patients properly. Thus the idea of establishing training schools in psychiatric care came into being. The first of these training schools was at the McLean Hospital under Dr. Edward Cowles, and was a department of the

Massachusetts General Hospital. The first class graduated in 1883, and was composed entirely of women. However, after that, the classes were mixed, containing both men and women.
The first state institution to have such a training school was the Buffalo State Hospital. The class was started by Dr. W. D. Granger in 1883. He also published a useful textbook, "How to Care for the Insane".
Kankakee was next, starting a school in 1886. The course here was two years in length. This course was continued until 1893. In 1892 it was suddenly interrupted by a political upheaval which dismissed the medical superintendent. However, the movement for such schools was definitly in motion, and by 1927 there were sixty one training schools in psychiatry standardized under the rules of the American Psychiatric Association, and more in the process of being standardized.

A State Board of Public Charities was created in 1869. As a result of this, two new institutions, the Northern Hospital at Elgin, and the Southern Hospital at Anna, were established. The secretary of this Board was Frederick Howard Wines who was interested in a different and newer type of construction of institutions. Up to that time all the institutions were built on the plan of a massive central building. He started the "cottage system" or detached wards. These were two story buildings of different varieties, which only cost about a third as much as the old type. Dr. Wines had tried to have this type of building at Elgin or Anna but

was unsuccessful. In 1877 it was decided to build the new institution at Kankakee after this plan. Experience with this type of building was favorable and it was adopted by other states.

Though the buildings to house mentally ill patients had been improved, the care they received could not be said to have improved to any great extent. Mechanical restraint had not been abolished. This was probably partially due to ignorant, untrained attendants and lack of supervision. With many people, even today, an unconscious remnant still exists of the old idea of demoniacal possession. Mechanical restraint was considerably less used in England and continental Europe than in America. To explain this fact, it was first claimed that patients in American asylums were more independent and unruly than the subjects of monarchies, or else that the climate was more stimulating and led to greater excitement. However, by 1890, America had at least started improvement in care and abolishment of mechanical restraint. The use of quieting drugs has since been lessened and the various therapies substituted for them. Hydrotherapy has been found most helpful. In Germany, force was employed as to its use, but this was soon found to be unnecessary as patients would stay in the tub willingly for even days at a time.

The first psychopathic hospital and clinic was established at Albany, New York, under the direction of Dr. J.

Montgomery Mosher in 1902. This was known as "Pavilion F". In 1906, Dr. William J. Herdman succeeded in having a psychopathic addition established at the University of Michigan Medical School. Thus, the first psychopathic clinic in connection with a medical school was established. This was an important step forward.

Separate wards were established for receiving acute cases and for giving hospital treatment at state hospitals at Buffalo, Kankakee, Pontiac, Kalamazoo, Bloomingdale, McLean and Butler. Dr. A. L. Singer conducted a state psychopathic institute at Kankakee from 1907 to 1909. In 1913 the Boston Psychopathic Hospital was opened.

We have spoken of the difficulty experienced by the young medical student who wished to enter the psychiatric field in the early days of psychiatry. Any training that he received was accomplished by self instruction through reading and through attending some of the institutions of the day. Psychology was purely an academic subject and was of no help to him. But progress in psychiatry is closely linked with progress in psychology. In fact, psychiatry took the lead and stimulated psychology to take an active part in life activities, to apply its many theories to practice. Let us look for a moment at some outstanding psychiatrists of their day and their contributions. The contributions of this group

of psychiatrists lies not so much in their beliefs but in what they were able to accomplish in the psychiatric field. Each of them stressed the fact that the patient was an individual and should be studied and understood as such. They studied the symptoms, but with the purpose of finding out why the individual had such symptoms. This was their method of work, as it is also the modern day method.

Janet, with his conceptions of dissociation and possible psychopathology of hysteria and psychesthenia, marked an advance in psychiatry. In America, Morton Prince and others carried on his views. This period gave the first indication of a change toward placing the emphasis in abnormal mental conditions on causative factors.

Charcot and Levinsky did much work with hysterical paralyses. From this has developed hypnotic treatment and treatment by suggestion in lighter forms.

The next great step was accomplished by Dr. Sigmund Freud, an Austrian neurologist. Under him, psychiatry became an increasingly live subject, one that could be, and was, applied to the individual patient. Freud can be said to be responsible for placing psychiatry on a personality development basis, which marked the beginning of the development of modern psychiatry. Freud noticed that many hysterical patients recovered after understanding and facing the events which preceded the attack. From this observation, he developed the principle of the analytical approach. He let his patients

talk freely, usually with a slight amount of guidance, until they had told every part of their problems. Thus, he secured a knowledge of the difficulties and conflicts that were responsible for the disturbed mental condition. Freud's whole theory was built around the concept of sex. This, he thought, was responsible for all mental tie-ups and complexes because it was a subject that was both taboo and powerful in the lives of individuals. There is scarcely a field of psychiatry today that does not use some of Dr. Freud's principles in the treatment of mental conditions. Freud's work was based on clinical observations, it appeared to be confirmed biologically, and it offered an explanation of the apparently unexplainable symptoms of mental disease.

Freud's principle of psychoanalysis was not accepted by all psychiatrists. The greater part of the opposition has come from two other workers, Jung and Adler.
Jung's work on "Psychological Types" is well known. According to the way an individual meets the conflicts in his environment he is classified as either an extravert or an intravert. The normal individual, of course, strikes a half way point. Jung places emphasis on the immediate environment of the individual.

Alfred Adler is one of the most outstanding psychiatrists of the time. He deals more with the ego or self preservation instinct. Psychoses, according to Adler, result from conflicts

arising from a desire to dominate, on the one hand, and a feeling of inferiority on the other. The child is spurred to action by a realization of his helplessness and a desire to compensate for that. All psychoses have to do with inferiority. The presence of an inferior organ in the body is a great factor in causing the feeling of inferiority.

Kempf "has correlated all factors relating to unconscious tendencies to conduct based on unsatisfied instinctive desires and laid particular emphasis on the necessity for studying the motor sets of the individual (paths of discharge -- emotional, ideational, muscular, neural, glandular, etc.), for the different instinctive tendencies."[1.] Kempf has done much to further the development of the unitary body mind concept.

Early in the beginning of the twentieth century psychiatry was under the influence of Kraepelin. Kraepelin was principally concerned with the diagnosis and description of mental disease. Hence, the term "descriptive psychiatry", came to be used. He observed the familial trends of mental diseases and came to believe that heredity was responsible. Kraepelin worked out a classification of psychoses based on symptoms that was very complete. This classification was accepted in Europe and the United States.

Kraepelin's descriptive psychiatry is now being replaced by Bleuler's interpretative psychiatry. Bleuler is a teacher and investigator in Zurich. He uses the psychoanalytical

(Note 1. "Outlines of Psychiatry" by White)

principles developed by Freud and his followers, thus working with the unconscious mechanisms which cause the mental condition, and give meaning to the symptoms. Bleuler has also contributed much to literature.

Another very active worker is Dr. Adolf Meyer. Dr. Meyer came to this country from Switzerland in 1893 and accepted a position in Kankakee Hospital as pathologist. An idea of the amount of work to be done in a hospital at that time is given in the statement of Dr. Meyer when he said that there were two thousand two hundred patients and six assistant physicians. Dr. Meyer went to Kankakee just at the time of the political landslide mentioned above and remained for two years. At that time the "cottage plan" was just coming into effect. Psychiatry was trying to solve the problems of mental disease by means of state institutions, care, and commissions. Dr. Meyer realized that psychiatry needed to be put on an individual basis, that its work should consist of helping to solve the intricate problems of individual health, happiness, and efficiency. But psychiatry was then, as it is now in some places, an institutional and legal task. There was very little time to deal with individuals and their life problems. Science was still principally in the laboratory, it had not become alive by applying itself to the problems of actual individuals. But, as Dr. Meyer said "It was on the way".

At Worcester Lunatic Asylum Dr. Meyer became head physician

over four assistant physicians. Here, there were twelve hundred patients and six nundred admissions per year. He tried, in nis work with the other psychiatrists there, to give a vision of what the real psychiatry meant, to give them a vital interest and pleasure in it. Besides his hospital work he taught psychology to graduate students at Clark University. At Worcester Asylum he was working for a broader understanding of the patients, of the circumstances in their environment which had a bearing on their condition, their family settings, community life, school, and the like. The fiftieth meeting of the American Medico Psychological Association showed that there had been much thought on the subject of psychiatry and its possibilities. Dr. Weir Mitchell gave an inspiring address which acted as a definite spur to progress. So far, most of the scrutinizing of psychiatry had come from the outside. At this time Dr. Meyer urged a move from within. As a result, a printed public document was responsible for the first open examinations for internship in state hospitals.

In 1905, an after care scheme threatened to develop which was antiquated and not at all desirable. To head this off, the Worcestor Lunatic Asylum offered home visiting. To do this, they obtained what was probably the first psychiatric social worker. In the hospital, ward work was initiated, and folk dancing given for group treatment and pleasure.

In 1906, Dr. Meyer described the fundamental principles in

the development of dementia precox as he saw them. As the main causative factor in this disease, he saw faulty mental hygiene, a disorder of the personality due to a deterioration of mental habits. Thus, we may say that the present day conception of mental hygiene was laid by him. Dr. Meyer was working so whole heartedly in his attempt to get the new conception of psychiatry as he saw it across to his coworkers that Dr. Southard humorously said of him, "I don't know that we could abide two of him. But in our present status we must be glad there was one of him".

In 1913, Dr. Meyer was called to direct the Phipps Psychiatric Clinic at the John Hopkins University Medical School.

Dr. Meyer believes that the worker in psychiatry needs both institutional practice and extra mural experience. He believes that the large hospital is the place of the most important work. It is the place where training should be given to, and experience secured by the future community worker. Dr. Meyer's desire was that he might have a model community hospital for service, teaching, and research, but he did not believe the community was ready for such an institution. Neither did he think that conditions were ready for a normal expansion of psychiatric problems into schools, courts and industries. There was no recognition of the urgency. He believes that the work done in the educational line in mental hygiene is very worthwhile but care must be taken that it does not get out of control. Through the writings of Clifford Beers and

Vernon Briggs he saw real needs and opportunities for the betterment of those needs. Among his coworkers in the psychiatric field he especially mentions the following: Drs. Southard, White, Jelliffe, Kempf, Hutchings, Salmon, Podstata, Ebaugh, Bond, and Strecker. Dr. Salmon he describes as a "big, sympathetic soul who lived his experiences in broad contacts and helpfulness to colleagues, patients and their families, in true mental hygiene, largely non-technical". About 1915, Dr. Salmon took the leadership in the study of the different systems of care.

Dr. Charles Macfie Campbell initiated a period of nation wide surveys of school populations by his first survey in Locust Point district in Baltimore in 1914.

Let us for a few moments consider the evolution of the meaning of psychiatry. In the middle ages it was expressed as the philosophy of health, individual and social. It was largely common sense applied to living. Later, it became enmeshed in the hypotheses that grew around the experiments and concepts of hypnotism and hysteria which finally led into Freud's beliefs. This stage dealt entirely with the abnormal mind. During this same period Kraepelin's work appeared which still based all the emphasis on the abnormal. Then came a separating out of constitutional types and reaction sets and a background of biological and normal every day critical common sense. Now we are entering a period when psychiatry

is not confined strictly to the abnormal field but enters the normal as well. It assists in the adjustment of normal individuals who are finding life situations too difficult for them to meet successfully without help. If psychiatry can help the individual to live profitably to his fullest ability in all situations and conditions of life then it is good psychiatry. This is, of course, the preventive angle which is ordinarily known as mental hygiene. Dr. Meyer makes the statement "Psychiatry and its meaning is usually slow in coming to an individual".[1] He goes on to say that it became real to him only when he met it through experiences in actual life situations when he saw the need of it in people close to him, and when he handled patients whom he had known previously without the mental disorder. He found he could view them more as persons who had lost for a time in the battle with life situations and needed help in readjusting themselves. This is only another way of saying that we can only fully appreciate these experiences or others when we have had the same or similar experiences ourselves or seen them at first hand in a way that brings them home to us. The task of educating the public in mental hygiene principles should really not be difficult if we can give that public a thorough understanding of the field of mental hygiene and its uses and successes. There are very few persons who have not had experiences in which they would have profited by the knowledge of mental hygiene principles. As soon as the public realizes this, appreciation of the field should

1. Article by Dr. Meyer "Thirty Five Years of Psychiatry in the United States and our Present Outlook", American Journal of Psychiatry)

follow very quickly. Of this, Dr. Meyer says " I take it to be one of the important tasks of my life to make sure that students and physicians and the public can, more quickly than I did, get a natural sense and interest and curiousity and determination to know when and how those human problems come up which even today are largely dodged by medical and general training, but which may complicate or undo the chances of many a good start in human health and success".[1]

Though the importance of the application of preventive psychiatric principles had been realized nothing definite had been done in this line. No leader had arisen who could be the intermediary between the medical profession and the public. This task remained for one who had been a patient in mental hospitals in the days when both care and treatment were poor, but who came out a sane individual with an intense desire to spend the remainder of his life helping to better the condition of the "insane" and to prevent mental illness.

Clifford Beers' early life was seemingly very usual and normal. He went to grammar and high schools and took the examinations for entrance to Yale University. In the same year that he finished his high school course his brother was stricken with epilepsy. Mr. Beers was with his brother much of the time afterward and gradually a great fear developed in his mind that he, too, would become an epileptic. He went to

1. (Article by Dr. Meyer " Thirty Five Years of Psychiatry in the United States and Our Present Outlook", American Journal of Psychiatry).

Yale and graduated, though his whole course was a great effort as this fear was steadily becoming more intense. His graduation was in June 1897, and immediately afterward he accepted a position as clerk for a life insurance company. He remained there until the mental crash came in June 1900 and he was compelled to stop work. Then followed the typical treatment given to mental patients in those days, and in many places, given today. His mental disease was the manic-depressive type and he was keenly aware of all that was going on at all times. Even before his recovery, when he was still in the manic stage, he determined to spend the remainder of his life exposing the treatment of mental patients and working for an improvement of their condition. On September 10, 1903, he was discharged from the institution and went back to his former position. In 1905 he wrote his book, " A Mind That Found Itself", which tells of his experiences while a patient at the various institutions, and which proved to be the motivating force for renewed zeal in work with mental patients. In his book, he advocated education of people in general and an arousal of public sentiment against ignorance of mental diseases. He advised the formation of a National Committee for Mental Hygiene with subordinate organizations in each state. He believes that there should be modern psychiatric hospitals in connection with medical schools that medical students might receive training in this field and that scientific research might be carried on as to the cause and cure of mental illness. General hospitals also should have separate buildings for the care of mental patients. Another

institution that he believed was greatly needed was one which would fill in the intermediary stages from dismissal from a hospital until a position could be found. Some patients need a few months of treatment of this sort to put them on their feet in the social world, thus doing much to prevent another collapse. Mr. Beers aroused the interest and support of several prominent citizens, and on February 19, 1909, founded the National Committee for Mental Hygiene.

The chief objects of the National Committee were:

"1. To protect the mental health of the public.

2. To raise the standard of care for tho se who are becoming or who are insane.

3. To promote the study of mental disorders and educate about their causes, treatment and prevention.

4. To find data from reliable sources regarding the conditions of, and methods of dealing with mental cases.

5. To enlist the aid of the Federal Government as far as is desirable.

6. To coordinate existing agencies and organize a Society for Mental Hygiene in each state, allied, but independent of the National Committee.

The aims of the National Committee were:

1. To be a clearing house for the nation on subjects of mental health, prevention, care and treatment of the insane.

2. To be a coordinating agency between the state and local agencies.

The plans of the National Committee were:

1. To keep the facts regarding the subject of mental health before the public.
2. To publish pamphlets and reports and give lectures and exhibits.
3. To enlist the support of the public that there may be adequate appropriations for each state.
4. To establish hospitals similar to those at Ann Arbor, Michigan, and Boston in all states.
5. To enlist the aid of philanthropists that incipient cases may be treated promptly and fully in psychopathic hospitals.
6. To encourage people who are familiar with conditions in their states to help organize state societies and local committees.
7. To give medical students instruction in the mental field.
8. To study the relation of immigration to the prevalence of mental disorders. To control immigration with regard to the insane and defective.
9. To secure uniformly good laws in all states and thus raise the standards of care. For this purpose the National Committee published the document by Mr. John Koren "Summaries of the Laws Relating to the Committment and Care of the Insane in the United States".

10. The National Committee is studying conditions among the insane in the United States under a gift of $50,000 for the purpose of ameliorating their condition."[1]

In addition to the above named objects and plans of the National Committee the same pamphlet gives the following outline of what every person can do in the mental hygiene movement:

"1. Inform yourself thoroughly regarding the causes of mental diseases.

2. Help to make the facts you now possess generally known.

3. Refrain from those acts and habits which are liable to result in mental disorder.

4. Speak and think of insanity as a disease and not as a crime.

5. If relative, friend or acquaintance seems to be suffering from bad physical or mental habits, take steps to see that he is given the information you possess and receives proper medical care without delay.

6. Inform yourself of the modern methods of caring for the insane, and lend your voice and influence to all projects which make for better or earlier care of those suffering from mental diseases".

Among the chief original workers of the National

(Note 1. "Origin, Objects and Plans of the National Committee for Mental Hygiene", a pamphlet by the National Committee for Mental Hygiene).

Committee for Mental Hygiene were Dr. Thomas W. Salmon, Charles Burnham, PhD., Dr. Frankwood Williams, and Clifford Beers. Mr. Beers was made secretary and still holds that position.

The states have gradually been forming their own societies Connecticut's was established in May 1908 by Mr. Beers, as a model. Its objects were:

1. To conserve mental health.

2. To raise the standards of care of the mentally ill.

Illinois was second, forming her Society in June 1909. Its objects were similar to those of Connecticut and, in addition, any object of the National Committee that might be accomplished by a state agency.

In May, 1910, New York formed a Society, the third one to be established. New York's was slightly different from the others, being an outgrowth of the Committee on Aftercare of the Mentally Ill of the State Charities Aid Association of New York. Thus, it is not an independent society. Its objects are similar to those of Connecticut and Illinois. In addition it has been working for the education of the public as to the causes of insanity, has established clinics for nervous and mental diseases, and is assisting those individuals who need medical treatment.

The formation of state societies has continued until in the winter of 1931 - 1932 there were twenty six. Oregon's

was formed in the fall of 1931. Its objectives are similar to those of the other states. It cooperates closely with the Department of Psychiatry at the University of Oregon Medical School.

For three years after its formation, the National Committee was so hampered by lack of funds that it was unable to accomplish much actual work. Henry Phipps relieved the situation by a gift of $50,000. The years 1909 to 1917 were spent principally in collecting information and statistics about mental diseases and existing legislation. Surveys were made and conditions in institutions studied. In connection with the educational side a library was started and a search made for reliable literature. Professors of psychiatry were appointed at Universities to direct the scientific work in state hospitals and to initiate mental hygiene extension activities in the Universities.

Psychology had been making rapid progress in the field of mental testing. Both psychology and psychiatry owe much to Terman and others who revised the Binet and other tests so that they are now of real value in measuring the degrees of intelligence and deficiency. A large percentage of criminals and delinquents were found to be subnormal. Of later years and with greater perfection in the methods of mental testing, we have come to the conclusion that feeblemindedness does not play a part as a causative factor in crime and delinquency, but is a

contributing factor. The delinquency or crime is worse if the individual is subnormal mentally.

In 1916, under the direction of Warden Osborne, a psychopathic clinic was established at Sing Sing Prison. The plans were prepared by Dr. Salmon. Dr. Bernard Glueck, a psychiatrist of international reputation, who was in charge of the Government Hospital for the Insane at Washington and who had previously studied mental factors in crime and delinquency, was placed in charge of the work at Sing Sing. This was the first step in securing careful examination and treatment of every prisoner. It was hoped to make Sing Sing the reception prison through which all admissions would pass. Thus, many defects could be corrected and the mental and physical standards among prisoners raised. Plans were also made to supply other prisons with psychiatrists. The plan at Sing Sing was to eliminate the feebleminded, ill and degenerate and send them where they could receive the proper treatment. The study was made over a year's time. The family history of each prisoner was studied, his childhood as well as his later life, his mental status was taken, his attitude and conduct in prison observed and his reaction to confinement. A thorough physical examination was given.

The first report covered the examinations of the prisoners

during the first nine months of the work. During this time there were 683 admittances, and 608 of these were studied. The following results were obtained:

"1. Of 608 adult prisoners studied by psychiatric methods out of an uninterrupted series of 683 cases admitted to Sing Sing Prison within a period of nine months, 66.8 per cent were not merely prisoners but individuals who had shown throughout life a tendency to be at variance with the behavior of the average normal person, and this deviation from normal behavior had repeatedly manifested itself in a criminal act.

2. Of the same series of cases, 59 percent were classifiable in terms of deviations from average normal mental health.

3. Of the same series of cases, 28.1 per cent possessed a degree of intelligence equivalent to that of the average American child of twelve years or under; of the 98 native born defectives, 80.6 per cent were recidivists in crime, whose average number of sentences to penal or reformatory institutions was 3.5; and 85 per cent of the group will have to be returned again into the general community within a period of five years.

4. Of the 608 cases, 18.9 per cent were constitutionally inferior or psychopathic, to so pronounced a degree as to have rendered extremely difficult if not impossible, adaptation to the ordinary requirements of life in modern

society. This lack of capacity for readjustment is reflected on the one hand, in the fact that of the 91 native born in this group, 86.7 per cent were recidivists in crime, whose average number of sentences to penal or reformatory institutions was 3.9, and, on the other hand, in the fact that a very significant number of them had been totally economic failures thus far. Furthermore, 82.4 per cent of these cases will have been discharged again into the general community within a period of five years.

5. Of the 608 cases, 12 per cent were found to be suffering from distinct mental diseases or deteriorations, in a considerable number of whom, the mental disease was directly or indirectly responsible for the anti social activities". 1.

The program of the National Committee, just started, was interrupted by the World War and the Committee shifted its work to that in the military field. The work here centered around shell shocked and those other nervous and mental cases who broke down under the strain. The mental hygiene program adopted by the army and navy was as follows:

"1. The creation of a Division of Psychiatry, Neurology, and Psychology within the medical corps of the United States Army for the purposes of:

a. Securing psychiatrists and neurologists for the

(Note 1. " Crime and the Criminal" by Parsons)

the medical corps.

b. Establishment of special training schools in military psychiatry.

2. To exclude the mentally and nervously unfit.

3. To treat those likely to succumb to mental ills or who were already incapacitated.

a. To prepare plans for special neuropsychiatric wards in base hospitals and other hospitals.

b. To select and standardize equipment for thses wards.

c. To recruit skilled nursing personnel, both men and women.

d. To assign psychiatrists to field operations in the Expeditionary Forces.

4. Reconstruction:

a. Recommendation of changes in military regulations for discharge and transfer home of men suffering from mental and nervous disease.

b. Obtaining cooperation of individual states in caring for men discharged from the army for mental causes.

c. Recruiting of skilled occupational and special workers for reconstruction work with the discharged men.

d. Giving technical advice to the United States Public Health Service concerning construction of special mental hospitals for ex-soldiers and in the inauguration of country wide plans for vocational

training and other forms of rehabilitation."[1.]

Another of the psychiatric activities during the war was that carried on by Dr. A.L.Jacoby at Portsmouth Naval Prison. Warden Osborne was in charge of this prison at the time. The work was started in November 1917, and consisted of psychiatric examinations of naval prisoners to determine the incidence of nervous or mental disorder in general court martial prisoners, and, if possible, to find a way of reducing the economic loss by military delinquency. One hundred fifty prisoners were examined. The examination included a complete family and previous history taken from the prisoner himself and corroborated whenever possible by communication with other institutions where he may have been confined. A mental test was also given, using Terman's revision of the Simon-Binet Test. Special examinations were given when indicated, such as Wassermans, X-rays, cerebro-spinal fluid examinations, and the like. Seventy eight examinations were of prisoners already there. The remaining 72 were routine admittance cases. The results of the examinations showed 26.6 percent subnormal, 12 per cent hysterical, 2 per cent dememtia precox, 4 percent chronic alcoholism, 2 per eent cerebro-spinal syphilis, 5.3 per cent psychopathic personality, 6 per cent constitutional inferiority, 12 per cent other

(Note 1. "National Committee of Mental Hygiene" by Mildred Haughawout)

forms of deviation from normal mentality. The total abnormal mental condition was 67.7 per cent. These results show that two thirds of the total number examined were afflicted with nervous or mental disorders. Though a relatively small number was examined the results compare closely with King's results in his study of one thousand military delinquents. He found 65.4 per cent to be nervously or mentally abnormal.

With the end of the war the National Committee found itself faced with an extremely large field of work. As was the case after the Civil War, so after the Great War mental problems came to the front. Mental hygiene embarked upon a program of prevention and treatment such as it had never tried before. A brief outline of the program is as follows:

a. Promotion of psychiatric and mental hygiene research.

b. Improvement of medical education with regard to mental hygiene and psychiatry.

c. Integration of mental hygiene principles into the practices of education, social work, nursing, religion, public health and industry.

d. Securing a more effective working relationship between law and psychiatry in dealing with the problems of delinquency.

e. Improvement of facilities for the treatment and control of those suffering from mental disabilities, and strengthening mental hygiene clinic organization.

All that can be said for the first division above is that psychiatrists are working continually for better methods of care and treatment for those mentally ill. With the National Committee they are entering the preventive field, the field in which the greatest hope lies. Mental illness, after its development is much more difficult of cure than its prevention would have been. Then too, is not prevention the field to stress? Of course we must always have hospitals for there will always be some who will break and for these we want the highest type of care and treatment, but let us prevent these breaks if at all possible.

The necessity for the medical student to be given at least enough psychiatric training so that he has an understanding of the value of the field is now recognized. We are really not so far removed from the time when psychiatry was entirely lacking in the medical school. The medical school curriculum is already crowded until it can scarcely hold more. Yet psychiatry is a subject that should not be left in the amateur stage even though there does not seem to be sufficient time to include it without extending the medical school period. For those medical students who specialize in psychiatry the education beginning with college should take about twelve years. Few students feel they can afford to spend the time or money to take a course this length. It is possible of course, for those who specialize in psychiatry to spend less time in other

fields which they will probably never use. But what of the patient with a mental difficulty not particularly noticeable as yet who comes to the general practitioner? Will the practitioner recognize it and send his patient to a psychiatrist or not? If he does send the patient will that patient be able to stand the extra price of a specialist's service? A partial solution is offered by fellowship training in psychiatry. The Commonwealth Fund Fellowships began July 1,1928 in Colorado. They now include two year fellowships to Boston Psychopathic Hospital, Henry Phipps Psychiatric Clinic, and Colorado Psychopathic Hospital. The medical student must have first had his medical training and internship. These fellowships give the student 1, a survey of the fundamental literature, 2, direct clinical contacts and responsibilities in ward work, 3, clinical contacts in the out patient clinic, 4,clinical contacts in the community clinics, 5, participation in clinical research, and 6, miscellaneous activities to broaden and further participation in community program and teaching.

The work done during the war period with military delinquents stimulated further work in the post war period. Juvenile delinquency was becoming a great problem and many investigators were becoming interested in finding and correcting the factors leading to it. Judge Lindsay, of Denver, had long been a friend of all youthful offenders

and realized the necessity for constructive work on the subject. He, however, did not have the necessary facilities for carrying on such a study. It was Dr. William Healy who organized the first psychiatric clinic for the study of emotional, nervous and mental conditions of children. Dr. Healy worked with the Juvenile Court in Chicago and formed the Juvenile Psychopathic Institute. 1000 juvenile offenders were studied. By a complete study of the child, his past history as well as present, Dr. Healy was able to trace the development of those traits that led the child to his delinquent acts. There were bad home conditions, bad school conditions, personality interactions that were not conducive to good emotional development of the child. In fact, one could not expect a child to develop normally in most situations in which his children were placed. The reactions to the unsatisfactory environment were different depending on the personality of the child. The particular group which Healy studied had resorted to delinquent acts, but others sometimes give up the battle and become unhappy mental cripples, ineffective, and often in later life develop definite mental disease.

The National Committee for Mental Hygiene was conducting similar studies including about 20,000 dependents and criminals and about 50,000 school children.

The New York State Commission of Prisons, on June 4, 1918, adopted a resolution that an investigation should

be made on the subject of mental disease and delinquency in certain New York prisons by a committee of the commision. A report of this study was prepared with the help of Dr. V.V.Anderson, Psychiatrist in charge of special work in mental deficiency with the National Committee for Mental Hygiene. The results in some of the institutions studied were as follows: Percentage of inmates with nervous or "mental abnormalities:

Institution	Authority	Percentage
Sing Sing Prison	Dr. Bernard Glueck	59.0
Auburn Prison	Dr. Frank Heacox	61.7
Clinton Prison	Dr. V.V.Anderson	60.0
Auburn Prison (Women, feebleminded only)	Mabel Fernald PhD.	31.9
Westchester County Penitentiary	Dr. Frank Christian	
New York State Reformatory	Dr. John Harding	58.0
New York State Reformatory for Women,(feebleminded only)	Mabel Fernald Ph.D.	25.0

Similar studies in other states gave the following results:

Institution	Authority	Number studied	Percentage
Elmira	Dr. J.R.Harding	400	58.0
Mass. State Reformatory (Men)	Dr. G.G.Fernald	1,376	59.0

Institution	Authority	Number studied	Percentage
Mass. State Reformatory (Women)	Dr. E.R.Spaulding	500	63.0
House of Correction Holmsburg, Penn.	Dr. L.S. Bryant	100	69.0
Western House of Refuge for Women, Albion, N.Y.	DR. J.L.Herrick	185	82.1
Westchester County Penitentiary, N.Y.	Dr. B. Glueck	225	57.0
Mass. Reformatory for Women(on probation or sentenced to institutions in 1915)	Jesse D. Hodder	5,310	72.2" [1.]

The Medical Service of the Municipal Court of Boston made a study of 1000 offenders. 23 percent were found feeble-minded, 10.4 per cent psychopathic personality, 3 per cent epileptic, and 9 per cent nervously diseased. This makes a total of 456 cases out of 1000 showing abnormal nervous and mental conditions.

In 1921, the National Committee was asked by several Cincinnati public agencies to make a study of the Cincinati social problems. An exhaustive study was made and the results very enlightening as to the prevalence of nervous and mental disease. Of adults who were dependent on society, three out

(Note 1. " Crime and the Criminal" by Parsons).

of four were not in normal mental health and their abnormal condition serious enough to be responsible for their dependency. 25 per cent of these adults were mentally diseased.
Of the jail population, 75 per cent were psychiatric probelms. Of the juvenile court cases, two out of three were mentally abnormal, their abnormality being psychopathic, epileptic, feebleminded, mentally diseased or subnormal intelligence. What was still more startling was the fact that thirteen out of every hundred school children were not in normal mental health. 2 per cent were feebleminded, 4.8 percent were subnormal, 2 per cent were of borderline intelligence, 3.5 per cent were psychopathic, 0.2 of one per cent were epileptic, and 0.7 of one per cent had endocrine disturbances.

In 1920 a study was undertaken at the Women's Day Court, New York. The psychiatrist was provided by the New York Probation and Protective Association. 300 women were studied with the following results: 33 were normal, 129 had inferior or psychopathic personality, 52 were of border line intelligence 71 were mentally defective, 14 were insane, and one was a drug addict.

The results of the above studies give us an idea of the great amount of work that is waiting to be done in the psychiatric field. Especially is this true when we realize that with the proper environment and training the majority of these cases could have been prevented. Most of the above

studies centered around courts. But there are many individuals with nervous and mental abnormalities whose behavior is not such that they come before courts. The fact that we now believe so many of these cases can be prevented if reached early enough in childhood should spur us on to action in this field. Beside the great econ omic saving which would result with the prevention of all possible cases such as these, there is the humane element. These people were misunderstood as children. They were battling odds too great for them. All sorts of situations come up in the ordinary home life of children, the results of which no one but the trained psychiatric worker can see in time to prevent them. Human personality is not an easy thing to understand, in fact, it cannot be thoroughly understood. Every individual is different and reacts to the factors in his environment in a way that is peculiar to him. It is no disgrace then if parents cannot understand why Johnny does not profit by this form of training or experience when Susie or Robert did. It does not mean that Johnny is "bad", that he acts the way he does purposely, just to spite his parents. Johnny needs to be understood, not punished. And with the understanding, viewing the situation through Johnny's eyes one is usually struck with the normality of Johnny's reaction. Often the paradoxical statement is true that these socalled abnormal

children are more normal than we realize. It is really no wonder sometimes, that with the many hard factors of environment such as broken families, unsatisfactory personality interaction, inconsistency of behavior of adults, and all the other problems, that childhood is troubled and tries to work its own way out by so called anti social behavior. In some cases the child may be a very stable, well adjusted little mortal in spite of all his difficulties and come into adulthood with the same fine adjustment. Usually though, if one searches closely in these cases he will find some stabilizing factor in the environment which builds up the child's feeling of security. Without this there are personality difficulties, and the bewildered youngster is known as a "problem child". But, as a friend of childhood expresses it " let us always remember that a problem child is a child with a problem". Children have, in general, two great needs which must be provided if they are to have a normal emotional development. These are a feeling of security and an opportunity for development. By security we mean a sense of being loved and wanted, a sense that he fills a very definite and necessary place in the group and that no one else could fill quite that same place. At the risk of straying from the subject for a moment, let us try to see what happens to this sense

of security when a child grows up in an institution. If he has never lived in a home, if he has always been in the institution, he may not feel a lack or loss. But when that child grows up and goes out we find him often peculiarly lacking in normal attachments, in the sense of social obligations. Often he has no sense of property rights. He knows, of course, that everything does not belong to him, and that some things he must not appropriate for his own use, but there is no sense of moral responsibility there, the child is not socialized in the real sense of the word. Love, gratitude, kindly feeling or attachments are great socializing factors which carry over from the attachment or feeling for special personalities to all of society.

The chance for development is also very important. The child, at first, has no unselfish love or attachment for anyone. He loves his mother because she cares for him and feeds him. Later, he realizes his dependence on her and on the other members of his family, and a feeling of gratitude develops. As he becomes older, he becomes more independent and senses himself as a separate individual. He needs to feel self confident, the mental and emotional factors in his environment should make for the development of an integrated personality. He grows into a different relation to his

mother and father, he becomes interested in society and becomes an independent individual. Parents, though not realizing it, often hinder and sometimes ruin their child's chances for developing normally emotionally. By over care and over protection it is possible to stop the child's emotional development at the stage where he must be cared for, thus making him dependent for the rest of his life.

As a result of the various studies that had been made the field of child training had come somewhat before the eyes of the public . Need for understanding and help for children still in the elementary schools was recognized. In 1921 the Commonwealth Fund determined to assist in this psychiatric preventive work with children and organized a five year demonstration program for the prevention of delinquency. The plan included the training of workers, the promotion of visiting teacher service in the public schools, and the establishment of clinical facilities in the larger cities. The Commonwealth Fund realized that educational, health, and social welfare problems of children had been dealt with previously, but never in an integrated fashion. The child had been educated by his teachers, his health had been taken care of by school nurses and doctors, and problems of social welfare had been cared for by

social workers. But the child is not normally split into such definite and separate parts. He is a whole personality composed of these different parts, each part overlapping and influencing the others. The Division on the Prevention of Delinquency planned to study the child as a unit, to coordinate the medical, psychiatric, psychological, and social phases. The agencies to do this work were to be known as child guidance clinics. The children with whom the guidance clinics would work would be those with personality difficulties of all sorts, intangible difficulties in the psychological realm. Modern mental hygiene or preventive psychiatry looks on these as symptoms of more serious deep seated disturbances just as a physician might think of a sore throat as the possible beginning of diphtheria or scarlet fever. With the successful treatment of these difficulties there should be a marked reduction in mental disease, delinquency, dependency, and other social troubles. This attitude is a direct outgrowth of the work of Dr. Meyer, Dr. White, Dr. Salmon, Dr. Southard and others who realized the importance of treating each individual as a unit in relation to his environment.

The Bureau of Children's Guidance was established as part of the Commonwealth Fund Program for the

Prevention of Delinquency and was to remain in existance for a period of five years. The Bureau began service with Dr. Bernard Glueck as Director and Dr. Marion E. Kenworthy as assistant director. There were two physicians on the medical staff, one psychologist, and one director of social work. At the end of the five year period Porter R. Lee was Director;Dr. Kenworthy medical director; there were three psychiatrists, Dr. Kenworthy and two others; one psychologist, one director of social service, and two assistant directors of social service. Demonstration clinics were to be established in cities that had advanced sufficiently to be organizing good health, educational and social work, where local leadership could be secured, and where funds would be forthcoming for a permanent clinic. The community had to be developed sufficiently along social lines that it might be able to appreciate the value of such a field of work. The first guidance clinics were developed in St. Louis, Dallas, Minneapolis, St. Paul, Memphis, Richmond, Los Angeles, Cleveland, and Philadelphia. For a picture of a clinic set up we may describe the one established at Cleveland which was as follows:

" One director-- a psychiatrist who acts as consultant and general supervisor but sees few cases himself. Thirty six hours weekly are spent outside the clinic lecturing, in consultation with outside bodies, etc.

One assistant psychiatrist, full time.

One fellow in psychiatry- in training for taking up a directorship in another clinic.

Two psychologists.

One chief of social service who decides upon the acceptance of cases, trains students, supervises case work, etc.

One cooperative supervisor- a social worker who deals with cases referred by social agencies. She sees that case histories furnished by them are adequate, and after the child has been studied, advises on the after treatment of the case.

Three psychiatric social workers who do all the case work and social treatment for children brought to the clinic for full study.

Social service students in training work with a few cases under supervision and attend lectures and staff conferences.

One clinic secretary and three stenographers."[1.]

Only those cases were taken where the Bureau could carry full responsibility for treatment and where there was potential cooperation from strategic persons in the child's environment.

During its period of operation the Bureau received applications from 822 children. 591 were carried through a period of sustained treatment. All sorts of problems

(Note 1."Training Classroom Teachers to Deal With Personality Problems" by Gladys E. Hall)

were taken, nervousness, school failures, destructiveness, any problem of every day life. Much of the value of child guidance clinics comes in the contact with and the education of the parents. There is also a great emotional benefit as far as the parents are concerned when they are given understanding help. With some of the worry and uncertainity as to how best to treat the case removed and a practical, definite plan of procedure substituted, the parents are able to work in the solving of their own problem much more efficiently than before. The four fold approach was always used, social, psychological, physical, and psychiatric.

The above is a description of the demonstration clinics. When they were taken over by the city changes were made to satisfy the individual needs of that particuln city. The clinics demonstrated by the Commonwealth Fund were all community clinics, all agencies dealing with children cooperated. Experience with this plan showed that symptoms were not recognized early enough, that the children were often referred when it was too late to do anything to help. Because the school was one place where all children congregated and where personality traits were very evident and easily observed early, it was decided that the school would be a good place for the guidance clinics. The Board of Education in Minneapolis

took over the demonstration guidance clinic, and the Board of Education of Newark after observing the results of the demonstration clinic, established a clinic of its own. Some of the reasons for placing the community guidance clinic in the schools were:

"1. Public schools reach practically all children from pre school age up to those attending night school, and thus it is the logical agency to be concerned with mental hygiene problems of the community.

2. In many instances there are psychological, health, and visiting teacher departments already functioning so that the addition of a psychiatrist affords a complete clinic set up. The income is stable and this gives the clinic greater permanency than other sources of support.

3. Children and parents are accustomed to using these services and no one is set apart as abnormal who is referred to them, while the child sent to a clinic under other auspices may be so considered.

4. Information regarding all phases of the child's problems is more easily and thus more economically secured by a visiting teacher already familiar with the schools and community setting.

5. Therapeutic measures can be more effectively worked out when all school people feel the clinic is a part of their work and they are included in conferences to work out plans. Changes in the

curriculum are often made for the benefit of many because the need has appeared in the study of one child.

6. All teachers in the system as well as all the homes patronizing the school can be reached in an educational program which is difficult if carried on by an outside agency.

7. The actual work of the clinic can likewise be more preventive and effective since it will be easier to select the cases for service when a worker is in close contact with all school buildings. Too frequently community clinics reach only 'end results'.

8. A very useful by product is the personal service to the teachers and parents who may be given a better understanding of their own behavior through conferences with the psychiatrist and others".[1.]

Obviously, not a great amount of progress would be made without educating the parents with regard to mental hygiene. They are the ones who, after all, should be responsible for the training of their children. They then, must be brought to realize the importance and necessity of the application of mental hygiene principles in child training. There have been many lectures given to parent groups but this is not a very satisfactory

(Note 1. First International Congress on Mental Hygiene)

way of education. A lecture series with the group split into small discussion groups several times during the series for a round table discussion, will probably be a much more successful method for parent education as the scope of the work broadens.

The visiting teacher is another worker whose importance has been realized with the development of the mental hygiene movement. The visiting teacher movement was started two years before the child guidance clinics were established. Because she saw the need for better cooperation between home and school with a view to helping the child with his problems, Miss Mary Marot, a resident of Hartley House Settlement in New York City, attempted to work out a plan which would take care of this need. She organized a visiting teacher committee. This committee became a member of the Public Education Association in 1907. Soon after, Miss Jane Day was employed as the first regularly appointed visiting teacher. The Public Education Association demonstrated the work of visiting teachers to the Board of Education until, in 1913, the Board set aside a fund for the carrying on of this work.

Boston, also in 1907, through the Women's Education Association instituted a Home and School Visitor who

did the same work as a visiting teacher. During the same year the West End Neighborhood Association employed a visitor to work with their children coming from poor families. Later, settlements provided schools in their districts with workers. By 1925 there were nine such visitors in Boston, and by 1930 there were fourteen. The visiting teacher in Boston is not supported by the public school system, but by some community organization to which she is responsible. There is no centralization of this work.

That the public was becoming aware of the need for this type of worker is shown by the fact that different cities began at approximately the same time, and independently of each other, to establish such workers. In 1907 Dr. Dawson of the Hartford Psychological Clinic engaged a visiting teacher to work with this clinic. This was under public auspices and was the first of its kind to be so supported.

In Philadelphia the Friends Quarterly Meeting established a similar visitor to work out from a settlemant. In 1916 the White Williams Foundation became interested in this field and in 1930 their staff contained fourteen of these workers known as school counselors.

The greatest impetus to this movement was given

by the formation of the Joint Committee for the Prevention of Delinquency organized by the Commonwealth Fund. Since that time the visiting teacher and the child guidance movements have cooperated very closely, usually working together. The National Committee on Visiting Teachers was formed by the Commonwealth Fund in 1921. To facilitate organization, this Committee affiliated with the Public Education Association of New York City. Demonstrations of visiting teachers working in conjunction with boards of education were put on in thirty different sections of the country. When the National Committee on Visiting Teachers was formed there were twenty eight communities with some form of visiting teacher service. In 1930 there were 263 communities with at least one worker.

The visiting teacher combines the work of the social worker and the teacher. The direct object of her work is, of course, the child, but indirectly she reaches the family and the community. Her method of approach is the psychiatric. She works with children who are not adjusting normally to their school situation. This means working with the family for troubles in school usually have their origin in the home. It is a work in the preventive field, the application of mental hygiene

principles to the child nature.

A case taken from the records of a guidance clinic will illustrate both the work of the guidance clinic and the visiting teacher and the cooperation between the two and the court. In this case we see Gordon who steals and lies and who is doing poorly in school. We find in the record of the guidance clinic that he day dreams and that he seems unhappy. In the home we find a strained relation between the mother and father. We find a father who punishes severely one day and not at all the next. We find an abnormal sex experience and we find that Gordon had had no sex information whatever before this abnormal experience. There is a discouraged atmosphere in the home. There is also probably a starved emotional situation since the mother says she cannot show her affection. Also, bearing on this, is the fact that the father is very dependent on the mother and would therefor resent any affection shown to the children. Altogether, the home situation is such that we could not but expect the children to grow up with crippled personalities. The one well adjusted child is an example of the occasional child who seems to remain adjusted almost in spite of his environment.

Case of Gordon Winters.

Name: Gordon Winters.

Address: 1940 South Elm Street.

Birth Date: March 1, 1919.

School: South Elm. Grade: 7.

Referred by: Visiting teacher.

Preliminary Statement of Problem: Steals, lies, not doing well in school.

I. Sources of Information:

Name: Mrs. Lucy Winters.

Address: 1940 South Elm.

Relation to Child: Mother.

Worker's estimate of informant's intelligence and reliability: Intelligent, cooperative, quite emotional about her problem. Realizes the home situation is faulty. Is eager for help.

II. Family History:

A. Paternal:

Grandfather: Strict Methodist. Was "cranky", stayed away from home a great deal. Father was very fond of him probably because the grandmother held him up as an ideal. Father was thirteen when grandfather died.

Father: Health has always been poor and according to mother, becomes worse with sympathy. Is dependent on mother. Is poorly

educated, did not finish grades. Farmed before marriage and has done some carpentering and clerking in stores. Is somewhat irritable if cannot have his own way. Is close with money. Takes no household responsibilities. According to mother he is untruthful. Has a slovenly appearance. Until a few weeks ago he had always whipped the patient severely.

Paternal Uncle: Cowboy in Arizona. Married but does not care for his wife. Steals.

Paternal Uncle: Fairly well educated. Married, has a large family. Seems to be a good type of man.

Paternal Uncle: Very well educated. Held high teaching position but lost it because of immoral practices.

Grandmother: Quiet, kindly person, good housekeeper. Still living. Father very fond of her. Poorly educated.

B. Maternal:

Grandfather: Quite a well educated man. Poor health. Farmer. Was strong disciplinarian but was well controlled. Did not show affection.

Grandmother: Poorly educated. Had rather poor health. Did not show affection.

Maternal Aunt: Married. Not strong physically. Have one adopted child.

Maternal Uncle: Good health. Is farmer. Married and has large family.

Maternal Aunt: Fairly well educated. Is married. Physical condition apparently good but is "nervous".

Maternal Uncle: "Nervous". Cannot settle down. Moves about the country so much the family cannot keep track of him.

Maternal Uncle: Not much information available. Is a farmer.

C. Married Life of Parents:

Parents were acquainted many years before their marriage. Father's family approved of the marriage. Mother's family did not. Both parents desired children.

D. Fraternity:

1. Olive: Wanted child. Normal birth. Has never been well physically. Looks badly. Did fair work in school. Finished high school. Has always been troubled with lying and stealing. Took small things first, then larger. Charged merchandise under wrong name. Was turned over to the Women's Protective Division. Is married now and stealing has stopped. Mother is afraid that if finances pressed she would steal again.

2. Weston: Wanted child. Normal birth. Has always stolen some. Has indulged much in masturbation. Father has never paid any attention to him. He went through the grades and started to high school but was not interested and stopped. Left home and shortly afterward was arrested with others for stealing a car. Was sent to a detention home. When released he roamed about over the country for awhile, then came home. While at home he slept with Gordon. When Gordon was later found to have syphilis of the rectum, Weston was also found to be syphilitic and confessed to having forced Gordon to have abnormal sex relations with him. Weston was sent to the penitentiary.

3. Robert: Unexpected child. Normal birth. Seems well adjusted. Has never had any trouble. Gets along well with father. Has finished high school and is planning to go to college.

4. Elsie: Unwanted child. Normal birth and pregnancy. Did not do well in school. Stole, lied,

ran away. Sent to Girls' Training School.

5. Gordon: Patient.

6. Benjamin: Unwanted child. Normal pregnancy and birth. Does fair school work. Is very quarrelsome, steals and lies. Has nocturnal enuresis.

7. Nancy: Unwanted child. Normal birth. She is negative and destructive. Is irritable, steals. Is severely beaten by father.

E. Home Conditions:

The family has moved fairly often. At present the home is in a crowded district. The standards of living are low. The mother is a poor housekeeper. There are few educational opportunities outside of the school. The only recreation consists of an occasional church party. All of the family except Nancy belong to the church. The mother seems to have real affection for the family but says she just cannot show it. The children do not confide in her and she has no control over them. She has little affection for the father. Says she feels the marriage is not on a firm basis. She wants to make a budget for the household expenses but the father will not permit any plans being made.

Father says the mother is a hypocrite because

she goes to church and teaches a Sunday School class and then nags at home.He has shown jealousy of the mother and children. He wants the children to side with him. There is evidence that he has attempted sex familiarities with his daughters.

The children are continually afraid of being whipped.

F. Personal History:

Pregnancy was normal. Just before birth the mother was injured by being caught in a door. Delivery was normal. Gordon was breast fed and well nourished. His teeth erupted at the normal time, he walked at eleven months and started talking at eight months. He has never been troubled with enuresis. He had many childhood illnesses and contracted syphilis at twelve years. Was treated for this.

He was given no sex information except by Weston.

His I.Q. By the Binet Test was 97.

G. School:

Gordon has never liked school. Has always reacted negatively to the teacher. Is truant only rarely. Has stolen small articles and a bicycle. He failed the fourth grade twice and the sixth once.

H. Work History:

He does odd jobs that he may go to the theater.

Reading is his favorite form of recreation. Next to reading he enjoys working with tools, and liked his manual training course. He likes to play ball.

He told some neighbors that his mother never cared for the house so he did'nt see that it mattered if the children did tear it up.

He is not particular about his personal appearance.

He wants to be an aviator.

It is hard to get him up in the morning, he is so tired. It is just as hard to get him to bed at night. He blames others for his difficulties. He has food fads, doddles, runs away. He steals and lies and is a problem in school. He has little opportunity for recreation and companionship.

Because of stealing from his teacher he was required to stay after school every night for a week. His father whipped him for staying in, then when he refused to stay because of the whipping his father whipped him because he did not stay. The visiting teacher was able to find out about his trouble from him and arranged with his teacher that he would not need to stay in any longer. He was very grateful and made a

confidant of her from then on. She got beneath the surface to the real boy and learned of his interest in manual training, that he wanted to be a Boy Scout, and that when he grew up he wished to take up aviation. The visiting teacher explained his situation to the other teachers and with their cooperation Gordon has been adjusting much better in school.

The visiting teacher, realizing that they had not begun to reach the cause of his trouble yet, took him to the guidance clinic. The guidance clinic records show him to be a very unhappy appearing child, but attractive. At first he was very apathetic but gradually became more animated. The day dreaming continued.

Realizing that the home was not a fit place for any of the children the case was taken up with the court, which is at present working to break up the home and place the children in suitable foster homes where they will receive the care and attention they need. The psychiatrist advised the placement of Gordon immediately.

The prognosis was very guarded, the psychiatrist fearing that Gordon's state of mind was already too well established.

Some significant statements of Gordon's are to

the effect that he does'nt know if he can stop stealing bicycles or not. He does'nt have much that he wants and other boys have so much more than he. He feels different from other boys and is worried about the sex affair with his brother.

The mother says he has never respected the rights of other boys. He has always been aggressive and dissociable. They have tried all forms of punishment and none have done any good.

The formulation of the psychiatrist was that of a constitutional psychopathic inferior.

He recommended placement where Gordon would have regular discipline and an opportunity to develop self reliance.

Gordon was finally placed in a good boarding home. He is very happy there and is already much improved. His prognosis now is pronounced good.

The visiting teacher works with many types of problems. Sometimes a child's problem may be due principally to the school situation, perhaps a personality minunderstanding between child and teacher. Jane Culbert gives a short case history of a child with this type of difficulty.

Case of Dorothy.

" Problem as stated: Teacher reported Dorothy was failing in her school work because of irregular attendance. She said Dorothy 'was one girl she was unable to like'. Stated she found the girl's loudness and coarseness most unpleasant.

Home Situation: Hardworking mother, finances straitened. Family recently moved to community had not been able to make new friends, and parents, as well as Dorothy, were homesick. Mother ill, often in bed, had kept Dorothy home to take care of her.

The visiting teacher found what was not apparent in the classroom, that underneath Dorothy's boisterous manner, loud voice and tom-boy ways, was a genuine desire to be liked, to be attractive and to be accepted by these girls who found her so different. Happy in her old background, a member of the group, she could not understand the reasons for the attitude of the new school. Not being accepted, and feeling that even the teacher did not like her, she set about to 'show them she did'nt care', bolstering up her waning self-regard with boasting tales of past achievements.

Assets: The visiting teacher found a good comradely relationship between the mother and daughter, respect and obedience on the part of the girl, sincere

interest on the part of the mother, who, since Dorothy's previous school record had been good, had not realized what effect the absences were having.

She also found in Dorothy, underneath her unhappiness and resentment toward her new group, a certain frankness, a willingness to face her own difficulty, and a readiness to respond to a sympathetic friend.

Measures found effective: With improvement in the mother's health and new realization of school difficulty, the attendance was more regular. Continued contact with Dorothy and several long talks helped the girl to see just why her behavior had alienated her group, and made possible several suggestions which led to improvement of her untidy appearance, style of dressing and the boisterous manner.

The teacher, because of the new information, aware of the other side of Dorothy, helped with encouragement and by giving the girl little responsibilities in the classroom. A few older girls the visiting teacher knew and could trust were asked to make more friendly advances and to help the newcomer adjust.

Dorothy responded by attacking her problem directly, and showing by the end of the year considerable improvement"[1].

Note 1. "The Visiting Teacher at Work" by Jane Culbert.

The visiting teacher must be a teacher with experience that she may know the psychology of the clasroom teacher in dealing with a child. She must also have social case work training including mental hygiene because her technic of work is taken from both these fields. A period of at least a year of supervised field work is necessary for practice in applying principles learned and in working with people. The most successful visiting teacher is the one who can enter into any phase of community life, who will give talks when the occasion arises, who can lecture before parent study groups, in short, be able to do anything which will further education in the mental hygiene field.

Work with school children in the mental hygiene field has brought up another difficulty. The classroom teacher was often so ignorant of mental hygiene principles that she was unable to cooperate even when wishing to, and other times just did not see the importance of the work. The older type of teacher judged her pupils according to her own personality pattern. This is difficult to avoid with any one, but with an understanding of mental hygiene principles applied to self as well as others, the danger of this is largely eliminated. Hence, the mental hygiene movement saw the need of special courses for teachers that they might share in the work of child development and rehabilitation, with a working knowledge of the importance of the field and the technic of doing it. The first step was to make a study of the courses

already given. Dr. Carson Ryan of Swarthmore College, in 1926, made such a study of 200 universities, colleges, and normal schools. He found that at least twenty gave courses which helped teachers in the management of problem children or offered other mental hygiene courses.

In 1925 the National Committee for Visiting Teachers put on a demonstration in Burlington, Vermont. In Burlington, the visiting teacher is a regular instructor in the department as well as carrying on her visiting teacher work. The student teachers, in their training period, work under her supervision in solving problems of maladjustment. Hence, they become acquainted with the behavior symptoms of maladjustment and have practice in the technic of mental hygiene treatment.

The Richmond Normal School in Richmond, Virginia, followed a similar plan.

The National Committee on Visiting Teachers in 1927 started summer session courses in a nunber of colleges and universities. These were given by visiting teachers which meant a more face to face meeting of actual problems in actual communities than is ordinarily found in those courses in this line given by college instructors.

The National Committee for Mental Hygiene was also working on this subject. It cooperated with the State Department of Education in New York and the State Committee

of Mental Hygiene in 1928 to give lecture courses dealing with mental hygiene problems in the classroom in each teacher training school in the state. As part of the program of achieving a mental hygiene program in the classroom Dr. Ryan makes the following suggestions:

"1. A broader conception of education. Education must no longer confine itself to books alone. It must serve humanity, must play its part in helping each individual to develop to his fullest extent.

2. A new type of teacher. The personality of a teacher should be stressed even more than the scholastic requirements. The teacher must be emotionally adjusted, must understand the part played by mental hygiene in the lives of individuals.

3. Teacher participation. In order to be the type of person described above, the teacher must have sufficient and proper recreation, she must be living a life that is satisfying to herself that she may be unhampered by unsatisfactory personality traits of her own.

4. Modernized psychological content. Teachers in training must have opportunities to observe the methods of the new type schools, as guidance clinics, visiting teacher work, etc.

5. Education and other agencies. The school must come to think of itself as a social agency. It must help in the

adjustment of individuals and families and cooperate with other agencies."[1.]

Another form of education in the mental hygiene field is directed to the child of preschool age. This takes place in the so called habit clinics. Here, the child from infancy to school age is studied and the parents helped to an understanding of the essentials of child training. We know that a child's behavior pattern or life pattern is molded very early and fairly well set by the time he enters school. Hence, the training during the very early years is extremely important. The child is trained in correct habits of eating, sleeping, emotional control, and all the other habits which a young child must develop in order to become a well balanced, well integrated school child and adult. These clinics are fine means of parent education also, as are the guidance clinics. The parent learns why he must be consistent, he learns how to satisfy the innate needs of the developing child, how to be a satisfactory mother or father person to that child. The parent also learns to understand himself here as in the other clinics. This helps him to explain his own attitudes toward his children, which, as in the case of the teacher, are colored by his own personality development. By the correct

Note 1. "Training Classroom Teachers to Deal With Personality Problems" by Gladys E. Hall.

training of the child, and because of the emotional satisfaction of that child such undesirable characteristics as temper tantrums, enuresis, food fads, and all the other expressions of faulty emotional adjustment do not develop. This is true prevention, treatment before the symptoms even appear.

The field of public health nursing is realizing the part played by the emotions in the lives of individuals. The public health nurse, no matter in what field she specialized, has long met the results of the interaction of personalities. She sees it in the home, in the school, in the various clinics which she sponsors. It plays a most important part in her daily life. She knows that true education is a changing of attitudes, she knows that she can make no impression whatever upon an individual unless she uses tact and the correct approach for that particular personality. She has learned it in her relation with her patients, with her physicians, with every one with whom she deals. Like the teacher, the amount she is able to accomplish depends not so much upon her time as upon her personality. She is realizing more and more too, that body and mind are very closely linked together. She cannot remedy a physical condition when there is a mental or emotional situation in the way.

She has learned that one may be very ill with a well body and a bad emotional adjustment, and she has also learned that one may really have a much healthier outlook on life with a sick body and a well mind than the reversed condition. She has learned through experience the importance of mental hygiene.

The public health organization is coming to have a mental hygiene unit which consists of a psychiatrist, a psychologist, and a mental hygiene supervisor. The generalized program is being more and more accepted by public health agencies and the mental hygiene supervisor is the connecting link between the psychiatrist and the district worker. There are frequent conferences with the supervisor and the psychiatrist and clinics are held regularly for both children and adults. Courses and lectures on mental hygiene subjects are given for the benefit of the district workers. The nurse herself, cannot be the worker unless she is especially trained, but, as was pointed out above, her basic training makes her especially keen as to symptoms, and she is able to tell when the attention of a psychiatrist is needed. Because she goes into the home she meets every member of the family and sees all in their most natural setting where personality traits stand out most distinctly. Thus, she is in a position to recognize a symptom before it is

too late for treatment. She does not usually have to spend time developing the necessary personality relationship between herself and the family, for that is, or should have been, already developed by the other care and advice she has been giving. Thus, she has a particularly good setting for a mental hygiene worker, and if she has special training in the mental field, how much greater her service can be!

The first public health nursing organization in this country to develop a mental hygiene program was the Infant Welfare Society of Chicago. This was done in 1925. This Society has one mental hygiene supervisor. The aim has been the education of the staff members along mental hygiene lines so that eventually every worker may be able to carry the minor mental problems in her field. The children who need prolonged and intensive treatment are referred to psychiatric clinics. The mental hygiene supervisor arranges for periodical mental hygiene study groups.

The Community Health Association of Boston also started its mental hygiene program in 1925, shortly after the Infant Welfare Society of Chicago. The work in Boston is carried on by psychiatric social workers, varying from one to three workers. Two of the workers have had experience in social case work while the third is a

public health nurse who has taken special psychiatric training.

Since April, 1927, the Henry Street Visiting Nurse Service, with the cooperation and assistance of the National Committee for Mental Hygiene, has been developing a mental hygiene program. The pur pose of the program here has been to study the possibilities of the public health nurse in this field. The Henry Street Service Believes the nurse should play a large part in the education of the public to an understanding and appreciation of the mental hygiene field. It believes that she should be able to detect mental and emotional disturbances in their early stages and refer the patients to psychiatrists for help. Henry Street has eighteen different nursing centers and at least two hundred graduate nurses doing a generalized type of work. The National Committee for Mental Hygiene provided a psychiatric supervisor. Conferences are conducted every two weeks in each center office at which a lecture is given by the mental hygiene supervisor and is followed by a discussion of case problems. Reading lists including pamphlets and recent books are provided for the nurses. Special supervision is given by the mental hygiene supervisor in the matter of history taking for the psychiatric clinics to which patients are referred. The various New York psychiatric

clinics handle the cases which need psychiatric attention. The nurses are trained to use them intelligently. Of course the nurse is supervised in her mental hygiene work in the home. Here, there is an excellent chance, as we have spoken of above, to reach the pre school child especially as well as all the other members of the family. The nurse's part in mental hygiene treatment has been outlined by Glee L. Hastings, Psychiatric Supervisor of the Henry Street Service in her pamphlet " Mental Hygiene in the Henry Street Visiting Nurse Service" as follows:

"

1. Recognition of the patient's need for psychiatric study and treatment.
2. Establishment of good contact with the patient in order to obtain the information necessary for the mental hygiene history.
3. Writing of an adequate mental hygiene history.
4. Arrangement for the patient's appointment at the psychiatric clinic that seems best suited to the patient's problem, (taking into consideration the type of problem, the accessibility of the clinic to the patient's home, the ability of the patient to pay for clinic examination, etc.)
5. Forwarding the mental hygiene history to the clinic in advance of the patient's appointment.

6. Making certain that the patient keeps his first appointment and that a contact has been established with the clinic. From this point on the clinic is responsible for examination, treatment, and follow up, although the nurse usually keeps in friendly contact with her patient and frequently assists the clinic by urging her to persist in clinic attendance and to follow clinic suggestions and orders."

During the year from April 15, 1927 to April 15, 1928, the number of mental hygiene cases handled was 405. 228 of these were closed by the end of the year. Children and adolescents formed by far the greater number treated which show the emphasis on the preventive field of childhood. Thirteen nationality groups were represented, those presenting the greater number of cases being the American, (including native born children of native born parents), Italian, Russian, and Irish.

The East Harlem Nursing and Health Service has discontinued its mental hygiene clinic and is approaching the field from the standpoint of the needs of normal children and the importance of a well adjusted worker. The children who need psychiatric attention are sent to the community clinics where they are studied psychiatrically, psychologically and socially. Through the mental hygiene and social case work supervisor each nurse carries the facts of mental health as well as physical into the

homes. They are thought of not only as nurses but as teachers in the field of adult education.

The Dutchess County Health Association started a mental hygiene program in 1932 with the addition of a psychiatric social worker, (not a nurse), to the staff. With the exception of a few instances she does not do case work herself but confers with the fifteen public health nurses. She assists at the child guidance and mental clinics conducted by the State Department. The educational program includes talks to various groups, newspaper publicity, and the Monthly News Letters. There is also a small library available. Assistance is given in special cases found by the parental educator of Vassar College. Under Vassar College also classes in preventive mental hygiene are carried on in the county for parental education.

The following is a list of the public health nursing organizations having psychiatric supervisors in January, 1933:

Boston Community Health Association, Boston, Mass.

Infant Welfare Society, Chicago, Ill.

Visiting Nurse Association, Cleveland, Ohio.

Visiting Nurse Association, Hartford, Connecticut.

Visiting Nurse Association, Minneapolis, Minn.

Infant Welfare Association, Minneapolis, Minn.

Visiting Nurse Association, New Haven, Connecticut.

Association for Improving the Condition of the Poor, New York, New York.

East Harlem Nursing and Health Service, New York, N.Y.

Henry Street Visiting Nurse Association, New York, N.Y.

Judson Health Center, New York, N.Y.

United Workers of Norwich, Norwich, Conn.

Dutchess County Health Association, Poughkeepsie, N.Y.

District Nursing Association, Providence, R.I.

Visiting Nurse Association, St. Louis, Mo.

Visiting Nurse Association, Scranton, Pa.

Visiting Nurse Association, Milwaukee, Wis.

Another great opportunity of education and service in the psychiatric field lies in the out patient clinics connected with general hospitals. The National Committee for Mental Hygiene recommends that there be a psychiatrist on the staffs of all general hospitals. There should be a psychiatric division also where mental cases can receive treatment. People do not become "insane" suddenly. It is a matter of development of years, and the value of a psychiatric department of hospitals is unestimable in regard to the help it may give to these patients. The psychiatric outpatient clinic should also be under the supervision of

the psychiatrist. It should serve men, women, and children, helping them to understand and face their problems, see wherein they have made their mistakes, and helping in the process of readjustment. There should be trained psychiatric social workers in connection with the clinic and working with the psychiatrist. The ordinary medical social worker is not equipped to deal with these cases. A psychiatric department in general hospitals is also of great value in the education of nurses. They have an opportunity of seeing the advanced cases, the borderline cases, and those in which symptoms of an abnormal mental condition are just beginning to appear. When the nurse goes into her specialized field of service how much more accurately will she be able to observe and report symptoms. In the public health field this is most important. Often the decision as to whether psychiatric care is needed or not rests with her. If she understands the symptoms she is able to work with the patient himself much more effectively. Usually, all chances of working with these patients successfully depends on the initial approach.

A most interesting program in this field is being carried out at the Pennsylvania Hospital, Pennsylvania. There has within the past few years been organized an Institute for Mental Hygiene in connection with this hospital, with Dr. E.D.Bond as Superintendent. Dr. J, Allen Jackson, in the

"Modern Hospital" gives the objectives and purposes of the Institute to represent the latest thought in:

"1. An approach to the understanding of human ills and human misfits.

2. An approach to economic distress from the medical angle.

3. Research into causes, reactions, and their control in individuals classified as suffering from diseased minds."

The patients who are welcomed include that group so often thought of as normal, those having marital difficulties as misunderstandings, jealousies, and disagreements. Neurotics and psychoneurotics are taken, as well as those unclassifiable cases, the fearful, the apprehensive, the irritable, the oversensitive, and so forth.

Besides offering help to adults the Institute welcomes children. Individual school instruction is offered by the Franklin School for problem children. In addition the children receive intensive psychiatric treatment. The problems of adolescence are accepted. Behavior difficulties following encephalitis are treated for rehabilitation. The preschool children are helped to a successful start in life. There are classes for parents in child management and the mental hygiene of childhood. A summer camp is maintained at Ashley, Pennsylvania, for the children. No feebleminded children are admitted at the Franklin School.

There are no committments to the Institute. Only voluntary

patients are accepted. Resident as well as out patients are taken. The Institute is primarily for work in the preventive field and does not take psychotic cases. Classes in occupational and physical therapy, music and recreation are given and are open to any patients of the Institute and to any patient of a member of the county medical society. Private, full rate patients are received and the Institute has worked out an actual cost of care service for those patients of moderate means who cannot pay the full price. Low rate and free patients are taken. The building is well equipped. It consists of a main building of four stories and basement with a wing of three stories and basement. The treatment department has the latest equipment for physical therapy, as well as a gymnasium and swimming pool. There are facilities for continuous baths and sun therapy. There are very completely equipped laboratories for special studies.

The staff of the Institute consists of psychiatrists, a medical director of laboratories, psychiatric social workers, psychologists, specialists in different medical fields, a school teacher, experienced nurses, occupational teachers and technicians.

There are 120 beds for adults and 24 for children.

The Institute marks a definite step in the understanding and treatment of those so called normal individuals who

are not able to meet their problems alone.

Mental hygiene and social work are closely connected. The social worker has always dealt with personalities, that is, since the old idea that relief giving alone constituted social work has been outgrown and replaced by the ideal of rehabilitation. Rehabilitation of necessity includes mental hygiene, means working through personality interaction. How much more successful then, would be the social worker who is trained to understand the symptoms of maladjusted personalities leading to maladjusted emotional states, and from here to any number and variety of the social problems that develop as a result. The ideal social case worker would be an individual with the proper personality traits who has a three fold training, social work, mental hygiene and, if possible, public health. This means a long period of preparation. There are, however, many similar phases in the training of each field. If some plan could be evolved to include the important phases of each type of training, the resulting worker would be excellently equipped for work with human personality in her three fold approach, social, mental, physical.

The place of mental hygiene in industry is obviously an important one. However, we are coming to

realize that the school a child attends, the training he receives before and after he starts to school, his emotional adjustment and all the rest that is of importance to the normal development of the individual, are responsable for his success in whatever field his work lies. Of course, the work must be the type that the individual enjoys, he must feel himself engaged in a worthy occupation that fulfills his need of a life task. The work must also be of the type that the individual is capable mentally of doing. This is a large and important field and one in which relatively little has been done by industrial concerns. The "dissatisfied worker" is entitled to know the cause of the dissatisfaction and how to prevent it.

There are also found "dissatisfied workers" in other fields than those included in the term, industrial. They are found in the professional groups, they are found everywhere. The solution of much of the problem lies, as we have already stated, in the preventive field of childhood. But what is to be done with the individuals who are "misfits" now, who have somehow gotten into the wrong job? Is it not the duty of the employer or the teacher or whoever the supervisor might be, to help these individuals rather than just telling them that their work is unsatisfactory and would they please

resign? Such work is being started although it is still in its infancy. The contribution of the psychologist in the field of various tests is of much use here. Personality tests, or tests of emotional make up give, along with other factors of the individual's personality, the supervisor a helpful means of determining whether this person will make a success in a certain field of work or not. If the individual seems to show lack of ability in, or dissatisfaction for the field, then the mental hygiene policy would be to help that individual find the field of work in which he will be satisfied. Above all, he should not be allowed to continue until he fails and becomes discouraged.

The relation of immigration to mental disease has been a subject of interest. In 1923, of 35,000 first admissions to state hospitals for mental diseases, 29 % were foreign born. The high percentage is explainable when one stops to think that probably many who come to this country are of the unsatisfied, unstable type. In the rush and hurry and strain of congested city life, when the struggle for existence is very hard sometimes, it is no wonder that many break mentally. Being away from home and family probably plays a large part also. One would think that the two countries would have a duty toward these people. In the home country there was probably

reason for the development of dissatisfaction which gave rise to the search for a better location. After they have come to this country it would seem that we have a duty to them also. After we have accepted them we should help them to adjust.

This paper has dealt, after the formation of the National Committee for Mental Hygiene, only with progress made in this country. I should like to mention, though it is too large a subject for discussion, that mental hygiene work is progressing rapidly in other countries also. The child guidance work of Alfred Adler in Vienna is internationally known. Germany and Austria are really more advanced in the field of child study and prevention of delinquency than the United States. Russia, too, is doing much along this line. There are traveling clinics and psychiatrists available to a larger group of people. One method by which Russia is controlling and helping to develop its youth is making the child acquainted with his duty, his purpose, his job, if you will, for the good of his country. Thus, at an early age, the child feels his responsibility and grows into it. Parents are inclined to be really too protective of their children it seems. One likes to think of protecting the child as long as possible from the struggles and trials of life. But, without

stating approval of Russia's national policies, perhaps we could learn something from her in her reduced juvenile delinquency problem and see that what the child needs as well as the adult, is a job, a position in life for which he feels responsible and in which he is satisfied.

Thus, it seems that the mental hygiene movement is bearing fruit. We have at least made a beginning in the study of human personality, its desires, hopes, needs, and limitations. We are just realizing its great possibilities when surrounded by an environment which allows for the development to its fullest ability.

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