PSYCHOTHERAPY and the MENTALLY ILL

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PSYCHIATRY AND ITS BASIS UPON PSYCHOLOGY

Present day psychiatry as we know it is based entirely upon psychology. The theories of Freud and others of a later day were the foundation of the methods as we know them now. The conflict between restraint and non-restraint and the subsequent arguments are directly responsible for the more humane method with which the mentally ill are now treated.

Psychology is defined in the Encyclopedia-Britannica as "the science of the mind; systematic knowledge and investigation of the genesis, powers and functions of mind." The Encyclopedia goes on to say that previous to the nineteenth centure psychology was generally considered a branch of meta-physics. In the earlier developement it consisted cheifly of a doctrine of mental faculties or powers discriminated by introspection and is hence called the faculty psychology. The rise of the associatism or associational psychology of Hartley, Hume and the two Mills, paved the way for the new psychology of the nineteenth century, which has divided into many specific branches. In respect to method, psychology is divided into two great divisions--analytic or introspective psychology, devoted to description of mental processes as they are immediately apprehended; and experimental psychology which includes:

1. psychophysics--which is sometimes restricted to the re-

lations of physical stimuli to sensations and sometimes extended to include-

2. psychophysiology or physiological psychology--which treats of physiological and psychical processes in their mutual relation, and-

3. psychopathology, which is the study of aberrant mental conditions and includes psychiatry and abnormal psychology."

Psychiatry may be defined as that "branch of medecine which is concerned with disorders of behaviour". We may say more precisely that its terms of reference are 'disorders of behaviour at the social or conscious level.' General medecine is concerned with disorders of behaviour but in a more narrow sense than psychiatry, as it only deals with disturbances in the behaviour of the organism at the unconscious or physiological level. General medecine is primarily interested in what the organism is doing, and psychiatry in what the individual is doing.

Devine says that to "study the living human being as a physiological organism is to study an abstraction. To study him as a biopsychic organism is to study him as a whole". He also states in his book 'Recent Advances in Psychiatry' that the past in its entirety, is prolonged into the present and abides there--actual and acting. The behaviour of an individual is thus determined by the prolongation into the present of his past experiences; by his inherited peculiarities, by his physiological state; by the rythm of his

vital processes and the various transformations of the reproductive functions; and by the manifold life situations with which he is confronted.

Life begins for us all as an unformed and unconscious effort and continues for most people as an eager if somewhat blind sturggle toward the attainment of desires. These desires are based upon our environmental and hereditarial background and the perception and growth of ideals which we perceive through our five senses. A human being expresses his personality by striving to experience life. The science of human behaviour can point out ot us some conditions and principles to guide us in our struggle to obtain happy living, which in itself is an art and can only be learned through practice.

Common observation and exact physiological tests show that our mental experiences, or the nature and direction of our mental processes, are controlling agents in the expenditure of our energy. Patterns of behavior are developed by the energy discharging stimuli found in civilized environment. It is known that a human being reacts as a total integrated unit. The major circuits of ones energy are gradually built up onder the influence of ones habits of work, rest, relaxation, sleep, diet and elimination and by our aims and ambitions and personal interrelationships.

In dealing with the application of medical psychology

it is necessary to draw a dividing line between Fruedian and pre-Freudian conceptions, or to be more exact, between the psycho-analytic and the hypnotic periods of investugation and treatment. The hypnotic period did not contribute much of impotance to psychology apart from the abundant evidence it provided of the far reaching influence of suggestion. From a practical point of view, the latter is the most important, but owing to imperfect theoretical understanding of the nature of suggestion, many false notions found currency about the part played by suggestion in ordinary life and about the structure and functioning of the normal mind.

Many people have called hypnotism an "unclean thing"—that is why numerous physicians have taken the attitude towards hypnotism and suggestion that they have. To them hypnotism deals with a realm of the subconscious which borders close to the spiritual and awakens reactions which might prove uncontrollable. Realizing that neurotic disorders must be treated through the mind and also being cognizant of the fact that the behavior of neurotics, as revealed by their symptoms, is "unreasonable", these physicians set themselves, however, to appeal to the reason of their patients—explaining to them the nature of their disabilities and endeavoring to convince them that they could, if they would, free themselves of their disabilities. This

the doctors did either by persuading, or failing which, by command.

Many neurotics were relieved by this means called persuasion, i.e.--the reason of the patient being appealed to-- but this explanation does not hold true since a neurotic symptom is unconsciously determined and no appeal to the reason has any effect upon it. However, in making an approach to the reason in seeking to convince and to persuade, the subtle action of the suggestion cannot be avoided; and suggestion, being a form of appeal to the unconscious, has, when successful, the same result in treatment by persuasion as it has in treatment by hypnotism.

Suggestion has been said to produce its result by "artificially causing, in the form of impulsion, the function of a tendency that the subject cannot obtain in the form of personal will".

Regarding hypnotism, Freud says quite frankly- "From being in love to hypnosis is evidently only a short step. The respects in which the two are alike is obvious. There is the same humble subjection, the same compliance, the same abscence of criticism towards the hypnotist as towards the loved object--- No one can doubt that the hypnotist has stepped into the place of the Ego-ideal". It has been shown that the subject yields as a child, to the hypnotiser-- the strong-willed, stern, powerful hypnotiser reminding the

subject of a stern, determined father and the soft-spoken, soothing and caressing hypnotiser reminding the subject of a loving mother.

From observations that among gregarious animals we find relations of dominance and submission, McDougall argues that the tendencies of some members of a herd to submit tamely and quietly to the dominance of a leader is instinctive, and that such behavior is the expression of a distinct and specific instinct of submission which is evolved by the agressive or self-assertive behavior of older and stronger members of the herd. Human beings are also endowed with this instinct and in them it is similarily evolved by those who give evidence of superiority or have a reputation for power. McDougal maintains that "the impulse, the emotional conotive tendency of this instinct, is the main conotive factor at work in all instances of true suggestion, whether waking or hypnotic". He dissents from the view of Trotter that suggestion is sufficiently accounted for by invoking the herd instinct, for he holds that submissive tendencies are independent variables and cannot be ascribed to the same instinct.

GROWTH OF CARE
OF THE INSANE
FROM EARLY TIMES

In the "Mentally Ill In America", Albert Deutch relates that before the advent of medicine the art of magic prevailed. Primitive man peopled the world about him with gods and demons. He saw spirits in the trees, the winds and the moving clouds, in storms and lightening, in fact, in everything with which he came in contact. These spirits, which were both good and bad, controlled his destiny as they desired. The primitive mind did not regard sickness, disease, or even death as the result of a natural phenomenon--but regarded them as the results of natural intervention on the part of the spirits which filled his world.

The explanation for disease was simple and all-inclusive; it might be brought on by the "good" deity or spirit as a punishment for some sin or slight--more often it was attributed to an evil demon acting out of sheer malevolence. Disease became identified with a personal demon. If demons could thus be attached to physical conditions, it is evident how much more they could be related to the mental disorders which manifest themselves in such awesome and mysterious forms.

Since spirits were thought to cause these mental conditions--it was obvious to these so-called primitive people that the disorders should be treated with magic. Out of the

need in the community for someone with a special adaptability evolved the sorcerer, wizard, medecine-man, priest and priest-physician---all forerunners of the modern doctor.

From time immemorial, the confounding of mental illness with demoniacal possession has existed. It survives today over a large portion of the earth. Mental disease can be assumed to have always existed among mankind, but in all probability, however, it was less prevalent in ancient times than it is now. The mental and nervous strains arising from participation in a progressively complex civilization were absent; life was more stratified, competition between individuals was less fierce and breakdowns, attributable to social causes of this kind, were probably much less frequent.

Popular belief among the ancient Hebrews also attributed mental illness to the "seizure of a persons body by the soul of a murdered man which could find no rest elsewhere".

Among the Ancient Egyptians the care and treatment of the mentally ill was naturally conditioned by the prevailing notion of demoniacal possession. For that reason, the words "relieve" and "care" seldom occur in papyrus prescriptions which have been preserved to us. The art of healing was practiced in Egypt exclusively by the priesthood who jealously guarded the secrets of the craft as sacred mysteries.

With the passing of the centuries, incantations

began to be accompanied more and more by physical remedies such as herbs, vegetables and ointments. Precious stones were also prescribed.

Nineteenth century commentators on the history of insanity were prone to regard the practices of Ancient Egypt as a "golden age" in the care and treatment of the mentally ill. One commentator writes, "In remote times enlightened views of insanity were entertained, intelligent and humane treatment was taught and practiced, first by the learned priests of Egypt—the meloncholies being brought in considerable numbers to the temples. Whatever gifts of nature or productions of art were calculated to impress the imaginations were there united to the solemnities of an imposing superstition. Games and recreations were instituted. The most voluptios productions of the painter and sculptor were exposed to public view. Groves and gardens surrounded these shady retreats, and invited the distracted devotee to refreshing and salubrious exercise. Gaily decorated boats sometimes transported him to breath, amid rural concerts, the pure breezes of the night, in short, all his time was taken up with some pleasurable occupation, or by a system of diversified amusements enhanced and sanctioned by a pagan religion.

In early Greece, as in Egypt, mental disorders were looked upon as divine or demoniacal visitations. Theurapeutic measures in mental illness were based on the pre-

vailing theory of causes. Greece, as Egypt, had her healing shrines, temples of Aesculapeus, the god of healing. Ritual and incantation served at first as the only form of curative treatment, but as the years went on pharmaceutical remedies were gradually added.

During the middle ages the natural therapy of earlier centuries was succeeded by a superstitous mixture of astrology, alchemy, and a retreat to theology, magic rites and exorcisms, with the accompanying belief in demoniacal possession.

On the continent many shrines were erected and dedicated to saints. Many miraculous cures were accomplished in cases of mental disorders--that these cures were real can hardly be doubted because the efficacious influence of that intangible something sometimes known as faith, the will to believe, auto-suggestion, etc. in mental therapeutics is no longer considered a matter of mere credulity, but a scientically demonstrated fact. These treatments were at least characterized by tolerance and even sympathy toward the insane.

During the Medieval period the mentally ill found no more understanding and no better treatment than at the hands of the so-called "heathen" Moslems. In the Mohammedan cast the torch of medical science lit by Hippocrates was still held aloft, dispelling the darkness of superstition in the

treatment of mental and physical diseases. While the insane in Europe were being sent to churches and monasteries to be exorcized of possessive demons, the great Arab physician-philosopher, Avecinna, was insisting that they were simply suffering from mental maladies, and should be treated as sick persons.

Benjamin of Tudela, a famous Jewish traveler of the twelfth century gives us an idea of the Moslem asylum, which, on the whole, speaks well for the attitude of the Arab towards insanity.

"Here (in Baghdad) is a building which is called Dar-al-Maristan, where they keep charge of the demented people who have become insane in the towns through the great heat of the summer, and they chain each of them in iron chains until their reason becomes restored to them in the winter-time. Whilst they abide there, they are provided with food from the house of the Caliph, and when their reason is restored they are dismissed and each of them goes to his house and his home. Money is given to those who have stayed in the hispices on their return to their homes. Every month the officers of the Caliph inquire and investigate whether they have regained their reason, in which case they are discharged. All this the Caliph does out of charity to those that come to the city of Baghdad, whether they be sick or insane."

The first asylums for the insane were established as early as 1369. These were monasteries open to those in need of shelter and comfort. The first European asylum devoted exclusively to the care of the insane, of which there is an indisputable record, was that built by Fray Gope Gilaberto at Valencia, Spain, in 1408. A number of other asylums were established in various parts of Europe during the sixteenth century.

The period of witchery with the accompanying belief in demoniacal possession again laid its hold on Europe. Witches were sought and persecuted--unlimited numbers of them being burned at the stake. This was particularly true in Central Europe, and the British Isles. The historian Lecky writes of this period, frequently called the psychopathic, "Never has the power of imagination been more strikingly evinced. Superstitious and terror-striken, the minds of men were impelled irristably towards the miraculous and the satonic, and they found them upon every side. The elements of imposture blended so curiously with the elements of delusion, that it is now impossible to separate them. Madness is always peculiarly frequent during great religious and political revolutions; and in the sixteenth century all its forms were absorbed in the system of witchcraft and caught in the color of prevailing predisposition."

Witchcraft was not only confined to the middle ages but raged and reached its intensest from during the Rennaisance. Even the concurrent religious revolution known as the Reformation did not bring about any lessening in the persecution of the witches.

Strange as it may seem--so strong were the prevailing superstitions during this time that even the medical men subscribed whole-heartedly to the custom. As late as 1664 Sir Thomas Brown, an eminent doctor and author of "Religio Medici" gave "expert" evidence against two women and was instrumental in convicting them as witches. That many of these so-called "witches" were in reality insane can hardly be doubted. In the records that have been handed down to us, we can find excellent examples of the various psychoses. As far as can be judged from the testimonies and records that have been preserved at least one-third of those executed were mentally unsound.

Among the earliest of those who cried against such inhuman treatment was Paracelsus, a dabbler in alchemy and astrology, an eccentric and a braggart, but a great physician. He ridiculed the notion of demoniacal possession. "Mental diseases", he declared, "have nothing to do with the evil spirits or devils, the individuals who are mentally sick merely drink more of the "astral wine" than they can assimilate. The experienced doctor should not

study how to exorcise the devil, but rather how to cure the insane.... The insane and the sick are our brethern. Let us give them treatment to cure them, for nobody knows whom among our friends or relatives this misfortune may strike".

Dr. Johann Weyer, of Cleves, published in 1564 a vigorous if cautious letter against the cruel and inhuman treatment of witchcraft.

Reginald Scott published in 1584 his famous "Discoverie of Witches", in which, with consummate skill and fearlessness, he laid bare and ridiculed the childish impostures and absurdities involved in the witchcraft superstition. Many poor creatures accused of witchcraft, he wrote, required relief from disease rather than chastisement for supposed sins; physicians to help them rather than executioners or torturers to hang and burn them. Scott's work, however, had very little influence.

The late seventeeth century witnessed a growing revolt, participated in by philosophers and physicians, against the superstitions of witchcraft and demoniacal possession and their cruel effects upon the insane. It was not until 1736, however, that the laws against witchcraft were repealed in the United Kingdom, but local persecutions against the insane suspected of practicing witchcraft and sorcery continued intermittently for some time.

In Colonial America, medical practice was on an even lower plane than in Europe. There was little incentive for the skilled, European-trained physician to chance the practice of his profession in America. A large clientele was impossible, due to the thin, poverty-striken, widely separated settlements. Furthermore, there was no opportunity to study medicine in halls of learning. It was not until 1765 that a medical school was established. This was founded at Philadelphia College.

The age-old tradition of the four humours were held responsible in the early American days, for all illnesses. Mental diseases, when treated as medical problems, which was seldom, were commonly regarded as an excess of bile.

Governor John Winthrop of the Connecticut Colony was, besides other titles, known as an administrator of medicine. So great was his demand that he felt it wise to keep in touch with London doctors.

In 1643 Winthrop received a letter from Dr. Edward Stafford of London, informing him of several remedies for mental disorders.

"For my worthy friend Mr. Winthrop; For Madnesse: Take ye herbe Hypercon (or St. John's wort) and boile it in Water or Drink, until it be strong of it, and reddin colour; or else, putt a bunale of it in new drinke to Worke, and give it ye patient to drinke, permitting him to

drinke nothing else. First purge him well with 2 or 3 seeds; (or more, according to ye strengthe of the partie) of Spurge. Let them not eat much, but keep dyet, and you shall see Wondrous effects in fewe dayes. I have knowne it to cure perfectly to admiration in five dayes".

This is a sample of the type of remedies that were used for anything and everything. The astrological note was also found in many perscriptions in Colonial days.

Among the Colonial doctors who gained renown as specialists in mental illnesses was Dr. Thomas Kittredge of North Andover, Mass. Towards the end of the colonial period we find him treating ten to twelve mental patients at the same time. He boarded them out to a few families in Andover where they were closely supervised by the members of each family. Apparently little restraint was applied, although the patients were subjected to occasional blood-letting in order to weaken them and thus render them more manageable.

There were very few of the colonial doctors who were acquainted with the true meaning and nature of mental disorders, or of positive methods of care and treatment. They reverted to the Old World type of diagnosis and medications. The belief in demoniacal possession was particularly rampant in seventeenth century America. It reached its height in the Salem witch craft mania in 1692 and gradually subsided thereafter.

Cotton Mather, a great theologian of the late seventeenth Colonial America, is held partly responsible for the Salem witchcraft in which twenty-five were sacrificed. However, in his firm conviction in the reality of diabolical possession, Mather was merely sharing a dogma that was adhered to by most of the educated and advanced men among his contemporaries. It is true that the witchcraft mania had broken out in the mid-seventeenth century but it reached its apogee during Mather's time and at his instigation.

Puritanism, with its stern repression of healthy human instincts, its abnormal orientation around religion, and its exaggerated expressions of alternate suspicion and credulity, offered a fertile soil for the developement of this mania. Comets, thunderstorms and meteorites were regarded as solemn signs direct from either God or Satan. New England was prone to regard itself as the special concern of the spiritual powers at war.

The mental aspect of the witchcraft delusion is perhaps best summed up by Sir Thomas Brattle, a contemporary eyewitness of the Salem tragedy. Brattle was one of the very few who managed to keep his common-sense clear of the mental storm that swirled about him. Significantly enough, he was under constant suspicion of being an infidel and apostate because of his enlightened views.

In a letter sent by him to a clergyman in October, 1692,

Brattle gives a minute description of the occurences in Salem. Of the fifty-five persons held in jail on charges of witchcraft, he observes that "Some of them are known to be distracted, crazed women". In his letter, Brattle affirms his general belief in sorcery, witchcraft and evil demons. But having carefully observed the particular "witches" who had confessed to horrible deeds at Salem, Brattle remarks:

"They are deluded, imposed upon, and under the influence of some evil spirit; and therefore unfit to be evidences either against themselves or anyone else. These confessions (as they are called) do very often contradict themselves, as inconsistently as is usual for any crazed, distempered person to do".

Turning to the accusers, Brattle finds reason to doubt their mental soundness also, and observes of them:

"Many of these afflicted persons who have scores of strange fitts in a day, yet, at the intervals of time are hale and hearty, robust and lusty as if nothing had afflicted them. I strongly suspect that the devil imposes on their brains, and deludes their fancye and imagination; and that the Devills Book (which they say had been offered them) is a mere fancye of theirs, and no reality".

The witchcraft craze finally subsided and its doom was hastened, no doubt, by the fact, that with the mounting hysteria, some of the "afflicted" were beginning to point

accusatory fingers at prominent and substantial citizens.

The provisions by the Colonial Americans for the care of the insane can be placed in two categories: private and public. Mentally ill persons who had relatively well-to-do families or friends were usually cared for in their own homes. In the rare instances when the affliction was recognized as a disease produced by natural causes, they received whatever medical treatment was available and which has already been described. If violent or troublesome, even the wealthy insane were locked up without compunction. They were even frequently chained by their families in strong rooms, cellars and even in flimsy outhouses. In some cases, where the illness manifested itself in a mild and harmless manner, the individual was permitted a degree of freedom of movement. Very often, however, mentally ill persons were confined for years on end in attic rooms so that the family "disgrace" might be hidden from the public eye.

Until the closing years of the Colonial period there were no hospitals where the insane might be cared for. It was not until 1752 that the first general hospital was established, while the first asylum for the exclusive care of the insane was opened two decades later.

Public attention was drawn to the care of the insane only in so far as the distribution of their estate was concerned.

The responsibility for the determining of insanity was always placed in the hands of civil officers—never of medical men—and the guardianship of estates was variously entrusted to governors, town selectmen, churchwardens, vestrymen, justices of the peace and so on depending on the civil set-up of the several communities.

When insanity was publicly recognized, it was usually for the purpose of punishing or repressing the individual; when it was not, indifference to his fate was the predominating note. There was no uniform theory for dealing with the mentally ill. These unfortunate people were disposed of in a number of ways. Provision was of the rough and ready nature that characterized pioneer life; individual cases were considered and decided upon as they arose. The "violent" insane among public dependents were ordinarily treated as common criminals, while the "harmless" were disposed of in a manner differing only in degree of severity from that accorded to all other paupers. In Colonial times pauperism was looked upon as merely a lesser type of crime.

Public provision, as it was extended to the mentally ill, was mainly directed to the problem of safely disposing of the violent cases. Incarceration in jail was the common solution. The first provision for the mentally ill in Pennsylvania was described in the Upland Court records in 1676 in the following form:

"Jan Verelisson, of Amesland, Complayning to ye Court that his son Erik is bereft of his naturall Senses and is turned quyt madd and yt, he being a poore man is not able to maintain him; Ordered: yt three or four persons bee hired to build a little blockhouse at Amesland for to put the same mad man". A small tax was levied on the community for the building of the blockhouse and the care of Erik.

In New York, the first "institution" for the insane was a special structure which was ordered to be built in 1677 for the incarceration of Peter Paull, a "lunitick" who was to "bee confined into prison in the hold" until the completion of the strong-house for his special care.

Special provision for the insane poor was rare and was chiefly confined to the violent types regarded as social dangers. As to the non-violent dependents they were ordinarily classified and treated, not as mentally ill, but simply as paupers.

Provisions for the insane can not be entirely blamed upon our forefathers, but that the attitudes and modes of treatment arose out of and were founded upon beliefs and conditions in the Old World.

With the passing of the years came a rise in psychiatric knowledge, with analysis and synthesis evolving from the simple into the complex processes, which inevitably broughtinto its wake numerous theoretical controversies.

Of the many questions that stirred American asylum superintendents during the half-century following the organization of the Association, one of the most discussed questions was the doctrine of "non-restraint". On the surface it seemed merely the abolition of mechanical restraint in the care and treatment of mental patients, but in reality it was quite complicated and was the cause of much discussion and dispute.

Dr. John Connoly (1794-1867) formulated the theory of "non-restraint" into a system, although he was not the first to practice it. It gradually evolved and developed, dating from the first removal of chains and fetters by Chiaruge, Pinel and Tuke toward the end of the eighteenth century. The English parliamentary investigation of 1815 was another step in its developement.

The non-restraint methods introduced by Dr. Charlesworth and Mr. Gardiner Hill at Lincoln Asylum in 1837, were closely studied by Dr. Conolly, who was profoundly impressed by them. In 1839, Conolly was appointed medical superintendent of the Middlesex Asylum located in Haneville, England, where he proceeded to establish the principles of non-restraint. He extended these new principles and finally formulated them into a complete pattern of mental hospital management.

The method of non-restraint was widely adopted in England but in America it met with an opposition remarkable

for its extreme bitterness. This antagonism was mostly due to a misunderstanding and misconception of the true meaning of non-restraint. There still remained many opponents to this new method, chief among them being Dr. Isaac Ray. After devoting much attention to the subject Dr. Ray put forth his arguments which may be summarized:

1. In the final analysis, the ideal of non-restraint could never be realized. Hence, it was idle to even consider putting such a system into operation. Some forms of forcible restraint would always be necessary to the proper discipline of a mental hospital. The very walls and gates were coercive. Institutionalization of the insane per se implied coercion, as it was often effected against the will and wish of the patient. As for mechanical restraint proper--that is, limitation of the bodily movements of the patient by means of external devices--it would continue to be required in very special instances, as most "conollyists" freely admitted. This being the case, it was more honest to champion restraint in principle, rather than non-restraint.

2. The abolition of mechanical restraint meant merely the substitution of another form of coercion--"manual restraint" or force exercised at the hands of attendents--which was hardly more desirable.

3. To supplant mechanical restraint by attendents would necessitate larger staffs and consequently greater expense.

4. Suicidal, destructive and unmanageable patients required some form of personal restraints, of which mechanical applications were least onerous and most effective.

5. Mechanical restraints were also required for patients who were prone to exhaust themselves and lower their energy and vitality by excessive physical excitement.

6. The patients in European institutions, accustomed as they were to unquestioned acceptance of authority, might willingly submit to "moral restraint", but not your liberty-loving American, who, sane or insane, would never agree placidly to the imposition of authority by an individual, and hence could only be restrained by mechanical means.

7. In certain institutions where the abolition of mechanical restraints had been tried, it had resulted in dismal failure, and the old restraints had been resumed.

Strangely enough, many medical superintendents in America were, of their own accord, reducing mechanical coercion to a minimum while they continued to belabor the non-restraint principle.

Many believed that Dr. Conolly held that all restraint should be abolished but in reality he held that restraint might not only be useful but necessary in exceptional cases, for example in surgical operations.

The boundaries of the abolition of mechanical restraint,

as first defined by Conolly, can best be illustrated by the rules promulgated by the New York State Department of Mental Hygiene in 1933 which read in part:

Mechanical restraint or seclusion is to be used only for satisfactory surgical or medical reasons, or to prevent a patient from injuring himself or others.

Mechanical restraint or seclusion shall be employed only on the signed order of a physician, setting forth the reasons for its use; and a physician shall always be present at the first application of restraint. A full record of restraint shall be kept from day to day and shall be subject to inspection by authorized persons.

Mechanical restraint consists of an apparatus that interferes with the free movements of the patient, and which he is unable to remove easily. The only forms of mechanical restraint permissible are the camisole and restraining sheet.

The maximum period in the day which a patient may be kept continuously in restraint shall be two hours and such patients shall be visited at least every hour.

A patient shall be considered in seclusion, either in the day time or at night, when in a room alone with closed doors which it is not possible for the patient to open from the inside.

The ideas and ideals of the care of the insane progressed

more or less steadily until the question of care by the State was pronounced by young Horace Mann. He brought forth to the Massachusetts legislature that the "insane were wards of the state".

The evolution of state care followed a long and winding trail before reaching its most significant expression with the passage of the New York State Care Act of 1890.

This state care can be traced back to the founding of the Pennsylvania Hospital at Philadelphia in 1751. The next step was the founding of America's first institution used exclusively for the insane, which was the Lunatic Hospital at Williamsburg, Virginia in 1769. The Eastern Kentucky Lunatic Asylum at Lexington--established in 1822--seems to have been the first one that was established for the pauper and indigent insane. As in the others, the cost of the care of the insane was borne by the state alone. A different policy was followed by the Worcester Lunatic Hospital in Massachusetts and the Utica Asylum in New York. In these two hospitals the maintenance of dependent patients was charged to the localities in which the persons had settlement, the state paying only for non-resident and alien insane.

The opening of the Worcester State Hospital in 1833 marked the beginning of an extensive asylum-building movement throughout the country. At first, in accordance with

the prevailing belief that fully 90% of mental cases could be cured, it was expected that one centrally located hospital in each state would be sufficient provision for all the insane. In several of the sparsely settled states in the West, however, one asylum was for a long time all that was necessary. In most states, however, that was not sufficient.

The hospitals were barely opened before their capacity was over-taxed by the increasing flow of patients. This overcrowding soon forced the authorities to face the problem of selection. To solve this problem of admitting some patients and excluding others the authorities quite naturally favored the more recent or curable cases and expected the hopeless or chronic cases to be cared for in the homes of relatives or friends or if funds were not sufficient to be placed in the poorhouses or jails as the case might be.

New York seems to have been the state most concerned with the problems of care of the insane for the earliest organized movements toward complete state care of the insane came in 1855 from a group of county superintendents who held a convention in Utica. This convention was primarily for the purpose of formulating a definite policy of public provision for the dependent insane. The question of removing the mentally ill from poorhouses to state hospitals received the most attention.

As a result of the convention in Utica a series of

resolutions were adopted which included the following:

"Whereas, it is already conceded, and has been adopted as the policy of this state, that insanity is a disease requiring, in all its forms and stages, special means for treatment and care; therefore;

Resolved, that the state should make ample and suitable provision for all its insane not in a condition to reside in private families.

Resolved, that no insane person should be treated, or in any way taken care of, in any county poorhouse or almshouse, or other recepticle provided for, and in which, paupers are maintained or supported.

Resolved, that insane persons considered curable and those supposed incurable should not be provided for in separate establishments.

In this historic instance a state care movement was not only supported but actually initiated and served as a primary example for the nation as a whole--even if the New York State officials were eventually the greatest advocates against state provision.

CARE AND TREATMENT
OF THE
MENTALLY ILL

Psychiatry, in its attention to disorders of the mind, has from the beginning, been reluctant to consider the mental life apart from its organic foundation. This ideal has been commendable, but it has often been maintained at the expense of progress, through anchoring a dynamic psychology to a more static biology. Attempts have been made to gain more detailed knowledge of the relationships of psychic and physical factors which find common ground in maladies such as certain digestive, endocrine, and cardiac disorders.

From the practical standpoint of treatment it has been proven useful to consider the patient as not one person but two--a physical man and a mental man. As is the case of general medicine, so in psychotherapy the treatment varies with the individual. Treatment by mental means of the various disorders and difficulties which involve the mental man is termed psychotherapy.

In the Renaissance, which terminated the Dark Ages, psychotherapy was left strickly alone, except where religion and charlotism took joint possession. This must seem a strange combination yet the two had one thing in common--in that both operated inside the field of the natural phenomena and the scientific approach. From the

standpoint of science and intellectual public opinion, this method of treatment fell into disrepute, from which it has only emerged in recent times. The presence of some form of psychotherapy has, however, been inevitable, on account of the nature and needs of psychic difficulties. So far as medical men were concerned, they avoided a dilemma by practicing psychotherapy without knowing what they were doing, or else hiding it behind some physical agency, such as drugs or diet, which seemed to them to be more respectable.

The neuroses have had to wait, in the developement of medicine, until more important and pressing business was disposed of. They do not sweep through the communities and bring sudden disaster and death—instead they are limited to individuals and the few people in close contact with them.

The more serious mental disorders, the so-called insanities and other gross abnormalities and defects of the mind, have always been of concern to society, but up until recent times such persons have been considered more as criminals than as sick people.

Disorders of the mental man that demand psychotherapy may result from two groups of causes:

1. Those that are external.

2. Those that are internal—i.e. within the mind itself.

In the first group it can be clearly recognized that "the slings and arrows of outrageous fortune" may produce distressed states of mind which cannot be permitted to continue and which somehow must receive help.

In the second group the causes are hidden and even though the results are expressed in the nervous systems, whatever is responsible for them seems to be something alien and inexplicable to the sufferer himself and to others. It is these people who have a predisposition to neuroses who need the help of mental medicine. It is the conditions arising from inner causes that require technical psychotherapy, whether or not these causes operate alone or are reinforced by outside factors.

Mesmer, an eighteenth century Viennese physician, was the first to grasp the principles of so-called suggestive psychotherapy in the hypnotic states. In spite of Mesmers repudiation by medical men of his time, his theories, basically viewed, must be accepted as the basis of modern psychopathology and the first substantial contribution to a sane psychotherapy.

In 1882, the French Academy of medicine, finally allowed Charcot to present before it his conclusions in regard to hysteria and hypnotism. This marked the official admission of psychotherapy into respectable company and was the birthday of scientific treatment of illness by mental means.

The World War gave a healthy impetus to the subject of mental treatment due to the number of nervous disorders that occured among the soldiers of all nations. Progress has since been rapid.

The evolution in the application of physical energies for the treatment of nervous and mental diseases forms an interesting chapter of therapeutics. It represents a change from crude superstition and empirical therapy into some well controlled clinical methods resting on a rational theoretical and experimental basis. The theory of demoniacal possession led to cruel physical restraint such as was imposed upon theives and murderers.

Modern progress in physical therapy, besides placing at our disposal many newer and more efficient forms of physical treatment methods, has given us the correct conception of the mode of action of physical energies and their relation to pathological changes. Every physical measure exerts a primary physical effect on the body-thermal, chemical or mechanical, and upon the extent of this action depends subsequent physiological effects and influence or function sensation or local pathological changes. These effects can be utilized either for treating the original cause or seat of disease, or to ameliorate its results and to maintain or restore necessary function.

Thermal measures applied locally within physiological

toleration, cause hyperemia and sedation of sensory of motor irritation. Clinically they are potent means for promoting resorption of the products of inflammation following trauma or infection and also to relieve many forms of local pain. Modern methods of diathermy and short-wave diathermy allow penetrating heat of deep structures including the brain. An additional effect of both local and general heating is the killing of thermalobile organisms as seen in the treatment of the venereal diseases.

General heating at sufficient intensity bring about an increase of the circulatory rate and the metabolism, a rise in blood volume and oxygen consumption and a change in the urine, blood and sweat to an alkaline reaction. Artificial fever therapy has come to the fore in recent years in increasing the protective and defensive mechanisms of the body to many disease conditions. Physical agents offer the advantages that they are always available, that the febrile reaction is under control and that the procedure is sterile. In these procedures, heat energy sufficient to overcome the heat regulating mechanism of the body is employed while suitable insulation prevents loss of heat by evaporation.

The presumable clinical benefits of fever therapy have been summed up by Slocum and Popp as:

1. A direct bacteriolytic or bacteriostatic effect due to the influence of heat itself on bacteria.

2. An indirect bacteriolytic or bacteriostatic effect resulting from increasing formation of mobilization of immune bodies.

3. A local effect from vasodilatation, providing an augmented blood supply to inflamed tissues.

4. A general effect from the heightened metabolism incident to fever.

Frigorific measures are employed in the form of cold wet packs for general sedation, short cold baths, douches and showers for circulatory stimulation and general tonic effects as well as in depressions and stupouous cases.

Photochemical measures in the form of natural or artificial heliotherapy are useful for general tonic effects in conjunction with general medical treatment. Electrochemical measures in the form of galvanic current serve as mild counterirritants and metabolic stimulants. Cerebral galvanism has a definite field of usefulness. The static head breeze is a mild sedative. Low frequency currents, including the faradic are indispensible means for electrodiagnosis and for the stimulation of weak and paralyzed muscles. Electrical muscle exercise is of special importance in preserving muscular function in lesions effecting the lower motor neuron and causing real paralysis.

Mechanical measures in the form of massage and the static wave current serve to keep up muscular tone in case of weakness due to disease or general systemic inactivity. Therapeutic exercise is invaluable for muscular reeducation. Occupational therapy is the most important factor in the physical and mental reeducation of all forms of organic and functional disorders.

Hydrotherapy, which is the treatment of disease by means of water is used mostly in nervous and mental cases. It can be given internally and applied externally in many forms such as baths, sprays, ablutions, affusions, packs and douches. It is used at temperatures from hot to cold--never at body temperature, since at body temperature there is little therapeutic effect.

When cold water is first applied to the surface of the body a blanching of the skin is produced. This is a reflex action--the sensory nerves of cold are stimulated and the impulse is then conducted to the vasomotor center and there stimulates the vasoconstrictor nerves which contract the muscles in the walls of the arteries thus diminishing their size and decreasing the amount of blood in the capillaries. This has the effect of raising the blood-pressure--making the heart beat stronger and increasing the supply of blood to the deeper structures. When the cold is removed the action of vasodilitation takes place and a sensation of

warmth and well-being is experienced.

Heat is considered to be one of the most powerful stimulants, but it may become a depressant if its action is too prolonged. When first applied the action is one of constriction of the cutaneous vessels and a diminished supply of blood in the capillaries. This is quickly replaced, however, by a vasodilatation with reddining of the skin and lowered blood-pressure. The dilation of the cutaneous vessels diminishes the blood supply to the brain and other deeper organs and structures, nervous and muscular energy are decreased and a feeling of languour develops.

Water under pressure is applied by means of hose and nozzle. The effect of the impact of the water aginst the muscles and tissues is very similar to massage. When water is thus applied it acts as a strong stimulant, as an eliminative and a sedative.

The douche treatment is of five types:

1. Jet douche, in which a small stream is directed under pressure.

2. Circular douche, in which the water strikes at an angle and the patient turns slowly around.

3. The Scotch douche, in which hot and cold water are alternately applied.

4. The rain douche, in which the stream is directed from above.

5. The fan douche, which is produced by placing the

finger over the outlet of the nozzle.

Before beginning the treatment the pulse and blood-pressure are taken and recorded on the hydriatic chart. The patient is then placed in a warming cabinet after being undressed. Here ice compresses are applied to the head, water is given freely and the pulse is checked frequently. When the patient has begun to perspire or after five minutes, the patient is removed from the cabinet, wrapped in a sheet and quickly placed in position for the douche treatment. The patient is then dried with the use of a rough twoel and friction, again wrapped in a sheet or blanket and allowed to rest. The pulse and blood-pressure are again taken and recorded.

Ablution is the treatment usually given for insomnia and consists of applying water either with the hand or with the aid of a sponge to a small portion of the body at a time--rubbing the skin vigorously for one to two minutes then drying with a coarse towel and proceeding to the next part until the whole body has been covered. The treatment will usually result in quiet restful sleep.

Affusion is a simple treatment and is best administered with the patient in a sitting or standing position in a bath-tub. A sheet is placed aroung the body under the arms and water at 50-60° F. is poured from a pitcher for fifteen to twenty seconds. The patient is then rubbed with a coarse

towel until reaction has occured.

Cold baths or plunges are excellent tonics and are usually given in the morning. A tub is filled two-thirds full with water at 60° F. The treatment lasts ten to twenty seconds and reaction should take place almost immediately.

In a half-bath the tub is filled with sufficient water at 60-65° F. to cover the extended limbs and pelvis of the patient. In this treatment the patient can assist the nurse in splashing water on his body and applying friction. This treatment may last one to ten minutes depending on the condition of the patient.

Cold foot baths are occasionally given when the circulation is sluggish, and in cases of insomnia and neurasthenia. The feet are placed in a tub of water 50-60° F. and vigorously rubbed and dried with coarse towels.

A prolonged bath is frequently given to relieve fatigue, induce sleep and relieve nervous tension. The water should be 90-100° F. and the patient should be encouraged to recline and relax. This treatment usually lasts twenty minutes. A cool spray or sponge may be given upon being taken out of the tub. The patient is then dried, gowned, wrapped in a warm blanket given a warm drink and placed in bed. The room should be quiet, with lights low and good ventilation and there should be no conversation.

The continuous bath is generally used in the treatment of delirium and the excitement of mania. The temperature of the water in the tub, which should be 98° F., can be maintained with the aid of a bath thermometer, by adding hot water as necessary. A hammock or canvas strips are adjusted in the tub so that the patient may be almost completely immersed in the water. The patient is lightly rubbed with lanolin, especially the heels, soles of the feet and palms of the hands. A gown or pajamas is put on, cotton is placed in the ears, a bathing cap is put on to protect the hair, the feet are elevated to keep them out of the water as much as possible and a rubber sheet and spread are put over the tub and pinned in place. Water is given freely and the patient is never left alone. This treatment usually lasts eight to nine hours but may last twenty-four hours if necessary.

The salt glow is a vigorous circulatory stimulant. About two pounds of coarse salt are moistened and allowed to stand for a short time. The treatment should be given in a wet-room or a bathtub. The skin is moistened and the salt applied evenly to an area, then the skin is rubbed vigorously until it glows.

Packs are given which may be wet or dry, hot or cold. These packs consist of wrapping the patient in sheets or

blankets that are either wet or dry as prescribed by the physician. These treatments are quite effective in cases of insomnia, convulsions, the spasms of chorea and extreme restlessness.

There is more to relieving mental conditions than would appear from the types of physical therapy that are employed. Psychiatric nursing demands the better understanding of the patient. It is necessary that the inconsistencies, alterations, defects, distortions and disorganizations of personality may not prove disconcerting to the nurse and render her efforts ineffective.

The tendencies and characteristics given by nature and ingrained into the physical organization are constantly being activated, energized and antagonized by the physical, intellectual, social and moral forces of the environment, so that they are modified and changed into other tendencies and reactions, which through repeated expression become habitual and produce the ensemble of mental habits, interests and attitudes termed personality.

Those persons, who, through their innate characteristics are more interested in other people, and in the different elements of their environment, are more likely to be better adjusted socially than those whose native tendencies produce the opposite effect by being chiefly interested in themselves and their own problems.

When a student nurse is assigned to a psychopathic ward for the first time she is generally at a loss as to what is expected of her. This feeling of insecurity may be based primarily on her own preconceived ideas of insanity and its symptoms or it may be due to a lock of established procedure.

Most people will treat the psychiatric patient as an odd member of society; they seem to fail to recognize that his condition is as much a disease as pneumonia or scarlet-fever. If the patient with a distinct pathological condition suffers a delirium they are prone to pass over that symptom lightly, yet when a mental patient becomes noisy the average person snaps up such behavior and connects it with every mental case.

The hardest part of teaching psychiatric nursing is to uproot such ideas which have become ingrained in the minds of the nurse. The student is amazed when she finally appreciates the fact that in much of her psychiatric nursing care she is dealing with people who are very much like her patients in general nursing, especially when she considers those patients in terms of personality.

In psychiatric nursing we are not dealing with such things as fever that can be reduced by bathing, or flatus that can be dealt with by the right kind of enema, we are dealing with the patient as an individual, with his personal

problems, passions, senses, likes and suspicions. The course of conduct and the effects therefrom depend upon the nurse herself and her ability to handle well the situations that arise. The nursing care is by and through contact, and the nurses groundwork is a delicate adaptation to personal feeling that can take place only as she is truly a part of the situation. The work is individual and subjective, and it is the individualization and subjectivity that make the established procedure of limited use in psychiatry as an effective nursing method.

The nurse must learn that the patient is not some one to be fitted into the scheme of hospital routine, but that she, the nurse, must suit the care to meet the patient as he is.

MENTAL HYGIENE AND CHILD GUIDANCE IN OREGON

In "Mental Health in the community", Clara Basset states that "Mental hygiene is that growing body of knowledge and technic which has for its purpose the understanding of the evolution of human personality; the promotion of mental health as an expression of the highest developement and integration possible, at each age level, of the physical, emotional and mental powers of personality; the study, treatment and prevention of emotional and behavior disorders which preclude the happy and effective individual or the social functioning of personality as well as of the more radically incapacitating nervous and mental diseases and defects; the efficient organization and operation of community facilities which may be necessary for the achievement of these aims and the progressive modification of social institutions and agencies which vitally affect the mental health of large groups, so that the principles, methods and practices in use may more successfully conserve mental health and contribute to the growth of personality".

Mental hygiene is based upon years of study and developement in all the sciences relating to the growth—both mental and physical—of the human race from a

physiological, historical and psychological basis.

Mental hygiene as an organized movement began in 1908 with the founding of the Connecticut Society for Mental Hygiene and the National Committee for Mental Hygiene in 1909. City, county, state, national and international societies and committees soon developed. With this developement came the necessity for the incorporation into the curriculum of doctors, lawyers, ministers, teachers, nurses, social workers, probation officers, prison officials, industrial executives and parents of training which would enable them to deal thoroughly and properly with all types of mental conditions.

During the nineteenth century the right of the insane to kindly care was explicitly recognized, although it was only through prolonged effort in the face of opposition that this theoretical recognition was translated into practical measures. The nineteenth century not only acknowledged the right of the insane to humane care, it also saw the medical profession accept mental disorders as topics of systematic investigation and teaching on an equal basis with the diseases with which general medicine dealt. The early attacks on these problems were carried out under the domination of pathological anatomy and the century closed with a creditable record of advances in our knowledge of the

structures of the brain and of the detailed changes in the parenchyma and supporting structures of the brain in a variety of morbid conditions. But the behavior of the insane, their beliefs and subjective experiences remained about as mysterious as ever. The industrous clinician could only study the external manifestations and the evolution of these disorders, and analyze the individual clinical picture to the best of his ability in the light of the current psychology of the period.

Before the century was over a new movement of basic importance to the present day psychology was initiated. Sigmund Freud, beginning with studies on hysteria, had revealed the importance of unconscious factors in the structure of the personality; he had put forth the view that not only hysterical and compulsive symptoms, but also ideas of reference, hallucinatory voices and visual images, might have their origin in repressed tendencies and memories. In 1896 he had already published the presentation of a Schizophrenic psychosis as an attempted adaptation of the inner personality to conflicts.

Nissl had finally arrived at a precise formulation of the histopathological picture in general paralyses; the changes in other forms of cerebral lues, in cerebral vascular disease, in senile degeneration were differentiated

from each other. New technical methods were being elaborated and it was hoped that these new methods might reveal structural changes not previously demonstrated and thus throw light on the more baffling mental disorders.

Psychiatry was helped to a certain degree by the elucidation of other diseases. Disorders of motility, hyperkinetic and akinetic conditions, anamoulous postures and gestures, were illuminated by the increasing knowledge of the functions of the lower centers. Wilson's pioneer work on the lenticular nucleus, the analysis of the changes of the striatum in Huntington's chorea, in Sydenhams' chorea and in Parkinson's disease, the lessened initiative, or marked motor drive in epidemic encephalitis, offered suggestions for the interpretation of disorders of motility in mental patients. Experimental work by De Jung and H. Baruk showed that it was possible to produce in animals by a drug (bulbocapnine) or by an organismal toxin (colon bacillus toxin) morot disturbances and postures strikingly similar to those observed in mental patients. As with the production, so with the removal of certain symptoms; experiments with patients demonstrated the rapid relaxation of muscular rigidity as well as the temporary cessation of mutism, on the administration of certain drugs such as carbon dioxide or sodium amytol.

Pavlov experimented with dogs and their reaction to

various stimuli. As a result he drew an analogy between Schizophrenic patients and his experimental animals, and suggested that Schizophrenia might be looked on as a state of chronic hypnosis of inhibition, an adaptive reaction for the protection of the cortical cell. Whatever the validity of such analogies may be, such experiments at least show that under even simple conditions striking symptoms may be developed, which are not to be explained merely in localizing structural terms in the light of past experiences of the individual.

Clinical studies of many different physical symptoms have shown that these conditions are not often of physical origin but are due to unsolved and sometimes unknown mental and emotional problems which project themselves to the physical level. The outcome of a definitely physical disease is often determined by the willingness or desire of the patient to help in acquiring a satisfactory result. The attitude of the patient will depend to a great extent upon his or her mental condition prior to the illness and also to the sympathetic understanding and help that the nurse will give in the performance of her routine duties. Emotional factors such as chronic anxiety, anger, hatred and resentment, thwarted ambitions or affections, are being recognized as playing a very important role in predisposing the individual to the onslaught of disease.

In those hospitals where psychiatrists are frequently called in for consultation, it has been demonstrated that a large number of patients who claim to be suffering from a host of weird physical symptoms are in reality suffering from purely mental disorders. The nurse with training in mental hygiene, who is alert to the symptoms of mental and emotional problems and who realizes the intimate bearing that these may have on physical treatment, may render invaluable service and assistance to the physician in diagnosis and treatment by the careful observation and recording of details of behavior and personality reactions which come to her attention in her intimate and more continuous contacts with the patient.

In the, tuberculous clinics, the gynecological clinics, the urological or genito-urinary clinics the nurse is constantly confronted with particular mental and emotional problems which are intimately associated with the physical disease and which are playing an important role in the process of restoring the patient to physical and mental health.

The objectives of a public health nursing service in mental hygiene are:

1. To make more productive all of the nurses contacts with individuals and families through her better understanding of human psychology and teaching methods.

2. To increase her awareness of the significance of variations of human behavior so that she may make more intelligent use of mental hygiene resources.

3. To equip the nurse to assist in the care of the mentally sick in their own homes.

Mental hygiene training will help the nurse in public health work to appreciate to a greater extent the unwholesome effects which physical deffects and diseases may have on the personality developement of the child, on the relationships to the childs schoolmates and the family, and on his educational progress.

In the industrial nursing services which are gradually being recognized as a necessity, the nurse with psychiatric training is able to help the employer and the employee in coming to a better understanding of each other. She is able to help settle difficulties which may arise between fellow employees, and employees and their supervisors.

The nurse in the training school is in great need of an adequate training in psychiatric problems. While it is essential for the nurse to be familiar with neurology and the symptomatology of mental disease, it is also necessary to learn something about the evolutionary developement of "normal" personality and about the attitude and emotional reactions, the experience of which contribute to or undermine mental health and stabillty. She needs particularly

an introduction to the mental hygiene of childhood and to the mental and emotional aspects of the various types of diseases.

Medical education with its application to psychiatry has made great strides during the past few years in Oregon, with the establishment of a Division of Psychiatry in the Department of Medicine of the University of Oregon Medical School.

At the beginning of this period the curriculum of this subject was revised in order to take into account the advanced studies and schools of thought and the modern idea of the care and treatment of the mentally ill. Before this change in the curriculum in psychiatry, the approach to the mental problem had been from an organic or neurological basis.

This psychobiological school has had a profound influence upon the practice of medicine in the Pacific Northwest, probably due to a conscious on the part of practicing physicians of the importance of the functional as well as the organic phases of mental disorders. Psychiatry has come to be emphasized as a part of general medicine, however, it is emphasized with the idea of placing proper weight with reference to the whole subject of medicine.

The Medical School and the Department of Psychiatry have been intensely interested in the establishment of a

psychiatric hospital for the state of Oregon, as a part of the Medical School project. The various states have more or less assumed the responsibility of the care of the mentally ill; but at the present time this has been extended to the permanent custodial care of always increasing numbers. Many of these patients could avoid commitment by receiving adequate care and treatment in a modern hospital equipped with the facilities and personnel to manage mental disease in its incipience. It is known that many cases committed to asylums are of the type that are most readily relieved or cured by the proper treatment. It is hoped that in the near future a psychiatric unit may be established in connection with the University of Oregon Medical School in which the most modern treatment and care can be offered to those patients who are considered curable.

The intelligent approach to any medical problem implies efforts at prevention, relief and cure and in those instances not amenable to relief or cure, humane custodial care. This has been traditional practice in all forms of infectious or other physical disease, and should apply with equal force in the matter of mental disease. In the State of Oregon, as far as the latter group is concerned, patients have been divided into two great classes:

1. Those requiring commitment to state institutions for which the state has provided humane and excellent care.

2. Those with mental disorders who are not committed and for whom little has been done with the exception of a small beginning in the Department of Psychiatry and the Child Guidance Clinic at the University of Oregon Medical School.

In the Child Guidance Clinic children who are problems in school, wayward, out of joint with their surroundings and other children, and wards of the Juvenile Court who have delinquent tendencies based upon mental and emotional deviation have been studied and treated for the past few years with increasing success. It has prevented the commitment of a large number of children to the state training schools and has, through medical and psychiatric treatment and social readjustment cured many of these cases which hitherto have drifted on to uselessness in society.

The purpose of the Child Guidance Program is to affect the educational and emotional readjustment of those children handicapped by an inability to learn through the usual teaching methods adopted in the public school system, and those needing adjustment other than in school rooms. For example: There are certain children who have a high intelligence quotient that are unable to progress in school because of a word blindness or because of purely visual memory or other such handicaps who fall behind in their work. These childrend, many of whom are classified as mental deficients, are

oftentimes not promoted.

It has been demonstrated that many children, after a year or more of the proper type of reeducation, are able to continue normally in the public schools; emotional conflicts arise in children when they are forced to consider themselves as "dumb" or inefficient which is caused by children's attitudes towards themselves and the attitude of other children toward them. This group in particular needs special guidance.

There are other groups that can be mentioned:

1. Those individuals who, because of physical handicaps, need special encouragement and direction in order to become adjusted in a community or in their own group.

2. Another group of individuals with an intelligence quotient which is not average can be benefited by special room instruction. Such a procedure prevents pupils from leaving school and becoming discouraged. This group can be taught to adjust itself. Although a high plane of efficiency may not be reached in the educational system, this group will be capable of adjustment with community society.

3. Many cases which come to the attention of the courts are in reality emotional problems which are the result of misunderstanding of the social standards of life and are not amenable to disciplinary measures but rather to clearing up the misunderstanding and attitude toward life. Such cases follow logically under a guidance program.

S U M M A R Y

Kraepelin, to whom we owe the dominance of the concept of dementia preacos, considered that the later phases of a mental disorder give the truest insight into its nature and make its interpretation and its classification more certain.

As to the forms that dementia praecox might take Kraepelin divided it into three groups, namely: paranoid, hebephrenic, and catatonic.

The Kraepelinian formulation seems to draw rather definite boundaries where no actual boundaries exist; it gives an appearance of certainty with regard to prognosis which the facts hardly warrant; the personality receives scant attention, the life situation is considered to be more or less irrelevant.

A modern community finds that non-conformity is disturbing and unpleasant, but with softened manners takes the non-conformist to a psychopathic hospital instead of subjecting him to mediaeval or primitive penalties such as we have already described. The fact that an individual is so-journing in a psychopathic hospital is not presumptive evidence of disease. It indicates, rather, that he feels in need of help, on account of some inner handicap or disharmony, or that his fellows find him a perplexing or

disturbing member of the group. The difficulty may be the result of an underlying disease or it may be a maladaptation of more complicated origin. To understand the nature of the disharmony or maladaptation one must take into consideration not only the facts if internal medicine but also the complex forces involved in the human personality and the environmental factors involved in a single life history. The orderly classification of material is a matter of great difficulty, and it is not easy to present results of extensive observation and analysis in any brief systematic body of doctrine. Life is not a very orderly process; unexpected, irregular, unusual situations develop. Human nature is a very imperfect system, the individual is not a standardized article. No rigid system of classification can do justice to the great variety of life experiences.

On the other hand, however, chaotic life may be, however varied human nature, in surveying the experience of our patients one is repeatedly confronted by the same reactions, the same major forces and major issues. We see a certain limitation in the number of ways in which man meets the challenge of the environment, and we can outline certain general principles regarding the disorders observed.

When an individual enters a hospital for the insane there goes with him an impression of stigma, of misunderstanding, of hopelessness. To the patient and his relatives

the institution is nothing but a specialized kind of jail. The relatives too often believed--and often justly so--- that corporeal punishment was a part of the hospital management. These relatives were often reluctant to sen anyone to an asylum for fear that they would never return from that "living death". Due to this many people built barred rooms in attics or cellars in which the psychotic could receive a minimum of expense and publicity.

A generation or so ago, medical men considered psychiatric patients and institutions for their care of such little importance that they received little or no attention in the medical school curriculum. It will be recalled that our present-day Psychiatric Association originated as a group of hospital superintendents, by some of whom matters of administration and of financial management were better understood than any more clinical or therapeutic measures, even though those latter evoked a great deal of interest.

We can ask--what are the purposes of a psychiatric hospital? These can roughly be divided into three chief aims--to cure, to mitigate, and to maintain. We should see each type of hospital as contributing to one phase of a complicated social problem. Some give a service in offering continued care, while others are more like distributing stations, retaining the individual case hardly long enough

to initiate much therapy.

In this age of specialization, relatives can find the type of hospital best suited to the patients needs whether the criteria are financial, religious, homopathic or climatic--whether they involve psychoanalysis or recreational advantages, or culinary variety or architecture--these are to be found as needed.

In this fact lies a twofold significance. On the one hand it implies that the public has made the mental hospital one of its accepted traditions, one of its regularized institutions, indispensible and dependable. And on the other hand, it suggests the influence that the hospital may exert upon the public in developing better standards for care and treatment, more adequate cooperation in carrying out plans of therapy.

We need a twofold process of education. We should have a social education that would act as an unrelenting influence toward improved and ever improving hospital standards.. And we need that understanding vision and guiding direction from the mental hospital which in turn will further and interacting cooperation of the public and of related organized agencies for the greater benefit of the psychotic.

For the mental hospital to send patients out "on parole" or "on visit" to return for out-patient clinic follow up, is

useful not only as psychotherapy for the patient and as a means of reducing crowded conditions in the hospital, but also of the educational influence such out-patient services exert upon the laity. The State hospital which has tried the experiment of instituting out-patient clinics has found not only that it makes the treatment of ambulatory patients simpler for the staff, but also that the relatives in the community come to take a much more intelligent understanding in the problems of the patient. The present willingness of institutions to receive voluntary cases helps to palce mental disease on the same footing as other diseases.

There is a type of hospital called the "psychopathic hospital" whose functions are research study and the meeting of special problems which particularly call for expert investigation.

To most people the fact of having a mental disease seems particularly horrible, as if it must be something weird and apart from the everyday course of events which move by natural and understood laws. By its quiet application to the problems at hand, by its specific attempts to meet specific symptoms, by its unruffled equanimity in the face of varying manifestations, by the patient, impartial and often impersonal way of dealing with the case, and especially by its attitude during the period of quiet convalescence, the hospital is

often able to remove, or at least diminish, attitudes in the patients mind which have always been a source of sensitiveness, fear and perhaps an inferiority feeling.

The grounds of an institution, the buildings, the equipment, the financial resources, and the policy of its managing board, like the parts of a person, are mutually interactive so that any one of them is to some degree modified by the condition of others. It has its purposes, its problems, and its triumphs. And like a person, too, the hospital changes its appearance and some of its objectives, its policies, and its methods, as it grows older and more experienced.

As the science of psychology advanced and the psychopathological conditions were studied, newer and saner methods of treatment were devised for the mentally ill. Principal among these is recreational therapy. This of course necessitates an intensive study of the individual and his reactions to social behavior. Excellent results are obtained, however, with the use of time and patience.

Hydrotherapy is another type of treatment which has proven very effective. This too requires a study of the individual—his likes and dislikes and various reactions.

Some newer treatments, which are, however, still in their infancy, but are gradually advancing in effectiveness

are fever therapy and the insulin or hypoglycemic treatment.

But, hapy to relate, the treatment and care of the insane is now rapidly progressing to a saner and truly more Christian point of view. This viewpoint is still somewhat limited to those making a study of such conditions; but as time goes on the layman is gradually losing his antagonism towards the various forms of insanity and is now being educated up to the point that if the problem of treatment of the insane is to be solved, it must be approached from a scientific viewpoint.

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