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BULLETIN of the
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ORIGINS OF THE STATE MENTAL HOSPITAL: A CASE STUDY*

GERALD N. GROB, Ph.D.†

I

To many individuals concerned with the care and treatment of the mentally ill, the state mental hospital has often stood as the epitome of all that is wrong with an institutional system created to care for the insane. But it is important to understand that the state hospital was not always the kind of institution that we are accustomed to seeing. At the time of its founding the mental hospital had therapy, not custodial care, as its primary function. The results achieved by this therapy, primitive as the methods used might seem, were impressive even by modern-day standards. The purpose of this article is to analyze the motivating factors that led to the establishment of mental hospitals in the early 1800's and to describe the ideals the first founders had in mind in caring for the insane.

Like most institutions that arise in response to the needs of society, the mental hospital grew out of a specific cultural milieu and reflected the unique characteristics of its indigenous environment. The history of Worcester State Hospital, with which this article will deal primarily, is particularly revealing in this respect. The institution was a logical outgrowth of a number of historical trends and ideas current in 1830—the date of its founding. But the study of this institution is more important because the Worcester hospital pioneered the development of a rational and cohesive system of public mental hospitals throughout the country. What were the factors operating in Massachusetts that set in motion a movement that was destined to spread throughout the nation and to play an increasingly prominent role in American society?

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II

When Massachusetts was first settled as a Puritan colony in the early seventeenth century, the colonists brought over with them from England the outlines of a social system whose framework had been laid down in the fifteenth and sixteenth centuries. This system, codified in the famous and influential Elizabethan Poor Law Act of 1601, fixed a corporate responsibility upon society as a whole for the support of the poor. Thus the principle of public rather than private and philanthropic responsibility for the poor and sick (including the insane) was established in Massachusetts from the very beginning.

The colony never did develop on a broad scale the kind of organized system of private charitable organizations similar to those that existed in England. To local town officials, therefore, fell the task of providing for the poor as well as the indigent sick. This responsibility was made mandatory by a series of acts passed by the Massachusetts General Court, the supreme legislative body, during the seventeenth and eighteenth centuries. These acts had established the principle of public responsibility for the insane by the end of the eighteenth century.

From the very beginning of the colony the General Court was forced to cope with the legal, social and economic problems arising from the presence of insane persons. The first legal code of the colony adopted in 1641, for example, provided legal protection for idiots and "distracted persons."[1] Not until 1676, however, did the Court explicitly fix responsibility for the insane upon the local authorities. In that year an act was passed which delegated to town selectmen the power and responsibility for those insane persons who, because of their mental condition, were a menace to their own families as well as to the community. Selectmen were granted the authority not only to care for such individuals, but also the power to manage their property. In the event that the estate of the distracted person was insufficient to pay for his upkeep, the town was to assume financial responsibility.[2] During the remainder of the seventeenth century, and in the eighteenth, additional laws rounding out the system for the care of the insane slowly found their way into the statute books.[3]

Although such laws made the care of the insane a town function, they failed to stipulate how this function was to be carried out. One reason for this perhaps was because insanity was not a major social or medical problem during the early colonial period. Society was predominantly rural and deviant behavior, unless extreme in nature, was tolerated because fewer

people were threatened by it than was the case in more congested urban areas. Only if deviant behavior—and it was this which constituted clear evidence of insanity—was carried to an extreme and the community felt itself threatened did the mentally-ill individual come within the scope of the law. Even the indigent insane, who were usually considered harmless, came under the jurisdiction of local authorities largely because of their inability to support themselves rather than because of their confused mental state.

Generally speaking, the lot of the dependent insane who came under local jurisdiction was anything but ideal. Local authorities who were responsible for the poor under precedents established by the Elizebethan Poor Law Act of 1601 as well as legislation passed by the General Court usually did everything within their power to avoid spending public funds. One method of accomplishing this end was to make certain that only bona fide residents could receive aid. It was not surprising, therefore, that laws defining legal settlement were harshly enforced because localities hoped to exclude all individuals who might conceivably become a public charge.

Until the middle of the seventeenth century, poverty was not a particularly grave social problem in Massachusetts, for emigration to the colony was fairly selective and labor was in widespread demand. Hence, the settlement laws were not harsh; normally a residence of three months was sufficient to make an individual a legal resident of a town. But the social dislocation brought about by King Philip's war and the reluctance of the various localities to assume responsibility for persons not bona fide residents soon led to some changes. In 1675 the General Court passed a law which set up a separate category of the poor for which the province rather than the town assumed responsibility. The distinction between the town poor and the province poor was to prove of great importance because it led to a dual system of governmental charity.[4] This act encouraged towns to avoid as much responsibility as possible for various categories of paupers in the hope that the state would provide for their support. Thus the poor frequently became a pawn in a power struggle between the towns and the province, for both hoped to keep their responsibilities in this area to a minimum. In fact, in the eighteenth century the legislature passed several laws giving it the power to deport individuals who had not legally settled in the province and who were in danger of becoming public charges.[4] Since the insane were generally lumped together indiscriminately with the poor, they failed to receive any special consideration, medical or otherwise.

Indeed, most local officials sought to fulfill their responsibilities toward the indigent insane in the cheapest possible manner.[5]

As the population of the colony increased, there was a proportionate rise in the number of poor and the existing unorganized system began to break down. Boston, the largest city in the province, found that its urban character had rendered the old ways of dealing with poverty and insanity obsolete. As a result, the city began to experiment with newer approaches. In attempting to cope with its social problems, it decided to build an almshouse with funds received from several bequests for charitable purposes. Because of its mixed character, the new almshouse that opened in 1662 was never able to perform any function except keeping the poor alive. Various persons, including the aged, the lame, the blind, the insane, orphans and idiots were all housed together.[6, 7] The situation in the almshouses of other towns was not very different, since such institutions usually served as jails for criminals or as institutions to provide custodial care for those individuals whom the community believed to be social undesirables.

Private philanthropy and charity undoubtedly made the lot of many paupers and insane persons considerably easier. Various charitable and religious bodies, as well as well-to-do individuals, performed pioneering work among the needy and destitute, especially in times of acute distress. Moreover, it should be noted that not all mentally-ill persons constituted a social problem that required public or private aid. Insane persons coming from wealthy families generally had such advantages as went along with their secure economic position, including private attendants and personal physicians. Although the medical remedies of the time may have done more harm than good, it is possible that such private patients benefited if only because they were receiving some sort of attention instead of being neglected and forgotten as were their lower-class counterparts.[8]

Despite all of the efforts to deal effectively with the social problems of pauperism and insanity, it was becoming increasingly evident by the end of the eighteenth century that the towns were simply incapable of meeting their responsibilities. Their ability to raise money was limited by the restricted taxing powers. Even had they possessed ample resources, most towns simply were not large enough to support institutions like mental hospitals, which required a minimum number of patients if they were to function at all. Although many towns made valiant efforts to cope with the social problems of their growing population, they failed to achieve any great measure of success.

Thus, in its early days, colonial Massachusetts failed to develop a rational and comprehensive policy toward the indigent insane. Nevertheless, the province had established a precedent of major importance: namely, that the care of the insane was a public responsibility. The fact that the towns had been unable to fulfill their obligations in no way detracted from the principle itself. Later generations would attempt to solve the problem by shifting this responsibility to the state government, which possessed not only a broader financial base, but a more enlightened outlook than the municipalities.

III

Before serious reforms in the care and treatment of the insane could be undertaken, there had to take place a fundamental restructuring of the attitudes toward the mentally ill. New views concerning possible cures of insanity had to be widely disseminated. The traditional attitudes concerning the obligation of society toward the insane had to be restudied. Fortunately, such developments did take place beginning at the end of the eighteenth century and stretching into the early decades of the nineteenth.

There is considerable evidence to show that some of the new ideas for the treatment of the insane expounded by Pinel, Tuke and Rush began to find a wider audience in the United States in the early nineteenth century. Educated laymen in the upper classes as well as physicians began to show great interest in the findings of these pioneers.[9] Both of these groups maintained close intellectual and personal contacts with their European and English counterparts, and consequently were relatively well informed about developments abroad. Some Americans were educated abroad, and thus brought back to the United States first-hand knowledge of European practices. Others were influenced by the printed page, since most important English and European books were quickly imported into the United States. Language difficulties proved to be no barrier, for Pinel's famous work on insanity was translated into English only five years after it had appeared in French.[10]

The exchange of ideas was facilitated also by the contacts maintained by various religious and benevolent groups. American Quakers, to cite an outstanding example, were greatly influenced by the work of their English brethren in treating the insane. Not only did they establish the Friends' Asylum in Pennsylvania in 1813, but individual Quakers also played significant roles in helping to found other private nonsectarian hospitals, in-

cluding the Bloomingdale Asylum in New York. Indeed, half of the mental hospitals established in the United States prior to 1824 drew heavily upon the experiences of the Quakers.

Surprisingly, much of the leadership in the movement to reform the condition of the insane during the end of the eighteenth century and early nineteenth was provided by upper-class laymen rather than physicians. Perhaps the unspecialized nature of society made it easier for laymen to assume such positions of leadership. Most of these laymen were broadly educated and thoroughly versed in the scientific knowledge of their day. Having been influenced also by the optimistic and humanitarian currents that had grown out of the Enlightenment, they sought to eradicate the evil remnants still existing within society. Those who were attracted by the plight of the insane did not simply confine their efforts to fund raising; they served as pioneers in spreading and popularizing the newer and more optimistic theories about insanity.

The movement to reform the condition of the insane, however, was not only a product of English and European influences; it had indigenous roots as well. Foreign ideas were important only to the degree that they found a social and intellectual climate in America that was conducive to them. Early in the nineteenth century, a vigorous reform movement was being set in motion by the resurgence of Christianity in an event known as the "Second Great Awakening."

Beginning about 1800, the Awakening had the immediate effect of weakening the Calvinistic emphasis on the essential depravity of human nature and the inability of men to save themselves. In place of such pessimistic tenets, Protestant leaders substituted the idea of a loving and benevolent God, whose first concern was the happiness of his creatures. The twin themes of their liberalized theology were the doctrine of the free individual and the belief in a moral universe. When the belief in the free individual was fused with the millenial vision of a society performing a divine mission of eradicating all evidences of evil, Evangelical Protestantism was transformed into a radical social force seeking the abolition of the restraints that bound the individual and hindered his self-development. Thus, many ministers and laymen began to work actively to destroy the evil institutional restraints that imprisoned the individual. All persons, they maintained, were under a moral law that gave them a responsibility for the welfare of their fellow man. As a result of the teachings of Evangelical Christianity, virtually dozens of reform movements sprang forth during the first half of the nineteenth century.

In New England, the reform impulse was influenced to a large degree by certain indigenous forces. Since the colonial period there had existed a tradition of *noblesse oblige* held by the dominant social and economic elite residing in and around Boston. Members of this elite insisted that their wealth was not to be squandered indiscriminately, but was to be used for the benefit of society. Holding strong religious convictions, they emphasized the Christian doctrine of stewardship, which taught the responsibility of the rich for the poor. Thus they justified their participation in various reform and charitable movements of the day on religious grounds and rationalized their actions in terms of a paternalistic philosophy. After all, they claimed, was not the purpose of many of the reform crusades of the first half of the nineteenth century to free the individual from evil institutional restraints and thus enable him to compete in a free and open society where his talents and ambitions would ultimately determine the level that he would reach? For this reason the elite strove to better the condition of the insane, the inebriate, the blind, the deaf, the slave, the convict and other less fortunate members of society.

IV

By the beginning of the nineteenth century it was becoming clear that the care of the indigent insane within the general framework of the poor laws was becoming increasingly inadequate. As the population of Massachusetts continued to grow, towns and cities began to find it more difficult to handle their mentally ill on an individualized basis. The concentration of population in relatively small areas also led to a greater public awareness of "queer" or deviant behavior. Consequently there were demands that special provision be made for the insane not only to protect the general public but to provide for the care and welfare of such persons. Because towns lacked special facilities for this purpose, it became the accepted practice to confine the insane along with paupers and prisoners in either poorhouses or jails.

Although a number of proposals to found a lunatic hospital in the early nineteenth century were offered, nothing was done until a group of prominent Bostonians succeeded in establishing the Massachusetts General Hospital in 1811. Provision was also made for a mental institution affiliated with the general hospital. The privately-endowed McLean Asylum, as it later became known, received its first insane patient in 1816. While making

significant contributions by successfully utilizing and popularizing the principles of "moral treatment" (as the new humane and hopeful treatment was called in contrast to punitive, custodial and mechanical treatment), McLean's limited facilities and narrow financial base made it completely unsuitable for dealing with the more general problems posed by the insane in the state. The overwhelming majority of its patients were affluent individuals whose families could afford the high costs of protracted individualized care (although occasional charity cases were accepted). In short, private philanthropy, while more successful in a general hospital where the average stay was measured in days rather than months or even years, proved completely inappropriate insofar as caring for the growing numbers of mentally-ill persons was concerned. It was becoming increasingly clear to many persons that a new departure from the traditional policies of the past was essential if something was to be done for this class of unfortunates.

Before the state could adopt a new policy, however, the public and their elected representatives had to be made aware of the inadequacy of the existing facilities employed in caring for the indigent insane. Oddly enough, this function was performed not by the same formal group that had conceived of the idea of a general hospital, but by a number of prison reformers. Some of the public-spirited citizens in the Bay State had formed a national organization called the Boston Prison Discipline Society in 1825 under the leadership of the Reverend Louis Dwight to investigate conditions in prisons in Massachusetts and elsewhere. In the course of their investigations, they found that it was an accepted practice to confine mentally-ill people in jails when no other accommodations were available.

The Boston Prison Discipline Society in its early years devoted most of its energy to developing an informed public opinion on prison discipline. To arouse support for its views, the Society undertook extensive investigations of American prisons, and each year it published an *Annual Report* giving the results of its findings. Generally speaking, Dwight and his colleagues were highly critical of the penal system in most states. Especially appalling in their eyes was the confinement of lunatics and insane persons in jails where they lived amidst conditions that defied description. In 1827, for example, the Society's investigations revealed that no less than 30 lunatics were confined in the Massachusetts prisons that had been visited. One prison had three such inmates, another five, and one had as many as

ten. In one institution Dwight pointed out that one lunatic had been confined to the same apartment for nine years.

> "He had a wreath of rags round his body, and another round his neck. This was all his clothing. He had no bed, chair, or bench. Two or three rough planks were strowed around the room: a heap of filthy straw, like the nest of swine, was in the corner. He had built a bird's nest of mud in the iron grate of his den. Connected with his wretched apartment was a dark dungeon, having no orifice for the admission of light, heat, or air, except the iron door, about two and one-half feet square, opening into it from his Prison. The wretched lunatic was indulging some delusive expectations of being soon released from this wretched abode."

In the institution with ten lunatics, one man had been confined in a plank apartment on the first floor. During the previous eight years he had left this room but twice. Food was furnished through a small hole in the door and there was no fire for warmth in his room. "As he was seen through the orifice in the door," Dwight wrote, "the first question was, is that a human being? The hair was gone from one side of his head, and his eyes were like balls of fire."[11]

Descriptions of existing conditions such as these had a pronounced impact upon important segments of public opinion, particularly among the Boston aristocracy. Many prominent Bostonians not only lent their name to the Society but also contributed funds. In fact, the membership list of the Boston Prison Discipline Society was in many respects strikingly similar to the list of individuals who had conceived of the idea of the Massachusetts General Hospital and then had endowed that institution. The important role played by the clergy in prison reform can also be gleaned from the fact that 12 out of the 21 vice-presidents of the Society and six out of the eleven managers were drawn from their ranks.

Since the membership of the Prison Discipline Society was composed largely of the dominant upper-class elite of the city and state, the action of the legislature in appointing a committee in 1826 to investigate conditions in the jails of the Commonwealth and recommend desirable changes was not at all surprising. The choice of George Bliss as chairman of the committee was equally understandable. Bliss, an eminent Springfield lawyer, had graduated from Yale in 1784, received an honorary degree from Harvard in 1823, and served for many years in the Massachusetts legislature. Besides taking an active role in the affairs of the Congregational Church, Bliss served as president of the Prison Discipline Society from the time it was established until his death in 1830.[12]

Bliss's committee in 1827 presented its report on the condition of the state's prisons to the General Court. Although most of the report centered upon the penal system, the members also reported a considerable number of "Lunatics, and persons furiously mad" confined in the various jails. Even more shocking was the inhumane treatment accorded those unfortunate individuals.

> "The situation of these wretched beings calls very loudly for some redress. They seem to have been considered as out of the protection of laws. Less attention is paid to their cleanliness and comfort than to the wild beasts in their cages, which are kept for show. . . . However humane gaolers may be they are generally ignorant of the proper method of treating insane persons, and this ignorance makes their treatment of them operate to render them more furiously mad."

To remedy this situation, the committee suggested that all lunatics should be sent to the Massachusetts General Hospital if suitable accommodations were available. If such accommodations were not available, the committee recommended that a separate building be erected for the poor insane near McLean Asylum and that the institution be placed under the jurisdiction of those managing McLean. Under the committee's proposal, it would be illegal to send any mentally-ill person to a jail or house of correction.[13]

Despite the detailed and impassioned report of the committee, the General Court failed to take any action on the committee's recommendation. A second effort to reintroduce the bill a year later also did not meet with any measure of success.[14] New life was breathed into the proposal in February, 1829, when Horace Mann, who was just embarking on his brilliant career, introduced a resolution that some action be taken on the bill. Mann (who was then 33 years of age and had been elected to the House of Representatives for the first time in 1827) was appointed chairman of a committee that was charged with the task of ascertaining "the practicability and expediency of erecting or procuring, at the expense of the Commonwealth, an asylum for the safe keeping of lunatics, and persons furiously mad." The order directed local selectmen to furnish to the Secretary of State the number, age, sex and color of all insane persons, and whether they were at large or kept in confinement.[15, 16]

The state census of the insane was completed by January, 1830, and provided for the first time some statistics on the magnitude of the task facing Massachusetts. Of the 310 towns in Massachusetts, only 114 had provided the required information. Within these towns there were nearly

300 insane persons. Of this number 161 were in close confinement, including 78 persons in poorhouses, 37 in private homes, 19 in jails, 10 in insane hospitals and 17 in undetermined places. If the figure on the number of insane were extended on the basis of the state's total population, there was a minimum of at least 500 insane persons for whom no adequate provision had been made. As a result of its findings, the committee recommended that the legislature authorize the establishment of a state lunatic hospital for 120 patients, and provide an appropriation of $30,000.[16, 17]

Early in February, Mann addressed the House twice on the subject of the insane, an issue that had become one of his primary concerns. "Justice, no less than mercy required the Legislature to do something and no longer to let this class of unfortunates be thus neglected," wrote a reporter summarizing Mann's remarks in his first address. "As to the *interest* of the Commonwealth to do it, he would say nothing; it must be apparent—If we do nothing we may well envy them their incapacity of crime."[17] The people of Massachusetts, Mann argued later, had little to be proud of in their treatment of the insane. The laws of 1796 and 1816, which had been intended primarily to confine the dangerous and pauper insane in local jails for lack of better facilities, had simply made conditions worse. Insane people should be cared for by qualified personnel. In the long run, a hospital might very well be cheaper to the citizens of the state, Mann maintained, because many persons might be cured and removed from the welfare roles.[18]

But Mann refused to justify the proposed hospital on the grounds of economy. Having prepared his speeches on the basis of reports from contemporary English and European medical records, he knew that the new therapeutic approach involving the so-called moral treatment of the insane had been responsible for a substantial number of cures. Citing the findings of the well-known English physician, Dr. George M. Burrows, as well as the experiences of 40 European hospitals, Mann maintained that 50 percent of the insane were curable, provided that they were given a suitable environment and proper therapy. He concluded his address by delivering an impassioned peroration on the responsibility of the state toward its unfortunate insane:

> "But let us reflect, that while *we* delay *they* suffer. Another year not only gives an accession to their numbers, but removes, perhaps to a returnless distance, the chance of their recovery. Whatever they endure, which we can prevent, is virtually inflicted by our own hands. Let us restore them to

> the enjoyment of the exalted capacities of intellect and of virtue. . . . It is now . . . in the power of the members of this House to exercise their highest privileges as men; their most enviable functions as legislators, to become protectors to the wretched, and benefactors to the miserable."[18]

Mann's speeches made a profound impression upon the Massachusetts politicians. Effective reformer that he was, Mann had prepared his case thoroughly and appealed not only to the hearts of the legislators by emphasizing their Christian and humanitarian responsibilities, but to their intellects as well. Swayed by his eloquent words and persistency, the legislature on March 10, 1830, overwhelmingly passed a resolution to provide for the erection of a lunatic hospital, which would accommodate 120 patients, and appropriated the sum of $30,000. The Governor, with the advice and consent of the Council, was to purchase a suitable site, keeping in mind the center of population in choosing the location. Three commissioners were also appointed to oversee the project.[19]

While more than 30 sites were considered by the Governor and his advisers, the field was quickly narrowed down to Boston and Worcester. There was little doubt in anyone's mind that no town could match Boston's attractiveness, either in terms of facilities or financial inducements. Nevertheless, Boston also had certain inherent disadvantages. Its extreme easterly location would make it difficult for central and western towns to make use of the new hospital. Perhaps more important was the fact that the central and western parts of the state were beginning to challenge Boston's hegemony, and there is some indication to show that Bostonians did not want to leave themselves open to the charge that they were monopolizing all state activities. In June, therefore, the Governor and the Executive Council decided to locate the new hospital in Worcester. Its healthful atmosphere, central location, and adequate medical facilities all played a role in the decision.[20]

Shortly thereafter Governor Levi Lincoln selected Horace Mann, Bezaleel Taft of Uxbridge, and William B. Calhoun of Springfield as commissioners to oversee the planning and construction of the new hospital and to recommend a system of government and discipline. For the next six months, the three commissioners were busy planning and letting out contracts for the various sections of the asylum. They had decided from the outset to give out construction contracts on a piecemeal basis rather than giving the job to one or several large contractors. All three men were determined to build a structure that would prove conducive to the welfare of the insane; hence they were not unmindful of aesthetic or architectural considerations. On the other hand, they were concerned also with keeping expenditures to an absolute minimum. With these factors in mind, they struck a compromise between their desire for economy and an aesthetically pleasing structure. Brick was chosen over granite, which meant a saving of about 30 percent on this item alone. Mann and Calhoun voted against Taft's proposal for a dome to the center structure, partly for aesthetic and partly for economical reasons.[21-23]

By the end of 1831 construction of the buildings was complete, except for furnishing the inside. The hospital consisted of a center building 76 feet long, 40 feet wide and four stories high. Extending laterally from both sides of the center structure were two wings, 90 feet long in front and 100 in the rear, 36 feet wide, and three stories high. All three structures were connected by a center passageway. The center building was intended not only to house the staff, including the superintendent and his family, but also contained the dining rooms. The two wings, on the other hand, were exclusively for the use of the inmates. On each side of the wing there were apartments measuring eight by ten feet. Every apartment had a large window with an upper sash of iron and a lower one of wood. Outside the wooden window, there was a false iron one to prevent suicide or escape. Each story in the building had its own bathing and washing rooms and was completely separated from the other stories. There was a separate stairway in each story leading to the outer yard. Such an arrangement was intended to facilitate classification and separation of categories of patients.[22]

The physical plant of the Worcester hospital resembled that of the McLean Asylum in many respects. Nevertheless, there were significant dissimilarities between the two institutions that arose out of their divergent origins. Because McLean was a predominantly private institution serving private patients, its governing authorities were granted considerable freedom. Under the leadership of Dr. Rufus Wyman, its first superintendent, the physical plant at McLean was made to serve the needs set by the requirements of moral treatment. The Worcester hospital, on the other hand, was intended from the very beginning as an institution for the indigent insane. While its supporters hoped that many of these unfortunates could be cured—and there is little doubt that the optimistic attitudes of this period played an important role in securing legislative approval—they were not unmindful of the fact that the project was dependent upon governmental support. Economy, therefore, was a prime factor.

future years, the inadequacies of the hospital (which, after all, not had been built economically, but was also planned by three men, of whom was an experienced alienist) were to become more appar- Two decades later Dr. Isaac Ray, one of the greatest and most ortant American psychiatrists of the nineteenth century, bitterly con- ned the Worcester institution in harsh words. Ray was not unaware most mental hospitals built after 1833 were modeled after the one in cester. While recognizing the fact that Worcester resembled McLean, pointed out that:

> "... it wanted many of the details designed to meet definite and important ends, while its cheap and flimsy style of construction presented a striking contrast to the finished, massive features of the other. Being intended for the poorer classes, it was unwisely concluded that every subordinate object might be disregarded, provided the principal one—the custody of the patient—was secured. It was the first considerable example of very cheap construction, and one, unfortunately, which building-committees have been too ready to imitate."[24]

ay's strictures, however, were not altogether fair. At the time the cester hospital was being built, there were few psychiatrists in the ed States with sufficient professional experience to establish minimum irements for a mental hospital. The fact that Worcester was a state er than a private hospital made it even more difficult to apply what irements were known for mental hospitals; the institution was intended ter to a different class of patients and had an administrative and legal ture quite unlike its private counterparts. The Worcester hospital, for nple, had relatively little control over the number of entering pa- s—a problem that private institutions did not have to face—and the crowding that resulted exacerbated the problems of its physical plant. was the Worcester hospital in a position to benefit from the experience arlier state mental institutions. While it is true that several state hos- s had been founded prior to 1830, few of them in the first third of the teenth century evolved into such a mental institution as Worcester. ed, the fact that later mental institutions consciously modeled them- es after the Worcester hospital is an indication that other states facing same problem felt that Massachusetts had come up with a satisfactory tion.

here can be no doubt, however, that with the passage of time criticisms as those levied by Doctor Ray became increasingly justifiable. In fact, the trustees of the Worcester hospital and an investigating committee

appointed by the Massachusetts legislature came to recognize the shortcomings of the physical plant in 1854.[25, 26] This situation was not due to any lack of ability on the part of Mann and his fellow commissioners, but rather was attributable to the fact that they had planned for a solution to an immediate instead of a long-range problem. Subsequent events had made their solution obsolete. Efforts to remedy the situation in later years had to take place within an existing institutional framework which made it difficult, if not impossible, to inaugurate any radically new policies.

But in the 1830's, the State Lunatic Hospital in Worcester was justified in considering itself a model institution. Mann, Taft and Calhoun eagerly awaited the day that the first patient would be admitted. By January, 1832, the project had reached a stage where the three commissioners felt that they could present a progress report to the legislature. The document was probably prepared by Mann, for it was a masterful statement and showed the same thoroughness and care that characterized his subsequent reports as secretary of the Board of Education in Massachusetts. After providing a detailed description of the physical plant, the report went on to recommend an administrative framework within which the hospital could function most efficiently. Insane persons in Massachusetts were broken down into three categories: The first included all those committed to jails and houses of correction by justices of the Supreme Judicial Court and justices of the peace under the statutes of 1797 and 1816[27] because of their supposed danger to the security of the community. The second consisted of "town pauper lunatics" who were confined in poorhouses by the municipal authorities or auctioned off to the lowest bidder. The last group consisted of harmless insane persons whose families had sufficient means to care for them and of whom the law took no special cognizance.[22]

With respect to the first category, the commissioners felt that a strong case could be made for remedial legislation. Confinement of the dangerous insane was involuntary; yet these individuals were placed in jails and houses of correction where their chances of recovering were practically nonexistent. The reports of the Boston Prison Discipline Society had clearly shown that such penal institutions were totally unsuitable for the care and treatment of the insane. Citing the significant results achieved by moral therapy at the York Retreat in England and the Hartford Retreat in Connecticut, and the writings of Dr. George M. Burrows, the commissioners recommended that the dangerous insane be taken out of jails and committed to the Worcester hospital instead. As they aptly noted:

"Until a period comparatively recent, insanity had been deemed an incurable disease. The universal opinion had been that it was an awful visitation from Heaven, and that no human agency could reverse the judgment by which it was inflicted. During the prevalence of this inauspicious belief, as all efforts to restore the insane would be deemed unavailing, they of course would be unattempted. . . . It is now most abundantly demonstrated, that with appropriate medical and moral treatment, insanity yields with more readiness than ordinary diseases. This cheering fact is established by a series of experiments, instituted from holier motives and crowned with happier results, than any ever recorded in the brilliant annals of science. A few individuals, justly entitled to a conspicuous station among the benefactors of their race, have exploded the barbarous doctrine that cruelty is the proper antidote to madness, and have discovered that skill, mildness and self-devotion to the welfare of the insane are the only efficacious means for their restoration."

The report urged, therefore, that legislation be passed requiring that such patients be sent to the new hospital, but that localities retain financial responsibility for these persons by paying the hospital a rate established by law. Once a patient was cured and there was no longer any need for confinement, he was to be released.[22]

As far as the second and third groups were concerned, the commissioners felt that the state could do little more than offer them the benefits of the hospital. Legal responsibility, however, would remain with the towns and families who were to decide whether or not they would send their charges to Worcester and thereby incur the financial obligation that came with a commitment. It was hoped that towns would take advantage of the new hospital for in the long run it would be cheaper to cure an insane person than to have to support him indefinitely.[22]

The report concluded by recommending that a Board of Visitors be established. The Board was to be charged with the responsibility of looking after the over-all interests of the institution and to make certain that the hospital was run in accordance with the laws of the state. The Governor and Executive Council were to appoint the five visitors, who would in turn choose a superintendent to be responsible for the estimated 120 patients.[22]

The report was so thorough and logical in its presentation that within three months the legislature passed a comprehensive law incorporating most of the features recommended. Under the new statute the Governor, with the advice and consent of the Council, was to appoint five trustees, in whom control of the hospital would be vested. The trustees were to oversee the affairs of the hospital, establish bylaws, and, with the approval of the

Governor and Council, determine salaries. Monthly visits by at least one trustee were required, semiannual visits by a majority, and annual visits by the entire board. There was to be a written report after each visitation and in December of each year an annual report was to be forwarded to Boston. The law amended the acts of 1797 and 1816 so that in the future all dangerous lunatics would be committed to the hospital, and those already confined in jails and houses of correction were to be sent to Worcester "as soon as may be practicable." Along with the courts, the trustees were authorized to discharge such patients once there was no longer any need for confinement. So far as the support of lunatics who were town paupers was concerned, the law stipulated that communities could not be charged a rate by the hospital greater than the actual costs incurred in providing care and maintenance for such individuals. The trustees were authorized to charge even less than the normal costs with the hope of encouraging communities to send patients who had been "recently attacked by insanity," the theory being that recent cases were more amenable to therapy.[28]

The legislature in general accepted most of the recommendations of Mann and his co-workers. The purpose of the law was to rectify a socially undesirable situation by removing all dangerous lunatics from the jails and confining them, for humanitarian and medical reasons, in a mental institution. Private and pauper insane, on the other hand, could be disposed of as their families and towns saw fit. This distinction between categories of insane persons was to have significant long-range results that the framers of the law may not have intended. The law, in essence, took control of admissions out of the hands of the hospital authorities, and thus provided an automatic increase year after year in the number of resident patients. Equally important, it emphasized that the hospital was intended largely for the indigent insane. In the long run this feature increased considerably the emphasis upon distinctions made between socio-economic classes in American society when treating and caring for the mentally ill. As the number of patients at the Worcester hospital increased, it became more and more difficult to offer individualized moral therapy to its inmates. Thus the hospital, like most other state institutions, gradually became custodial in nature. Private hospitals which catered to the high socio-economic classes, on the other hand, continued to place heavy emphasis upon therapeutic functions.

In January, 1833, the Worcester hospital opened its doors and began accepting patients. Under the leadership of Dr. Samuel B. Woodward,

superintendent from 1833 to 1846 and also one of the original founders as well as the first president of the Association of Medical Superintendents of American Institutions for the Insane (later the American Psychiatric Association), the hospital quickly gained a national reputation. Not only was Woodward extraordinarily successful in helping patients by applying the precepts of moral treatment, but he also stimulated interest in the reform of the care and treatment of the insane.[29] More than a dozen other states, influenced by the example of Massachusetts, quickly established their own hospitals, which became the nucleus of a comprehensive system of state hospitals that developed during the nineteenth century.

What is especially noticeable about this early period of hospital founding was the optimism and hope of the reformers who led the movement. Not only were these individuals adamant in their belief that society could no longer ignore its obligations toward the insane, but they were equally convinced that mental illness was a curable malady, given proper and early treatment. Ironically, the lead for reform was taken not by professional physicians themselves, but by nonprofessional laymen like Mann and others. This fact was of crucial importance, for it meant that the early hospitals were to a great extent influenced by the prevailing optimism of that era. In later decades, as psychiatry emerged as a distinct specialty and psychiatrists became the dominant figures within the hospital, there was a progressive diminution of the hope and enthusiasm that had made these early institutions such exciting as well as successful places. While many other external as well as internal influences operated to hasten the transformation of the therapeutic hospital to a custodial one during the nineteenth century, the loss of the early fervor, drive and optimism that had originally generated the movement was of no minor consequence. Despite the fact that later psychiatrists were to ridicule the claims of successes achieved during the first half of the nineteenth century, the example of Massachusetts as well as of other states was to prove of considerable importance in the evolution of the state mental hospital.

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THE USE OF UNRESTRICTED DIET IN THE TREATMENT OF TWO EMOTIONALLY-DISTURBED DIABETIC PATIENTS

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The expression "one mouse is no mouse" was frequently used by a revered medical school professor of mine.‡ It was his way of reminding his students of the dangers involved in making sweeping generalizations from limited data. In this paper, I will describe the value of a free diet in the total treatment program of two severely emotionally-disturbed, diabetic patients with no attempt to generalize and with the full realization that "two mice are no mice."

Prior to the advent of insulin, diabetes mellitus was treated by manipulating the patient's diet. Most often this took the form of dietary restriction and often amounted to literal starvation. While there has never been agreement regarding the ideal treatment method, most clinicians today use both insulin and diet in order to maintain the diabetic in as nearly a normal physiologic state as possible. Adherents of the so-called Joslin School advocate the exact measurements of dietary intake; others believe that hyperglycemia in itself is not harmful.[1-7] This latter group believes that the secondary diabetic lesions are caused by acidosis and ketosis, not hyperglycemia, and hence advocate dietary freedom with appropriate insulin balance.

Many authors have emphasized the emotional difficulties of the diabetic patient and some, including Mirsky,[8] Daniels,[9-11] Dunbar,[12, 13] Hinkle,[14, 15] and Menninger,[16, 17] have indicated that emotional factors may play an important role in etiology of the disease. Still many practitioners treat the diabetic patient without taking into account his emotional state, and without considering the fact that food, dietary restrictions and other aspects of treatment may have important psychological meaning to him. It is the purpose of this paper to describe and to discuss the behavior of two severely emotionally-disturbed, diabetic patients whose psychological condition dramatically improved when they were allowed complete dietary freedom.

Case Report: L.M., at the time I saw him first in 1958, was a bright but severely disturbed 40-year-old male, who had first been hospitalized in 1942

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with a diagnosis of schizophrenic reaction, paranoid type. He remained hospitalized then for a period of five months and was discharged unimproved and against medical advice, to the care of his father. In the following years, this pattern was repeated with many admissions to the hospital lasting from a few months to a period of two or three years. His father successfully sabotaged any sustained benefit his son received from hospitalization by removing him, often against medical advice, only to find it necessary to hospitalize him at a later date.

At the time of one of his readmissions, in 1947, L.M.'s diabetes was discovered. Treatment with insulin and a special diet was instituted. L.M., however, had difficulty understanding what he was not supposed to eat and was uncooperative and belligerent about his diet. He had to be watched in order to prevent him from sneaking extra food or eating between meals. A note dated March 31, 1949 is typical of many throughout his chart and reads in part: "Patient carries newspapers, magazines, or books constantly, fumbles through them but never reads; plays piano occasionally, standing up to play; is diabetic, receiving 2,500 calorie diet which he continually cheats on by stealing food on the ward." A constant management problem, L.M. rummaged through hospital garbage cans in search of food. He was often incontinent and at times it was difficult to keep clothes on him.

There were marked fluctuations in his blood sugar values; he experienced numerous severe hypoglycemic comas. His food stealing continued but at times he skipped meals. In March, 1953, he developed an ulcer of his left leg which required skin grafting. He prevented the skin graft from healing properly by picking at it, burning the area with a cigarette and rubbing the ulcerated area with feces. At this time, he was considered a grave medical, surgical, and psychiatric management problem and cuff restraints were necessary in order to allow the ulcerated area to heal.

L.M. first came under the author's care in December, 1958, when he was transferred from a maximum security unit to a ward for chronic, "regressed" patients. His behavior remained essentially unchanged; he was seclusive, unkempt, withdrawn, masturbated openly, hallucinated, smoked constantly, and carried with him a large stack of magazines and books which he seldom read. He was underweight. Marked fluctuations in his measured blood sugar on a day-to-day basis continued and during a three-month period he had nine severe insulin reactions.

In March, 1959, a decision was made to treat the patient in accordance with Tolstoi's ideas,[6, 7] allowing him to eat whatever he wanted and whenever he wanted to do so, within the limits of the regular hospital routine. This decision was made because previous attempts at medical management had proven inadequate and indeed had, at times, been medically and psychologically harmful to him. His urine, however, was watched closely for acetone. It was hoped that this program might help L.M. to assume some responsibility for his illness.

With this treatment, his condition improved dramatically. He stopped stealing food, became increasingly cooperative, and his appearance improved.

He no longer experienced episodes of severe hypoglycemia. He became more interested in his surroundings, started attending church, and actually began to take an interest in his diabetes by counting calories and keeping track of his own caloric intake. There was an improvement in the control of his diabetes as reflected in laboratory examinations of his blood and urine, and he gradually gained weight more nearly approximating the "ideal" for a man of his size.

Case Report: T.D., a 54-year-old construction worker, was admitted to the hospital, August 4, 1958, because of depression, confusion, inability to care for himself or his family, and chronic alcoholism. He had been a known diabetic for 20 years and his diabetic condition had been difficult to control.

He had a long history of excessive drinking, usually consuming five or six quarts of beer daily. On weekends he drank even more heavily and often went without food, behavior which resulted in numerous insulin reactions at times requiring hospitalization and intravenous glucose. In July, 1958, while intoxicated, an overdosage of insulin resulted in a profound insulin coma lasting 16 hours. In spite of intensive medical care with intravenous glucose, the hypoglycemia resulted in brain damage and left him in a confused and disoriented state. He became increasingly depressed, cried and begged to die. At this time his wife sought hospitalization for him.

Physical examination at the time of admission was essentially normal except for microaneurysms noted in funduscopy. His blood sugar was elevated (605 milligrams percent) on admission. Skull X-rays and electroencephalogram were normal. He wandered about the ward, staring into space, showing marked emotional lability, alternately laughing and crying. His knowledge was meager; both recent and remote memory were poor; his thinking was concrete and his ability to verbalize was limited. His attitude toward the examiner was that of a small child pleading for help. He was diagnosed as suffering from a chronic brain syndrome and in September, 1958, was transferred to my unit where he could receive a special diet for his diabetic condition. The diabetes remained in poor control. Like the first patient, L.M., he stole food sporadically and at times would forego his meals, precipitating an insulin reaction. In February, 1959, I placed him on a free diet and allowed him to eat whatever he wished.

The change in T.D.'s attitude on the ward was striking. He no longer stole food, became less complaining and more friendly with other patients and with ward personnel, and began helping with the ward housekeeping. By March, 1959, he had improved to the point that he could be given an industrial assignment as a food handler. Later he was able to manage a grounds pass and after numerous visits home, where his behavior was described as excellent, it was felt he had received maximum benefits from his hospitalization. Plans were made for his discharge on July 1, 1959. A nursing note just prior to his discharge reads: "Patient seems to be a different person since he had a little more responsibility, like watching his own food and working in the canteen."

Although good control of his diabetic condition was never obtained, laboratory examinations of his blood and urine showed some improvement. A gain of 10 pounds brought his weight to within four pounds of his "ideal."

Discussion

My decision to treat these two diabetic patients with a free diet, as advocated by Tolstoi, was made when it became obvious that they were unable to cope with dietary restrictions. Both patients placed an inordinate emphasis on food, as evidenced by the fact that they would steal from other patients' trays, raid the hospital garbage cans, and ransack packages other patients received from home, in hopes of finding food, in spite of our best efforts to keep them under observation.

Menninger[18] has emphasized the self-destructive nature of man and the variety of expressions that self-destructive impulses can take. Interesting forms of this self-destruction have been noted among diabetic patients. Rosen and Lidz[19] studied psychiatrically twelve patients who were repeatedly hospitalized in diabetic acidosis. They found that the failure to maintain diabetic regulation was due to the active abandonment of the diabetic regime with the patients utilizing their diabetes as a means of escape either into the shelter of the hospital or as an attempt at suicide. Sterns[20] has specifically described the self-destructive behavior of some young diabetics who misuse their diet and insulin to produce either hypoglycemia or coma. He found that the behavior simultaneously and alternately expressed a need for punishment, a wish to be loved and taken care of, the intent to punish a parent or an urge to self-destruction. According to Sterns, parental limitations of eating may be experienced as a recurrent manifestation of rejection or hostility.

Food has many deep psychological meanings. One of the most vital psychological meanings of the giving and taking of food is its equation with love. According to Masserman,[21] to be loved is to be fed. Benedek[22] equates food with mother, security, and as representative of life itself.

In an excellent article on feeding problems of psychogenic origin, Lehman[23] reviewed the literature. Among the meanings of food he included were love (Alexander); security (Selling and Ferraro); substitute gratification (Abraham); and comfort (Bruch). The refusal of food may be a reaction to real or imagined rejections (Deutsch, Moulton). Thus, food may become "a vehicle of love and punishment" (Lorend).

Cameron[24] writes: "Eating may . . . come to symbolize acceptance and approval; only the worthy may partake." This theme is vividly expressed by Sechehaye[25] in the autobiography of a schizophrenic girl as follows:

> "During the evening an awful rage against myself surged up. I detested, I loathed myself. I deserved death. I sobbed in hate and guilt and

struck myself with violence. . . . All the self-destructive forces were re-activated, hurling themselves furiously against me, trying to demolish me. Nothing now could check them, for not only did Mama refuse to feed me, as she did the others, but she had forbidden me to eat, showing clearly she did not love me and had rejected me. . . ."

Bettelheim[26] mentions the refusal of food as a method some children use to punish or control others. Because of the limitation of staff and the pressure of time, it was impossible to determine what specific meaning or meanings that food had, or what the occasional refusal of food symbolized to our patients. Our feeling as a team (doctor, nurse and aides) was that the meanings varied. At times it appeared that the patients used their diabetes in a destructive manner; at times to punish themselves, but often to punish the staff. They did obtain more staff time and attention because of their diabetes; angry admonitions when they stole food and solicitous concern when they experienced an insulin reaction. Food became an extremely important issue to both the patients and the staff, and resulted in the staff focusing attention on "problems of eating," instead of on the patients' total condition.

Benedek[22] states that in the analysis of the diabetic "so long as the analyst himself adheres to the concept that a rigid diet is essential, he represents to the patient the same level of reality as does the remainder of the patient's environment. In such circumstances, the therapist becomes the defender of the existing inadequate adaptation . . . ." John[2] has advocated an almost free diet for the diabetic, emphasizing that to force a diabetic patient into an artificial and distasteful routine is not sensible. He notes the adverse psychological connotations of the concept of diet and states that even though a person may be allowed more food on a given diet, the very fact that he has lost his freedom to choose will cause him to feel starved and deprived. This is consistent with the author's experience with these two patients.

Zee[27] has emphasized the importance of the patient's recognizing and assuming the responsibility for his illness as an essential step in his motivation for treatment. Treatment, medical or psychological, can seldom be forced upon a patient. The success or failure of any treatment process is to a large degree dependent upon the patient's ability and willingness to involve himself in that process. The value of treatment is enhanced when the patient recognizes his contribution and responsibility, not only for the illness, but also for his movement toward health.

Follow Up

L.M. continued to improve psychologically. He accepted his diabetes and became cooperative in the management of its treatment. There was improvement in his capacity to socialize and he managed extended visits home. By December of 1961, he was given the responsibility for the care of himself and the control of his diabetes. He was placed on parole in April of 1962. While on parole, he cared for himself, managed his own money and was able to make decisions without parental assistance. In the spring of 1963, L.M. spent three months with his parents in Europe, where he assumed the responsibility for the travel arrangements on the trip. His physical health was good, he checked his own urine, administered his own insulin and watched his own diet. He was discharged from the hospital "not restored" but on a trial basis on July 12, 1963, and he continued to maintain the progress he had made. He behaved well in social groups, renewed contacts with former classmates living in the area, and spent his free time playing golf, watching television and reading. On October 31, 1963, he was dismissed from the hospital "fully restored."

T.D. made a fair adjustment for a period of several months following his discharge from the hospital in July of 1959. He did not, however, find steady employment and gradually returned to his former pattern of drinking. He became depressed, displayed extreme jealousy toward his wife and children and acted in an erratic and childish manner. He was readmitted to the hospital in November 1960, again improved there, and was discharged in June 1961. A third admission was necessary in July 1963, and he remained hospitalized until May 1964 when he was discharged to the care of a nursing home. His physical and psychological condition had deteriorated considerably and, 17 days after his discharge, he died.

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EXPERIENCES WITH OPEN GROUPS ON A STATE HOSPITAL ADMISSION WARD*

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The term "open groups" is used in this paper to describe a group of patients in which a rapid turnover takes place due to the introduction of new members and the loss of older members through transfer or discharge from the hospital.

In the experience to be described I was one of two physicians in a closed admission ward for female patients, a ward which averaged eight to ten admissions a month with approximately the same number leaving each month by transfer or discharge. Because of the difficulty of seeing all the patients individually as often as we wished, we agreed to divide them into two open groups, assigning from eight to fourteen patients to each physician, regardless of age, descriptive diagnosis or any other criteria. For eight months, each group met three times a week, for one hour, with a physician, and an aide acting as an observer. Each individual member participated for an average of three months. The record of attendance at the meetings was more than 85 percent, and a total of 42 patients attended during the eight-months observation period.

The patients in this ward participated in an intensive program of activities ranging from household duties to crafts and sports. The patients' descriptive diagnoses included acute psychotic reactions, psychotic depressions, organic brain syndromes, severe neurotic reactions and "acting out" character disorders.

Role and Participation of the Leader

My purpose was to observe the interactions of the patients in the group, and to try to clarify for them the treatment setting and their participation in it. In the course of four months of work with the group, I realized that if I assumed the role of an active participant rather than that of an authority, the group atmosphere changed significantly; so, I became more informal and direct in my behavior and verbal participation. I also changed my seat in the meetings, a clue I took from the patients. This change of attitude had a pronounced effect in reducing silences to a

* Presented to the staff of the C. F. Menninger Memorial Hospital, February 14, 1964.

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minimum and made the group atmosphere much more spontaneous and active.

My part in the session consisted of correcting patients' misconceptions about their status in the hospital and the administrative aspects of the ward. It also included my attempts to engage the group interest in any particular situation that involved one of the members, *e.g.*, discussing with the group that Mrs. P. did not dare to attend because she felt that she was not dressed properly. I encouraged the group to comment about their members' general behavior, postures, facial expressions, tone of voice, their visits home and their progress in the hospital. I also encouraged the group to compare their impressions with mine, trying to increase their ability to speak up and observe reality correctly. Their individual requests, such as asking for privileges, were answered briefly or delayed if it seemed that they would interrupt the general discussion. I encouraged those communications which were in tune with reality and logical thinking and I endeavored to counteract their image of the leader as an authoritarian or arbitrary person. Therefore, criticisms and active discussions about the leader were encouraged. For example, a patient said she wanted to make a reasonable request yet she assumed I would answer negatively. I expressed surprise at this assumption while the group listened attentively to the clarification of this misunderstanding.

The technique of asking each member what he thought or felt was a constant source of failure. Not only did the patient become inhibited and withdrawn but such interventions intensified the patient's impression that the leader was a figure of authority who was just there to question, not to participate. The technique of direct interpretation of silence also was rarely successful.

Observations

Our observations that follow were in agreement with the cited findings in the literature about the use and value of open groups.

1. *Controlling or organizing the behavior and verbal manifestations of the patients.* During the entire eight months, there was never a physical fight among the members, and a patient seldom left the room. On the contrary, although the leader did not give any explicit instructions, most of the patients stayed for the whole hour. The controlling influence did not stop during the group meetings but influenced the behavior of the patients and their reactions on the ward.[5, 8, 13]

Group Situation 1: Mrs. H. was a married woman in her middle twenties who had required three hospitalizations since the age of 17, because of acute schizophrenic reactions. She was a withdrawn and shy woman who professed to be unaware of her problems. During her first sessions in the group, the patients pointed out to her that it was disagreeable to them to see her chew gum during lunch time and stick the gum on her hands. Mrs. H. was quite shocked about this. Four weeks later, when the group was criticizing the clinging and obnoxious behavior of a patient, the following passage occurred:

Miss S.: "If you are irritated with someone and keep it inside of you, it makes it worse. Mrs. H. used to irritate me with her popping gum and I told her about this." *Doctor*: "Do you remember the time you were told about your chewing gum in the dining room?" *Mrs. H.*: "When I came it was almost a compulsion to chew gum. I never chewed gum when I was at home. Now I don't feel I have to chew gum." *Doctor*: "I wonder whether you were not hurt when this was discussed." *Mrs. H.*: "At the time, I thought it was an uncomplimentary thing to bring up, but when I thought about it, I realized that chewing gum could be irritating to other people."

Group Situation 2: After a fight between two patients one morning, the incident was mentioned during the group meeting. Miss M., one of the combatants, told the group: "I don't think we need to repeat the words we used there. I would like to know what some people think of me. I think I am an average person and I need to know." The group joined then in an active discussion of the incident.

2. *Facilitating the integration of the newcomer in the group and into the life of the ward.* Because of the fact that newcomers arrived all the time, the group developed flexibility toward the acceptance of new members. It was reassuring for the new patient to hear from others that after a time she would feel much better. It was also more helpful for the patient to hear them talk about rules and regulations than it was to be instructed by a nurse. The isolation of the acutely ill patient was effectively counteracted by the group.[4, 10, 11]

Group Situation 3: A newly-admitted patient, Miss G., stated: "At the beginning, this group was about the only one I had any contact with on the ward."

Group Situation 4: Because she had cried while being interviewed at a staff conference, a tearful patient told the group she believed her chances for a prompt discharge had been harmed by her emotional display. Another patient who had not yet had the interview comforted her by saying, "Don't worry, I think I'm going to cry, too, during the interview; after all it's quite stressing to be in front of so many people."

Group Situation 5: Miss M. was acutely anxious and could hardly keep herself on her chair. During her first session she heard from another patient who had experienced equally anxious feelings with the group: "In three or four weeks you will be feeling much better, without this constant fright feeling you seem to have now."

Although Group Situations 4 and 5 might happen spontaneously between two patients, the presence and sympathy of the whole group served to strengthen the meaning of the experiences.

3. *Helping elderly patients regain a better level of functioning.* We were able to confirm the findings by Linden[12] who states that group therapy provides an opportunity for elderly patients to establish object relationships, to assist in the resolution of depressive affects, to increase their alertness and to diminish their confusion. (Remarkably, Linden's observations are based on patients whose average age was 72 years.) We also agreed with Linden that such a program has a positive effect on the family who felt that their relative was in an effective treatment program. Linden also reports the improvement of psychotic symptoms, patients' increased concern about their appearance and the disappearance of incontinence, all of which we were able to see in our group.

Group Situation 6: Mrs. A. was a 69-year-old widow who had been admitted to the hospital because of a psychotic depression with delusional paranoid ideas. She could hardly eat, isolated herself, and stayed for hours with her head bent on her chest. When encouraged to participate in hospital activities, she would sulk or have periods of incontinence, which increased her isolation. Mrs. A. did not wish to attend the group meetings because, she said, she felt worthless and was not dressed well. The group was told what she said before she was encouraged to attend. The patients responded for the first time with a warm reaction toward Mrs. A. After only ten sessions (*i.e.*, after two and one-half weeks) Mrs. A. was able to talk to some members in the group and seemed to care about other patients. She became more alert, spoke more rationally and appeared to enjoy the meetings. She later elicited warm feelings from the group and became one of the popular patients on the ward, before she was discharged as greatly improved.

Group Situation 7: Mrs. S., a patient who had been admitted to the hospital bedridden and dysarthric, was so stimulated by her regular attendance in the group that she made efforts to walk and to talk. Her impairments proved to be reversible and after three months Mrs. S. left the hospital to return to her home. The group seemed to have been an important factor in her recovery.

4. *Providing the patients with opportunities to interact with one another in therapeutic ways.* Frequently the patients grouped together to support a member in distress or to offer useful suggestions, or at times to express sharp observations of one another.[3]

Group Situation 8: Mrs. H., who had initially been criticized by the group because of her chewing gum habit and her constant avoidance of work assignments, had later reached the point of discharge and had just returned from a visit home.

Mrs. H.: "I feel very good. The ward looks cleaner now that I have come back from home." She then related that she hadn't had too much to do at home. *Miss S.*: "Don't you think you could find more to do? I think that you act more cheerful and more energetic now." *Mrs. L.*: "I can tell a big difference; she acts happier; she participates more." *Doctor*: "What do you plan to do at home now?" *Mrs. H.*: "I will take care of my child, visit with my mother and neighbors and paint the two bedrooms." At this point the rest of the group, knowing that Mrs. H. has a tendency to remain alone, suggested that she go bowling and visit friends. Mrs. H. responded, "I plan to. I read in the doctor's office that bowling was a very good exercise."

Group Situation 9: Miss M. monopolized the conversation, always presenting herself in a good light while criticizing everyone else. The group tolerated her talking for four or five sessions. Then Miss W. pointed out to her, "One time Miss M. asked why people didn't like her. And at times I think I know. She always says she's not perfect and then she goes to saying, 'I wouldn't do this or I wouldn't do that' and she never points out any mistakes of her own. When there is anything bad you push it away from you." Miss M. protested this confrontation and Miss W. responded, "I like you myself; it is some of your actions I dislike. Some of the things you say I dislike."

Group Situation 10: Mrs. O., a 50-year-old woman who had been admitted suffering from an involutional depression and pathological jealousy, had turned into the "doctor's assistant" and monopolized the sessions of the group, asking the other patients questions but never discussing anything personal. Miss S., one of the most disturbed patients, after answering one of the rather intrusive questions, said to her, "Mrs. O., I don't think you should just break in on people." Mrs. O. was so impressed that she immediately began to reflect on this trait of hers.

5. *Reassuring the patients and listening to their demands.* It is known that patients use requests for privileges and their somatic complaints as a means to establish some type of communication with the ward physician.[10, 18] With this group the patients' demands decreased, to be replaced by more direct expression of their problems.

Group Situation 11: During one session the patients commented about the impact of the group meetings. They talked about another ward physician who did not have meetings with his patients.

Mrs. H.: "Dr. E.'s patients work up to him. He says he will talk to them later, but he never returns. At least this way we have you trapped for an hour." *Miss M.*: (referring implicitly to the ward physician) "I think in these group meetings we know each other much better than someone we know vaguely on the ward. When the new patients come, you wonder what their problem is and what they are like, and here you can get acquainted. . . ."

6. *Correcting the distorted ideas that the staff might have concerning "difficult or special patients."* Miss R. was a 16-year-old epileptic, mentally-retarded girl who had become a management problem through her regressive behavior and resistance to performing and participating in the

activities of the ward. Yet this behavior was accepted by the personnel from whom she induced a mixture of overprotective and guilty feelings, which handicapped the staff in working with her in a helpful way. During the group sessions, Miss R.'s clinging behavior was discussed critically by the group. The observer, an aide, was quite surprised to see that Miss R. behaved more independently in the group and improved considerably in her appearance and interaction. The observer communicated her impression to the rest of the staff who found it was possible to deal more effectively with this patient.

7. *Permitting the comparison of the behavior of patients in the group and in individual interviews by the ward physician.*

Group Situation 12: Mrs. B. was delusional when she came in. She was acutely assailed by the feeling that the staff as well as a patient might attack her homosexually. Yet, in the group she came to realize that this was an inappropriate and unrealistic idea. She progressively gave up her ideas as the group began to interact more with and appreciate other aspects of her personality.

Some patients with "acting out" character disorders, whose behavior was relatively appropriate when seen individually, reacted with "psychotic-like behavior" in the group, characterized by inappropriate laughter and giggling, ideas of reference, inappropriate interventions, depersonalization, lack of empathy with the rest of the group, frequent silence and withdrawal.

Group Situation 13: Miss X., a patient who had been referred from the girls' industrial school because of promiscuous behavior, excessive drinking, and outbursts of aggression, was observed in the meetings as usually tense, laughing inappropriately, at times sucking lollipops and very frequently not understanding what was going on in the group. On one occasion, she stated that she had the ability to make the leader fade away when she was angry and, at that very moment, added that she saw the writer as if she were very small. This behavior was not apparent outside the group meetings.

Group Situation 14: Miss D. was a girl in her late teens who had run away frequently from her adoptive home. She had been involved with drug addicts and indulged in promiscuous behavior. On the day of admission she appeared as an outgoing young woman, who felt at home with everybody from the very beginning, yet in the group she was isolated and withdrawn, hardly ever participated, and when she did, repeated some conventional clichés in an unconvincing way. She giggled frequently and seemed unaware of the discussions.

The patients with acute schizophrenic reactions or acute exacerbations in chronic reactions of all types showed some ability to overcome their isolation, and their group behavior was more adequate than that of the so-called "acting out" characters.

Group Situation 15: Miss S., a 37-year-old single woman, on admission displayed marked disorganization of speech and thought as well as bizarre mannerisms. After two months of group meetings she was able to say to a newcomer: "Bring your chair more into the circle, so that you can feel better in the group." Although silent and distracted by her own thoughts, Miss S. improved progressively in her ability to share in group feelings and responded to the group interactions.

Group Situation 16: Miss Y., a 33-year-old single woman with paranoid schizophrenia, improved progressively in her confidence in the rest of the members of the group, and requested to be told when she was not making sense, as she needed very much to have someone to check her in a helpful way. She developed effective bonds with some members of the group as well as the writer and was able to empathize with the others.

The patients with depressions (involutional melancholias or severe depressive reactions) tended to behave in a narcissistic way, namely trying to control the group, rejecting any help, and appearing extremely self-centered and hostile.

Group Situation 17: A depressed, middle-aged woman, Mrs. Z., was admitted because of a suicidal attempt. On her arrival in the ward she was trembling and shaky. Yet her shakiness disappeared when she attended the group. She commented: "I would like to get out and take a walk. I like to get out and I work out in the yard a lot of the time at home." *Doctor*: "Just yesterday you were complaining of feeling fatigued." *Mrs. Z.*: "Working didn't seem to bother me. The extra big things bothered me, like cleaning up and the spring planting. It worried me and it got to be an obsession. I feel restless. A year ago my husband had a heart attack and things that I liked to do were restricted. We used to belong to card clubs and used to dance. We have had to give up these things because he had to have his rest. My life has changed completely since his heart attack. I am still having my sleeping problem. When I attended my club meeting, no one knew how nervous I was." During the session, Mrs. Z. refused consistently to listen to any suggestions or advice and seemed to get satisfaction out of her complaints.

Group Situation 18: A 32-year-old woman was admitted because of suicidal ideas and severe depression. At her first meeting, 24 hours after admission, she said, "There's a lot on my mind. I think my problem is solved enough now. I could go home and I would be glad to take outpatient therapy. I am not planning to bring the children home for a while and now my husband will not ask me to go on working any more." When the leader pointed out to her that she should allow more time than one day to have at least a period of evaluation and see what really was upsetting her, she responded angrily, "I came in voluntarily and I thought I could leave whenever I wanted to. Do you want me to get angry at you? I don't like to get angry; it is wrong to get angry." Two days later this patient left the hospital against medical advice. Later, the rest of the group commented on her difficulties in listening to them and to the doctor.

Conclusions

The findings that impressed me most were: (1) The disorganization to very regressed levels of "acting out characters" in the group situation, regression which by far exceeded their functioning before hospitalization. One could assume that this group setting, which did not offer any planned, immediate or concrete benefits, made this type of patient perplexed and confused. Besides, their tenuous and frail object ties might account for their marked inability to be responsive to other people. (2) The surprising capacity of acutely regressed schizophrenic patients to empathize with other group members and present in the group potentials for psychological growth which were not readily detectable from previous information about them. (3) Although I had not expected the group to have therapeutic effects, I came to see that it represented a therapeutic situation for the patients, especially in regard to decreasing their sense of low self-esteem and feelings of loneliness. (4) Open groups represent a worthwhile additional device for the evaluation and initiation of patients to the treatment program of the hospital.

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SUICIDE DURING PSYCHIATRIC HOSPITALIZATION*

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Suicide is the eleventh most common cause of death among all ages in the United States. Between the ages of 20 and 45 among Caucasians, suicide is the fourth most common cause of death, exceeded only by accidents, heart disease and cancer.[1] Suicide is one of our major mental health problems, yet it has been infrequently studied within the general or psychiatric hospital where the suicidal process can be examined most comprehensively. During the past ten years there have appeared three published studies of suicide among patients in general hospitals[2-4] and only five studies of suicide by hospitalized psychiatric patients.[5-9]

Eighteen psychiatric patients committed suicide while hospitalized at the Topeka Veterans Administration Hospital between 1946, when the hospital opened, and December 31, 1962. Data about each case was collected retrospectively, focusing upon the patient's past history and hospital course by examining all available clinical hospital records.

Findings

During the 17-year period of this study, there were 23,006 neuropsychiatric admissions to the hospital, making the suicide rate 78 per 100,000 admissions. In the same period of time there were 30,469 medical and surgical admissions to the hospital, but not a single hospital suicide among this group.

Seventeen of the 18 suicides were native-born, male, Caucasian Protestants (except one whose religion is unknown), with an average education of 10.6 years. Their age range was between 22 and 52. The only female was a 42-year-old, native-born, American Indian Protestant with a college education.

Eight of the 18 suicides had made from one to five previous suicide attempts, with the shortest interval between attempted suicide and completed suicide being six months. Communication of suicidal intent was difficult to evaluate from the hospital records, but eight of the 18 were recorded to have talked of suicide to someone, usually to someone other than hospital staff, at some time prior to their death. Only one of the total

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group left a suicide note. There were no cases of double suicide or associated homicide.

Following are the case summaries of the four men who committed suicide within the hospital:

Case 1

The patient was a 52-year-old, married greenhouse-owner, who was admitted to the hospital because of severe depressive symptoms of approximately five months' duration. He had no history of previous attempted suicide and denied suicidal preoccupation at the time of admission with the remark, "I would be afraid to meet my God."

Within ten days of admission to the hospital he improved enough to be cleared for electroconvulsive therapy. Within the hospital he was mildly suicidal, being placed on suicide precaution, but not suicide status. He refused to eat because he said he did not want "to prolong the agony." He had not expressed suicidal ideas directly, denying them when asked by nurses. The day before his suicide he reported, "It's no use, no one can help me," at the time of refusing to eat. Another quotation from the nurse's notes: "Seclusion on ward, spending most of time on bed. Complaining of being all washed up."

Following his death by hanging on the 12th day after admission, this letter was received from the patient's wife: "Everyone has been so kind and thoughtful, and it makes this terrible tragedy a little easier to bear. I remember my husband as always reasonable and rational—a good and faithful husband and a kind and loving father. If in his terrible sickness he was ever otherwise I would not want to know of it. He and I had such hopes for his recovery."

Case 2

The patient was a 31-year-old, married truckdriver, who was admitted to the hospital with chief complaints of "seeing and thinking horrible things, being hypnotized by a preacher," and of having threatened to kill his wife. He had no history of previous attempted suicide or suicidal preoccupation. He was acutely disoriented upon admission, being described as confused and incoherent. During his six days of hospitalization he continued to hallucinate, finally being moved to a single room on the closed admission ward.

The nurse's notes contained the following comments two days before his death: "Patient agitated. 'I keep thinking of things I never thought of before.' Crying and restless. Asked to have his door locked 'so I won't bother anyone and no one will bother me.'" On the day of his suicide the following nursing note was made. "Patient told aide before supper that if he had poison he would take it." Later that day the patient committed suicide by hanging.

One week after the patient's death, his social worker received this letter from his wife: "I am writing you as I don't know who else to write. I don't want to rush things, but I would like to know why they haven't sent his things. I'm sure he would want me to have them. I would rather his death didn't happen. If you can help me or know who I should write, it would be deeply appreciated."

Case 3

The patient was a 37-year-old, married, former psychiatric nursing assistant, who was admitted to the hospital with a history of intermittent episodes of violence and crying. He had voiced suicidal thoughts during the previous six weeks on three occasions, including "I'll just put a bullet through my head" and "I'll just end it all." There was no history of attempted suicide. Following admission, the patient denied any suicidal ideas or thoughts, although he was noted to have manifested self-destructive behavior by breaking a bone in his hand while banging on a door. He was felt by the staff to have a great deal of repressed anxiety and hostility.

His first improvement occurred after seven months of hospitalization following a visit by his wife. Two months later, however, his wife visited again, telling him she planned to separate from him. For the two weeks following this visit the patient became quite restless and depressed, frequently crying and requesting hydrotherapy and chemical sedation. He was not considered actively suicidal, denying suicidal ideas when asked. He died after jumping from a catwalk in the gymnasium; his last words, just before jumping, were: "I'm going home to my wife and children."

Case 4

The patient was a 22-year-old, single laborer, who was admitted to the hospital as a transfer from another hospital where he had been admitted following an episode of confused psychotic behavior at a bus terminal. He had no history of previous suicide attempts or suicidal ideation. At the time of admission both his parents and one of his three sisters were in mental hospitals.

The patient's hospital course was characterized by no response to treatment, which had included 57 hours of deep insulin coma and 17 electroconvulsive treatments. "He continued to be negativistic and at times verbally or physically assaultive." At the time of his suicide he was on the closed ward, having completed his course of insulin comas six weeks previously. There were no comments recorded in the hospital chart to indicate the patient had communicated any suicidal intent to anyone.

This is a description by a nursing assistant of the patient ten minutes before he hanged himself: "Well, he was walking back and forth and talking quite a bit, talking to himself, you know—he was upset, yes, but he was talking and laughing to himself, but he didn't seem like he was in any mood for what happened—he seemed to be in a good mood."

Following are the case summaries of the four men who committed suicide while on unauthorized absence from the hospital:

Case 5

The patient was a 46-year-old, single painter and mortician's assistant, who was admitted to the hospital because of complaints by his sister that he had gone into a "dream state," his behavior becoming bizarre and assaultive the week before admission. He had suffered a cerebrovascular thrombosis 17

months previously with residual expressive aphasia, agnosia, some apraxia and a right hemiplegia. His father had died a year earlier after being an invalid for several years following a stroke. There was no history of previous suicide attempt or suicidal ideation in the patient.

Following admission to the psychiatric service, the patient made marked improvement within three months on a closed ward. At the time of his transfer to an open neurological ward to obtain corrective speech lessons and posthospital planning, the transfer note listed the following liabilities in the patient: "Anxiety over his deficiencies, concretistic thinking and depression and resignation about his infirmities." He had voiced no suicidal ideas within the hospital, although his sister had informed the hospital that he could not return to stay with her, resulting in uncertainty about disposition plans for him.

One week after his transfer to the neurology service, the patient eloped from the ward. His only comment at the time, directed to several of his fellow patients, was that he was "pulling up stakes." He had been offered a pass the day before his elopement, but refused it, saying he was not ready to leave the hospital. He hung himself in a building on the hospital grounds, his body not being discovered until nine days later.

Case 6

The patient was a 23-year-old, single truckdriver, who was admitted to the hospital because of "nervousness" and suicidal ideas associated with his discharge from the Army one week previously. He had no history of previous suicide attempts or prior suicidal ideation.

Five months after admission, the patient was moved from an open to a closed ward and placed on suicide status because of verbalized suicidal ideation. After six months he was transferred to another closed ward with a more active milieu therapy program, no longer on suicide status. He attended group psychotherapy twice a week but was not an active participant. He had been receiving Reserpine but this was discontinued the week before his suicide because he was felt not to have benefited from the medication.

Two weeks before his death, the following letter was addressed to the hospital: "Being the mother of my son, I would like to see him get a break. How about it? It seems to me the only way to see if he responds to it all, and he will be getting stronger and will have more confidence in himself and feel like things are more worthwhile. He has too much time to think of himself and feel sorry for himself that isn't too good I know for his condition. A little work that isn't too hard isn't going to hurt him and will help him to release his tension and put his mind at ease once and help to get his strength back quicker than just sitting there in the hospital doing nothing."

The patient eloped from a group of patients in transit from an activity to the ward. He drowned in the hospital swimming pool, having left this suicide note among his personal effects: "To whom it may concern: This is the only way out. I have tried to get well but I can't. God please forgive me." He had been visited by his parents for two hours on the day of his death.

Case 7

The patient was a 47-year-old, single, former aircraft engineer, who was admitted to the hospital because of angry, hostile behavior, including using obscene language in public. He had no history of attempted suicide or suicidal preoccupation either before admission or during his two and one-half year hospitalization. There was no staff expectation of suicide. He was not considered to be improving, having remained on the same semi-open ward for eight months.

Two weeks before his elopement, the patient received the following letter from his sister, which was found on his body: ". . . Mother is bedridden after several strokes. She doesn't know me now. But she is well looked after and comfortable. She is in a nursing home near me which is a blessing. Now (my son) and I are alone after 23 years . . . Mother's birthday is the 22nd of January, but as I told you she knows nothing now. I am happy I could look after her all these years."

The patient eloped from the hospital, committing suicide by hanging in a building on the grounds adjacent to the hospital. When notified of his death, the patient's sister exclaimed: "For heaven's sake. Well you know I blame myself because he wanted to know why his mother wasn't writing him (for over 10 years) and that was the last letter I sent to him—said that her mind was gone. And I shouldn't have told him. . . . Well, he wrote me a wonderful letter after he got mine and he said that he was glad she was near me and he knew that I had taken care of her and I thought, well, I thought everything was all right."

The following comment was made in the final hospital summary: "Even in retrospect, this examiner and all of the personnel had been given no changing signs or symptoms of gross behavior on the part of the patient that would have led them to at all suspect suicidal intentions on the part of the patient. The patient had continued to perform in his compulsive, automatonlike manner even up to a very short time before his demise."

Case 8

The patient was a 42-year-old, divorced salesman, who was admitted to the hospital as a transfer from another hospital where he had been treated for complaints of nervousness, people influencing him and having his food poisoned. He had no history of attempted suicide or suicidal preoccupation prior to his admission, but during his nine and one-half years of hospitalization was considered suicidal enough to warrant suicidal precautions or status on six occasions which coincided with times when the possibility of discharge was being discussed with him. In addition he made two suicide attempts while hospitalized, one by striking his head against a wall and the other by lacerating his wrists with a paper clip.

The patient was not considered to be improving at the time of his elopement from his open ward. He had been in group therapy for two years without

significant change. Although there was a chronic staff expectation of the possibility of suicide, there was nothing recorded in the chart to indicate the patient had grown more suicidal. Nevertheless, there was again recent consideration of discharging the patient.

This was the final nursing note: "(Another) patient told nurse that before he left on pass at 6 P.M. that he had seen (the patient) standing in hallway crying and saying something awful had happened and all he would say was 'It's President Kennedy.'" After his elopement from the hospital, the patient checked into a hotel where he shot himself.

The ten remaining suicides were all by patients on authorized absence from the hospital. Of the four who died while on three-day passes, all had made from one to four suicide attempts prior to hospitalization and all four had been on suicide status while hospitalized. Two of them were on their first pass, one on his second. Each one utilized a different method of suicide (hanging, jumping from a building, lacerating his wrists, gunshot). Each had been hospitalized between two and eight months. Two were receiving psychopharmaceutical medication (Equanil or Stelazine) and one had been in group psychotherapy for six weeks. The presumptive precipitating causes of these four suicides found in the available hospital records were: reaction to mental illness, to wife's mental illness, to wife's death nine months previously, and to son's hospitalization for ulcerative colitis.

Two of this group of ten suicides were by patients on their first leave of absence from the hospital of from five to 14 days duration. Neither patient had been suicidal either prior to or during hospitalization. Both died by gunshot. Both were receiving psychopharmaceutical medication (Thorazine or Stelazine) and one was in the terminal phase of three years of individual supportive psychotherapy. The presumed precipitating cause of death was reaction to the death of an uncle one month previously and reaction against the hospital's decision to commit the patient to the hospital. The latter patient left the hospital at his lawyer's request to attend his commitment hearing, and committed suicide at home before the hearing was held.

The last four of the group of ten suicides were by patients on trial visits from the hospital of from 16 to 120 days duration. None was considered suicidal while hospitalized, but three of the four had made from two to five suicide attempts prior to hospitalization. Two were on their first trial visit, one on his second. Two died by gunshot, one by strychnine ingestion and the one female by an overdose of barbiturates. Each had been hospitalized between four and 12 months. Two were receiving psychopharmaceutical medication (Thorazine or Elavil) and one had been in casework for four months. One man had had a lobotomy nine years previously. The apparent precipitating causes of the suicides found in the records of this group of patients included reaction to mental illness in two cases; failure of the patient's parents to take seriously the hospital's admonition that their son might become suicidal and require return to the hospital; and depression following retirement and a recent divorce.

Discussion

The present review reveals two approximately equal-sized populations of suicides among the hospitalized psychiatric patients studied. The first group is composed of eight patients who committed suicide within the hospital or while on elopement. The second group of ten patients died by suicide while away from the hospital on authorized absence.

The most significant finding in the first group of suicides is the complete absence of any history of attempted suicide prior to admission to the hospital. None of the eight patients had such a history and only two had expressed any suicidal ideation prior to admission. A second important finding is that six of these eight patients were not improving in response to their hospital treatment. This finding runs counter to the widely-held conception of suicide occurring unexpectedly during a remission of mental illness.

Seven of the ten patients in the second group of suicides were admitted to the hospital as actively suicidal at the time of admission, yet none attempted or committed suicide within the hospital. The suicidal behavior of these patients is thus more related to factors in the prehospital environment. These patients responded to hospital treatment by a significant decrease in their previous suicidal behavior, but the effectiveness of this response was lost once they left the hospital and returned to their previous nonsupportive environment.

One interesting finding is that the leaving of a suicide note is less frequent among the male hospitalized suicides studied than in the general suicidal population. There is only one suicide note among the 17 male suicides in this study compared with 189 notes among the 540 male suicides studied in Los Angeles County by Shneidman and Farberow.[10]

Levy and Southcombe[5] found that the introduction of the convulsive therapies did not decrease the suicide rate among patients in their state hospital. The period of time covered by the present study spans the introduction of psychopharmaceutical medication into this hospital. Since the general introduction of these drugs into the hospital in 1957, there has been no change in the suicide rate. Seven of the 18 patients were receiving psychopharmaceutical medication at the time of their suicide, but no single drug predominated and none of the patients used their prescribed medication as a method of suicide.

Karl Menninger[11] defines the basic motives for suicide as the wish to kill, the wish to be killed and the wish to die. The wish to be killed implicates other people, and within the psychiatric hospital the wish to be killed implicates the hospital staff. Therefore, the most productive area for suicide prevention within the hospital lies in discovering ways in which patients may be looking for members of the staff to act as unwilling accomplices in their suicidal plans. Such patients may be those with an obvious history of suicidal behavior who, for unconscious reasons, request passes prematurely. Others are patients who have demonstrated an extreme dependency upon the hospital, yet ask to be discharged without having any adequate substitute for the hospital. The critical period of time for leaving the hospital is the first or second pass or trial visit.

A combination of the following three factors should alert the psychiatrist and hospital staff to a heightened potential for suicide in a patient: (1) a history of a previous suicide attempt more than six months previously, (2) a history of having been defined as actively or potentially suicidal during the current hospitalization and (3) leaving the hospital for the first or second time to return to an environment which has not been significantly changed or prepared for the patient's arrival.

In the past, most of the understanding of the dynamics of suicide resulted from the study of psychiatric outpatients with depressive reactions. One of the ways in which inpatient psychiatric treatment of depressive reactions is more effective than outpatient treatment is that the hospital fosters the patient becoming dependent upon the hospital as a replacement for the object, the loss of which has frequently resulted in the original depressive reaction. Thus the problem of dependency replaces the problem of depression as a central issue in suicide by hospitalized patients.

These hospitalized patients are those whose object relations are much more severely disrupted and chaotic and whose dependency needs may go unmet or become increased during hospitalization. Meerloo[12] has emphasized this: "The paradox is that overprotection in an institution and the conflict of losing one's personality in the midst of the mentally deranged may fortify the original problem of the individual feeling a contemptible outsider."

Sixteen of the 18 patients in the present study were given final diagnoses of the most severe degree of disorganization. Fourteen of the 16 were diagnosed as having schizophrenic reactions, one a psychotic depressive reaction and one a chronic brain syndrome. (The remaining two were given diagnoses of depressive reactions.) The occurrence of suicide among this most severely mentally ill population is in accord with the formulation of Karl Menninger[13] of suicide as a fifth order of dyscontrol, representing mental disintegration at its greatest extreme.

Stengel[14] has called attention to the limitations of attempting to obtain a comprehensive understanding of the interpersonal dynamics of suicidal behavior from the retrospective examination of hospital records. He emphasized the need for a comprehensive study of the suicidal process at the time it occurs, including pointing out the usefulness of "cohort" studies of the psychological impact of a suicide upon the relatives of the suicidal patient. At the same time it is necessary to study the psychological impact of suicide by a hospitalized psychiatric patient upon the entire hospital, staff as well as patients.

Within the psychiatric hospital there already exists an instrument for performing a psychological autopsy of any given suicide—the administrative investigation. The expansion of the administrative investigation to include the clinical findings or observations of the hospital staff about the suicidal process in a given case would be a valuable way of implementing Stengel's recommendations. Recorded inquiries aimed at producing understanding of the suicidal process would have a salutary effect upon not only the patient's family but also the hospital staff, both of whom have lost someone.

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In Memoriam

HENRY W. WOLTMAN, M.D. (1889–1964)

Dr. Henry W. Woltman, a member of the Board of Trustees of The Menninger Foundation since 1946, died in his home in Rochester, Minnesota, on November 27, at the age of 75. He had been a personal friend of Dr. C. F., Dr. Will, and Dr. Karl since the early 1920's. It was the Mayo Clinic which gave Dr. C. F. Menninger inspiration for founding the Menninger Clinic, and it was Doctor Woltman of the Mayo Clinic who visited, counseled and encouraged the growth of the young Menninger Clinic, once established.

For many years he was chairman of the Section on Neurology and Psychiatry at the Mayo Clinic, but he came to Topeka many, many times usually staying in the home of Dr. and Mrs. C. F. Menninger, being very interested in mineralogy.

"Only a few weeks ago," comments Dr. Karl, "Dr. Nat Uhr and I spent an evening in Doctor and Mrs. Woltman's home. We first made a jolly expedition to a nearby orchard, where the overladen apple trees were almost as red as they were green. We all three picked apples and brought some of them home, where we looked at agates and played records and talked about books. We talked about the old days when Henry Woltman's encouragement kept the small fire of our early activity burning brightly and showed us visions of what our Clinic might become by taking us through the Mayo Clinic. He was one of the kindest, gentlest, friendliest men I ever knew."

BERNICE SCHULTZ ENGLE (1893–1964)

Mrs. Bernice Schultz Engle, director of educational therapy in the C. F. Menninger Memorial Hospital, 1942–1944, and a member and active friend of the Foundation since its beginning, died in San Francisco, October 21. She was nationally known as a writer, editor, educator and authority on psychiatric literature, and as a student and teacher of Latin, Greek and ancient history.

Her interest in psychiatry began while she was head of the Latin and English Department in Omaha Central High School, from where her influence was spread around the world by her students, many of whom became distinguished in various professions. She began her psychiatric career as a research associate of Dr. A. E. Bennett. From 1945 to 1949 she was a research writer at the New York Psychiatric Institute, and was co-author with Dr. Nolan D. C. Lewis of a book, *Wartime Psychiatry*. Later she went to San Francisco as editorial assistant to Dr. Karl M. Bowman and continued to work at the Medical

Center at the University of California School of Medicine. After her retirement in 1963, she continued research and writing until she became ill during a long-anticipated trip to Greece last summer.

Her extraordinary scholarship was exceeded only by her ability to inspire, encourage and animate her friends, her students, and her fellow staff members. She carried with her the memory of the specific interests and projects of many persons, and took the greatest joy in contributing her knowledge to them. In the art of friendship she found her highest vocation.

DOROTHY G. WRIGHT (1904–1964)

Mrs. Dorothy G. Wright, therapist in the Children's Hospital of The Menninger Foundation, 1943–1964, died suddenly November 2. Her life was one of service to others, and prior to joining the staff of the Foundation she taught school, was employed by Travelers Aid, and worked with what is now the Family Service and Guidance Center in Topeka. She was president of the Topeka Council of Social Agencies for several years, and was a Fellow of the American Orthopsychiatric Association.

Her life goal was to help disturbed children, and she began it early when one of her pupils got into difficulty and was to be sent to the Boys Industrial School. The school principal (who later became her husband) persuaded the judge to let her work with the boy, which she did successfully. Nothing further was heard from the boy until forty years later when he called to ask if he might attend her memorial service because she had meant so much to him. In this he was one of many.

Dorothy Wright had a unique talent for working with the most difficult, the most troubled, the most unreachable patients. She brought hope and inspiration to patients and staff alike by her great devotion, by her complete willingness to continue the work regardless of how frustrating it might be. She committed herself to each child for however long was necessary—a few months, a few years, a decade. And when they were ready, she helped them to go.

She retained her skill in teaching and was generous with her time and talents. Many have benefited from her supervisory sessions and training seminars, and for years a clinical research group studied her treatment processes, from which came a number of pioneering scientific papers. One of her colleagues has written, "As I remember the many seminars, the conferences, the days of clinical research together, I know that the person who has left us is irreplaceable. There will never be anyone like her again, except that a part of her will continue to live with us, and thus we have identified with her as a psychotherapist, as a warm friend, and as a productive and creative person."

READING NOTES

In these Reading Notes for the November issue I proposed that Heinroth first used the term "psychiatry" in a book published in 1818, taking this information from the *American Journal of Psychiatry* for February, 1951, an unsigned article to which I neglected to give the reference.

Later that year a more comprehensive note was printed in the *American Journal of Psychiatry*. Dr. Edward Margetts of Vancouver had called the editor's attention to the appearance of the word in a volume by Reil and Hoffbauer published ten years earlier. Dr. A. W. Elgin also wrote the journal calling attention to the fact that in the first century B.C. Diodorus, the Greek historian, translated an inscription on a sanctuary as "Healing-place of the Soul," rendering this into Greek as "*psyches iatreion.*" But he didn't join these two words into one. Jean Jones, our librarian in the American Psychiatric Association offices, has just sent me a photostat from *Nervenarzt* for September, 1963, in which a von Achim Mechler reviews these facts and adds a considerable bibliography.

Dr. Jerome Schneck writes me that Heinroth is usually credited with the first use of the word "psychosomatic," and that Erwin Ackerknecht, in his *Short History of Psychiatry*, credits Johann Christian Reil (see above) with coining the word "psychiatry."

* * * *

I have tried several times to improve on and condense this beautifully written gem by one Dr. Alexander Gode in the *JAMA* (190:125). I can't do it. I submit it with admiration and the hope that no one will ever again employ words like "psychopath," "osteopath" and "homeopath."

> A psychopath, says Old Faithful Webster, is (1) a person affected with a mental disorder and (2) a person who treats disorders of the mind. Hence it must happen at times—when both (1) and (2) are lucky—that a psychopath heals a psychopath, which beautifully exemplifies homeopathy's *similia similibus curantur*.
>
> Actually, we need have no recourse to facetiousness but can stick to historical facts to hold Christian Friedrich Hahnemann accountable (if not responsible) for the internationally confused functions of the compounding elements "-path" and "-pathy." Of the four patterns, using (1) "-path" = "patient," e.g., "neuropath," (2) "-path" = "therapeutic specialist," e.g., "osteopath," (3) "-pathy" = "therapeutic system," e.g., "hydropathy," and (4) "-pathy" = "disease," e.g., "myopathy," the first three are—philologically speaking—neoplastic parasites, and only the last is (philologically) sound.
>
> It was the French—normally so tidy in language matters—who set the

pattern for "-path" = "therapeutic specialist" by drawing *homéopath* from *homéopathie*. With this they opened the sluices for the whole (linguistically) absurd clan of "magnetopaths," "hydropaths," "naturopaths," and so forth (though not including "warpath," "bypath," and such). They also laid the basis for the later, pseudocorrective argument that since pathos meant "pain," compounds in "-path" had to designate sufferers and not healers.

The underlying misunderstanding in all this was that since homeopathy was a particular therapeutic system, the word *homéopathie* itself could not possibly signify anything but "the therapeutic system ('-pathy') of that particular orientation ('homeo-')," which implied simultaneously that "homeopathy" could be used as the model for the clan of "electropathy," "hydropathy," "heliopathy," and divers others.

The man who started this chain reaction, innocently guilty Hahnemann, would doubtless have been horrified had he lived to witness the effect of his decision to refer to his doctrine by a classical Greek synonym of "sympathy." For that, in fact, is all he did and meant to do.

* * * *

The Thinking Animal (Little, Brown, 1964) is a collection of articles contributed to the lay press by the science writer, Morton Hunt. Hunt was here several years ago and impressed us by his conscientious wish to explain psychiatric mental health matters clearly and accurately. I was very glad to write a comment to the article he wrote on suicide, which has been included in this book. Ten years ago it was the best article on suicide I had seen, and I still think so. Suicide is only one of twoscore topics touched upon, representing sound mental hygiene reading.

* * * *

When *The Vital Balance* was published a year ago, Norman Cousins, the editor of *Saturday Review*, telephoned to tell me how enthusiastic he was about its thesis. Apparently his associates disagreed, however, for it was later gloomily reviewed there by a physician who seemed to be upset and discomfited by its challenge to conventional ways of thinking about mental illness.

But now, a year later (December 5, 1964), comes same said *Saturday Review* with *two boxed pages* citing the discovery by Dr. Jason Aronson, of Harvard, of Professor Kazimierz Dabrowski of Warsaw and in particular of the latter's recently translated book *Positive Disintegration* (Little, Brown, 1964). This book advances the theory proposed in *The Vital Balance* using many of the same terms. "Disintegration" rather than our neologism "dysintegration" is used, but defined similarly. "Anxiety, psychoneurosis, and psychosis," Dabrowski says, "are symptoms of disintegration . . . In general, disintegration refers to involution, psychopathology, and retrogression to a lower level of psychic functioning."

Dabrowski's special point is that disorganization occurs between "hierarchical levels" of integration whether the process is ascending or descending. He is more emphatic than we were about the recovery process depending upon disorganization and then reorganization. One must lose one's balance in order to make progress, and even if one loses one's balance too far, he can recover, march ahead, and become even "weller than well."

We are just as excited about this idea as the *Saturday Review* is and to find a sympathetic colleague 5,000 miles away is a boon indeed. We are glad that the *Polish* version of this idea caught the eye of the *Saturday Review*. The main thing is to get the good news around. "Comfort my people," said the prophet, "their suffering is over." But earlier he had asked, "Who hath believed our report?"

* * * *

Masserman, Grinker and Rioch continue to publish from year to year papers presented at the meetings of the Academy of Psychoanalysis. This year the topic was *Science and Psychoanalysis: Development and Research* (Grune & Stratton, 1964), and there are contributions in the book by various members of the so-called neo-Freudian persuasion. I found Dement's "Experimental Dream Studies" and Harry Harlow's "Behavioral [meaning monkey behavior] Approaches to Psychiatric Theory" especially interesting.

* * * *

Henry Davidson, whom I so often quote in these notes because of his trenchant English and his clear thinking about psychiatric ideas, has become editor of the journal *Mental Hygiene*. He succeeds George S. Stevenson, a contemporary of mine in the early days of the American Orthopsychiatric Association and other ventures. Readers can be certain that there will be no dull pages, for if Dr. Davidson writes them they are never dull, and if someone else writes them, they had better be good or, at least, clear.

* * * *

British medical publications are always most readable and I was looking through *The British Journal of Psychiatry* for November 1964 when my eye fell upon an article entitled "The Source of Man's 'Intimations of

Immortality.'" This poem of Wordsworth's has always intrigued me, as it has many others, but I took it to be entirely a matter of faith.

Now comes this scientific journal with an article which seems at first to wave it all away as a poetic fantasy; but presently it begins to cite physicians who "have suggested independently" that the infant mind has some kind of intimate extrasensory communication with the mother or mother substitute. Well, possibly.

But the author goes a step further. Maybe, she suggests, the infant also has some extrasensory communications with God at that time so that instead of God being created in the parental image, as Freud believed, our idealized "good mother" may be created somewhat in God's image! From this the author derives an explanation of Wordsworth's "Intimations."

Too mystical for most of us, I guess, but we have to remember that the poets sometimes know more about things than the scientists. The author is a colleague, Joan Fitzherbert, whose name is followed by eleven of those inscrutable but impressive British initials of scientific qualification. Her beautiful address is Derwen Fawr, Swansea, Glamorgan.

* * * *

In *The Image of an Oracle* (Garrett, 1964) Ira Progoff submits the tape records of a great number of interviews he had with Eileen Garrett while she was in a trance. Both Doctor Murphy and I have met Eileen Garrett, and as Doctor Murphy says, these interviews sound like her all right, but who is this we hear? She has names for the voices heard but the question is still that with which Progoff introduces the first chapter: Who is speaking and how did he get there?

* * * *

Erica Anderson was a photographer who wanted to make a documentary of Doctor Schweitzer after she learned about him in 1949. He declined time after time to cooperate in this but her persistence won out. They became very good friends and he became much involved in the picture taking. Since her first visit to Lambarene, Africa, in 1951, Mrs. Anderson has made 19 more visits, and in these 152 pages she conveys with appealing, intimate photographs some of the fascination this project has held for her. (*Albert Schweitzer's Gift of Friendship* by Erica Anderson, published by Harper & Row, 1964.)

* * * *

Jim McCain, President of Kansas State University, recommended a book by one of his faculty members, Professor Russell Laman, about a "typical" Kansan who grew up here about the time my parents did, passing through the panic of '93, the drouths, the Populist Regime, and all the other events of the first half of the century. It is a long book, over 500 pages, and I dipped into it to get the flavor, thinking to put off reading it until later, but found myself caught up in its simple, readable narrative style and kept at it to the end. The latter part recalled many of the political arguments and events of my early life. (*Manifest Destiny* by Russell Laman, published by Henry Regnery, 1963.)

* * * *

At long last I was able to obtain Charles Amsden's *Navaho Weaving* (Fine Arts Press, 1934) and George James' *Indian Blankets* (Tudor, 1937). Both are out of print and secondhand copies are hard to come by. Both have magnificent colored plates of many types and styles of Navaho weaving. The James book has an excellent interpretative description of sandpainting rugs including one of those which we have in our Museum through the generosity of Robert Hulsen of Quincy, Illinois.

* * * *

In my January Reading Notes I was mentioning again the degradation and despair into which we have forced some of the American Indians. I said this was still true, not just once true. I said that the people of South Dakota were at the very moment trying to take federal protection away from the South Dakota Indians.

I am happy to say I was wrong. I should have said "*some* of the people of South Dakota" were so endeavoring; *four to one* the people of South Dakota voted *against* doing this and I am proud of them.

But hear this, hear this: Over 7,000 Rosebud Sioux live on their 2,500 square mile reservation in South Dakota, but 90 percent of their homes have no electricity, no running water and only outdoor toilets. Eighty percent of the employable Indians are unemployed. The average *family* (not *individual*) income is $800 a year!

* * * *

Approximately 4,000 years ago the primitives living in South Central England had made such careful observations of where the moon and the sun rose and set in the course of their daily and annual and 18½- and 46-year cycles that they could construct a perfect circle of holes in the ground, dug in chalk and filled with cremation remains, and by moving

marker stones around this circle predict eclipses of the moon! So believes Professor Gerald Hawkins of Boston University, who is also astronomer at the Smithsonian Observatory, who writes in *Science* for January 8, describing the Stonehenge monument most lucidly.

Professor Hawkins says that several hundred monuments and circles have been discovered in Great Britain and over fifty years ago the Callanish stones on one of the Scottish islands called Lewis were reported. A careful examination of these shows that these people, too, may have observed and predicted eclipses and they certainly had a calendar and perhaps cooperated with Stonehenge in some unclear way. Callanish is so located that the moon barely clears the southern horizon; Stonehenge has a critical latitude of another sort. This was almost certainly not accidental, and if it was intended, then "the builders may have been aware of some of the fundamental facts which served later as a basis of accurate navigation and led to a knowledge of the curvature of the earth."

* * * *

Do you know what the asses' bridge is? Do you know what Pythagoras demonstrated? Do you know what the square on the hypotenuse is equal to? Do you know who *first* proved it?

Very well, then. Pythagoras did his demonstration in 540 B.C. Subsequently, as you can imagine, several other people have found proofs for this piece of elementary geometry. But do you have any idea how many proofs there are—algebraic proofs as well as geometric proofs? Scores—actually *hundreds*—of people have proved this in *different ways*. Collecting these proofs has been the lifetime hobby of an interesting gentleman, Elisha S. Loomis, Professor Emeritus of Mathematics at the Baldwin-Wallace College in Cleveland, who published some of them as a book, *The Pythagorean Proposition*, in 1940.

K.A.M.

BRIEF BOOK REVIEWS

New Dimensions in Psychosomatic Medicine. CHARLES WILLIAM WAHL, ed. $8.50. Pp. 340. Boston, Little, Brown, 1964.

The director of the Psychosomatic Department at U.C.L.A. has collected 20 essays and articles, some of them his own, some of them contributions of other contributors including Franz Alexander, Martin Grotjahn, and Eugene Pumpian-Mindlin, covering many areas of the psychologic problems of medical practice. Most of these articles have been written in terms understandable to the internist or general practitioner. Chapters on coronary artery disease, emotional reactions to mutilating surgery, problems arising in obstetric and gynecologic practice, etc., should prove interesting both to the physician and to the psychiatrist consulted by him. (Russell M. Wilder, M.D.)

Introduction to the Work of Melanie Klein. By HANNA SEGAL. $4. Pp. 118. New York, Basic Books, 1964.

There has been such a need for a simple, comprehensive, authoritative summary of Melanie Klein's formulations, that even a less well-written summary would be a welcome contribution to the psychoanalytic literature. This book provides us with an up-to-date, clearly expressed, brief but profound exposition of Kleinian viewpoints. Its eight chapters cover the basic contributions of Mrs. Klein, from the importance attached to very early unconscious phantasy to the description of the paranoid-schizoid and depressive positions and their relationships to psychotic and neurotic mechanisms. Melanie Klein's relatively late studies on envy, recent Kleinian studies on projective identification, Rosenfeld's observations, and especially Bion's concept of "bizarre objects" are included.

The author's own contributions clarify a number of issues. Unfortunately, some of the most controversial issues and some rather unclear assumptions of Melanie Klein, which have been subject to many criticisms, are very little touched upon: the assumption of oedipal conflicts and of rather sophisticated sexual information as mental contents during the first year of life; the relationship of the "world of inner objects" to the structure of the psychic apparatus, and to ego structures in particular.

Abundant and valuable clinical examples accompany the theoretical formulations. There is nothing of the peculiar kind of interpretations that one finds in some Kleinian literature. This reviewer was especially impressed with the clinical illustrations of analytic therapy with patients suffering from schizophrenic, borderline and manic reactions. The book is warmly recommended to the psychoanalytic reader. (Otto Kernberg, M.D.)

The Growth and Development of the Prematurely Born Infant. By CECIL M. DRILLIEN. $9.50. Pp. 376. Baltimore, Williams & Wilkins, 1964.

A comprehensive study of the consequences of prematurity of birth has been under way in Edinburgh, Scotland for over ten years. An initial sample of 595 children was recruited, half of whom were controls. At 5 years, 529 were still under study. On almost all of the variables chosen, including ratings of physical and emotional health, school progress, and intelligence testing, the premature children as a group showed relative im-

pairment. The careful planning of the study, and the clear presentation of the results make this a significant work of interest to those concerned with the biological basis of behavior. (Phillip M. Rennick, Ph.D.)

Evolution of Psychosomatic Concepts. M. RALPH KAUFMAN and MARCEL HEIMAN, eds. $10. Pp. 399. New York, International Universities, 1964.

This book has as its purpose the description of the evolutionary process of psychosomatic concepts, using one illness complex, anorexia nervosa, as a paradigm. The authors begin with key historical observations on this disease, including those of William Gull, Lasegue, Janet, and Charcot, and continue with reports from Felix Deutsch, Franz Alexander, and Sandor Lorand. Final chapters on psychodynamisms by Masserman and the Mount Sinai Seminar Group help to bring the major themes to a focus. The book fulfills its purpose and makes a superior contribution to the history and development of psychosomatic theory. (Russell M. Wilder, M.D.)

Lives in Distress. By MARJORIE FISKE LOWENTHAL. $5.95. Pp. 266. New York, Basic Books, 1964.

This is a lucid report of outstanding research. The study included all first-admission patients over 60 who were admitted during a period of one year to the psychiatric screening ward of the San Francisco County Hospital. This sample of 534 persons was matched with a sample of 600 persons of the same ages who were living in the same areas in San Francisco. The questions asked were: How do older people get to a psychiatric hospital? For how long has the process been going on which culminated in psychiatric care, and what measures were used to help the person before he became a psychiatric patient? What were the predisposing factors, and what precipitated admission?

The data show remarkable endurance on the part of families, and high community tolerance of many idiosyncrasies of older people. The data also show that social agencies are rarely turned to for counsel for older persons but that practicing physicians are often consulted. Usually it does not occur to the family or friends that psychiatric help may be needed. Mrs. Lowenthal closes with an excellent summary and suggestions for community action or education. (Prescott W. Thompson, M.D.)

The Psychiatric Professions. By WILLIAM A. RUSHING. $6. Pp. 267. Chapel Hill, University of North Carolina, 1964.

Doctor Rushings' subtitle "Power, Conflict, and Adaptation in a Psychiatric Hospital Staff" is quite enticing. From a psychiatric unit in a large university hospital, he has drawn data from four professional groups—clinical psychologists, social workers, one recreationist, and psychiatric nurses. He states that all groups were studied within a "social-psychological" theoretical framework, but the concepts are primarily sociological. Psychiatrists, though not interviewed by Doctor Rushing, are nevertheless discussed and criticized quite frequently. If one does not become too preoccupied with terminology one can learn of a psychiatric setting where treatment is secondary to education, where the psychologists do routine tests and do not like it, where social workers must beg for referrals, and where nurses play havoc with logic in order to maintain self-esteem. (Harry T. Hardin, M.D.)

The Psychiatric Hospital as a Social System. ALFRED F. WESSEN, ed. $6.75. Pp. 190. Springfield, Ill., Charles C Thomas, 1964.

This is another of an increasing number of publications about the social structure of psychiatric hospitals or units as studied primarily by sociologists. The description of a research instrument, "Characteristics of the Treatment Environment," as a means of comparing mental hospitals is difficult to comprehend for one lacking in sophistication in sociological research, in spite of the author's attempt to reach a general audience. Further contributors describe the therapy of the community and milieu therapy, including a review of the literature by John Vitale. William Cone's paper, "The Therapy of a Community in Action: A St. Louis Experience," is an attempt to describe the operation of a therapeutic community in dynamic terms. The uneven quality of the papers and variety of foci make the book difficult to read. (Harry T. Hardin, M.D.)

Man and Transformation. JOSEPH CAMPBELL, ed. $5. Pp. 413. New York, Pantheon, 1964.

Papers from the Eranos Yearbooks, resulting from round-table discussions sponsored by Olga Froebe-Kapteyn and C. G. Jung, are always edifying and enlightening. This fifth volume of English translations (including some papers originally written in English) combines studies by Mircea Eliade, Fritz Meier, Henry Corbin, Paul Tillich, Daisetz Suzuki, Ernst Benz, Lancelot Whyte, Jean Danielou, Adolf Portmann, Heinrich Zimmer and the late Gerardus van der Leeuw on the theme of transformation. It ranges over a thoroughly interdisciplinary territory, including comparative religion, mysticism, theology, history of ideas and animal biology. Whereas all contributions are in their way outstanding, I found the presentations by Portmann on "Metamorphosis in Animals" and by van der Leeuw on "Immortality" the most unique. (Paul W. Pruyser, Ph.D.)

Social Work and Social Problems. NATHAN E. COHEN, ed. $3.50. Pp. 391. New York, National Association of Social Workers, 1964.

Seven distinguished social workers discuss seven major social problems. The reader who wishes to learn more about poverty, marital incompatibility, child neglect, deterioration of the inner city, unmarried mothers, the broken family, and racial discrimination will find in this volume some of the richest contemporary thinking on these matters.

These experts, in making their explorations, used a carefully designed "model" for analyzing such problems from a social work point of view. Doctor Cohen's suggestion that the model be tested out in communities as a means of looking at local problems in preventive terms seems to this reviewer to have rewarding possibilities. However, his proposal that a "review be undertaken of the possibility of training social workers to study, diagnose, and recommend plans of action for larger social problems in the same way that practitioners are trained today to handle individual family and group problems," seems to this reviewer to be perhaps premature. While it is clear that such planning for societal action must be done in a team with a board constituency from a wide variety of disciplines, it is by no means conceded unequivocally that the captaincy of such a team is a social work responsibility. (Richard E. Benson, M.S.W.)

Psychiatry and Religion: A Sociological Study of the New Alliance of Ministers and Psychiatrists. By SAMUEL Z. KLAUSNER. $6.95. Pp. 299. New York, Free Press, 1964.

Some 1,347 books, journal articles and monographs were abstracted, punch-carded and "questioned" in this study to determine the nature of the "religio-psychiatric movement." Questions were derived by combining independent variables—"psychiatrist" and "clergyman"; dependent variables, such as religious affiliation, social status, and geographical location. The results pinpoint a number of significant intervening variables important in determining participation in the "new alliance." The results were tested by a case study of a clinic in which psychiatrists and clergymen practice in partnership. The radically atypical form of religious and psychiatric cooperation in this clinic distort some of the book's conclusions, but it remains a landmark study, rich in methodological and conceptual gems. (Thomas W. Klink, B.D.)

Pastoral Care in the Church. By C. W. BRISTER. $5. Pp. 262. New York, Harper & Row, 1964.

The author of this important new volume is professor of pastoral ministry at Southwestern Baptist Theological Seminary. He is one of the contemporary religious leaders seeking to maintain a continuity of modern ministry with historic models and ideals yet seeking to avoid that well-surfaced highway paved only with good intentions. He begins his analysis of the situation with a theological redefinition of "pastoral" as the ideal characteristic of a whole church rather than the unique function of a religious professional. The religious leader's task is seen as facilitation and support of the functions of a concerned community. The inclusive functional concept is "pastoral care." Within this fall such "caring concerns" as reconciliation, discipline, mutual encouragement, and social welfare. Pastoral counseling is one important mode of pastoral conversation; others are administration, calling, preaching, group activity, sharing life's "primary moments." (Thomas W. Klink, B.D.)

Continuities in Cultural Evolution. By MARGARET MEAD. $8.50. Pp. 471. New Haven, Yale University, 1964.

Using examples from her rich experience, Doctor Mead presents a kaleidoscopic overview of models for cultural evolution and introduces the concept of "evolutionary clusters"—an "innovator" and his "followers." As an example she describes in detail the Paliau Movement in the Admiralties. She pleads eloquently for the creation of such "clusters" (*e.g.*, the Menninger School of Psychiatry) to make the necessary innovations which can save us from the destruction of our "cultural evolution." (James B. Horne, M.D.)

Hypnosis and Suggestion in Psychotherapy. By HIPPOLYTE BERNHEIM. $10. Pp. 428. New Hyde Park, New York, University Books, 1964.

This is a much needed reprinting of a neglected classic. Freud's introduction to the German edition, which he translated himself, is an important statement on hypnosis worth rereading. Hilgard's introduction to this printing succinctly fits Bernheim's work into place historically and in relationship to subsequent advances and current major issues. Even more timeless and remarkable than Bernheim's theoretical contribution are the detailed summaries of 105 cases treated by hypnotic suggestions. His impressive results should stimulate and reawaken interest in more frequent and systematic applications of suggestion in treating all kinds of psychiatric conditions. (Lawrence Stross, M.D.)

When and How to Quit Smoking. By EUSTACE CHESSER. $2.95. Pp. 126. New York, Emerson, 1964.

This tightly-packed, readable volume is a thoughtful response to all smokers who are asking themselves what they should do about smoking. The discussion includes its history, smoking as a sedative, smoking as an addiction, the physical dangers of prolonged smoking, quitting, cutting down and decreasing the danger. Doctor Chesser is against, but not optimistic about, early addictive smoking by children and youth because of their tendency to identify themselves with and to take as examples parents, teachers and doctors. (Robert E. Switzer, M.D.)

The Residential Treatment Center. By LYDIA F. HYLTON. $5. Pp. 251. New York, Child Welfare League of America, 1964.

A description is given of administration, physical plant, treatment program, funds, fees, expenses, and certain aspects of the staff and patient population of 21 residential treatment centers and two day-care centers for children. Information was collected by questionnaire and interview in 1959, 1960, and early 1961. The Children's Hospital of The Menninger Foundation is included and described as it was before the move to the new buildings. The differences between centers in administration, costs and treatment practices are emphasized. The overview presented will interest those planning, administering or studying residential treatment centers. (Edwin Z. Levy, M.D.)

Word Association Norms. By DAVID S. PALERMO and JAMES J. JENKINS. Pp. 469. Minneapolis, University of Minnesota, 1964.

This book, as good as its title, has only a few introductory pages of text; mainly it is a listing of associations to a stimulus list of 200 words (including the Kent-Rosanoff list). Subjects were 1500 middle and upper socioeconomic level students, grade four through college, who wrote their associations under pressure of time. Data is reported in terms of frequency of various responses to each stimulus word and broken down according to school grade and sex, idiosyncratic responses, and an alphabetical index of responses along with the stimulus words to which they were given. (Stephen A. Appelbaum, Ph.D.)

The Self and the Object World. By EDITH JACOBSON. $5. Pp. 250. New York, International Universities, 1964.

This monograph might well be destined to become a psychoanalytic classic, and is one of the outstanding contributions to psychoanalytic theory of the last 20 years. Doctor Jacobson brilliantly examines one of the most crucial and yet most controversial areas of the development of the mind, namely the relationship between object relations, on one hand, and the origin and development of the ego and of psychic structures in general, on the other. A profound analysis of our present knowledge in regard to the earliest mental development is followed by the clarification of ego identity, the relationship of self and objects, and the development of identifications throughout childhood. The second part of the book deals with superego formation and the latency

period, and the third part with puberty and adolescence. Many outstanding, original contributions in this relatively small book make it a "must." (Otto Kernberg, M.D.)

Child Psychotherapy. Mary R. Haworth, ed. $8.50. Pp. 459. New York, Basic Books, 1964.

In this compilation of major writings which have appeared elsewhere are such contributors as Erik Erikson, Virginia Axline, Ralph Rabinovitch, Sibylle Escalona, E. N. Rexford, Dorothy Burlingham, J. L. Despert, F. H. Allen, Melanie Klein, Jessie Taft, Lili Peller, Anna Freud, Selma Fraiberg, Earl Loomis, Jr., Rudolf Ekstein and Robert Wallerstein. The book includes discussions of play techniques; diagnosis; involvement of parents; developmental aspects; research and training. This is an excellently organized source book for those wishing to do child therapy. (Ernest A. Hirsch, Ph.D.)

The Rorschach in Practice. By Theodora Alcock. $12.50. Pp. 252. Philadelphia, Lippincott, 1964.

The author, a psychoanalytically-oriented child psychotherapist, summarizes in this book her point of view regarding Rorschach interpretation arrived at in 30 years of experience with the test. This is the first Rorschach textbook to come out of England and shows how well the Rorschach test lends itself to the synthesis of psychodynamic principles with some of the pioneering contributions of English psychologists to the psychology of perception and behavior. The book is replete with evidence of the author's sound judgment and is free of any tendency to develop an esoteric Rorschachese. The text should quickly prove to be a useful adjunct to the teaching of Rorschach in both elementary and advanced courses and seminars. (Martin Mayman, Ph.D.)

The Fusion of Psychiatry and Social Science. By Harry Stack Sullivan. $7.50. Pp. 346. New York, Norton, 1964.

This book consists of 17 articles, along with historical comments by the editor, written during the last half of the author's professional career (1936–1949). It brings out, from the interpersonal point of view, the mutual importance of psychiatry and the social sciences to the understanding of personality, sociological and cultural problems. Some of the articles give a nice exposé of the author's interpersonal theories. The articles are written in a cumbersome style and are, unfortunately, not always adequately clarified by the editor. The book will appeal largely to those interested in the history of the closer amalgamation of the social sciences with psychiatry. (Hugo J. Zee, M.D.)

Antisemitism. By James Parkes. $5. Pp. 192. Chicago, Quadrangle Books, 1964.

It is a significant tribute to this book that it was well received by the *Manchester Guardian* and Reinhold Niebuhr. It is the best, relatively brief, yet comprehensive study available, and has the advantage of being tautly and clearly written. Parkes' main thesis is that anti-Semitism is a "political neurosis" utilized as "a smoke screen for an attack on democracy." The most original contributions are in the final chapter, "The Sterilization of Prejudice," which warns of current revivals of racism, and states the duty of those other than the threatened minority to "sterilize" the disease at the first instant. (Lewis F. Wheelock, Ph.D.)

Shamanism: Archaic Techniques of Ecstacy. By Mircea Eliade. Willard R. Trask, tr. $6. Pp. 610. New York, Pantheon, 1964.

The Shaman has varied roles and techniques as priest, healer of the sick, and tribal magician; but the author's hypothesis is that all true Shamanistic experiences have one essential element in common—the Shaman's capacity for ecstacy. It is this ecstatic experience, clothed in the magico-religious rituals of the particular community or culture, which enables the Shaman to transcend the mundane world. There is a fascinating account of Shamanistic initiation which characteristically involves symbolic death and resurrection, the Shaman being "reborn" with special "spiritual powers." The similarities between Shamanistic ecstacy and certain aspects of the mystical tradition of Christianity and Eastern religions are striking. This book is written from the author's perspective of an historian of religion. It is an impressive, scholarly work. (Philip Woollcott, M.D.)

Introduction to Psychiatry, Ed. 3. By O. Spurgeon English and Stewart M. Finch. $7.95. Pp. 656. New York, Norton, 1964.

Through their continued efforts to present a broad survey of psychoanalytic psychiatry which is not only understandable but comprehensive and meaningful, the authors have further refined and updated their third edition. Notable among the changes are the revisions in the chapters on Child Psychiatry and Therapy and the addition of a chapter on Mental Health and Community Psychiatry. The book continues to be a basic text for both student and practitioner. (Anthony Kowalski, M.D.)

Educating Tomorrow's Doctors. By Milton J. Horowitz. $5.95. Pp. 264. New York, Appleton-Century-Crofts, 1964.

Doctor Horowitz and his colleagues studied longitudinally over four years a sample of 20 students attending Western Reserve Medical School, using periodic observations, interviews, admission records and examinational data. The result is a readable book presenting these students' "case histories," amplified by chapters discussing the processes whereby knowledge and skills are obtained, the vicissitudes of self-appraisal, the role of values and challenges in the study of medicine, preference for task-orientation or person-orientation, and conscious and unconscious motives for selecting a medical career. (Paul W. Pruyser, Ph.D.)

Disorders of Communication. ARNMD, Vol. 42. David McK. Rioch and Edwin A. Weinstein, eds. $22. Pp. 519. Baltimore, Williams & Wilkins, 1964.

This is a diverse and rich collection of current viewpoints on the process and theory of both verbal and nonverbal communication. For example, essays range from communication solely between animals to communication solely between humans. Interspersed between these extremes are topics such as the use of a vending machine to establish communication with a severely disturbed child, the impact of social factors on communication, clinical studies and some pioneering attempts to quantify the various dimensions of the voice. Knowledge on the part of the reader of the works of Shannon, Skinner and Ruesch is helpful. (Clyde L. Rousey, Ph.D.)

The Crystal Arrow: Essays on Literature, Travel, Art, Love, and the History of of Medicine. By FELIX MARTI-IBÁÑEZ. $6. Pp. 712. New York, Clarkson Potter, 1964.

Marti-Ibáñez is well-known in medical circles as the founder, editor and publisher of *MD* and as the author of several books on the history of medicine. In the present volume are the author's observations on the fields indicated by the subtitle. The writing is rich in imagery and contains many interesting and provocative insights. (Lewis F. Wheelock, Ph.D.)

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