CLINIC CASES OF MENTAL DISORDER

IN

A FAMILY AGENCY

A Descriptive Study of Sixteen Cases With Mental Problems Known to the Family Service Society of Richmond, Virginia, and the Medical College of Virginia Dispensary.

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BY

WARRENE BARBER
SUBMITTED IN PARTIAL FULFILLMENT

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BY

WARRENE BARBER
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CHAPTER I -- INTRODUCTION

MANY nations are today suffering from the economic depression of the last few years. It has been uppermost in our minds, and rightly so, because it holds a threat of insecurity for all. As undesirable as such a period is, it is not without certain benefits. Because of its prolonged nature, the depression has made possible studies of the reactions of those affected, which are not possible in those disasters of shorter duration, such as a flood or storm in which the demands for immediate relief are imperative.

Such studies have been numerous and have dealt with the depression from many angles. The mental effects, the moral, the physical and the economic aspects have been considered in detail. The material is too plentiful to enumerate here, but one has only to glance at any periodical or newspaper to realize what a wealth of material exists, particularly in The Family, Mental Hygiene, and the medical journals. It is hoped that from the studies that have been made, guidance will
be forthcoming that will enable us to prevent or cope more ably with the catastrophes of the future.

The majority of the articles appearing in current publications are short and non-technical, dealing superficially with the mental effects of worry and anxiety caused by economic insecurity. They are addressed generally to the layman.

In reviewing the material published in the more specific field of the mental effects of the depression, such articles are found as "Morals: The Mental Hygiene of Unemployment," by George K. Pratt, a booklet published by the National Committee for Mental Hygiene in 1933. Of value also is "Mental Hygiene and the Depression," by Douglas A. Thom, appearing in Mental Hygiene, October 1932.

In this statistics are presented on the admissions to Massachusetts State Hospitals for 1927-31. It is Doctor Thom's belief that "one can find little to substantiate the contention that the depression has actually caused any appreciable increase in frank mental diseases." 1.

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However, the effects of the depression are difficult to measure with any degree of accuracy, because of the complexity of the involved factors.

Mr. Horatio Pollock presents interesting figures on the "Economic Loss to New York State and the United States on Account of Mental Disease," appearing in Mental Hygiene, April, 1932. Dr. Drewry reviews a few figures in answer to his question, "Why is Virginia Interested in Mental Hygiene?"

No material bearing on the exact topic of this study, supported by case studies, was found to exist. For that reason and because of the importance of the field as stated below, the writer has selected this subject. A descriptive study has been attempted because only by considering the case individually can the factors be determined, because of the complexity of the subject.

The purpose of this thesis is four-fold:

1. To make a study of mental disorder during an economic depression, to note in what degree the financial crisis has been a factor in producing mental disorder.

2. To determine in what manner the dependency of a family affects the mental health of the patient.
3. To note in what way mental disease affects the ability of the individual to maintain self-support or the support of his family.

4. By a descriptive study, to note the significance of mental disease in nineteen cases of the Family Service Society of Richmond, Virginia.

The study attempts to answer such questions as:

1. Do these patients now suffering with mental and nervous disease come within the group which feels the depression most keenly, namely, the wage earning group, or

2. Do they come from the group that have been known continued dependency for a number of years?

3. Have the patients had mental difficulties before, or is the onset of recent origin?

4. How has the depression affected mental health?

The direct and indirect effects of a financial depression on mental health are difficult to estimate with any degree of accuracy. "Yet there is little doubt that many cases of mental disease, suicide, mental breakdown of a neurotic type and incapacitating mental attitudes follow in the path of a depression"
in the business cycle. There is a strong feeling among psychiatrists, psychologists and sociologists that the mental strains of the past two years will leave behind considerable evidence to support the contention that there is a definite relationship between a general widespread attitude of pessimism as produced by an industrial depression and serious sociological problems. 2. Care and anxiety are fully appreciated by all physicians as a cause of nervous and mental disease.

The terms, mental and nervous disease, are in such common usage as to make a detailed definition unnecessary. Because the symptoms associated with the different types of mental disorder present such a variety and may involve any mental process, definition is difficult.

Doctor Emerson considers "those deviations or abnormal conditions of mentality and emotion which appear to call for professional assistance in the interest of the individual and social health," as constituting mental and nervous disease. 3.

By considering mental health, a clearer concept of mental disease may be obtained. Doctor Pratt believes mental health may be summed up as the "adjustment of one's self to inner and outer strains in a manner that will be reasonably satisfying, both to the individual and to the customs of the society in which he lives." 

Dr. C. Macfie Campbell believes "a disorder is a mental disorder if its roots are mental." "A headache is a mental disorder if it comes because one is dodging something disagreeable." A pain in the back and sleeplessness are mental disorders if their bases lie in personal worries, emotional tangles and feelings of insecurity.

There is no clear cut line dividing mental health from mental disease. It is a matter of degree rather than kind. "The personality traits and behavior patterns which characterize such functional disorders as dementia praecox, manic-depressive psychoses, paranoid conditions and psychoneurotic states are found also

5. Ibid., p. 11.
6. Ibid., p. 11.
in every day life among individuals who are adapting themselves fairly well to economic and social demands. The picture is exaggerated in the maladjusted person, to be sure, but is nevertheless recognized as the same."

7

The word dependency is taken to mean in this study, dependence on a social agency for financial aid.

The cases used in this study were selected by the method of complete enumeration of the field selected. The Mental and Nervous Diseases Clinic of the Medical College of Virginia Dispensary was selected as the basis of study. Every case known to the clinic between January 1, and April 1, 1932 was considered. The daily intake sheets of the Dispensary gave the medical history number, the name of the patient, and, frequently, whether or not a social agency had referred the case.

The Dispensary is the out-patient hospital of the Medical College of Virginia. There is a slight fee for services for those who can afford to pay for it, otherwise no fee is charged. Prescriptions are

filled at cost. Few children are referred to the clinic, because of the existence of the Children's Memorial Clinic, a child guidance clinic which handles most of the children who present mental difficulties. There are few cases of insanity known to the Mental and Nervous Clinic. This may be accounted for by the fact that the most serious cases of mental disorder are referred to the state hospitals. No cases of insanity were found to exist in the field selected for this study.

The selected cases were cleared with the Social Service Exchange of this City, in order to obtain a summary of the social contacts of the patient.

These cases that were found to be known to the Family Service Society of Richmond, within the accepted dates of study, were selected for descriptive study. There were nineteen such cases. This agency represents one of the two family case work agencies of Richmond, the other being the Bureau of Catholic Charities. Because the Family Service Society was familiar to the author and had fairly complete family histories in an easily accessible form, it was selected to supply the desired social data.

The total number of cases known to the Mental and Nervous Diseases Clinic during the accepted dates of study was 112. The following table represents the
distribution of this group of cases according to sex and race. Columns number 4 and 5 represent the number of cases that had additional registrations of social agencies at the Social Service Exchange. The last column represents the number of cases that were known to the Family Service Society.

**TABLE I.** Analysis of the Cases Attending the Mental and Nervous Diseases Clinic between the dates of January 1, 1932, and April 1, 1932.

<table>
<thead>
<tr>
<th></th>
<th>TOTAL</th>
<th>SEX</th>
<th>S. S. E.</th>
<th>F. S. S.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>MALE</td>
<td>FEMALE</td>
<td>P.R.</td>
</tr>
<tr>
<td>Total</td>
<td>112</td>
<td>61</td>
<td>51</td>
<td>52</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W</td>
<td>81</td>
<td>39</td>
<td>42</td>
<td>36</td>
</tr>
<tr>
<td>C</td>
<td>31</td>
<td>22</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>61</td>
<td>61</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>F</td>
<td>51</td>
<td>0</td>
<td>51</td>
<td>12</td>
</tr>
</tbody>
</table>

**Key:**
- **S.S.E.** -- Social Service Exchange
- **P.R.** -- Previously Registered
- **N.P.R.** -- Not Previously Registered
- **F.S.S.** -- Family Service Society
- **W** -- White
- **C** -- Colored
- **M** -- Male
- **F** -- Female
The total of 112 cases includes the 19 cases known to the Family Service Society. These 19 cases constituted 16.9 per cent of the total number of cases selected.

We notice that 54.4 per cent of the group are males; 45.6 per cent are females.

The white race predominates over the negroes, with per cents respectively of 72.3; 27.7.

Of the total group of cases 63.4 per cent had other registrations at the Social Service Exchange, 36.6 per cent had no other registrations at this agency. However, of 41 cases which had no previous registrations, 8 were from out of the city, and consequently, would have no registration.
CHAPTER II

NATURE AND CLASSIFICATION OF MENTAL DISEASE.

"The adjustment of the individual as a whole to the environment is a mental function. Such an adjustment constitutes life itself." It would include the influences which environment brings to bear on the individual and the active part which the individual assumes in modifying environment. The most complete mental life is one which permits the individual to maintain satisfactory human relationships. The ability or lack of ability to maintain satisfactory human relationships will be determined by the potentialities of the individual for physical, intellectual and emotional growth on one hand and favorable opportunity for growth on the other.

"A psychosis is the expression on the part of the individual of his type of reaction to the environment." It can be considered a disease only in so far as it represents failure on the part of the individual to effect a

1. White, William A., Outlines of Psychiatry, p.16.
2. Ibid., p. 17.
 harmonious adjustment. Disease is a failure occurring in the interrelationships between the individual and his environment, the result of an unequal contest between the individual and certain factors in his environment. 3.

Mental disorder is a matter of degree of unadjustment. As standards of satisfactory adjustment are arbitrary, there can be no sharp line dividing mental health from mental disease. Mental health may be thought of as excellent, good, fair, and grading on down the scale to the point where mental disease enters the picture and the individual is no longer considered as being capable to evaluate the consequences of his actions. It is extremely difficult to locate the point where mental disease enters, because standards vary with each group and what might pass for merely a poor or even fair degree of mental health among one group, might be labelled a mild degree of mental disease in another.

The problem of classification is made doubly difficult because the "psychoses include a great multitude of different reactions due to a host of different

kinds of causes. Classification on any one basis alone is hardly practical because the great mass of cases seen are combinations, more or less intermediate in character.

There has been much discussion from time to time regarding what might be considered an adequate classification of mental disorders. Attempts have been made, which date back almost to the beginning of medical history. Hippocrates is said to have recognized three forms of mental disorder, mania, melancholia and dementia; although it is likely that he did not use the terms in accordance with their present day conception. The Roman Law divided the dements, or mad, into two classes, the excited or violent and those deficient in intellect.

There followed many classifications by such writers as Aretaeus, Felix Flater, Pinel Esquirl. In 1844, Flemming, of the German School, prepared an elaborate scheme of classification. About 1907 the Royal College of Physicians of England adopted a classification which recognized seven varieties of mania, seven of melancholia, and six of dementia.

5. May, James V., Mental Diseases, pp. 235-241.
Kraepelin in the eighth edition (1910-15) of his text book, gave the following classification, which has been widely used. Only the main divisions will be included here to offer a general comparison with the American classification:

1. Psychoses accompanying Injuries to Brain.
2. Psychoses accompanying Diseases of the Brain.
3. Intoxicating Psychoses.
4. Infectious Psychoses.
5. Psychoses of Syphilis.
6. Dementia Paralytica.
7. Senile and Presenile Psychoses.
8. The Thyriogenious Psychoses.
10. The Epileptic Psychoses.
11. The Manic Depressive Psychoses.
12. The Psychogenic Disorders.
13. Hysteria.
15. The Constitutional Disorders.
16. The Psychopathic Personalities.
17. Defective Mental Development.

6. Ibid., p. 243-244.
At that time there were practically as many classifications as there were hospitals. Almost every textbook announced a new classification. They have been based on etiology, pathology, symptomatology and psychology. English, French, German, Italian and American classifications have appeared, each representing generally different schools of psychiatry.

By a compilation of statistical data relating to various activities of the hospitals for mental diseases in this country, the American Medico-Psychological Association decided on the following classification in 1921. Only the main topics have been included:

1. Traumatic psychoses.
2. Senile psychoses.
3. Psychoses with cerebral arteriosclerosis.
4. General paralysis.
5. Psychoses with cerebral syphilis.
6. Psychoses with Huntington's Chorea.
7. Psychoses with brain tumor.
8. Psychoses with other brain or nervous disease.
10. Psychoses due to drugs and other exogenous toxins.
11. Psychoses with pellagra.
12. Psychoses with other somatic diseases.
15. Dementia praecox.
16. Paranoia and paranoid conditions.
17. Epileptic psychoses.
18. Psychoneuroses and neuroses.
19. Psychoses with psychopathic personality.
20. Psychoses with mental deficiency.
22. Without psychosis.

The majority of writers have selected in their classifications terms which have been descriptive of symptoms, while others have been largely based on the etiology of the psychoses.

Because classifications are arbitrary, Professor Henry divides mental disorders into four large groups:

"One group, which is composed of those psychoses in which the disorders are largely psychological in nature, includes the depressive, manic, and paranoid, schizophrenic, and psychoneurotic disorders. A second group, called the toxic psychoses, is composed of those disorders due essentially to abnormal physiological conditions and includes what are commonly referred to as toxic infectious and exhaustive psychoses. A third group,

7. Ibid., pp. 248-250.
called the organic psychoses, is composed of those psychoses in which there is an actual anatomical charge in the nervous system, and particularly in the brain. This group includes those psychoses which result from injuries, tumors, infections or such conditions such as cerebral arteriosclerosis and senility. In this last group there is actual change or destruction of essential structures in the nervous system. The fourth group called constitutional inferiority, is composed of those personality deviations which are due to constitutional, physical, intellectual, instinctive or emotional defects. This group also includes those psychoses in which a constitutional defect forms the most conspicuous characteristic."

Modern psychiatry also divides mental diseases into two classes, - the organic and the functional. "About 30 per cent of mental diseases, according to recent figures, are of the organic type." In this group belong those disorders which have a definite physical basis. It consists of those cases in which there is either:

1. A pathological process having its primary seat in the central nervous system, as
   a. General paresis (softening of the brain, due to syphilis),
   b. Brain tumor,
   c. Cerebral arteriosclerosis (hardening of the arteries of the brain).

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d. Senile dementia.
e. Other degenerative lesions of the brain.  
f. Multiple sclerosis and the like. 
g. Injury to the brain, as from a blow on the head, a gunshot wound, etc.

2. An injury to the brain secondary to disease in the body, such as:
   a. Fever delirium.  
   b. Uremic toxemia.  
   c. Injury due to disorders of the endocrine system, as exophthalmic goitre, myxoedema.

3. An injury to the brain due to poisons taken into the body, as alcohol, drug, metallic poisons (Lead, mercury).  

The treatment for diseases of this group makes use of the practices of general medicine. "It is a matter of treatment of the underlying disease, and the results depend largely upon whether or not the disease from which the patient is suffering is amendable to medical or surgical treatment. Thus the treatment of

10. Solomon, Harry C., "Serious Cases of Mental Disorder or So-Called 'Insanity', A Mental Health Primer. p. 6."
of mental disease arising from brain tumor is opera-
tion. The treatment of fever delirium is the treat-
ment of the disease which is causing the fever and the
delirium. The treatment of general paresis is the
treatment of a syphilitic infection.".  

In the functional mental disorders, there is no
known pathology of the brain tissue. Functioning of
the brain is obviously impaired, however. As the
disturbances are usually in the emotional field, empha-
sis must be on the life experiences of the individual
in understanding his disorder. Hereditary and constitu-
tional factors have a bearing upon the development of
these psychoses, also. 12. From a practical stand-
point, we may think of the functional disorders under
two headings: "(1) Those in which recovery without
defect occurs, and (2) those in which there is a
strong tendency to chronicity or deterioration, or
improvement with defect." 13.

The cases with good prognosis are in a majority
of these cases which receive the diagnosis of mania-
depressive or involutional melancholia. "While the

11. Ibid. p. 6.
12. Ibid. p. 7.
13. Ibid. p. 7.
symptoms may be exceedingly marked and disturbing; the prognosis on the whole is good; in fact, complete recovery is the rule in cases of manie-depressive. 14

The cases of involutional melancholia are of longer duration and the prognosis is not so favorable as none of these cases do not recover.

In the second large group of functional disorders are found those diagnosed as dementia praecox and paranoia. Dementia praecox, having a bad prognosis, begins usually at the adolescent period. It is characterized by disorder of thought (delusions, hallucinations). This condition progresses slowly and the deterioration of intellect is very slight. It represents a twist of mind rather than a distinct mental disease. 15

Within the functional group also fall the psychoneurosis and the neurosis. The names and frequency of occurrence are given in the following table: 16

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Paralysis</td>
<td>10.6 percent</td>
</tr>
<tr>
<td>Severe Psychoses</td>
<td>12.1 percent</td>
</tr>
<tr>
<td>Psychoses with Cerebral Arterio-</td>
<td></td>
</tr>
<tr>
<td>Sclerosis</td>
<td>2.1 percent</td>
</tr>
<tr>
<td>Epileptic Psychoses</td>
<td>2.7 percent</td>
</tr>
</tbody>
</table>

14. id. Page 76
15. id. Page 76
16. Stricker, Edward A. And Ebaugh, Franklin C. Clinical Psychiatry Page 55
Psychoses with Huntington’s Chorea  1
Brain Tumor and Other Brain and Nervous Diseases  1.2 per cent

Traumatic psychoses  0.3
Encephalitis  No statistics available.

Functional Disorders.

Dementia Praecox 27.0
Manic Depressive Psychoses 16.0
Involution Melancholia 3.3
Paranoid Conditions 2.8
Psychoneuroses and Neuroses 2.1

Streckner and Ebaugh did not include in either group the alcoholic psychoses, drug psychoses or psychoses which occur in association with certain physical diseases. The percentages do not add up to a hundred because certain rare forms of mental disease were not included.

When mental disorders are classified according to degree of severity, they fall into two or three groups. The psychoses or the insanities, are more pronounced or severe disorders. The neuroses and psychoneuroses are occasionally considered as distinct and of less severity respectively. They are borderline states.
Neuroses, on the other hand, may be considered the more

16. Ibid. p. 12.
inclusive term. "The usual forms of neurosis may be classified according to their manifestations, as (1) hysterical, including various episodic forms and the so-called conversion neurosis in which there appear various bodily symptoms, such as paralysis, anaesthesias, functional loss of special senses; (2) psychasthenic (anxiety and obsessional neurosis) exhibiting marked fears, obsessions, doubts, impulses, feelings of insufficiency, nervous tension, anxiety and sometimes marked depression and agitation; and (3) neurasthenic (invalidism) characterized by mental and motor fatigue and irritability, hyper aesthesias and paraesthesias, hypochondriasis, and varying degrees of depression." 17.

CHAPTER III

THE ECONOMIC AND SOCIAL ASPECT OF THE PROBLEM OF MENTAL DISEASE.

The tremendous waste of the resources of this country in mental disorders constitutes one of the most serious and far-reaching economic and social problems. Statistics show that there are more persons mentally sick than physically sick in our hospitals; 75,000 patients are admitted annually to mental hospitals. The Surgeon General's report relative to the second examination of first military recruits drafted in 1917, emphasizes the economic importance of mental disease. "Twelve per cent of these were rejected on account of nervous and mental disease. The number disqualified for service finally reached a total of over sixty-seven thousand." There are over 50,000 new admissions and 14,000 readmissions to our hospitals. "At the end of 1919 there were approximately 250,000 patients with mental disease on the books of the hospitals of


this country." 3. When one considers the patients who never reach hospitals, being cared for privately, and the numerous borderline states such as the psychoneuroses, which are just as disabling as psychoses, yet do not require institutional care, we see what a serious problem mental disease brings about. 4. "One out of every 21 persons in the general population has been or will be at some time in an institution for mental disorders. One out of every seven families show a history of insanity." 5.

Statistics apparently show that mental disease is on the increase. The ratio of patients in hospitals per 100,000 population in the country as a whole is illustrated by the following table:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1880</td>
<td>40,942</td>
<td>81.6</td>
</tr>
<tr>
<td>1890</td>
<td>74,928</td>
<td>118.2</td>
</tr>
<tr>
<td>1904</td>
<td>150,151</td>
<td>183.6</td>
</tr>
<tr>
<td>1910</td>
<td>187,791</td>
<td>204.2</td>
</tr>
<tr>
<td>1918</td>
<td>223,957</td>
<td>217.5</td>
</tr>
<tr>
<td>1920</td>
<td>232,660</td>
<td>220.1</td>
</tr>
<tr>
<td>1923</td>
<td>161,566</td>
<td>218.5</td>
</tr>
<tr>
<td>1927</td>
<td>178,353</td>
<td>226.9</td>
</tr>
</tbody>
</table>

From the above table it is seen that during the past several decades the number of insane in institutions has been increasing at a faster rate than the

5. McCartney, J. L., op. cit., p. 943
6. Above table is compilation of figures given by:
general population. Thus in 1880 there were 81.6 patients in institutions for the insane per hundred thousand general population; in 1927 the number had increased to 226.9.

There can be no doubt that, to some extent, the increase of patients in institutions is due to the fact that, as people have acquired a better understanding of mental illness, they have turned more frequently to the hospitals for aid. But it must be remembered that remarkable improvements have been made in prevention of mental disorders, which should balance to some degree, this effect of lay education. The general improvement in the kind and adequacy of facilities for the care of the mentally ill has also been a contributing factor to the increase. If the statistics of various states are compared, marked differences are found which correspond to the stages of progress in social organizations, and are altogether analogous to those shown by the entire country in years separated by decades. For

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example, in 1910 there were in the State of Oklahoma 67 patients in institutions per hundred thousand general population, while Massachusetts had a ratio of 344.6. Between these extremes, all degrees of transition were presented by statistics of other states. 7.

It is obvious that the number of patients in institutions cannot be taken as a correct measure of the prevalence of mental disorders. Attempts have been made to enumerate the number of insane persons, both in and out of institutions. The undertaking is so fraught with difficulties that such findings are not trustworthy. Perhaps the greatest difficulty lies in formulating a definition of insanity that is workable and objective at all times. Furthermore, if it were possible to sharply distinguish sanity from insanity, the line can be drawn only in relation to some more or less arbitrary standard of normality. The difference in standards of normality may account for the contrasts in statistics of the insane in institutions at different times and places.

In Oklahoma there are undoubtedly many insane persons who are at large and whom their fellow citizens

do not consider proper subjects for an insane hospital, but who would be promptly committed if they took up their residence in Massachusetts. "In the last analysis, it is a difference in tacitly accepted standards of normality that accounts largely for the fact that in Oklahoma, as already stated, there were but 67 patients in institutions per hundred thousand of general population, while in Massachusetts there were no less than 344.6 . . . . ." 8.

In the United States there are some 200 hospitals for mental illness, maintained by the State or Federal government. An investment of $246,348,925 is represented by these hospitals, as shown by reports based on figures from 165 hospitals. The annual maintenance costs amount to approximately $63,673,159. 9. In New York State alone it comes to over $17,000,000 or nearly $150, per capita. 10.

In considering the economic loss due to mental illness, another item must be considered along with the cost of maintenance and original investment. The complete picture would include the loss of earnings due to disability or premature death of the patients.

The expenditures for maintenance of patients in institutions in New York State for the year ending June 30, 1931, amount to $44,913,504. The present worth of the loss of net future earnings of all first admissions is $84,425,269. Adding these, we have a total of $129,338,773, which represents the loss in 1931 to New York State, due to mental illness. 11.

As the data for the United States are incomplete, the estimates for the country as a whole are based on data derived from incomplete census reports and figures from New York State.

The cost of maintenance for patients in the United States for the year ending June 30, 1931, is estimated at $207,896,479. The loss of earnings amounts to $534,249,477, which added to the above figure gives

$742,145,956, which constitutes a fair estimate of the economic loss due to hospital cases of mental disease in the United States in the year ended June 30, 1931. 12.

In addition to financial loss in mental disease due to hospital investment and upkeep, loss of earnings and premature death, mental disorders are a drain on the country's resources in many ways. The intimate relation between mental disease, alcohol, poverty, prostitution, criminality and mental defects suggests economic and social problems of far reaching importance.

The price paid by society because of the presence of the criminal has never been adequately estimated. State and city budgets give evidence of the vast expense of criminality, this being understood to be the largest single item in the public budget. "The cost of the detention, indictment, trial and other disposition of the average felon is conservatively estimated at $1,000. On this basis, the 2,279 felons received into the State prisons during the year 1917 cost the state

12. Ibid., p. 299.
approximately $2,279,000. Of these individual, 87 per cent were recidivists and by their release into the community the state had spent approximately two million dollars to dispose of them again.\textsuperscript{13}

Facts are already at hand which point to a definite relationship between delinquency and mental disease. Reports coming from New York State Reformatory at Elmira, New York, State Reformatory for women at Bedford Hills, Auburn Prison and Sing Sing Prison, speak in no uncertain terms of the conditions found with such a high degree of frequency among prisoners, particularly recidivists, as to make clear a definite relationship between delinquency and mental disease.

"Dr. Bernard Glueck, in the first annual report of the Psychiatric Clinic in collaboration with Sing Sing Prison, states that of 608 adults prisoners studied by psychiatric methods out of an uninterrupted series of 683 cases admitted to Sing Sing Prison within a period of nine months, 66.8 per cent were not merely prisoners but individuals who had shown throughout life

\textsuperscript{13} Anderson, V. F., "Mental Disease and Delinquency," \textit{Mental Hygiene}, Vol. 3, April 1919, p. 776.
a tendency to behave in a manner at variance with the behavior of the average normal person, and this deviation from normal behavior had repeatedly manifested itself in a criminal act.  Further, "of the same series of 606 cases, 59 per cent were classifiable in terms of deviation from average normal mental health. Of the same series of cases 28.1 per cent possessed a degree of intelligence equivalent to that of the average American child of twelve years or under." 14.

Such findings confirm similar reports coming from prisons, reformatories and courts throughout the country as indicated in the tables which follows: 15.

<table>
<thead>
<tr>
<th>Institution</th>
<th>Authority</th>
<th>Number of Inmates Studied</th>
<th>Percentage Found to have nervous or Mental Abnormalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auburn Prison, N.Y.</td>
<td>Dr. Frank L. Heacock</td>
<td>459</td>
<td>61.7</td>
</tr>
<tr>
<td>Sing Sing, N.Y.</td>
<td>Dr. Bernard Glueck</td>
<td>608</td>
<td>59.0</td>
</tr>
<tr>
<td>Indiana State Prison</td>
<td>Dr. Paul E. Bowers</td>
<td>100</td>
<td>45.0</td>
</tr>
<tr>
<td>Mass. State Prison</td>
<td>Dr. A. Warren</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stearns and C. G. Rossy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. Ibid., p. 779
15. Ibid., p. 779
"From this table it is seen that at least 50 per cent of the inmates of state prisons are suffering from some form of nervous or mental disease or defect."

<table>
<thead>
<tr>
<th>INSTITUTION</th>
<th>AUTHORITY</th>
<th>Number of Cases Studied</th>
<th>Percentage Found with Nervous or Mental Abnormalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>N.Y. State Reformatory, Elmira, N.Y.</td>
<td>Drs. F. L. Christian and John B. Harding</td>
<td>400</td>
<td>58.0</td>
</tr>
<tr>
<td>Mass. State Reformatory, (for men)</td>
<td>Dr. Guy G. Fernald</td>
<td>1376</td>
<td>59.0</td>
</tr>
<tr>
<td>Mass. State Reformatory, (for women)</td>
<td>Dr. Edith R. Spaulding</td>
<td>500</td>
<td>63.0</td>
</tr>
<tr>
<td>House of Correction of Holmsburg, Pa.</td>
<td>Dr. Louise E. Bryant</td>
<td>100</td>
<td>69.0</td>
</tr>
<tr>
<td>Western House of Refuge for Women, Merrick Albion, N.Y.</td>
<td>Dr. Jessie L. Blueck</td>
<td>185</td>
<td>82.1</td>
</tr>
<tr>
<td>Westchester County Penitentiary</td>
<td>Dr. Bernard Blueck</td>
<td>225</td>
<td>57.0</td>
</tr>
<tr>
<td>Mass. Reformatory (women)</td>
<td>Jessie D. Hodder</td>
<td>5,310</td>
<td>72.2</td>
</tr>
</tbody>
</table>

16. Ibid, p. 779
The foregoing figures show not only the number of persons with mental defects but include those cases of insanity, epilepsy, psychopathic personality, drug deterioration, alcoholic deterioration and other abnormal and mental conditions, all of which seriously handicap the individual in his ability to adjust himself to the conditions of normal living. All of these mental conditions are most important in considering any real constructive attempt at rehabilitating the criminal.\(^\text{17}\) 

One of the most important groups of which society needs to take cognizance is the feeble-minded. The feeble-minded furnish the nucleus of the most expensive body of individuals who clog the wheels of justice. However, as this thesis deals primarily with mental diseases, the cost of mental deficiency will not be included here. However, it is known that feeble-minded delinquents comprise from 27 to 29 per cent of the inmates of penal and correctional institutions throughout the country. \(^\text{18}\)

\(^{17}\) Ibid. p. 780
\(^{18}\) Ibid. p. 781
CHAPTER IV.

MENTAL HYGIENE AND THE DEPRESSION.

The depression and its effects is uppermost in the minds of those who are attempting a study of social problems. Along with relieving hunger, cold, and sickness, in these times of unemployment, has come a recognition that other problems are involved if the needs of the individual are to be met adequately. Social workers, unemployment relief officials, and executives, have seen a vital need for relieving the emotional strains of the period, as well as considering the problems of material relief.

The mental concomitants of the situation cannot be ignored, because the mental health of these people will determine whether in the future they are to be malcontents with a grudge against society or self-respecting members of the community.

Much has been written about the morale of unemployment and the mental effects of the depression. Consequently this chapter is not offered as original research in the field, but rather as a summary of existing opinions.
There is a common belief that the present economic depression will leave in its wake many cases of mental disease, suicide and mental breakdowns. However, inquiries do not show a general rise in hospital admissions that can be traced to the depression. Its effects may possibly be felt later on, when certain factors in the precipitation of mental disorders have had time to operate. This is in accord with the belief of psychiatrists that mental diseases do not occur suddenly but develop gradually over a period of time.

It is true the number of patients in hospitals over the country have multiplied, but this may be attributed to the improvement of treatment facilities, coincident with the advent of the mental hygiene movement. More mental illness has been uncovered, but it is difficult to isolate the economic factor as a determining cause. The field of mental disease is too complex and there are too many unknown factors to select one item as a cause.¹

The extent to which our impressions can be confirmed by statistics is limited by lack of knowledge of

what would have happened to those who have succumbed if the depression had not occurred. In consideration of statistics, we must keep in mind that the hospital population is made up of wage earners, who experienced no emotional shock at being suddenly reduced in their social and economic status. Their mental breakdown, if any way associated with the depression, was precipitated by anxiety over holding their jobs. We must also remember that cases probably are now transferred to public hospitals, that might otherwise have been cared for privately.

The statistics from New York and Massachusetts are of interest, though they contribute little to support the impression that economic stress is a factor in the causation of mental disease.

Number of first admissions to State and Government hospitals for mental disorder in Massachusetts and New York per 100,000 of general population, 1927-1931.¹

<table>
<thead>
<tr>
<th>Year</th>
<th>New York</th>
<th>Massachusetts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1927</td>
<td>73.6</td>
<td>66</td>
</tr>
<tr>
<td>1928</td>
<td>77.3</td>
<td>75</td>
</tr>
<tr>
<td>1929</td>
<td>76.8</td>
<td>72</td>
</tr>
<tr>
<td>1930</td>
<td>76.6</td>
<td>75</td>
</tr>
<tr>
<td>1931</td>
<td>76.9</td>
<td>70.6</td>
</tr>
</tbody>
</table>

"Whatever the direful influence may have been, it has been compensated for by other factors which have tended to lessen physical stress and mental strain, and,

on the whole, have not altered the relation between the so-called normal group and those who need hospitalization."

However, when we consider all government hospitals for mental disorder, we find an increase in new admissions and readmissions.

**Admission to all government hospitals for mental disorder 1927-1931.**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Admissions</th>
<th>First Admissions</th>
<th>Percentage of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1927</td>
<td>71,967</td>
<td>32,025</td>
<td>44</td>
</tr>
<tr>
<td>1928</td>
<td>73,270</td>
<td>35,576</td>
<td>48</td>
</tr>
<tr>
<td>1929</td>
<td>83,168</td>
<td>41,447</td>
<td>49</td>
</tr>
<tr>
<td>1930</td>
<td>92,115</td>
<td>46,906</td>
<td>50</td>
</tr>
<tr>
<td>1931</td>
<td>109,649</td>
<td>60,792</td>
<td>55</td>
</tr>
</tbody>
</table>

The indirect effect of the depression upon mental health of this country is probably quite as devastating as it is intangible. Although but a relatively small portion of all those affected by the industrial depression show to the outside world what might be called "obvious evidence" of any mental illness, in the sense of a psychosis or neurosis, a large number have had their attitude toward life twisted and distorted, temporarily at least, by an ever present sense of economic insecurity."  

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2. Ibid, Page 567.
3. Ibid, Page 568
4. Ibid, Page 569
The problem of insecurity is a universal one. The search for security, physical, economic and emotional, is considered by many psychologists as one of the fundamental drives or instincts. It must be clear to everyone that the present economic condition menaces security on all sides.

A large proportion of the undesirable reactions to the depression have their roots in various insecurities.5 "Loss of employment or reduction of income requires a change in physical habits along with lowered standards of living."6 As standards of living are often regarded by the individual and his neighbors as symbols of his success and his status in the community, the need for lowering them tends to light up existing feelings of personal inadequacy. Thwarting of attempts to cling to old securities in the form of community status grows acute and depending on one’s pattern of behavior, a reaction is produced in any one of a score of different ways.7

"Physical or economic insecurity every one can understand. Threats to life itself, to bodily comfort, to physical habits long established cause fear, and fear

6. Ibid., Page 17.
7. Ibid., Page 17.
in turn produces symptoms of worry, anxiety or depression. No less acutely, however, does emotional insecurity cause fear and its resulting chain of symptoms. Thus, threats to our pride, our sense of power, our success in attainment—which come after economic frustration and its resulting insecurity may cause any variety or degree of mental disorder.\(^8\)

One way to meet the loss of security occasioned by loss of job is to take the aggressive—a refuse-to-be-beaten attitude. Within bounds, this is the most constructive and desirable course. The fight must be kept free from bitterness and ruthlessness and directed toward a goal that is perceived clearly.

An undesirable reaction is that which admits defeat immediately at the first sign of frustration and lapses into a childish state of dependency, wherein one tries to regain some feeling of security by leaning emotionally, as well as financially on one's family, or on a social agency.\(^9\)

A third way of meeting unpleasant situations is to try to run away from them. As physical escape is often impossible, escape in a psychological sense is attempted. Excessive day dreaming, fruitless dwellings on the good times of the past, are examples. Alcohol and

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\(^8\) Ibid, Page 16.
\(^9\) Ibid, Page 18.
narcotic drugs are other devices for offering a temporary flight from unpleasant reality. In cases where losses of security have such emotional value that the individual can make no satisfactory adjustment, reality becomes so intolerable that some form of serious mental disorder is required to blot it out. 10

Franz Alexander classifies reactions to external events as: 1. Overreaction. 2. Indifference. 3. Paradoxical reaction. 11 Economic losses are considered as an instance of external events known as traumatic events. These external stimuli create inner tensions which the mental apparatus cannot resolve.

Those individuals who consider unfavorable events seriously, become depressed, lose their interest in life, and even consider suicide, may be cited as examples of overreaction, especially if the external cause of this reaction is not serious. This occurs in cases in which the mental equilibrium is already weak, especially with those persons whose self-confidence is based on possession rather than on innate personal qualities.

To the second group belong those individuals who are so preoccupied with their inner conflicts that external events have little meaning for them. They seem

10. Ibid, Page 17-20
to be exceedingly indifferent to all kinds of misfortune. Such a stoical attitude can be just as pathological as an overreaction.

A most interesting group is the last one. Here we see those individuals who seem to be relieved of their symptoms by unfavorable events. A real loss, such as loss of position or money, has called forth an improvement in mental disturbance. Usually these people suffer from a need for punishment created by feelings of guilt. They want to suffer because that is the only way to get rid of their guilt feelings. Their psychology is not so strange, if one will remember that criminal justice is based on the same principle. Punishment expiates crime and suffering is considered as atonement for misdeeds. As it is difficult to know just what percentage these paradoxical reacting types constitute in comparison with the overreacting and indifferent types, it is hard to foretell whether the economic depression will increase or diminish mental disorders. 12

The foregoing constitute some of the more spectacular reactions to the insecurities produced by the depression. By far the greater number of reactions are to be found in the mild departures from good mental health, expressed in such forms as chronic irritability.

sensitiveness to fancied slights, discriminations, bitterness and sullenness. Such attitudes are damaging to happiness and efficiency, but are far from mental disorders.\footnote{Pratt, op.cit., Page 21.}
CHAPTER V.

Causes of Mental Disorders.

Because there is such a variety of factors that may contribute to mental disease, enumeration is impossible. The non-specificity of mental disorders demands that a long view be taken, which considers heredity and environment, conscious and subconscious mechanisms, rather than a cross-section survey, which would include only immediate causes, symptoms and behavior at the time of study. ¹

Many investigations place a great deal of emphasis on the influence of heredity because they have been unable to find a satisfactory explanation of the functional disorders. Rosanoff advances a theory that the onset of mental troubles is predetermined in harmony with the Mendelian laws.² Popenoe states that while mental deficiency is believed to be definitely inherited, there is some dispute as to the precise mechanism.³

However, many psychiatrists believe that the experience of the individual, molding his reactions into certain patterns of response, have far more to do with his ability to resist mental strain than the absence of psychopathic individuals in his ancestry.⁴

² Rosanoff, A. J.; op. cit.; Page 2-6.
⁴ Groves, E. R. and Blanchard, Phylis; op. cit.; Page 37.
The factors which enter into mental disease are sometimes classified as the constitutional or physiological, the environmental and the psychological.5

There are two classes of causes operating in the occurrence of mental disease, the exciting and the predisposing. The predisposing causes are those conditions within the individual which render him more susceptible to mental disorders.6 "From their nature, they are, in the main, constitutional, although a predisposition to mental disease may be acquired, i.e., by systematic poisoning (alcohol) or the prolonged debilitation of disease (tuberculosis)"7 The exciting causes are those conditions, which precipitated the actual attack, usually upon predisposed soil.

In considering the individual predisposing causes more fully, the inherited predisposition deserves attention. The study of heredity as it relates to mental disorders is in a most incomplete state. Much of the confusion is due perhaps to the fact that until recently insanity has been dealt with as if it were a simple concrete affair instead of the complex thing it has proved to be. Insanity

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7. Ibid., Page 34.