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GHQ/SCAP Records (RG 331, National Archives and Records Service)

Description of contents

(1) Box no. 2830

(2) Folder title/number: (7)
Mental Health

(3) Date: Jan. 1943 - Jan. 1947

(4) Subject:

Classification	Type of record
750	t

(5) Item description and comment:
American Publications

(6) Reproduction: (Yes) No

(7) Film no. Sheet no.

(Compiled by *National Diet Library*)

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JANUARY, 1947 vol. 4, no. 1

The Psychiatric Aid

formerly the ATTENDANT

OPPORTUNITY AND THE ATTENDANT

Published for

mental hospital and training school personnel
by the National Mental Health Foundation

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Now that Christmas is over and we've been sufficiently reassured that there really is a Santa Claus, it's high time we made some New Year's resolutions. Perhaps if we make them publicly, we won't be as likely to forget them as some people we know who only write them in their diaries.

We resolve, for instance, to do somebody-knows-what before somebody-knows-when, so somebody-knows-who won't be disappointed. Maybe you don't know what we're talking about, but somebody will if somebody happens to read this.

We resolve to get every issue of THE PSYCHIATRIC AID *out on time, and in the mails the first of the month it's intended for. No more January-issue-out-in-June, June-issue-out-heaven-knows-when for us. No, sir! From now on, this train runs on schedule.*

We resolve to answer letters promptly, particularly if they come from readers of THE PSYCHIATRIC AID. *Whenever they contain manuscripts, or are publishable as letters-to-the-editor, we resolve to give our secretary a half-day off to help us celebrate. (We don't think Marty reads these editorials, but if she does, we're only kidding about the half day off.)*

We resolve to do everything in our power to help our readers take good care of their patients. That means we'll do our best to publish helpful techniques, to suggest helpful attitudes, and to give readers plenty of opportunity to exchange useful ideas with one another.

We resolve to continue seeking professional recognition and status for qualified attendants. A lot of people are with us on this wagon and we intend to do our full share of the pushing.

We resolve to continue seeking adequate training for attendants, and will probably keep our hand in by helping the National Mental Health Foundation publish additional sections of its popular Handbook for Psychiatric Aides. (We hope to give readers a preview of a forthcoming handbook for training school attendants in the February issue.)

It's probably just as well that these are all the resolutions we have space for. One resolution more, and we'd have to hire an associate editor to help us toe the line.

Phil Steer

THE PSYCHIATRIC AID, Vol. 4, No. 1, January, 1947. Published monthly by the National Mental Health Foundation, Inc. Ten cents a copy, $1.00 a year. Two-year subscription $1.90. Ten to 24 copies to one address, 95c a copy per year; 25 to 99 copies, 90c; over 100 copies, 85c.

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Address all correspondence to The Psychiatric Aid, P. O. Box 7574, Philadelphia 1, Pa. Make checks payable to "National Mental Health Foundation, Inc."

The National Mental Health Foundation welcomes the participation in its program of all who share its concern for the welfare of the mentally disabled. Membership dues, $1.00. For further information, write to Harold Barton, Executive Secretary, P. O. Box 7574, Philadelphia 1, Pa.

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MIGHTY POWERFUL

Here's a case where friendliness and good will turned out to be more powerful than a patient's fear and the fight she put up because of it.

When I came on the ward, the attendants pointed to a little woman—four feet, eight inches tall and weighing about ninety pounds.

"She's mighty little, but she's mighty powerful," one attendant told me. "She doesn't like attendants. Whenever we come near her she turns to the wall and hangs on to the bench for dear life. She just sits there all day—never speaks to anyone.

"When it comes to giving her a bath we always have a battle royal on our hands. She puts all of her ninety pounds into the scuffle, and it usually takes three huskies to get her undressed. Sometimes she gets so upset we have to put her in packs."

I took a fancy to Katherine. I had a suspicion that she was really afraid of us, and that if someone took the trouble to get acquainted with her and show her good will, we wouldn't have much trouble with her. So I decided to get acquainted. At first I would just speak to her—a few friendly words of greeting when I happened to be around her part of the room. In the beginning, she paid no attention to me. Every time I came near her she would turn her face to the wall. But I didn't give up, even though it seemed hopeless. I kept letting Katherine know that I wanted to be friends, even if she did not.

Then one day my little project brought results. Katherine actually came up to me and spoke. "I like you," she said, "You're good to me." After that it was not hard to get her to take her bath or to feed her. And I felt that I had proven a point.

Katherine was not naturally mean or stubborn. We only thought she was. She was really afraid. And when people are afraid, they put up a fight in self-defense. Once Katherine was convinced that I was not going to do her any harm, that I was just trying to be friendly, her fear broke down, and when her fear went away, there was no more need to put up a fight.

It also proved that it pays to study a patient like Katherine and try to find out why she doesn't want to take a bath or eat. And if you keep working on it, there is a good chance you will find an answer.

It saved a lot of time and trouble in the long run to try to understand Katherine and to win her confidence. If I hadn't taken the trouble to make a friend of her, we would still be going through the same old fights and tussles, simply because we hadn't used our heads.

—MARJORIE STEER.

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All this being so, what is inconsistent in the statement that the best attendant, the most seriously interested one, is also the one least likely to feel that working as an attendant offers him an opportunity to be useful *and* to live, off duty, under conditions as respectable as every man has a right to expect so long as he tries to lead a useful life in the service of others.

When a man applies for work at an institution, let it be known that he is expected to be, as a matter of course, a gentleman. Grant him the facilities and the opportunities really to live as near like a gentleman as conditions in general may permit. Above all, treat him as a gentleman—the chances are he may turn out to be one. Along that line—and along that line only—lies the solution to "that difficult attendant problem."

—R. HEIDENBLAD.

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Opportunity and The Attendant

We first printed this fine article in August, 1944. A few of our present readers will remember it. To them as well as to the rest, its viewpoint and inspiration will remain as fresh as if it had been written yesterday.

If I were an attendant I would try to learn psychology first-hand from the patients with an occasional glance at my fellow-attendants, the physicians and myself.

I should study delusions in action and try to see in what way they differed from my own prejudices. I should study obstinacy and pig-headedness and compare them to my own firm determination. I should be interested to discover the unreal worlds which patients build to live in, to see what dreams give to people that they can find nowhere else, to see what evil realities patients were getting away from, and then I should wonder how academic retreats and ivory towers might serve the same purpose. I should notice how, in the severe depressions and exhilarations of patients, the reasoning processes were humble slaves of strong emotions, and I should wonder how many votes in the November elections were going to be determined by reasoning about the present national situation. After talking with patients who had delusions of persecution I should consider what to call many of the ideas that groups of people have about "The New Deal" or about "Wall Street."

I should like to study further the relation of aggression to frustration. In some patients a closed-in space, a locked small room, an abrupt order which admits no argument, a hand on the arm, brings violence and continuing struggle. Undoubtedly many would lose the drive to struggle if they could be set free, and yet freedom for them is clearly impossible in our present society, as an attendant can see. Here is where the attendant can see the good results of compromise: the greatest immediate freedom for the patient, as large as possible a space which symbolizes freedom, a request instead of a command, the refraining from laying on of hands.

A patient said of an attendant, "When he says 'come' he is gentlemanly and quiet, but somehow or other you know you might as well come." Inasmuch as a patient gives consent to a proper restraint it is no longer restraint but a self-discipline which preserves his self-respect.

I should put a lot of attention on the normal thinking and behavior of patients with mental disease. It is seldom that all of a mind is out of order; some parts can continue to run smoothly and it is up to the attendant to be quick to notice the normal functioning and try to encourage it—in conversation or in games or occupational therapy or work. I should

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especially notice how sometimes a good personality shines through the clouds of illness.

I should try to understand every symbol which the patient uses, and there are usually thousands of them in the speech of every schizophrenic or depressed or excited patient.

If I were dealing with patients lacking in intelligence, I would try to develop in them that reliability and training in small things which is a good substitute for a bright mind.

There is an evolutional hierarchy inside of personality that I should study, unfortunately on the devolutionary side. As the brain is built up, its first pathways are those of the infant and animal, and its last pathways have to do with those fine, complicated ethical strivings which mark man's consideration for his fellow man. The first pathways must be solid and durable for on them life immediately depends; the last pathways are delicate and easily hurt. And so, when sloppiness in eating habits appears, one can see the beginning of a return to the primitive and to the infantile.

In hundreds of men over forty-five, damage to the higher delicate layers of the brain brings a regression toward childhood. In one man I saw a process more difficult to understand; from a great success as an active businessman he became like a two-year-old; he was fed by spoon, bathed, taken to the toilet, dressed by his wife and a nurse; they even wheeled him outdoors in a chair that was a substitute for a baby carriage. Other patients turn back to a careless schoolboy stage, and still others to a homosexual adolescence. The daydreaming, the taking of a symbol for a fact, living a fairy story, are all things appropriate to early childhood, as are the activity and distractability of excited patients.

As an attendant in war time, I should see an opportunity to advance the cause of humanity in large mental institutions by twenty-five years. In the turning over of society there have come to these institutions many well educated, sensitive, conscientious men who would never have known anything about the care of mental patients. In the past one attendant out of perhaps ten has lived up to the full demands of his work, has seen his patients as fellow human beings and has given himself to their needs. What can the present attendants do when they return to their communities to see that good men can be attracted to this service for humanity and kept there? Should pay be doubled for men who stay three years and show the right spirit? Some way or other the benefits conferred on mental institutions by a new set of attendants should be kept for a peacetime world.

—EARL D. BOND, M. D.

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Reflections of a Fireman

If there are interdepartmental rivalries and grievances in your institution, this article may help you overcome them.

From all appearances, a job on maintenance in an institution is a far better lot than the attendant's, from the standpoint both of pay, and of peace of mind.

But there are some things that an attendant gains, in dealing with large groups, that never come to us. First, he learns how to get along with individuals who are often hard to control. Second, his own personality is built up by the strengthening of such qualities as patience, forbearance, and self-discipline, which is the result of overcoming the humdrum monotony, and by facing tasks which are often disagreeable. In the end, his "glory" would seem greater because he faces a larger challenge.

Those on maintenance realize the difficulties of the attendants on the wards. Yet at times they are too critical of them. It is not uncommon to see a maintenance man cut loose with a tirade of invectives when he sees a plugged hopper, a valve, a switch, or some other detail which seems to require attention *too often*. It is quite easy to blame the attendants as well as the patients. Many times he goes on without trying to analyze the situation with regard to the limits of an attendant.

It is interesting to look at the institution as a whole and note the rivalry and the individualism among workers in the various buildings, the hospital, the kitchen, the laundry and the farm, the boiler fireman and the maintenance crews. Each has a strong departmental spirit. In many instances, he seeks to magnify his own problems and build himself up on the inequalities and injustices done to him by workers in another department.

No one quite understands the other's position. No department should feel superior to another, although one must admit some have heavier duties than others. All are essential and interdependent, and each is working for the good of the whole. Much could be done by intimate friendly talks whenever there is opportunity.

In the maintenance department there are irksome details, too, just as there are in any other part of the institution. Supplies are hard to get now. It is not uncommon for six months, a year or occasionally two years to go by before a requisition is filled.

Another thing that is irking to maintenance men is to be called up about fifteen minutes before quitting time to fix something that could have been done sooner had they been notified. Some patients are repeatedly destructive, and

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that necessitates doing a job over and over again; that, also, is irritating.

One distinct advantage most of those on maintenance enjoy is the fact that they don't have so many patients to deal with. But strange to say, in many cases, they don't get along with the patients who work for them any better or even as well as the attendant with a much larger group.

Many of the cardinal rules of a good attendant's creed are broken when a patient is bribed, flattered, or given extra privileges, in order to make him "work good." This sometimes makes the patient cocky, and indifferent toward his attendant. Then, too, he is prone to "impress" his fellow patients and deliberately make them jealous. Too often, some of the trouble makers in the wards are those who have been spoiled by non-attendants outside the building.

In more instances than one, this is a very just criticism the attendant has to make of the non-attendant. Almost all of us could do better if we would take the time to cross-examine ourselves more frequently, and keep ourselves ever aware of the influence we have on those around us.

If one is to progress ethically in the direction of a better understanding of human foibles and weaknesses in this sort of work, it is necessary to cultivate tolerance toward the actions of patients to the 'nth' degree. The one virtue that is to be praised and prized is patience . . .

The feeling of helplessness to cope with patients in the mental sense is in all probability the most discouraging factor for the attendant . . . It is like running up against a translucent glass wall, through the blur of which objects . . . are almost discernable, yet not quite . . .

Since it sometimes seems that they cannot 'feel' mentally, one somehow becomes calloused, at least to some degree, to the fact that they can feel physically . . .

—HARRY HINES
Quoted from "Anniversary Review," published at the Harrisburg, Penna., State Hospital

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The Attendant Problem

Why is there an "attendant problem"? What can be done about it? Here's one man's answer to these important questions. He is an attendant in a state hospital in New England.

It is obvious that any and every effort to raise the standards—economic, professional and social—of the group to whose interest THE PSYCHIATRIC AID is devoted must begin at the very bottom with an effort to improve upon the type of men who make up this group. That, at first glance, may seem a rash and uncharitable statement, implying, as no doubt it does, that there is not only room for, but a real need of, improvement of the type. To admit that is not, however, to claim that all attendants are below standard. Every institution devoted to the care of the mentally afflicted has, undoubtedly, a reasonable share of attendants of the right type—the high type. Unfortunately, it has also, just as surely, its share of attendants that are not of a wholly desirable type.

Anyone knowing anything at all about the conditions under which institutional employees live, knows also that of the two categories of attendants just referred to, the ones falling within the higher category are the ones apt to feel the least at home or in the right place.

The writer is inclined to believe that in touching upon this seemingly strange fact, we are touching the very roots of some of the difficulties which have created for every mental institution an "attendant problem" that is anything but encouraging. The very fact that it is the high-type man that feels out of place, and not at home as an attendant, proves in itself that he is working and living under conditions not compatible with his ideas of respectability. On or off duty, he is constantly made to feel that he is working and living under conditions that may possibly be considered good enough for the transitory workers, the floaters, or, in general, the workers who care not a great deal beyond three meals per day, a bed to sleep in and a check on time, but that most certainly represent no inducement for a man who takes his work seriously, who wants to stick with it, and who wants to build his life on the basis of it.

There is a school of philosophy according to which, to whomsoever God giveth a task, He also giveth the power to perform. We don't have to stretch that bit of philosophy very far to feel justified in saying that most men are apt to be just what they know they are expected to be. And that is the point where most mental institutions, by their flagrant failure to recognize it, or at least to acknowledge it, lay their own foundation for a difficult "attendant problem"—bound to be always with them unless they change—and change radically—their attitude toward

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that particular group of employees.

No one can work as an attendant very many months, or even very many weeks, without becoming shockingly aware of the fact that in many hospitals—probably in the majority of them—the attendant is looked upon more or less as a necessary evil, as one of the "untouchables," as one necessary to contend with because there is a lot of dirty or otherwise disagreeable work that no one else can or would want to do, but who, in every other respect, is definitely not within the pale.

On the ward, the attendant does all the hard and disagreeable work and faces all the dangers when such present themselves. To that he does not object, because he knew when he took the job that just that would be expected of him. But he may reasonably object to being ordered around in lordly fashion by teen-age student nurses, just out of high school and with only the vaguest ideas—if any at all—of how properly to "handle help."

Off the ward—in the dining room for example—he is again reminded of the fact that as "just an attendant" he is not of much account, if, indeed, of any at all. He knows that he is not getting the best of food, often not even good food, and if he is a sensible fellow, he tries to overlook that, reasoning that there are so many of him that it would probably be more than the budget could bear to feed him right. But he does find it hard to overlook the environment in which he is compelled to "enjoy" his meals—more often than not, a cafeteria style dining room where, in spots, table manners are something entirely unheard of—or considered something that only "sissies" bother about. In many hospitals, the attendants' dining room is shared by working patients, some of them coming in directly from one of the barns or piggeries, with little or no preparatory ablutions. The right type of attendant is not too "high hat" to sit down at a table beside a patient, but he does resent having to eat his dinner with the fumes of the barn and the piggery in his nostrils.

But it is probably after his day's work, seeking rest or relaxation in his room, that the attendant faces the most heartbreaking disappointment of his day. It is probably no exaggeration to say that in most hospitals the housing situation is, at least in so far as the attendants are concerned, entirely inadequate and surely all out of tune with a modern and more enlightened trend in the handling of "help."

It would probably come close to heresy to say that of all the people working in a mental hospital, the attendants have the weightiest claim to every possible consideration as regards rooming facilities. Nevertheless, there are a good many arguments to offer in favor of such a contention. Of all hospital workers, from the physicians all the way down the line, no one spends as much time on the wards and in direct contact with the patients as do the attendants. That means that they spend every hour of their working day (or night) in surroundings as sordid as human misery and misfortune can make them. And when the day is done, where are they to find relaxation or rest except in their rooms? Inadequately paid, they must of necessity reduce their social activities to an absolute minimum. Most of them are from out of town, and therefore lack any nearby family connections that may be utilized to brighten a generally gloomy outlook. It is safe to say that by far the greater part of the attend-

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ant's life is spent either on the ward or in his room. And what kind of room does he have? Generally, the least desirable room the institution has to offer—almost anywhere from the basement to the attic. A room without a really comfortable chair in which to sit down and read. A room without a desk at which to write. Often a room without a closet. A room without a bookcase. A room that isn't a room at all, according to civilized standards.

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Then one day my little project brought results. Katherine actually came up to me and spoke. "I like you," she said, "You're good to me." After that it was not hard to get her to take her bath or to feed her. And I felt that I had proven a point.

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It also proved that it pays to study a patient like Katherine and try to find out why she doesn't want to take a bath or eat. And if you keep working on it, there is a good chance you will find an answer.

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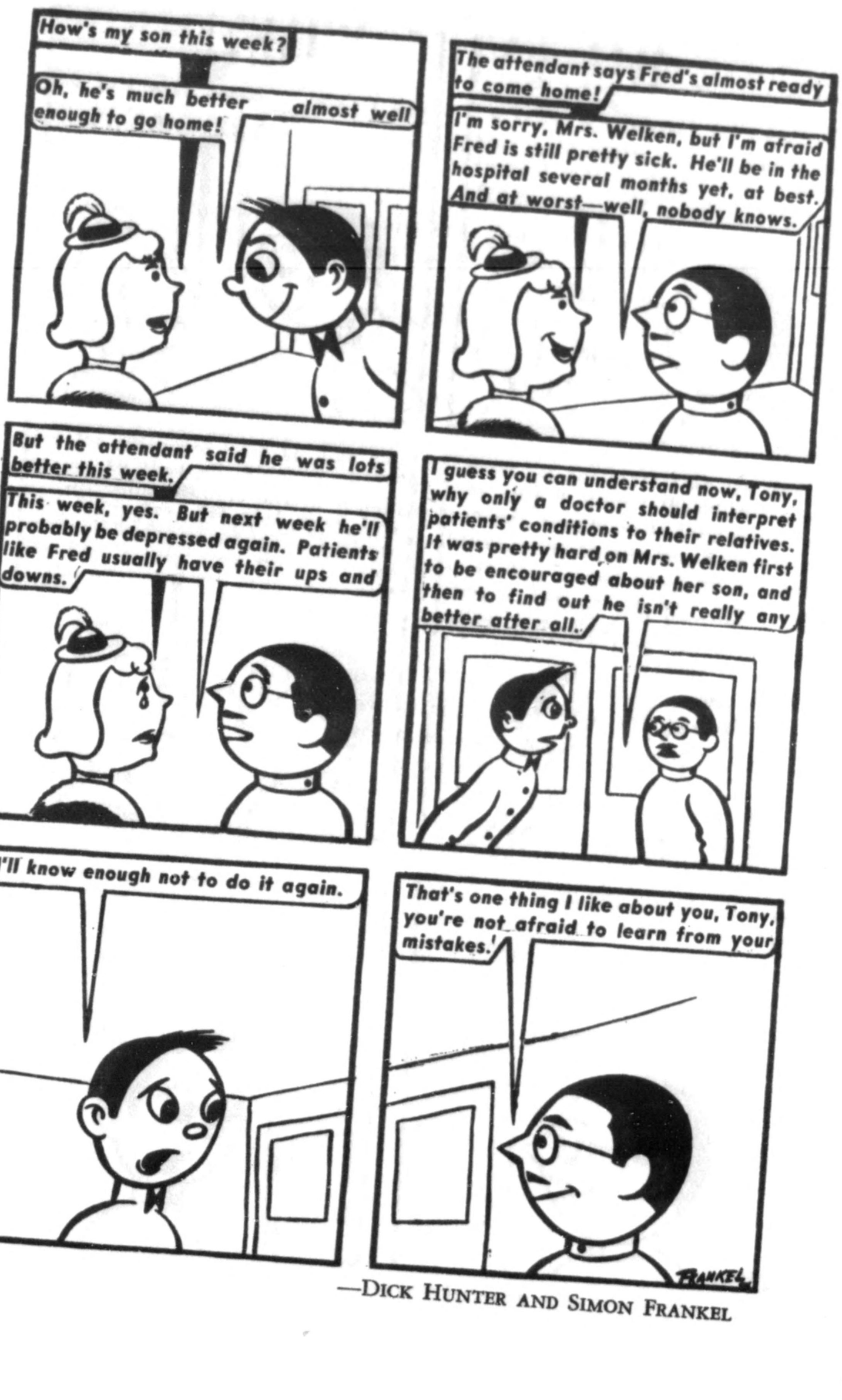

—DICK HUNTER AND SIMON FRANKEL

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WIN EXTRA MONEY!

Can you sell subscriptions to THE PSYCHIATRIC AID? *It's worth trying!*

To the attendant or nurse who sends in the most subscriptions to *The Psychiatric Aid* between January 1 and March 31, 1947, the National Mental Health Foundation will send a cash prize of $10.00. Similar contests will be held in each succeeding three-month period throughout the year. And to the person who sends in the most subscriptions during the entire year, the Foundation will present a grand prize of $25.00. That's a total of $65.00 in prizes!

Only attendants and nurses employed in mental institutions are eligible to compete. To be considered in the contest, subscriptions must be accompanied by a letter stating the sender's name, address, position and place of employment, and must be addressed to Circulation Contest Manager, The Psychiatric Aid, P. O. Box 7574, Philadelphia 1, Penna.

An up-to-date statement of subscription rates appears on page two of this issue. A two-year subscription will count as two subscriptions. Renewal subscriptions will be considered the same as new subscriptions. Subscriptions in quantity, sent to one address at quantity rates, will count as separate subscriptions. Names of contest winners will be announced in *The Psychiatric Aid*. In the case of ties, duplicate prizes will be awarded.

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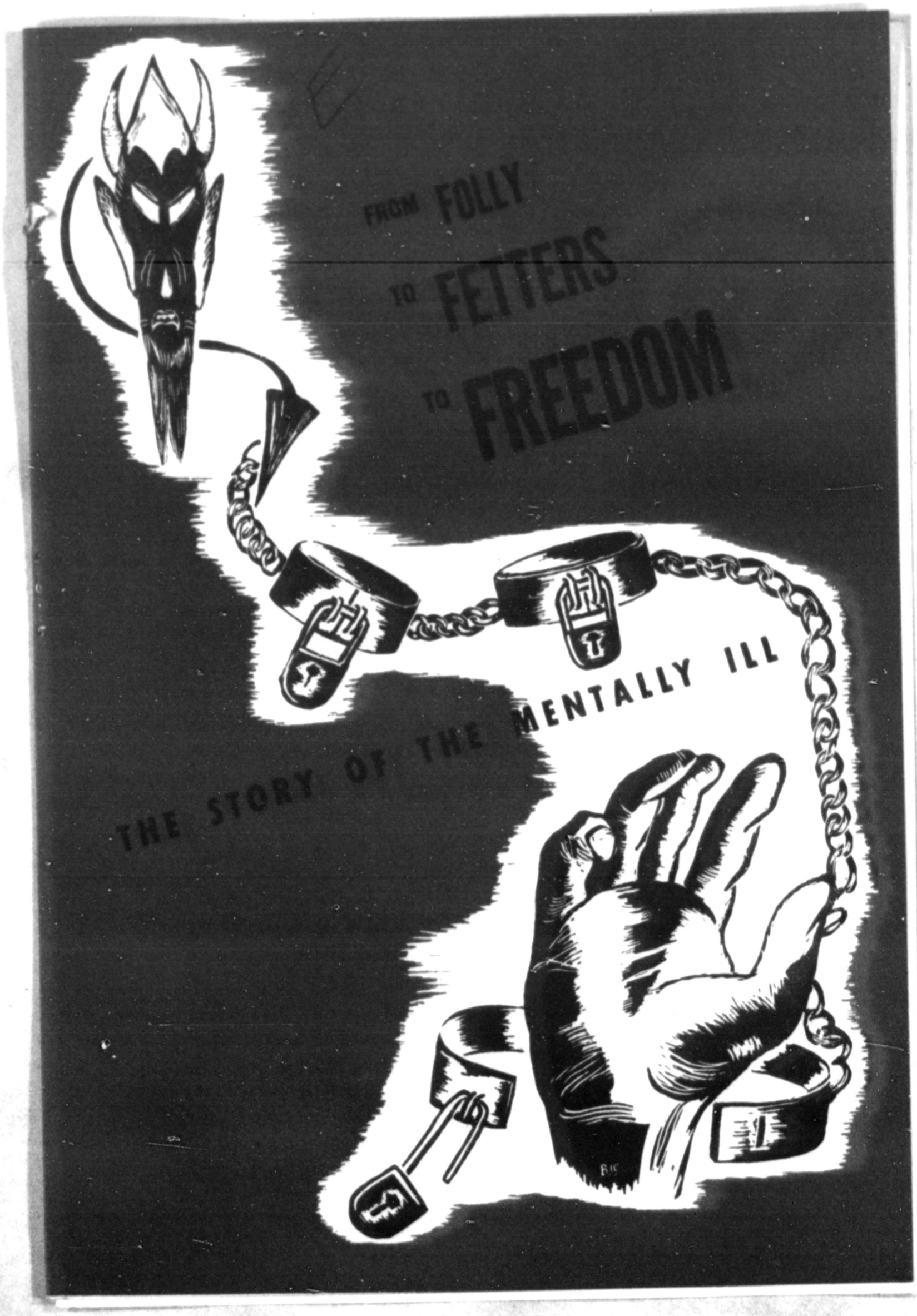

BEFORE MEDICINE THERE WAS MAGIC

Ancient man had an easy explanation for everything, including mental illness and mental deficiency—if the gods hadn't done it, the demons had. If a man became mad, a demon had seized him unless, perchance, his madness was of such a nature that he could be termed one of "God's true minstrels." In either case, treatment was to drive out the demon or worship the god. Ancient Egypt and Babylon cared for their mental cases just this way.

In the Grecian temples of the Asklepiads, the major treatment was still ritualistic, but suggestion, beauty, peaceful surroundings and healthful living contributed to the possibility of cure.

A medical view of mental illness was first expressed by Hippocrates about 400 B. C., and he used diet control, massage, baths and exercise for treatment along with bloodletting and purging. Soranus of Ephesus wrote some directions for care of the mentally ill in the second century that could be used without change in a modern attendants' manual. Medicine began to replace magic—but only for a time.

MAN IS BORN FREE, BUT EVERYWHERE HE IS IN CHAINS

The Middle ages saw a retreat to the old demon-view of mental illness. At first the mentally ill and deficient were treated with tolerance and sympathy, even though shrines, magic rites, fetishes and exorcism were the only treatments offered.

Soon after the first European asylum was established in Spain in 1408, treatment became more and more fanatical and barbaric. Monks who did not stop at scourging themselves in order to reduce the influence of the "evil one" certainly could not be expected to give sympathetic care to creatures who had allowed the devil to take complete control. The success of this mistreatment is indicated by one famous exorcist who reported that he not only forced five demons to relinquish possession of a victim but actually made them sign an agreement not to molest him again.

This attitude culminated in the famous witchcraft mania of the sixteenth and seventeenth centuries. Then over 100,000 persons—and many of them were mentally ill—were executed as witches. Through the whole period up to the late 1700's, the mentally ill were hanged, imprisoned, tortured and persecuted as agents of Satan; they were chained in kennels and cages like wild beasts; they were jailed and flogged like criminals; at best, they were left to wander about naked and starved, the butt of taunts and teasing. Such treatment prevailed for many centuries, but it could not last.

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'DESE BONES 'GONNA RISE AGAIN!

Just before the end of the eighteenth century men in all walks of life were beginning to break the chains that bound them—humanity was ready to rise again. Philippe Pinel in France (1792), William Tuke in England (1796) and Chiarugi in Italy even earlier performed this task for the mentally ill. They not only struck off the chains but began to treat the mentally ill as sick human beings.

Special institutions for mental cases had been established before this time; but ignorance of better methods had allowed restraint and blood-letting to remain the major treatments. In 1752, Pennsylvania Hospital was founded in Philadelphia, and Quaker influence saw to it that occupational therapy was provided for the mental patients admitted. The first hospital exclusively for the mentally ill in America was opened as a state hospital at Williamsburg, Va., in 1773. There were mental hospitals in nine states before 1825. The outlook was up—but it soon turned down.

OVER THE HILL TO THE POORHOUSE

Busy America could not be bothered with any poor wretch who couldn't make a success of life in the early 1800's. Yet it needed to get such people out of the way so that fortunes could be made without any interfering conscience. For a time the helpless—including the mentally ill and mentally deficient—were kept at home at public expense or auctioned off to the man who would keep them at the least expense. Then a cure-all and catch-all was offered: Why not build institutions and send to them all of the poor and incompetent?

Often built at the least possible expense, operated on a miserly budget, and regarded as places for sub-human beings anyway, the poorhouses of the nineteenth century exhibited remarkable conditions. One institution reported:

—a garret room, unheated and unsealed, accommodated twelve women and children in five beds,

—five men, three women and eleven children occupied another chamber with ten beds,

—ten women and children were crammed into a 17 x 9 foot room with three beds.

It was a sorry road that led over the hill to the poorhouse. And the least regarded of those who journeyed it were the mentally ill.

LET MY PEOPLE GO!

Dorothea Lynde Dix, conducting a Sunday School class in a Massachusetts jail in 1841, saw that mental cases were confined there, beaten and neglected. Her experience launched her on an international crusade which caused the founding or enlarging of thirty-two mental hospitals before her death in 1887.

A new era of reform was under way. The organization which is now the American Psychiatric Association was founded in 1844. The first school for the feebleminded was established in Massachusetts in 1848; the first training school for nurses in a mental hospital was opened in Massachusetts in 1882; an outpatient clinic for mental cases was added to Pennsylvania Hospital in 1885; and a full-blown program of state care became law in New York in 1890.

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Meanwhile, John Conolly had precipitated a violent debate among hospital superintendents when he presented his philosophy of non-restraint in 1856; James Braid had used hypnotism as a therapy in the 1850's; medical discoveries in neurology, endocrinology and related fields had shed new light on the nature of mental disorders; and Emil Kraeplin presented the first organized system of psychiatry in 1896.

A MIND THAT FOUND ITSELF— THROUGH ABUSE AND NEGLECT

Yet in 1900, when Clifford Beers was forced to spend three years in mental hospitals, he found conditions such and was mistreated so thoroughly that he wrote on the walls of his room, "God bless our Home, which is Hell."

He told the country about his experiences in a book, *A Mind that Found Itself,* and went on to give the rest of his life to the National Committee for Mental Hygiene which he founded.

Humanity could no longer plead ignorance; this time its only excuse was neglect and indifference. At last we knew better —but our actions mocked our knowledge.

PROGRESS IS THE REDUCTION OF IDEALS TO FACTS

Ideals are not enough; we must not only know where we want to go, but we must know how to get there. The last thirty years have seen many ideals about the mentally ill and mentally deficient become facts.

—Adolf Meyer became the dean of American psychiatry by uniting many streams of thought into a comprehensive mental hygiene movement.

—Wagner-Jauregg developed fever therapy as a cure for mental illness in 1917.

—Manfred Sakel announced insulin shock therapy in 1933.

—Von Meduna used metrazol therapy successfully in the same year.

—Three doctors in Italy produced similar results with electric shock treatment in 1937.

It thus became a known fact that some mental illnesses, previously thought incurable, could be cured by medical means.

We now have the ideals in mind for great improvements in hospital architecture, nursing care, treatment and therapy. We have seen successful demonstrations of programs to prevent mental illness, to rehabilitate mental cases, and to provide proper legal controls. But rarely have these ideals been reduced to facts.

Three thousand young men who gave emergency service to mental hospitals in this country during 1942-46 found conditions not at all unlike those Clifford Beers experienced forty years earlier.

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NOW IS THE TIME—

THE FUTURE MUST REPLACE THE PAST

The history of the care and treatment of the mentally ill and mentally deficient is a spotted history, showing many advances, many regressions. Again and again, waves of reform have assaulted the passive shore only to recede: their work begun but yet undone.

A new and greater wave of reform is gathering now and is rolling shoreward. This time the substance, power and vision are all at hand to keep the wave rolling—united direction is all that is needed. The wave must not recede this time, but roll on to attain the new vistas opening before us.

FROM FOLLY . . TO FETTERS . . TO FREEDOM . .

That is the story of the mentally ill. It leads back to folly again, unless we do our part. Freedom is never a gift—it is earned and maintained only by effort. If the care of the mentally ill fails to improve in our generation, remember—

WE ARE ACCOUNTABLE!

(References: Albert Deutsch, *The Mentally Ill in America,* and Marie B. Ray, *Doctors of the Mind.*)

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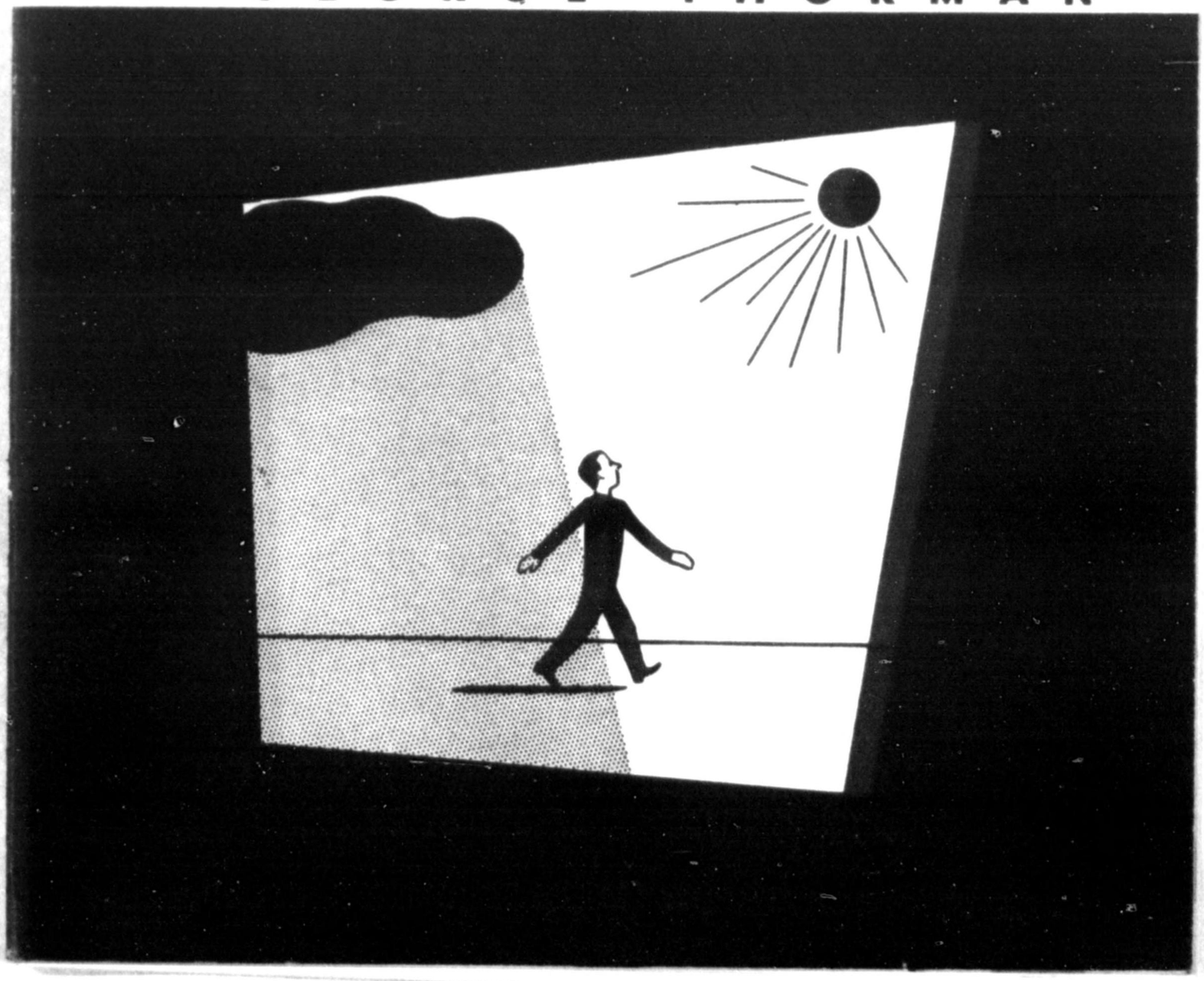
PUBLIC AFFAIRS PAMPHLET No. 120

TOWARD MENTAL HEALTH

BY GEORGE THORMAN



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Prepared and distributed by

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TOWARD MENTAL HEALTH

By GEORGE THORMAN

THE story of nervous and mental disease is a story about people you know—your neighbors, friends, and relatives. It is a story about nervous people like Fred, moody people like George, lonely people like Mary—people who have cracked under the strain of living.

NERVOUS AND ANXIOUS PEOPLE

FRED was a good mechanic. In fact, he was so good that his boss decided to promote him to foreman. About a week before the promotion was to be made, Fred took to his bed, said there was something wrong with his leg, and insisted that he couldn't move. X rays were taken; general practitioners were called in. They could find nothing wrong.

This pamphlet was prepared in cooperation with the National Mental Health Foundation and has been carefully checked by a number of the country's leading psychiatrists.

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What had happened to Fred? When he was to be promoted or start on a new job, he became anxious and fearful. He knew how to operate a lathe and was happy while he was doing it. But responsibility for supervising other men had him scared.

Fred's Fears

The psychiatrist—a doctor who has made a study of the emotions and the mind—diagnosed his case as *hysteria,* a form of neurosis. "Fred's bad leg," says the psychiatrist, "was his way of solving a problem. If he had a bad leg, he couldn't be expected to go back to work and face a situation of which he was afraid. Fred wasn't faking. His fears actually interfered with his walking. He was firmly convinced that he couldn't use his leg. Back of his fear of the new job as foreman were a lot of fears and conflicts which he didn't even know he had.

Our fears often grow out of experiences long forgotten

"He felt that he ought to take the promotion. His wife, his friends, his fellow workers all expected him to. A refusal would put him on the spot. How could he explain it? He couldn't say that he was afraid of the added responsibility. And yet he was.

"He was afraid because he thought he would fail. And he was afraid he would fail because of an earlier experience—one which he had forgotten. When he was ten years old, Fred had been left to take care of his younger brother while his mother went on an errand. While she was gone, his brother ran into the street and was almost killed by an auto. When the mother came back, neigh-

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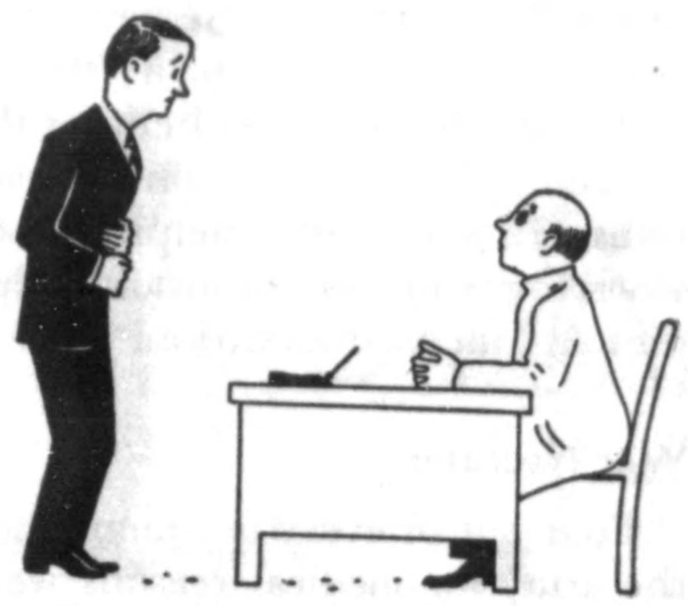
bors told her the story. She punished Fred severely and told him that never, never, would he be left to take care of his younger brother again. This was an unfortunate experience in Fred's life and it left its mark. It made him panicky when he was faced with the supervision of others."

Over a long period of treatment Fred was able to find the reason for his fear and overcome it with the help of the psychiatrist. Now he is back at his old job.

John's Nervous Indigestion

John is a bachelor. For the past ten years he has been going to the family doctor because of nervous indigestion. He complains of poor appetite, dizziness, pains around his heart. Yet the doctor can find nothing physically wrong with him. It is not fair to say that John is only imagining his nervous indigestion. To him it is very real. As a matter of fact, he is sick — emotionally sick.



He says the trouble is in his stomach. But he is emotionally sick

The real cause of John's illness is an emotional conflict which he doesn't realize. If you told him so outright, he would deny it. He does not think of himself as emotionally tied up. He will tell you that if he could get his stomach in good shape, he would be O.K. But here is what John looks like from the point of view of a doctor who understands emotional as well as physical ills.

John was an only child of an overly protective mother. He has turned all of his attention upon himself. Other men find an outlet for their energy in a job or a

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cause. But John is not interested in anything except himself. Consequently, he feels frustrated and unhappy. This frustration comes out in the form of nervous indigestion.

Mind and Body

Our minds and emotions are closely connected with our bodies. Mind and body interact. Our physical condition can affect our emotions, and our emotions can affect our physical well-being. Doctors have found that more than half of the persons who visit their family physician for treatment of a physical ailment suffer from emotional difficulties which partially explain their physical symptoms. For example, stomach ulcers are frequently connected with worry and anxiety. The help of a psychiatrist may be necessary—or the family doctor himself, if he approaches the patient as a person rather than as a "cardiac patient" or a "stomach case," may be able to bring relief through helping the patient to an understanding of the connection between emotions and symptoms. In such cases, helping the patient overcome his worrying is just as important to his recovery as is proper diet and medical attention.

War Neuroses

Four out of every ten men who were discharged from the army for medical reasons were suffering from some nervous or mental illness. About 60 per cent of these men did not see combat service. They cracked after a few months or a few weeks of training because they were unable to adjust to the drastic changes which army life required. Some of them had never been very successful in civilian life. Others could get along well enough in their peacetime jobs and homes, but could not fit into army life and had to be discharged.

Few of those who were discharged for neuropsychiatric

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reasons needed hospital care. Most of them were returned directly to civilian life and were able to take up their normal peacetime activities again without much difficulty. In many communities, service organizations, mental hygiene clinics, and Veterans Administration guidance centers are helping them with their problems of readjustment.

IN HEAVY COMBAT 1 OUT OF EVERY 4 SUFFERED FROM NEUROSIS

War neuroses were much more common among those who saw combat. For example, infantry divisions, while in heavy combat, frequently had 250 neuropsychiatric casualties for every 1,000 men, while the troops who stayed in the U. S. had only 50 cases for every 1,000 men. The combat cases (sometimes called combat fatigue) were usually treated successfully near the battle front immediately after the first symptoms of mental breakdown appeared.

New Treatments for War Neuroses

One interesting treatment used for these war neuroses starts by injecting a sedative (such as sodium pentothal) into the patient until he becomes semiconscious. He is then led to relive the battle scene which first brought on the nervous breakdown. The psychiatrist usually plays the part of a fellow soldier, calls out to the patient in an alarmed voice, tells him to duck gunfire, and in every possible way reproduces all the conditions of actual combat. By so doing, the psychiatrist forces the patient

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to recall the original incident which he is trying to forget because it was an extremely painful experience. Perhaps it is the death of his comrade, the fear of an air raid, the horror of having killed someone.

Once the patient recalls his experience and expresses the feelings he has covered up, he finds relief from his anxiety. The doctor then follows up each treatment in which the sedative is used with an interview of fifteen to thirty minutes. This is essential to the patient's recovery. Group sessions at which the patients are encouraged to talk over their symptoms and feelings have also proved quite helpful.

Neuroses Are Common

None of us is perfectly balanced. All of us are subject to emotional conflicts to some extent. Neurosis is one of the most common forms of emotional disorder. About one out of ten of us suffers from such disorders because of an underlying conflict. Most of these conflicts go on inside us without our knowing that they are there. We only know the symptoms: frustration, unhappiness, obsessions, strange compulsions, fears that we cannot account for, ailments that have no physical basis. The psychiatrist helps us look back of these fears, anxieties, tensions, shows us how they are connected with earlier experiences, helps us resolve our emotional conflicts. Freed of tension, we are able to solve our problems and overcome our frustrations.

In most cases these emotional difficulties do not stop us from doing our work. Neurotic people can work and take care of their personal affairs. They do need treatment, however, for their own well-being and should not hesitate to get help from a psychiatrist who has had much experience in dealing with emotional and nervous disorders. Delay in getting treatment will only bring more unhappiness, frustration, and worry.

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MOODY PEOPLE

SOMETIMES not only are emotions seriously disturbed, but the mind becomes confused and the whole personality is profoundly changed. These more serious types of illness which affect the emotional and mental life are called psychoses—a medical term for what we sometimes improperly call "insanity." The psychoses account for a much smaller number of persons who need psychiatric treatment, but because they are more easily recognized and more dramatic they are sometimes better known. Yet even the most severe form of psychosis may develop gradually, and it is sometimes easy to pass it by in the early stages, as we shall see in the cases of George and Mary.

George's Changing Moods

We are all more or less subject to changes in mood. One week we feel on top of the world. The next week we hit a slump. When these changes become extreme in nature, doctors regard it as a serious form of mental illness called *maniac-depressive psychosis*. George is an example of a person who is suffering from this illness.

Most of George's friends and business associates thought he was a hard worker who never knew a day of worry in his life. He had impressed them as one of those successful people with enough energy for three persons. He worked late into the night—was at his desk early again the next morning. They often told him he ought to take it easy, but George seemed to thrive on hard work.

He did quite well—had the highest salary in his office. Still he wasn't satisfied. Success only spurred him on to greater efforts. He began to spend his money lavishly —bought a large house, sank most of his money in a risky investment. His friends became worried about his reckless spending, but George was full of optimism, sure that

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he would win. He became more and more excited, and was in such a state that he couldn't sleep or eat.

Then George began slowly to change. He lost his feelings of self-confidence and optimism. He was no longer sure of his business judgment, stayed away from his office, sat staring into space for hours. He said that he would surely lose his job, blamed himself for having brought ruin to his family, cried out to God to spare his soul. It was in this state of depression that he sat home all day, afraid to go to the office, afraid the telephone would ring.

What Causes Moodiness?

Doctors are not so sure about the causes of these cases of extreme moodiness. Some cases seem to be brought on by grief or some emotional crisis. Others are not. But the psychology of the manic-depressive illness seems to be fairly clear. These persons become depressed because they feel that they are not attaining the goal which they have set for themselves. Most of them are ambitious. They are overly anxious to achieve success, and they often set their ideal far above what they can accomplish. When they find themselves falling short of their ideal, they plunge into the depths of despair.

Sometimes the illness may be due to childish emotional bonds to father or mother which the individual wants to break, but somehow cannot. At the same time that these persons want to have parental affection and guidance, they yearn for freedom from emotional ties and harbor a deep-seated resentment against those to whom they are closely bound. They are torn by intense inner conflict and turmoil.

Danger of Suicide

Some of these depressed people are potential suicides. Many of the stories you read in the newspaper about someone who committed suicide because of disappoint-

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ment in love or financial failure are about persons who are really mentally ill. They could have recovered and lived useful lives if their relatives had recognized their illness and placed them under treatment in time.

Many families make the mistake of thinking that the patient will "snap out of it." Melancholy persons cannot be cheered up, jollied out of their moods, or reasoned with. As soon as symptoms of moodiness are recognized, consult your physician. He may suggest psychiatric advice. If the symptoms are so severe that there is danger of suicide, adequate precautions must be taken. The psychiatrist will give advice on this point and can help the family physician and the patient's relatives make proper provisions for care and treatment. He will know whether institutional care is needed or desirable. The family should assume responsibility for seeking and following professional advice.

THE RETREAT FROM REALITY

Mary's Breakdown

Everyone said Mary was headed for big things when she went to college. She had been the best student in her graduating class in high school and seemed on her way to a brilliant career as a concert pianist. In the middle of her second year at the state university she failed in half her subjects and at the end of the year she was forced to drop out of school.

At home Mary was flighty, irritable, and moody. Her conversation came in jerks. She would start a sentence and then be unable to finish it. She wanted to be left alone, wouldn't go out of the house, stayed up late at night reading, burst into crying spells. Her family called the doctor and Mary was sent to a mental hospital.

"Mary is a victim of *schizophrenia,*" says the psychiatrist, "one of the most common forms of mental illness

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found in our mental hospitals. The word schizophrenia means 'splitting of the personality' and it is a good word for this disorder because it describes what seems to happen. These patients are physically in the real world, but mentally they are in a dream world of their own—they lose contact with reality.

"In Mary's case this withdrawal from reality results in a dull state, a complete breakdown of the will to act, to move, to survive. Mary won't eat, refuses to dress, seldom talks. She just sits all day long with her legs drawn up under her chin, gazing off into space. Lift her arm and it falls back lifeless and limp; talk to her and you get no answer—no response of any kind.

"Not all withdrawals from reality take this particular form. For example, one of our patients insists that she is the wife of a famous movie actor. Another patient believes that we are trying to poison him. Such delusions are usually found in cases of schizophrenia. No amount of reasoning will change these mistaken notions. The patient clings to them desperately because they satisfy an emotional need, and he cannot seem to check his ideas against the real facts. This does not mean that the illness is unreal. It is just as real as scarlet fever."

Why Did Mary Retreat?

Mary was an unhappy, lonely child dominated by a mother who never let her child play with other children, made all Mary's decisions for her, kept her weak and

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dependent. Consequently, Mary was never strong enough to assert herself or rebel against her mother's tyranny. She may have wanted to rebel, but she could never bring herself to do it. The problems which Mary faced and the strain they put on her emotional life were too great for her. She had no friends to whom she could go. Her father was too absorbed in his own problems to give her any attention. Mary turned inward, withdrew completely from those around her, and finally broke under the load.

Doctors aren't entirely certain that this is a complete explanation of how schizophrenia develops. Some of them believe that this psychological explanation isn't the whole story and that someday we shall find an organic cause for schizophrenia. Perhaps it is some complicated bio-chemical process we haven't yet disovered. Probably the cause will be found neither completely in the body nor entirely in the mind—but in both together. For after all, man is a living being. Part of this living being is physical, but another part of it is mental and emotional.

Hopeless Cases?

Even though we don't know all about the causes of schizophrenia, it can frequently be cured. Cases like Mary's would probably have been labeled incurable twenty years ago. But medical science has developed new and more effective ways of treating schizophrenia. In many hospitals shock treatment—insulin or electric—and modified forms of psychoanalysis are bringing good results.

For example, here is a patient who before his treatment was confused and bewildered, and talked to imaginary voices. The doctor walks up to him.

"Good morning."

"Hello."

"Where are you?"

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"I don't know for sure. You're a doctor, aren't you?"

"Yes, do you remember me?"

"Maybe. I think I've seen you before."

"Do you hear any strange voices talking to you, John?"

"Voices? No, not now. I do hear them though, sometimes."

"I know. That's why we're giving you these treatments, to help you get rid of those voices."

What a strange contrast to the incoherent, confused conversation of an hour ago. "He's much better now," the doctor explains. "Tomorrow he may slip back into the same mental confusion and emotional disturbance. But each treatment brings some improvement, brings him closer to reality, clears up some of the mental chaos. Of course, the shock treatment doesn't cure all cases, but it is one of our most effective treatments for schizophrenia."

How does insulin shock work? Medical authorities are not agreed on this. Perhaps chemical changes produced by the insulin restore the proper balance in the mental and emotional processes. Perhaps certain brain cells are destroyed, new pathways made in the brain, and normal association reawakened to functioning again. Some day medical science will discover what lies back of this miracle, but today we can only marvel and theorize.

Other Treatments

Shock treatment isn't the only therapy for patients like Mary. Work is one of the mainstays for rebuilding wrecked personalities. It helps the patient gain confidence in his abilities, gives him a feeling of importance and usefulness, prepares him for his return to the community, develops a sense of responsibility so essential to his recovery.

A planned recreational program can often do wonders in drawing a patient out of himself into social contact with others. In play, a patient gets to know those around

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him, starts talking, becomes responsive, friendly, and cheerful. With this renewed interest in one's fellow man comes a pride in one's personal appearance, morale goes up, the process of learning to live with others develops.

Psychiatrists can often help these patients get well through friendly understanding and scientific knowledge of how the mind works. Once the patient knows that the psychiatrist does not blame him for his abnormal behavior, he feels freer to talk with him about his problems; he may tell the psychiatrist about feelings that he has never talked about to anyone else; he may express fears that disturb him which he has never dared mention before. The assurance and insight which the patient acquires helps him reorganize his emotional life and speeds recovery.

All of these influences—known technically as psychotherapy, occupational therapy, and recreational therapy—provide a friendly environment in which sick minds can become well again.

OTHER MENTAL ILLNESSES

SCHIZOPHRENIA (which accounts for about 20 per cent of all patients admitted to our mental hospitals) and manic-depressive psychosis (10 per cent of first admissions) are sometimes referred to as *functional psychoses.*

There is another group of mental diseases called the *organic psychoses* because they are known to have a definite organic basis. Among these are *psychosis with cerebral arteriosclerosis* (hardening of the arteries of the brain) and *senile dementia,* both of which come with old age and are due to the breakdown of the human machine. These two types of mental disorders account for almost 22 per cent of the patients admitted to our hospitals, and there are strong indications that they will make up even a larger percentage of chronic cases in the future.

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General paresis is caused by the attack of the syphilis germ on the brain. About 7 per cent of all patients admitted to mental hospitals are victims of this disease. Basic nerves are affected, legs and arms move in a disjointed, awkward manner, speech is difficult, and in advanced stages total mental derangement results. Malaria treatment and artificial fever therapy are proving effective in combating neurosyphilis. Regular injections of antisyphilitic chemicals or drugs can usually stop the disease in the early stages.

OTHER DISORDERS

Psychopathic personalities are persons who show lack of emotional maturity, unwillingness to take responsibility, emotional instability. They may be impulsive or socially antagonistic—lie, steal, and are sometimes sexually perverted. Some psychopathic personalities are addicted to drugs or alcohol.

Alcoholism, especially when it becomes chronic, is a form of personality disorder. In extreme cases, toxic effects result in delirium tremens, which is characterized by tremors, fears, and hallucinations.

Mental deficiency, or feeblemindedness, is an arrested development of the brain. Mental deficiency cannot be cured in a medical sense. It is sometimes difficult to know whether a child or adult is feebleminded, but special tests given by experts can determine his limitations. Contrary to popular opinion, most feebleminded children can be given special training and taught to do manual work. It has been estimated that there are more than 1,500,000 mentally deficient persons in the United States.*

There are still other disorders in which personality

* See *Forgotten Children, The Story of Mental Deficiency,* National Mental Health Foundation, Inc. Philadelphia, Pennsylvania.

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changes may occur. Sometimes serious mental illness develops, though in very many cases the mind is unaffected. A few of these disorders are listed below.

Brain tumors or other injury to the brain tissue may interfere with certain functions of the nervous system and affect the legs, arms, speech, or sensory mechanism. Only about .5 per cent of first admissions to mental hospitals are classified in this group. Brain surgery may sometimes remove the cause of the disorder in certain types of tumor and restore proper functioning of the brain.

Encephalitis, or sleeping sickness, and *multiple sclerosis* are also organic neurological disorders.

WE CAN CUT THE TOLL

EACH year serious mental illness strikes thousands of new victims and takes its toll in human suffering and misery. Each new case means a promising career cut short, another family without a mother or breadwinner, a tremendous social and economic waste. Translated into dollars and cents, the cost of mental illness in lost earnings amounts to almost a billion dollars each year. The other costs of nervous and personality disorders greatly increase this burden. What can we do to prevent this terrific human and economic loss?

Safeguarding Our Children

First of all, we can safeguard the mental health and happiness of our children. Prevention starts at birth. A baby is a bundle of desires and wants. He wants to be fed, to be otherwise physically comfortable. When these wants go unsatisfied the baby becomes restless, begins to cry. Feed him or change his diaper and he stops crying. If you fail to satisfy these basic desires, his whole organism is affected—his emotional life gets out of balance,

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he feels frustrated and unhappy. Most important of all —give your baby the love he needs and wants. Without this love and affection, he feels lost. The strange new world into which he is born is "a buzzing, booming confusion." He needs to feel secure and protected, and he looks to his parents for this sense of security and protection. Don't fail to give it to him.

Helping Them Grow Up

The time comes when babies must grow up and learn to do things for themselves. Some babies find it hard to break away from their mothers, and some mothers find it hard to give up their babies. Don't keep your child tied to your apron strings all his life. He needs to explore things, learn to get along with other children, and cooperate with them successfully. Encourage him to dress himself, to develop new skills as he grows older. Give him freedom. If you hedge him in with all kinds of unnecessary do's and don't's, he will be irritable, unhappy, and bad-tempered.

Don't make invidious comparisons

Give him a feeling of self-confidence by showing pleasure at what he does well. And don't compare him unfavorably with other children or with his brothers and sisters. Remember that each child has his own characteristics and rate of development. Youngsters are sensitive and feel inferior and unloved when you do this. A child needs all the self-confidence that he can muster and you can help him develop it.

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When They Are Afraid

All of us are afraid. It is no wonder that children have fears. Sometimes children catch their fears from parents—become afraid of snakes because mother is afraid of snakes. Some fears are caused by a feeling of insecurity. A family quarrel, for example, can make the child very disturbed and fearful. Some parents deliberately frighten their children with threats of bogeymen, goblins, or policemen. This is extremely cruel.

One way to get attention

It is a mistake to try to shame the child out of his fears because they are very real to him. A feeling of being loved, calm assurance, and an explanation that there is nothing to be afraid of is the best cure. You can sometimes take the child's mind off his fears by telling him an exciting story or getting him to play his favorite game. Often just the physical presence of the parents is enough to give the child a feeling of security.

What To Do With Johnny

"I don't know what I'm going to do with Johnny. He won't go to school half the time, and when he does go the teacher sends notes home that he has been a bad boy." This is an old story—Johnny's not getting along well in school.

Why is he loud and why is he always getting into trouble? Maybe it's the only way he has of getting a reputation for himself. Maybe he can't work arithmetic problems as fast as Jimmy or play ball as well as Harry. Consequently, he feels inferior—he, too, wants recogni-

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tion. Making noise is one way of getting it. He becomes anxious and loses his self-control.

Why doesn't he want to go to school? The reason he gives may not be the real one. The real trouble may not be school or Johnny, but something no one has taken the trouble to find out. Maybe he hates his father. Every-time Johnny thinks of school he thinks of father. Why? Because in school you have to behave yourself, and if you don't you get punished. So Johnny stays away from school because it reminds him of father's authority, father's scolding, father's whipping.

Once we have learned to understand why Johnny acts as he does, we can begin to help him with his problems. In many communities mental hygiene clinics and child guidance centers do this very thing. Frequent conferences between teachers, parents, social case workers, child psychologists, and child psychiatrists can do a lot to change Johnny from a misunderstood boy to a happy one.

About Sex

About the time that Johnny starts to school (if not considerably sooner) he becomes interested in sex. He will probably begin to ask a lot of questions about it. The chances are he has heard a number of things about sex from other children at school. Maybe he will begin showing off some obscene words he has learned—words of which he doesn't know the meaning. He will probably play with his genitals.

This is not the time to take Johnny behind the woodshed or give him a good "talking to." From then on he might not mention any more "bad words" but he would think about sex more than ever. (Sex is much more interesting when we make it obscene and forbidden.) Answer Johnny's questions directly and honestly. You will have taken away the false notion that sex is wrong and sinful, and his curiosity will be satisfied.

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Unhappy Grown-ups

Some of us grow up unhappy and stay unhappy. We never quite know why. We just have the feeling that our lives lack something, that we aren't up to our best. We are dissatisfied with ourselves. We see others succeed, and we feel that we have failed. We worry about the future, develop all kinds of anxiety about ourselves and our family. Or we may feel guilty about something we have done and blame ourselves without reason. Maybe we feel "mixed up inside," torn first one way and then another, unable to make decisions and unhappy after we have made them. Somehow we aren't able to "pull ourselves together."

These mental conflicts not only cause us to be unhappy, but they wear us down emotionally, tire us out physically, and if they remain for a long time, finally cause us to reach the breaking point. We need to face these conflicts and problems openly. This may be hard to do. Some of our feelings are very sensitive. We may not want to talk about them or even think about them. All the more reason for bringing them out into the open where they can be examined and dealt with intelligently. It is when we suppress these conflicts that they cause us most of our trouble.

What Kind of World?

Some of our mental breakdowns are caused by the kind of a society in which we live—a highly competitive society in which there are few winners and many losers. The drive for success puts an added strain on living, and some can't survive the struggle. Everyone is in competition with everyone else—not only for economic gain, but for esteem, love, respect, and recognition. The impact of competition is felt even in the family. Brothers and sisters vie with one another for the affection of their par-

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ents, sons are rivals of their father's for the affection of the mother, and daughters are rivals of the mother.

Competition brings with it hostility. Since everyone is a rival, we view one another as enemies, each seeking a share in the stake. Competition also brings with it feelings of inferiority because it means that the fear of failure haunts us. We feel that we must succeed and our self esteem suffers if we fail. Hostility, fear of failure, a feeling of guilt, insecurity — these are the things out of which neuroses are made.

Two worlds

Our society places a great deal of stress on money. We must keep up with the Joneses. But the majority of us can't get all of the things we want. The result is frustration and dissatisfaction. For a still larger number of persons, our economic order has even more drastic consequences—the anxiety which comes from low wages and fear of unemployment.

Conflicts within our personality are often embedded in our culture. For example, on the one hand we are taught to love one another, and on the other hand everything is done to spur us on to success at the expense of our fellow men. We are told that we are free to make our mark on the world, but we find that we are limited and hedged in by social convention and circumstance. It is no wonder that these contradictions in our culture reflect themselves in our emotional life and pull us in opposite and wholly different directions.

We are trying to reduce these conflicts in order to can provide a happy, normal life for all our people. Laws

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are passed to give us economic security and remove the fear of hard times. Our schools are placing less emphasis on competition and more on cooperation. We are beginning to recognize that every person has his own limitations, and his success must be judged in terms of his own particular abilities.

Parents are learning about child training and psychology. We are trying to help people make a success of marriage. Social workers are helping people with their personal and family problems and are also assisting courts, psychiatrists, and schools in working with warped per- provide a happy, normal life for all our people. Laws sonalities. Teachers in public schools are taught to recognize emotional disturbances and how to deal with problem children in the classroom.

Industry is beginning to see why the mental health of workers is important. Enlightened personnel practices under the direction of a competent industrial psychologist and social case worker can serve as an effective prevention measure. Theological students are now being trained in many seminaries to understand psychiatric problems and get first-hand contact with mental disorders in clinical training courses.

These are all important steps toward cutting the toll which mental illness takes. But more needs to be done.

The Dark Past

Ancient man's cure for mental ills was magic. Strange rituals were concocted to drive out evil spirits that were causing the derangement. During the Middle Ages this primitive practice persisted. Even as late as the 18th century mentally ill persons were hanged, imprisoned, tortured, and persecuted as agents of Satan, chained in kennels like wild beasts, jailed and flogged, or left to wander about naked and starved.

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ONE OUT OF EVERY 22 SPENDS PART OF HIS LIFE IN MENTAL HOSPITAL

Coming of Age

The middle of the 19th century brought in a new day in the concept of mental abnormality as an illness, and in the scientific treatment of sick minds. Discoveries in neurology, endocrinology, and related fields, and a growth of humanitarian pity for the sick brought new hope to the mentally ill. In 1896 Emil Kraeplin presented to the scientific world the first organized classification of psychiatric disorders. Freud was outlining his new approach to the understanding and treatment of neuroses about the same time, and Adolf Meyer was developing his mind-body approach; Wagner-Juaregg was curing neurosyphilis with fever treatment in 1917; Manfred Sakel announced insulin shock treatment in 1933.

NEEDED: A NATIONAL MENTAL HEALTH PROGRAM

THE problem presented by nervous and mental diseases is an enormous one—the most serious medical problem facing our nation. Out of every twenty-two living persons, one will spend part of his life in a mental hospital. Recent studies indicate that one out of every ten persons in the United States is emotionally or mentally maladjusted and needs treatment for some personality disorder. More than half the patients who visit their family doctor for some physical ailment are really suffering from some type of emotional disorder. Nervous and mental disease takes a larger toll than do cancer,

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infantile paralysis, and tuberculosis combined. How can we cut this toll?

We Need More Clinics

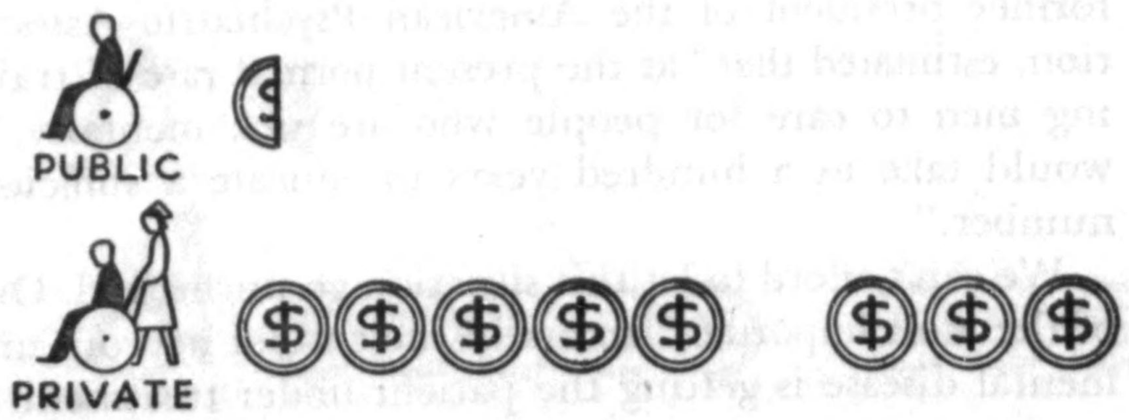
We can cut the toll if we have more mental hygiene clinics where parents can come to talk over with trained persons their own problems and the problems of their children. These clinics can sometimes ward off an impending illness by giving prompt treatment and save persons who might otherwise have serious breakdowns. In other cases life is made more bearable and productive.

Every community should have such a center. Yet there are twenty-five states which do not have even one clinic and there are vast areas of other states where no psychiatric treatment can be had. We have only one-fifth of the number of clinics we need. Experts are now at work planning the best methods of setting up clinics throughout the country, but wider support is needed for such measures if the job is to be done effectively.

Better Hospitals

Maintaining our public institutions for the care of the mentally ill costs us over $200,000,000 dollars each year. Yet these funds are not enough to maintain minimum standards of physical well-being. Some of our states spend

SOME STATE HOSPITALS SPEND ONLY 40¢ A DAY PER PATIENT WHILE PRIVATE HOSPITALS SPEND $8



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as little as forty cents a day to care for each patient as compared to private institutions which spend upward from $8.00 a day a patient. In some instances, state-supported institutions spend only seventeen cents a day a patient for food. Some of our public institutions are now crowded to almost twice their capacity. Mentally ill persons are forced to stay in buildings that have been condemned because there is no money available for new structures. Few new hospitals are being built and most architectural plans follow traditional but outmoded patterns.

More Psychiatrists

A good hospital needs enough doctors, nurses, and attendants to give each patient the care that he requires. When one doctor has to care for as many as 1,000 patients (as is the case in some instances) he simply can't give intensive and individualized treatment. Authorities estimate that we need at least four times as many psychiatrists as are now available.

Now let's take a look at what we are doing to make up this tremendous deficit. If a medical student wants to go into psychiatry as a career, he first must serve as a resident doctor attached to a hospital approved by the American Psychiatric Association. There are less than 300 vacancies available each year in approved centers for psychiatric training, and in December, 1944, there were only 237 residents in training. Dr. Edward Strecker, former president of the American Psychiatric Association, estimated that "at the present normal rate of training men to care for people who are sick mentally, it would take us a hundred years to educate a sufficient number."

We can't afford to let this situation go unchecked. One of the most important factors in the cure of nervous and mental disease is getting the patient under treatment at

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the earliest possible date. The longer the patient goes without treatment, the slimmer are his chances of recovering. With the severe shortage of doctors, nurses, attendants and other staff facing our hospitals, patients go too long without any specific treatment and eventually are added to the growing number of chronic cases that are already overcrowding our institutions.

More Psychiatric Nurses

We need five times the number of psychiatric nurses now available. It is not uncommon to find only one nurse for 1,000 patients in our state hospitals. Under these conditions, standards drop to a dangerously low level. Nursing care is summed up in these brief notes: "Patient bathed once per week; shaved two times per week." This is not scientific care. It does not even come up to the standards we maintain in our almshouses.

The training of nurses lags far behind the need. Of the 1,307 accredited nursing schools in this country, only 32 are located in mental hospitals. Fourteen states have no training course in psychiatric nursing. Yet more than half of all the hospital beds in this country are occupied by mental patients.

More Trained Attendants

We can't have good hospitals without good attendants, and good attendants are hard to get—especially at the paltry wages some of our state institutions pay. Attendants are seldom given any training in the proper care of the mentally ill and have no understanding of emotional and mental disorders. Sometimes they are neglectful, abusive, and brutal.

But there are not even enough of such untrained, incompetent attendants available to meet minimum requirements. Often one attendant is placed in charge of more than one hundred patients. Most institutions hire

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anyone who applies for the job, and put him on the wards without any instruction. No licensing or training of any kind is required to carry out the very important job of caring for those who are mentally ill.

More Scientific Research

In the development of scientific investigation of the causes and treatment of mental disorders lies our chief hope for the future. Yet a study made several years ago showed that out of our 557 institutions caring for psychiatric cases, only twenty-nine were engaged in some active research project. Less than 20 per cent of our public institutions can be designated as research centers. Without scientific research, our institutions become stagnant, scientific interest dies for want of encouragement, and the patients suffer for lack of care and treatment.

More Psychiatric Wards

Although modern medical science recognizes the close interdependence of the physical, mental, and emotional processes, most of our general hospitals have no facilities for diagnosing or treating psychiatric diseases. This means that the term "general hospital" is wrong, since it really excludes the large number of patients who suffer from disorders that are definitely mental or which are complicated by mental factors. If the patient is to be assured that he will receive an accurate diagnosis when he comes to a general hospital, psychiatrists will be needed on the general hospital's staff. Only about a hundred general hospitals have taken this necessary step. And only about fifty of them have separate wards for diagnosing and treating mental diseases.

Legal Reform

In most states the law does not come near providing the kind of protection and care for the mentally ill that

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it should. Often legal procedure runs counter to the best interest of those it should protect. Patients are compelled to face the humiliation of court commitments as if they were criminals, are "detained" in jails for thirty days or longer, taken to the hospital by police officers,

A MENTALLY ILL PERSON IS NO CRIMINAL BUT THIS IS THE WAY HE IS TREATED

deprived of their civil rights. Far too often there is no provision for impartial, frequent inspection of institutions or adequate supervision of their administration. Most states fail to provide any help or service to the patient during the crucial period after he leaves the institution.

Thorough revision of the law is needed to correct these practices and bring our legal treatment in line with a scientific and enlightened attitude toward the mentally ill. State legislatures have been largely indifferent to re-

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vising their statutes or providing adequate funds for the care of their mentally ill.

What Is Being Done?

Various professional organizations are trying to meet the problem of nervous and mental disease. The American Psychiatric Association sets up standards for care in psychiatric hospitals, encourages the training of psychiatrists, psychiatric nurses, and psychiatric aides. It furthers psychiatric education and research, and the development of out-patient clinics and all other agencies concerned with the social and legal aspects of mental disorders. The Association publishes the *American Journal of Psychiatry*. Offices of the organization are located at 9 Rockefeller Plaza, New York City. Austin M. Davies is the Executive Assistant.

The Commission on Hospital Care of the American Hospital Association is encouraging the development of psychiatric wards in general hospitals. Some training centers are being established to train psychiatrists and nurses. A heartening recent development was the establishment of the Menninger Foundation School of Psychiatry at Topeka, Kansas, in October 1945. The school is assisted by the cooperation of the Veterans Administration and plans to receive 150 doctors in successive classes for graduate training in psychiatry. A large proportion of the doctors and psychiatric aides now being trained enter service with the Veterans Administration.

Government Aid

The National Mental Health Bill, introduced to Congress in 1945, shows promise of closing some of the gaps in our facilities for the treatment of mental disorders. Recognizing the need for more psychiatrists and therapists, the bill authorizes the United States Public Health Service to form a National Institute of Mental Health to

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serve as a center for training and research. The bill also makes provision for grants-in-aid to public and non-profit institutions for training interns and residents in psychiatry, and makes liberal provisions for fellowships in psychiatry in graduate medical schools.

The bill is not designed to furnish federal funds for the routine care of patients in mental hospitals. Rather, it provides for a program of early diagnosis and prevention in order to reduce the number of patients needing long-term care. To meet this need for an effective program of prevention, grants can be made to the states for the establishment of centers for prevention and diagnosis. A National Advisory Council composed of six leading medical or scientific authorities is to be responsible for reviewing research projects and providing information about mental health. The bill will greatly expand the present advisory services of the United States Public Health Service.

Laymen Are Helping

Professional organizations and government agencies are not the only ones who are working for a more adequate mental health program. State societies for mental hygiene and other citizen groups are active in expanding facilities in their local communites for the treatment and care of the mentally ill. Some state societies are organized by professional persons; in others, laymen carry on the program. Every citizen has a stake in the work of his state mental health organization and should give his support to its efforts for bringing better understanding of the prevention and treatment of mental disorders.

National organizations are developing nation-wide programs of public education for the improvement of services to the mentally ill. The National Committee for Mental Hygiene, founded in 1909 by Clifford Beers, who had been a patient in a mental hospital himself, works for the conservation of mental health; the reduc-

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tion and prevention of mental disorders and defects; improved care and treatment of persons suffering from mental diseases; special training and supervision for the feebleminded; and the issuing of reliable information on these subjects and on behavior problems in such fields as education, industry, delinquency, and dependency. The Committee publishes occasional bulletins on psychiatric rehabilitation and two journals: *Mental Hygiene* and *Understanding The Child.* Dr. George S. Stevenson is medical director of the organization, whose headquarters are at 1790 Broadway, New York City.

The National Mental Health Foundation, more recently established, sponsors a nation-wide program of public education to create a better understanding of mental disorders, their prevention, and cure. Its purpose is to correct false beliefs about mental disorders, cooperate with other agencies in stimulating research and training and in providing better care and treatment for the mentally afflicted, and replace outmoded laws with enlightened legislation. A magazine, *The Psychiatric Aid,* and handbooks published by the Foundation for psychiatric aides and attendants in mental hospitals and schools for mental deficients, give institutional workers a better understanding of the proper care and treatment of the mentally ill and deficient. Headquarters of the National Mental Health Foundation are located in Philadelphia, Pennsylvania (address Box 7574).

WHAT *YOU* CAN DO

YOU can join with others in the fight against nervous and mental disorders by supporting those organizations that are working for the improvement of mental institutions, pressing for enlightened legislation, and helping to establish centers for prevention, treatment, and research.

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You can help by acquainting yourself with the truth about mental illness—how it develops, how it is treated, and how it can be prevented. You can treat mentally ill persons as sick persons in need of sympathetic understanding and scientific, humane care. You can convince others to take the same intelligent attitude.

You can see to it that your community provides facilities for prevention and early treatment. Good hospitals and clinics won't come by just wishing for them. They will come only when an enlightened citizenry sees the need for them and is willing to spend the money it takes to operate them. In a democratic society, each of us is responsible for all matters of public concern. We cannot blame others unless we have done everything we can to see that these needs are met.

The fate of the 8,000,000 persons who would profit from expanded psychiatric services hangs in the balance —people like Fred, George, and Mary—people who are your neighbors, your friends, and your relatives. We are accountable to them. We must not fail.

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First Edition, August, 1946

Printed in the United States of America

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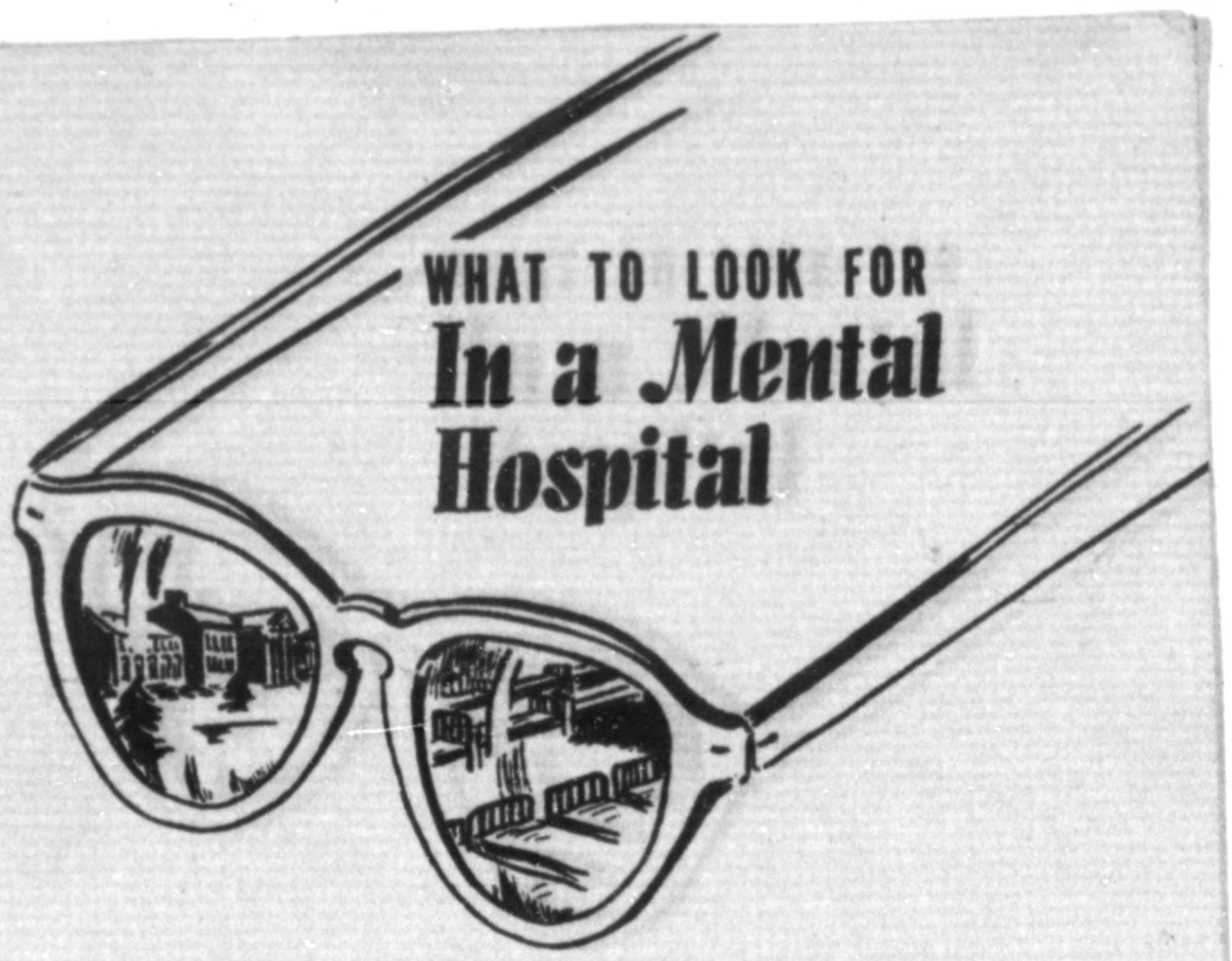

WHAT TO LOOK FOR *In a Mental Hospital*

What kind of care does your state give to its mentally ill? This is a question which concerns YOU. You are the taxpayer who foots the bills. You are the citizen the state serves. You are the one who decides whether the three-quarters of a million patients in our mental hospitals are neglected and abused or whether they are given the best treatment possible.

One way to find out about conditions in your state mental hospitals is to visit them and get your information first hand. Your friends, and members of your club, church or civic organization can join you in your visit and make it a profitable and interesting group project. It might be advisable to write a letter to the superintendent in advance so that you will make your visit at a convenient time.

After you arrive, explain to the superintendent that you feel a responsibility for providing good care for the mentally ill in your state; that you want to know more about his institution—the good and the bad—so that you can be helpful to him; that you realize he may be working under handicaps.

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ASK THE SUPERINTENDENT

1. How many doctors on his staff are members of the American Psychiatric Association. Since practically all trained psychiatrists belong to the APA, the answer will help you form an opinion as to how competent his medical staff is.

2. How many patients each doctor is responsible for. On the average, there should be one full time doctor for every 150 patients.

3. Whether he feels that special treatments (such as electro-shock, insulin shock, hydrotherapy and malaria treatment are being used extensively, or whether he feels that more patients should be receiving such special therapies.

4. Whether the hospital is carrying on any research to discover the causes and cures of mental diseases.

5. What the hospital pays its doctors, nurses and attendants. Do wages and hours compare favorably with those in other occupations demanding the same training and involving the same responsibility?

Ask to see the back wards as well as the good wards. Here are some of the things you can observe:

1. The condition of the buildings—are they run down and in need of repair?

2. Are the toilet facilities adequate and clean?

3. Do the buildings give the appearance of a prison or a modern hospital?

4. Do the wards smell bad?

5. Are the patients reasonably neat and properly clothed?

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6. Do the attendants and nurses show an understanding and sympathetic attitude toward the patients?

ASK THE NURSE

1. How many patients are on the ward—how many patients the ward was built for.

2. How many patients she takes care of. On wards where active treatment is being given, there should be at least one nurse for every thirty patients and every ward should have at least one graduate nurse.

3. If she has had any special training in psychiatric nursing.

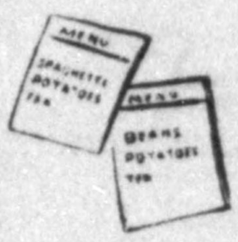
ASK THE ATTENDANT

1. How many patients he has under his supervision. There should be at least one attendant to every twenty patients on the average ward.

2. What kind of instruction he received in caring for mental patients when he came to the hospital. Does he feel that the training was as helpful as it should be?

3. What he does when patients become disturbed and overactive. Does he have to have the doctor's order for putting a patient in restraint?

4. If he has an opportunity to talk with the doctor and nurse about his patients' welfare.



Visit the kitchen and dining room. Are they clean and sanitary? Are precautions taken against contamination? (Refrigeration, screens, good health of kitchen workers, etc.) Ask the dietician how much is spent per day per patient for food. Get a menu. Compare it with what is actually served the patients.

Ask to see the occupational therapy department. Find out what percentage of the patients get occupational therapy, how many are left to sit idle on the wards. Find out if worker patients—those who do much of the cleaning and maintenance work at the institution—are given due consideration such as days off and a reasonable amount of free time.

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Find out what is being done to provide recreational activity for the patients.

Find out if there are religious counselors and religious services available to the patients.

Before you leave find out whether the institution has an out-patient clinic where people can come for treatment. Also, whether it has an adequate staff of social workers to help patients with their problems when they leave the hospital. There should be one social worker for every hundred patients admitted to the hospital in one year. Find out what percentage of patients are discharged each year and compare this with the rate of discharge in other hospitals.

When you go home think over the situation. If you come to the conclusion that you have provided good facilities for the treatment of the mentally ill in your state, write a letter to the superintendent and ask him if he agrees. If your impression of the institution is unfavorable, point out to the superintendent where you think the hospital is falling down on the job and ask him if he agrees. Ask him what you, as an interested citizen, can do to help improve your hospitals.

You can join the National Mental Health Foundation, Inc., in its program for the improvement of services to the mentally ill and support the work of the local mental health organization in your community. The well being of the three-quarters of a million persons in our institutions depends on your efforts to see that they get the care they need.

Single copies of this leaflet are free. Quantity rates given on request.

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IF YOUR CHILD IS SLOW

Your child may learn more slowly than others. This is not necessarily a sign that he is below normal in intelligence. Sometimes a child who is mentally normal is kept from doing his best by difficulties that are physical or emotional. But it is true that slowness in learning *may* be an indication that your child has definite mental limitations.

If there is serious doubt about the mentality of your child, he should be given an intelligence test. This service is available at little or no cost from schools, welfare agencies, departments of health and mental hygiene clinics. The results of such an examination will be kept confidential, and the testing agency, though it may offer helpful advice, will make no plans for your child's future without your consent.

If an intelligence test shows that your child is handicapped mentally, this little booklet will help you to understand him, so that you can help him make the best of the abilities he has.

CAN MY CHILD GO TO SCHOOL?

If your child is feeble-minded (mentally deficient) there will be a definite limit to what he can do. He will not be able to compete with children his own age, and it is unreasonable to expect him to do so.

Whether he should go to school depends on his mental ability. If he is a high-grade mentally-deficient child, he can learn manual arts in special classes. If he is in the middle grade, he can perhaps go through the third grade in school. Children who are low-grade deficients should not be sent to school at all. Talk this problem over with the principal of the school and the psychologist at the clinic. They will arrange for the proper placement of your child.

Don't try to keep your child in school beyond the point where he can learn. Some parents are over-anxious to push their child along. This causes the handicapped child to become discouraged and he may not try to do even the things he *can* do. The teacher can gauge your child's rate of learning and is the best judge of how much he can benefit from further school work. Some schools have special classes for retarded children. If your school does not have such classes, see what can be done to get them started.

WILL HE BE A BEHAVIOR PROBLEM?

Not necessarily. Some mentally deficient children are restless and unmanageable, but a mentally deficient child is not always a problem child. He can become a likeable, attractive person. Like normal children, he has his own personality.

Only a small percentage of mentally deficient children become delinquent. Since they are more suggestible than normal children, the mentally deficient may be misled by unscrupulous persons or older delinquent boys. Adequate supervision and, in some cases, in-

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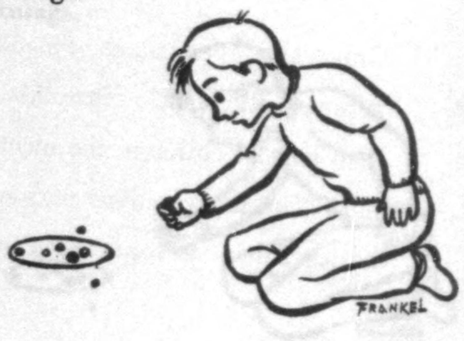
stitutional care, is needed to protect your child from delinquent behavior.

WILL HE BE ABLE TO EARN A LIVING?

A large number of mental defectives are able to support themselves under proper guidance and supervision. Others earn spending money and can do simple but useful jobs at home and in the neighborhood. It is not possible to make any general statement about what your child can or cannot do. The chances are that if his ability is not too limited, he can do some suitable routine work under supervision. Proper training will help him make the grade. He should be taught to save his earnings.



WHAT CAN BE DONE FOR HIM?

You can do much to help your child by giving him good training and proper discipline at home. Nearly all methods which are recommended for the care of normal children apply to the care of the mentally deficient child. You will need to have patience and make allowances for his slowness. You can train your feebleminded child to have agreeable manners and a pleasing personality. This will help him to get along well with other people, and will do much to offset his mental limitations.

You can discipline your feebleminded child by giving rewards and withholding privileges, much as you would a normal child. Many parents are too lenient, others too severe. A good rule to remember is that discipline does not have to be severe to be effective, but it must be consistent. You will find that, like the normal child, your mentally retarded youngster will

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not do things which always occasion unpleasant results.

Don't make the mistake of keeping your child penned up like a prisoner. He needs recreation just as normal people do. If he cannot play with children his own age, let him play with younger children.

If the strain of caring for your child becomes too great, or if he becomes unmanageable at home, it may be wise to give him the advantages of an institution. Here he will be supervised and trained, and find companionship with others. If he responds well to the training he receives, he may return home after perhaps two to five years. On the other hand, it may be wise for him to stay at the training school indefinitely. Arrangements for admitting your child to a training school can be made through one of the welfare agencies or mental hygiene clinics in your community. In some cases, feebleminded children can be cared for in foster homes or in day nurseries. This will relieve the family temporarily from the strain of caring for a difficult child. Your social agency can tell you more about such arrangements.

You may be able to find two or three mothers of other feebleminded children who are willing to take turns with you in caring for each other's children. This will give all of you more free time.

You should face the fact that if your child is feebleminded he cannot be cured. While he can learn to do some things, he will never be able to do all the things that normal people do, or have the judgment that normal people have. This may seem hard to accept, but once you do accept it, you will want to set about doing the best you can for your child. You will help him to make the most of the abilities he has, but you will not expect him to do more than he possibly

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can do. That would not only be unfair to him, but it would also spoil his disposition. And remember to give him credit for doing his best. As long as it is his best, he deserves just as much credit as the most brilliant child in the world—indeed, even more, since most of us with normal minds seldom make the best use of them!

An encouraging pat on the back will do a lot to spur your child on. He wants affection and he should have his full share of it for the proper development of his personality. Even his feeble mind knows when you are giving it to him.

PUBLISHED BY

THE NATIONAL MENTAL HEALTH FOUNDATION
BOX 7574, PHILADELPHIA 1, PA.

Single copies, 8¢ each. Quantity rates and a list of other publications in this field are available upon request.

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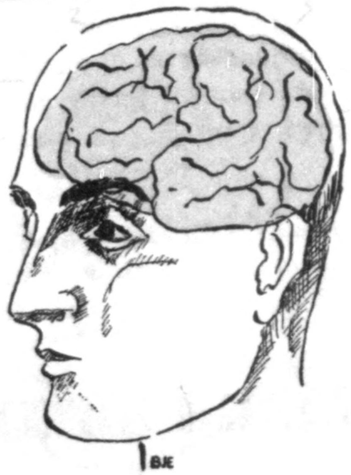
ONE OUT OF TEN



One out of ten persons in this country is in need of treatment for some emotional or mental disorder.

One out of twenty will spend part of his life in a mental institution.

Each year mental illness sends a quarter of a million persons to our mental hospitals. It reaches into one family out of every five, brings untold misery and suffering to hundreds of thousands.

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HOW CAN IT BE PREVENTED?

By providing clinics where people can come to talk over their problems and receive help before their illness becomes serious.

By parents giving their children the feeling of being wanted and loved—helping them grow up mature and self-sufficient adults, free from fear and emotional conflict.

By teachers, parents and social workers discovering early symptoms of disorders and seeing that they receive immediate attention.

By building the kind of a world in which men are free from fear, insecurity and frustration.

CAN IT BE CURED?

Yes. Most of those who are mentally ill are not hopeless cases.

With proper treatment and care, about half can recover—lead happy, normal, useful lives.

Psychotherapy helps these patients overcome their anxiety and worry. Occupational and recreational therapy get them back to normal living again.

Special treatments such as fever therapy, shock therapy and brain surgery are curing disorders which were once called incurable.

Kind and humane care can make comfortable those who cannot leave the institution.

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WHAT CAN YOU DO?

You can acquaint yourself with the truth about mental illness—how it develops, how it can be prevented, how it is treated.

You can convince others that mental disorders are not shameful, that mentally ill persons are just sick persons in need of psychiatric care.

You can join the National Mental Health Foundation in its nation-wide program for creating a better understanding of mental illness.

You can help the Foundation bring the best possible care to America's mentally ill, see to it that enlightened legislation is passed to protect those whom mental illness strikes.

You can obtain further information about mental illness and mental deficiency by writing to the

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WILL THEY BE CURED?

Eight million Americans are mentally or emotionally ill. They are not hopeless cases. They are sick people who are in need of the best treatment we can give them. It is up to us to see that they get it. Here is what you can do.

FIND OUT THE FACTS

ABOUT MENTAL ILLNESS . . . What it is like, how it develops, how it is cured, how it can be prevented.

ABOUT YOUR INSTITUTIONS . . . Are they overcrowded? Do they come up to professional standards? Do they use the best methods of scientific treatment? Do they have enough doctors, nurses, therapists, attendants, or aides?

ABOUT YOUR COMMUNITY . . . Does it have out-patient clinics where treatment is given before the patient becomes seriously ill? Does it have child guidance clinics where teachers and parents can talk over the problems of their children with some person who has been trained in child psychology? If not, is there some person or agency who recognizes mental illness and makes necessary referrals? Do your schools have special classes for exceptionally bright children? For children who are slow in learning?

ABOUT YOUR LAWS . . . How are mentally ill persons committed to hospitals in your state? Do your state laws provide for the proper protection of the mentally ill?

THEN ACT

VISIT YOUR INSTITUTIONS for the mentally ill and the mentally deficient. Find out whether they are doing a good job of caring for their patients. If not, find out why not. Is it because the personnel is incompetent? Do you, the citizen of the state, provide enough money for proper care? Are the citizens in your state uninformed and indifferent?

ASK THE SUPERINTENDENT what you can do to help him solve his problems. Perhaps you can do some volunteer work at the hospital or give home care to patients who are well enough to leave the hospital.

INTEREST OTHERS . . . your minister, the president of your club, your neighbors, your friends. Arrange for speakers, discussion and study groups. Most people don't know what mental illness is like. They have never been told what a large toll it takes. They do not realize how important it is to prevent and cure mental disorders. Talk with them about conditions in your state. Convince them that action must be taken. Tell them about the Mental Health Foundation. We will be glad to send you literature for free distribution.

CONTACT YOUR LEGISLATORS after you know what the facts are. Tell them the facts. Show them what your state needs. Urge them to appropriate more money for preventive work and for the care of the mentally ill in your state. Convince them that it is penny wise and pound foolish not to spend the money needed to prevent and cure mental illness.

JOIN OTHERS in the fight against mental illness. There may be a Mental Hygiene Society in your state. If so, join it. If not, help organize one. Support the National Mental Health Foundation in its nation wide program for creating a better understanding of mental illness. Help it bring the best possible care to America's mentally ill.

SEND FOR THESE

THE TRUTH ABOUT MENTAL ILLNESS
Essential facts given in brief readable form.

UNDERSTANDING THE MIND
A list of books for further reading.

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WHERE DOES YOUR STATE STAND
Shows how your state's institutions compare with those of other states and with professional standards.

WHY A CITIZENS' NATIONAL MENTAL HEALTH PROGRAM
WHY A CITIZENS' STATE MENTAL HEALTH ORGANIZATION
Show the part citizens' groups play in improving the nation's mental health.

WHAT TO LOOK FOR IN A MENTAL HOSPITAL
Gives a basis for evaluating care and treatment.

NEWS VIEWS
Gives periodic information about recent developments in the mental health field. Special issue on "Foster Home Care."

THE PSYCHIATRIC AID
A monthly publication for mental hospital and training school personnel. One dollar for twelve issues.

HANDBOOK FOR PSYCHIATRIC AIDES
Gives useful information about mental disorders and their treatment. Single copy 50 cents.

Single copies of these publications are free except as otherwise indicated. Quantity prices will be quoted on request.

The Foundation will attempt to answer your questions about legal provisions for the care of the mentally ill in your state. It also attempts to meet requests for speakers and special services to groups interested in the problems of mental illness.

Order from the

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PUBLIC AFFAIRS PAMPHLET No. 98

Epilepsy—THE GHOST IS OUT OF THE CLOSET

BY HERBERT YAHRAES

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Epilepsy—THE GHOST IS OUT OF THE CLOSET

By HERBERT YAHRAES

WHEN Helen was twelve years old, she began having what she called "attacks." Without warning, she would rub her eyes, fling her arms around, and tremble violently. Once in a while she would fall down. The attack would be over in two or three minutes, and Helen would not remember what had happened. Her parents took her to the family doctor and then to several specialists, who said: "fainting," "hysteria," or "behavior disorder." But not until a year after the attacks started did a physician, after careful study, tell the parents what the trouble was. Helen, he said, had an unusual type of epilepsy. They protested that he could not be right. Nobody in their families had ever had that shameful disease, and nobody had been insane. Besides, Helen had always been bright, healthy, and active.

This pamphlet was prepared with the assistance of Dr. Jerry Price, Neurological Institute and Baird Foundation Clinic, New York.

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The doctor told them that epilepsy was not a shameful disease—even though most people seemed to think so—that the seizures were not inherited and the condition had nothing to do with insanity. He wrote out a prescription and explained that it was for a new kind of medicine which in many cases had worked excellently. He could not promise what it would do for Helen but he saw no good reason why she should not continue being bright and active.

That was a year ago. Helen's attacks began falling off almost immediately. She kept on with her school work and resumed the social activities that she had begun shying away from—dancing, supervised swimming, and ice-skating. She knows that she is no different from any one else except that once in a while she has a seizure. She also knows that these seizures are called epilepsy and that the medicine she is taking is helping to control them. She has reason to believe that eventually they may disappear.

Her parents say the doctor has worked a miracle. It was a miracle, all right, and the doctor had a good deal to do with it. But the more important miracle-workers are the medical men who have recently discovered new methods of diagnosing and controlling epilepsy. As a matter of fact, the healthy—and health-bringing—attitude of Helen's parents, once they knew the truth about the disease, had something to do with the miracle, too.

Mary, for instance, is much like Helen in every way (she even has the same doctor), except that Mary's parents treat her as though she were in mortal danger. They won't let her go to school alone, stay in the house by herself, or go on a hike. Shrinking from the word *epilepsy*, they won't tell her—or let the doctor tell her—what is wrong; they refer to her seizures as "fainting spells." They won't even let her be responsible for taking her medicine on time. They permit her to have no responsibilities; Mary depends upon her parents for everything. She is developing an immature personality that she will have a hard time correcting later on even though her seizures stop completely.

There are thousands of cases like Helen's and Mary's. Doctors

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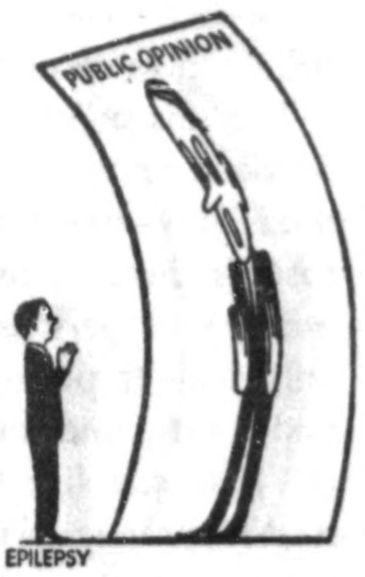
now are learning how to control epilepsy but they are having a hard time rolling away the ignorance, superstition, and fear that block the way to the most effective use of their new knowledge.

WHAT EPILEPSY IS

THE word *epilepsy* is Greek for *seizure,* and a seizure is the most easily recognizable way in which the disorder shows itself. But it is hard to define a seizure simply and exactly. Perhaps the best way to put it is this: a seizure is a temporary loss or impairment of consciousness; it usually occurs without apparent cause; and it is usually accompanied by muscular movements which may range anywhere from a slight twitching of the eyelids to a violent shaking of the entire body.

Epilepsy is a fairly common disease and it affects persons in all walks of life. As many people suffer from it as from diabetes or active tuberculosis—at least 500,000 in the United States. After the war we shall have more epileptics than ever. This is because head injuries and the strains of military life may contribute to the onset of seizures.



Even now the cost to us is tremendous. Measured in money—and not counting lost manpower—it amounts to at least $60,000,000 a year. Measured in heartaches and in wrecked lives, the toll is sorrowfully high. Much of the economic drain and most of the heartaches can be prevented. For doctors now know that, given adequate medical and social care, 80 out of every 100 persons with seizures can lead relatively normal lives. If doctors and laymen can provide for all patients the knowledge and treatment now available, the battle against one of the world's great scourges will be largely won.

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How It Got Its Bad Name

We now know that a person with tuberculosis or infantile paralysis has an excellent chance of recovering and living normally—provided that he has good medical care and that he and his family learn to work hand in hand with the physician. The same is true of a person with epilepsy. Too many people still regard the illness as an incurable horror, though if pressed they could not say why they think so.

This attitude, which is ages old, springs from our fear of the unknown. In ancient times a person with seizures was thought to be possessed of demons. That was the only way people could explain his occasionally strange behavior. Even as recently as two hundred years ago, some of Europe's leading doctors thought epilepsy was the work of witches. Educated people no longer believe that, of course, but some of them act as if they did. Their feeling may spring partly from the fact that a convulsion, which is one type of seizure, is not a pleasant sight. Or they may have known a small-town idiot. They were told he had epilepsy and since then have considered the disease as synonymous with feeblemindedness or mental illness.

For this belief the medical profession itself is partly to blame. Medical textbooks of a generation ago—and even some of those used now—based their theories about epilepsy on a study of cases in institutions. But these were only a fraction of the total number of persons with seizures. Out of every hundred cases, only ten—or perhaps fewer—are severe enough to need institutional care, and under the new methods of treatment even some of these can live normally. Nevertheless, most of our doctors started practice with the idea that epilepsy was hopeless, and often they conveyed that idea to patients.

Epileptics Are Mentally Normal

The truth is that the great majority of persons subject to seizures are in every other way perfectly normal human beings. Dr. William G. Lennox studied the records of nearly 2,000

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clinic and private patients. The intelligence of 67 per cent was judged to be average or above; of 23 per cent only slightly below average; and of only 10 per cent grossly deficient.

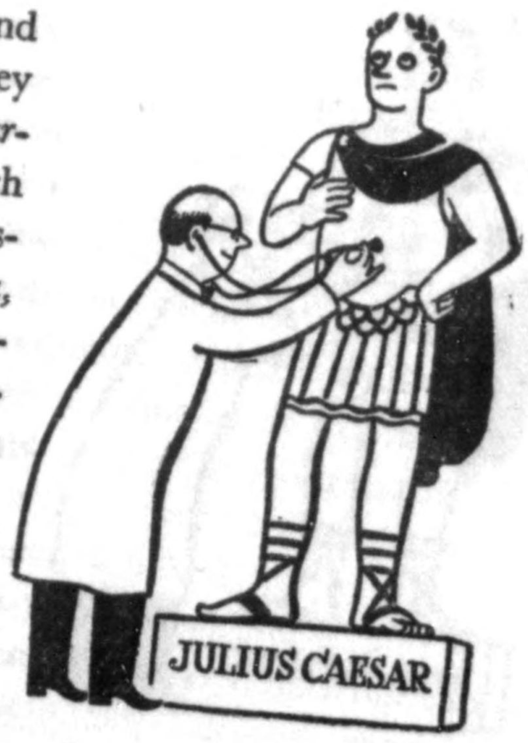
Many Geniuses Were Epileptics

Some epileptics have I.Q.'s at the genius level, and some great, historical figures have suffered from seizures—among them Julius Cæsar, Alfred the Great, Lord Byron, Algernon Charles Swinburne the poet, Guy de Maupassant the writer, Paginini the violinist, and Van Gogh the painter.

Migraine, or sick headache, is thought to be a relative of epilepsy, yet those who have it are not looked down upon at all. Education will make epilepsy socially acceptable, too.

If Epilepsy Has a Bad Name, Why Not Change It?

Some doctors advocate giving the disease a name that won't remind people of something distasteful. They have suggested such names as *paroxysmal convulsive disorders,* which emphasizes one symptom of the disease, and *a cerebral dysrhythmia,* which calls attention to the disordered brain wave pattern of an epileptic. But other doctors point out that when an effective treatment is found for a disease—and there is one for epilepsy—the dread that surrounded the disorder's name dies away—as with tuberculosis and diabetes. "You can paint a race horse purple," says one of them, "but it won't run any faster."



The trend among those fighting epilepsy is to make a frontal attack—to retain the name that has come down from the Greeks and to remove the stigma by means of education.

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WHAT CAUSES EPILEPSY?

THE ultimate or final explanation of most—or perhaps all—diseases is unknown because it requires knowledge of the chemical make-up and metabolism of minute body cells. In this respect, epilepsy is no different from illnesses like diabetes, high blood pressure, or the common cold.

The ultimate factor in most bodily disorders is a predisposition, or a susceptibility, to that disorder. In common speech, this is referred to as a family "tendency" or "weakness" for this or that disease. For most diseases the presence of a predisposition can be suspected only by scanning the family tree. Fortunately, for epilepsy, a laboratory test may prove of value.

Doctors are beginning to employ an instrument called the electro-encephalograph (see page 10). It records the electric waves given off by the brain, and it has shown that the brain wave patterns of most persons subject to seizures are different from those of most healthy persons. Work with this instrument indicates that about *one person in ten* has some irregularity of the brain wave pattern. This may indicate a predisposition to seizures or an allied disorder. But only *one person in every 200* does have seizures. Therefore, something more than a predisposition must be responsible for epilepsy.

Among the influences which can bring on seizures in persons predisposed to them are:

An Injury to the Brain. Such an injury may occur before a person is born, or during birth. It may be the result of an infection that has settled in the brain after diseases like sleeping sickness, measles, meningitis, or whooping cough. It may come from a severe head injury or from a tumor in the brain.

Bodily Disorders. A disorder in some other part of the body may react unfavorably upon the brain and lead to seizures. A kidney disease may have such an effect, as may also a disturbance of the glands influencing sexual maturity and body growth.

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Emotional Upsets. These are common in adolescence and occasionally seizures are attributed to them. Emotional disturbances are often thought to be a factor in cases that develop later in life, too.

How Seizures Develop

Factors contributory to the onset of epilepsy are illustrated in the diagram on page 8, which was adapted from one in Dr. William G. Lennox's book, *Science and Seizures.* Here we have the causes of epilepsy represented as the water in a reservoir. The reservoir is fed by various underground streams—brain damage, bodily disorders, emotional disturbances. The height of the water depends upon how fast those streams flow —one of them or all of them. There will always be some water in the reservoir, however, because of the patient's predisposition. To hold the water in, there is a dam labeled *seizure threshold.* As long as the dam is high enough and the underground streams do not run wild, no water flows over the spillway. When water does overflow, there is a seizure.

Obviously, to control seizures we must block off as well as we can the flow of those underground streams. Since we cannot block them off entirely, we must also build the dam high, using the materials best fitted to the individual case.

When Do Seizures Start?

At least 70 per cent of patients display their first symptoms before they are 20. The peak age for the development of seizures is during the first two years of life, presumably because heredity and prenatal and birth injuries are most likely to show themselves then. Another high point is during adolescence. Mothers need not be unduly alarmed, though, if a young child has several convulsions. Seventy out of every thousand children do have one or more during their first five years. But most of them outgrow the attacks. Only five out of a thousand adults display such symptoms.

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EPILEPSY IS LIKE THIS

GRAPHIC ASSOCIATES FOR PUBLIC AFFAIRS COMMITTEE, INC.

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HOW DOCTORS RECOGNIZE EPILEPSY

THE seizure is epilepsy's main symptom, though something like it occurs in other disorders. A fainting spell may look like some epileptic seizures but a person faints after he sees a bloody accident, has stood a long time in a hot place, or has heard shockingly bad news. His blood pressure suddenly drops and he falls down pale and limp. A seizure occurs without apparent cause and the person may or may not fall.

Psychomotor seizures of epilepsy are often mistaken for hysteria. But the symptoms of hysteria, unlike those of epilepsy, are due to subconscious impulses, tend to follow emotional upsets and to occur in the presence of another person.

The Patient's History

To find out whether a person has seizures, and what kind, and what may have brought them on, the doctor wants to know a number of things that only the patient himself or his family can tell. After getting an accurate description of the seizures, the doctor may ask if any blood relative had seizures or migraine or any other form of nervous disorder; if the patient has ever had scarlet fever, whooping cough, measles, mastoid infection, meningitis, or encephalitis; if his birth was difficult; if he had convulsions as a baby; or if he has suffered any serious head injury. He may ask if there has been a severe emotional upset, bedwetting, sleepwalking, periods of weakness, headaches, or temper tantrums.

The doctor asks these questions because he knows that at least some of the conditions mentioned are found more frequently among people with seizures than among other people. Besides asking these questions, the doctor will make a physical examination, carefully test the response of nerves to stimulation, and perhaps have X-ray and other examinations made. In the great majority of cases, nothing seriously wrong will be discovered.

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(Even an autopsy does not show anything wrong unless the person's brain has been injured.) He may then advise a brain wave test with the electro-encephalograph.

If the description of the seizures and these various examinations (excluding the brain wave test) have not disclosed a cause or causes for the seizures, the case is called "true" or "essential" or "idiopathic" epilepsy. Contrary to the popular opinion, it is better to have "true" epilepsy than so-called "symptomatic" epilepsy. The latter form is usually caused by some injury to the brain, which complicates recovery.

How the Electro-encephalograph Works

The word looks formidable but it isn't so bad if you break it down—*electro* (electric), *encephalo* (brain), *graph* (writing). The electro-encephalograph is a device for recording the electric currents given off by the brain. And an electro-encephalogram —called an E.E.G.—is the written record of those currents.

It has been known for a long time that the brain—like the heart—gives off electric currents. But these currents are extremely tiny. It wasn't until 1929 that a German, using radio apparatus, showed that the currents could be stepped up a million times and made to register on paper. Only within the last ten years have research workers, led by Dr. and Mrs. F. A. Gibbs at Harvard Medical School, shown how this discovery can be used to help diagnose and treat epilepsy.

Simple and Painless

The taking of an E.E.G. is simple and painless. The person sits in an easy chair, and a number of small flat discs—called electrodes—are attached to various parts of his head by dabs of colloidin. Fine wire leads from these discs through a series of radio-like boxes, which amplify the currents coming from the brain. These currents move a series of pens—which touch a moving band of paper. The pens record the brain currents as a series of little squiggles or waves.

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Brain Wave Patterns Differ

Every person has his own brain wave pattern, just as he has his own handwriting. The pattern is not the same when he is awake as when he is asleep. If he closes his eyes, breathes hard, or focuses his attention, the waves change in depth or frequency. The wave pattern does not reflect thoughts or intelligence.

Each of the three main types of epileptic seizures is accompanied by a brain wave pattern which is different from other types (if the record is taken during a seizure). About 85 per cent of patients show some degree of irregularity during any fifteen-minute recording, while only 15 per cent of persons without seizures have irregular brain waves and the irregularities are usually minor. Much depends on the degree of abnormality. The presence of one type of tracing, an alternate dart and dome, is definite indication of petit mal epilepsy. Bursts on the record for a second or two of extra large waves, either very sharp or very blunt, are strongly suggestive of epilepsy. Waves which are merely a little slow or fast can only be interpreted with the aid of the diagnosis already made from a description of the seizure. Having the patient sit still and breathe heavily for a minute or two will often disclose incipient abnormalities of the brain waves, and in patients subject to petit mal will usually precipitate an attack.

Comparatively few machines—and few trained operators—are yet available, and these usually in some of the big cities or in medical centers. Certain makes of apparatus produce records which are unreliable. If your doctor wants an E.E.G. taken, but doesn't know where to find one, consult the organizations described on page 28.

Another Test

The E.E.G. and other evidence may suggest the presence of a tumor or a scar in the brain. In this case, the doctor may want to confirm it by having a kind of X-ray picture, called an

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encephalogram, taken. Air is injected through the spine into the cavities of the brain. The air-filled cavities can be seen by X-ray and any abnormality like a tumor noted.

HOW SEIZURES AFFECT A PERSON

SEIZURES are infinitely varied in form but doctors recognize four main types:

GRAND MAL

This "great illness" affects more persons than other types of epileptic seizures. During a grand mal attack, the patient loses consciousness, his muscles tighten, and he falls. He may cry out or groan, although he does not remember pain. Saliva appears on his lips. His face may be first dusky and then pale. He twitches violently for a minute or so—it *seems* much longer to the worried bystander. Usually in a few minutes he lies relaxed. Then he may sleep heavily for hours, or he may get up but feel dull for a short period.

PETIT MAL (pronounced petty-mahl)

Seizures are much more frequent in this "small illness" but are often overlooked because they last only a few seconds. Usually there is a rhythmic twitching of eyelids or eyebrows. The patient rarely falls.

Dr. Tracy Putnam gives this account of petit mal attack: "The patient was sitting calmly in the office, discussing his symptoms. He stopped in the middle of a sentence, stared vacantly, blinked, and went on with what he was saying, only slightly confused." Parents often disregard petit mal attacks in a child, supposing that eventually they will disappear. Usually they do. However, out of a large group studied, one out of every three patients with petit mal later developed grand mal.

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PSYCHOMOTOR

This is the most difficult type to diagnose because the attacks vary greatly from one patient to another and because mild forms may look like petit mal and severe forms like grand mal. The name indicates that a psychic disturbance is the principal feature of the attacks. This type of seizure is infrequently found.

In a psychomotor seizure the patient is amnesic; that is, he may appear to be conscious, although afterward he does not remember anything that happened. Most such attacks last only a few minutes but with a few patients they continue longer. Patients have even gone to a strange city without knowing what they were doing. The psychomotor seizure may appear to be only a temper tantrum or a period of queer behavior—as in the case of a man who would wander around the room pulling down pictures and throwing books on the floor. When such episodes begin abruptly, are contrary to the person's ordinary character, and are not remembered by the patient, they are suggestive of epilepsy. In many cases it is hard for parents and associates to believe that the patient's behavior is caused by anything but a "mean streak." But evidence that it is caused by a form of epilepsy can be shown by the electro-encephalograph, or by the alleviation or the elimination of such attacks following medical treatment.

JACKSONIAN

This type, named after the neurologist who first described it, is a modified grand mal. The patient remains conscious but there is a twitching or numbness of one leg or arm or side of the face, which may gradually spread until consciousness is lost. A Jacksonian seizure indicates that the attack arises in a certain part of the brain's surface—opposite to the side of the body in which the attack begins. This means that something—perhaps a tumor or a scar—is irritating the brain at that point.

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The Warning

A good many patients—perhaps half—get some kind of warning before a seizure starts. With some persons the warning may be a "queer feeling" in the stomach, or nausea—which may lead the patient to suspect that the trouble springs from indigestion. Others describe a feeling of giddiness or of "things going black." Doctors call the warning an *aura,* which is the Latin word for wind. Like a gust before a storm, it is really part of the seizure. Parents or associates may suspect an approaching attack because of unusual irritability, or pallor, or enlarged pupils. Epileptics should learn to recognize the sensations and distinguish between them and the many similar sensations that have no connection with the attacks and which are experienced by almost anyone.

HOW EPILEPSY IS TREATED

PRIORITY in treatment goes to the correction of any condition discovered by the examinations that might contribute to seizures. Occasionally—a few times out of a hundred—seizures are caused by some condition in the brain and can be relieved by an operation on the brain. After correction of significant defects and institution of proper hygiene, the doctor tries to strengthen and to increase the height of the dam which restrains the seizures.

The chief means of increasing resistance is medicine. The right medicine, used under expert guidance, will in most cases greatly lessen the number and severity of seizures and in many cases stop them entirely. Which medicine is the *right* one to use in each case is, of course, something to be determined by the physician.

Bromides have been employed in the treatment of epilepsy since the time of the Civil War. They are still used to some extent but are likely to cause skin eruptions, and if used in large doses, they may depress activities and dull the memory.

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Most doctors now prescribe a drug called phenobarbital. (Luminal, more expensive but not more effective, is the trade name used by one manufacturer.) Phenobarbital was originally prescribed as a sleep-producer, but in 1912, Alfred Hauptmann of Germany discovered that it would also cut down the number and severity of seizures. With that discovery, the treatment of epilepsy took a great step forward.

It took a much greater step in 1935 when Tracy Putnam and Houston Merritt, then with the Harvard Medical School—now in New York—began searching for a new anticonvulsant drug. They wanted a drug designed specifically to control seizures. They tried many combinations of drugs related to phenobarbital, especially those that carried more than one of the phenol radicles. These trials involved endless experiments with animals. Finally, in 1937, they selected a compound that has been given the name of phenytoin sodium. The trade name used by the one company which up to the present time makes it, is dilantin sodium.

Dilantin is one of the great medical discoveries of the times. It is effective in a far greater percentage of cases than the older drugs, and—unlike them—does not produce drowsiness. Incidentally, none of the drugs mentioned is habit-forming.

The Effect of Medicines

The chart on page 16 shows the relative effectiveness of various medicines when used with a group of patients in a certain institution:

Before they were given any medicine, each patient averaged about twenty seizures a month; after starting bromides, about ten a month; with phenobarbital, seven a month; and with dilantin sodium, two and a half a month. These were *institutional* cases—part of that small fraction of cases in which the disease is very severe.

Dilantin's record with private patients has been even better. Remarkable improvement has been reported in from one-third to one-half of cases, and definite improvement in all but 10 or

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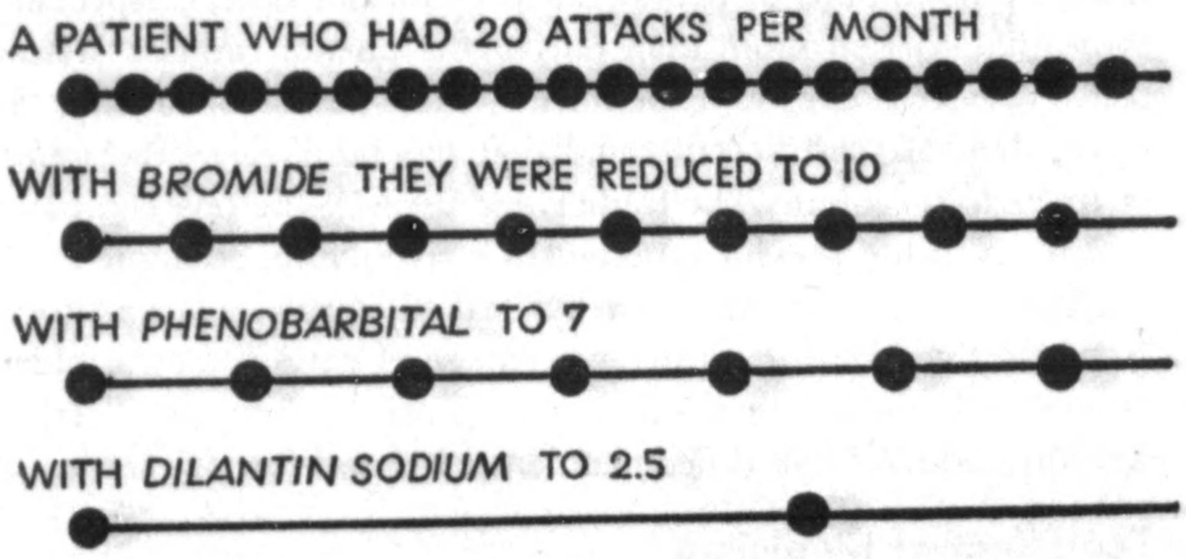
20 per cent. Dilantin works least well in cases of petit mal (pykno-epilepsy). Results are most gratifying in psychomotor seizures, which are usually not helped by phenobarbital or bromides.

Dilantin is given in capsule form, and every case becomes an experiment in which the doctor and the patient work together to find the correct dosage. The usual procedure is to start with

SEIZURE CONTROL IS MORE EFFECTIVE TODAY



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a certain number of capsules and to increase the amount gradually until either the maximum benefit is obtained or toxic symptoms appear. Doctors accustomed to using the older drugs may not prescribe enough dilantin to stop attacks. Overdosage has to be watched for, also, since it produces unpleasant symptoms like instability in walking, dizziness or nausea, or skin eruption. But these and other less common symptoms quickly disappear with a slight reduction in the amount of medicine.

Other medicines besides those mentioned are sometimes used,

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and drugs not yet on the market are being tried out in various laboratories and clinics.

No matter what medicine is used, it must be taken daily and continued long after seizures have ceased.

Epilepsy "Cures"

Sooner or later a person with seizures will encounter advertisements of patent medicine treatments. The ad will point to letters from "cured" patients and to the fact that a doctor reads the form filled out by the patient and prescribes for him individually.

Diagnosis and treatment of any disease by mail is a dangerous business; it may even be fatal. It is also expensive. The principal ingredient of these "cures" is bromide or phenobarbital, or both, usually in a dosage too strong to be safe without personal face-to-face supervision. A year's supply of phenobarbital tablets might cost about $3; of sodium bromide tablets, about $5; of sodium bromide solution, about $18; or dilantin sodium capsules, about $22. But a year's supply of an "epilepsy cure" comes to about $50.

Diets

Patients have a habit of blaming whatever they ate at the last meal for any seizure that follows it. Doctors used to humor them that way, so a number of curious, and useless, dietary restrictions arose. A patient should eat whatever the rest of the family eats, provided the rest of the family eats a balanced diet. He should take little alcohol. Tobacco, apparently, is as bad for the epileptic as for anybody else—but no more so.

There is one diet that has worked out well for some children—the ketogenic, or acid-producing diet. Under it the patient eats scarcely anything but fatty foods such as heavy cream, butter, egg yolk, olive oil, and bacon. Eventually, substances called ketone acids accumulate in the blood, and these have a soothing effect on the nerves. The diet must be weighed and measured, is costly,

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difficult to follow, and requires rigid supervision; authorities now hesitate to recommend it except where other measures have not been effective.

Physical and Mental Activity

The acid-producing measure that is most widely beneficial is exercise—of muscles and of brain. One authority, Dr. Jerry Price, expresses its importance this way:

"Exercise to the point of athletic conditioning is often the difference between success and failure of drug therapy in the treatment of epilepsy."

Many doctors still reason that since epilepsy is a nervous disorder, what the patient needs is a complete rest. But this idea has now been shown to be wrong and even dangerous—except, of course, where the patient's general health is definitely below normal. For it encourages the natural tendency of the person subject to seizures to pull away from life, draw into himself, give up his contacts with the world, to sit and mope and feel sorry for himself. And case histories show that seizures increase when the patient hasn't enough interests to keep his body and mind occupied.

Psychological Treatment

Any sort of handicap—or a run of bad luck, or membership in a minority group that others look down upon—is likely to interfere with a person's feeling of security and well-being. In the case of an epileptic, the uninformed may treat him like an outcast; some of his playmates may call him crazy; the school may forbid him to use the gym; his boss may fire him for having a seizure; his family may not let him go anywhere alone. Obviously such treatment may discourage, alienate, or profoundly disturb a patient.

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Most psychological difficulties are an indirect result of seizures rather than a cause of them, but they may make the seizures worse. For instance, a young woman who had had daily petit mal since adolescence became engaged to a young lawyer. She did not tell him of her seizures, and he did not notice them. But they became worse because the girl lived in dread of being found out. She was advised to confess her ailment even at the risk of breaking the engagement. She did so and is now happily married.

There are cases in which emotional tension brings on seizures. For these patients the doctor needs to find not only the medicine which will control the seizures, but also the psychological treatment which will relieve the mind.

WHAT TO DO IF SOMEONE HAS A SEIZURE

GENERALLY, once an attack has started, nothing can stop it—medical treatment will only *prevent* seizures. But if the patient's associates recognize the warning signals, they can get him to a spot of safety or seclusion.

A person having a petit mal seizure requires no attention. In the case of a grand mal attack, an enlightened bystander can do a good deal:

1. If the patient is seen at the start of an attack, lower him to the floor, away from furniture or other hard objects.

2. Put an object too big to be swallowed—a folded handkerchief or a rolled newspaper will do—*between the back teeth on one side* of his mouth. This is to keep him from either biting his tongue, or breaking his front teeth. Don't use force—wait till the mouth opens naturally. By all means, remain calm and collected; a child is likely to absorb the tension and apprehension of the adults about him as the seizure ends.

3. Keep other bystanders from throwing water over the patient, pouring whiskey down his throat, or rushing him to a hospital. (Each patient should carry a paper stating that he is subject to

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seizures.) When the convulsive movements have ceased, the patient should be moved to a quiet place and allowed to regain consciousness naturally. He may or may not wish to lie down—because he is drowsy or has a headache. As for a child, the traditional hot mustard bath is without value.

A patient having a psychomotor attack, in which he wanders about, should not be forcibly restrained because restraint may increase the severity of the seizures.

What an Epileptic Can Do for Himself

Epilepsy requires experienced medical care. But even with the best of medical care the patient must want and work to get well. The first thing for him to do is to place himself under the care of a doctor who will treat his illness with skill and thorough understanding of the newer methods of treatment. If he cannot find such a doctor, the Association to Control Epilepsy or the American Epilepsy League (see page 28) will assist him in getting in touch with one.

Then he must strengthen his restraining dam against seizures by keeping in the best of physical condition and by taking his medicine regularly. There may be some illnesses in which no harm results from leaving off medication for a day, or several days, but epilepsy is not one of them.

During the period of adjustment to treatment, the patient can help his doctor by keeping a record of his seizures—when they occur; what relation, if any, they seem to have to other occurrences; what medicine he is taking.

It is better to eat a normal amount of the right kind of food and to sleep a normal number of hours than to follow what one doctor aptly calls "mail-order instructions" and "cult practices."

He should keep busy. He can build up his muscles by all sorts

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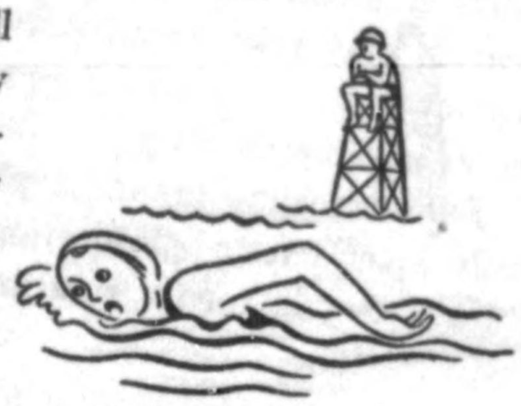
of exercise. He can follow the news and discuss it. He can become interested in politics. He can resurrect an old hobby or begin a new one.



Reasonable precautions are all that are required to prevent injury to himself or others. Attention, concentration, and activity seem usually to ward off a seizure. Driving a car, running an elevator, or working near moving machinery is unwise. Doctors say it's all right for him to go swimming if there's someone around who knows of the attacks.

He should inform himself about his disorder so that he can work more intelligently to cure himself. He will find two popularly written books on epilepsy which contain more information than this pamphlet can give. These books are *Science and Seizures: New Light on Epilepsy and Migraine,* by William G. Lennox, M.D., published by Harper & Brothers; and *Convulsive Seizures: A Manual for Patients, Their Families and Friends,* by Tracy J. Putnam, M.D., published by J. B. Lippincott Co.

In reading these books, the patient ought to keep in mind the fact that there is no such thing as an average epileptic. Epilepsy is the most individualized of disorders, and some of the conditions that apply to other patients may not apply to him. Finally, the epileptic can consider himself a perfectly healthy, normal human being—which he may be except during his seizures—and live like one. He has a handicap, to be sure, but so have most other persons. It may disappear very quickly under the right treatment or it may linger. How big a handicap it is depends a good deal on how big a handicap he allows it to be.

Should an Epileptic Ever Be Sent Away from His Family?

Ordinarily the young person with seizures gets much better care at home than anywhere else. In the rare instances in which his ailment so upsets the rest of the family that they cannot

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treat him intelligently, a change of scenery is frequently helpful.

When the family is unable to give the patient proper care while a medication schedule is being worked out, relatives or friends may take over for a few weeks or months, or a social agency may be able to suggest temporary placement on a farm or in a summer camp.

For that small group of patients who are physically or mentally incapacitated, institutional care is oftentimes the best answer. The laymen's organizations can supply you with this information.

Should a Child with Seizures Go to School?

A child who is generally healthy except for his seizures needs to have his brain kept busy and his body active—a double insurance against seizures. Cooperation from teachers should be enlisted; they should be told that the child is subject to attacks. A letter from the doctor explaining the situation is a help. Of course, parents can hardly expect the school to accept a child if his seizures are frequent and severe or if he is not securing adequate medical care. But even where seizures are well controlled, some school authorities may object to accepting the child, saying that they cannot be responsible for any injury he might receive on school premises or that they cannot subject other pupils to the shock of seeing a seizure.

The answer to such objections is adult education. The student himself or his parents or the doctor may be able to enlighten the authorities. (Helen, the patient mentioned in the beginning, helped to do this by reading the book *Convulsive Seizures* and reporting on it to her high school English class.) As for subjecting other pupils to an unpleasant sight—a seizure arouses a child's curiosity but does not frighten him, unless, of course, an adult shows alarm. Once a situation has been explained by the teacher, subsequent attacks should arouse little excitement. Psychiatrists emphasize that too careful shielding of children from the facts of life creates serious problems later on.

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Should an Epileptic Marry?

This is really a double question. The first is whether a couple can get along well together if one partner is subject to seizures. The answer depends upon whether the person who marries an epileptic loves him enough. Most persons' seizures *can* be controlled and, since a contented person is less likely to have seizures than a discontented one, a marriage that brings contentment should be beneficial. Intercourse probably does not affect seizures one way or the other; nor does pregnancy.

The second question is—

May an Epileptic Have Children?

A generation ago almost all doctors would have said no; today the men who have studied the question most thoroughly say yes.

Epilepsy is no exception to the rule that a tendency or a predisposition is an underlying factor in the causation of disease. (Read again what was said under "What Causes Epilepsy?" on page 6.) On the basis of family histories, the inheritance factor is 1/10 of that in diabetes, and 1/25 of that in migraine.

In the case of epilepsy, we find that one person out of two hundred is subject to seizures. Among those who suffered head injuries in World War I but had no epilepsy in the family, one out of sixty had epileptic attacks. Among those who had head injuries *and* epilepsy in the family, one out of forty suffered attacks. The difference between one out of sixty and one out of forty clearly demonstrates the scientific heredity factor, but shows it to be very small.

This question of inheritance has also been studied by Dr. William G. Lennox and several associates through an analysis of the histories of more than 12,000 near relatives of epileptics and through recording of the brain waves of 400 relatives and of 100 healthy or epileptic twins. Among the patients' near relatives, approximately one in forty was subject to seizures and one in two had some disturbance, usually slight, of the brain wave pattern.

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Thus, it can be said that epilepsy is found about five times as frequently among the relatives of an epileptic as among the general population; and irregular brain waves about one hundred times as frequently.

In other words, the chance that the average person will have an epileptic child is about one in two hundred, while the chance that an epileptic will have such a child is about one in forty. In a world that is full of chances, one chance in forty that any given child will be subject to seizures is not to be regarded as alarming.

These figures concern only the average person; individual prospects may be altered more or less favorably. Here are conditions making them more favorable: evidence that a brain injury—whether caused by infection or accident—preceded the beginning of the illness; absence of epilepsy or migraine among relatives; evidence that the seizures began later than infancy or childhood; normal intelligence of the patient. Perhaps the most important thing to remember is that a child can be treated just as successfully as an adult.

Can an Epileptic Hold a Job?

The best answer to this is to be found in a report of the American Epilepsy League about its efforts to find jobs for persons with seizures. The report covers a recent nine-month period and deals with a group of slightly more than a hundred persons in the Boston area who previously had not been self-supporting. Eighty per cent of these persons were found to be employable, and they held jobs bringing them an aggregate annual income of $120,000. Epileptics, like other persons, have a right to be hired on the basis of what they can do. In a study of the physical and mental condition and the occupational history of more than 1,000 adult epileptics, Drs. Lennox and Cobb found that about three-fourths were both capable of work and were employed. Occupations included doctors, lawyers, ministers, engineers, teachers, salesmen, farmers, clerks, laborers, me-

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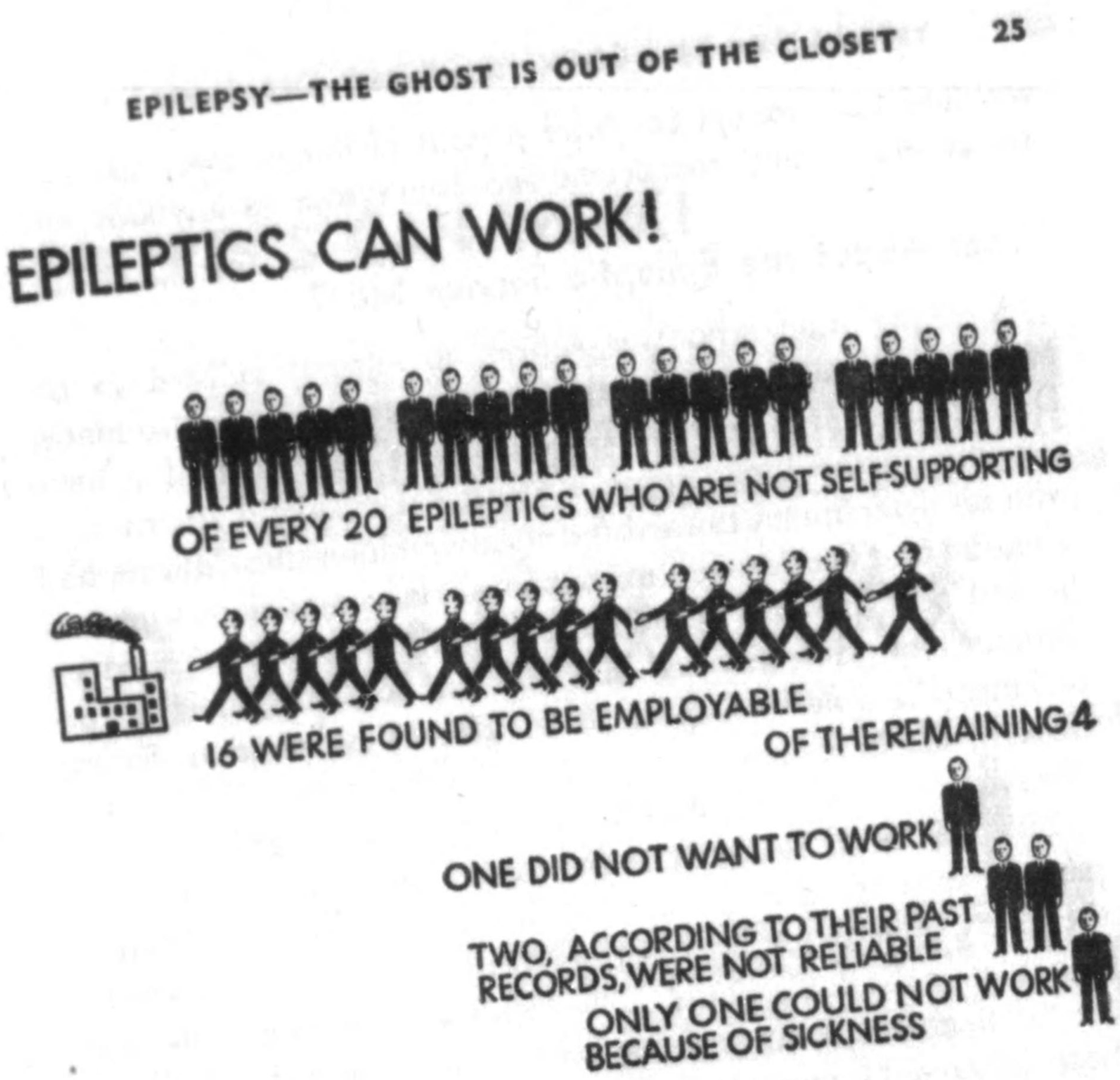

chanics, stenographers, dressmakers, reporters, interior decorators, factory workers, beauticians, actresses, dancers, writers, plumbers, and musicians.

Work Is Part of Treatment

Work is an important form of treatment for most patients. There is no evidence that epileptic workmen have a high accident rate. Employers should recognize the small amount of time that the worker actually loses and the great decrease in seizures made possible by modern medical care. Fellow workers

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will find that, except for brief periods of illness, most epileptics are as likable and competent and courageous as anybody else.

What About the Epileptic Service Man?

A young man who was subject to seizures enlisted in the Marines, where his occasional attacks were shielded by his mates. During his fourth year of service he was a member of a force cleaning up the Japanese on a South Pacific island. In running with his detachment toward the enemy position, this Marine had a seizure and keeled over, unconscious. His companions supposed he had been hit and when the enemy fire lightened dashed on without him. He recovered in a few minutes, and joined his detachment in time to help clean out the enemy position. Sailing back to his base, however, he had another seizure which was observed by a medical officer, and he was discharged.

Like this Marine, many thousands of men with seizures slip past the examining doctors, either because the men don't know they have epilepsy or because they deny it. An observed seizure brings a medical discharge. Thousands of other cases develop for the first time during service because the seizure threshold has been lowered by emotional shock or excessive fatigue.

Brain Injuries

More important are the cases that follow an injury to the brain. But only a small proportion—from 5 to 15 per cent—of men with severe head injuries later develop seizures. The seizures may come almost at once or years later. Removal of the injured portion of the brain, if this is deemed advisable, is a task for a skilled brain surgeon. (This whole subject has been discussed in the book—for doctors—by Drs. Wilder Penfield and Theodore Erickson of Montreal: *Epilepsy and Cerebral Localization.*) Fortunately, the danger involved in opening the skull is hardly any greater than that which is involved in opening the abdominal cavity.