ON THE METHODS IN VOGUE AT THE BOSTON PSYCHOPATHIC HOSPITAL.*

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THE scope of this contribution is to give an account of the administrative and clinical methods at the Boston Psychopathic Hospital, to give a picture of the clinical material, and to discuss the advantages and disadvantages of the system.

HISTORICAL NOTE.

The Hospital was opened in 1912 under the administrative care of the State of Massachusetts. It was designed essentially to deal with acute, recent and recoverable types of mental illness. The scheme was actually started in 1900 by Vernon Briggs and others. It received the support in this country of Maudsley and Macpherson. There were many difficulties in the way, and much inter-departmental strife occurred before the Hospital finally came into being. A full account of these difficulties and the various legal and semi-political arrangements which had to be made have been published by Vernon Briggs (1).

SOURCES OF MATERIAL AND MODES OF ADMISSION.

The Hospital draws its cases from private practitioners, general hospitals, various charitable institutions, courts of law, schools and the police.

The mode of admission is usually one of the following:

(1) The patient may come in voluntarily on signing the necessary paper.

(2) The patient may be brought to Hospital on the strength of a "10-day care paper."

This is a paper which authorizes the Hospital authorities to hold the patient for ten days. Such a paper may be signed, not only

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by a physician, but also by a policeman, a member of the Board of Health, or an agent of the Institutions' Registrations Department. It does not even require the signature of a relative.

For example, a person who is behaving curiously in public may be picked up by a police officer and brought direct to the Hospital, the officer signing the paper at the Hospital; the Girls' Parole Department (a State-controlled welfare scheme which takes charge of girls who present such anomalies of behaviour as sex delinquencies, thieving, running away from home, temper tantrums) frequently refer their charges to the Boston Psychopathic Hospital for a period of ten days to have them investigated from the psychiatric standpoint and to have the psychiatrist's advice as to the future management of the case; or, again, the law courts may refer the accused to Hospital; a family confronted with a problem of behaviour in one of its members and being unwilling to send the subject straight to a State hospital, may send him to the Boston Psychopathic Hospital without feeling the common misgivings about a "lunatic asylum." After due investigation, advice as to the disposal of the case is given to the relatives.

Admission Rates, Accommodation and Disposal of Patients.

The Hospital deals annually with about 4,000 patients, of whom one-half are out-patients. From this simple statement the necessity for the existence of such a hospital is clearly apparent. It accommodates only about 100–110 patients, equally divided between males and females. With such limited accommodation it follows that the residence of each patient must, on an average, be short. Actually the vast majority of patients stay in hospital only ten days; that period is usually sufficient for an adequate diagnostic investigation to be made and advice to be given accordingly. At the end of that period one of several things may happen to the patient:

(1) The patient may continue in residence. This happens in (*a*) cases of special interest on which research is to be done; (*b*) cases in which the diagnosis is not clear, and which require further investigation; (*c*) cases which are likely to recover at an early date; (*d*) early cases of general paralysis which are suitable for malarial treatment; (*e*) cases whose physical condition is such that it would be unwise to move them.

This continuation in residence may be done on one of several bases: (*a*) The patient may sign a voluntary paper which becomes effective on the expiration of the "10-day care paper"; (*b*) the "committing physicians" (two outside practitioners who visit the Hospital twice weekly to examine patients who have been deemed "committable" by the clinical staff) may sign a "35-day care paper." This is done chiefly in cases of group (*b*) above; (*c*) the "committing physicians" may sign an ordinary commitment paper (corresponding to our ordinary certificate) for the patient to be detained at the Boston Psychopathic Hospital.

(2) The patient may leave Hospital at the end of ten days and may be referred to the Courts or to some welfare organization; to the Out-Patient Department for follow-up work; to the Social Service, or the patient may simply be committed to a State hospital. The latter course is the one taken in all chronic cases which are unlikely to yield fruitful results in investigation or therapy.

It will be clear, then, that the Hospital is a centre for cases in which there is a question of mental illness, with the privilege of keeping for itself cases of special interest. Ordinary committable cases are not supposed to come to the Psychopathic Hospital; they should go straight to the State hospitals. It is essentially designed to deal with those "in-between" cases that are not clearly psychotic, but which present such anomalies of behaviour as to render psychiatric examination advisable. In actual practice, however, it is extremely difficult to maintain this ideal.

Financial Arrangements.

The cost to the State of each patient per week is $42.00. If the relatives of the patient can pay this, well and good; if not, they pay weekly as much as they can, or they may pay nothing at all.

General Structure.

The Hospital itself is a small T-shaped building standing in two acres of ground, and in its general lay-out conforms closely to our own general hospitals. There are five wards in use, namely, an acute ward and a convalescent ward on each side (male and female), and a special ward of eight beds set aside for the malarial treatment of general paralysis. The wards themselves are subdivided into small dormitories with day-rooms, and in each acute ward there are about eight single rooms. There is also in each acute ward a place called the "tub-room," where there are facilities for six continuous baths going on simultaneously under the supervision of one nurse or attendant. In addition, each ward has an "examining room," very completely equipped, where mental and physical examinations may be made privately.

General Disposition and Duties of Staff.

For purposes of concise description it is desirable to regard the staff as consisting of two great divisions, namely, the Executive Staff and its subservient departments, and the Clinical Staff and its subservient departments.

1. *The Executive Staff.*—This is under the control of the Chief

Executive Officer (corresponding to the superintendent). His duties are similar to those of a general hospital superintendent—that is, the general supervision of all administrative and legal matters. He has two assistants who take alternate 24-hour duty. They are the members of the staff who admit all patients, see that the papers are in order, make financial arrangements and, apart from taking history, do all the interviewing of relatives—for example, in regard to the progress and disposition of the cases. Although they make formal rounds of the wards, they play no part in the mental examination of patients. On them rests the final decision in all legal matters such as commitment, discharge, transfer, permission for lumbar puncture, whether or not the patient shall have his eye-glasses, etc. They are kept in touch with the progress of the patients by the daily ward reports, and they receive recommendations of the Clinical Staff at short meetings held thrice weekly.

The subsidiary departments of the Executive Staff, such as the Dietician's Department, the Treasurer's Department, the Housekeeper's Department, etc., are not in any way peculiar to the Hospital and do not merit special description.

2. *The Clinical Staff.*—This is under the control of the Director. Immediately subordinate to him is the Chief Medical Officer. The duties of each of these include both male and female services and the general management of clinical work. Then on each service (*i.e.*, male and female) there is an Assistant Medical Officer or "Chief of Service," and under him several internes (four or more), students and voluntary workers.

Acting on an independent but co-operative basis is the Chief of the Out-patient Department, who is assisted in turn by the junior members of the indoor staff.

The subsidiary departments of the Clinical Staff are:

(*a*) The Psychological Laboratory with its chief and three or four psychologists.

(*b*) The Social Service Department with its chief, four social workers and a number of students.

(*c*) The Biochemical Laboratory; (*d*) the Neuropathological Laboratory.

(*e*) The Department of Therapeutic Research; (*f*) the Radiologist.

(*g*) The Dentist; (*h*) the Occupational Therapy Department.

(*i*) The Superintendent of Nurses and her department.

(*j*) The Hydrotherapy Department; (*k*) the Record Room and stenographers.

To illustrate the uses of these departments, let us follow the course of a patient through the Hospital:

The case is taken by an interne in rotation as it comes in, and he is at once informed of its admission when the necessary formalities have been gone through by the executive officer on duty. The interne then interviews the relatives for the purpose of taking the history and after that he does not see them again. Within three hours of admission a preliminary physical examination must be made and recorded on the patient's chart. This is done merely to prevent any gross injury or physical illness from being overlooked. The interne then has three days in which to make a complete mental and physical examination, calling in the advice of such subsidiary departments as are indicated. For example, the Social Service if he thinks the history is not reliable; the Psychological Laboratory in all minors, police and court cases, as well as those in which there is a question of intellectual deterioration. After writing up this preliminary survey of the case, he then hands his notes into the record room and a typed copy of the case record is duly presented to him for correction. After that the case is presented at ward rounds, which are made on each service on alternate days by the chief medical officer. At these ward rounds the case is presented on a purely descriptive level for the purpose of allowing the chief medical officer to make a formal diagnosis and recommendation. The interne makes notes of the chief medical officer's remarks and then hands them into the record office. By this time the patient has been in hospital four days, and a preliminary survey of the case has been made, together with the formal diagnosis. On the days when the Chief Medical Officer does not make rounds the Director does so, and our case, which was presented the previous day to the Chief Medical Officer, is now presented to the Director, but in a very different way. It is not taken up in a formal descriptive way, but essentially from the dynamic interpretative point of view. The case is discussed at length, and an attempt is made to reconstruct the total situation from the data obtained so that the Director can sketch out the lines along which further study should be made. For example, the Biochemical Laboratory may conduct extensive investigations into the state of the patient's metabolism; the radiologist may investigate the condition of the gastro-intestinal tract; the bacteriologist may take up the question of infection. In the meantime the patient may be undergoing hydrotherapy or he may attend the Occupational Department, and at the same time further conversations with him are carried out so that more insight into his mental state may be obtained. Cases of special interest are presented at meetings of the whole staff which are held on five days of the week, so that they may be fully discussed from all points of view. It is apparent then, that the Hospital is so managed

as to provide the fullest possible investigations of the case in the least possible time.

There now falls to be considered the work of the individual departments.

The Psychological Laboratory and the Social Service will be dealt with particularly, as they have shown themselves to be of very great value in the practical handling of the cases. The biochemical and other laboratory work need not be considered in technical detail, because it is by no means a feature peculiar to a psychopathic hospital.

The Psychological Department.

From the point of view of clinical psychiatry the principal function of this Department is to do intelligence testing. Let it be said at once that this does not consist merely of going through the Binet-Simon scale, or one of its modifications, and then labelling the patient with a number to designate his intelligence. Except in cases of uncomplicated mental deficiency, comparatively little can be learnt from such a number, and a very great deal can be learnt from the way in which the patient does the tests; which particular ones he fails in; what his behaviour is during the examination, and so on. Intelligence testing is not a formal ritual which can be conducted by any layman who happens to have a copy of the Binet-Simon tests; it is an art calling for experience of clinical psychiatry and a thorough knowledge of psychology.

The method used at the Boston Psychopathic Hospital is the Stanford Revision of the Binet-Simon Scale (2), which, although it does not take linguistic difficulties into account and is considerably influenced by scholastic attainment as opposed to native intelligence, is found to be the most useful and rapid method of dealing with a large number of routine cases. It is possible to state from a study of these tests—(1) whether deterioration has occurred; (2) whether the patient was originally defective; (3) whether a low intelligence quotient is due to psychotic disturbance of thinking or to poor endowment (3).

The importance of these points is great. Only too often do we say of a schizophrenic patient that he is demented, and we give our prognosis accordingly, while tending to adopt an inactive and fatalistic attitude which does not result in any practical effort being made in the way of therapy. This subject has already been taken up in patients who have been for many years in a mental hospital (4), but so far no extensive work has been published on early schizophrenic cases. These old cases do show deterioration, but it is evident from the findings at the Boston Psychopathic Hospital that many early cases do not show any such change.

Intelligence testing provides a means of differentiating between simple dementia and high-grade mental deficiency, or between mental deficiency and some other deteriorating psychosis, such as alcoholic states or general paralysis (5). In general paralysis itself it is a valuable index as to how far the patient has deteriorated, and may be used as a guide and check for malarial treatment. In certain behaviour problems where the patient makes a pretty good superficial showing the psychologist may lay bare a mental defect of fairly pronounced degree.

In addition to intelligence testing, the Psychological Laboratory conducts memory tests (6) on a more elaborate scale than that usually employed in routine mental examination. The Department also undertakes word-association tests as part of a psychological analysis.

It deals in all with 1,500 cases per year, and from this figure its uses must be apparent.

The Social Service.

When a case is referred by the clinician to the Social Service, it is assigned to one particular worker, who then interviews the patient and the interne concerned, and obtains from them and from the ordinary medical case-record such social information as she can. This includes place of employment, school history, names and addresses of interested parties and the patient's statement of home conditions. She then registers the case at the Confidential Exchange of Information, and finds from the Exchange whether the case is known to any other social agencies, welfare schemes or charitable organizations. In addition to the information obtained from these sources, the worker visits the patient's home, interviews his employers, looks up his school record, interviews his doctor or clergyman, and takes up any other line of investigation which may be indicated, such as looking up the records of other hospitals, police records, etc. It is amazing how often this Social Service ferrets out important information which is blankly denied or omitted by the relatives when they first give the history to the interne. Moreover, it does obtain first-hand information regarding the correctness or otherwise of statements made by the patient. The Service is called in as a routine in all court cases and in all minors. It is of very great value in the "behaviour problem" type of case, as it is necessary to have the fullest possible information before any attempt to understand these cases can be made. Apart from the mere gathering of facts, the Social Service deals actively along social lines with those cases which are not already within the scope of some other agency.

This side of the work consists of (1) arranging with employers to let the patient have time off to attend the out-patient clinic; keeping in touch with the patient and persuading him to attend the Hospital regularly; (2) general supervision of the patient at home to see that he carries out the physician's orders; (3) arrangement for holidays for the patient through various charitable institutions; (4) arranging employment for the patient along the lines suggested by the clinician, and enlisting the aid and co-operation of employers; (5) arranging for financial assistance with one of the many charitable institutions; (6) general supervision of home conditions, and securing of a visiting housekeeper; (7) personal supervision.

This is of particular importance in behaviour problems such as sex delinquencies. It is a question of tiding the patient over a difficult emotional period and guiding her into suitable modes of reaction. This implies a sympathy and understanding for the patient which cannot be achieved so long as there is any officialdom in the atmosphere, which results in the patient adopting the attitude of a naughty child towards a school-mistress. Too often is this the case with some of the so-called Welfare Associations, but it may be unhesitatingly averred that the social workers of the Boston Psychopathic Hospital get an amazingly good contact with their charges with a more gratifying prophylactic result. This type of case is one which is particularly liable to degenerate into prostitution. The social worker with her tact, her unofficial and friendly mode of approach can do a great deal for these patients and for the community at large. It is essentially a question of proper and wholesome outlet for the patient's emotional life, and this is taken up by the social worker along lines of arranging for money for clothes, cultivating an interest in social clubs, wholesome moving pictures and other recreations. The social worker is a girl, more or less of the patient's own age, whom the patient can approach frankly and without fear of being regarded as a criminal. Once this attitude is established, healthy reactions on the part of the patient are soon acquired.

This personal supervision is also of importance in those psychotic cases which are suitable for home care. Here the social worker's problem is largely one of making certain that the patient's illness does not get him into social difficulties, whilst she also sees that he reports regularly at the Out-Patient Department, and she keeps the Hospital in touch with any changes in the patient's condition that are observed at home.

In addition to the regular Social Service there are two special workers, who, whilst carrying out their duties along essentially the

same lines as the Service in general, work with special groups of cases. These are: (1) The syphilis follow-up worker, whose duties aim at preventing a spread of infection, in addition to personal care; (2) the "Red Cross" worker, who confines her duties to the ex-Service patients.

Work of the Other Departments.

There is little that is novel in the other departments of themselves, but the manner in which they illustrate the application of the principles of general medicine to psychiatry is very striking. For example, the X-Ray Department is freely utilized for obtaining data as to the size of the pituitary gland, the question of a persistent thymus, the movements and positions of the viscera and their relationship to, say, the affective states.

The Biochemical Laboratory is extensively used to obtain data relating to metabolism and the endocrine system in relation to mental illness.

A vast amount of work along these lines is done, and because of the large quantity of cases which passes through the hospital, it takes a comparatively short time to collect observations on a large series of cases.

An outstanding feature of the Hospital is its Library, which is under the care of a trained librarian, and is completely equipped with works of reference and regular periodicals. A system of indexing enables former publications to be looked up with ease, thus making the Library a valuable aid, and a stronghold of all psychiatric literature.

A Picture of the Clinical Material.

The cases, as seen clinically, fall under three heads: (1) Ordinary chronic forms of mental illness; (2) ordinary forms of mental illness in an early or mild stage; (3) a group of special cases—types of illness which one does not see outside a psychopathic clinic.

Cases of the first group do not call for description in this contribution, but some examples of the other two groups may be given.

Early and Mild Stages of Ordinary Forms. (Group 2.)

Case 1.—An Irish-American, æt. 39, came to Hospital voluntarily, ten weeks after the birth of her child, because she felt unusually elated and could not settle to anything. She was restless, over-talkative, cracked jokes with the physicians and showed considerable flight and distractability. The intellectual functions were unimpaired; she realized that she was mentally ill. She had a well compensated mitral lesion; gynæcologically nothing was found. After three weeks in

Hospital, during which she had many conversations with the physicians, she was able to go home, and she had at least sufficient insight into her conduct and general strivings to enable her to appreciate her own difficulties and guard against them.

CASE 52.—An Irishman, æt. 36, was brought to Hospital by his wife. He was in an anxiety state. He had been in a general hospital following an injury to his foot, and the Wassermann reaction, which was done as a routine at that hospital, was positive. He became so disturbed about this that his wife brought him to the Psychopathic. Clinically, he was in an anxiety state with hypochondriacal trends. He wondered if a pimple on his face meant syphilis; he was continually asking to have his genital organs examined. A careful examination of his intellectual functions showed no deterioration whatever. Physically the pupils were fixed; blood and cerebro-spinal fluid—Wassermann reactions, were positive and the other cerebro-spinal fluid findings were characteristic of general paralysis. He remained voluntarily for malarial treatment.

CASE 32.—An Irishwoman, æt. 25, was brought to Hospital because she had gone into an hotel, got outside on the window-ledge and had then gone up on the roof and had sat on the edge of a chimney. Clinically, she was tearful and at times agitated; in conversation she was quite clear, but definitely retarded; there were no delusions or hallucinations. Her mental trend centred around the fact that she had entered the U.S.A. illicitly and was afraid she would be deported and sent from her $20 a week situation in the States to the poverty of her Irish home.

CASE 29.—A Nova Scotian, æt. 63, was sent in from a general hospital because she had threatened to jump out of the window and was "seeing animals." She presented the picture of a delirium; she wandered about in a purposeless way. During the night she was constantly out of bed watching the "kittens running up the ventilator." It was almost impossible to get her attention as she kept calling out to her son, whom she believed to be in the corridor. She confabulated, saying that she had seen the physician at a general hospital, describing how he had been called in in consultation and what he had said and done, etc. She was grossly disoriented and was unable to retain names from one minute to another. Physically she was very weak, sallow, emaciated and very constipated. There was visible peristalsis in the left umbilical region; the liver was felt 1½ in. below the costal margin and was tender, but smooth and regular. Neurologically there was nothing but a coarse tremor of the tongue and a fine tremor of the fingers. The history showed that for many years she had been constipated and for the past four months had complained of indigestion. For several years she had suffered from headache and sleeplessness, and had taken veronal in 10-gr. doses regularly over that period. The delirium had come quite "out of the blue" two days prior to admission. Malignant disease of the colon was suspected, but repeated X-ray examination failed to detect it. After repeated enemata the condition cleared up, and when the enemata were discontinued she again became sleepless, irritable and mildly excited. Further eliminative measures cleared up the symptoms again.

Special Forms. (*Group* 3.)

CASE 27.—An English girl, æt. 17, was under treatment for myxœdema at a general hospital in February, 1926. She was discharged in March and was getting on well on thyroid. In April a man took her for a motor run; he parked the car in a side street and offered her a drink; she refused. The man then had some drink himself and attempted to rape the girl. She was terrified and fought her way out of the car. She ran some distance and managed to get a taxi, which took her home. For about a week after this she felt all right, and then one day at her work she had a fainting "turn," and woke up a few hours later to find herself back in the general hospital where she had been before. These fainting spells continued daily for about a week. She herself had no recollection of them, but those who saw her stated that she re-enacted the whole of the unpleasant experience which she had gone through in the car and went through all the fighting and struggling in a most vivid way. She was referred to the Psychopathic Hospital from the general hospital. Clinically no psychotic features were present. The intelligence quotient was 104; there were no signs of myxœdema. She discussed her case frankly and intelligently; she recalled the original incident vividly, and said,

"I hate to think about it so much that I go off in a subconscious state." No deep analysis was made in this case. The girl after discussing the incident seemed to have sufficient insight to readjust herself with a little help and she made a good recovery.

CASE 2.—A clerkess, æt. 25, was referred to Hospital by the courts, where she was being tried on a charge of forgery. Clinically there were no psychotic symptoms. She was rather casual about the whole situation. Her intelligence quotient was 102. Her story was that she was infatuated with a certain man who was very hard up; he had induced her to forge a small cheque and had then threatened to expose her if she did not continue forging larger cheques. She said this was her first misdemeanour. The patient's sister, when interviewed, confirmed this statement. On the face of it, then, there was no evidence of any mental illness; no terms in which the patient's conduct could be explained. It is in this type of case that Social Service proves itself of such great value. They took up the case and found that the patient had been expelled from school for stealing money from other pupils. She used to indulge in very strange forms of behaviour. For example, she would go into a shop and order a pair of shoes, and when the bill came in she would refer her creditors to her twin sister, who did not exist. A whole string of delinquencies came to light, and furthermore, the patient was well off and there was no necessity for her to do these things. As a result of the Social Service investigations it became quite clear that the girl's behaviour was explicable only in terms of mental illness, and the courts were accordingly informed.

CASE 30.—A girl, æt. 19, of Franco-Irish extraction, was sent to Hospital by a charitable institution because she had run away from the house where she was a domestic servant and had threatened to commit suicide. She had first come under the care of the Charitable Institution at the age of 13 at the instance of her mother, because she had been having sexual relations with a boy at that time. Since then she had not lived at home. Clinically she was of the bright, vivacious, rather attractive type that one associates with the cycloid make-up. She suffered occasionally from mild depressions of a few days' duration. She was very impressionable and easily swayed emotionally. Her intelligence quotient was 96. She showed no psychotic symptoms whatever. She discussed things openly and frankly. She said that since the age of 13 she had experienced at irregular intervals great sex longings and had yielded to them. Over a period of six years she had had affairs with four different men and appeared in each case to be genuinely fond of them; there was no question of monetary gain. She appreciated the fact that her conduct was opposed to accepted standards, and one felt that she was not wilfully promiscuous, but rather was unable to make an adequate compromise between the demands of her instincts and the demands of society. The Social Service investigated this case and found that her environment was just about as unsuitable as could be. Her father was alcoholic, her mother was a weak-undisciplined cripple. The family was supported by an 18-year-old brother. The patient had picked up her sex instruction casually and associated with rather a low crowd. She worked from 7 a.m. to 9 p.m., had no regular evenings off and was taken out once a month by a visitor, whom she cordially detested. Personal contact with the Hospital Social Service and the feeling that she could always come to the Hospital and talk over her difficulties with a psychiatrist made all the difference in the world to this girl's happiness and efficiency.

CASE 34.—A woman, æt. 37, of English extraction, was referred to Hospital by the Social Service of one of the general hospitals, where she had been operated on for salpingitis. Their reason for doing this was because she was separated from her husband and had had an illegitimate child by another man within the previous two years. Mental examination failed to reveal any evidence of psychosis, but her grasp of general information was poor. She lacked the proper appreciation of her position and behaviour. The aid of the Psychological Laboratory was called in and they found that the intelligence quotient was only 60. She reasoned very poorly. There was no scattering of performance, which was uniformly low and consistent with mental deficiency. This woman had been able to earn her living as a cook prior to her marriage. The family history was quite negative, and the patient's own children, of whom there were three, were all efficient. She herself had little or no schooling, being kept at home on a variety of excuses. It is noteworthy that a mental defective should have managed to carry on as well as this woman did before finally coming under proper supervision and care.

Discussion of Advantages and Disadvantages.

Advantages to the community.—The most striking advantage of the Psychopathic Hospital system is the fact that a patient, even although he is unwilling to come to hospital, does not need to be grossly ill mentally before he is brought under the care of the psychiatrists.

The early examination and treatment of cases tends to keep down the admission-rate to custodial asylums, and so tends to preserve the economic status of the individual and prevents him from becoming a burden to the State.

The executive officers and Social Service interview, in the course of a year, many thousands of relatives, and to them they impart the modern attitude to mental illness, and condemn the fatalistic and traditional attitude of the past.

The service given to courts, police, welfare schemes and schools goes far to prevent many anti-social and criminal acts from occurring.

Advantages to the individual.—The fact that the Hospital provides for the management of early cases renders its advantages at once apparent.

The great thing is that the policy of the hospital is not to condemn apparently deteriorated cases as hopeless. Psychologists have shown that many so-called states of dementia are really psychotic disturbances of thinking and that the intellect is well preserved; even the general paralytics are given every chance of improvement.

The Hospital does not lose sight of its patients when they are discharged; the Social Service follows them up, and they know that they can come back to the Out-patient Department at any time when they are in difficulties—a singular contrast to the ordinary mental hospital, where the unfortunate relatives have to wait until the patient is certifiable before they can bring him back.

Advantages to the profession.—The general practitioner can send difficult cases to the Psychopathic without the need for certification. He may be in doubt as to whether certification is the proper course; the relatives may be unwilling to accept his view that it is the proper course. In such cases the opinion of the physicians at the Hospital is generally accepted, and tides over a difficult situation.

The value of the Hospital as a teaching centre for students and post-graduates is enormous.

Criticism.—No criticism is offered of the theoretical system of the Boston Psychopathic Hospital, but in practice certain difficulties arise which are briefly indicated below:

(1) Far too much of the wrong kind of material finds its way into the Hospital; 60% of all admissions go on from the Psychopathic

to State hospitals (7). The fault lies with the general practitioners and with patients' relatives, principally the latter. The executive officers could simply refuse to admit unsuitable cases, but they must stand by the general practitioners in emergency.

(2) Ten days is rather too short a time in which to make a complete investigation of a case, consequently some of the diagnoses which are made would perhaps be altered were the patient in hospital a little longer. This point has been investigated, and it has been found that, of those cases which go to State hospitals, the diagnosis has to be altered in one case out of four, most of the errors being in the manic-depressive and schizophrenic groups, particularly in states of excitement (8).

(3) The staff is too rigidly subdivided; thus the relatives only get, so to speak, second-hand information about the patients, as they do not come in direct contact with the clinical staff. Sometimes executive and legal matters make it necessary for a patient to leave hospital whilst his case is perhaps the subject of an elaborate biochemical investigation.

Conclusions.

(1) There is a certain class of case which is quite unsuited to chronic mental hospitals, and for which general hospitals have not yet made provision.

(2) This material consists of (*a*) early or mild cases of orthodox forms of mental illness; (*b*) certain anomalies of the personality and behaviour problems.

(3) In the majority of cases, a thorough analysis of the whole situation shows modifiable factors either in the individual or in his environment. It also shows how many of the illnesses could have been prevented.

The cases quoted above are a sample of what is met with in a psychopathic hospital. In the vast majority of cases the patients were thankful that they had come to the "Psychopathic"; they felt that their interests were being looked after by people who at least made an attempt to understand and not to judge them, and the knowledge that at any time in the future they could come back for advice and help gave them added confidence to face the world, while there was absolutely no stigma attached to having been in the Psychopathic Hospital.

(4) The management of these cases demands a special type of hospital in which a well-organized out-patient department, social service and psychological laboratory are essential.

A strong plea is made for the erection of psychopathic hospitals

in this country. There is a wealth of material which the psychiatrists in the ordinary mental hospital practice never touch. These patients are not physically ill; their doctors can do very little for them; and the fact that such material exists in this country is supported by even a casual survey of the 400 cases who visited the Psychiatric Clinic of the Western Infirmary, Glasgow, in 1926, to say nothing of the material which must have presented itself at other out-patient clinics throughout the country.

Failing the establishment of psychopathic hospitals, the next best thing is a good out-patient clinic at a general hospital with a proper social service. But the good that can be done by these means is nothing like so great as that which can be done if the patient is actually in hospital for a short time, so that a more complete investigation can be made.

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