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SOCIAL BACKGROUNDS OF ONE HUNDRED-SIX FAMILIES UNDER CARE AT CENTRAL STATE HOSPITAL

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CHAPTER I

NATURE AND SCOPE OF STUDY

Never before has there been as much public interest in mental health and in the adequate care and treatment of the mentally ill. In spite of the persistent fear and aversion toward mental illness that has been carried over from past centuries, there has been a constant trend toward a more sympathetic and understanding program for its prevention and treatment.

Once mental illness was considered as a visitation of evil spirits which inhabited the body of its unfortunate victim. With the growth of modern psychiatry and an increasing awareness of the interaction of society and of the individual, a new concept has been formed. A socially conscious society should recognize its share in the failure of the individual to adapt. As society assumes its responsibility for mental illness, the stigma to the individual decreases.

Society is increasingly concerned with the prevention of illness by adapting the environment of the individual, as well as by helping the individual adapt to society. There is increasing evidence that social forces are at work which are beyond his control. Some of these factors are positive, others are negative, and many of them may be utilized in the treatment plan of the patient who is mentally ill.

The purpose of this study is to make a survey of the social backgrounds of a selected group of persons with mental illness who were hospitalized for treatment and custodial care. From this survey some conclusions may be drawn concerning the extent to which social factors have contributed to the mental illness and how such factors may be utilized in treatment.

The case records of all persons admitted to Central State Hospital during the month of October, 1951, were selected for purposes of the study. The 106 admissions for this period represented both voluntary and court commitments and included the new and the returned admissions to the hospital.

Central State Hospital is located at Norman, Oklahoma. It is the largest of four state hospitals for the mentally ill in Oklahoma and admits patients from the central counties of the state. The patient population averages 3,000, and slightly over 100 persons are admitted each month. The

western counties of the state admit patients to the Western State Hospital at Fort Supply, which has a patient population of about 1,400 persons. The eastern counties are served by Eastern State Hospital at Vinita. This hospital has a patient population of about 2,400 persons. Since this is a southern region, segregation of Negroes is practiced. The Negro patients are committed to the Taft State Hospital at Taft. That institution has an average population of slightly less than 1000 persons.

The centrally located counties served by the Central State Hospital are both urban and rural in character. The area includes the state capital of Oklahoma City and its suburban district, and is one of the densely populated parts of the state. Other cities include Norman, home of the University of Oklahoma, Guthrie, the former state capital and now an agricultural center, and Muskogee, the center of an industrial area of coal and oil. Other cities are Ada, Clinton, Ardmore, Chickasha, Duncan, El Reno, Shawnee, and Seminole. All of these places have a fairly large urban population.

During the period covered by the study, there were admissions from twenty-nine counties. These were: Atoka, Blaine, Bryan, Canadian, Carter, Cleveland, Comanche, Custer, Garvin, Grady, Jefferson, Johnston, LeFlore, Lincoln, Logan, Love, McClain, Marshall, Murray, Muskogee, Okfuskee,

Oklahoma, Payne, Pontotoc, Pottawatomie, Seminole, Stephens, Tillman, and Washita. Admissions from some of these counties were transfers from another district: these were Blaine, Custer, LeFlore, Murray, Tillman, and Washita Counties.

Each of the hospital case records used for study of the social backgrounds of the patients included a copy of the court commitment; the intake sheet, with identifying information taken by the clerical staff at the date of admission; the report of the physical and mental condition of the patient made by examining physicians; and the reports of the nursing staff. Each record also contained memoranda of visits made by relatives or friends of the patient, and copies of all correspondence. Many of the records included social information taken by the social worker at the time of admission, and often they contained a formal history sheet which was filled out by an interested relative. Some of the records included data on results of psychological testing given the patient and the psychologist's interpretation of these findings.

CHAPTER II

THE SOCIAL SETTING

Oklahoma gets its name from two Choctaw Indian words meaning "land of the red man." For many years it was a huge Indian reservation, and its culture today retains much of the Indian influence. First discovered by the white man when Coronado crossed it in 1541 and one of the last states to be admitted to the Union, it is one of the more progressive of the states. It lies within the golden circle of Roger Babcock's chart of the country's best opportunity for expansion and prosperity.

Its broad plains, once marked by Indian and buffalo trails, now are crossed by air lanes, paved highways, and many miles of railroads. Most of this progress has been attained since 1879 when the "boomers" began to encroach upon the Indian reservations, only to be driven out repeatedly by federal troops.

Finally the government yielded to the demands of the settlers and on April 22, 1889, opened central Oklahoma to white settlement. Within a few days such towns as Guthrie and Oklahoma City had about 10,000 persons each, and there were over 50,000 in the entire central area. The majority

of these came from Texas, Arkansas, Missouri, Kansas, and Illinois. Thus the state was settled almost overnight by men of varied interests and widely different backgrounds and customs.

In 1893 Congress purchased lands from the Choctaws, Creeks, Chickasaws, Cherokees, and Seminoles, and included the eastern portion of the state for settlement. At about the same time the Cherokee Outlet was opened, adding a western section. In November, 1907, Oklahoma became a state. Its population growth was rapid between 1900 and 1910, with an increase of 446.0 percent in that decade. Growth was continuous until 1930. The period between 1930 and 1940 showed a loss of population of about 2.5 percent. The census of 1950 showed 4.4 percent fewer persons than in 1940. The loss in population has apparently been largely due to the development of mechanized agriculture without the compensating factor of industrial growth. Table I gives some comparative figures for the growth of the state up to the present time.

The 1950 census revealed that Oklahoma had a total of 2,233,351 persons. Of this number 51 percent was classified as urban and 49 percent as rural. Table II describes the population as to distribution by age and sex. Table III gives figures as to urban-rural distribution. The population density in the state, according to the 1950 census report

TABLE I

Population changes in Oklahoma from 1890 to 1950

Decade	Number of Persons	Percent of change over preceding decade
1890	258,657	--
1900	790,391	205.6
1907*	1,414,177	91.6
1910	1,657,155	17.3
1920	2,028,283	22.4
1930	2,396,040	18.1
1940	2,336,434	-2.5
1950	2,233,351	-4.4

U. S. Census, 1950, Population of Oklahoma, Number of Inhabitants. pp.6.

* Date of statehood in Oklahoma.

TABLE II

Age and Sex Distribution of the Population of Oklahoma, 1950

AGE	NUMBER OF PERSONS			PERCENT OF PERSONS		
	Total	Male	Female	Total	Male	Female
	2,233,351	1,115,595	1,117,756			
Under 5 years	240,472	122,475	117,997	10.7	5.3	5.4
5-14 years	398,908	203,871	195,037	17.8	8.9	8.8
15-24 years	345,347	172,981	172,366	15.7	7.8	7.9
25-34 years	321,527	158,227	163,300	14.4	7.1	7.3
35-44 years	302,411	148,004	154,407	13.4	6.1	6.3
45-54 years	245,658	121,612	124,046	10.9	5.3	5.6
55-64 years	185,140	91,880	97,343	8.5	4.1	4.4
65 years and over	193,088	96,545	97,343	8.6	4.2	4.4
Median age	...29.1	..28.7	..29.5			

U.S. Census, 1950, Population of Oklahoma, Characteristics of, p. 2.

TABLE III

Urban-rural distribution of the population of Oklahoma, 1950

AREA	NUMBER OF PERSONS	PERCENT
Urban	1, 139,481	51.0
Rural	1, 093,870	49.0
Total	2, 233,351	100.0

U.S. Census Report of 1950, Characteristics of the population of Oklahoma, p.2.

was 32.4 percent. Oklahoma City, the state capital, is the largest city. Its population in 1950 was 243,504, while that of Tulsa, the second largest city, was 180,586. In general, it may be said that the portion of the state served by Central State Hospital at Norman is more densely populated than the western section and similar to that of the eastern section. The average population of the counties in the eastern area is approximately the same as in the area served by the Central State Hospital.

The state as to race is largely white and native-born. About 9 percent of the population are Negro and 3 percent are Indian. The 1950 census report showed a figure of 2,032,555 whites (including Mexicans and Indians) and 200,796 Negroes. About 98.7%of the population are native born. Most of the foreign born are Germans, who live in the central part of the state. About 2.7 percent of the population as of 1950 were of "other races." These included Japanese, Chinese, and Filipinos. (See Table IV.)

Oklahoma has a dry, mild climate. As an inland state its temperatures vary widely. It is drained by two river basins, the Red River and the Arkansas, and the eastern portion is covered by low mountains extending from the Ozark range. A strip of rough land covered by scrub oaks crossing the center of the state from north to south is called the Cross Timber Country. Much of the scrub oak and hill

TABLE IV

Percentage by Race of Population in Oklahoma

All classes	White	Negro	Other Races
100.0	90.1	7.2	2.7

Information from Report of U.S. Bureau of Census, 1940, Characteristics of Population, Vol. II, Table 22.

country is not suited to agriculture. The most fertile section is along the north and south boundaries. As a whole the state ranks seventh in the nation in agriculture. It is the eighteenth state in land area, with an area of 69,031 square miles.

Oklahoma is rich in minerals, being first of all the states in the production of zinc, third in oil, and fourth in lead. It also produces large amounts of asphalt, tripoli, magnesium slates, and calcium-magnesium chloride. Lumber and coal are other important industries. Among the chief manufacturing industries are: flour mills, meat packing plants, building materials, petroleum refineries, and plants producing gravel, glass, and gypsum.

The state in 1950 had an annual per capita income of only $1075 as compared to the national average of $1436. In 1945 its per capita income was $894 as compared to the national average of $1191. As the figures show, the average income is increasing, but it is still considerably below that of the United States as a whole.[1] It naturally follows that those states with a lower per capita income could be expected to have a higher rate of welfare assistance. In 1950 the Department of Public Welfare of Oklahoma spent $75,000,000 for all phases of public assistance administered

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[1] Report of Department of Commerce, World Almanac for 1952, p. 674.

by that department. Oklahoma has the second highest ratio of categorical assistance in the nation, ranking next to Louisiana in assistance to the aged and to Florida in aid to dependent children. Over one-half of the population of Oklahoma sixty-five years of age or older were drawing public assistance. There were 98,128 persons in this category. Aid to the blind was received by 2,619 persons, while 21,873 families received aid to dependent children. In Oklahoma the average payment for assistance to the aged was $48.64, whereas in the nation as a whole the payment averaged $43.23. It ranked eighteenth among the states, however, in amount of payment. It ranked thirty-first in amount of payment in aid to dependent children and twenty-first in aid to the blind. The national average payment for aid to dependent children was $73.32 as compared to that of $72.57 in Oklahoma. The average payment for aid to the blind was higher, however, than the national average. Its payment was $51.66, as compared to $46.77 for the United States as a whole.[2]

The high rank of the state in the amount of assistance given its average recipient of categorical assistance reflects its liberal philosophy in regard to responsibility for the welfare of its citizens. It is noted also that

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[2] Figures given for public assistance were obtained from the report of Oklahoma Department of Public Welfare, 1950-51.

the state has more than its average share of the nation's aged population. As shown in Table II , 8.6 percent of its total population in 1950 were sixty-five years or over. In the United States as a whole, however, there are only 5.7 percent in this age group. The state has also a larger percentage of aged persons receiving public assistance, with more than one-half of this group receiving aid. In the country as a whole, there are only about one-fifth of this group who receive aid.[3]

It has been estimated that there are over 475,000 persons in the entire country who are committed to hospitals for the mentally ill. In Oklahoma as of 1950, about 7,850 persons were confined in such hospitals.[4] In a state with a low per capita income which has need for meeting large public welfare needs for financial assistance, the cost of mental illness has been a real problem. The state has attempted to cope with the problem, and considerable progress has been achieved, both in the care of the mentally ill and in a program for education toward prevention.

Some of the more notable improvements have taken place in Central State Hospital where several new buildings have been added. Additions to personnel have also been made. These include ward attendants and psychiatric nursing staff.

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[3] Information as to U.S. averages obtained from Social Security Bulletin, June, 1950.

[4] World Almanac, 1952, 47.

CHAPTER III

CHARACTERISTICS OF THE PATIENT POPULATION

Psychiatry has been defined as "that branch of medicine which deals with the genesis, dynamics, manifestations, and treatment of such disorders and undesirable functioning of the personality as disturb either the subjective life of the individual or his relations with other persons."[5] It is concerned primarily with the individual as he tries to satisfy his instinctive and emotional needs in the face of a culture and environment that often operate against such satisfactions.

Many of these individuals who have been recognized as disturbed either within themselves or in their relations with other persons are patients in mental hospitals today. Even when organic disturbances exist as elements of a mental disease, the behavior that accompanies these elements cannot be readily understood without knowing something of the cultural and environmental pressures of the individual,

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[3] Arthur P. Noyes, Modern Clinical Psychiatry (Philadelphia: W.B. Saunders Company, 1949), 78.

and how these have affected him. It is known that in psychogenic disorders personal and social factors are predominant in their causation. For this reason, any information regarding the social backgrounds of any specific group of disturbed persons will add to the field of knowledge concerning the extent to which such factors affect all mental illness. Physicians are becoming more aware of the necessity for treating the whole patient rather than his illness alone. The physical and mental health of an individual can be best understood on the basis of an adequate knowledge of his social background and the factors in his environment which may have precipitated his illness.

John Maurice Grimes, who compiled statistics on conditions in mental hospitals of the United States as of 1934, says: "Patients are hospitalized, not because they are mentally ill, but because of unsocial or anti-social manifestations." [6] The geographic and cultural environment of the patient must be studied carefully, both in making a diagnosis of his illness and in evaluating the advisability of his eventual discharge from the hospital. Since an interpretation has to be made of the "unsocial or anti-social manifestations" of the patient, it follows that

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[6] John Maurice Grimes, Institutional Care of Mental Patients (Chicago: Published by the author, 1934), 90.

recognition of mental illness varies greatly from one community to another. For example, while the erratic or unusual behavior of an individual might not be noticed in an isolated rural section, such behavior would be more easily recognized in a populous area where the individual is more likely to come in contact with others and in conflict with them.

A man going barefoot along the highway in Atoka County, a rural and comparatively undeveloped county, would seem quite normal, but would be quickly apprehended by police on a city street in Oklahoma City. It is also true that the barefoot man in Atoka County might perhaps only be adhering to the social customs of many of his neighbors and therefore quite acceptable in his behavior, whereas in Oklahoma City he would be considered as a person exhibiting "unsocial or anti-social manifestations."

Some reasons for the greater incidence of mental disease in urban areas include the difficulty of caring for the mentally disturbed person under crowded city conditions, and also the greater accessibility of the mental hospital to the urban population. There are undoubtedly factors in urban life itself, however, that are conducive to the incidence of mental illness. These factors include the more rapid tempo of daily life, monotonous work, and lack of incentive. Conversely, it is often true that the isolation of some rural sections contributes to incidence of illness.

In his recent book on the subject of social pathology, the sociologist, Lawrence Guy Brown, says:

> A person becomes insane in the process in which he develops human nature. He becomes insane in the process in which he acquires a world in which to live. If this world is too private, too far removed from the general social world, then he is insane. The mentally ill person has rejected existing social definitions and has his own private interpretation of culture.[7]

The private world he mentions, however, may be as easily created in the loneliness of a large city as in a sparsely settled farming community.

A large number of admissions to Central State Hospital are from the counties of chiefly urban population. Of the 106 patients admitted during the month of October, 1951, the period under study, exactly one-half were admitted from the five counties adjacent to the populous Oklahoma City area. These counties included Canadian, Cleveland, Lincoln, Oklahoma, and Pottawatomie Counties. Table V shows the number of admissions from each county served by Central State Hospital and the percentage of each county per 100,000 population. This may readily be compared with Table VI, which shows the total number of admissions for the preceding twelve-month period.

Cleveland County, in which the hospital is located, had

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[7] Lawrence Guy Brown, Social Pathology (New York: F. S. Crofts & Co., 1946) 260.

TABLE V

Number of Admissions and Number per 100,000 of the General Population by County

County	Number Admissions	Percent per 100,000 Inhabitants
Atoka	2	14.2
Blaine	1	Transfer
Bryan	3	9.8
Canadian	4	15.7
Carter	3	8.9
Cleveland	4	10.36
Comanche	3	5.8
Custer	1	Transfer
Garvin	1	3.6
Grady	2	6.1
Jefferson	1	9.1
Johnston	3	28.7
Leflore	1	Transfer
Lincoln	2	9.4
Logan	2	Transfer
Love	2	27.8
McClain	3	21.1
Marshall	1	11.2
Murray	2	Transfer
Muskogee	2	3.8
Okfuskee	3	18.1
Oklahoma	40	8.13
Payne	1	2.1
Pontotoc	2	6.5
Pottawatomie	11	39.5
Seminole	2	4.9
Stephens	2	6.1
Tillman	1	Transfer
Washita	1	Transfer
TOTAL	106	

Table VI

Number of Admissions and Number per 100,000 of Population by County During a Twelve Month Period

County	Number Admissions	Number per 100,000
Atoka	22	12
Blaine	0 (transfer county)	
Bryan	20	5
Canadian	24	9
Carter	50	13
Cleveland	81	20
Comanche	8	2
Custer	2 (transfer)	
Garvin	27	8
Grady	78	22
Jefferson	23	21
Johnston	13	12
LeFlore	6 (transfer)	
Lincoln	23	9
Logan	32	15
Love	6	7
McClain	24	15
Marshall	7	8
Muskogee	17	3
Okfuskee	27	18
Oklahoma	502	16
Payne	34	7
Pontotoc	52	13
Pottawatomie	78	12
Seminole	50	12
Stephens	30	15
Tillman	4 (transfer)	
Washita	2 (transfer)	

four admission, while Pottawatomie County, with about the same population, had eleven admissions. It was interesting to note that Lincoln County, one of the five counties in the urban area adjacent to the state capital of Oklahoma City, had no town of more than 3,000 population. In general, the higher rates for admissions per 100,000 population were found in the more urban counties.

Table VII shows the distribution of patients admitted by geographic location and by sex. As indicated on the hospital face sheets from which this table was compiled, "urban" is defined as a city of 2,000 population, "village" a town of up to 2,000 persons, and "rural" the strictly rural section, comprising farming communities. The table shows that 76 patients came from urban places, 14 from villages, and 15 from rural sections. One was not reported. The figures show that almost 90 percent were from village or urban areas, and only about 10 percent from farm areas. A larger percentage of women than men came from urban areas. The percentage in rural sections was almost equal. The status of one woman was unknown.

An interesting comparison of rural-urban factors in mental disease is given in a study by the Federal Census Bureau. The report contains some comparative figures, both as to rural-urban characteristics and to sex distribution in mental illness. These were based on first admissions. In

TABLE VII

Distribution of 106 Patients Admitted to Central State Hospital by Sex and Geographic Location

Location	Males		Females		Total	
	Number	Percent	Number	Percent	Number	Percent
Urban	44	67.0	32	77.0	76	72.0
Village	10	15.0	4	10.0	14	13.0
Rural	11	17.0	4	10.0	15	15.0
Unknown	0	0	1	-	1	-
TOTAL	65	100.0	41	100.0	106	100.0

compilation of this report of 63,624 cases it was found that there were very few admissions under 15 years of age for either sex. As adult life was reached the rate increased rapidly, both for men and women. Increase with advancing years was less marked, but in the years of old age it was again accelerated. Urban men had the highest rate in each age group. Urban women had the next highest rate in each age group except that of 20 to 24 years. Rural men had higher rates than rural women in every period except that of 50 to 54 years. Rural women had the lowest rates of all.[8]

In the study of admissions made, as may be seen in Table VII, urban women had a higher rate of mental illness than urban men, but there was a larger proportion of rural males. The urban patients numbered 72 percent of the total patient group, as compared to the general urban population average of 51 percent. The figures show that 65 men and 41 women, a total of 106 patients, were admitted to the hospital during the period under study. This is a percentage of 63 percent of men as compared to 37 percent of women. The average represents about six men to four women who were mentally ill as compared to the national average of six men to five women. On the whole, the higher incidence of male patients seems to be partially due to the types of mental illness more prevalent among men, such as general paresis,

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[8]Horatio M. Pollock, Mental Disease and Social Welfare (New York: State Hospitals Press, 1941), 134-144.

alcoholic and drug psychoses, traumatic psychoses, psychoses with epilepsy, and psychoses with cerebral arteriosclerosis. Among the diseases more prevalent in women are the manic-depressive psychoses, involutional melancholia, paranoia, schizophrenia, and psychoses with somatic disease.[9]

The graph in Figure I illustrates the variation in age range of men and women patients at commitment. This graph is based on the actual age of the patient at the date of commitment, whether a new or a return admission. The graph in Figure II shows the age of these patients at first admission to any mental hospital. Number of admissions to a hospital varied from one to thirteen times. The graphs show that the highest incidence in both men and women patients of the group occurred in early and middle adult life.

The onset of illness, as illustrated in Figure II, occurred most often in both men and women during the period from 30 to 39 years of age. This age range in men corresponded to the most active earning period of the average man. It is also the age when the most physical trauma might be expected, such as that resulting from injuries to the head or spine. These are often a causative or precitating factor in psychosis. In this particular group, however, there was only one patient, while the remainder were paranoids, alcoholics, and psychopathic personalities. The peak of incidence in women occurred during the most active years

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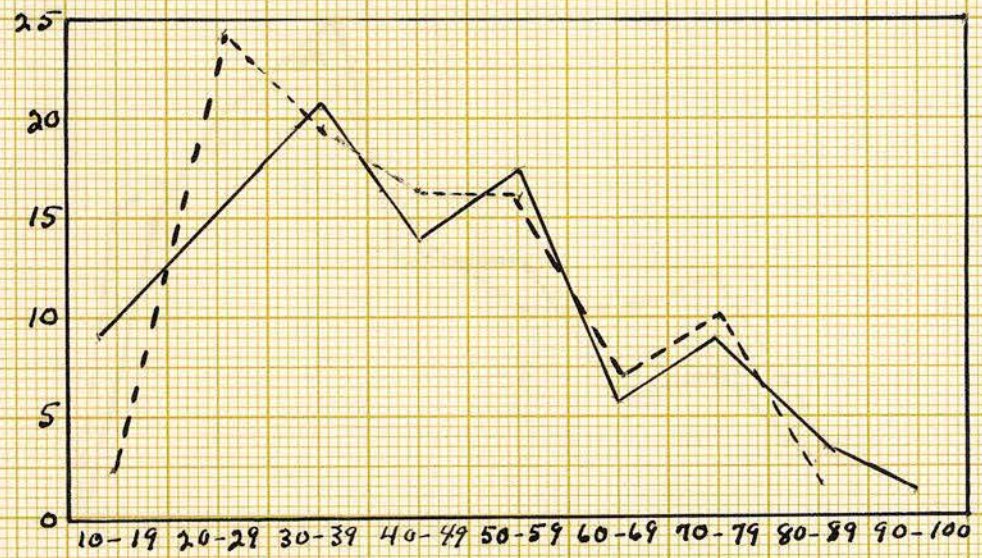
[9]Arthur P. Noyes, Modern Clinical Psychiatry (Philadelphia: W. B. Saunders Company, 1949), 90.

Figure 1

Age and Sex Distributions of 106 Patients Admitted to Central State Hospital

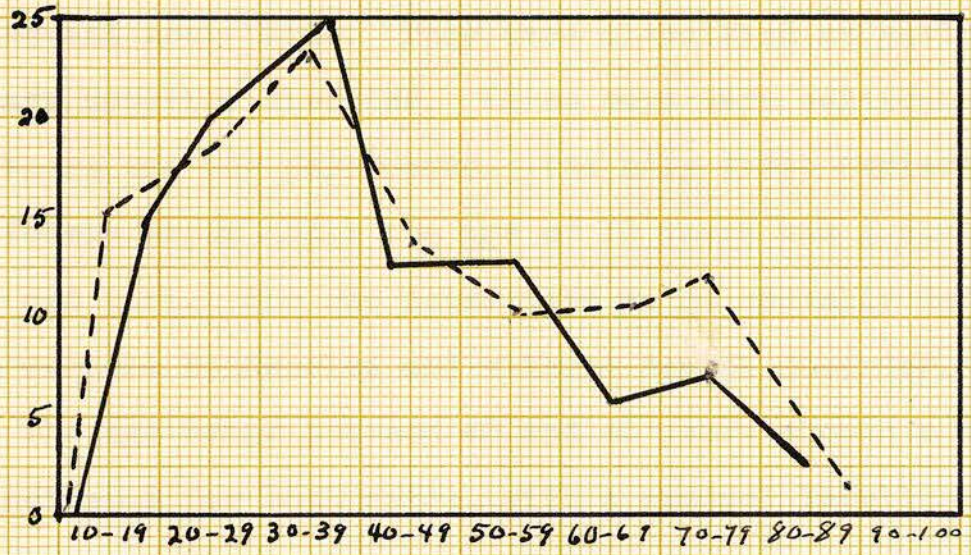


Legend: Men ——
Women – – –

Figure 2

Age and Sex Distribution of 106 Patients

At Age of First Admission To A Mental Hospital



Legend: Men ——
Women - - -

of child-bearing. This period is usually considered to be characterized by special physical strain and psychological stress.

The graph in Figure II shows that there were 10 males and 6 females in the very early age group of from 10 to 19 years. This was the first admission for six of the 10 males in this group. Two were boys of 12 and 16 years of age, who had been apprehended by county authorities for their delinquent activities. They were classified as having a primary behavior disorder. Three boys were schizophrenics, and there was one psychopath. The only first admission of the female group under the age of 19 years was a sixteen-year old girl. She was determined to be mentally deficient, with schzoid tendencies and without mental disorder.

The age range between 40 and 45 years showed a decline in incidence for both sexes, with a gradual levelling out to age eighty. The decline was sharper for women than for men patients, with each sex showing a slight peak in the period between 70 and 79 years. The sharp decline after the age of 79 years is evidently due in part to the high mortality rate of the aged. The oldest women admitted during the period under study was 84 years old. The oldest man was 91 years of age.

Table VIII shows distribution of patients by race and sex. It should be remembered, in studying racial composition that there is a separate mental institution for Negroes which is located at Taft. During the period under

TABLE VIII

Nationality and Sex of 106 Patients Admitted to Central State Hospital

Nationality	Women	Men	Total
White (native-born)	40	63	103
Indian (native-born)	0	1	1
Irish (foreign-born)	1	0	1
Jewish(foreign-born)	0	1	1
Total	41	65	106

consideration only one Indian was admitted. Two foreign-born persons, one of whom was a Jewish displaced person and one of Irish birth, were also admitted.

Information concerning length of residence is given in Table IX. The residence of a number of patients was not reported. Of those whose length of residence was given, 48 persons, approximately one-half the total, had resided in the state for their entire lives. Seven persons had lived in the state for less than a five-year period. About one-seventh of the group had lived in the state for a period ranging from ten to twenty-five years.

Five patients who were not legal residents of the state became ill while temporarily in the state. These were committed by county authorities. The residence of one of these patients was unknown. The others were from Ohio, Connecticut, Indiana, and Utah. One was a college student, one a cattle buyer, and another a salesman. The fifth was a housewife who came voluntarily for treatment of alcoholism. Although the length of residence had not been determined in twelve cases, there was evidence in each instance to indicate that all of these were legal residents. This evidence was contained in the social history or work record, or in the fact of previous treatment in a state hospital. In one case the elderly patient was a recipient of old age assistance.

The information gained from the survey as to residence

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TABLE IX

Patients by Years of Residence in Oklahoma Before Admission to Central State Hospital

Length of Residence	Number	Percent
Less than a year	5	4.7
1 to 5 years	2	1.9
5 to 10 years	0	-
10 to 25 years	14	13.2
Over 25 years	22	21.7
Life residence	48	45.3
"Legal residence"	1	-
"Years ago"	2	1.9
Unknown	12	11.3
TOTAL	106	100.0

indicates that the state has little difficulty with transient patients as a group, and that most of the admissions are long-term residents. The majority of these patients were evidently inclined to remain in their home communities where they might find some measure of stability among their relatives and acquaintances.

According to Table X, all but two of the 106 patients listed were born in the United States. The woman who was born in Ireland had been naturalized. The Jewish displaced person was an alien who had been in this country only a few months under the auspices of the Jewish Charities of Oklahoma City. Forty-eight of the patients had been born in Oklahoma. As might be expected, the states adjoining Oklahoma on the east and south were the birthplaces of the largest number of persons born outside the state.

Nine of these claimed Texas as their birthplace. Arkansas and Missouri accounted for eight persons each. Three each were from Kansas and Tennessee. The states of Alabama, Georgia, Connecticut, Louisiana, Iowa, Nebraska, North Carolina, New York, Ohio, Indiana, and Utah were represented with one each. The birthplaces of 11 persons were unknown. Some of those whose birthplaces were listed as unknown were too confused at admission to give accurate information, and their relatives were not available to assist them.

TABLE X

BIRTHPLACE OF PATIENTS

Place of Birth	Number of Persons
Alabama	1
Arkansas	8
Connecticut	1
Georgia	1
Illinois	4
Indiana	1
Iowa	1
Ireland	1
Kansas	3
Louisiana	1
Missouri	8
Nebraska	1
North Carolina	1
New York	1
Ohio	1
Oklahoma	48
Poland	1
Tennessee	3
Texas	9
Utah	1
Unknown	11
TOTAL	106

CHAPTER IV

SOCIAL AND HEALTH HISTORY OF THE PATIENT POPULATION

The general characteristics of the patients were studied in the preceding chapter. These included race, sex, age, urban-rural distribution, and length of residence. Some comparison was made of the age and urban-rural characteristics of the patient group with the mentally ill of the country as a whole.

This chapter is concerned with the social environment and developmental history of the patients as an aid in further understanding the factors involved in mental disease. The causes of mental disorders are multiple and long-continued.[10] Personality weakness exists in both hereditary and environmental factors in varying proportions. The environmental factors are cumulative. Heredity transmits a general capacity rather than a specific mode of behavior and may be called a constitutional tendency. Sadler also states that a predisposition may also be acquired through faulty training and education in the years of childhood.

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[10] William A. Sadler, Modern Psychiatry, (St. Louis: C. V. Mosby Company, 1945), 184-188.

He defines psychosis as a phenomenon of defective adjustment to a life situation.

In describing the various disturbances of personality, Sadler believes that classifications of these are useful in that they clarify teaching, and therefore contribute to progress in understanding such disturbances and in planning for their treatment. He states:

> In arriving at a diagnosis of...mental, emotional, and personality disturbances, it is necessary to search carefully for the mechanism of the individual's reaction to his environment. In other words, the psychiatrist must make sure that he has done his best to find out what the patient is trying to accomplish...by these indirect phenomena of personality misbehavior, neuroticism, and psychotic performance.[11]

The diagnoses agreed upon, in general, to classify mental illness of the patients studied at Central State Hospital fell into eight chief groups, as seen in Table XI. The largest incidence of men patients was found in the group diagnosed as alcoholics, either with or without psychosis. Sixteen men patients, one out of four, were in this classification. In several other instances, the psychosis was accompanied by problem drinking. Two of the alcoholics were classified as psychopathic personalities. Among the women patients, there were two alcoholics without psychosis. Alcoholism was noted as a contributing factor in the illness of another woman patient who was a schizophrenic. In other words, almost one-third of all men were excessive drinkers,

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[11] Ibid., p.206

TABLE XI

Distribution of 106 Patients Admitted to Central State Hospital by Sex and Type of Psychosis

Type of Psychosis	Total		Men		Women	
	No.	P.C.	No.	P.C.	No.	P.C.
Alcoholic psychosis.....	4	3.7	4	4.6	0	0
Alcoholic without psychosis..	12	11.3	10	15.4	2.	4.8
Involutional melancholia.....	5	4.7	1	1.5	4	9.6
With other somatic change....	28	26.4	21	32.4	7	17.0
Paranoid.....	4	3.8	4	6.1	0	0
Schizophrenia.....	30	28.4	11	17.0	19	46.3
Psycho-neurosis.....	5	4.7	1	1.5	4	9.6
Psychopathic.....	4	3.7	4	6.1	0	0
All other cases.....	14	13.2	9	14.0	5	12.2
Total.....	106	100.0	65	100.0	41	100.0

as compared to one of thirteen women.

Psychoses which were accompanied by other somatic changes included various organic diseases, such as brain tumor, Huntington's Chorea, neuro-syphilis, meningo-encephalitis, and circulatory disturbances. The latter classification included many of the senile patients. It is interesting to note that all the patients listed as "paranoid condition" were men. While there were no women with true paranoia, eight women schizophrenics were diagnosed as having a paranoid type of illness. Altogether there were 10 men and 8 women who had paranoid tendencies mentioned as part of their mental disorder. There were no alcoholics among those noted to have paranoid conditions. However, one of the four paranoids was a moderate drinker.

Involutional melancholia was given as the diagnosis for five patients. Of these, four were women. The man with this diagnosis was 68 years of age. His wife was already a patient at Central State Hospital as a schizophrenic, and his sister was diagnosed as having involutional melancholia. The patient had been alcoholic and suicidal, and unwelcome in his daughter's home.

The three women patients with involutional changes had also come from home environments that did not seem happy. One was an English teacher, fifty-five years of age. Her intelligence quotient was noted as 152, but she had not completed college. When she had been quite young,

her mother had died of mental illness and her father of tuberculosis. She had always been extremely shy and retiring in her behavior. A second patient was also a teacher, fifty-seven years of age, who had completed her master's degree. She had recently been divorced after twenty years of marriage, and shortly before her admission had been crippled by a fall.

The third was only thirty-five years of age. At the age of twenty-one she had a hysterectomy, following syphilis in childhood. Her only child of an early marriage had been born dead. She was separated from her husband, and had recently been injured in a car wreck. The fourth was forty-three years of age, a high school graduate. She had two illegitimate children before her three marriages, all of which had terminated in divorce. The instability of this patient's personality seemed to have been present in her childhood and had led her into a very disturbed and unhappy life.

Schizophrenia accounts for about fifty percent of all mental patients in the hospitals of the United States.[12] This disease also showed a high incidence in the patient group under study. Nearly one-half of the women patients admitted during the period were diagnosed as having some type of schizophrenia. Seventeen schizophrenic patients

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[12]Albert Deutsch, The Mentally Ill in America, (New York: Columbia Press, 1949), 486.

were men. Types of schizophrenia included simple, mixed, hebephrenic, catatonic, and paranoid. Altogether there were 30 persons, or about 28 percent of the total, who represented this classification of mental illness.

A small number of patients were diagnosed as having a psycho-neurosis. Four of these were women, and there was one man. Four men were classified as psychopathic personalities. No women, however, were so classified. Under "other" types of illness were grouped such classifications as: primary behavior disorder, mental deficiency with or without psychosis, and psychosis due to drugs or other exogenous poisons. Also in this classification were included psychoses with senility. The diagnosis with the largest number of men patients was that of psychosis with other somatic change, including the circulatory disturbances. There were 21 men in this group, as compared to 7 women.

Only one of the 106 patients in this study was determined not to have any mental disorder. This person, however, had psychotic episodes with fugue states. He had been committed for psychiatric evaluation after attacking a girl with a pistol during one of these fugues. The fact that all the 106 patients were confirmed to be quite disturbed may indicate that their symptoms of mental disorder had probably been apparent before becoming so acute that professional advice was sought and treatment undertaken.

Health History

Health factors were frequently associated with mental illness in most of these 106 cases. Figures giving the health history of patients may be noted in Table XII. These figures classify the more obvious health problems and do not include patients noted as needing extensive dental repair, correction of vision, or hearing aids. These problems were noted, however, in connection with the physical examination given the patient at admission. Sometimes the health problem was listed as a "contributory factor" in the mental illness. According to the figures in Table XII, five out of six men and three out of four women patients had some physical disability, either in their past health history or at the time of admission.

According to Sadler, the physical examination of the patient and his health history are important in diagnosis. Physical illnesses with their associated exhausting and toxic effects may be possible etiologic factors in the mental disorder of the patient. He states: "Not only the disease but the patient's emotional attitude toward the affliction are of diagnostic value."[13] The attitude of the individual toward general biologic epochs, such as puberty, pregnancy, or menopause may yield valuable diagnostic clues.

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[13]Sadler, op. cit., p. 234.

TABLE XII

Chief Physical Disabilities of 106 Patients Admitted to Central State Hospital by Sex

Disability	Men	Women	Total
Blindness	2	1	3
Circulatory disturbances	10	4	14
Cortical atrophy	1	0	1
Deafness	3	1	4
Long hospitalizations, surgery	10	15	25
Gastric disorder	1	0	1
Old injuries	4	1	5
Recent injuries	4	0	4
Severe illness	9	5	14
Other disorders	8	2	10
No major health problem noted	13	12	25
Total	65	41	106

He suggests that the emotional depression which is often a prominent feature of physical illness is itself predisposing to personality disturbance, and that illness may serve as the culmination for a long emotional struggle between personal desires and social demands.

In the table describing the physical disabilities of the patients of this study, drug addiction and alcoholism were not included. Blindness was mentioned in three cases. Circulatory disturbances, which were noted as contributory factors in 14 cases, were found chiefly in aged persons as affecting senile psychoses. Cortical atrophy had occurred in one case. Deafness was determined to be contributory to mental illness in four cases. The largest percentage of health problems, however, was found in the history of long hospitalizations and extensive surgery which occurred in nearly one-fourth of the whole patient group. A larger percent of women than men had this type of background. Old injuries to the head or back had occurred in five cases, and recent head injuries in four cases. Chronic gastric disturbance, noted as possibly of neurotic origin, was found in one case.

A large number of patients had a history of severe illnesses, including tuberculosis, pellagra, syphilis, influenza, diptheria, pneumonia, and meningitis. Other disorders included epilepsy, convulsions, and various glandular disorders.

All the men patients classified as "paranoid condition" were noted in the physical examination as being in average or excellent health. Among those with no major health problems were three men and woman who were mentally deficient, and two adolescent boys diagnosed as having primary behavior disorders.

In two cases of polio in which extensive surgery had been performed, the patients manifested feelings of helplessness and self-consciousness. Other health conditions included cosmetic problems which might ordinarily be considered as social handicaps. For these, see Table XIII. The table shows that twenty-two patients, or approximately one-fifth of the total number, had these special problems.

These conditions included blindness, deafness, club feet, an artificial limb, facial paralysis, eczema on the face, scars from operations or accidents, and speech defects. One patient had no apparent health problem except that he was noted to be " ridiculously elongated in body." He was an individual with marked inferiority feelings, who came from a home environment with high social standards and an emphasis on conformity. The examining psychiatrist had remarked that his ungainly appearance had served to increase his emotional difficulties. His diagnosis was that of an anxiety state, with episodic fugues. The woman who had a club foot was noted as suffering from acute guilt feelings because her child had inherited her physical handicap.

TABLE XIII

Special Problems of 22 Patients Admitted to Central State Hospital, by Sex

Special Problem	Male	Female	Total
*Ridiculously elongated body	1	0	1
Artificial Limb	1	0	1
Blindness	2	1	3
Club feet	0	1	1
Deafness	3	1	4
Facial paralysis	0	1	1
Eczema on face	0	1	1
Scars	4	3	7
Speech defect	3	0	3
Total	14	8	22

Many frustrations and disappointments must have complicated the lives of these patients. Karl Menninger says of the physically handicapped person: " Defects in the inherited constitution, or physical accidents and diseases, impair, to varying degrees, the adaptive capacity of the individual." [14] Emotional disturbances may arise from the feelings of insecurity and isolation of the individual who carries a type of physical handicap which is visible to others. Deafness and blindness are certain barriers to normal social contact. Hardly less isolating is defective speech, which prevents ready communication of thought to others. Such persons might be expected to have difficulty in establishing satisfactory social relationships.

In the cases under study, it was interesting to note that all three persons with speech defects were men. The case involving facial paralysis was that of a twenty-eight year old woman who had been committed at her own request for treatment of chronic alcoholism. The case of facial eczema was also that of a woman. She was of middle age, divorced, and was employed as a hotel housekeeper at the time of onset of the skin ailment. Her efforts to relieve it had led to a psychosis due to bromides. The majority of cosmetic handicaps involved scars caused by operations or accidents. Almost one-third of patients with special problems were in

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[14] Karl A. Menninger, The Human Mind (New York: Garden City Publishing Company, 1930), 29.

this group.

Economic Levels

The economic status of the patients under study was not clearly stated in the hospital records. The amount of actual income for each patient was not given. Instead, the records classified the patients into three general economic groups, designated as "dependent", "marginal", and "comfortable".

As defined for purposes of the records, the dependent group consisted of patients of school age, or of adult patients in the homes of relatives because they had been unable to support themselves prior to their admission to the hospital. The marginal group included patients from the families of low income brackets. These were chiefly designated as common laborers, tenant farmers, or those persons dependent upon public welfare. It also included farmers, skilled workers, and semi-professional workers. The comfortable group consisted of those whose incomes and standards of living were higher than that of the average person committed to the hospital.

Table XIV describes the economic levels of patients admitted during the period under study. The data were based largely upon the check list from the face sheet of the hospital record. The material was revised, however, to include as dependent those patients who were receiving some type of

TABLE XIV

Distribution of 106 Patients Admitted to Central State Hospital by Economic Status and Sex

Status	Total	Men	Women
Dependent	13	10	3
Marginal	81	51	30
Comfortable	11	3	8
Unknown	1	1	0
Total	106	65	41

public assistance at the time of commitment. The number of patients listed as marginal in income may partly be accounted for by the lack of private or public facilities available in the state for either limited or extended treatment. Although the scope of the mental health program in the state is being enlarged through the National Mental Health Act of 1946, there are still relatively few clinics where symptoms of mental illness may be observed and diagnosed.

Two free clinics are already in operation in Oklahoma City, and one in Tulsa. The Community Mental Hygiene Clinic, which is sponsored by the community chest of Oklahoma City, serves persons in Oklahoma County, affording both diagnostic service and treatment. The Mental Hygiene Clinic associated with University Hospitals is also located in Oklahoma City, giving statewide diagnostic service and limited treatment. Also giving state-wide service on a fee basis is the Research Foundation Sanitarium in Oklahoma City, formerly known as the Spencer Road Sanitarium. This hospital, which had been privately operated for several years by Dr. Coyne Campbell, was given by him to the Medical Research Foundation in 1950. It is available to all psychiatrists. The clinic in Tulsa is concerned with child guidance, and is sponsored by the community chest of that city. The Oklahoma Committee for Mental Health has recently been reorganized and has plans for creating county chapters throughout the state to promote mental health.

Of the 106 patients included in the study, only one in nine were listed as being in "comfortable" circumstances. Many of the patients thus listed had already been examined at private clinics and referred to the state hospital for extended care. The statistics of state hospitals showed that in 1950 there were only 244 patients in hospitals for the mentally ill of Oklahoma who paid for all or part of the cost of their care. The total annual payment of these patients in 1950 amounted to $68,654, or $281.35 per person. This figure amounted to only 2.1 percent of the total cost of patient maintenance. Oklahoma ranks among the ten lowest states in the cost of care. Eight other southern states, also Indiana and South Dakota, had lower per capita costs. The per capita expenditure in Oklahoma was $443.22, as compared with that of $636.03 for the United States as a whole. Per capita costs increased in the state, however, by 101.8 percent in the period from 1939 to 1950. A part of the increased cost was attributed to improved methods of care, and the remainder to the higher cost of living in general since 1939.[15]

The per capita cost of patient care is not the only loss to society. Frequently the patient has lost his earning power for life. In some instances, families have exhausted their own resources in the attempt to maintain the patient prior to commitment. In an illness that may last for many

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[15] Material from Mental Health Programs of the 48 States, (Council of State Governments, 1950), 115.

years, many families would be unable to continue to contribute materially toward the cost of patient care. The average length of hospital life of those who die in hospitals for the mentally ill is between six and seven years. About one-half of all patients who enter these hospitals die there.[16]

Work History

Most of the patients studied had been able to achieve some education and a degree of earning skill commensurate with the standards of their communities and home environment. A large proportion of them had retained their ability to maintain themselves until the progression of mental illness had cut off their productivity. In some cases the patient had worked at his ordinary occupation until the time of commitment. In a few instances the patient had been mentally or physically incapacitated since birth and had never been able to work outside his own home. In analysis of the work history, it was found in some cases that mental illness had often seriously affected the efficiency of the individual long before he had found it impossible to work at all. A few records mentioned that the patient had changed jobs frequently or that he had been unable to keep a job. Sometimes the loss of self-maintenance had been due

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[16]Horatio M. Pollock, Mental Diseases and Social Welfare, (New York: States Hospitals Press, 1941), 78.

to the usual incapacities of old age rather than to mental illness itself.

Table XV shows the "usual occupation" of men patients, and Table XVI shows that of women. Both of these tables revealed considerable variation in types of skills, ranging from common laborers to professional workers. Five men were still in school and as yet had no specific job training. Included in the professional skills of men were a teacher, an engineer, an attorney, and a musician. A larger number of farmers were represented than any other occupational group. Next in number was common labor. This classification included unskilled workers in both rural and urban areas.

Other occupations with one or two patients in each were: barber, blacksmith, carpenter, cook, electrician, mechanic, nurseryman, oil field worker, peace officer, paper-hanger, plumber, printer, salesman, soldier, railway fireman, road contractor, telephone linesman, and truck driver. Three men patients listed no usual occupation. They were entirely dependent on relatives or on public assistance. All three were mentally deficient. The usual occupations of three men were not secured.

About one-half of the women admitted during the period under consideration were home-makers. Four patients who had no homes of their own were employed as maids, and one

TABLE XV

Occupational Distribution of Men Patients Admitted to Central State Hospital

Occupation	Number	Occupation	Number
Attorney	1	Peace officer	1
Barber	1	Paperhanger	2
Blacksmith	2	Plumber	1
Carpenter	3	Printer	1
Cook	1	Railroad(fireman)	1
Common labor	10	Road Contractor	1
Electrician	1	School	5
Engineer (civil)	1	Soldier	1
Farmer	13	Teacher	1
Mechanic	2	Telephone(lineman)	1
Musician	1	Truck driver	2
Nurseryman	1	None	3
Oil field	2	Unknown	3

TABLE XVI

Occupational Distribution of Women Patients Admitted to Central State Hospital

Occupation	Number	Occupation	Number
Beauty Operator	1	Maid	4
Dressmaker	1	Nurse	1
Factory employee	2	Stenographer	1
Hotel Housekeeper	1	School	1
Housewife	21	Telephone operator	1
		Waitress	2
None	1		
Unknown	1		

was a hotel housekeeper. Seven other occupations were listed for women. These were: beauty operator, dressmaker, factory employee, nurse, stenographer, teacher, and telephone operator. Two women patients were still in school. One whose usual occupation was noted as "unknown" was a widow of seventy-one years of age. In many instances these women who had a job skill and were working outside the home were also doing the housework for their families.

Educational Status

The academic attainments of the patients studied were quite varied. Four persons were classified as illiterate, all of these being men. On the other hand, one patient had a master's degree. Table XVII gives the school grades reached by the patients, by sex.

The average illiteracy of this group was 4.6 percent as compared to 2.5 percent of the general population in the state and 3.7 percent in the United States as a whole.[17] Thirty-five persons had from one to seven years of schooling. Almost three times as many men as women had left school before completing the eighth grade. Seventy percent of all men were reported to have reached the eighth grade. About one-half of the women had reached this grade, also. A large proportion of men had left school in the tenth grade.

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[17] Statistical Abstract of the United States, 1951, p.111.

TABLE XVII

Grade Reached in School by 106 Patients Admitted to Central State Hospital, by Sex

Grade in School	Men	Women	Total
No School	4	0	4
First Grade	1	0	1
Second "	0	0	0
Third "	3	1	4
Fourth "	3	1	4
Fifth "	3	1	4
Sixth "	5	1	6
Seventh "	5	0	5
Eighth "	12	15	27
Ninth "	0	3	3
Tenth "	8	3	11
Eleventh"	3	1	4
Twelfth "	10	4	14
1 Year College	2	3	5
2 Years "	2	2	4
3 Years "	0	1	1
4 Years "	1	1	2
M.A Degree	0	1	1
Total Persons	65	41	106

Twenty-one men had some high school education, and ten had graduated. About one-fourth of the women patients had from one to four years of high school education, and about one-half of this number had completed high school. The failure of some of the patients to graduate may be partly be accounted for by social and economic reasons. In general, the patients left school in greater incidence as they reached the tenth grade. The tenth grade is ordinarily reached when the student is about sixteen years of age. Girls of this age group are of legal marriageable age, and it may be presumed that some of the women patients left school to be married. Since most of the patients in this study were from families of low incomes, it may be inferred that many of them left school for economic reasons, rather than because of failure to adjust to the school situation. In a number of cases, however, the social history sheet stated the patient got along very well until about sixteen years of age, when he began to have trouble in school.

Thirteen of the 106 patients had one or more years of college training. Five of these were men, and eight were women. Only one man and two women had completed four years of college work. The man who had completed college was a graduate of the University of Oklahoma School of Law. He had been a practicing attorney prior to his admission for treatment of chronic alcoholism. One of the women had

completed college before she became ill with psychosis due to syphilitic meningo-encephalitis. This person was a high school teacher. A fifty-seven year old woman with a master's degree in education had been a teacher prior to the onset of her mental disorder.

In the group of women with college training, only one had become mentally ill while enrolled in college. This person had been studying speech correction at the University of Oklahoma in order to prepare herself for teaching. She had been having a difficult time, both at home and at the school, because of a severe physical handicap resulting from polio. Her feeling of rejection by her parents was thought to be a factor in her psycho-neurosis and acute anxiety state. One of the men patients was also a student whose progress in school had been intermittently interrupted by emotional disturbance. He had been diagnosed as being without mental disorder, but had an anxiety state which resulted in fugues. In regard to the other four men who were reported as having had some college training, it is a rather curious fact that all were diagnosed as chronic alcohlics without mental disorder.

At the opposite extreme of the educational scale were the four patients who had never attended school. One of these was mentally deficient, with a psychosis due to metabolic disease with pellagra. A second man had been

blind since birth, and apparently he had not attended school because of his visual handicap. He was of normal intelligence. A third illiterate person was a displaced Polish Jew, who could not read or write in his mother tongue. His illness, diagnosed as a paranoid condition, was noted in the hospital record as having been precipitated by his long imprisonment in a concentration camp. Just preceding his admission to the hospital, the scrap paper factory where he was currently employed had been destroyed by fire, and he had had a narrow escape from death. This event seemed to have intensified his fears of the past, since he began to have hallucinations in which he imagined he was again in the concentration camp.

Among the persons noted to be mentally defective, only one had not progressed beyond the first grade. One had a third grade education, one had reached the fifth grade, and three had reached the seventh grade. The only woman determined to be mentally deficient had reached the seventh grade, and had been attending school at the time of her admission.

Religious Life

Some knowledge of the religious life of the mental patient should be helpful in understanding his total situation. The cultural patterns of the individual are deeply affected by the nature of his religious beliefs. It has

been said that the religious fanaticism of whole peoples has been brought into relation with obsessional neurosis.[18]

Otto Fenichel implies that the religious faith of the individual may sometimes be utilized in treatment of his personality disturbance. He states that: "Christian Science and other institutions or sects, which promise health and magical protection as a reward for faith and obedience, may, due to their history and surrounding awe, achieve better and quicker cures than many scientists."[19] Fenichel also states that the "ancient magical power of faith" is a factor not to be under-estimated by the analyst in therapy.

In admitting also the influence of religion on the life of the individual, Jung takes a slightly different point of view:

> Among all my patients in the second half of life--that is to say, over thirty-five--there has not been one whose problem in the last resort was not that of finding a religious outlook on life. It is safe to say that every one of them fell ill because he had lost that which the living religions of every age have given their followers, and none of them has been really healed who did not regain his religious outlook.[20]

He adds that he does not advocate a particular creed or membership of a church, and asserts that often the therapist takes the role of priest, occupying himself with problems which belong to the theologian.

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[19]Otto Fenichel, Psychoanalytic Theory of Neurosis, (New York: W. W. Norton Company, 1945), 562.

[20]Carl Jung, Modern Man in Search of a Soul , (New York: Harcourt, Brace & Company, 1934), 264.

The churches of Oklahoma are largely Protestant. The Catholic influence centers primarily in the foreign-born and urban population. The Baptist Church holds the numerical lead among the Protestant denominations, with a membership of about 360,000 persons. Next in number are the Methodists, with about 48,000 members, and the Churches of Christ, with about 25,000 members. It has been estimated that there are about 46,000 Catholics in the state. About 70 percent of the population in the state as a whole has no church membership.[21]

Table XVIII gives the religious preferences of the 106 patients under study. Their church preferences represented most of the well-known religious faiths. The church most frequently listed was the Baptist Church. Twenty-seven persons gave it as their preference. The Methodists were second in number of preference, with 11 persons listed. Six named the Church of Christ, and three were Presbyterians. One was a member of the Episcopalian Church, one of the Congregational, and one of the Seventh Day Adventist. Nine persons preferred the relatively new denominations. These included the Holiness, the Church of God, the Assembly of God, the Pentecostal, and Jehovah's Witness. Other religious affiliations mentioned were Jewish and Mormon. Approximately

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[21] Religious Bodies, Report of the U.S. Department of Commerce, Bureau of the Census, I, Table 29.

TABLE XVIII

Church Preference of 106 Patients Admitted to Central State Hospital

Church preferred	Number	Percent
Baptist	18	17
Catholic	5	5
Christian (or Church of Christ)	6	6
Congregational	1	1
Episcopal	1	1
Holiness, etc.	9	9
Jewish	1	1
Methodist	11	10
Mormon	1	1
Presbyterian	3	2
Seventh Day Adventist	2	2
"Protestant"	11	10
None	18	17
Unknown	10	8
Total	106	100.0

one person in six had no religious preference. The religious backgrounds of 11 persons were unknown.

Marital Status

While some studies show that mental disease is more common among the single than among married persons, there is also a marked incidence among the divorced. Noyes states:

> Mental disease is much more common among the single than among the married. The development of mental disorder before marriage naturally decreases greatly the prospects of subsequent matrimony. Frequently, too, those whose emotional and other personality limitations are so great that they are predisposed to mental disorder are never sought as partners because of their obvious maladjustment....There are several factors that contribute to the unusually high incidence of mental disorder that exists among divorced persons. In many cases maladjustments representing early stages of mental disorder lead to discord and divorce before the personality disturbances are sufficiently developed to be recognized as constituting mental disease.... The same deeply seated factors tend to lead both to marital maladjustment and to the psychosis.[22]

Table XIX gives the marital status of the patient group. Of the 19 single men in the study, six ranged in age from 12 to 21 years. Three other single men were mental defectives. Two were chronic alcoholics without mental disorder, and one was a psychopathic personality. One was found to be without mental disorder, but with psychotic episodes. Three were paranoid conditions and two were schizophrenics. The relationship between the diagnoses of single

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[22]Arthur P. Noyes, Textbook of Psychiatry (New York: Macmillan Company, 1940), 54.

TABLE XIX

Marital Status of 106 Patients Admitted to Central State Hospital, by Sex

Marital Status	MEN		WOMEN	
	Number	Percent	Number	Percent
Single	19	24.3	6	14.6
Married	27	41.2	21	51.2
Separated	1	1.6	3	7.5
Divorced	11	17.0	4	10.0
Widowed	6	9.2	6	14.6
Unknown	1	1.6	1	2.1
Total	65	100.0	41	100.0

men patients and their basic personality maladjustments may be observed in these cases. The percentage of single women in the patient group was only half as large as that of men.

There were only six single women. One of these was only sixteen years of age and until admission had been an inmate of the training school for girls at Tecumseh. Two women were slightly older, but were both post-polio victims with physical handicaps that might be a deterrent to marriage. One had a diagnosis of Huntington's Chorea of long standing. Another was a schizophrenic, a paranoidal type. Though unmarried, she had recently delivered a child. The sixth person was thirty-four years of age, with an anxiety type of psychoneurosis. She was from a family in which there were three daughters past the usual age of marriage, all living together with their parents. In the latter instance it seems likely that unknown factors in this home may have led to maladjustment of a whole family. All of the unmarried women had been living with relatives at the time of admission. The home situations of these patients indicated that in case of recovery, they could again be cared for in their homes.

Forty-five men patients, or about two-thirds of the number, had been married. About one-fifth of this number had been separated or divorced. Over 84 percent of the women patients had been married, with 7 separated or divorced. There was a higher percentage of separations among women

than among men. There was a change in trend, however, in the higher incidence of divorce among men patients as compared to women. Seventeen percent of the men were divorced as compared to 10 percent of women.

In a study of the women patients whose marriages had terminated in separation or divorce, it was found that three were diagnosed as involutional melancholia, two as schizophrenia, one as toxic psychosis due to bromides, and one was a chronic alcoholic without mental disorder. Three of the women patients had been married only once. One had one previous marriage, and two persons had been married three times. The median age of first marriage of the divorced women patients was 23 years of age. The age range of first marriage in the cases varied from 18 to 32 years.

All the women patients who had been separated or divorced were over 35 years of age, with an age range varying from 35 to 57 years of age. Information as to the dates of divorces or separations of the patients was not available. It was noted in one hospital record, however, that the patient had been divorced "shortly before" her admission to the hospital, and in another case that the patient was "worrying about her divorce." One of the patients had been admitted for the tenth time, for treatment of alcoholism without psychosis. The other patient had been a high school teacher and was middle-aged. In both cases described, the

marriages were of long standing. The study of divorced or separated patients gave some indication that their pre-psychotic conditions had not precluded a satisfactory marriage relationship for an extended period.

Table XX gives some of the characteristics of marriages of the 48 patients who were noted as married at the time of their admission to the hospital. Information regarding happiness in marriage was usually obtained from the social history sheet filled out by the husband or wife, or by the relatives of the patient. Occasionally an evaluation of the happiness of marriage had been noted by the history obtained by the examining physicians. Over one-half of the married persons of both sexes were reported as being happily married. One-third of the women patients were described as unhappily married, as compared to one-fourth of men. Seventy-five percent of the married men had children, as compared to 86 percent of women. There was one unmarried girl in the patient group who had a child.

While most of the married persons had children, the hospital records contain a note of pathos in regard to them. Examples are: "four children, three deceased", "mother unbalanced since birth of first (illegitimate) child", "one child, died at birth", "three children living, one born dead." In contrast to the disappointments indicated in these, one record mentioned that one happily married man had fourteen living children.

TABLE XX

Characteristics of Marriages of 48 Patients Admitted to Central State Hospital

Description	Men		Women		Total	
	No.	P.C.	No.	P.C.	No.	P.C.
Happy	14	49	11	51	25	50
Unhappy	6	24	7	33	13	27
Doubtful	0	0	1	3	1	4
Unknown	7	27	2	10	9	29
Total	13	100.0	21	100.0	48	100.0

Early Home Conditions

One of the most revealing aspects of the survey of the 106 patients was the study of their childhood homes and conditions found in environmental situations. In spite of the lack of detailed information regarding the early lives and developmental history of the patients, most of the hospital records contained material indicating that the majority of the patients had a degree of unhappiness in their home circumstances, and often there were losses of love objects in early life.

County authorities had submitted little data to the hospital regarding the social history of patients. Often the patients were too confused to give information relating to themselves, and some of them had no relatives available to assist them. In some cases the court commitment had noted that the family from which the patient came was known to be "thrifty", "stable", "good", or "excellent". In other instances the family was characterized as "defective" or "unstable". Sometimes the commitment included a brief paragraph describing the relationships of family and patient and circumstances leading to the court order.

Statements relating to environmental situations were usually obtained from the patient or a relative at the time of admission. A number of hospital records contained formal

social history secured from relatives after the admission. Often correspondence and records of visits of relatives and friends were of value in evaluating the social background.

The home situations of the patient in childhood are described in Table XXI. The heading "broken home" included records of separations and divorces of parents, deaths of parents, and the removal from the home of either parent because of mental illness. These items were noted as they occurred either during the early childhood or the adolescent years of the patient. Homes listed as "defective" included those in which there were obvious mental defects noted in the family, or those in which there had evidently been a notable degree of social and cultural deprivation. The "stable" homes included those who had been noted in various ways as "thrifty", "good", or some other word denoting stability. The "happy" homes were those in which there was no obvious insecurity for the patient, as described in the material of the record, and in which the patient or other persons had mentioned the father and mother as "jolly" or "congenial". Those described as "unhappy" included a history of friction between parents or siblings, a notation of the problem of alcoholism in either parent, or a history of crime. Those classified as "not contributing" included those in which the family history was meager as to recording, but which had been so evaluated on the admission sheet. The

TABLE XXI

Home situations of 106 Patients Admitted to Central State Hospital

Home Situation	Men No.	Men P.C.	Women No.	Women P.C.	Total No.	Total P.C.
Broken Home	12	19	10	25	22	27
Defective	6	10	2	5	8	7
Stable	13	20	3	7	16	15
Happy	9	13	6	14	15	14
Unhappy	9	13	14	35	23	28
Not contributing	3	5	4	9	7	5
Unknown	13	20	2	5	15	14
Total	65	100.0	41	100.0	106	100.0

status of the home situations of 15 persons was unknown.

Over one-fourth of the patient group had come from broken homes. In each instance this meant that the individual was partially or wholly deprived of one or both parents. In some cases the patient had been reared by a grandparent or other close relative, and sometimes the patient knew very little about his parents or siblings. About one-fourth of the patient group came from unhappy homes in which there must have been little security for children. In a few instances the father had been addicted to drugs, and in one case the entire family, including the woman patient, had been drug addicts. Several records mentioned the suicide or attempted suicide of some member of the family. In others there was a history of lawlessness, with jail sentences of one or more members of the immediate family. A smaller proportion of patients came from "defective" homes in which there probably was little opportunity for normal, well-rounded development of personality.

The "stable" home seemed to indicate the desired place of the family in its relationship with the community in general. Sometimes the adjectives "frugal" or "responsible" were used in the commitment paper to describe the habits of such a family. Occasionally other corroborating material was contained in the hospital record. The terms denoting stability did not necessarily mean, however, that the home

was one in which the child was afforded love and individual attention, or that the parents and siblings were congenial or well adjusted in personality.

The home listed by the hospital record as "not contributing" also was not necessarily happy or conducive to a normal childhood. Seven patients came from such homes. About the only premise that might be made of this group is that no flagrant neglect of the child had been evidenced in the descriptions given of these homes. Various terms had been used to describe them, such as "congenial", "sociable", or "happy". The interpretations had usually been made by relatives, who were in the difficult position of evaluating themselves or their parents. Consideration should be made of this factor in evaluating the descriptions given.

Table XXII mentions the factors found in the social environments which had been determined to be contributory to the onset of mental disorder in the patients of the study. In some instances, the physicians had remarked the relationship between the onset of illness and an existing condition in the immediate environment. Often it was noted on the face sheet as a "familial determinant". Factors noted included other mental illness in the family or in a close relative, suicidal tendencies in the family, alcoholism of parents or siblings, delinquency of the family as seen in "law-breaking," jail sentences, or other delinquent acts.

TABLE XXII

Family Characteristics of 69 Patients Admitted to Central State Hospital

Characteristic	Men	Women	Total
Alcoholic	4	4	8
Cruel to Patient	5	3	8
Epilepsy	0	2	2
Pellagra	2	0	2
Suicidal	3	3	6
Other mental illness in family	11	16	27
Parent "nervous, high-strung"	6	4	10
Delinquent	4	2	6
Total	35	34	69

Epilepsy and pellagra were noted as familial determinants. Cruelty to the patient was interpreted to include both the cases in which there was physical abuse or intimidation of the patient by a parent or spouse.

Almost one-fourth of the patients had some type of mental disorder existing among close relatives. The fact that a number of backgrounds were unknown indicates that the figure might have been larger if all background history had been available for study. The figure may indicate a strohg causative factor in heredity as a predisposition to mental illness, or it may be interpreted as an environmental influence in the life of the patient. In some cases the mother of the patient had been hospitalized for mental illness, and was not in the home even to give the children physical care. Worry and emotional tension caused by the illness of any member of the family might easily disrupt an otherwise normal home atmosphere, and thus contribute to the emotional disturbance of the individual. An additional factor in the high incidence may have been the early recognition of symptoms in the patient because of his known heredity.

The frequent history of suicide, delinquency, alcoholism, and "nervous, high-strung parents" is some indication of a constitutional weakness existing in such families. Some records mentioned friction of the adult patient with his siblings or with aged parents. Occasionally the adult pa-

patient was characterized as having been "pampered" or "spoiled" by aggressive or over-solicitous parents. In both cases of primary behavior disorder occurring in adolescent boys, the hostility and physical abuse of a parent toward the patient had been noted in the home community and reported to the court. The "possessive mother" was noted in several instances. The parents of two patients were first cousins. In one case involving the marriage of first cousins, two near relatives were mentally ill.

On the whole, the material relating to the patient's childhood was too meager to base even general conclusions upon them as to the factors contributing to the cause or onset of mental illness. Many records did not contain the developmental history of the patient. Many did not mention the patient's relationships with his parents or siblings, though usually information was obtained concerning the spacing of the patient in the family or mention was made of the number of brothers and sisters. A few records noted the social adjustment of siblings in general terms. Often the family history consisted of the birthplaces of the parents and the name of the relative who committed the patient. The records which contained formal social histories included the dates of birth and of death of parents, the cause of death, and social traits. They also included the developmental history of the patient and description of events leading to his

commitment.

One record contained the full account of the social background and developmental history of the patient. This was the case of a twenty-year old boy, a college freshman, who was admitted for psychiatric evaluation. He had been a patient at the Hartford Retreat at the age of ten years, and psychiatric observation had been continued. His enrollment to study forestry had been advised by the therapist as a means of finding a vocation that would not put too much pressure upon him. The report of the Hartford Retreat described the boy as the neglected and unwanted middle child of wealthy parents. The father was preoccupied with his business, and the mother was an individual with neurotic tendencies. The patient's older brother had been the center of attention in the household because of a crippling condition resulting from poliomyelitis, and the younger sister had been unusually attractive and responsive to attention. The patient had become anti-social by the age of ten, and he continued to be unable to adjust to the demands of his exacting social environment or to endure the competition with his siblings. At one point he improved with therapy sufficiently that plans were underway for his return to the home, but the mother became ill with one of her severe headaches and he was obliged to remain until plans could be revised for him to attend a boarding school in another state. His progress in school

was strongly affected by his inability to form relationships with individuals or groups, and in spite of psychiatric help he had continued to regress. This person, earlier referred to as "ridiculously elongated" in appearance, had made no friends on the college campus and had not even enrolled in school. In one of his fugue states, caused by anxiety, he attacked a sleeping girl with a pistol, and was apprehended by authorities. He had no memory of the event, and was unacquainted with the girl he had struck.

In the case just cited the social factors affecting the mental disorder of the patient were clearly indicated in the hospital record. One wonders how such factors would appear in all the other cases, if a complete background of these could be obtained. Hopefully, with the addition of personnel in the hospital that might help to assemble such information, a knowledge of each patient's earlier life might be utilized by medical persons in diagnosis and treatment plans.

The study of 106 patients indicates that, almost without exception, they have had many traumatic experiences for which they were not physically or emotionally prepared. Scattered throughout the case records of these persons were stories of repeated losses of love objects, financial reverses, extreme cruelty and deprivation, rape, murder, and suicide. Some patients had felt the impact of many missions

in the last war, as well as progressive physical disability that may have threatened disintegration of the physical body itself. Their histories confirmed that the psychoses may be, at least in part, the result of the exhaustion of the capacity of the individual for further life adjustment.

An English psychiatrist, who worked with the psychological problems of service men during World War II, says:

> The average person surrenders part of his cultural individuality with every new act of integration into a functionally rationalized complex of activities. He becomes increasingly accustomed to being led by others, and gradually gives up his own interpretation of events for those which others give him. When the rationalized mechanism of social life collapses in times of crises, the individual cannot repair it by his own insight. Instead, his own impotence reduces him to a state of terrifying helplessness.[23]

While this description of mental breakdown referred to the individual exposed to the stress of war, it may also apply to the person who is caught in an environment which he cannot control, and to which he is unable to adjust. The study of 106 patients at Central State Hospital indicated that environmental factors in the cause and onset of their mental disorders need further study, both for use in diagnosis and treatment while at the hospital and in evaluating the advisability of convalescent care in the same environment. The study indicated a need for a closer relationship between the families of the patients and the hospital personnel in order to plan more understandingly for convalescent leaves

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[23] R.D. Gillespie, Psychological Aspects of War (New York: W. W. Norton & Company, 1942), 134.

and eventual discharges from hospital care.

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