

Original Articles.

FEEBLE-MINDEDNESS AS A LEADING SOCIAL PROBLEM.*

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SHOULD I declare that the problem of the feeble-minded is the largest single practical problem before Massachusetts at the present day, you might be disposed to wonder how practical a person I might be. Is not insanity a larger problem? Or alcoholism? Or syphilis? Or even that narrow circle of diseases dealt with by boards of health, the so-called public health problem? Are not crime, graft, undesirable immigration, illiteracy larger problems? What also of the high cost of living, classes *versus* masses, anarchistic socialism? On still broader planes, one might pause to contemplate the lowering of moral standards, and the decay of religious thinking by the people at large. What chance has the problem of the feeble-minded with such problems as these and countless other problems of civilization?

Perhaps I may justify my declaration, which smacks at first of such superlatives as are sometimes fed to legislative committees, as follows: By "problem" I do not mean an unsolvable problem or a set of conditions working out in *saccula sacculorum*, so that, if there be a problem, it would require philosophical or even divine wisdom to solve. By problem I mean something concrete, finite, practical, a set of conditions whose dimensions and quality are known or can shortly be known, for us in Massachusetts as well as for the angels in the sky. A problem, as I somewhat narrowly use the term, means a problem for solution, a problem that can by human means be solved.

Insanity is a larger problem financially, perhaps, than feeble-mindedness. Within ten years or much less time, we shall know the comparative costs of the insane and the feeble-minded. Yet the facts of mental disease are of infinite complication beside those of feeble-mindedness. The problems, so-called, of paranoia, of Booth, of Guiteau, of Czolgosz, of Schrank; or the problems of genius and psychopathic states, of Mohammed say, or of Rousseau, or of Nietzsche, or of Roosevelt,—these problems are not to my mind as yet problems; the would-be solvers of

such problems cannot agree even on definitions. We may put away as many psychopaths as we like here in Massachusetts; is any one so skilful as to catch up them all as they pass? So much of the insanity-field as, in the present state of knowledge, can be regarded as a problem is either solved or is on the road to solution shortly. Shortly we may say perhaps, as I was told in the Berlin district in Prussia, "There are beds enough for the insane; the numerical question is settled, at least for the present output of insane about Berlin." We may, it is true, need more psychopathic hospitals, that is, clearing-houses where the diagnosis can be made days earlier than by former methods and to which patients will be brought so that diagnoses can be officially made months earlier than was formerly the case. We may need sanatoria for mental cases, where people who can pay less than \$25.00 a week can be safely brought through their early attacks or through conditions falling short of frank insanity. We may need extensive developments of the colony system for the able-bodied insane and of the family-care system for the harmless insane. Yet most, if not all, of these developments are officially under way and in a state to be appreciated and furthered by the interested public, that is, by the social workers. That is to say, as I see it, what the state can do has been done or is about to be done for the insane; we must now wait for science to make for us new practical issues, real problems, such as seem to be coming in the science of the nervous system at about the rate of one in five years.

You will readily see how I should logically dispose of such so-called problems as those of alcoholism and syphilis. Much of each so-called problem is in no condition for practical effort. We can readily calculate the cost and human effects of alcohol and syphilis. We lightly say they are preventive problems. But who has anything concrete and universally convincing about ways to head off the desire to get drunk and the desire for sexual intercourse when that desire has no justification in morals, art, or even pride? To be sure, the alcohol problem is being approached on its reform aspect, and a clearing-house for all alcoholics with a follow-up system for each case has been dreamed of. Yet the psychological problems lodging therein, as well as those surrounding the sex instinct, are in no condition for public propaganda. Preaching against alcohol and sex indulgence is in my experience often pointless. Drunkards, prostitutes, and their associates may present a dire "condition"; they do not promise to yield a "theory" for many years.

Those partial aspects, then, of the huge complexes of conditions which I have mentioned (alcoholism, syphilis, tuberculosis, and typhoid fever, in the public health field, crime, etc.), which have been really and seriously reduced to the simplicity of "problems" are either tolerably well met or do not in my opinion meas-

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ure up to the size of the feeble-mindedness problem. So far as insanity is understood, Massachusetts has met or is about to meet the problem well. The same may be said of alcoholism and of crime in general. The psychology of the alcoholic, the sex offender, the criminal, hardly presents the aspect of a problem. It is the same with precisely that portion of insanity that interests us most. Was Mohammed an insane epileptic? Doubtless the Mohammedans are the better for their belief in God which Mohammed drove in. Was Rousseau a madman? With more like him, education would present more real problems. Was *Also Sprach Zarathustra* indirectly an outcome of syphilis? With more Nietzsches, much more good German would have been written. A melodramatic thrill runs down our backs when somebody says Roosevelt is crazy, but only on the erroneous hypothesis that "crazy" means he should be locked up. If crazy means genius, and really means it, if we knew enough about genius to say that it is a form of insanity and really think so, then to call Roosevelt crazy would be campaign ammunition for Roosevelt.

As a fact, the psychology of alcoholism, of the sexes, of crime, of genius, of many borderland and complex types of insanity is so far virtually devoid of problems in the perhaps narrowly social and practical sense in which I have applied the term.

The problem of the feeble-minded is a practical one for us for many reasons.

In the first place, our social sense concerning feeble-mindedness has been aroused. We look sharply at each other nowadays to see if we are not in some degree feeble-minded. To be a moron or high grade feeble-minded person is getting to be as common as having a Darwinian tubercle on one's ear. We look suspiciously at persons of other races and religions to see if they be not feeble-minded. Our friends even are thought often to be contracting imbecile marriages. I often excuse myself for social errors by considering that such and such factors have been left out of my composition. Even officials are interrupted in their conservative tasks by eager social workers who want something done with this or that person who ten years ago would never have been termed—with safety—an imbecile.

With this arousal of our social sense concerning the true range of feeble-mindedness has come a certain pessimism. Are we not all a little weak as well as a little queer? Are we not all fit subjects in some sense for commitment to a school for the feeble-minded, if not for commitment to a hospital for the insane? Where shall the line be drawn?

As a matter of fact, our laws concerning the commitment of the feeble-minded as concerning the commitment of the insane are effective enough. As with the insane, so with the feeble-minded, the present problems no longer touch those legal processes involving judges. Little or

no doubt attaches to cases suitable for commitment by the court.

More doubt attaches to the proper fate of those considered by some as suitable, by others as not suitable, for admission to institutions without court process. The line of distinction roughly runs between custodial cases adjudged by a court suitable for commitment and what might be termed educational cases which the institution sees fit to receive as mentally deficient.

The ground for optimism here is the popularization of the Binet-Simon tests which, combined with common sense and some medical knowledge, make it possible for a comparatively inexperienced examiner to do in a short time what formerly depended on the teacher's trial and error. The intellectual educability within well-defined limits can now be safely declared for a given case by scores of workers,—scores as compared with a handful twenty years ago.

But intellect is not all. Will tests and tests for capacity to do things remain to be placed on the same plane with the Binet-Simon intellectual tests? Here is where inexperience in the examiner counts and where the off-hand Binet-Simon diagnosis of the psychologist and social worker meets shipwreck at the institution. Aside, however, from the complex and high-grade cases, where will disorder and criminal tendencies enter, the popularization of the new tests has rendered much more easily possible the winnowing of cases for the new beds which the legislature has granted and will surely continue to grant.

Psychopathic hospitals and out-patient departments, which naturally go therewith—it is a question whether every great district hospital for the insane should not support an out-patient department for these and other appropriate cases—will aid extensively in the solution of the problem along the lines of the out-patient department conducted at Waverley for many years. Already, before its formal opening, the out-patient department of the Psychopathic Hospital in Boston had had a large number of such cases brought for diagnosis—a majority, in fact, of all out-patient cases there.

What is the size of the problem? A conservative estimate in 1911 stood at 6,700. A special study now being made by Dr. William Noyes*

* A sample of Dr. Wm. Noyes' work done under the State Board of Insanity has been published in the Fourteenth Annual Report of that Board, being Document No. 63. A summary is as follows:

KNOWN FEEBLE-MINDED IN MASSACHUSETTS.	
By present census:	
Males	2640
Females	2367
	5007
Reported by overseers of the poor.....	245
	5252
Total not in institutions.....	
In School for the Feeble-minded (at Waltham)....	1497
In Wrentham School.....	418
	1915
In State hospitals and asylums.....	672
Total in institutions.....	2587
Total in State in feeble-minded status.....	7839

under the Board of Insanity, taking account of undoubted cases (so as not to cloud the issue with mental and criminalistic cases), has not approached this number as yet, but over a third of the number have been found almost at the outset by carefully guarded inquiries.

The result of such inquiries is at first sight pessimistic. I get the impression that the majority of people regard feeble-mindedness as a necessary affliction of society, classing feeble-mindedness in this respect with poverty and crime.

I have to observe in this direction that, whereas a certain minimum of feeble-mindedness may be constantly found in different societies, there is much to be said that the problem is in large part a preventive one.

I have myself of late spent much time upon the geographical distribution of degeneracy and defectiveness in Massachusetts and have to report a surprising *chiaroscuro* in that distribution. I cannot as yet assign definite values to the correlations being studied. It seems, however, that the movement of insanity and other forms of mental defect corresponds rather with the movement of physical disease than with that of crime and pauperism. The mental problems as a whole appear to be rather medical matters, to be attacked by a philosophy of prevention. The crime-pauperism complex statistically appears rather more an economic matter. There is probably a middle ground where feeble-mindedness especially approaches criminalism and where a change of economic status might be the reverse of an aid to society. Mayhap all these tentative conclusions of statistical study will be overthrown.

I should suppose, however, that statistics as a whole and the special kind of analytical statistics known as eugenics has gone far enough to prove that the social philosophy of prevention has wide scope.

To be sure, studies in Massachusetts seem to show that many a case of feeble-mindedness is due in some sense to encephalitis, congenital syphilis, or meningitis in the childhood of the case, so that the particular warnings of eugenics have not a universal scope. Still the practical problems remain preventive. It is probable that there is an interplay of hereditary and somatic factors at work in many cases, not yet sufficiently studied.

What the eugenics workers have abundantly demonstrated is the old law of assortative mating. Part of the statistical *chiaroscuro*, which shows far more defectives in some places than in others is doubtless due to such assortative mating, combined with the propinquity entailed by barriers.

Society, therefore, can readily find out statistically where to work; it can start such preventive mechanisms at work as the somewhat threadbare experiences of public health workers afford: it can thwart assortative mating of the

unfit; it can educate; it can transplant; it has means of determining which persons belong undoubtedly in institutions (whatever doubt may rage in criminalistic cases); it knows where to study further; it sees a sufficiently large, if not the largest single, practical problem before it.

I will sum up and conclude as follows:—

1. The status of the feeble-minded in Massachusetts is such as to offer a large and immediate practical problem.

2. The availability of Binet-Simon and other intellectual tests makes desirable the establishment of numerous dispensary centers for preliminary diagnosis, so that cases suitable for well-tried educational methods in our state schools may be winowed out.

3. The criminalistic group has been singled out, hardly so far as a problem of the present, but as a problem of the future, dependent for solution on psychological data not yet available.

4. Estimates of the numerical size of the problem are available, and a promising preliminary survey is being made by the Board of Insanity.

5. Social sense of the importance of the problem has been aroused, though not, it may be hoped, to the point of impatience with the degree of progress humanly possible.

6. The interest of specialists in children's diseases has also been aroused, and the eventual results of certain children's diseases are being shown in the concrete case.

7. Workers in eugenics are being enlisted to study the hereditary factor in some of these so-called "acquired" cases, and, it is hoped, will solve the problem of the interplay of heredity and somatic factors in the pathology of feeble-mindedness.

8. Statistical inquiries seem to justify the idea of a *chiaroscuro* of distribution, which means that society is not just generally degenerating and that the places to begin preventive work can be chosen scientifically.

9. Statistics tend to indicate that the problem is rather a medical than an economic one, or perhaps better, more medical than economic, standing a bit one side perhaps from crime, some part of which is economic.

10. The interplay of hereditary and somatic factors promises to show lines of prevention both eugenic and environmental.

11. We can educate communities in eugenics and we can conceivably transplant, by a proper family-care system, feeble-minded persons from neighborhoods where they would unite with others of their kind to regions where they would either not marry or would marry normal persons, thus diluting the strain (feeble-minded males are probably less dangerous in the community than feeble-minded females, which latter should be segregated by preference in institutions).

12. Socialism of the Fourier-Marx type will have to reckon with this problem; it would not appear that communism has any ready solution

for the problem of those who, being feeble-minded, are by nature neither free nor equal. On the other hand, some form of socialism of the St. Simon type, or what may be termed state socialism, is the most practicable form to cope with this problem. Indeed the practical solution of these problems of feeble-mindedness and allied defects is fast leading us to something of the sort, whether we choose to call it socialism or not. Yet how many would-be socialists face the congenital or acquired inequalities of men with frankness and clear understanding?

UNDER WHAT CONDITIONS IS THE DIAGNOSIS OF "TUBERCULOSIS" IN CHILDREN JUSTIFIED?*

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THE question raised in the title of this paper is an important and pertinent one. There are many who believe that the theory of childhood infection is being carried too far. However opinions may differ as to this, everyone will agree that the diagnosis and treatment of tuberculosis in childhood is one of the most important, if not the most important problem, not only in tuberculosis and its prevention, but in the entire field of preventive medicine. The children of today are the men and women of tomorrow; the weak and sickly children of this decade are the consumptives of the next, whether or not scientists still wrangle over the problem of the path and the exact time of infection. It is, therefore, urgently necessary that some definite standard be adopted and recognized by every one as to the exact signs and symptoms, or group of signs and symptoms on which it is just to make such a diagnosis. Of course I do not refer in this paper to children with advanced pulmonary tuberculosis, with or without a positive sputum.

It is indeed a step which demands the utmost consideration to stamp a young child as tuberculous and to cast on him and on the family the stigma, however slight this may be, that the name carries with it. Tuberculous infection is one thing,—tuberculous disease is another. Statistics, based on careful pathological investigation, as well as on the results of tuberculin tests, offer clear proof that a large proportion of children, 60% to 90%, according to different observers, are infected with tuberculosis by the time the fifteenth year is reached. This does not mean tuberculous disease, or what we generally term "clinical tuberculosis." Many of these children, indeed the great majority, are perfectly well and without symptoms. How to recognize and do justice to the comparatively small proportion in whom the disease is active and is causing symptoms, what should be their

treatment, and how radical steps should be taken in reporting and segregating these patients are most important and ever-present problems.

In Boston, and I presume elsewhere, there is at the present time a great diversity of opinion among doctors at the various clinics as to diagnosis and treatment of this class of children. It is perfectly possible for an anxious mother to take her small boy of ten to one large clinic and be told that he has consumption and must (and is made to) leave school; at the earliest opportunity she takes him to another clinic where the boy is again examined by equally skillful and conscientious physicians, who tell her that her boy has a cold, but certainly has not "consumption." Much relieved, but still anxious, she takes him to a third clinic, where an x-ray of the chest is taken. This discloses a few "bronchial glands and peribronchial thickening with a slight haziness at the right apex." The x-ray expert reports his diagnosis as "Bronchial Glands. Ph?" Exactly what this means may be, but usually is not, explained to the mother, and in any event, as can be readily imagined, fails to relieve her worry over her boy. And so the case drags on, the mother naturally (and quite properly) refusing to allow her son to be sent to a sanatorium or hospital for consumptives, and the physicians at one, at least, of the three clinics visited, still firm in the belief that here is a case of tuberculosis which needs radical treatment.

The following case is a striking example of this state of affairs:—

L. R., a little Armenian girl of 7, living in the thickly settled Armenian quarter, was sent to me for examination from one of the settlement houses of that district. There was a doubtful history of exposure from a grandmother, who had recently died of tuberculosis, and from a brother in whom such a diagnosis had been made, but later not substantiated. The exposure from the grandmother was also eliminated as a factor, to my satisfaction at least. The child had been examined on the morning of the day she was sent to me at a local tuberculosis clinic by two leading authorities in tuberculosis in this city, and pronounced tuberculous on the following evidence. Cough at night, morning temperature, night sweats, and history of exposure,—the last somewhat doubtful, as shown above. Examination at this clinic showed "a definite active process at the right apex, with a limited right basal expansion and well-marked signs of bronchial glands." The mother was told that her child had consumption, and that she must leave school. My examination in the afternoon showed a strong, well-developed and nourished, healthy-looking child. The tonsils were very much enlarged,—sufficiently so to account for any cough or fever which she might have at night or any other time. In the lungs aside from very slightly increased signs at the right apex, I could find nothing abnormal in any way. No râles were heard at any time.

* Read before the New England Pediatric Society, March 27, 1914.