

From One to Another

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Man wishes to be confirmed in his being by man, and wishes to have a presence in the being of the other. The human person needs confirmation, because man as man needs it. An animal does not need to be confirmed, for it is what it is, unquestionably. It is different with man: sent forth from the natural domain of species into the hazard of the solitary category, surrounded by the air of a chaos which came into being with him, secretly and bashfully he watches for a Yes which allows him to be and which can come to him only from one human person to another. It is from one man to another that the heavenly bread of self-being is passed.¹

Martin Buber

From One to Another

Today on the basis of a generation of experience, many psychiatrists insist that every emotionally ill patient who does recover successfully does so with another human being's help and understanding.

The present generation has rediscovered an ancient hygiene: "Love thy neighbor as thyself."²

These are psychiatrists speaking, putting into words what has become more and more apparent in these past few years. In the care of the mentally ill, science has come full circle and ended by officially rediscovering what many people have suspected all along – that the person who cares about another person, and is able to show that he cares, often in ways seemingly small in themselves, can give a kind of help in illness that drugs or surgery cannot give.

This is not to say that drugs or surgery are going out of fashion. On the contrary, in the treatment of mental illness especially there are hopes for drug therapy higher than have ever been held until now. But it is one thing to bring a sick person's illness under control by medical means and quite another to bring about his true recovery, which means his acceptance of himself once more as a healthy person and society's acceptance of him without which he cannot hold the gains he has made. "Tender, loving care" has been part of the healing armamentarium in children's hospitals for many years now. Today it is coming into its own in mental hospitals too – the last place, traditionally, into which the outside world was able to reach. The authors of a recent study made in Massachusetts speak of "the changing climate of attitude surrounding mental illness from one of fear, repulsion and neglect, to one of acceptance, understanding and help."

The sick person who suffers the special refinement of misery which mental illness brings has always been one for whom the Churches had a special care. Even in the last hundred years or so, when such sick people were for the most part shut away behind high walls and locked gates, and out of sight was all too often out of mind, there have been ministers of all faiths who have felt impelled to serve as chaplains in such hospitals, facing a day-by-day experience which continually drove home to them how little they were able to help. This is a far cry from the medieval *Hotel-Dieu* where nuns cared for all the sick as a sacred duty, but it still is an acknowledgment that the unfortunate have a claim on people who seek to practice

their religion in the more difficult and thankless ways. The Quakers above all others in the past three hundred years have felt this responsibility laid upon them. What will the churches do, what in particular will the Quakers do, to meet the possibilities which the doctors are holding out to us now, possibilities of service going far beyond what has ever been open to us before?

To a fellowship of people whose view of the universe includes a belief in an Inward Light, in what has been called “that of God in every man,” there has always been something especially challenging about the predicament of the mentally ill. Such an Inward Light cannot in its nature be extinguished while the body which harbors the soul still lives: this is basic to Friends’ attitudes toward many whom society has rejected, such as prisoners and slaves. In this faith they have worked for the reform of prisons and the manumission of slaves and have made long journeys to the courts of cruel and absolute monarchs whom no one else dared approach. In this faith, from their earliest days as an organized group, they have been especially tender of the mentally ill.

In George Fox’s *Journal* occurs a famous passage taken from a letter addressed to Lady Claypole, who evidently was suffering from extreme mental distress and from delusions or hallucinations which a later age would have characterized as definite mental illness.

Whatever temptations, distractions, confusions, the light doth make manifest and discover, do not look at these temptations, confusions, corruptions; but look at

the light, which discovers them, and makes them manifest; and with the same light you may feel over them, to receive power to stand against them.

Recent research into the belief in witchcraft in colonial America has shown clearly how closely the kind of behavior that was felt to show possession by demons resembled what we today should immediately recognize as mental illness. It must have been clear, even then, to those who did not join in the prevailing hysteria that the insane and the possessed were not far apart. At a time when trials for witchcraft were sowing terror among the simple-minded in Salem and elsewhere, it seems that not more than one such trial took place in the whole of Pennsylvania, and in that the victim was not condemned. Not only did Quaker beliefs inhibit the fear of possession by an outside diabolical force, stronger than the person's natural and God-given strength; all kinds of dabbling in the occult, such as interest in the casting of horoscopes, were thought by the Friends to run counter to their view of the essential nature of things, and members of some Monthly Meetings were warned against any dealings of this kind. The kind of group psychosis so hideously documented in Massachusetts history could not find in Pennsylvania a spark to set it alight. No man might blame the devil for his own loss of the light of reason; final responsibility for his salvation rested always with the individual, but his help against temptation was never far away.

It is natural that most of the evidence illustrating the development of the Quaker attitude toward the mentally ill should be drawn from the early history of Pennsylvania.

Here, for the only time in the world's history, a consistent attempt was made to build a frame of government in accordance with Friends' view of man's true nature and the type of society in which alone that nature could be fully realized. In most organized societies care of the mentally deranged, especially those who are violent, is a problem which goes beyond the individual family's capacity to solve. In one way or another the community is drawn into the attempt to find a solution to the immediate everyday problems raised by a highly disturbed individual for those closest to him.

When William Penn first came to the New World, the best that had been thought of to protect the sick person and his community from each other was to place him in a tiny house, without heat or light, where he endured like an animal for as long as his body could sustain life. There is an early account of this desperate remedy drawn from the records of Upland, near Chester, Pennsylvania, in the year 1676 – just six years before Penn landed a mile or two from that very place:

*Jan Vorelissen, of Amesland, Complaying to ye Court that his son Erik is bereft of his naturall Senses and is turned quyt madd and yt, he being a poore man is not able to maintaine him; Ordered: yt three or four persons bee hired to build a little block-house at Amesland for to put in the said madman.*³

A similar “blockhouse” ordered to be built in Massachusetts a few years later was specified to be “7 foote long and 5 foote wide.”⁴

Friends were pioneers in the establishment of the kind of prison which was designed to do something toward the prisoner's rehabilitation, instead of merely bringing down upon him the vengeance of outraged society: the Walnut Street jail and Cherry Hill in Philadelphia are often-quoted examples. For many years in Pennsylvania, in the absence of knowledge of any other possibilities, it was the prison which received the insane person who could no longer be tolerated by society because of his violence to others or to himself. The essential thing to bear in mind, in considering a practice which certainly was responsible for a great deal of suffering, is that it was not deliberately inhumane.

Quaker penology of that time was unique in that it looked toward the redemption of the individual who for one reason or another was at odds with the community in which he lived. Faced with that perennial problem of practical men in government – what to do with the anti-social individual who for whatever reason either will not or cannot conform – the Quakers like other rulers elsewhere were obliged to shut him away. But they did it with respect for his individual dignity and always with the hope and intention that he should be deprived of his liberty only so long as it took him to decide to live peacefully at home. It was probably difficult for them to explain to themselves the puzzling fact that some people seemed to prefer being out of step and out of communion with their fellows.

There was, however, an early realization that the person who was mentally ill was in fact *ill* and not either bewitched or merely perverse. As early as 1709, at a monthly meeting of Friends in Philadelphia, a proposal was

made that a hospital be built for members of the Society who were ill in body or mind.

Philadelphia Monthly Meeting Minutes 1709 9 mo 25

Thomas Griffith is ordered to pay Edward Shippen . . . toward defraying the charges of negotiating matters in England in relation to ye School Charter and one that is endeavored to be obtained for an Hospital, according to ye agreement and concurrence of this Meeting, some time past, and was accordingly to send over by Isaac Norris to request of William Penn who was willing to grant ye same, but upon advice thought it not proper to have ye School and Hospital in one, which this meeting desires may be moved again by James Logan who is now going over to England.

It does not appear that much was done to follow up this early suggestion. In 1750 it was again a group of weighty Friends, led this time by the redoubtable Benjamin Franklin (who was probably enlisted for the magic of his name) who drew up an actual proposal for such a hospital in Philadelphia. The Pennsylvania General Assembly, in which Quakers still played an important part, passed an Act in 1751 to provide an institution for, among other things, “the reception and care of Lunatics.” This was the Pennsylvania Hospital, officially opened in 1752 in a private house secured to serve while the main building was under construction. The records show that one of the first two patients received there was “a lunatick,” and the directors of the establishment, having little notion of treatment apart from custody, relegated him to the

basement. In the hospital building itself, opened in 1756, lunatics also found their way to the basement, and here received treatment which is horrendous to read of but which nevertheless, according to Albert Deutsch, was the best that the time and the state of scientific knowledge afforded. Those lunatics who were able were put to work, not to make money, but as a rudimentary form of occupational therapy.

There must have been a steadily-increasing proportion of mental patients among the Pennsylvania Hospital's early population. Statistics from those years are still in existence, in a form uncannily similar to the tables published by state welfare departments today; they show that while lunatics did not form the largest category among the admissions, they were always the group from which few or none had been discharged at the end of the calendar year.

Benjamin Rush, who came to the Pennsylvania Hospital in 1783, is known nowadays as the Father of American Psychiatry. He was reputed to have been a kind and humane man – which did not keep him from ordering bleeding, flogging and other forms of violent interference with the body of the patient when he believed that the long-range effect would be good. With all of this, he was the first doctor in America to bring the study of mental diseases up to a scientific level. His treatment – for instance the notorious “tranquilizer,” a chair in which the patient's head was firmly clamped in one position with the object of steadying his pulse – was based on reasoning about possible physical causes of mental disease. He also

believed firmly in the efficacy of fear to dispel confusion of mind.

It was eight years after Benjamin Rush began his pioneer work in Philadelphia that the Quakers in England appointed Dr. William Tuke to be head of the York Retreat. From 1791 until today, this remarkable hospital has been consistently among the world's leaders in caring for the mentally ill. Its Annual Report presented to London Yearly Meeting in 1957 announced the need for a special fund-raising campaign to finance necessary changes in the old buildings, which would allow the hospital to adopt the "open door" policy, a method so new that only ten or twelve institutions in the whole world have yet been courageous enough to give it a trial. This policy is exactly what its name implies. All the doors of the hospital are unlocked, and patients remain of their own free will. Pennsylvania was the first among the modern United States to experiment with an open hospital, but slowly the idea is spreading and first results are beginning to come in. An attempt made earlier, in the latter half of the nineteenth century, by the famous Quaker psychiatrist Thomas Kirkbride in West Philadelphia was abandoned because, as someone has said, Kirkbride "had absolutely no theory" and could not explain to his successors the controlling idea of his experiment.

The York Retreat was designed for members of the Society of Friends, though members of other churches would not be automatically excluded. It was planned, according to the original minutes, as "A quiet haven in which the shattered bark might find the means of reparation and safety." Chains

were never used at the Retreat (as they were at the Pennsylvania Hospital). An occasional case was found where the use of the strait jacket or solitary confinement could not be avoided, but nevertheless the distinctive Quaker approach to the problem of insanity was taking shape.

The York Retreat has in its records some remarkable case histories. One tells of a man who had been so continuously violent that his clothes were fitted with strings so that he could be dressed and undressed without removing his manacles, and who left the Retreat – apparently completely cured after four months during which he never wore the manacles at all. The York Retreat sought to provide kind treatment in a sheltered environment, and encouraged patients to keep small animals as pets as a means of appealing to their better instinct. According to a modern English writer, “it removed the final justification for neglect, brutality and crude medical methods”⁵ – and this in the late eighteenth century! We seem not to have moved very far in a hundred and fifty years.

The York Retreat was the model for the Friends’ Asylum (now the Friends’ Hospital), opened near Philadelphia in 1817 and now completely encircled by the steadily advancing city. This hospital, according to its constitution, was “to furnish, besides the requisite medical aid, such tender sympathetic attention and religious oversight as may soothe [the patients’] agitated minds, and thereby, under the divine blessing, facilitate their restoration to the enjoyment of this inestimable gift.” Very soon after the Bloomingdale Asylum in New York State was opened, also under Quaker

inspiration. “Moral treatment,” the great invention of the York Retreat, was highly esteemed in these two hospitals and in a number of others which were opened during the next few decades. It was a period of rising hopes, most of them doomed to be disappointed.

It must never be forgotten, however, that these pioneer hospitals experimenting with new methods of caring for the mentally ill were all privately owned and received only paying patients. Those who had no money still continued to be herded into prisons and almshouses under frightful conditions, and we read little to show that anybody cared very much about their plight. They had to wait until the 1840’s and the advent of that extraordinary woman, Dorothea Lynde Dix, who came not from the Quaker but from the Puritan tradition.

It is rather a startling commentary on medical knowledge in the eighteenth century that a reigning monarch (George III) should have been subjected to threats, beatings, chains and starvation in an earnest attempt to restore his wits. His quick recovery was highly important to a number of people for political reasons, but the best advice that they could get (presumably they did not consult the director of the Retreat) was that the patient should be kept in constant fear. The King did recover from his first attack, and remained well for twelve years; it seems rather unlikely that the treatment he received had anything to do with the remission, or with later and shorter remissions, and in fact at the time of his death in 1820 he had been hopelessly ill for ten years.

After the opening of the Friends' Asylum and the Bloomingdale Hospital, the Quakers seem to have rested on their laurels for a hundred years. The movement started by Dorothea Dix, which led to the building of state hospitals all over the country, had little or no support from the Society of Friends.⁶ It was not until World War II that their attention was brought back almost by accident, to the wretched condition of people who were mentally ill and could not afford to be cared for in expensive private institutions. Only a handful of patients had families or friends who could pay for this kind of care. The enormous majority, certainly well over 90% of all those who became mentally ill, remained in the state and county hospitals in appalling conditions, treated little better than animals, deprived of all hope of medical care which might give them the chance to become well again. A few fortunate and determined ones, like Clifford Beers, founder of the modern mental hygiene movement, recovered by themselves more or less in spite of the hospitals. For the rest, no help could be given because everyone believed their cases hopeless and state legislators and taxpayers saw no point in supporting in even minimum decency people who had no votes and produced nothing that society could use.

Friends and the other historic peace churches produced, in the early forties of this century, a group of young men who refused military service on religious grounds but nevertheless accepted an obligation to give the state service of some alternative kind. Many members of this group found themselves serving as attendants in state mental

hospitals. What this experience did to them, and indirectly to the hospitals, was described by one of them in a pamphlet written ten years ago.⁷

In the decade since this account appeared, the mental health picture in North America has been transformed, and a very important part in the transformation has been played by the young men, Quakers and others, who as human beings were outraged by what they found in the hospitals. They determined not to accept, or allow society to accept, the continuation of conditions repugnant to anyone who believed that man was made in the image of God. The young men spoke and wrote about what they found, and as the public outcry grew, so did the bills which the taxpayers of the state had to pay. Along with the bills went a clamor for a constructive solution to the enormous problem with which society now realized it had to deal. Medical research, neglected since Benjamin Rush's day, began to come to grips with mental illness as a clinical entity, or rather as a number of clinical entities, since one of the first discoveries was that there are many different illnesses which may attack the mind, and in every case there is a difference in the causation, the symptoms, the treatment possibilities and the hope of cure. This is not to suggest that medical science had been ignorant of these things, but it had been starved of money for research and weighed down by the hopelessness born of public apathy and neglect.

This brief glance backward over the history of Friends' interest in mental illness has been designed to suggest three things:

There is in the Quaker theory about man and his relationship to God a basis for concern about people who are troubled in their minds or emotions, and for hope that many of them may be helped to overcome these troubles. The Light Within cannot be extinguished and upon this we believe it is almost always possible to call.

Friends throughout their history as a Society have made this concern effective in their dealings with their own members, and in their early days they were pioneers in seeking ways to help all sick people according to the knowledge of their time. They failed often, because that knowledge was insufficient; but they never became discouraged, and they succeeded sometimes where failure might have seemed almost inevitable.

In the twentieth century, Friends have hardly, until now, taken very seriously the need for help to the unfortunate, when those unfortunates were people outside their own fellowship. They have made a beginning in helping patients in public mental hospitals, along with other people of good will, but the full potentiality of that which they should have to give is still very far from being realized.

Friends' early concern for the insane derived from a way of thinking about man and his problems which was absolutely central to their belief – the refusal to accept the doctrine that any human being could be finally alienated, that any man or woman could be irrevocably cut off from awareness of God and fellowship with his children.⁸ But this insight seemed to have lost some of its force during the long period when no one knew how to break through the barrier which

a man's mental illness placed between him and his fellow-men.

We have already seen that something radically new has been occurring in psychiatry in the last few years. To put it in its simplest terms, it is the sudden realization by many who care for the mentally ill that no one, or almost no one, actually is totally out of reach. A new approach, using new drugs along with the ancient remedies of patience and perseverance, has brought some of the inhabitants of the "back wards" to a point where even after thirty or forty years in a hospital they can go home. With others life has become so much easier that though they cannot leave the hospital, they can mingle with their fellow-patients, have the satisfaction of productive work and the joys of human companionship within their still limited world. And there are those for whom a minimum of communication has been established after many years of total silence and withdrawal. That early Quaker insight – that no one is utterly out of reach – is well on its way to becoming a respected scientific fact. One very new textbook puts it this way:

*The patient must be accepted as a person of value, who has the potentiality for improvement in the future, regardless of the degree of observable psychological deterioration.*⁹

Making due allowance for the terminology, this is a statement which would be regarded as fully acceptable to the kind of people who came together to set up Friends' Hospital or the York Retreat. But in the language of the

medical profession it is something almost startling in its novelty. Here and there, doctors are beginning to say tentatively that the hospital itself, its expectations or rather its failure to expect good of the patient, its rigid organization, its lack of personal satisfaction, may be standing in the way of better health for those it serves.

The typical state hospital as it has grown up during the past hundred years is a huge agglomeration of barrack-like buildings in which thousands of people drag out days, months, years in almost total inactivity. People who have long since lost any kind of initiative are behind a whole series of locked doors.

No one who has visited one of these places can ever forget the long halls with their lines of hard wooden chairs, on which sit people who for the most part are silent, expressionless and unresponsive to the occasional kind word from doctor or attendant as he hurries by. For so many years no person from the normal world outside has had time to stop and talk to them, to revive their interest in the society they have left. Pennsylvania's Secretary of Welfare recently found that in a dozen of the largest hospitals in the state, two patients in every five had never once had a visitor in all the years since they were first admitted. Why, he asked, should these people feel that the world wanted them? Why should they try to get well?

In the typical state hospital ward there is absolutely nothing to do. The television set, placed high in the air in case someone should be moved to attack it, for the most part dispenses sound and movement into a vacuum of response.

Many patients are not sufficiently interested even to turn their chairs and face the screen.¹⁰

This in its hugeness and hopelessness is a more frightening thing than the occasional episodes of violence on the part of some frightened or sadistic or just intolerably over-driven attendant which make a public stir and then are forgotten till next time. If we are to do anything about carrying out our new knowledge – the discovery that people who have seemed completely lost to their world can still be brought by patience and love to recognize its existence and want to live in it once more – where can we possibly begin?

Clearly a large part of the responsibility for reaching out to those who cannot make a gesture for themselves must fall on the ward attendants. They are the people who spend day after day, year after year, perhaps, in close contact with the patients. True friendships sometimes develop; but how much time has a man for demonstrating friendship when he is in sole charge of a ward housing one hundred or more, many of them helpless, many of them disturbed?

In the past few years attendants have started to win more understanding of the importance of what they do, but the service is still poorly paid and little respected. People drift in and out of it who are more in need of help themselves than able to help others. In times of general unemployment, there are always plenty of applicants for jobs at the state hospital; it provides a minimum livelihood and will fill a gap until something better paid comes along.

In World War II young men and women from the historic peace churches and some others who put in periods of service in mental hospital wards learned a great deal about the real problems of these hospitals, and where things might be improved with enough goodwill, even without the needed money which the state legislature was and is so unwilling to provide. There still are conscientious objectors doing such alternative service in a few hospitals. But there is a wide need for more and more concerned young people who will enter such service for its own sake, because they see it as a way of discharging an obligation to their fellow men. Now, for the first time, such young people can feel a hope that they may have a real part in healing sick minds. In addition to the full-time jobs, there are summer service units which have made use of the vacation time of college students; some of these students at the end of the summer have felt that they saw the possibility of a life work which would give them a kind of satisfaction not easily found in a regular nine-to-five commercial job.

In the past the state hospital service in many parts of the United States has been notorious for its involvement in politics. It is hard enough to find people able and willing to give a particularly thankless kind of service, without also requiring of them that they gain the approval of the county political boss and pay a regular percentage of their earnings into the party fund. A considerable revulsion against this state of things has set in within recent years, and more and more states are extending civil service to cover all the people who work in hospitals, giving them reasonable security of tenure and a chance of promotion in return for

good work. This affects the professional staff even more than it affects the attendants; and it is among the various professions in the field of mental illness that some of the greatest opportunities are now waiting.

It takes many years of graduate study to become a psychiatrist; Friends and others who are drawn to the profession of medicine by a desire to be of service might think about the special opportunities of the psychiatrist at this time and in the years immediately ahead. The longer the training, the more urgent the need, and the more important it is that preparation should begin soon.

Not so many years are needed to become a psychologist, a psychiatric nurse or a psychiatric social worker, and here too the rewards in terms of satisfaction may be very great and the need almost defies measurement. To take an example almost at random, in the state hospitals of Pennsylvania the American Psychiatric Association in a survey in 1957 found only 40% of the number of psychologists it believed were needed to maintain a good level of service to patients. For all the other types of professional workers the situation is nearly as bad. Both the state and federal governments are awaking to the fact that there is a major emergency here, and scholarships and fellowships to help in the cost of training the right kind of people are being provided as fast as the money can be found.

Astonishing things, hopeful things, are beginning to happen inside public mental hospitals, even those most heavily burdened by ancient and crumbling buildings, lonely

locations, outworn equipment, and the chronic shortage of staff and money which results from public indifference or fear. Perhaps the most astonishing of all is something which has not yet happened in very many places – the opening of the hospital doors. Never before in history have those who cared for the mentally ill dared to throw away their keys, even knowing as they did that to be locked up like a criminal was a cruel injustice to the great majority of their patients. But everybody was afraid. Above all, the community on the outside was afraid – the supposedly normal, well-balanced, Christian community, which believed that its only safety lay in locks and bars to keep people penned like wild animals.

In the past twenty years this too has started to change. There is no longer a high wall between the hospital and its community. Sometimes there is no longer any wall at all, even a low one. The spiritual walls are crumbling too. At first in one hospital in southern England, then, as the experiment proved successful, in others there and here, the daring experiment was tried of opening the locked wards and letting the patients realize that they were free to come and go. It could not be done all at once, even in that first hospital, for community, staff and patients had to get used to the idea. They had to begin with the easiest wards and work toward the more difficult. But finally it was done. The patients responded to this proof of trust in them as human beings; the first thing that was noticed was that there was much less disturbance on the wards, even without the help of tranquilizing drugs. “We just don’t expect bad behavior on an open ward,” said an English psychiatrist to an

American colleague visiting the part of the hospital which housed the patients most seriously ill. And the American, bringing back a report to his fellow doctors in this country, spoke of this as one part of the picture of mutual respect and acceptance which he found in the English hospital – good relations between patients and staff, and good relations between the hospital and its community. More walls than those of brick and stone are tumbling down.

If the world outside the hospital is changing in its attitude to the mentally ill, this is due in great part to a very remarkable man named Clifford Beers. Many people know him as the author of a book named “A Mind That Found Itself,” (Doubleday – reprinted in 1953), the story of his own mental illness and his final recovery without, or even in spite of, the help of the hospitals of the first decade of this century and the people who treated him there. Not so many people are aware of Clifford Beers as the founder of the citizens’ mental health movement. It was in 1908 that he founded the Connecticut Society for Mental Hygiene, as a pilot project for the National Committee for Mental Hygiene which was created in the following year.

The Prospectus of the Connecticut Society, the first manifesto of the new movement, opens with these words:

After all, what the insane most need is a friend!

In this pioneer document, just fifty years old, are a number of statements which have a very modern ring:

“The Society shall endeavor to spread a knowledge of the principle of Non-Restraint, with a view to bringing about the universal adoption of this individualizing principle in the treatment of insanity.

“Patients should be given every deserved privilege and their rights should be protected by law.

“Men and women, suited to the work, shall be delegated by the Society to visit the hospitals and take an interest in friendless but responsive patients.

“It shall be an aim of the Society to frame a statute affecting attendants. Good attendants should be protected and properly rewarded; bad attendants should be punished and eliminated from the ranks of hospital workers. It will thus become possible for self-respecting men and women to engage and remain in the work.

“The Society for Mental Hygiene in proving itself a friend to the insane will, perforce, prove itself a friend to humanity; for no man knows when he himself may stand in need of its assistance.”

All of these things sprang directly from Clifford Beers' own hospital experience. He knew at first hand that mental patients were considered less than human when it came to their elementary legal and social rights; that mechanical restraints stood in the way of the sick person's recovery of his awareness of himself as a responsible individual; that

many patients who could start to rebuild their own bridges to the outer world were deprived of the opportunity because they had no friends and no one came to talk to them; that attendants were often brutal and unimaginative, and that this was perhaps largely because their conditions of work interfered with their own self-respect; above all, that the mentally ill are not a category forever doomed and set apart. They are people with their roots in the real world, people who before they became ill were just like you and me, people who can live in the world again if we do not deny them the chance to come back.

In the years since 1908, Clifford Beers' small movement,¹¹ based on one man's knowledge, determination and faith, has achieved size and weight. By accretions and mergers with other groups interested in the mentally ill it has grown into a national movement with divisions in over forty states and territories, and county associations in probably half of the counties in those states. It employs altogether hundreds of trained professionals, holds a big Assembly every year in some large American city and puts out publications on a wide variety of subjects connected in one way or another with mental health. In 1957 the first of a series of annual Clifford Beers memorial lectures was given at Yale. The Connecticut Association, with which Beers' movement made its start, has now a list of principles and objectives which could be put side by side with the list drafted in 1908, to show how well Clifford Beers built for the future and guessed what the shape of the movement he was founding might turn out to be.

Perhaps the most vital thing about this achievement is that those who are responsible for it have all one motivation – the desire to be friends to the mentally ill. There is among the nation-wide membership a substantial number of people who, like Beers himself, have been patients themselves in mental hospitals, have recovered and now want to help others to do the same. For this reason the volunteer side of the movement is strong and growing stronger all the time. The people who gave it driving force have overcome that primitive fear of the mentally ill, have looked at the insides of hospitals and have determined that they shall become places fit for human beings to inhabit. The new open hospital has brought us a long way towards this goal.

The strongest link between the hospital wards, open or closed, and the community outside is the volunteer. Such service is open to anybody. One person who organizes the work of volunteers in a whole chain of state mental hospitals puts them into four large categories, ranging from the “regulars,” who come every week or even more often, are assigned to definite programs and may wear uniforms to tell who they are, all the way to those who never see the inside of the hospital at all but are willing to undertake some job as undemanding as collecting and wrapping Christmas gifts.

For those who want to come regularly to the hospital and spend a good deal of time with the patients, there are usually tests designed to find out what they can best do, and perhaps to catch the few who are not suited to direct contact with sick people and would be happier and more useful somewhere else. But the task does not require a

person of outstanding gifts. A story is told, a true story, about a man who wanted to help but thought very poorly of his own abilities. He did not know how to organize a party or a basketball team, and he was timid about talking to people. But he undertook to sit every day with a patient who had not spoken for so many years that most of the staff believed him to be dumb. Weeks went by, months perhaps, the timid man kept patiently to his service, and at last one day the silent patient spoke to him.

It is not so much what you are able to do as how you do it. A prominent psychiatrist, looking back over some medical experiments which had not turned out quite as expected, recently put it this way: “Even an intrinsically worthless drug” (that is, one which later tests show not to have the properties attributed to it) “is known to be effective if administered to the patient in the right spirit.”¹² Another scientist puts it like this: “It has been reasonably demonstrated that expectations have a great deal to do with the curing of patients.”¹³ The spirit the volunteers bring into the hospital, the expectations with which they approach their task, these are the things that give them sometimes what seems like a magic touch.

One of Pennsylvania’s vast barrack-type state hospitals started a volunteer program on its wards in 1953. A woman who has been part of this service from that day to the present was asked not long ago to say what the volunteers did and why. She listed some of the things that were done:

Nine groups are now giving monthly parties on the wards. All kinds of parties. Some have themes

based on a coming national holiday There was a spring millinery show, with the patients making hats out of crepe paper, then parading past a volunteer who used to be a fashion coordinator Once in a while groups import talent, such as quartets from churches and clubs. Some groups recognize birthdays of patients born in each month.

Not all patients participate, and not the same patients every time Many of those who don't actively join in react in their own way. They may kibitz a game or tap a foot or wave a hand to the music.

Volunteers take patients out for rides to places they want to see-to the airport: "Does this go on every day? All these people, all these planes?"

The patient who hasn't been out of the hospital for fourteen years and who panics at the idea of getting out of the car, entering a snack bar and ordering a soda or sundae is persuaded, cajoled, encouraged into making that great effort, and praised for doing so well.

Volunteers teach painting and ceramics . . . help patients make clothes for themselves. One volunteer is editing a monthly newsheet, finding and helping patients to write articles, stories and poems.

All of us serving at the hospital are learning while doing. There's a corps of citizens who are growing

in knowledge they're getting through their hearts, first, then through their minds. We like to think we're helping patients to turn outward toward their fellows.

The last word on volunteer programs always rests with the superintendent. Like the captain of a ship at sea, he has ultimate responsibility for the health and safety of a self-contained community as large as a small town. But doctors are generous in what they say about the help given by the volunteers, by ordinary members of the community, most of whom never had any training beyond the brief orientation the hospital gives:

The volunteer movement showed that change in a positive direction at a state hospital is possible, and that it is primarily a matter of emotional rather than intellectual understanding. The changes that were wrought in the community and at the hospital were not achieved because means employed were either new or different in themselves. They came about largely as a result of reaffirmation of community social consciousness and of foresighted hospital administration beliefs and practices.

Where do the volunteers come from? As a rule, from the local mental health association. Clifford Beers' movement now has a tentacle in a very large number of counties. The people who build the local associations are volunteers too, from the President, who is probably an important figure in the community, to the high school group that comes in to help address and stamp envelopes at the time of the annual

drive for Christmas gifts. An increasing number of such local associations now have a paid executive and a secretary, and indeed the executives of local mental health groups are a small but growing and recognized subdivision of the social work fraternity. But always the responsibility rests with the volunteers, the people of the town or county who care enough to give many hours of their time attending committee or board meetings, speaking to local groups like the PTA, the Kiwanis, a church fellowship or a women's club, going to state and national conferences to find out what is going on elsewhere that the county association can make its own. As a rule, a modest amount of money comes from the community chest, or from a fund-raising drive in the spring. Many such groups like to raise their own money because it gives them a chance to ring doorbells and carry into hundreds of homes the story of friendliness in action which they want so much to tell. All that the paid executive does is to advise when asked, and to carry out the program the volunteer board has worked out for itself.¹⁴

The fact that so many people formerly patients in mental hospitals are finding their way back to their own communities and families is something which we have not been confronted with before, and it throws a glaring light on a most distressing problem – the unwillingness of people in general to accept a former mental patient without rejection or fear. A survey made in Massachusetts to discover how employers and unions felt about hiring former patients produced some discouraging results. For one thing, both employers and unions were inclined to say that they, of course, would welcome back the former

patient – but that the other party probably would not. Fantastic fears were expressed of what might happen. A number of people thought that providing employment for discharged patients was something the government should do; but it turned out that the government was itself setting a bad example in that community by refusing to hire a former patient until he had been out of the hospital for a full year. It did not concern itself with how he was to be supported during that first year, nor with the question of whether discouragement and financial pressure might force him to take refuge in the protected life of the hospital once more.

Part of this same problem is an ugly spectacle which is seen whenever a proposal is made for the building of a new state hospital. Sometimes years go by while one community after another resorts to protest meetings, publicity campaigns and finally hair-splitting court action in a desperate attempt to have the hospital put somewhere else. This is a place where a county association has an awe-inspiring task of public education on its hands.

Two scientific investigators recently published a book in which they give a factual and unemotional study of an attempt to carry on such public education in a Canadian prairie town.¹⁵ Here a psychiatrist and a psychologist, working as a team, tried to see what they could do to change the attitudes of the people in the town towards their former friends and neighbors who had been in mental hospitals but were now well and ready to come home. After six months of careful educational programs, the people employed to evaluate the results found that in this town full of decent citizens they had become so unpopular that they

were more than once openly asked to leave. Talking about the possibility that former mental patients, their own friends and neighbors, might recover and come home had stirred up in the townspeople so much anxiety and fear that they formed a defensive alliance against the unwelcome idea.

If, as the doctors now tell us, it is possible for eighty or ninety per cent of all those who become mentally ill – ill enough to need hospital treatment – to recover enough to leave in anything from three months to one year, what is going to happen to these people? Must they become ill again because they are shut out of life, feared, cold-shouldered by their families and those whom they used to think of as their friends? How much is such friendship worth?

Dr. Paul Hoch, Commissioner of Mental Hygiene for New York State, said something not long ago which is very much to the point:

As large numbers of patients are improving, even though they are not fully cured, and they will need further support in the community, the attitude of the community towards these patients is a very important one. Maintenance of a patient in the community, treatment of a mental patient in the community, doesn't depend on the patient alone. It depends also on the attitude of the community toward the patient. If the community is rejective, if its citizens have the feeling that these people should not be among them because they are not 100% cured, that they should be locked up

somewhere away from them, this attitude obviously will influence not just the patients who are already in the community but the chances for discharge of those patients still in the hospital.

The mental hospital volunteer quoted earlier also had something wise to say about this:

We used to think that the most wonderful thing that could happen to a patient was to go home. Now we know that to him it is a crisis.... I'm thinking of one elderly patient who has recently been dismissed. He was our friend, and we were his. We're told not to become too personally involved with patients. But the very essence of friendship, which is really what we have to offer, is personal involvement. It seems mighty cool to drop him just because he's no longer a patient. Maybe he needs some friendly encouragement more now than ever. Could ordinary citizens help here, after the patients go home? Could foster homes be found for them to bridge the span between release and eventual return to family surroundings?

It is reasoning like this which has led to the creation of many small groups here and there which are dedicated to helping the returned patient cross this bridge back to the everyday world. Some, like Fountain House in New York or in Philadelphia, offer not only friendship but professional help in getting back, through social gatherings, help with job-hunting, finding temporary homes and the like. Some are entirely made up of ex-patients who meet

together to encourage one another. Some are correspondence groups which never actually meet.

An offer of friendship and support here will never be refused. No one thinks it is really the best thing for ex-patients to spend all their spare time with people whose recent experience has been similar to their own. The little circles need to broaden out as confidence is won. The ideal ex-patient group is one whose members steadily drop away as they find themselves more and more accepting and being accepted by the ordinary struggling world again.

There is hardly anything more challenging than this in the whole range of difficulties and problems which mental illness brings for people as individuals or in groups. And to people who call themselves Friends, it should come with a force impossible to resist. It is clear enough, when we stop to look honestly at the facts, that our own lack of love is condemning to years of what amounts to imprisonment, people who could live again in the real world, share its work and its happiness, fulfill their obligations as human beings and live as fully as they are able to do. To deprive a human being of his right to develop freely as a member of a living community is a fearful thing. If by our fear or indifference we are doing this to our fellow-creatures, how can we forgive ourselves?

In 1955 a new national organization came into existence—the Academy of Religion and Mental Health. It arose out of the growing feeling among people of many different faiths that religion, since it dealt with the whole man, must deal with him in that rather hazy territory where body and mind

shade off into each other. The new medical concepts of the intimate relationship between psyche and soma are not so new to religion, but religion in the past has felt somewhat helpless in dealing with an illness which might originate in the soul but nevertheless manifested itself in the body, or one in which a bodily imbalance seemed to distort the emotions or the mind.

The founders of the Academy felt that the time had come to alter this state of things. They wanted to see that religious instruction had a positive, rather than a negative effect on the emotional patterns laid down in children, and that what people heard in the churches and synagogues helped them toward the healthy mind which should declare itself in the healthy body. Above all they were concerned for a better ministry to the mentally ill.

“We were embarking,” they said, “upon a task and a quest that would help bring healing to the minds and souls and bodies of the children of God who are walking this earth in pain, fear, guilt, anxiety, sorrow, loneliness, and often in utter mental darkness.” They did not know what they must do or how, but they determined to find out, because “we were engaged in man’s greatest privilege – the giving of his love to his fellow men.”

In three or four years the Academy has come a long way. It has more than 2,000 individual members, and hundreds of local groups throughout this country and in a number of places overseas. It is able to give scholarships to people who are willing to prepare themselves especially for ministering to the mentally ill in hospitals. It has

demonstrated that mental illness and the things which go with it are objects of deep concern to a great many people who in an earlier time might have felt compelled to leave those who suffered in this way to the mercies of doctors and attendants who professed to know little or nothing about how they could be helped.

It is easy and superficially comforting to turn away when one feels that one can do nothing to help. This avenue of escape is being closed to us now, because we are learning that there is something to be done and that we must do it. The churches, like other bodies of people who come together for a purpose, are starting to respond to the new hopefulness about the possibility of rebuilding the broken bridges between the mentally sick and their fellow men. They are starting on a courageous effort to show by their actions that to say we are all children of one father is more than a pious platitude. It is a commonplace to assert that the churches have often fallen short of their profession; where they make an effort such as they are making here, we owe them our respect and our active help.

Above all, there is a challenge here to those of us who call ourselves Friends. We cannot ignore it if we are to be faithful to our traditions. Quakers have refused to recognize the existence of artificial barriers cutting men off from one another; they have treated the slave as a fellow human being, the prisoner as one whose feet are also set on the way. They have approached despotic rulers in confidence that the voice of friendship and reason could still be heard by the man imprisoned in the monstrous carapace. And they built hospitals for the mentally ill as an alternative to

shutting them in cages like wild beasts, and pleaded for kindness and the striking off of chains in an age when brutality born of fear and lack of understanding was almost universal in the treatment of persons who were deranged.

Those same beliefs should lead us now to join the people who are working for what, to them, is a new goal – the bringing of the mentally ill out of darkness into full fellowship with their brothers. We as Friends were among those who gave some of the earliest demonstrations that this could actually occur, even in an age when it took place rarely because the physical aspects of treatment were not yet understood.

If the doctors are now giving us scientific reasons for what religiously minded people have long instinctively known, validating through their experiments the insight upon which Friends have sought to act over the past three hundred years, it must be that there is a place for us, more now than ever before, among those who are making the door of the mental hospital a door into life rather than a door into death.

Notes

1. Quoted by Carl A. L. Binger, M.D., in *Mental Hospitals*, June 1958 from an article by Martin Buber in *Psychiatry*, Vol. 20, No. 2, May 1957.
2. Karl R. Butner and Nathan G. Hale, Jr., *Emotional Illness: How Families Can Help*, G.P. Putnam's Sons, 1957

3. Albert Deutsch, *The Mentally Ill in America*, Columbia University Press.

4. Though it may be hard for us to realize, the treatment philosophy behind this was not fully extinct even towards the middle of the nineteenth century; Dorothea Dix was told by a prison keeper in Illinois in 1847 that the mentally ill were insensitive to cold and there was no need to provide them with any kind of comfort. A record from England at about the same period describes the “single lunatic” who had the misfortune to come from a family unable to afford medical care: “The portion of the domestic accommodation usually assigned to these unfortunates is that commonly devoted to the reception of coals . . . namely, that triangular space formed between the stairs and the ground-floor. In this confined, dark and damp corner may be found at this very time no small number of our fellow-beings, huddled, crouching and gibbering, with less apparent intelligence and under worse treatment than the lower domestic animals.” (*Westminster Review*, March 1845)

5. Kathleen Jones, *Lunacy, Law and Conscience*, London, 1955.

6. We must not forget, however, that a number of the great men in nineteenth century psychiatry had Quaker backgrounds, among them Pliny Earle and Thomas Kirkbride.

7. Leonard Edelstein, *We Are Accountable*, Pendle Hill Pamphlet

8. Here the Friends differed radically from the Puritans, who held that the Holy Spirit is present only in the redeemed and in them only incompletely. Others were “totally depraved,” because of Adam’s fall.
9. Otto von Mering and Stanley H. King, *Remotivating the Mental Patient*, Russell Sage Foundation, 1957.
10. There is hope for a reduction in the vastness of mental hospitals in the current British experiments, which have demonstrated the possibility of cutting down new admissions to hospital wards by greatly extending the services to which patients can have access while they still remain in their own homes.
11. Now the National Association for Mental Health.
12. Jack R. Ewalt and others, *Practical Clinical Psychiatry*, McGraw, 1957.
13. Elaine Cumming and John Cumming, *Closed Ranks – An Experiment in Mental Health*, Harvard University Press, 1957.
14. Anyone interested in these volunteer services is invited to write to Pennsylvania Mental Health, Inc., 1601 Walnut St., Philadelphia 3, for a copy of “I Am a Volunteer in a Mental Hospital” by Mrs. Ray Wetherbee.
15. Cumming, *op. cit.*

About the Author

Norma Jacob was born, educated and married in England, joining the Society of Friends there in 1935. With her former husband she represented the Friends Service Council in Spain (Barcelona) during the Spanish Civil War. In 1940 the Jacobs came to America and spent the year at Pendle Hill. Afterwards they experimented for four years with an intentional subsistence community in Vermont. Since then Norma Jacob has lived in or near Philadelphia, including a second year at Pendle Hill. She now lives in the Philadelphia Friends' Self-Help Housing Project and is currently administrative assistant for Pennsylvania Mental Health, Inc. Convinced that social workers should know something about government, she is completing work for a Ph.D. in Political Science, having earlier earned the degree of Master of Social Service from Bryn Mawr.

Pendle Hill

Located on 23 acres in Wallingford, Pennsylvania, Pendle Hill is a Quaker study, retreat, and conference center offering programs open to everyone. Pendle Hill's vision is to create peace with justice in the world by transforming lives. Since Pendle Hill opened in 1930, thousands of people have come from across the United States and throughout the world for Spirit-led learning, retreat, and community.

At the heart of Pendle Hill is a residential study program which encourages a step back from daily life for reflection and discernment in preparation for deeper engagement in the community and wider world. Because spiritual

experience is essential to Quakerism, Pendle Hill's education is experiential, or experimental, at its core. Adult students of all ages come for a term or a year of education designed to strengthen the whole person – body, mind, and spirit. The Resident Program captures the earliest vision for Pendle Hill while responding to the call of the world in which we exist today. Program themes include:

- Quaker faith and practice
- Dismantling oppression
- Spiritual deepening
- Leadership skill development
- Ecological literacy
- Personal discernment
- Arts and crafts
- Gandhian constructive program
- Building capacity for nonviolent social change.

Programs are offered in a variety of formats – including term-long courses, weekend workshops, and evening presentations. Those unable to come for a term or a year are encouraged to take part in a workshop or retreat. Information on all Pendle Hill programs is available at www.pendlehill.org. Pendle Hill's mission of spiritual education is also furthered through conference services – hosting events for a variety of religious and educational nonprofit organizations, including many Quaker groups.

The Pendle Hill pamphlets have been an integral part of Pendle Hill's educational vision since 1934. Like early Christian and Quaker tracts, the pamphlets articulate perspectives which grow out of the personal experience,

insights, and/or special knowledge of the authors, concerning spiritual life, faith, and witness.

A typical pamphlet has characteristics which make it a good vehicle for experimental thought. It is the right length to be read at a single sitting (about 9000 words). It is concerned with a topic of contemporary importance. Like words spoken in a Quaker meeting for worship, it embodies a concern, a sense of obligation to express caring or to act in response to a harmful situation.

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