# Psychiatric Rehabilitation in the Hospital

By RICHARD H. WILLIAMS, Ph.D.

THE CONCEPT of rehabilitation is fairly clear-cut when one is dealing with amputees or with persons suffering from chronic neurological diseases. Everyone knows what is meant, and the results have been striking. But as the concept has become more generalized and is used to refer to still other diseases, including mental illnesses, it is not quite so clear.

Dr. Pearce Bailey has stated, "The current rehabilitation movement . . . is rooted in the concept that the mission of modern medicine must extend beyond definitive medical treatment to a program of dynamic therapeutics designed to bring the chronically ill patient to the highest functional level of physical, psychological, and socioeconomic adjustment compatible with his disability" (*1*). Such a program is limited only by maximal development of residual functions.

This statement is clear as to the objectives of rehabilitation. It is not, nor was it intended to be, a definition because it does not delimit the process or operations involved. Furthermore, in a broad sense, all therapies have this same goal and may contribute to its realization. There has been considerable difficulty in demarcating a specific field of activities to be termed "rehabilitation," and there is some tendency to feel that rehabilitation is too loose a concept to warrant the development of a special program. On the other hand, there is a strong feeling that the goal of maximal development of residual functions requires a new orientation, the development of new techniques, and a new program if it is to be adequately attained.

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### The Rehabilitative Process

Several characteristics tend to distinguish the activities of people engaged in rehabilitation. A rehabilitation worker is often said to engage in adjunctive therapy as contrasted with specific medical therapy. Specific medical therapy is designed to cure, arrest, or mitigate a specific disease entity. Adjunctive therapy assumes an end product of specific therapy and is designed to restore or readjust the patient to the most adequate level of functioning of which he is capable, given this end product.

Dr. Howard A. Rusk's frequently used phrase "the third phase of medicine" also suggests a distinguishing characteristic of rehabilitation in terms of time. The rehabilitative process generally begins after diagnosis has been made and specific therapy used. It might be better to distinguish four phases of medical practice: prevention, diagnosis, specific treatment, and

rehabilitation. To be sure, no very sharp lines can be drawn in terms of time. All phases may overlap in many cases. Yet these phases are distinguishable, with general, average differences in time as one of the variables.

Another distinguishing characteristic of the rehabilitation process is that, in addition to the various adjunctive therapies which will vary from case to case, a complete approach must be used. The patient must be understood as a whole person in relation to his family, community, and job possibilities. As Rusk has stated, "If a man has a hearing disability, has lost a leg, or has a cardiac condition, his disability affects all phases of his life. It has a bearing on his vocational opportunities, his family, his social life, his recreation, and his mental and emotional outlook. Individual disabilities cannot be treated in rehabilitation; the whole man must be treated" (*2*).

At a discernible point the patient begins to get an "outside" orientation, and to think of himself as an "ordinary social person" rather than as a "patient." There is a problem of the best time and means to get him to this point and to keep him oriented. Also, there is a problem of getting the patient "over the hump." In other words, there are critical points in the total treatment process which need special attention. A part of the hump which the patient must get over results from the gap which generally exists between hospitals and the community. There is a problem of how or in what ways this gap may be bridged.

In short, patients have many needs which have not been wholly met in the traditional therapies. There is a problem, then, of determining what services can meet these needs and the kinds of people with necessary training required to perform them. Among these needs the patient's occupational role and other aspects of his social role are particularly important.

We suggest that "therapy" and "treatment" may be used as generic terms, and that rehabilitation is a special form of therapy, albeit relatively nonspecific and holistic in its approach. Rehabilitation is that form of therapy which is primarily concerned with assisting the patient to achieve an optimal social role (in the family, in a job, in the community generally), within his capacities and potentialities. Psychiatric rehabilitation is the application of rehabilitative therapy, thus defined, to mental and emotional disabilities. These disabilities may be primary or secondary. In its developmental research program, the National Institute of Mental Health began with the primary disorders—the psychoses.

### Treatment a Continuum

Total treatment may be viewed as a continuum, with specific medical therapies defining one end of the scale and rehabilitative therapies defining the other. The specific medical therapies are primarily (but not exclusively) concerned with helping the patient to recover from his illness. The rehabilitative therapies are primarily concerned with helping the patient live with his illness or its residue and helping him develop substitute capabilities and new adjustments as needed. The nearer one is to the specific medical therapies on such a scale, the more one is concerned with operations within a distinctly medical and protective setting. The nearer one is to the other end of the scale, the more one is concerned with the patient's ultimate adjustment in nonmedical settings in the community. In the field of mental disorders, at one end of the scale (deep psychotherapy) one is concerned with remodeling the patient's basic character structure, whereas at the other end of the scale, the primary concern is getting the patient to function in the social process, with the character structure which he has.

These two orientations do and should shade into each other in the total process of treatment. There is no sharp division between them on a basis of time, as it may be highly advantageous to develop the rehabilitative aspects during an early stage of treatment. There is no 1 to 1 correlation between type of personnel and type of treatment on this continuum. Psychiatrists can, and should, concern themselves with the full range of treatment problems, including rehabilitation. By and large, personnel concerned primarily with rehabilitation do not have the required training to engage in specific medical therapies, although it is advantageous if they have some understanding of these therapies and can communicate easily with physicians. Some therapists, notably occupational therapists, occupy an intermediate

position: to facilitate the specific medical therapy, as prescribed by a physician, and to facilitate the rehabilitation process. Possibly the term "adjunctive" therapies will be gradually dropped, because it gives the impression of something added on, secondary and expendable. They might better be called rehabilitation services and considered as an integral part of total treatment.

### The Importance of Research

Research in the field of psychiatric rehabilitation is in its infancy, but it has great potential importance for two basic reasons. In the first place, research is important operationally because it can lead to significant reductions in costs and wastage in the care of the mentally ill. As is well known, mental patients occupy more than one-half of our hospital beds, and the population in mental hospitals continues to increase—17 percent since 1939. There are a few private psychiatric hospitals, which provide good treatment and care, but they cannot possibly assume the whole burden of this large public health problem. State mental hospitals are generally overcrowded, and they are seriously understaffed.

There is considerable doubt as to the extent, if any, to which this increase is due to increases in the incidence of psychiatric disorders. Certainly, one of the major factors has been a series of changes in the organization and structure of the family, together with an increase in numbers of individuals who are detached and isolated from family groups. All of this has made it more difficult to tolerate and care for the mentally ill at home, individually and independently. Improved medical care has also reduced mortality rates in mental hospitals. Thus, the trend is toward higher admission rates and longer stay in the hospital, so that a large chronic population has developed.

It is not likely that a sufficient number of psychiatrists can be trained in the near future to meet the needs of the mentally ill for specific medical therapies. Given this situation, there is urgent need for research to determine the best ways to:

1. Prepare mental patients to live in less sheltered, less dependent, and less costly settings than the hospital.

2. Utilize all the hospital personnel, including psychiatric aides who have the most frequent contacts with patients, and utilize the entire hospital setting as a community to this purpose.

3. Mobilize existing resources in the community and create new, but less expensive, resources to maintain patients at an adequate level of functioning after they have left the hospital.

In the second place, research in psychiatric rehabilitation has a potentially significant contribution to make to basic scientific knowledge about mental disorders. Bailey (*1*) points out that the pathogenesis of neurological diseases is less well known than for other diseases. Hence there is more limited use of specific therapies and rehabilitation becomes all the more important. This statement applies equally well to mental illnesses. Furthermore, mental disorders, regardless of etiology, tend to involve disturbances in interpersonal relations and social adjustments in a direct way, more so than in most other illnesses. A significant proportion of mental disorders involve a failure of a person's system of behavior itself, rather than an inhibition of the system imposed by conditions stemming from the anatomical or biochemical systems of the organism—the "actor" is out of "whack," but the organism may be perfectly intact. Communication with others and emotional orientation to others are disturbed.

Rehabilitation of the mentally ill must thus be based primarily on an understanding of the emotional components of personality in the network of interpersonal relations, or, in other words, on the dynamics of social motivation. Research in psychiatric rehabilitation focused, as it must be, on ways in which patients may achieve an adequate social role and adequate functioning in the community, ways in which they may regain some interpersonal and social perspective, should contribute significantly to a basic understanding of this important component in mental disorders.

### A Pilot Study

The National Institute of Mental Health is currently sponsoring a pilot study in rehabilitation at the Boston State Hospital under the

general guidance of the superintendent. A research psychiatrist is project director, and psychologists, sociologists, and social anthropologists are used on the research and advisory staffs of the project. It is now in its second year of operation. Operations were necessarily on a small scale during the first year, and it is expected to run at least 2 more years.

The study encompasses an experimental group and a control group, with 30 men and 30 women in each group, selected from the reception service wards, and experimental and control groups, with 40 men and 40 women in each group, selected from the chronic service wards.

Control patients receive whatever service the hospital is conventionally able to provide, which is minimal. For example, on the chronic service wards for men there are 2 social workers, 3 occupational therapists, and 1 recreational therapist to cover the needs of 700 or more patients.

The experimental groups receive additional rehabilitation services from personnel assigned directly to the pilot study and from regular hospital personnel. These services include recreational therapy, educational therapy and counseling, hospital industry counseling, the services of a full-time vocational rehabilitation counselor, occupational therapy and social service. Also, an explicit attempt is made to bring physicians, nurses, and ward care personnel into the rehabilitation team.

However, the project has been explicitly designed with a relatively small number of additional service personnel (there are only four full-time service personnel attached to the project). We are convinced that rehabilitation services do pay off and that it is not necessary to make large additions to service costs. When the project was expanded in scope for the second year, additional research personnel but not service personnel were provided. The addition of research personnel bears a relation to "capital gains" to be derived from a project of this sort, which is quite different from the situation created by the addition of service personnel. Costs of additional service personnel would continue indefinitely in duplicated projects, whereas other hospitals can use the knowledge gained without having research costs. The latter is a primary objective of the project.

Definitive results are not yet available. Indeed, definitive results cannot be expected for at least 2 more years, because one of the criteria must necessarily be the extent to which patients can maintain themselves more independently over a period of time. Some experts consider 5 years to be a minimum period for making this judgment. The project has, however, learned much about methods of research in rehabilitation and about operational problems which are likely to be encountered. This is a type of knowledge which would be very useful to persons who might wish to introduce either research or service programs in other hospitals.

### Considerations of Method

In a pilot research study, considerable time and effort must be spent to determine the methods of research which will be feasible within a given setting and which will most probably answer significant questions. In fact, one of the major purposes of a pilot study is to do just that and to pave the way for further and more detailed research. Six months were allowed for this purpose alone in the Boston State Hospital study before any of the action programs were initiated. As was expected, further experimentation with, and revision of, methods were necessary after the 6-month period.

Three major considerations of method, which would have to be faced in any study of a treatment program, have been explored:

1. Establishing experimental and control groups and the criteria for selection of patients in each.
2. Defining the variables to be measured or otherwise analyzed.
3. Selecting or developing tools for measurement or evaluation to obtain baseline data and later comparisons.

### Selection of Groups

The establishment and composition of experimental and control groups on the reception service wards presented no serious difficulties, because existing administrative practices could be readily used for this purpose. This service has 6 similar wards in a 3-story building. The

2 wards, one for men and the other for women, on the third floor were arbitrarily chosen for the experimental patients, and the 2 wards on the second floor, for controls. Patients are assigned to these wards by rotation on admission, so that the composition of the group is determined by chance. Only committed and voluntary patients were chosen, patients for whom there is no arbitrary limit on hospital stay, thereby excluding certain other categories which are admitted for restricted periods of observation. However, if patients in these other categories were subsequently transferred to a committed or voluntary status they were involved in the study. The groups are thus composed of the first 30 patients on committed or voluntary status to be admitted to experimental or control wards, starting November 1, 1952, making a total of 120.

The establishment and composition of experimental and control groups from the very large chronic population presented numerous problems. Development of feasible and suitable means to solve these problems was a major accomplishment of the study during the first months. The final result has utilized five major steps:

1. An "eligible group," was designated according to the basic criteria of: (*a*) not under current treatment for physical illness; (*b*) under 60 years of age; (*c*) hospitalized for at least 1 year in the current illness. These criteria do not imply that excluded cases are incapable of profiting from rehabilitation services, but only that they involve different problems in rehabilitation, and we wished to focus the study more specifically.

2. "Prospects" were designated within the eligible group. Prospective patients for rehabilitation services were selected by the chief psychiatrist of the service on the basis of his personal knowledge of patients, a check on patients recommended as prospects by other service personnel, and a careful screening of all patients on ground parole. Severity of illness, potential responsivity to treatment, and potential for achievement after discharge were all considered. It was specifically decided to include some of the more seriously ill patients, whose chances for being discharged within 1 year would be slight, because one of the aims of the study is to determine what types of mental patients can best profit from rehabilitation services, and, consequently, the range of types should not be arbitrarily narrowed in advance.

3. A "drawing group" was obtained by cross-classification of all prospects by the three criteria mentioned above. Each patient was rated on a three-point scale for each criteria. Twenty-seven cells were thus formed, and a random selection of patients from each cell, in proportion to the numbers in each cell, was made to obtain a drawing group of 40.

4. The 40 members of the drawing group were matched with 40 members of the remaining prospects, according to 10 indexes.

5. Members of the 40 matched pairs were assigned to experimental and control groups by chance.

Analysis of the data after the selection was made indicates that "eligibles," "prospects," and study groups are very closely comparable in terms of level of hospital adjustment, so that we are most probably dealing with a broadly representative sample of chronic patients. About 80 percent of the prospects manifest an active paranoid or schizophrenic process. Also, it was possible to achieve very close matching between experimental and control groups. It was desired to develop methods of selection for the study which can be duplicated, which will not deviate markedly from hospital administrative practices, and which do not involve the use of complicated or expensive instruments (the validity of which has not been proved for rehabilitation, in any case). The method established came closest to satisfying all these considerations. Its feasibility, however, is dependent upon having a chief psychiatrist who has had sufficiently long contact with the patient group and who can be given the extra time necessary to make the selection of "prospects" from "eligibles."

### Defining the Variables

Defining the variables to be studied also presents a crucial problem in any research program in rehabilitation. In a sense, our major variable is the introduction of a rehabilitation program in the experimental groups (and its

nonintroduction in the control groups), but it is apparent that this is a very complex variable indeed. Several rehabilitation techniques are being used. Also, and probably more important (for reasons to be indicated in another section), the study itself introduces new problems, new attitudes, and new interpersonal relations for all of the personnel. The problem of contamination of control groups is very real, especially in relation to the new attitudes which the study may generate. It would not be possible, short of an enormously complex and costly design, to isolate each aspect of the overall variable, a rehabilitation program, and study it separately under strictly experimental conditions. We do believe it is both feasible and potentially valuable to maintain the overall experimental design and then to develop accurate descriptions of the subvariables and intervening variables involved. For this reason primarily two full-time sociologists were added to the project staff. Undoubtedly, numerous subhypotheses will develop concerning the rehabilitation program which will lend themselves to scientific analysis now and possibly to experimental testing in subsequent studies.

### Evaluation Tools

The selection or development of tools for measuring and evaluating the patients' status and movement is largely a problem of providing sufficient time and personnel to give a series of psychological tests and to use a number of rating devices. We are exploring a new field of developmental research, and we are not sure which psychological tests have adequate predictive value for rehabilitation potential. Several rating scales of hospital and posthospital adjustment have been developed in quite recent years, but further exploration is necessary to determine their usefulness in a particular research setting. Thus, within reason, the more instruments used, the better. Some of them will turn out to have sufficient reliability and validity to be useful and others can be discarded later on.

A battery of 7 or 8 psychological tests and several rating scales, some of which can be used under careful supervision by personnel engaged in ward care, are currently being used. Consultant psychologists and an additional full-time psychologist were added to the staff of the study to strengthen this aspect of data collection. In addition, detailed records are kept of the type and amount of the services given to experimental patients. It has been recognized from the first that a better inhospital adjustment can be a legitimate goal in rehabilitation, and a legitimate criterion of success of the program, even though the patient may not be ready for discharge. Not only is the patient "better off" in terms of broadly accepted human values, but also he creates less demands on the hospital staff, thereby lowering the costs of his care. Consequently, periodic ratings are necessary, and it would be misleading to rely on discharge rates as the sole index or even to give them special weight.

### Some Operational Problems

Numerous operational problems will be encountered whenever a new program is introduced into a large organization such as a State mental hospital. Both the formal administrative organization and the informal cultural atmosphere are likely to possess a certain rigidity and to be resistant to change. Two rather different attitudes may be taken toward such problems. On the one hand, they may be, and without great care are likely to be, regarded as "unenlightened" resistances to be overcome by all possible means. On the other hand, they may be regarded as representing very real forces in the social structure of the hospital, probably having important functional aspects, and, consequently, something to be understood, possibly modified, but not simply combated. The latter point of view has prevailed, wisely, we believe, in the Boston study.

Several of the operational problems encountered thus far revolve around the role of the ward physician. In the early stages of the study, it appeared that ward physicians were not making referrals for rehabilitation services (especially on the reception service wards) as frequently as would be expected or desired. Analysis showed that this was not due to blindly negative attitudes on the part of the physicians. They had suddenly been called upon to make a new type of referral and new

evaluations of patients for which they had not been prepared in their training, and no established routines existed. Also, examination of schedules revealed that the ward physicians did not have the necessary time to do the things they are supposed to do, according to general expectations. Furthermore, ward physicians are residents and are oriented toward their own training programs, which are heavily slanted in the direction of individual psychotherapy with patients (as a rule, with patients who are not on the same wards). The new rehabilitation program appeared as an additional hospital chore, taking valuable time away from training rather than adding to the value of the total training experience. The statement was made in a staff conference, for example, that if residents had a completely free choice they would not choose assignment to the experimental wards. Group conference techniques can, and have done, much to alter this pattern gradually, but it is deeply entrenched in the hospital culture and will have to be realistically faced in any rehabilitation program.

This example is but one of many of the general problems of facilitating communications and integrating a new program within the hospital. It has become a major goal of the pilot study to understand this problem as thoroughly as possible, rather than to treat it as a negative condition to be overcome, allowed for, or just tolerated. Such an orientation would certainly make it much easier to duplicate, in other hospitals, those phases of the action program which prove worthwhile.

### Some Results From the Data

As indicated previously, definitive results in the sense of evaluating the rehabilitation program as such cannot be expected in the first years of a pilot study. However, such a study does produce other kinds of results in the form of new knowledge that is useful for a variety of purposes. Sometimes the facts may not be entirely new or unknown, but the research on a new problem lends new perspective to them, or gives them a greater emphasis than they had before. A few examples of areas of knowledge gained thus far in the Boston study are cited briefly to illustrate.

The hospital has been more accurately informed concerning what has actually been going on in terms of releases. It was necessary for the pilot study staff to make statistical analyses of releases during a sample year, giving numbers released, location within the hospital prior to release, length of hospitalization, age, sex, type of provision for care on release and returns to the hospital.

The reception service handles "new" admissions, but it does not follow that these patients have recent or acute cases. In fact, less than 50 percent of this group in the pilot study had come into the hospital for the first time. Some of them had as many as nine previous admissions to mental hospitals. It is a group representing a very wide range of problems in developing and testing a rehabilitation program.

On the first trial run of selecting prospects among chronic patients from the eligible group, it was found that a surprisingly high proportion (roughly, 70 percent among the men) of the prospects had serious organic deficits along with their mental illness, including mental deficiency, alcoholism with organic residuals, and various pathologies of the central nervous system. On the other hand, they were people who caused little trouble in the hospital and who had made a reasonably good hospital adjustment as evidenced by ground parole and ability to perform some tasks in hospital industries. Further analysis raised serious doubts about their potential for adjustment outside of the hospital. Rehabilitation efforts in this direction might simply result in the transfer of a custodial problem from the hospital to some outside group. In any case, the group with serious deficits represents different and additional rehabilitation problems. Yet this is the group that hospital personnel tended to think of first as prospects for rehabilitation. These facts show that the selection of patients for intensive rehabilitation efforts is not a simple matter. In the Boston study there was need to broaden the base of selection so that an analysis could later be made of the most successful and the least successful types of cases.

It is known that the percentage of married patients in mental hospitals is low in comparison with the general population, but the extent of this difference is not often realized nor is its

importance sufficiently emphasized. About 70 percent of the male chronic prospects in the Boston study were "single." Thus, relations with a "family of procreation," that is, with a family in which one is a major responsible member (for example, husband and father), cannot be a part of the rehabilitation plan for many mental patients. The extent of the relation, and its potential usefulness, to a "family of orientation" (parents, siblings, or other relatives) is important to determine, as is the possibility of finding substitute groups for the family in many cases.

### Interpersonal Relations and Attitudes

Charlotte Green Schwartz (*3*), in an analysis of the literature on the rehabilitation of mental hospital patients, draws an important distinction between rehabilitation programs which focus primarily on the interpersonal relations and attitudes which come into play and result from activities in the program, and programs which focus primarily on the nature of the activities themselves. The latter emphasis tends to give major attention to the individual patient and the particular activities (for example, occupational therapy and recreational programs) in which he has engaged, whereas the former tends to give major attention to the whole context of social participation in activities regardless of their specific nature. The evidence is not all collected concerning the relative values of these two approaches.

The definitions and general perspectives on psychiatric rehabilitation, suggested above, in which the dynamics of social motivation and social reactivation are crucial, would favor the hypothesis that interpersonal relations and attitudes are more important than the intrinsic nature of the activities themselves. Sociological research in other areas, such as industry or the armed services, give credence to this hypothesis (*4*, *5*). If proved generally valid, it would have important implications for the development of training programs for rehabilitation personnel. Perhaps what is needed is a generic program which has major emphasis on social and psychological dynamics and provision for internships in which dynamic principles could be applied. In addition, there could be some specialization within the generic program on activities such as crafts, manual arts, music, drama, vocational development, and adjustment.

### The Mental Hospital as a Social System

There is growing awareness that the patterns of interpersonal relations and attitudes within an organization such as a hospital form a system, and that this system has profound effects upon all the participants. It controls and motivates their behavior to a very significant degree. Again, there is much sociological evidence concerning the nature and importance of this system in other fields, particularly industry and the armed services (*4*, *5*). Schwartz (*3*) analyzes some of the quite recent studies of the social structure of the mental hospital, studies which are most challenging indeed. She also indicates, on the basis of evidence thus far, some of the characteristics of social structure which are presumed to be rehabilitative or vice versa, such as degree of democratization, effectiveness of channels of communication, and clarity of definition of functions.

One of the broadest visions of this range of factors and their potential therapeutic value has been developed by Dr. Maxwell Jones and his co-workers in England (*6*). They have also made one of the most explicit and thorough applications of these concepts in practice. A program for rehabilitation of the chronic unemployed with psychiatric difficulties has been established in the industrial neurosis unit at Belmont Hospital. So-called psychopaths and others with various disorders of character, usually termed "hopeless" cases, have been treated with better than expected success. This group is convinced that individual psychotherapy and hospitalization alone are not enough and that every aspect of the patient's life in the hospital community can and should be part of the total treatment program. Extensive use is made of conferences, discussion groups, psychodrama, and other forms of group participation. Explicit attention has been paid to the roles of physicians, nurses, and others on the staff and to the patterns of interpersonal relations and emotional dynamics which grow up around these roles. The constant aim is to integrate

these roles and to draw the patient into the total pattern, as a "therapeutic community," so that he can function more adequately in his social roles after discharge.

As this group clearly recognizes, every hospital has its social system, but much of it has been established on an intuitive or empirical basis, or has grown by the accretion of traditions. Efforts to direct the energies of the social system into therapeutic, including rehabilitative, channels should prove immensely fruitful. We are perhaps looking beyond the solid acquisitions of research, but we believe we are looking in a direction to which research already points the way.


## Summary

Rehabilitation has been defined as that form of therapy which is primarily concerned with helping the patient to function optimally in society, within his capacities and potentialities. Research on psychiatric rehabilitation has high potential value, both in relation to programs of treatment and in relation to basic scientific knowledge about mental disorders.

In a pilot study of psychiatric rehabilitation in the hospital, much has been and is being learned concerning methods of research, operational problems encountered, and various facts about the population of a mental hospital.

The importance of interpersonal relations and attitudes and the value of mobilizing the forces in the social system within the hospital for therapeutic purposes have been emphasized.


We believe we are entering a period in which this type of knowledge will be increased, and operational procedures for its use will be thoroughly established. It should be a period in which significant gains are made in the treatment of the mentally ill and in an understanding of mental disorders.

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*Details of the procedures used in selecting experimental and control groups from the chronic service wards can be supplied interested persons on request to the author.*

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# Dr. Brownell Named Commissioner of Education

**Dr. Samuel M. Brownell,** 53, widely known educator, was named Commissioner of Education in the Department of Health, Education, and Welfare by President Eisenhower on October 14, 1953. He will succeed Dr. Lee M. Thurston, who died September 4, 1953, after having been in office for only 2 months.

The new chief of the Office of Education has been president of the New Haven State Teachers College in Connecticut since 1947 and professor of education administration at the Yale Graduate School since 1938. Dr. Brownell also has been a visiting lecturer in education at the Universities of Cornell, Harvard, Michigan, Southern California, and Wisconsin. A native of Peru, Nebraska, he was a graduate of the University of Nebraska in 1921. He received his doctorate at Yale in 1926 and for 9 years was superintendent of schools at Grosse Point, Michigan.

Dr. Brownell is president of the division of higher education of the National Education Association and has been a frequent contributor of articles to professional journals.