Clinical psychology has reached such a point of development that it must be definitely differentiated from the other branches of applied psychology which are related to it and which make use of clinical procedures in part. Clinical psychology is not educational psychology or educational tests; neither is it industrial psychology or vocational psychology. All of these branches of applied psychology make use, to a greater or lesser degree, of the methods and procedures developed first by clinical psychology, but in their aim, subject matter and method of approach they differ radically.

Clinical psychology is an outgrowth of a field which was originally thought of as lying entirely within the medical province. Psychologists developed and standardized procedures for the detection and diagnosis of mental inferiority and intelligence lack. Previous to the work of Binet such diagnosis was an incident in the work of the psychiatrists who were devoting most of their time to the study of the actual insanities. Needless to say the methods and technique they used when diagnosing feeble-mindedness were also largely incidental.

The value of clinical psychology, in so far as it has dealt with the diagnosis of feeble-mindedness and intelligence inferiority, lies in the elaboration of technique and the wholesale standardization of criteria employed in diagnosis. Today such standardized tests have practically eliminated the personal equation from the measurement of intelligence inferiority and superiority. It is the psychiatrist, retaining his confidence in his own individual methods and devaluing norms, who is content with a superficial study of the child before rendering a diagnosis of "feeble-minded" "inferior", or the opposite diagnosis which we meet so frequently in the probate courts,— "Nothing wrong with him".

If we go back to the beginning of Binet's work it has been thirty years since clinical psychology began to evidence itself. However, it is only fifteen years since the first group of standardized tests were evolved by the same master-mind. It is only ten years since the translation of Binet's work into the English tongue and its first usage on a large group of American children.
Psychologists working in the field of clinical diagnosis need not be discouraged over the progress their branch of psychology has made in that time. If I were able it would give me great pleasure to depict the beginning of clinical psychology in this country as I saw it in the laboratory of the Training School at Vineland in 1910. One little pamphlet on the Binet tests had been published in English at that time. One summer school class had been instructed in the use of the year scale, mimeograph copies being used for part of the work. The children of the Training School had all been examined once by the scale. In the fall of 1910 the public school children of Vineland, nearly 2000 in number, were given the whole scale in fear and trembling and with the greatest speed possible for no one knew how much parents might object to having their children tested. The laboratory helpers were enthusiastic over the method and when the day’s mail brought two or three requests for information about the tests everyone felt that the good work was growing rapidly. The helpers in the laboratory made all of the test material demanded by others outside the institution who wished to try the method and at that the work was far from onerous.

Today even the popular magazines feel it necessary to hash over in impressive fashion, fully illustrated, much of the detail of the so-called mental tests. Almost every large city in the country has its psychological clinic, managed by the educational system or by some other social service institution. Here problem children may be examined and advice and help given. Summer classes at many colleges are filled with teachers and social workers who are there merely for the purpose of learning how to give mental tests.

The growth of the work during the last ten years may be divided into several stages. Of course there has been the constant development of refinement in method, which has often been given impetus by the criticism the tests have evoked. Statistical methods have contributed their share to the progress. By far the greatest growth in the generalization of the acceptance of tests has come through the Army usage of tests on thousands of thousands with the practical demonstration that tests plus statistics brought practical results. Group tests are much more widely used in every field of applied psychology that they were before this Army try-out.

More recently the early idea that the Binet series itself, in some form, is sufficient to diagnose a child’s mentality has given way to Stern’s demand for the well-rounded study of the individual. This
change of attitude is not universal, to be sure, but it is the attitude of the more reputable clinics at least. The perspective of the clinical psychologist has broadened. Many tests of all sorts have been evolved. Some have fallen into disuse while others have been widely accepted. All of them have helped emphasize the need for multiple fields of study of the individual. Gradually the clinical psychologist has learned to utilize the history of the individual's behavior and development as a check on or corroboration of his psychological findings.

The literature of today is encouraging in its terminology. There are many terms in evidence which are practically unstandardized and which emphasize factors considered important by the various writers. There is constant evidence of the fact that workers all through the country are seeing new problems in their work day by day. The tone of many reports is that of dissatisfaction with existing theories and formulations. All of this means but one thing—clinical psychology is not dead but alive and growing.

There is, of course, a great deal of criticism of intelligence tests. Much of this may be neglected for it comes from those who know too little about the actual problem to criticize competently. But there is criticism from within the group of clinical workers, notably from the psychologists working with the insane. The last year gives us several publications of this nature which may all be resolved into the statement that an insane person, to whom the test should be applicable, may be violently insane and yet have no intelligence defect; in other words, his I. Q. rating may be 100 or more. From the standpoint of our clinic in Columbus we do not feel that this criticism should cause any disturbance of thought or discomfort of mind to those using the tests. The criticism indicates a line of development which is needed and expected of clinical psychology. It is merely an obverse statement of the fact that we need something else besides an estimate of intelligence level before diagnosing individuals, be they infants, children, or adults. This need does not show itself so plainly when one is working with individuals who are actually insane. Delusions, hallucinations and aberrational behavior point to the classification of the subject without the need for intensive study. Most of the time is usually spent upon the classification of the psychosis from which the patient is suffering.

When one is working with children or adolescents who seldom run to such extremes of mental disturbance the need for very definite
methods of estimating mental disturbance is much more evident. We have come to believe in our clinic that the future of clinical psychology involves and even demands the standardization, from a psychological viewpoint, of all mental disturbances be they minor or major. Such a standardization can not be accomplished by the psychiatrists for their viewpoint is essentially different and their handling of the individual is consequently different. The psychological standardization of this field of mental disturbance or mental disease must be a standardization which parallels the Binet standardization of mental level.

Although our clinic does not pose as being able to equal the work of a Binet we have begun in it a first standardization of mental disturbances. In their undifferentiated forms, too mild to be called actual psychoses, present only part of the time in some individuals, entirely dependent upon illness in others, we have grouped all disturbances of thought and mentality under the term "psychopathy." When a psychopathy becomes so serious that the individual is mentally deranged we speak of him as having a psychosis. Psychopathy is, in other words, the presence of mental disease. The general term which parallels it when we are speaking of intelligence level is "subnormality." Both terms admit of sub-classifications. Both include a wide variety of defects, from that which is barely noticeable to that which places the subnormal in an institution for the feeble-minded and the psychopath in a state hospital for the insane.

During the first fifteen months of work in our clinic no attempt was made to control the diagnosis of psychopathies in any fashion. In truth, we knew too little about psychopathy, as we have learned to know it in the last year, to make any generalizations or assumptions as to how the thing should be studied. Gradually, however, we found by keeping constant trace of the diagnoses used in the clinic that all of our workers were falling into the habit of using a two-fold terminology in diagnosing any case that was at all problematical. The diagnosis in the individual case almost always involved a statement of mental level and a statement of the other factors which we gradually grew to calling mental function. A year ago we generalized the usage of the two-fold diagnosis and now demand it on all cases. Our primary diagnosis is still the diagnosis of intelligence level. That is, the child may be diagnosed as feeble-minded of idiot, imbecile or moron level, or he may be precocious and score bright normal in level or he may be inferior normal or normal for his race or he may be designated as retarded with the real diagnosis deferred.
Such a diagnosis by no means explains a case, for no matter whether an individual is normal in mental level or feeble-minded it is quite possible for him to have a mental disease. The condition may be less pronounced and instead of being recognizable as mental disease may only be identified as a predisposition or diathesis which will provide the foundation for a real disturbance of mental function later in life. We have in such conditions not intelligence defect but something which is interfering with the full efficiency of that intelligence which the individual possesses. The amount of intelligence is not the determining factor but the way that amount responds to the demands the world makes upon it. If a feebleminded person has a disturbance of mental function, that is if he is a feeble-minded psychopath, he may, if the amount of psychopathy is sufficient, suffer from a psychosis and be, in the parlance of the man of the street, “insane.” If a normal person has the same degree of mental disturbance he, too, is insane, although the probabilities are that since he has more intelligence to be disturbed the mental disease will appear to be more serious. A superior normal adult may also have a disturbance of mental function which renders him psychopathic to the point of an actual psychosis, or “insanity.” Any mental level, or level of intelligence is subject to its functional disturbances, mental disease or psychopathies. Whether these are identical or even similar for all mental levels it is too soon to say but they are probably different in intensity of manifestation at least. There may be a correlation between level and function, between intelligence and intelligence function but only painstaking research will reveal it. At present we can say that at least there is no relation which allows one to hypothesize the presence or absence of mental disease from a knowledge of the intelligence level of the individual.

It is undoubtedly true that many of the attempts to diagnose psychopathy which have been made by psychologists are not actually psychological diagnoses, but are clinical diagnoses, based upon the history of aberrant social reactions rather than upon detailed examinations. The psychological diagnosis of psychopathy must be a diagnosis based upon psychological tests alone. In other words it must be a qualitative analysis of test findings. As such it is not necessarily based upon tests which are entirely distinct from those we use to diagnose intelligence level, but it is partly a refinement of analysis of the findings which are made incidentally while we are
obtaining the mental age rating. Such a psychological diagnosis of psychopathy is not necessarily the clinical diagnosis on the case. It becomes a clinical diagnosis of psychopathy when it is compared with, checked with, modified or strengthened by the social record of the case. These two must be made to agree and explain each other before the final statement or clinical diagnosis is pronounced.

In our clinic we are using at present a tentative standardization of some of the points of psychopathy which reveal themselves in the course of a full psychological examination of a subject and although the method is far from satisfactory it has been an immense step over and above the individual estimates of psychopathy prevalent before this year. Our classification is by no means final. It is quite possible that some of the factors now weighted with significance will prove less so as our case data increase. It seems unwise, however, in view of the various demands for suggestions along this line, to withhold a statement of our work until we have reached a complete standardization. Most of the factors which we count as significant have been studied by workers elsewhere although usually with specialized or small groups of selected cases. Several of the criteria have been evolved in our own laboratory. The justification or disproof of the method will need use and years of work. At present we can say only that the method has tremendously facilitated our clinical work and that no child has been found with more than eighty percent psychopathy who has not shown the presence of a definite psychosis after a few days of study.

At present we consider the following ten points in the diagnosis of psychopathy.

1. Range above basal year on Stanford-Binet. More than four years.
2. Distribution on Stanford-Binet.
7. Orientation. Very poor or very good.
8. School work. Above or below actual grade expected of intelligence level.
9. Incoherence, ambiguity, circumstantiality in own story.

These may need some explanation.

1. The range of tests on the Stanford-Binet is the number of years through which the child is able to do tests above his basal year. For instance, a child may have a basal year of 7 and have no credits above the 12th year except the design in the 18th year, yet his
range would be 18 minus 7 or 11 years. Almost all children have some range above their basal year but an inspection of about three thousand cases, as well as the reports of other writers, had led us to assume more than four years of scattering above the basal year as an indication of psychopathy.

2. The distribution on the Stanford-Binet may be significant aside from the range of distribution; that is, a child may fail on tests which definitely indicate instability or which definitely indicate mental defect. Thus the rote and immediate repetition of digits may not differentiate the feeble-minded from the normal child but it is apt to differentiate the psychopath from either feeble-minded or normal children who are not psychopathic. The psychopath is essentially poor in rote memory, in constructive and free association, etc., while he is good in reasoning and comprehension. The feeble-minded child probably does better in rote memory for digits but he fails on the comprehension tests.

3. The quality of the individual test response on the Stanford is also significant. The psychopath may give peculiar and unexpected individual reactions. He drives one to constant consultation of test norms because of the doubtful character of his responses. He is apt to fall into automatisms, use nonsense syllables in giving rhymes or the sixty words, etc. His report on matter read is peculiar and has extraneous interpolations. He is verbalistic or mono-syllabic. His reaction time may be accelerated or retarded or it may be normal. He does the unexpected thing and the unexpected as he presents it is peculiar, not clever or attractive.

4. If a child gives more than 10 individual reactions on the Kent-Rosanoff association test and is more than eight years old; or if he gives more than 45 of the most common reactions and is, in this latter instance, of normal level in intelligence, it may be taken as an indication of psychopathy.

5. When the analyzed Kent-Rosanoff association test is studied for quality, the test may be counted psychopathic in its indications if more than 10 reactions are found which are abnormal according to the Kent-Rosanoff definition of abnormality; or, if they give that many indications of perseveration, automatism, sound association, repetition of stimulus word, etc. (Separate study in preparation).

6. In the performance tests a difference of more than four years in the age norms for the various tests may be taken as an indication of instability and psychopathy but at least five or six well-standardized tests must be given.
7. The orientation test becomes significant if it is unusually poor when analyzed in the light of the child's mental age and past advantages; or if it is unusually good in a verbalistic, superficial fashion, or if it meets Franz' ideas of de-orientation.

8. If the school work of the child as indicated by his performance on actual school tests shows ability which is two or more years above what we would expect of his present mental level, or if it is similarly below, but the child is not potentially feeble-minded, the discrepancy may be taken as an indication of psychopathy.

9. The child's own story must always be evaluated in the light of his actual past experiences and also with a due consideration of his mental age and actual chronological age. If, despite allowances for all these, it shows lack of coherence, forgetfulness, lack of plausibility, etc., it is open to suspicion as indicating psychopathy.

10. The child's behavior during the examination is another, although often less certain, way of obtaining an indication of stability or psychopathy. The factors to be evaluated are such as extreme lack of adaptation, extreme apathy or excitability, negativism, automatisms, etc.

After completing the examination of a case we have fallen into the habit of checking the findings for these ten points and evaluating the number of indications found, such as 6 out of 7 on a child too young mentally for the association test and who had never been to school. A child can not be evaluated on such a scale unless all of the tests applicable to one of his age and ability have been given.

From the usage of these ten points of analysis we have already evolved several other points which will probably prove valuable additions to the list later on but they have not been tried out sufficiently to date. Whether any one of these criteria will stand the test of prolonged clinic usage we do not know but we feel sure that the only way we can evaluate a definite and standardized qualitative analysis of intelligence is through the use of a tentative scale from which we may deviate and the fallacies of which will indicate the amount of progress in our new work.

In so far as a definition of psychopathy itself is involved, our experience with this standardization has given us the following concept: For any mental level the person with normal mental function is the one who is most efficient.

Differentiation from feeble-mindedness. The feeble-minded or backward child is the child who has less intelligence than the nor-
mal child of the same chronological age. His mind has never developed to the level it should. He has stayed younger and more immature and does less quantitatively on the tests than he should. The psychopath may have developed to the normal level or he may be a precocious child or he may be a feeble-minded child. It is not the quantity of intelligence which determines his psychopathy but it is the pathological or abnormal way in which that amount of mind he has works. The feeble-minded child may be called a child who has a small amount of money in his mental purse but his way of spending it may be normal, or, in other words, he uses to good advantage that which he has. The psychopathic child may have any amount of money in his mental purse but his way of spending it is abnormal. That is, it is erratic and peculiar and full value is not received for the expenditure. The psychopathic child functions wrongly. His functioning does not bring about results which are valuable in just proportion to the effort and energy involved in them. The psychopathic child is qualitatively abnormal. He may be quantitatively normal or abnormal, that is, he may be feeble-minded, backward, dull, normal, superior normal.

Behavior indications. This wrong quality of functioning shows in the behavior of the psychopathic child. The major symptoms are similar in most of the cases although they may show very different phases. These children are frequently solitary. They do not get along with other children of the same mental level. If they are feeble-minded psychopaths they do not get along with the other feeble-minded children who are not psychopaths. The same is true of a psychopath of normal intelligence level among other normal children. Psychopaths are apt to prefer the company of adults, or, in deteriorative cases, of low grade imbeciles. Their games have a queer monotony which frequently makes even the family realize their peculiarity. They are especially apt to have strong likes and dislikes as regards food. Those of the lower grades are usually destructive with toys, clothing and sometimes with anything they grasp. They are apt to have violent tempers and have often been recognized as “different from the time they were born.” They may be moody. Most of them tend to be more easily depressed than to be pleasurably excited although the “exalted” case is sometimes met with. These children meet Hall’s description of individuals living at the ambivalent extremes of the emotional plane without enough emotional resiliency to swing back into a normal mood.
Psychopaths are not usually fond of other children or of pets and they may be quite cruel. They are apt to have queer hobbies. They are apt to sleep poorly and often suffer from night terrors.

School indications. They may get along fairly well in school until they reach third or fourth grade or even until they reach high-school, although other cases of early psychopathy are often inferior from the very beginning of school days. Relatively the psychopath is most apt to be poor in geography and spelling. These children are usually difficult to handle in the regular grade. Every schoolroom has one or more of them. They are the children on whom the teacher cannot rely and concerning whose misbehavior she is always concerned for they are different and rules and punishments never seem to fit.

Laboratory findings. On the psychological tests these children are relatively poorer in rote memory for digits, in discrimination of lifted weights, in copying the design, in free association and in constructive association. They are apt to be verbalists and have a good usage of language which is superficial. They seem to be always giving answers which at first appear creditable but which upon analysis prove to be relevant but alongside the point, for they miss the vital element of the situation. The usual mental age obtained is the result of a low basal year supplemented by questions gaining credit through a wide range of higher years. The performance tests of these children frequently indicate a far lower level than their actual mental age. The opposite of this is more frequently true with feeble-minded children. The psychopath is most apt to fail on the Goddard adaptation board and on the Healy first pictorial completion board. They do spectacular work on the Porteus but one cannot tell which extreme they will score. They are frequently poorly oriented but are much better in general information than feeble-minded children. A most marked indication of their abnormality is that found on the Kent-Rosanoff association test on which they give a curve with a high frequency of individual reactions. The mental age changes rapidly in some cases. In one boy recently studied we found a change of 18 months in level in a month and it was not due to chance learning. In other cases re-examination shows them at the same level but the mental age is achieved by the successes on tests previously failed on and earlier successes have become failures.

General comments. Compared with other children of the same mental level, whether these are feeble-minded children or normals,
the psychopathic child is unreliable. He is very apt to lie fluently. He is apt to be a runaway. It is far harder to predict what a psychopath will do when put into a definite situation than it is to forecast the behavior of even an unintelligent but normal-functioning child.

As we see it from daily practice in our clinic the work on mental function is an essential for the clinic which wishes to grow and meet the needs of its community. Much of so-called feeble-mindedness is merely inferiority of level due to poor functioning of an organism which has had normal endowment. Such cases are hopeful. Another group of so-called feeble-minded individuals is undoubtedly a group of deteriorates whose psychoses have reached the point of imbecile quiescence. Much inferiority is undoubtedly the inferiority of instability of function and not intelligence lack. In all of these cases the ascertainment of functional disturbance or normality is becoming more and more the keystone to reliability in the disposition which must be made of each case. The psychopathic child and the psychopathic adult give new evidence every day of the fact that they are more in need of institutional care than their fellow-men of the same mental level who are normal in function. Whether or not the state hospitals for the insane recruit their patients from the ranks of the normal or the psychopathic child it is too soon to say but all data point to the probability that the psychopathic child is the one who in adult life develops the extreme indications of psychopathy. However, psychopathy is harder to detect than the psychoses and only the continued study of psychopathy with the continued observation of normal-functioning and psychopathic children will give us definite information on this point, but, it is possible that one generation of caring for the psychopathic child would prevent a large part of the insanity of the next generation. Only a complete and delicate standardization of psychopathy from the psychological standpoint will give us the basis for such study and enable us to verify any such hypothesis.

(Manuscript submitted for publication September 7, 1920.)