Heinz-body anaemia of the newborn is not only of theoretical but also of considerable practical importance, as transfusions performed in time might save life.

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SOME OBSERVATIONS ON OUT-PATIENT PSYCHOTHERAPY

WITH A FOLLOW-UP OF 235 CASES

BY

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In the minds of most doctors the results of psychotherapy are still clothed in a certain amount of mystery. Yet with the development of the Health Service and the consequent increase in out-patient work it is important to try to estimate the value of this type of treatment. Several questions immediately spring to mind. "Is psychotherapy any good at all?" And if the answer is "Yes," then "How good?" And again, "What sort of cases should it be reserved for?"

Few papers seem to have been written on this subject, and only two will be quoted, both of which are pre-war. In 1935 Luff and Garrod reviewed 500 consecutive patients treated with psychotherapy at the Tavistock Clinic, all of whom had finished treatment at least three years previously. This is a creditable follow-up period, and the patients had had thorough treatment; indeed, half of them had between 20 and 60 interviews. The follow-up was based on information obtained from replies to letters sent out to the patient or the patient's practitioner, though occasionally other methods were used, such as a visit from a psychiatric social worker. Yet it was possible to contact only 70.4%, and there must be serious limitations to the value of a follow-up where only two-thirds of the series were contacted by letter and no patient was personally interviewed by a psychiatrist.

The second paper we quote is by Curran (1937), who records a follow-up of 83 patients. The psychotherapy was carried out under poor conditions (in a dental room of all places) at St. George's Hospital. The only

criterion for selection in Curran's series was that the patients were thought to present psychiatric problems by one of the out-patient physicians or surgeons who referred them to the psychiatric department. These cases were all seen by Dr. Curran at their first interview, though subsequently some were treated by Dr. Eliot Slater. Only 25 of the 83 attended for more than four sessions. It is important to note that these 83 patients represented only 40% of the total circularized. Another 40% did not reply to follow-up inquiry, and the remaining 20% of inquiries were returned "addressee untraced." 40% is a very small percentage of any group to be followed up, and, as Curran says, few deductions are possible. As in Luff and Garrod's series, no patients were interviewed by a doctor.

Present Investigation

Our investigation differed from the two investigations quoted above in that we endeavoured to interview the patients personally. Early in 1954 we studied the case papers and psychotherapy notes of 235 out-patients who had been selected by us as suitable for a course of out-patient psychotherapy from a total of 3,226 out-patients referred to us in Plymouth during the five-year period 1948-52. It should be noted that these 235 patients represented the total number who had been selected for psychotherapy. Thus a few patients had been discharged for nearly six years, while all had been discharged at least 15 months. In about 35% the follow-up period was two and a half years or more. It may be observed at this point that the recovery rates of those patients treated in the earlier years did not vary significantly from the recovery rates of the more recently treated, and also that the percentage of untraced cases did not increase with the passage of time. For the collection of documents we relied on the records department, and there is no reason to suppose that many cases were omitted or that the odd ones left out represented special types.

Before seeking to interview the patients we tried to reduce the mass of documentary information to some sort of order. This included placing each case in one of five diagnostic categories (as explained under "Diagnosis"), a procedure which we termed "diagnosis in retrospect." We also formed an opinion from the documents whether we considered the prognosis with treatment to be "good" or "moderately good," a procedure we termed "prognosis in retrospect." Briefly, the factors which weighed with us mostly in making this prognosis were: (1) intelligence (low, average, high); (2) attitude to life and previous adjustment (poor, average, good); (3) duration of symptoms (over 10 years, 1-10 years, under 1 year); and (4) effect of symptoms on function (very serious, serious, slight). We also had to define the terms we were using—for example, distributive analysis—and, lastly, we drew up a form for use at the time of the forthcoming interviews. Our results and conclusions were eventually arrived at through analysing the completed forms.

Types of Psychotherapy

The various types of psychotherapy used by us were divided into two main groups: (1) Superficial—by which we mean advice, explanation, suggestion, persuasion, reassurance, and encouragement. (2) Distributive analysis—by which we mean that more use was made of analytical principles and that certain experiences in the patient's life were dealt with on analytical lines.

Abreactions with the use of injections or carbon dioxide were occasionally employed, chiefly in conjunction with the main methods just defined. What is described as superficial therapy was given in 45% of the cases, and distributive analysis in 49%, while 6% were treated mainly by abreactive methods.

We based our therapy on the assumption that if a person is tackling his life problems badly and producing neurotic

symptoms as a result, then a change of attitude is necessary, and this change is best brought about by increased insight derived from some form of psychotherapy.

A few further notes are necessary in order to give some idea of our broad views on psychotherapy and our procedure in selection and technique. As part of every psychiatric consultation we try to assess how much we can help the patient by out-patient psychotherapy. This includes an opinion on the extent to which the patient can accept insight and, having accepted it, on whether he or she will be able to act on it.

The aim of our treatment has been the attainment of a suitable degree of insight and the positive encouragement of self-discipline. At some stage in treatment practical advice is often given in a friendly way.

For various reasons, including the length of the waiting-list and the time at our disposal, we aim at a course of about six to eight sessions, and in this series of cases it was unusual for any patient to have had more than 12 interviews. (Recently our practice has changed a little in this respect so that very occasionally we may treat a patient for a year or more.) The interviews are weekly and last about 45 minutes, but may vary from 15 minutes to an hour or more. The average number of interviews in this series worked out at 6.8 per patient, only two patients being given as many as 20 sessions. We decided to consider the discharge date as being the last occasion on which the patient had a regular interview at not longer than monthly intervals.

In choosing a patient for psychotherapy we kept four different considerations in mind, any one of which justified placing the patient's name on the waiting-list: (1) A severe illness, where there was no other form of therapy available; (2) the possibility of removal of symptoms; (3) the possibility of helping the patient to adjust to his symptoms; (4) the possibility of assisting the patient to adjust to future stresses of a similar nature to those causing the present breakdown. Finally, as we have already stated, we attach particular importance to assessment of the degree to which the patient can accept insight and act on it.

A patient who is severely ill and likely to be helped, even if only to a limited extent, is worth accepting, if no better form of treatment is available. One would not insist on the likelihood of cure to justify selection in this type of case.

It goes without saying that the removal of symptoms is a desirable change, but one is not always sure that there may not be a recurrence later in the face of repeated stress of a similar type. If the patient deals with later stress and cures himself or herself of a relapse, this would be regarded as a good result. (In several cases where there had been a relapse a further interview proved well worth while.)

It is not always possible to remove the symptoms while treatment is being given, but if the patient can be helped to live with his symptoms it is likely that the reduced anxiety will allow a gradual improvement. When we saw some patients after a length of time we were surprised how much they had improved in the interval as the result of discussions or advice given during the psychotherapy.

It is generally agreed that the shorter types of psychotherapy tend to be somewhat authoritarian in character. When using suggestion and persuasion one tries to get a patient to abandon his own method of dealing with his problems—namely, with neurotic symptoms or reactions—and accept instead a solution which appears preferable. If the solution one offers the patient does not seem preferable to him he will refuse it, and part at least of the skill in this type of psychotherapy lies in the manner in which the therapist tackles this difficulty. Some of the issues presented are quite straightforward, and most people would agree on the lines upon which advice shall be given; but many are highly controversial, and in these there is a danger of moralizing with the patient. It appears to us that there is no objection to giving the patient specific advice if one is asked for it, but it must always be borne

in mind that far more good advice is given in the world than is ever acted upon. Needless to say, when one is actively trying to influence a patient one's own personal integrity is especially important. We would like to observe at this point that psychiatrists give fewer dramatic instructions to their patients than any other breed of doctor. It is rare for us to advise a patient to get married or have a baby, and if occasionally we do give advice of this nature we do not do it lightly.

In our follow-up interviews one of the most striking revelations was the realization of the profound influence a psychotherapist has on his patient's attitude to life even after only a few hours of treatment. This teaches us afresh the need for the most careful consideration of all the many facets of every case; and once again we realized the problems presented in the selection of doctors interested in a training in psychotherapy.

While treatment progresses it is often borne in upon us that, though the ability to accept insight depends upon emotional and intellectual factors, the will to change a pattern of reaction depends greatly on the patient's philosophy of life. In many instances the patients fail to make satisfactory improvement because we ourselves fail to assess this philosophical "disease" (or "atrophy") adequately. We are not at all sure whether our credentials as psychotherapists entitle us to tackle problems of this nature as part of treatment, but we have come to realize that the experience of psychotherapy is often a most valuable education to the patient and inevitably affects his or her philosophy in an indirect way. Unfortunately, if we fight shy of tackling the philosophical issue it happens all too often that nobody else will do it.

These few paragraphs will, we hope, give some idea of our problems in selection and treatment. We may not have always selected the most suitable patients, but we have had definite ideas and are prepared to modify them as time goes on.

Diagnosis

We grouped the 235 cases into five main categories:

Mainly Anxiety States.—This label was also used for certain psychosomatic cases and tension states; 39.6% of our patients were so classed.

Mainly Hysterical States and Anxiety Hysteria.—This term was used for the majority of phobic and anxiety states with hysterical symptoms, as well as for the more classical types of hysteria; 42.6% came under this heading.

Obsessional States.—This was used for the patients with classical obsessional states, which therapeutically we considered a very different problem from the obsessional personalities with anxiety symptoms; 6.4% of our patients were true obsessionals.

Psychopathic Personalities, which accounted for 2.5% of the series.

Other Diagnoses.—This group totalled 8.9% and included psychoses, mild depressive states, etc., as well as the diagnostically difficult group of schizoid personalities.

This procedure of "diagnosis in retrospect" may be open to criticism, but it gives a more accurate diagnosis than that made at the first consultation, and it enabled us to separate off the few misdiagnosed patients who turned out to be paranoid schizophrenics. Furthermore, it made for simplicity when considering results of treatment.

Immediate Results of the Psychotherapy

From the case notes we also assessed the immediate results of treatment (that is, the state of the patient at the time of actual termination of treatment) on a four-point scale—namely, much improved, improved, not improved, and treatment broken off. The results are shown in the Table.

Like Curran we omitted, as being too difficult to define, the category "slightly improved" which is used by some authors.

Details of Results on Discharge and at Time of Follow-up

Diagnosis	Total	Condition on Discharge				Condition at Time of Follow-up			
		Much Improved	Improved	Not Improved	Psychotherapy Broken Off	Much Improved	Improved	Not Improved	Not Traced or Died
Anxiety states	93	41 (44.1%)	39 (41.9%)	5 (5.4%)	8 (8.6%)	48 (51.6%)	26 (28%)	7 (7.5%)	12 (12.9%)
Hysterical „	100	31 (31%)	36 (36%)	16 (16%)	17 (17%)	31 (31%)	35 (35%)	21 (21%)	13 (13%)
Obsessional „	15	7 (46.7%)	7 (46.7%)	1 (6.7%)	—	7 (46.7%)	6 (40.0%)	1 (6.7%)	1 (6.7%)
Psychopathic states ..	6	—	2 (33.3%)	2 (33.3%)	2 (33.3%)	1 (16.7%)	3 (50%)	1 (16.7%)	1 (16.7%)
Other diagnoses	21	7 (33.3%)	6 (28.6%)	4 (19%)	4 (19%)	7 (33.3%)	6 (28.6%)	2 (9.5%)	2 (9.5%)
	235	86 (36.6%)	90 (38.3%)	28 (11.9%)	31 (13.2%)	94 (40%)	76 (32.3%)	36 (15.3%)	29 (12.3%)

Other Treatment

It was also known to us, before we interviewed the patients, which of them had had any out-patient electroplexy during or since psychotherapy, or had been admitted to hospital for conditions of psychiatric importance. The frequency and effect of this additional treatment had to be taken into account as there were as many as 25 cases, which represented 10.5% of the whole series. When examined in detail, of the nine who had out-patient electroplexy, eight were improved, and the final results of our psychotherapy were influenced to this extent. In-patient treatment rarely helped anyone who had not already improved with psychotherapy, and, in fact, the 16 who were later admitted to hospital included a quarter of our "not improved" category.

Information Available at Follow-up

It should now be clear that at the time of interviewing the patient we had, in addition to the individual psychotherapy notes, the following information on each case: the date of last regular interview, number of regular interviews, type of psychotherapy, diagnostic category, condition on discharge (that is, *immediate* result of treatment), information regarding physical treatments such as out-patient electroplexy or in-patient treatment of psychiatric importance, and prognostic category.

Questionary Used at Interview

We were now ready to interview the patients, and we decided to adopt to some extent Curran's excellent questionnaire. In the course of the interview each patient was asked:

1. Have you regained your former health? (an answer "yes" or "almost" was required for a "much improved" classification).
2. Do you still suffer from symptoms which trouble you? If so, what symptoms?
3. Have you been able to go back to work or carry on with your work in a satisfactory manner?
4. Are you happier than before treatment?
5. Did the treatment help you? If so, in what way?

The essence of the patient's remarks was recorded verbatim. To those unable to attend, a standard letter with stamped addressed envelope was sent with these questions included in the letter. If the follow-up was carried out by a social worker she asked the same questions.

At the interview the difficulties in assessing the results were less than we anticipated, and any doubt was usually between the categories "improved" and "much improved" rather than between "improved" and "not improved." When the follow-up was carried out by means other than personal interview the information was carefully considered, and if it was regarded as inadequate for an assessment to be made the patient was classed as "not traced."

Of the total group, 59% were interviewed by their original therapist, 14% were followed up by letter, 15% by a social worker, and 12% (including two deaths, both from non-psychiatric causes) were untraced. In all, 88% were contacted. In Luff and Garrod's series none was seen by a doctor, follow-up was largely by letter from the patient or the patient's general practitioner, and 30% were untraced. In Curran's series none was seen by a doctor, and

only 40% were followed up at all. The percentage of patients traced in our series is much higher than in either of the above-quoted investigations, but we have the advantage that we work in a much more static community. Most of our untraced patients belonged to Service families, who are, of course, subject to frequent changes of station.

It may be noted that Luff and Garrod argue that their group of untraced patients have probably done as well as the traced group. Our untraced patients were regarded as a representative sample of the group as a whole.

Results and Comments

It remains now to consider our results of treatment at the time of the follow-up study, together with one or two other statistical details. Of our series, 44% were male and 56% female. Only 6% were over 50 years of age. Of Luff and Garrod's cases 9.6% were over 50. We may have been rather diffident at taking on the older patients. As already mentioned, the grouping into diagnostic categories shows that 39.6% fell into the mainly anxiety group; 42.6% into the mainly hysterical group; 6.4% had obsessional states; 2.5% were psychopathic personalities; and 8.9% belonged to "other diagnoses." One-third of our patients had been given a good prognosis and two-thirds a moderately good prognosis. Our follow-up revealed that 50% improved to the extent anticipated, 26% did less well, and 24% better than was expected.

We gave the anxiety states a better prognosis than the hysterics, and this was confirmed by our results. It is interesting that Luff and Garrod, who were apparently much more strict in the diagnosis of hysteria, came to the same conclusion. Of their anxiety states 80% were "relieved" as compared with 86% of ours. On review, their percentage dropped to 64%, while ours over a somewhat shorter period rose to 91%. It is noteworthy that their number of "much improved" anxiety states also increased. Their "relieved" rate for hysterical states was 50%, which remained at 50% after three years. Our figure was 67% on discharge and increased later to 76%. These rates we realize are embarrassingly high; but our opinion, based on so many personal interviews, is that these patients did in fact continue to improve after the termination of psychotherapy. It may be that the untraced patients, who reduced the size of the series slightly during the final review, were the less improved patients, but there is no indication that this is so. Of the obsessionals, 13 out of 14 followed up had improved, and this was consistent with our prognosis.

As a bald statement of results conveys little meaning unless prefaced by some explanatory remarks, we have left our results for the total series to the end. Of our 235 patients we know that 40% of the total are now "much improved," a further 32% are "improved," 15% are "not improved," 12% are untraced, and two patients have died. If, as in the other series, our untraced patients are excluded, our results are 45.5% much improved, 37% improved (making a total of 82.5% "relieved"), and 17.5% "not improved."

Summary

The purpose of this investigation was twofold: firstly, to examine the psychotherapeutic methods used by three consultants working independently in the same National Health Service out-patient department of psychological

medicine and to report on the aims of treatment; secondly, to follow up a series of out-patients so treated.

Out of a total of 3,226 consecutive referrals during the five-year period 1948-52 235 patients received a course of psychotherapy.

The types of psychotherapy used were: (1) superficial for 45% of the cases, and (2) distributive analysis for 49%; the remaining 6% were treated mainly by abreactive methods. The average number of sessions given to each patient was seven.

We followed up these patients early in 1954. No patient was followed up who had not been discharged for at least 15 months, and in about 35% the follow-up period was at least two and a half years. 59% were interviewed by the original therapist, 15% by a social worker, and only 10% were untraced. The method of follow-up is described in detail.

It was found that of our 235 patients 40% were "much improved," 32% were "improved," and 15% were "not improved"; the remainder were either untraced or had died.

It is our opinion that results of this order can be expected from short courses of psychotherapy in a provincial out-patient department provided that a careful selection of cases is first made.

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VAGAL RESECTION IN TREATMENT OF DUODENAL ULCER

BY

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Vagal resection for the treatment of duodenal ulcer has not been generally accepted in this country. It is not the purpose of this paper to discuss the theoretical grounds for its use, nor to review the voluminous literature on the subject, but to present the results obtained since late 1947 in one surgical unit. Pollock (1952) collected a large series, including 1,314 cases of duodenal ulcer, from various centres.

Present Investigation

As no large series from one source has been reported on in Britain, it seems worth while analysing the results of a series of 473 consecutive cases (401 male, 72 female) up to the end of 1955. These were entirely unselected. Every duodenal ulcer case referred to us for surgical treatment was treated as detailed below. The only exceptions were (1) those who refused surgical treatment; (2) those seen first with severe haemorrhage which it was impossible to control by any means other than a direct attack on the site of haemorrhage in the ulcer; and (3) those first seen with acute perforation requiring immediate operation—simple closure of the perforation was done. If persistence of ulceration or recurrence of ulceration or symptoms occurred the cases were dealt with in the routine manner and then included in the series. These exceptions comprised less than 2% of the total.

Table I shows the age incidence and the duration of symptoms. Perforation had occurred in 17% and notable haemorrhage in 17%. Medical treatment before

TABLE I.—Age Incidence and Duration of Symptoms in 473 Cases

Age:	10-19	20-29	30-39	40-49	50-59	60-69	70-79
	1%	16.5%	30%	30%	17%	5%	0.5%
Pre-operative Duration of Symptoms in Years							
0-	1-	2-	3-	4-	5-9	10-14	15-19
9%	10%	10%	9%	7%	27%	15%	5%
							8%

operation had been given at home in 76% and in hospital in 19%. Over 50% had had symptoms for more than five years, and over a third had had either a perforation or noteworthy haemorrhage before operation.

The normal routine before operation was: history; physical examination; barium-meal x-ray examination; gruel fractional test meal; and a Hollander (1946) insulin test meal. After operation the gruel fractional test meal and the insulin test meal were repeated. Routine post-operative x-ray examination was not possible in all cases; it was made in many, including every case with any post-operative symptoms. Pre- and post-operative weights were recorded.

For various reasons the full investigation outlined was impossible to carry out in every case, but in over 92% of cases the data were adequate for assessing the completeness or otherwise of the nerve section.

Operation

The patient is brought to the theatre with a naso-gastric Ryle tube in position. The surgical approach is through an upper left paramedian incision, the rectus muscle being retracted laterally. After inspection, including confirmation of the presence of the duodenal ulcer, a Balfour self-retaining retractor is inserted. The left lobe of the liver is then detached from the diaphragm by cutting the suspensory ligament, close to the liver, care being taken not to damage the left inferior phrenic vein. The left lobe of the liver can then be folded and held gently to the right with a Deaver retractor. The stomach is packed down as far as possible with two packs, the upper one being placed between stomach and spleen and retracted downwards and to the left with a Deaver retractor. This exposes adequately the lower inch (2.5 cm.) of the oesophagus. The peritoneum over the oesophagus is cut transversely, the left forefinger inserted, and the opening in the peritoneum enlarged up and down. With the left fore- and mid-fingers behind and the thumb in front it is easy to identify the oesophagus with its Ryle tube.

By "burrowing" behind and around the oesophagus from right to left the two fingers emerge at the left of the oesophagus, where they pick up a gauze tractor, one end of which is pulled back around the oesophagus. During the "burrowing" process if slight traction is kept on the oesophagus it is easy to feel the right vagus behind and include it in the tissues picked up. The two ends of the gauze tractor are caught together in an artery forceps on which an assistant makes firm traction. The vagus nerves are readily palpated as taut cords. Each in turn is isolated from the oesophagus; two fingers are inserted between the nerve and the oesophagus and spread widely to free at least 2 in. (5 cm.) of nerve from the oesophagus. The nerve trunk is then caught with long Kocher artery forceps and the nerve stripped cranially as far as possible. A section of the nerve is then resected, at least 2 in. (5 cm.) being removed.

When each nerve has been thus dealt with it is found that the lower 2-3 in. (5-7.5 cm.) of the oesophagus is more mobile and can be pulled up with the gauze tractor to allow careful inspection. Any structures resembling nerve twigs are seized with diathermy forceps and sectioned after coagulation; usually these "nerve fibres" are small blood vessels emptied by the traction, and coagulation before section expedites operation. By pulling first on one side, then on the