must lead to a better knowledge of the functions of the central nervous system. And if acetylcholine transmission should be proved to occur there as well as in the periphery, still further advances in knowledge of clinical importance may be expected.

REFERENCES

- Adler, H. (1937). *Arch. klin. Chir.*, **189**, 529.
 Aeschlimann, J. A., and Reinert, M. (1931). *J. Pharmacol.*, **43**, 413.
 Ammon, A. (1933). *Arch. ges. Physiol.*, **233**, 486.
 Begg, R. C. (1937). *British Medical Journal*, **2**, 581.
 Boothby, W. M. (1934). *J. Amer. med. Ass.*, **102**, 259.
 Briscoe, G. (1936). *Lancet*, **1**, 469.
 Carmichael, E. A., Fraser, F. R., McKelvey, D., and Wilkie, D. P. D. (1934). *Ibid.*, **1**, 942.
 Cooke, A. M., and Passmore, R. (1936). *Quart. J. Med.*, N.S., **5**, 21.
 David, W. E. (1935). *Lancet*, **1**, 1100.
 Edgeworth, H. (1930). *J. Amer. med. Ass.*, **94**, 1136.
 Frank, E., Nothmann, M., and Guttman, E. (1923). *Pflügers Arch.*, **201**, 569.
 Fraser, F. R., McGeorge, M., and Murphy, G. E. (1937). *Clin. Sci.*, **3**, 77.
 Goodman, L. S., and Bruckner, W. J. (1937). *J. Amer. med. Ass.*, **108**, 965.
 Grant, R. T., Pearson, R. S. B., and Comeau, W. J. (1936). *Clin. Sci.*, **2**, 253.
 Hamill, P., and Walker, M. B. (1935). *J. Physiol.*, **84**, Proc. 36.
 Harger, J. R., and Wilkey, J. L. (1938). *J. Amer. med. Ass.*, **110**, 1165.
 Harvey, A. M., and Whitehill, M. R. (1937a). *Ibid.*, **108**, 1329.
 — (1937b). *Johns Hopk. Hosp. Bull.*, **61**, 216.
 Kennedy, F., and Wolf, A. (1937). *Arch. Neurol. Psychiat.*, **37**, 68.
 — (1938). *J. Amer. med. Ass.*, **110**, 198.
 Kottlors, E. (1932). *Med. Klinik*, **28**, 366.
 Kremer, M., Pearson, H. E. S., and Wright, S. (1937). *J. Physiol.*, **89**, Proc. 21.
 Lanari, A. (1937). *C. R. Soc. Biol.*, Paris, **125**, 546.
 Laurent, L. P. E. (1935). *British Medical Journal*, **1**, 463.
 — and Walker, M. B. (1936). *Lancet*, **1**, 1457.
 — and Walther, W. W. (1935). *Ibid.*, **1**, 1434.
 Leiner, W. (1931). *Dtsch. med. Wschr.*, **57**, 2017.
 Lindsley, D. B. (1935). *Brain*, **58**, 470.
 McGeorge, M. (1937). *Lancet*, **1**, 69.
 Mann, P. J. G., Tennenbaum, M., and Quastel, J. H. (1938). *Biochem. J.*, **32**, 243.
 Marinesco, G., Sager, O., and Kreindler, A. (1936). *Rev. Neurol.*, **65**, 416.
 Matthes, K. (1930). *J. Physiol.*, **70**, 338.
 Miller, F. R. (1937). *Ibid.*, **91**, 212.
 Minot, A. S., Dodd, K., and Riven, S. S. (1938). *Science*, **87**, 348.
 Minski, L., and Stokes, A. B. (1936). *British Medical Journal*, **1**, 1095.
 Mitchell, R. S. (1937). *New Engl. J. Med.*, **216**, 96.
 Pichler, E. (1937). *Arch. Psychiat. Nervenkr.*, **107**, 669.
 Plattner, F., and Hintner, A. (1930). *Pflügers Arch.*, **225**, 19.
 Pritchard, E. A. B. (1935). *Lancet*, **1**, 432.
 Riven, S. S., and Mason, M. F. (1937). *Southern med. J.*, **30**, 181.
 Russell, W. R., and Stedman, E. (1936). *Lancet*, **2**, 742.
 Schweitzer, A., and Wright, S. (1937a). *J. Physiol.*, **89**, 384.
 — (1937b). *Ibid.*, **90**, 310.
 Stedman, E., and Russell, W. R. (1937). *Biochem. J.*, **31**, 1987.
 — and Stedman, E. (1937). *J. Physiol.*, **89**, Proc. 37.
 Tournoux, J. P., Petel, and Gouzi (1931). *Presse méd.*, **39**, 2138.
 Viets, H. R., and Schwab, R. S. (1935). *New Engl. J. Med.*, **213**, 1280.
 — Mitchell, R. S., and Schwab, R. S. (1937). *J. Amer. med. Ass.*, **109**, 1956.
 Wade, H. J. (1936). *British Medical Journal*, **1**, 1099.
 Walker, M. B. (1934). *Lancet*, **1**, 1200.
 — (1935). *Ibid.*, **2**, 47.
 Weigand, W. (1931). *Münch. med. Wschr.*, **78**, 1348.
 Winkelman, N. W., and Moore, M. T. (1937). *Arch. Neurol. Psychiat.*, **37**, 237.

J. T. Ingram (*Brit. J. Derm. Syph.*, February, 1938) differentiates simple coccogenic sycosis from seborrhoeic sycosis. The former is a staphylococcal dermatosis of external origin responding readily to eau d'Alibour and x-ray therapy; the latter is an intractable skin manifestation of a complicated medical condition. Seborrhoeic sycosis affects the beard and upper lip and is associated with the seborrhoeic diathesis, dyspepsia, and septic foci, particularly in nose and mouth. The treatment is that of the septic foci, and of malnutrition if present, with restriction of fluids and carbohydrates, the application of malachite-green paint night and morning, and fomentations to remove the scabs. X-ray therapy may be necessary for the worst cases.

THE UNCONSCIOUS MIND AND MEDICAL PRACTICE*

BY

ERNEST JONES, M.D.

President, International Psycho-Analytical Association

I shall divide what I have to say here into two groups: considerations bearing on the relation between the patient and the doctor, and those concerning the relation between the patient and himself, especially his disease.

Before coming to these topics themselves, however, I must first say something about the meaning of the unconscious mind in general. So immediate is the feeling of our own personality, and so intimate is our first-hand acquaintance with our thoughts and emotions, that it is exceedingly hard to bring home to oneself the idea that all this self-knowledge is only very partial, that the most important part of our conscious mind is merely a selection of what has been allowed to filter through from the unconscious mind, the primary fount of all our mental processes. Now what is this unconscious mind to which so much significance is nowadays attached since Freud's epoch-making discovery of it? To begin with, it represents our inborn instincts as they first manifest themselves in the dawning mind of the infant. But these never develop smoothly, as they seem to do with other animals. It is plain that in the past 50,000 years there have been brought about many extensive changes and modifications, if not in our inborn instincts themselves, certainly in the adult expression of them. The difficulties we perceive in the early mental development of the individual must be related to the fact that most of these extensive changes that the race took 50,000 years to accept have to be hurriedly recapitulated in the individual in the short space of five years.

In the contact between these instincts and the outer world, and perhaps for more intrinsic reasons, difficulties and conflicts arise from the start. The apprehending of outer reality is for long preceded by a period in which the mind is ruled by fantasy, and fantasy of such a grotesque and exaggerated nature as to seem quite incredible to our conscious mind. This is one feature of the unconscious that makes it so hard to believe in the reality of its manifestations and still harder to take them seriously enough to appreciate their grim significance.

Defensive Mechanisms

This phase of development is dominated by the problem of what in psychopathology is termed "anxiety," doubtless an expression of the remarkable activity on the part of the fear instinct. The majority of the mental changes that go on at this time consist of the building up of a large variety of defences against anxiety, and these defences, or "mental mechanisms," play an extremely important part throughout later life. Let me illustrate these at this point by a simple example—the reciprocal process of introjection and projection. When the infant's mind is terrified at feeling something bad, painful, and dangerous inside itself or its body, it often responds by seeking to take in something it conceives to be good and helpful from another person so as to assuage or neutralize the bad thing. I purposely say "thing," since the primitive mind never works in abstract terms, such as "evil impulse, hate," etc., but always in concrete physical ones. Thus when a kind mother reassures a frightened child he does

* An address delivered before the Swansea Division of the British Medical Association, March 31, 1938.

not feel that she has given him love with which to allay his terrors, but an actual part of her body, milk or flesh, which he feels to be good, helpful, and strong. This attitude of taking in or absorbing something from another person so that it is then felt to be a part of oneself is what we mean by the word "introjection." "Projection" is the reverse process. Here the mind deals with the bad thing by denying the possession of it and ascribing it to another person. I recently came across a pathetic example of this, and am sure you have all met with somewhat similar ones. A man was dying of a very painful cancer and was being given some relief by means of large doses of morphine. In a state of drug delirium he imagined it was his nurse who had the dread disease, and he uttered the most heartfelt expressions of sympathy and pity for her sufferings. Here in a critical hour the mechanism of projection succeeded perfectly in extruding from his personality all sensation of pain and distress, on the condition, however, that his unavoidable perception of them was deflected towards the outer world.

When these defensive mechanisms function imperfectly or break down, then the underlying anxiety breaks through or else there is mental pain—that is, suffering. I put at the outset these matters of anxiety and suffering, with the defences against them, in the foreground because I think this is the most instructive point of view from which to regard the various problems of psychopathology in general, and, I will add, even those of the psychology of the so-called normal as well.

Some of the defensive mechanisms are, when extensively employed, characteristic of the psychoneuroses, others of the psychoses. Neuroses and psychoses may become manifest, giving rise to specific symptoms, or they may show themselves more indirectly by producing what we call neurotic or psychotic character traits. In my opinion evidence of one or other of these conditions is to be found in every human being, and commonly enough all of them; it is simply a matter of degree. Now we know that in childhood the occurrence of manifest neurosis is universal: there is no child who escapes suffering from one or other of the familiar symptoms of night terrors, food phobias, and so on. What has only recently been appreciated is the extent to which still younger children—in the first two or three years of life—are affected by mental mechanisms especially characteristic of the psychoses. It would be inaccurate—or at all events loose language—to describe this, as some authors have done, as a psychotic stage of development. But one can at least say that in these phases the infant is more or less dominated by fantasies and convictions of a kind that, were we to encounter them in the adult, would have to be called insane delusions. Many years ago a Dutch psychoanalyst, Stärcke, startled us by asserting that the mentality of the normal is built on a psychotic basis. Nowadays, unfortunately, the sight of the world is such as to make this assertion less obviously absurd even to others than psychologists. There seems to be little doubt that there are temporal fluctuations in the extent to which these underlying mental attitudes shimmer through in social and political forms, and that we are at present in a favourable position for observing them.

The grandiose achievements that men of genius have in all ages encompassed in the spheres of art, of thought, and of science cannot but bring inspiring and elevating reflections to any contemplative mind. The sense of wonder is vastly heightened when one admits what formidable difficulties human beings encounter in the course of their development, and what an unstable basis most of

them have to build on. It is extremely instructive to examine from this point of view the various institutions of civilization, such as that of marriage, of religion, of class and caste, and—last but not least—the numerous political theories and devices of government. Such a study reveals both how complex are the methods by which man seeks to fortify himself against his inner weaknesses and also how ingenious are the ways in which he has socialized those defences.

We must now withdraw from these spacious perspectives and concentrate on the more purely clinical topics before us. I alluded to them only to indicate that we are concerned here with fundamental problems of human biology, of which neurotic troubles constitute only one aspect. I should have said "Only a minor aspect" were it not for the important fact that we owe to the neuroses, through their greater perspicuity and accessibility, the most fruitful approach to the deeper problems of human nature. Much of the interest of psychopathology proceeds from this consideration.

Medical Neglect of Psychology

When psychological factors play such a large part in medical practice it is astonishing how little attention is devoted to them in medical circles and in the medical curriculum. It is of course very hard to estimate in precise figures the proportion of ill-health that may be ascribed to psychological disorder. A distinguished physician recently gave as his opinion that it is as high as 80 per cent., but such an estimate certainly needs closer definition. I do not know what proportion of the populace is considered to be in completely perfect physical health. I should suppose it to be a rather small minority, but I am sure that those in perfect mental health constitute a much smaller minority. Most patients, therefore, who seek medical advice present a varying combination of both mental and physical troubles. Let us look at the matter in a different way for a moment. We know that the actual distress of which a patient complains often bears no close correlation to the illness which the physician thinks necessary to treat, especially since his bias must for many reasons be heavily in favour of treating the physical condition rather than the mental. There is no doubt that a much higher percentage of the patient's complaints are psychological in nature than the diagnoses made by physicians would indicate. Not that this would necessarily signify their greater importance. The relative importance is something that has to be judged in each case. If a patient with a cancer presents also some neurotic manifestations we go straight for the cancer. On the other hand, the fact that a severe and crippling neurosis may be accompanied by some slight bodily disturbance such as indigestion does not mean that the latter should necessarily claim precedence in therapeutic attention. The rarely attained ideal would be that judgment should be passed by someone equipped to estimate the significance of both mental and physical factors. At present the mental causes of ill-health are pitifully neglected, the attention paid to them being infinitesimal in comparison with that devoted to the physical causes.

A great many reasons are given for this state of affairs, most of which contain some truth: the difficulty of acquiring an adequate knowledge of medical psychology and of applying psychotherapeutic methods, the apparent contradictions and obscurities in medico-psychological writings, the time needed for dealing with neurotic patients, and so on. It is little wonder that medicine has always hoped to evade these tasks by discovering a remediable physical

"basis" for neurotic suffering, and that it clutches at every hint, endocrine or other, in this direction. This seems to me to be an attitude that combines an undue optimism with an undue pessimism. It is partly based on an over-medical view of psychoneurosis being a "disease" in the ordinary sense, the social and biological aspects not being taken into account. It is easy to see the point if one considers examples from other fields, examples that are more than analogies. Among the many problems that civilization has to deal with one may instance social conflicts, criminality, education, and the risks of distress and destruction due to the unsatisfactory uses that many ruling politicians make of their reasoning powers. Now it is no doubt arguable from a medical point of view that the difficulties I allude to are ultimately due to lesions in the brain or malfunctioning of the ductless glands. But to sit down and wait until these somatic causes are discovered, and—what is by no means the same thing—efficacious remedies found for them, would seem to be both a policy of despair and a dream of hopefulness. A teacher who adopted any such attitude about those of his pupils who were slow at learning French or coping with arithmetic would soon be dismissed from his school on the ground that he was lazily seeking excuses to evade his duty of finding psychological solutions for the difficulties in question. It may well be that in the future we shall regard the present-day attitude of the medical profession towards psychoneurotic difficulties as similarly misplaced.

No, the real reason for the medical neglect of psychology is, in my opinion, a very simple one. It is that, just as their patients, physicians too are human beings. And by that I mean that, without in the least being aware of it, they shrink from the unconscious mind and have built up their life on the basis of more or less successful protections against it. The dark fantasies and fierce impulses and dread fears of the unconscious, carefully repressed from consciousness, are completely unknown; at the most some distant issue of them, such as irritability, insomnia, intolerance, etc., may be perceived. Anything that tends to draw one, however slightly, nearer to the unconscious is automatically avoided, and the position of security is fortified by so-called practical matter-of-fact attitudes or by any other means that may present themselves. There is no reason for supposing that members of the medical profession differ from the rest of the community in all this.

The "Nightmare" Phenomenon

The only remark one might add is that one particular mode of defence offers itself to them with greater readiness than to other people: I mean the chance of displacing or projecting mental phenomena on to the somatic sphere. I will quote a classic example of this, which I have studied in great detail (Jones, 1931)—namely, the phenomenon called "nightmare." Actually this is an expression of a violent conflict between a certain unconscious sexual desire and intense fear; the admixture of these two components is infinitely varied, so that all transitions are found between the simple erotic dream, the anxious dream with seminal emission, and the pure fear dream. Until a couple of centuries ago the world saw in these manifestations the action of lecherous demons, who indeed often appear in the dream in various guises. It represented an important advance in thought when a scientific age sought for a more naturalistic explanation and contested the popular belief in devils, demons, and witches. But if ever there was a case of emptying the baby out with the bath water it was here. Medical thought discarded not only the

fancied demons but also the sexual conflict that was the essential cause, and they did this by taking full advantage of their readiest projection mechanism—somatic attribution. From now on nocturnal emissions were attributed to physical tension in the seminal vesicles, prostatic or urinary pressure, and the like, while nightmares were put down to gastric pressure on the heart, intestinal toxæmia, and a large variety of other processes implicating every system of the body. In this we safely got far away from the frightful struggle between incestuous desire and castration fear that provides the actual dynamics of the phenomena. The mediaeval writers, with their insistence on the *personal* sexual wishes as the causative agent, were perhaps after all nearer to the truth than modern physicians. Both used projections, on to demons or somatic processes respectively, but at least the earlier writers retained a hold on the psychological and sexual nature of the phenomena which was lost in the later medical projection.

This historical excursus will also serve to illustrate a momentous consideration to which I wish to draw special attention. It is that in medical practice we are concerned not alone with the patient's unconscious mind, with its incalculable influence on the clinical situation, but also with that of the physician. Most of all, perhaps, we are concerned with the subtle and extensive interaction of the two. On the physician's side this produces its effect not merely in the practical handling and treatment of individual patients, but in what is possibly an even more important sphere—that of diagnosis and pathology, particularly aetiology. It will, however, be easier to expound this theme after we have considered the various attitudes the patient's unconscious displays towards disease and therefore to the person treating that disease. I will next take these two topics in order: the influence of the patient's unconscious on his relation to himself (including any disease present) and on his relation to the physician.

Influence of the Patient's Unconscious

The first of these two topics naturally divides itself into the problem of neurosis itself and the attitude of the patient's unconscious to physical disease. To understand the latter one must have some knowledge of the former. There are fortunately many descriptions of the psychopathology of neurosis now available (Deutsch, 1932; Freud, 1929; Jones, 1938; Mitchell, 1921; Stephen, 1933), and I shall confine myself here to emphasizing certain fundamental features of the condition. First of all, neurotic manifestations do not themselves constitute a disorder except in a purely clinical and descriptive sense; actually they are only the visible symptoms or signs of an underlying disorder, just as jaundice is a sign of hepatic disturbance. They result from an excessive inner *tension* which has been provoked by some intolerable thwarting or *privation*. The tension itself proceeds from an unresolved *conflict* which has often been stirred to fresh activity by some current situation. They express in a variously disguised way both sides of this conflict, and thus are always what may be termed *compromise-formations*. In the conflict the important elements are sexuality, aggression, fear, and love, but these are involved in such an extraordinarily complicated fashion that one cannot describe the two sides of the conflict in any simple terms.

These four or five sentences state in an exceedingly condensed form the most essential basis of our knowledge about the meaning of psychoneuroses; but it is a basis that has been reached only as the result of extremely detailed studies of the characteristic unconscious

mechanisms that determine the structure of such formations, and the state of affairs is actually much more complex than I have just indicated. Let us look at it in another way. Thwarted and repressed impulses provide the active dynamic urge that starts everything going. These meet with opposition from other instinctive attitudes, and the conflict generates first fear, then mental pain and misery. This is the disorder itself, but then there comes into play a whole series of defences, one or two of which I mentioned earlier, and the manifest neurosis as we see it clinically is the resultant combination of all these factors, containing elements from each one of them. It expresses, therefore, something of the primary repressed impulses, something of the resulting anxiety and distress, and something of the defensive attitudes. The proportion of these varies considerably in different cases. In one the gratification of the repressed wishes is prominent, so that the neurosis brings unmistakably positive advantages to the patient, who is correspondingly loath to renounce it. In another the anxiety breaks through and dominates the clinical situation, either directly or in the form of protective phobias. In yet another case the defensive mechanisms play the largest part, and then the clinical type is apt to assume the form of what we call a character neurosis.

Factors in Neurosis Formation

It is important to distinguish between the current and the essential factors in neurosis formation, just as it is to distinguish between the exciting and essential causes of tuberculosis or heart disease. In the aetiology of neurosis we commonly, though by no means always, find current factors, such as overwork, over-excitement, privation, grief, misfortune. Yet none of these can by itself produce a neurosis. It evokes one only if certain specific conditions are present in the unconscious—namely, a serious unresolved conflict dating from childhood, one with which the current factors can become associated. The process set up is what we call "regression." The emotional responses reanimate the older ones and revert to an older type. This is the reason why a real cure of any neurosis necessitates the exposure of the essential childhood basis and the resolving of conflicts then left in an unsatisfactory state.

The central content of the repressed impulses may be summed up in two words: incest and murder. When we reflect that these refer to loved parents, that bitter hostility has to fight against the strongest feelings of dependence and affection, it is not astonishing that no easy solution can be found. On the physical side also there are many bewildering ideas with which the young child has to grapple: the problems of cleanliness, clashing with the extraordinary significance that excretory processes have for the infant; the instinctive knowledge of coitus, with the unknown dangers accompanying the idea of penetration; the sex differences, with their implication of castration. Small wonder that no child escapes an "infantile neurosis," tantrums, fears, eating difficulties, destructiveness, etc., manifestations which every adult does his best to discount.

If a neurosis proceeds successfully to its logical extreme it ends in a state of inhibition, more or less extensive according to the severity of the conflict. It seems plain that the function of a neurosis is, on the one hand to retain in an unaltered infantile form certain repressed impulses, and on the other to keep at bay the anxiety and distress that these impulses are prone to bring in their train. It is often very remarkable what extensive inhibitions people will bear before they consider them as

symptoms and seek for therapeutic help. Permanent sexual frigidity or a sexual perversion that confines gratification to the narrowest possibilities, the crippling effects of a phobia that may forbid all social life or even going out of doors (as with an agoraphobia): these and many similar restrictions are cheerfully borne if only the impulses and dread they cover are thereby successfully kept out of sight and never enter consciousness.

The Patient's Attitude towards Treatment

These considerations about the nature of neuroses enable us to understand a prominent and peculiar feature in the patient's attitude towards therapeutic help. It is of course common enough with physical disorders for there to be a conflict between patient and doctor over the question of what is to be treated. The patient naturally wishes to be relieved of whatever symptoms are giving him distress, whereas the doctor is more concerned with abolishing the cause of the symptoms than with merely alleviating them. No doubt the actual treatment will vary with the strictness of the doctor's professional code of ethics, since it is undoubtedly easier to fall in with the patient's wishes and alleviate the symptoms than to insist on giving him the trouble of having the underlying causes investigated and dealt with. Still, there is no doubt about what the medical attitude ought to be in such a situation, even if in practice doctors sometimes depart from it. Now with the neuroses the conflict between doctor and patient is much sharper. It must be very rare in organic disease for no wish for cure to exist in the patient's mind, but with neuroses this state of affairs is the rule. One may say that they constitute the only condition where the patient comes for help to sustain the disease and resists every effort to cure it.

To give up a neurosis would signify to the neurotic mind, which has not been able to encompass any alternative, to surrender certain cherished wishes and also, since this is inherently unthinkable, to dispense with the only protection it knows against the accompanying anxiety and mental misery. When a person is disturbed by neurotic symptoms his distress is only in part due to the painful effect of the symptoms themselves. What disturbs him far more is the inner feeling that his defensive systems are beginning to break down, which is indeed what the presence of manifest symptoms means. What brings him for help is his need to strengthen and reinforce these defences—that is, the neurosis itself.

This curious situation is further complicated by an even more peculiar feature—one which leads to a unique problem in therapeutics. With organic disease one can reckon not only on the patient for some will towards cure, but still more so on the part of the doctor; unless he panders to the patient's preference for the alleviation of symptoms his whole attitude is in favour of curing the condition. Now with the neuroses it is different. Here also there is agreement between doctor and patient, but unfortunately this time in the opposite direction—namely, of avoiding a cure. In a certain very important sense doctor and patient are psychologically in a similar position. Both have had to fight against their unconscious fears and to build up various complicated defences against them in the course of their early development. Both therefore show the strongest disinclination to open up these defences and expose the repressed material behind them. It is far easier to turn the other way, to discount or deny the significance of any signs of underlying emotions, to get away as far as possible from them, to strengthen and encourage what is called the "will-power." This is of course what the patient in particular wants, since it is

the only way he knows of to combat the neurotic affliction. And, with one single exception, this also has been the aim, avowed or otherwise, of all the various methods of psychotherapy from the beginning of medical history.

Psycho-analysis

The exception is, of course, psycho-analysis. And by psycho-analysis I mean *real* psycho-analysis, not the strange things that nowadays often pass by that name. The aim of psycho-analysis is in exactly the opposite direction to that of other forms of psychotherapy. It is to uncover and resolve the conflicts that underlie the whole neurosis. In this way it strengthens the ego, including the "will-power," not by the method of direct encouragement which has such palpable limitations but by diminishing the unconscious anxieties that are the real cause of its weakness.

This procedure, however, cannot be carried out except by someone who is prepared to face calmly the contents of his own unconscious mind, and who has had the personal experience of resolving the conflicts and anxieties in it. Without this his endeavours to help his patients would constantly be thwarted, unknown to him, by the powerful inner forces making for the opposite solution to the analytic one. At first sight no doubt it seems strange to ask that a doctor should have to undergo the same treatment as that which he proposes to employ with his patients. In no other branch of medicine is such a thing thought of. When it happens, as for instance with pulmonary tuberculosis, then certain advantages are perceived—the doctor is perhaps better able to appreciate the difficulties of the regime—but no one would dream of suggesting that the staff of a sanatorium must necessarily be tuberculous. With psycho-analysis, however, the whole situation is radically different. The very tool the analyst employs in the treatment is his own unconscious mind, and if this is not clear, perspicuous, and able to function quite smoothly he would be in the position of a histologist using a rusty and muddy microscope: everything would be distorted by artefacts.

Relation between the Unconscious Mind and Organic Disease

I should like now to say something about the relation between the unconscious mind and organic disease. Bodily processes are of the greatest interest to the mind, and especially so to its primitive, infantile, and unconscious layers. They are therefore one of the commonest ways by which unconscious mental attitudes find expression. We are very familiar with some forms of this—for instance, in conversion hysteria, where an unbearable loathing may express itself as chronic vomiting, or a wish to expel imaginary poison may lead to chronic colitis. But it is certain that the effects of unconscious attitudes go far beyond this, and it is at present impossible to set limits to our knowledge concerning the extent to which they may influence bodily processes. It is, for instance, probable that the greater part of ordinary dyspepsia takes its origin in this way. Much work in this direction has recently been done on very varied conditions, ranging from asthma and thyroid syndromes to duodenal ulcer.

Where, on the other hand, the organic disorder is essentially of physical origin we still have the question of how the mind reacts towards it, since this may not only influence the patient's attitude to treatment but may also exacerbate the physical condition itself or complicate it by the addition of neurotic symptoms. The unconscious invariably interprets every physical illness as a personal

attack, which it colours with a projection of its own aggressivity. In other words, someone has either malevolently or sadistically assaulted the person. This, it is felt, is equivalent to introducing a bad poisonous material that will corrode all that is good within, will exhaust and drain vital material, and prevent the acquiring of beneficial sustenance. The unconscious then conceives of help in coping with the invasion in one of two ways: the doctor is either to offer something good that will neutralize the malevolent foreign body or to display a violence greater than this. We are familiar with these two broad types of treatment, psychologically regarded, and perhaps also with corresponding types of doctor. The one is illustrated by a soothing cough medicine or a gentle manipulative massage, the other by most medicines or by surgical operations. I say "most medicines," for it is a familiar experience that a medicine with a pleasant taste is apt to be suspected of impotency.

There are three features in organic disease that are prone to activate a latent neurosis. In the first place every form of injury or illness signifies privation or deprivation in one form or another, whether it be interference with sleep, with freedom of movement, of eating, of working, or of other activities. Now, as I remarked earlier, privation is the characteristic starting-point for all neuroses. It sets in action the typical mechanisms of regression back to infantile fantasies and wish-fulfilments with all the symbolisms and disguises that clothe neurotic processes. With the details of these we are not here concerned.

In the second place the unconscious invariably responds to any kind of physical illness or injury by generating anxiety. Some of this is of course conscious, but much more is unconscious. We know that one of the two main functions of every neurosis is to provide a barrier or support against unconscious anxiety, so that is a second way in which organic disorders stimulate any latent neurosis.

Finally, most physical illness causes either pain or some other kind of suffering, and thus provides material for the various tendencies in the unconscious that seek for suffering. This search for suffering is perhaps the most remarkable trait in human nature, being so paradoxically anti-biological, but it is hardly possible to exaggerate its importance psychologically, and even the most experienced of us are constantly being surprised by its power and range. It has several sources. There is the curious component of the sexual instinct called masochism, which is far more subtle and widespread than is commonly thought. Then there is the tendency to self-punishment which plays a large part not only in neuroses but in everyday psychology. It comes from the fact that an important part of the conscience is itself unconscious, and that part is far more primitive and ruthless than the conscious part with which we are familiar, though of course even the latter can at times inflict considerable suffering and penance by remorse. Most subtle and dangerous of all, however, is the tendency of the mind, from fear and other motives, to turn its repressed aggressive impulses against itself instead of against the outer world. Suicide is of course its extreme form, but it has a thousand other manifestations. It is a motive that has always to be watched for, since in both neurosis and organic disorder it may succeed in baffling the most skilled therapeutic efforts.

The Unconscious Mind of the Doctor

I have not time to develop the interesting theme of the ways in which irregular functioning of the unconscious mind of the doctor may interfere with his clinical

judgment in making diagnoses and deciding on treatment, but I am persuaded that the potential skill of most doctors is considerably reduced by such aberrant activity. The commonest example is probably the way in which doctors share popular superstitions about the danger of cold air, but the grimmest example of all is, of course, when the patient's death results from such mistakes; but short of this I think one could trace more errors in medical practice to unconscious interference with knowledge than to lack of knowledge itself.

Conclusion

In summing up I would repeat the two main contentions of my paper: that there are few cases in which the unconscious mind of the patient does not play a part in the clinical situation, and, further, that the fact of the doctor possessing an unconscious mind is one of the importance of which is commonly overlooked.

REFERENCES

- Deutsch, Helene (1932). *Psycho-Analysis of the Neuroses*, London.
 Freud, Sigm. (1929). *Introductory Lectures in Psycho-Analysis*, London.
 Jones, Ernest (1931). *On the Nightmare*, Hogarth Press, London.
 — (1938). *Papers on Psycho-Analysis*, 4th ed., London.
 Mitchell, T. W. (1921). *Psychology of Medicine*, London.
 Stephen, Karin (1933). *Psycho-Analysis and Medicine*, Cambridge.

UTERINE RUPTURE FOLLOWING CAESAREAN SECTION

BY

C. E. B. RICKARDS, M.B., M.C.O.G.

*Chief Assistant to the Gynaecological Unit, Manchester
Royal Infirmary*

According to Eardley Holland (1920) 4 per cent. of Caesarean scars give way during a subsequent pregnancy or labour. Often this type of rupture is not accompanied by any abnormal signs or symptoms, and the surgeon, on opening the abdomen to perform a second section, is amazed to find a bulging sac of liquor amnii protruding through the old scar. At other times the clinical picture is one of shock or haemorrhage. None of these cases, however, resemble the ordinary type of uterine rupture which so often occurs as a terminal event in cases of obstructed labour and is described in the obstetrical textbooks.

Many cases of rupture of the uterus following a previous Caesarean section have been reported, and the condition may give rise to a perplexing and bewildering variety of signs and symptoms. An attempt is here made to classify this type of uterine rupture into five groups, with the object of facilitating its diagnosis.

Group I

In this group the rupture occurs through an old upper segment incision, and the placenta is situated away from the uterine scar. This is a common type.

Mrs. X., a woman who came under my care at St. Mary's Hospital, Manchester, belonged to this group. This patient was admitted to hospital during the last month of her first pregnancy. Her diagonal conjugate was estimated to be 4 inches and her interspinous and intercrural measurements were 9 and 9½ inches respectively. As the head showed no signs of entering the pelvis a medicinal induction was attempted. She did not tolerate the quinine, however, so drugs were discontinued and the patient was allowed to start in labour spontaneously. Trial of labour was unsuccessful, and I delivered her by Caesarean section twenty-three hours

after the onset of the pains. The classical operation was performed and the uterus sutured with two layers of interrupted catgut, an additional continuous suture being used for the peritoneum. She had a febrile puerperium, the temperature reaching 101.5° on several occasions between the second and the fourteenth day after operation. She was discharged from hospital on the twenty-second day in a satisfactory condition.

In 1936 she became pregnant again. During this second pregnancy the head never showed any sign of entering the pelvis, was extremely mobile, and "rode high above the inlet." It was often palpable in one or other iliac fossa. Towards the end of the pregnancy "overlap" could be demonstrated if the head were pushed over the pelvic inlet and pressure applied to the fundus of the uterus. As the patient had had a very fair trial of labour with her previous child, and as this second infant showed no signs of engaging in the pelvic cavity, it was decided to perform another Caesarean section.

We arranged to admit her into hospital on July 20, but on the morning of this same day she came in as an emergency. On being questioned she told us that she had been in labour fourteen hours before reporting at the hospital. The pains, she said, had been very bad most of the time, but their severity had diminished, and they had been less regular during the last one and a half hours. Her general condition was very good. The pulse was 80 and the blood pressure 120/80. She was having pains, but they were rather irregular and niggling in character. Immediate Caesarean section was considered advisable.

On opening the abdomen I was very much surprised to find that the scar of my previous operation had given way along two inches of its length. An intact bag of membranes was bulging through the aperture. The rest of the scar, which was a fibrous one, was thinned out and appeared to be on the point of bursting. The placenta was situated on the posterior wall of the uterus, and was nowhere near the scar.

This case impressed me very much by its lack of signs and symptoms. Many similar cases are to be found in the literature. Occasionally the bulging sac of liquor has been palpated through the abdominal wall (Casagrande, 1933). Sometimes foetal limbs have been recognized protruding through into the sac. These splits are often only discovered at operation. Prognosis is good when proper treatment can be administered.

CHARACTERISTICS OF GROUP I

1. Rupture tends to take place during labour.
2. Little or no haemorrhage occurs, and therefore the pulse remains good.
3. The pains may become niggling in type after the scar has started to give way.
4. The bulging bag of membranes may sometimes be palpated through the abdominal wall.
5. Prognosis is good provided that suitable treatment is available.

Group II

Group II consists of cases in which the rupture occurs through an upper segment incision and the placenta is situated underneath the old scar. This type of case is more serious, and presents a different clinical picture. When the placenta is situated underneath the old scar a gradual erosion of fibrous tissue by the placental villi occurs (Hornung, 1929). This erosion is an insidious one, and may cause marked attenuation of the scar during the latter part of pregnancy. In this type of case, therefore, rupture is said to be more liable to occur before the onset of labour. The eating away of the scar may be associated with vague pains in the lower abdomen (Potter, 1930). As the process is gradual, haemorrhage is seldom severe