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PSYCHOLOGICAL MEDICINE AND THE FAMILY DOCTOR*

BY

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The opening of the York Clinic for Psychological Medicine at Guy's is an opportune moment for discussing the applications of psychiatry to general practice. The need for doctors to pay attention to the psychological aspects of medicine has been recognized more and more in the past two decades; but tradition dies hard, even if it is not a very old tradition, and there is still reluctance on the part of many to take any lively interest in psychiatry. The curriculum is partly to blame. Although there was a curriculum conference not many years ago it did not succeed in producing more than recommendations that the teaching of psychological medicine should be supplemented in certain ways. The compulsory part was still left at attendance at lecture-demonstrations in a mental hospital. The fact that mental hospital patients are only part, and numerically a minor part, of the domain of psychiatry was not recognized by making anything else compulsory, nor was it made obligatory to have at least one question in this field included in the final examination. When a subcommittee of the British Medical Association surveyed the field of education in psychological medicine nearly 20 years ago it was discovered that one university in the Empire went so far as to include psychiatry as one of the subjects equivalent with medicine and surgery in the final examination. Now Edinburgh has followed suit at the request of the students themselves. This observation should be printed in italics. But, as Mr. Slesinger often points out to me, with some envy perhaps, the Scottish student is a far-seeing person.

Prevalence of Psychological Disorder

It would be very much to the advantage of medical men generally that more teaching of this sort should be available, not only in the interests of their patients but often in their own. To show how much the psychological aspects of disease matter, it is only necessary to quote the results of investigations that have been made in recent years. At Guy's Hospital, for example, it was found that one-sixth of all those who turned up at general medical out-patient departments were not suffering from any organic disease but from symptoms due to psychological causes. This series of Dr. Bruce Pearson's included over 1,200 cases, and has been supplemented at the same hospital by a study of a further 500 cases by Squad. Ldr. A. M. G. Campbell, who found that 13% were suffering from psychological disorder. Where illness of the more chronic type is concerned the proportion has been found in 1,000 cases to be approximately 35%. This was the figure arrived at by Halliday, acting as medical referee in a district of Scotland. These data are obtained from clinical material of the type that would as a rule appear in general practice.

Where a consulting practice is concerned the position is not very different. Prof. J. A. Ryle told me some years ago that anxiety neurosis was one of the most frequent diagnoses he had to make, and Air Cdre. Conybeare is of a similar opinion—at any rate, so far as war medicine is concerned.

Presenting Symptoms

These figures do not mean, of course, that the patients always or even usually come with their symptoms formulated in psychological terms as depression, worry, or what not, although it is my impression that on the whole they do so now more frequently than they did in the past. Whereas formerly they were apt to complain almost exclusively in terms of physical discomfort, it seems more common nowadays for them to say that they feel nervous or that they cannot concentrate or that their memory is bad. This is probably correlated with the decrease of gross hysterical symptoms in the form of paralysis, blindness, etc., as opposed to frank anxiety states, which have been relatively more frequent in this war in contrast to the last—a difference which some have sought to explain in terms of an alteration in war conditions, but which merely parallels a change that has occurred in civil practice in the intervening 20 years. The late T. A. Ross remarked the same thing in one of his reports of the work of the Cassel Hospital—that in the course of the years it had seemed to him that there had been less tendency for neurotic patients to emphasize bodily complaints and more inclination to talk in terms of fear and worry. I have received very much the same impression in both civil and military practice, and I have sometimes longed for the good old days when paralysed limbs and anaesthetized senses could be demonstrated in Sir Arthur Hurst's graphic manner to both patient and student, and when there was often something much more tangible to get hold of than a phobia or a blank depression of spirits. The change depends partly on public education and partly perhaps on doctors themselves knowing more about these matters as a result of advances in pathology on the one hand and in psychopathology on the other. The discovery of the Babinski reflex made it much more easy to distinguish organic from functional paralysis, just as other discoveries made it impossible for doctors to speak of Parkinsonism any longer as a "functional" disease, as Gowers did in his famous textbook.

"A Rose by Any Other Name"

It still happens, however, that a physical diagnosis covers a fundamentally psychogenic condition. Such diagnoses as "debility," "anaemia," "rheumatism," and "gastritis" are apt to be labels for what is really a psychoneurosis. Years ago Dr. Millais Culpin showed this very well when he produced a statistical table of the incidence of these alleged conditions in a large industrial concern. Taking the sick returns year by year, he found that when the number of diagnoses of anaemia, gastritis, and dysmenorrhoea went up those of neurasthenia, "nerves," and general debility went down; in other words, these are often interchangeable labels. Recently war experience has provided a further illustration of the same thing.

When a special unit was opened for the treatment of rheumatism it was found that more than one-third of the cases sent there were not rheumatic at all but were psychoneurotic in some sense. For example, a man aged 20, whose case was described to me by Wing

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Cmdr. J. Flind and Squad. Ldr. Barber, had complained of the fairly sudden onset of pain in his shoulder-, hip-, and knee-joint on the left side, about nine weeks before admission, associated with attacks of dyspnoea, palpitation, and dizziness. He had breathlessness and palpitation, but no pains, before entering the Service. When he joined up he was given disciplinary training; he felt very low in spirits, complained of aches and pains, and was put to bed. Being allowed up, he was transferred to another station, where his symptoms soon reappeared and he was sent to bed again. It was found that he had always been an excitable worrying person more or less afraid of the dark and upset by the sight of blood; his mother was herself nervous. His symptoms appeared in the Service when he was put to a type of training which he disliked enormously, and reappeared when he was put on guard duty, which he disliked still more. He said frankly that he was "scared stiff of these guards." He had no physical signs, and the only positive findings were psychological ones.

The same thing holds in many cases of appendicitis in which a normal appendix is found on operation. I still remember vividly the first case of this sort that I had under my eye as house-physician. I was not trained in psychological medicine then; but this man's appendix was quite normal, and I noticed during his convalescence that he was inordinately fond of self-display, wearing a gaudy dressing-gown, which he might be said to flaunt in front of the nurses as he strolled about the ward. I have no doubt now that had I known something of psychological medicine then one unnecessary operation could have been avoided. We all know of teeth taken out unnecessarily, on the assumption that symptoms, really psychogenic, were due to dental sepsis; of refractive errors of plus one or minus one dioptre corrected by glasses but without ultimate relief of the headache, which was due to anxiety of some sort; and of exploratory laparotomy with negative findings in, say, a depressive illness.

Psychosomatic Medicine

But it is not only conditions mistakenly diagnosed as physical that are to be accounted for by psychological factors. The term "psychosomatic medicine" covers also conditions which have a definite peripheral pathology of structure but in which psychological factors are important, sometimes the most important, determinants; for example, in some cases of asthma, of certain skin diseases such as prurigo, of duodenal ulcer, and of hyperthyroidism.

Not long ago I saw a man with a fairly widespread pruriginous eruption, which had been very persistent and was associated with a good deal of depression of spirits and insomnia. Repeated and vigorous treatment for his skin did not have any lasting effect. It was then found that his symptoms had begun when he was sent abroad on service and that his going abroad was only the last of a series of efforts to get into a really dangerous enterprise, although he was certainly over the age at which front-line service was usually permitted. He had volunteered for two of the most risky forms of service and had been refused these on account of his age. It was curious that he should have been so unusually persistent in seeking danger. It transpired that he had a sense of shame for having developed neurotic symptoms in the last war so that he was invalidated home; furthermore, he had a great admiration for, and at the same time considerable fear of, his father, who was a very severe man with an impulsive temper. A sense of unworthiness acquired *vis-à-vis* his father had made him want to live to please him. This apparently was the main driving force of his life, and although he was married and had a family his great desire was to justify himself in what he thought was his father's opinion, and it was this that caused him to volunteer for the dangerous jobs. In actual fact the attempt to face the rigours of a campaign had made him tense and nervous, had upset his health and helped to bring on his skin eruption, and kept him miserable at what he considered his failure. Discussion of this attitude and the realization of its immaturity enabled skin treatment to proceed with final success.

Another patient with impetigo which was suspiciously persistent turned out to be suffering from acute apprehension about return to duty—not because he was a coward, but because he had had an extremely disturbing experience which had stamped itself on his mind in a way that made him feel it was impossible to face a recurrence of the same situation, although previously he had behaved with courage and devotion.

It is possible to show that asthma has all sorts of relationships to mental events; that hyperthyroidism is especially apt to occur in people who have been anxious over a long period; and that rheumatoid arthritis is found more often in people whose emotional furniture is disarranged. Naturally the

relationship of the pathological bodily state to the psychological aspects is a very varied one, but the simplest is where the precipitating factor is psychological—for example, in asthma sustained by an unhappy domestic situation, or, as Rogerson showed, in children in whom the development of asthma may be precipitated by an over-anxious parental attitude.

Medical Scepticism

It is of course natural for anyone approaching the problem from the angle of general medicine to be very sceptical about the relationship of psychological disturbance to what is obviously physical disease. I remember a meeting of the Asthma Club many years ago, when it was obvious that some of the members were extremely resistant to the suggestion that an asthmatic attack could be precipitated by an idea just as much as by an injection of something. But appreciation even of the "conditioned reflex" process would have prevented anyone being surprised by this.

The story of the woman who had an asthmatic attack on seeing a bouquet of artificial roses has been paralleled a number of times; for example, in the case, recorded in an American journal, of a woman who was allergic to onions and who immediately developed conjunctivitis and a stopped-up nose on seeing, apparently, onion peelings on the rug. On withdrawing to another room, she told the maid that there were onion peelings on the floor and they had made her sick. The maid apologized and said they would be removed immediately, but soon returned and said that they were the remains of a narcissus bulb which a dog had chewed.

This type of thing is one of the simplest examples of the effect of a psychological fact on what looks like an entirely bodily ailment; but it is worth knowing that a great many more complicated psychological patterns—for example, a domestic situation—can have the same effect. It has also been noticed that a psychological upset, or at least a period of psychological tension, often precedes the appearance of a duodenal or even a gastric ulcer.

Terminology

The general practitioner is apt to treat psychiatry as an esoteric mystery, and this is probably in part the fault of the professors of the subject, but not entirely so. Many doctors profess to be deterred by the terminology, but I am inclined to think that this is a kind of rationalization for a refusal to become interested. Actually there is no branch of medicine which the general practitioner is more fitted to undertake or in which he has more opportunities. First, as to the objection about terminology: the best practical work in the English language about the psychological treatment of patients is T. A. Ross's *Common Neuroses*. It is written in the simplest English, and there is hardly a technical term anywhere. It describes mainly psychoneurotic conditions. But if the terminology is taken as a whole it will be found—for example, in a standard textbook of psychiatry such as Henderson's and mine—that so far as syndromes are concerned not more than half a dozen names are necessary for classification purposes, and of the half-dozen major groups the most outlandish designation of the lot (namely, schizophrenia) has become almost a household word—thanks, it is true, largely to the sensational press. It is only when you come to psycho-analytic terminology that much special knowledge is required; but the psycho-analytical method is highly specialized, and as it is of practical use, for a variety of reasons, only in a minority of psychological illnesses this problem need not trouble the general practitioner.

Special Opportunities of the Family Doctor

On the positive side the family doctor has certain advantages. First and foremost he has, or should have, a good working knowledge of human nature. General practice is one of the best training grounds in that subject. Psychological illness is, roughly speaking, a matter of human beings in personal distress, very often because of their ignorance, shortcomings, disappointments, and dissatisfactions, and still more often because of their fears. The study of human nature is therefore profitable not only in teaching one how to handle one's patients but in knowing how to cure, or at least to help, anything from one-sixth to one-third (some would say more) of the illnesses for which they consult their doctor. In this sense anyone who cares to

study this topic is capable of becoming a psychotherapist up to a point, although few people will deny that the best psychotherapists are born as well as made. It is, however, to be expected that so long as doctors as a whole tend rather to shun the psychological aspects of their practice, the number of irregular practitioners in this field is likely to be considerable. Many of the triumphs of those who practise suggestion in various disguises are achieved in patients in whom the doctors have not recognized the psychological basis for their illness. The medical man, however, has certain advantages of his own, although his very knowledge prevents him having that sublime confidence which comes so naturally to the quack. In the first place, the psychological distress which the patient is suffering expresses itself very often in terms of bodily discomfort—indigestion, palpitation, and so on—and only a doctor is in an authoritative position to evaluate such symptoms. Unfortunately medical education tends to over-emphasize the structural aspects of pathology. It is a pity that the student's physiological work does not concern itself a good deal more with the effects of the emotions on the bodily functions. He might then never forget that when symptoms of a disturbed organ are presented to him one of the causes that he must always remember is the emotional or psychological one. This, however, is the last that he usually thinks of, and a great deal of time may be spent on laboratory investigation before the patient is even asked whether he is worried or not. Psychological factors are so pervasive that they should enter into consideration in almost any differential diagnosis in the first instance. This, at any rate, would be safer than not considering them at all.

Suggestion

There is another advantage that the doctor possesses. Like the priest, he is a symbol of mysterious power in the eyes of his patients, and has in consequence a great capacity for allaying anxiety. We are apt to forget how thin is the veneer of culture and adult control, and how often in times of distress, especially if the distress is fundamentally distress of mind rather than of the body, people tend to think in primitive terms. It is in such circumstances that suggestion is particularly potent; yet few doctors consciously practise suggestion, although they are in a position to use a very enlightened type of it since they combine the authority conferred on them by the more childish aspects of their patients' minds with the enlightenment contributed by their own education in disease.

I am not advocating that suggestion as such should be widely used; yet it is more appropriate for the ill educated, and is sometimes the only form of psychological treatment that is applicable to them. How powerful it is is illustrated by the famous story told by Dr. John Brown of Edinburgh, who reported the case of a labouring man affected with colic, for whom he prescribed some medicine, directing him to take it and return in a fortnight, assuring him that he would be quite well. At the appointed time the man returned, entirely relieved and jubilant. The doctor was gratified at the manifest improvement in his patient's condition and asked to see the prescription which he had given him; whereupon the man explained that he had "taken" it, as he had understood the directions, by swallowing the paper!

Education and Suggestibility

I used to think that the more educated people were the less suggestible they became, but this is certainly not by any means always the case. Many years ago I acted as assessor for the Asthma Research Council to a doctor who claimed to cure asthma by suggestion. I selected 12 asthmatic patients for him, and he proceeded to use his method in my presence. He employed what to my mind was a very simple form of suggestion, and after one session three of the 12 patients proclaimed themselves better, and these were certainly among the most intelligent of the small group. Similarly, Prof. Witts and his co-workers found at the Asthma Clinic at Guy's that they had almost as much success for a time with injections of distilled water as they had with vaccines and the like.

The point is that suggestion is the simplest form of psychotherapy and does not require a technical knowledge of psychopathology in the modern sense. The family doctor is in a peculiarly good position to apply it, because of his special

prestige with the patient. It is true that he uses suggestion all the time, more or less unconsciously, when he gives a bottle of medicine or some other treatment that he himself has faith in, but deliberate and discriminating use of suggestion as an additional weapon is at present rather neglected.

Iatrogeny

There is a negative aspect of this matter of suggestion which is not so much to our credit. There is a chapter omitted from medical textbooks which might be headed "Iatrogenic Diseases"—that is to say, diseases produced by doctors. It is not well enough realized that it is dangerous to give a label to a set of symptoms of disease until you are convinced that it is the right one. If a syndrome is psychologically produced (which of course the patient does not know), and if the doctor also does not know this and calls it gastritis because the patient complains of indigestion, or a weak heart because he complains of breathlessness or precordial pain, or even if he attaches to it some cabalistic letters such as D.A.H., then he has implanted a suggestion in the patient's mind which fixes his anxiety in a way which, if not quite indelible, is at any rate very hard to undo.

The advance of clinical knowledge has definitely limited the scope for iatrogeny. The number of young people who were made into chronic semi-invalids by the diagnosis of a "weak heart" on the strength of a complaint of breathlessness or palpitation, or, in the pre-Mackenzie era, on the basis of a murmur, must be very much less than it was; and though no doubt we have all encountered a case or two of the sort, colitis is not diagnosed on such dubious grounds now as in Axel Munthe's day. "Dropped kidney" is not heard of any longer as a cause of general ill-health, but the old notions of "dropped stomach" and "dropped colon" die hard in spite of Hurst's demonstration years ago that a significant proportion of Guy's winning fifteens carried their stomach nearly in the pelvis. One still finds an occasional belt festooning the abdomens of neurotic patients. A prop of that sort only fixed the patient's conviction that he is physically incapable. All diets and regimes, and often medicines, that are not founded on definite physical findings—not necessarily x-ray or laboratory findings, but those based on a satisfactory clinical history and examination—are apt to produce the same result. This is even truer of operations that have been performed unnecessarily. The experience of such an operation is very impressive, and it is difficult for the doctor who comes afterwards to convince the patient that his symptoms are psychogenic, and rather unhappy for the doctor who has the task of somehow getting over the fact that a colleague of at least equal standing has gone the length of operating. I have known such operations to be performed for broken hearts, angry fathers, sexual guilt, depression of spirits, anxiety of all sorts, and even on account of mistaken pride—the patient herself knowing that she had no physical ailment really, but lacking the courage to tell her parents that she had simply been giving a demonstration and was not ill at all. In that instance the play went on and the appendix came out, and the patient was no better a character afterwards, but rather the reverse. It is, however, only fair to observe that the number of operations performed in the mistaken belief that an organic cause exists, when the condition is really psychogenic, is less than is sometimes supposed, as L. H. Ziegler has shown.

Types of Psychogenesis

It is worth while pointing out, what has not usually been said, that in the psychological approach to patients the family doctor has advantages not possessed by any specialist or consultant. The reason for this becomes clearer when we remember that the main causes of psychological ill-health can be classified as: (a) constitutional, (b) situational (to use an ugly but self-explanatory word), and (c) historical, in the sense of something dependent on events far back in the patient's life. It is especially in *a* and *b* that the family doctor possesses advantages. In connexion with both it is necessary to remember that there is no apparatus or technique which will make even the most able specialist always certain when the patient is telling the truth or is concealing it, and so he has to depend for some of his information on outside sources, which are often not nearly so accessible to him as they are to the family doctor.

Again, many psychological problems are closely related to the character and temperament of the patient, and there is no satisfactory laboratory or consulting-room test of character and temperament, although some things are helpful. Nothing that we have at present surpasses or even as a rule equals in reliability the knowledge of the day-to-day behaviour of an individual such as is accessible to those who are in contact with him in his, so to speak, natural surroundings. In contrast with the consulting-room—which represents a special and artificial environment in which it is very easy (in fact, almost inevitable for the patient, at any rate in his first interview) to display a façade that is extremely artificial—the family doctor is much more likely to be in a position to know when the patient is being truthful and to learn something about his temperament, not only from contact with the man himself but also from his relatives and possibly some of his friends.

These considerations have a very important bearing on the evaluation of the various types of causal factor, whether constitutional, situational, or historical. The assessment of the constitutional factor, for example, depends very much on a knowledge of the family history. A family whose child I was treating concealed from me for a whole year the fact that an uncle had died insane and that the brother was a "near-miss" to schizophrenia. The family doctor had sent this case to me by post, as it were, and I had not had an opportunity of talking with him. It is astounding with what aplomb people will say there is no mental illness in their family. One realizes this especially when, from some other quarter not known to either patient or relatives, one happens to hear that there is. Contrast this position with the possibilities of the family doctor, especially if he has lived in the same district a considerable time and knows the people. Sir Thomas Clouston made an inquiry into the family history of 83 families taken at random in a country parish in Scotland, all the members of which were personally known to him for three generations.

He said, "I took every family I really knew, and no others. I made no selection. They were all country people—decent folks, hard-working, thrifty, few very poor, indeed mostly money-loving, with scarcely any drunkards. . . . I took advantage of my intimate knowledge of the people as a doctor to count the lesser attacks of melancholia, the milder delusional states, and the milder degrees of imbecility that would not have gone into any public statistics of lunacy or census schedules. Still, they were all mental diseases or defects just as truly, from the scientific point of view, as our acutest case in Morningside" (the Royal Edinburgh Mental Hospital). "The result was this—that, of those 83 families, I knew that in 41 of them one or other of these four diseases had occurred."

His remarks refer, of course, only to more or less strictly mental diseases; but the same is just as true, and even more important because they are in greater number, of the conditions that we now know as psychoneurotic and psychopathic. There has been a tendency on the part of over-enthusiastic psychotherapists to neglect, and not to trouble to evaluate, the constitutional factor in the patients whom they undertake to treat. There is a fair amount of evidence that such disorders as phobias, which are often supposed to be entirely determined by complexes, are far more often apt to arise in those whose ancestry shows some neurotic stigmata as well.

I am thinking, for example, of a patient of mine who has a phobia of open spaces which prevents him from going far from his home, and whose father had a similar phobia; and of another patient with a such-like difficulty whose father was eccentric and extremely reluctant to meet anyone outside his immediate family. Another patient occurs to me who had a great deal of neurotic anxiety, whose mother had epilepsy, and whose uncle was insane. Instances of that sort are frequent enough to make the conclusion extremely probable that there is more often a constitutional factor in the psychoneurotic form of illness than has been admitted in the sometimes rather indiscriminating enthusiasm for psychotherapy. Dr. Felix Brown's researches on the familial incidence of psychoneurosis support this view.

A knowledge of these things, which certainly comes more readily to the family doctor, is of value in prognosis. It is of course desirable that the family doctor should reside for a considerable time in the same district. The rolling stone in medical practice will certainly gather very little of this essential knowledge. One of the best letters I have ever had about a patient came from an old practitioner in the North of England who said that he had known the young woman whom I was

to see since she was a baby, and had known her mother since she was a baby, and had also known the patient's grandmother. Such a long perspective is of course very rare, and I often think that the death of an old doctor is in this respect a much greater loss to the community he serves than we are apt to think. It is particularly in the psychological aspect of medicine that the life history is important. The specialist envies the family doctor his opportunities in this regard. The value of a life history obtained from direct observation from childhood into adult life is so great that it has always been my ambition to collect case records of the difficult or nervous children referred to us at Guy's, so that we could get in touch with them in their adult life. Healy has recently done this in America, but no psychiatrist has a similar opportunity here; and even with the best arrangements in the world it would be very difficult for the specialist to keep track for any length of time. For the general practitioner in not too urban a district the chances are very much better and his data potentially much more reliable. Healy and his associates took the opportunity of correlating their patients' childhood as they knew it with the history given retrospectively afterwards, and found striking differences, partly as a result, no doubt, of the falsification by the rosy mists of memory, or, more technically speaking, by the workings of selective repression.

"Situational" Factors

With regard to situational factors, as distinct from constitutional and historical ones, the family doctor has a special part to play and special opportunities for playing it. In fact, his opportunities of collecting data from the patients' immediate circumstances and from the patients' life history put him in a unique position as a kind of social pathologist. It seems to me that this may even be one of his chief roles in the future, which no one can take from him. One often hears that he is losing portions of his work to this clinic and to that organization, and so forth, but the fact that he lives among the people whom he serves, and especially knows something of their family life, means that he can fulfil a function that no one else will be in a position to do. I cannot see the English public admitting social workers to their homes on the same terms as the family doctor—not, at any rate, if the latter lives up to his best tradition and reputation.

Moynihan used to contrast the pathology of the dead-house, or morbid anatomy, with the pathology of the living. Psychological medicine is really the pathology of life or social pathology. This pathology concerns itself with the jealousies, disappointments, annoyances, grievances, dissatisfactions, fears, anxieties, and so on that produce the aches and pains that we call functional. The lumbar pain without discoverable basis which the gardener had yesterday, and which disabled him for the time being, can be traced to some annoyance at his master's attitude. The headaches that the dutiful daughter complains of may arise, if she did but know it, from a smouldering resentment at her invalid mother, whose invalidism in turn may be just a method of keeping her daughter at home; while Mrs. Jones's asthma may be nothing but an expression of her aversion to her husband.

The specialist confronted with functional symptoms due to situations of this kind has to start from scratch, and is very much at the mercy of what the patients care to tell him. I have known patients conceal for months facts about themselves which were fundamental and not at all unconscious, and this not only from myself, who am perhaps simple-minded, but from my colleagues. The family doctor, on the other hand, may know these things already. The fundamental truth implied in the term "situational" is that emotional situations generated by unsatisfactory circumstances and disappointing relations with other people cause emotional tension that generates symptoms—mental or *prima facie* physical—which are the complaints the patient brings to the doctor. The simplest situation is where the job is unsuitable.

For example, a young woman, a telephone operator, complained of attacks of faintness and dizziness which occurred at her work. Physically she was perfectly sound; intellectually she was considerably above the average and had won a scholarship at school; but on leaving she had to take a post which would quickly bring remuneration, as her father was dead and her mother was largely dependent on what the daughter could earn. Her desire to become a school

mistress was thus frustrated, and she became a telephone operator. The technique, such as it is, was easily mastered. This done, the work merely became monotonous, giving her ample time to ruminate over her frustrated career and later (in the sequence that is common) on her health. The usual hypochondriacal consequences ensued.

Again, there was the case of an elderly man, the father of a large family, who had suffered from headaches for thirty years—headaches which left him during his holidays. He was an intelligent man, who had worked on the same routine job, long since learnt by heart, for 40 years. For most of that time he had been heartily sick of the work, but he had hoped for promotion. At length it became obvious that he could justifiably hope no longer, and then the headaches which had already begun became permanently installed. Here, too, was a neurosis resulting from occupational misfit and monotony; but again there were other factors—in this case the disappointment of legitimate ambition.

The same situation may of course be pathogenic for one patient and not for another, and this is where knowledge of the character and temperament of the individual will be of the greatest service. This group of disorders is also one which the family doctor is fairly often in a good position to assess and even to treat: first, by explaining to the patient how symptoms are related to emotional tension; then, from his knowledge of the circumstances, advising whether the situation can be altered, as by change of job, or whether it must be faced; and, if necessary, not forgetting to point out where a fault of outlook or a defect of character has been mainly responsible for the failure of the patient to solve the difficulty on his own.

The usual objection made by the family doctor to the psychological side of medicine is his lack of time. The late T. A. Ross, who was himself in general practice for 20 years, used to reply that the proper use of time was necessary, and that an interest in psychological medicine would save the doctor's time in the long run. Another objection that may be urged is this: How can the general practitioner be expected to know the circumstances, dispositions, and temperaments of, say, 2,000 possible patients? But psychological disorders are very often related to family affairs, and although the general practitioner may have a clientele of 1,000 or 2,000 it is probable that the total number of family groups involved is considerably less than this, and the more neurotic families will probably consult him a good deal oftener than the rest.

"Complex" Factors

The third large group of psychological disorders consists of those in which neither circumstances nor situational factors are important, and the symptoms of which are a legacy of some far-distant miscarriage of psychological development. This, on the therapeutic side, is the specialist's domain, since the discovery of the pathological processes and their rectification require a special technique of exploration and many hours of painstaking work. But even here the family doctor can give useful hints from his knowledge of the patient's life history. Many of the complex-determined psychoneuroses originate in childhood or even in infancy. One of the most potent causes is emotional insecurity on account of insufficient parental love, or, as it is usually called, "parental rejection." Few people are in a better position than the family doctor to know whether a child has been wanted or not, and this knowledge may be a key to all that goes on subsequently. In fact, in the field of child psychiatry itself the family doctor has opportunities which the specialist might well envy, since he is often present in the early days of life and sees the mother's attitude, and whether there is over-protection or rejection, or both, these attitudes being so often determining factors in the subsequent behaviour of the difficult or the neurotic child.

Views on the deeper pathology of neuroses have been drifting away from exclusive preoccupation with the Oedipus complex—a development which might well be beyond anyone's observation at the time—to a more comprehensive theory of the causation of neuroses. It will be seen that, although the type of psychoneurosis that is dependent on early faults of psychological development may probably always remain the particular field of the specialist, nevertheless the family doctor can collaborate with him in providing bits of information that may give valuable hints on the nature of the early causes.

Sexual Factors

There is one type of situational problem which I have left for separate mention until now, and that is the sexual. In calling it situational I am of course not forgetting that its roots may extend far into the individual's past. It has long struck me as peculiar that practically no medical school in the country offers a course in sexual psychopathology to its students. I suppose it means that the parental attitude of the medical schools parallels the attitude of most parents in this country, in that it prefers to leave the young to find out for themselves. This is not a satisfactory position for a doctor, who as soon as he has qualified is regarded by the lay public as a repository of mysterious knowledge in this respect. It seems only fair to the doctor, and also to the public, that he should be provided with a modicum of information on the nature and cure of the most common group of maladies about which he is likely to be consulted.

The most frequent inquiries concern impotence, frigidity, masturbation, and homosexuality. It has been well said of impotence by Dr. Ernest Jones that it is either very easy or very difficult to cure, and there is every reason to suppose that many such cases can be, and probably many of them are, cured by a doctor who understands that their commonest causes are ignorance, fear, and misinterpretation of some previous experience. The deeper causes, often to be sought out only by the professed psychopathologist, are chiefly guilt-feelings and over-attachment to the mother. Similar factors, *mutatis mutandis*, are at the basis of frigidity. Homosexuality occasionally yields to superficial exploration and persuasion, but is more often a job for the specialist, who succeeds in curing only a minority of such cases. Difficulties of this sort naturally have ramifications in problems of domestic harmony. This may be the guise in which the thing first presents itself to the doctor; the other way is in the form of psychoneurotic symptoms elsewhere in the body, aches and pains generally, all of which are sometimes the direct result of sexual inadequacy or sexual dissatisfaction. But I imagine that a large proportion of doctors are shy of knowing these things about their patients and the patients are shy of telling their doctors, because it takes time to get down to a topic of that sort, and you cannot possibly broach it to someone who has only a short time to give you. It is nevertheless not true that the majority of nervous conditions, even in women, are the result of obvious sexual situations of this sort, but they do undoubtedly play a part in some of them.

Prognosis

The hysterical conditions, commonly so called—that is to say, the paralyses and sensory disturbances—can usually be cured fairly rapidly by persuasion, at any rate so far as the symptoms themselves are concerned; but, having done this, you may find in a number of cases that you are left with a state of psychoneurotic anxiety which replaces the headaches and what-not previously complained of.

It is my impression that one will only completely cure a hysteric if he has ceased to have a motive for his disability and merely wants to know how to recover without losing his self-respect. This accounts for some of the more dramatic cures of hysterical paralysis in the last war: few of these patients were expected to return to the front. Some, in peacetime conditions, you can cure even when the motive still exists, by showing them what that motive is. Other cases, more rare, depend on unconscious mental processes associated often with guilt-feelings such as only professional psychopathologists can hope to find and tackle.

As regards psychoneurotic anxiety states, some of which are called by the Freudians "anxiety hysteria," prognosis for the "situational" group is good as a rule; so also is the prognosis for those cases of this type which arise from faulty upbringing and the acquisition of wrong ideals, and so forth; but the cases that depend on historical factors in the unconscious await the advent of the skilled psychotherapist before much is likely to happen in them. In the two groups together the statistics in the Cassel Hospital collected by T. A. Ross showed a recovery or "much improved" rate of 76%. The data from the various psycho-analytic clinics recently collected by Knight showed a combined recovery rate of "cured" and "much improved" of 61% in approximately the same groups.

The trouble in assessing these results is the lack of satisfactory control groups, and there is no doubt that in some conditions a certain proportion of these people tend to get well themselves in the course of time. Any satisfactory investigation would require to distinguish not only loss of symptoms but durability of cure and its other features, such as the change in the social qualities of the patient concerned and the improvement in his general adaptation to life. Among cases of the obsessional or obsessive-compulsive variety the data are conflicting; I have no doubt that there are some cases which without special treatment would not improve at all or would improve very little, but it has to be remembered that here also there is a spontaneous recovery rate. I find statistics of this sort very unsatisfactory and the individual case much more convincing. Statistics should also take into account the duration of a treated case compared with one untreated. I believe that with treatment many psychoneurotic illnesses are shortened; and this, in fact, it would be fair to say—that psychoneurotic conditions are among the most curable of the chronic illnesses the doctor is called upon to treat.

Conclusion

There is an outstanding fact which should commend the practice of psychological medicine to the clinician—and the family doctor is first and foremost a clinician. It is this: that psychological medicine remains pre-eminently a field in which the clinical method, independent of the laboratory and the test-tube, is still the fundamental one. Even the most recondite psychiatric history—such as, for example, that which psychoanalysis involves—is essentially a clinical history of the patient. This history of the patient, which should be a history not only of his symptoms but of his life as an individual, is both a means of diagnosis and the foundation of treatment. For diagnosis, of course, one has to know as well the natural history of physical diseases, while to use the detailed history for the purpose of treatment requires a knowledge of the principles of psychological medicine. But these principles in what I have called the “situational,” and even in many of the historically determined conditions, are simple and can be applied successfully by anyone who cares to give his attention consistently to this aspect of his practice.

AN EPISODE OF “HOMOLOGOUS SERUM JAUNDICE”*

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The occurrence of jaundice in man after the administration of human blood products (plasma and serum) is now a well-recognized phenomenon, and a review of this “homologous serum jaundice” was recently published. The jaundice, which is of hepatic origin, is readily distinguished from the haemolytic icterus which may arise immediately after transfusion with incompatible blood or out-of-date stored blood. Clinically it is similar to, if not indistinguishable from, epidemic hepatitis (catarrhal jaundice), but the incubation period is unusually long—commonly from 2 to 3 months, in contradistinction to the 20- to 40-day period believed to occur in epidemic hepatitis.

A high incidence (57%) of this jaundice has been observed among 71 subjects during the course of an investigation into allergic reactions to human serum. All these subjects received pooled human serum from a single batch (No. 034); a few of them received in addition whole blood or serum from other batches. Batch 034 was, however, the only common factor, and was clearly incriminated as being icterogenic. Subsequently, icterogenicity was confirmed by the results of the deliberate

administration of batch 034 to four volunteer cases of rheumatoid arthritis in which it was desired to produce jaundice for therapeutic reasons.

From this experience it is possible to draw certain conclusions concerning the routes of administration and the effective dosage of icterogenic material: some of the findings are therefore reported.

Materials Used

No. 034 was a routine batch of dried serum issued by the Medical Research Council Drying Unit. It had been prepared from 106 litres of pooled, filtered human serum collected in late April, 1943, from donors in the London area. Sterility tests before and after filtration were negative, and the batch was issued in units (bottles) each equivalent to 400 c.cm. of liquid serum. The units were numbered 1 to 250: Nos. 84 to 146 were received by this depot as its quota of the batch and were reserved for purposes of investigation.

The other batches of serum also administered to some of the subjects were:

(a) *Batch 045*.—This was another routine batch of dried human serum issued by the Medical Research Council Drying Unit, and was prepared from 177 litres of serum from donors in the London area and East Sussex. It was collected in early June, 1943, and sterility tests before and after filtration were negative. Nos. 1 to 102 were received at this depot.

(b) *Pool 0*.—This was a small pool of serum prepared locally and, after Seitz filtration, kept frozen until used.

Any bottle of batches 034 and 045 was assumed to be of identical composition with any other bottle in the same batch.

Methods of Administration

Intradermal Tests.—Several bottles of batch 034 dried serum were reconstituted to normal strength with 400 c.cm. of sterile distilled water taken at random from stocks prepared at this depot. The resultant liquid was partitioned in 2-c.cm. aliquots into sterile test-tubes and kept frozen at 5° F. till required. It was used on numerous days, on each of which one or more tubes were thawed out and a sterile tuberculin syringe was charged with the fluid. Any unused fluid remaining in an opened tube was discarded at the end of the day. The same syringe and needle might be employed for several tests on the same day without sterilization between tests, but after each day's use the syringe was cleaned in chromic acid and resterilized. Needles were thoroughly rinsed with water and resterilized daily. Sterilization was by dry heat (160° C. for 2 hours).

For the intradermal test two intracutaneous injections of the reconstituted serum, each of 0.05 c.cm., were made into the skin of the back in parallel with extracts of dust, pollen, animal hair, etc., and carbol saline.

Transfusions.—A bottle of dried serum was reconstituted to 400 c.cm. as above or, in the case of pool 0, the serum was thawed out. Each transfusion was administered in approximately 30 minutes. This applied to all except the four transfusions given to rheumatoid arthritis patients, who each received 50 c.cm. of reconstituted dried serum (batch 034) added to 450 c.cm. of a group O concentrated red cell suspension.

Cases

Group 1.—47 subjects received intradermal skin tests on one to three occasions with batch 034 only. 25 of the 47 were allergic subjects (hay-fever, bronchial asthma, etc.).

Group 2.—9 subjects received intradermal skin tests and serum transfusions on one to three occasions with batch 034 only. 7 of these were allergic subjects.

Group 3.—19 subjects received skin tests or transfusions, or both, with batch 034, and, in addition, tests or transfusions with other human material (pool 0, batch 045, concentrated red cells). Of these, 7 were allergic subjects, 8 were non-allergic controls, and 4 were the cases of rheumatoid arthritis.

Results

All except two subjects who could not be traced were followed up for at least 150 days after exposure. The results

* A report to the Medical Research Council from the S.W. London Blood Supply Depot.