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THE GENERAL PRACTITIONER AND MENTAL CONDITIONS*

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Those who qualified in medicine before the war had, it is quite certain, very little training in the subject of mental disorders as part of their undergraduate work. A few visits to a mental hospital, with certain more or less amusing observations of peculiar patients, was the sum of the training of many people in psychological medicine.

The whole subject has been much more to the fore, and has become more interesting, since the war. The post-war generation in medicine has consequently been somewhat more fortunate in the matter of instruction, though even at the present day there is no medical school in this country which provides adequate teaching on the mental illnesses which are to form so large a part of the practice of the student when he is qualified. We must look forward hopefully to the suggestions for revision of the medical curriculum which are soon to be presented and trust that psychological medicine will be given the emphasis it deserves in the future training of students.

Recently, in the daily press, some prominence was given to a statement that the working days lost, per insured person, in industry, owing to neurotic illnesses, had increased by over one-third in the past six years. It would be a mistake to assume that that increase is due to a true increase of mental illness; the explanation is surely to be found in the growing interest and the better diagnosis of these conditions that obtains to-day.

Incidence of Mental Illness

Everyone in general practice has to deal with a small sample of the whole population, and in consequence the mental illnesses which he meets must be approximately proportionate to the total mental illness of the country. In England and Wales it is probable that there are about 300,000 persons who are mentally defective, only a small section of whom are under care. There are just under 150,000 persons under care at the present time suffering from psychotic illnesses. If these two groups of the more serious mental disorders be added together we may make a generous estimate and say that the group consists of half a million people, or that 1 in 80 of the whole population suffers in one or other of these ways. It is, however, worth noting that only 1 in 266 of the population has to be under care for what is usually called insanity. The third, and by far the most important group from the point of view of the general practitioner, and for the community itself, is the group of psychoneurotic patients—those who suffer from minor mental disorders. There are probably about six times as many of these patients as there are in the other two groups put together, and every practitioner who makes a careful diagnostic survey of his practice realizes the high pro-

portion of illness which is due to emotional or neurotic causes. Dr. James L. Halliday's work, recently published in the *Supplement* of the *British Medical Journal* (March 9th and 16th, 1935), is the first bit of clear statistical proof that we have had of the incidence of neuroses among those who are drawing sickness pay under the national health insurance scheme. His very conservative figure shows that 33.5 per cent. of the patients referred to him as a regional medical officer were in fact suffering in this way.

Minor Degrees of Mental Defect

The mentally defective patients who come under your care, if their defect be at all serious, may seem to present a hopeless problem. Certainly it is your responsibility to help the relatives to face and accept the truth of the situation and the fact that there is no method of treatment known to science by which an intellectual deficiency can be repaired. Education and care of the right sort can do a very great deal for any defective person, and it is important for the future of a seriously retarded child that he should be given the chance of proper environment and training. Recognition of the lesser degrees of mental defect is most important; we should make greater use of intelligence tests, by which alone we can accurately assess the degree of backwardness. So many children at school might be saved from unnecessary anxiety and strain if it were realized that their intellectual level was actually rather too low to permit of their coming up to the ordinary educational standards of the school. The average intelligence quotient of the public schools is said to be about 120, whereas the average for the whole population is 100. Boys and girls whose intelligence is too low for their particular educational environment should not have to be subjected to the carping disappointment of pedagogues or the undue pleading and pressure of home, which must produce a sense of inferiority and a lack of confidence, if nothing worse.

The Psychoses

The psychotic or insane patient is always a problem in general practice. Once the condition has developed it is not hard to recognize a delusional state, a serious degree of melancholia, or a senile dementia. It is, however, far more difficult to diagnose in their early stages conditions of cyclothymia or manic-depressive psychosis, or schizophrenia with its protean manifestations. The incipient stages of a melancholia, that all too often leads to suicide, are often extremely difficult to diagnose and to differentiate from the depression of an anxiety state. Depression as a symptom is always to be regarded seriously.

What can be done in general practice for the insane patient? Where he is a danger to himself or to other people certification can certainly be undertaken, unless the patient himself is willing to become a voluntary

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patient in an institution. The Mental Treatment Act of 1930 made it possible for voluntary patients to be admitted to public mental hospitals, and that facility has been made magnificent use of in many areas. The voluntary patient is to be encouraged every time; his morale and his chances of recovery are certainly likely to be better than that of the patient who has to be certified and taken to hospital against his will. The number of patients who, incapable of volition, can be temporarily certified under the regulations of the Mental Treatment Act is comparatively small, but that possibility must not be lost sight of.

In all our dealings with insane patients and their relations we should be careful to emphasize that institutional treatment is more a matter of therapeutics than of convenience. Mental hospitals increasingly merit the dropping of the old name of asylum. It is, however, well to insist that every insane person should have from his own practitioner, in the first place, the chance of thorough investigation and treatment before the stage of hospitalization is reached. Detoxication will, in a few cases, produce quite startling improvement.

An instance of this is a case of a woman patient with a very serious mental breakdown, who had been actively suicidal, had starved herself, and was definitely deluded. There were certain obvious emotional factors which had helped to produce the breakdown, and these were discussed with her, but no sort of impression was made on the condition. A careful physical investigation had given no indications of abnormality. The patient then developed tonsillitis, and an aural surgeon discovered deep tonsils which had previously been hidden from ordinary investigation; they were removed and found to contain small abscesses. From that time the patient's condition improved rapidly, she became a normal person, was decertified three months later, and has continued perfectly well for a number of years.

It is certainly the responsibility of the general practitioner to be sure that nothing which he can do for a psychotic patient on the physical side, or with the simpler psychotherapeutic and environmental measures, is left undone.

Psychoneurotic Conditions

It is, however, the psychoneurotic patients in his practice who concern (and often vex) the general practitioner most. The old use of the word "neurasthenia" to describe all these conditions is incorrect and distinctly misleading; it also hampers any attempt at treatment. The psychoneurotic conditions fall into certain fairly clear groups. Anxiety states constitute nearly 50 per cent. of the whole number. The next group in importance is hysteria, and by that is meant a condition in which anxiety has been converted into some physical symptom—gastro-intestinal disturbance, headache, paresis of a limb, a stammer, or whatever else it may be; this group provides about 12 per cent. of the total. Following closely on this about 11 per cent. of the psychoneuroses can be classified as belonging to the obsessional group. The obsessive-compulsive neuroses are among the most difficult to treat, for in every case the origin of the condition has to be sought far back in life, and sometimes it appears almost as if there were a constitutional basis for these conditions. Neurasthenia, as a term, should be kept for the exhaustion states, generally associated with low blood pressure. In part it is to be explained and to be treated physiologically. In our work at the Institute of Medical Psychology we find that only 2 per cent. of the total of patients come under this heading.

Disorders of Personality and Conduct

In addition to these fairly definite diagnostic groups, there is the much vaguer classification of the "personality and conduct disorders." Many of the sexual difficulties,

such as impotence, dyspareunia, and vaginismus, can be included under the headings of anxiety states or conversion hysteria, but there are a great number of other sexual abnormalities which come into this last group. Those commonly met with in general practice are the anxieties about sex, most often due to ignorance, which frequently lead to incompatibility, sexual inversion, and the various forms of perversion. All of these should receive our interest, and in their early stages they are certainly within the scope of the general practitioner to handle, provided that he knows something about them and is interested in their pathology and treatment. Delinquent conduct, whether in the nursery, the school, or the courts, is evidence of precisely the same quality of mental maladjustment as is responsible for the more obvious psychoneuroses, and the general practitioner should be able to advise and to give treatment for the majority of these conditions.

In addition to these more clearly marked groups, we constantly meet conditions in which "so-called mental" and "so-called physical" factors are combined. Anxiety states are partially responsible for a high proportion of cases of asthma and hyperthyroidism, as well as gastro-intestinal and cardiac disabilities. These are merely indications of the many conditions known to us all in which our campaign must include treatment of the mind as well of the body.

Need for a Change of Attitude

As one outlines, thus briefly, the extent to which emotional or mental illnesses are responsible for the total sickness and invalidism of the population, it becomes increasingly clear that the general practitioner has enormous scope for his activities in dealing with them; so much can, and should, be done by him. The specialist in psychological medicine should only have to come into the picture as often as the surgeon does in other types of illness. There is, however, very often need for a real change in our attitude, *au fond*, to these illnesses. There is no such thing as imaginary illness; we must attempt to give constructive advice, and not be sadistic to our patients because we fail to understand them; and we must help them to get away from the conception of a fearsome and untreatable disorder that is conveyed by the old misnomer "nerves."

We all of us, at times, make neurotic reactions. We forget things that we don't want to remember; we all have exaggerated some minor disability as a defence against doing things that we wish to avoid; everyone has at times been delinquent, self-pitying, and self-indulgent. Neurosis is a question of degree and opportunity. We cannot, and we must not, use the word *neurotic* as a reproach or have any feeling of superiority to those who suffer from this type of dysfunction. It is very fundamental that there should be, to start with, this more friendly, understanding, and interested attitude towards the psychoneuroses; without it we shall not as a rule have a chance of meeting these conditions in their earliest and most helpable stages.

Hints on Rational Treatment

Physical treatment, by the removal of toxæmia, by the occasional administration of endocrine products, by the relief of fatigue through rest, and by the diminution of anxiety with sedatives, can be of value. It is often possible, in the early stages of a neurotic condition, to rearrange the patient's life so that he readjusts himself. It is, however, a mistake to go on, for example, repeating the prescription of a holiday. Something more definite is needed for the patient who cannot get back on to his feet as the result of rest, and we must look for the pathology of the condition. For every psychoneurotic

state there is a cause, as certainly as for every physical illness. Warpings and distortions of development in childhood, early traumatic experiences, and conflicts between instinctive desires and conscious standards may be said to provide the original basis of most neuroses.

We may be able to use suggestion to remove symptoms, but much more often it is necessary to spend time in combining some analysis of the patient's emotional difficulties with re-education if treatment is to be effective. In a number of conditions, and particularly for those which have existed for a long time, more definite and skilful analysis will probably be necessary. Certain cases, particularly the obsessive-compulsive neuroses, will probably need the help of the specialist, if for no other reason than that a very great amount of time is necessary for treatment.

Between 55 and 65 per cent. of the patients who are treated by systematic psychotherapy can be permanently relieved or cured. It would seem right to be hopeful, therefore, that by early recognition and early treatment in their home surroundings, an even higher proportion of patients might be straightened out, and that the more serious conditions should be capable of being prevented.

The general practitioner who is willing to spend some extra time in letting his patient talk, perhaps directing that talk by questions, rather than holding the floor himself and giving advice and reassurance, is likely to do more for the patient. The talkative neurotic, who has been referred to so often, is usually the person whose efforts at self-explanation have been cut short repeatedly. To talk to an interested and healthily critical listener is in itself a therapeutic procedure which induces some small clarity of thought. Our responsibility is always to help the patient to realize for himself where he has gone wrong, rather than to try and tell him, even though we may ourselves see it quite clearly.

Specialized Psychotherapy

Specialized psychotherapy involves the expenditure of perhaps twenty hours on each patient when the time is averaged out over the whole group; some will need hundreds of hours of work, but equally it is true that many can be helped by just a few hours of friendly investigation and encouragement. To help a man recognize, for instance, that all his life he has been over-attached emotionally to his mother and, in consequence, too cautious, too safe, and not sufficiently independent or self-assertive, may very often give him the clue to the changes which he needs to bring about in himself, and so his impotence may be solved or his fears of responsibility and failure may be lessened or even completely cleared up. If we can let people talk about their sexual difficulties, and their sexual ignorance, and if we can give them a sane and truthful outlook on sex and its function in life, we shall do much to relieve their fears and strains. It is astonishing how, in these days, when sex is talked and written about almost *ad nauseam*, people are still fundamentally ignorant and frightened of the whole subject; this is especially true, of course, of the problems associated with masturbation and its supposed consequences. As a profession, we have much need to understand and think about these problems of sex and sexuality, because we certainly were not ourselves taught about them in our training for medicine.

The less we know about any branch of our profession the more it is likely to bore us. That certainly has in the past been true of mental illness. The increase in knowledge about these conditions, in the past twenty years, has made it clear that there is in fact no part of our work more full of interest or more rewarding in the way of the results that can be achieved.

AETIOLOGY OF CANCER OF THE SKIN

WITH SPECIAL REFERENCE TO OCCUPATION

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Occupation as a factor in the causation of epitheliomata of the skin has been recognized for some years past. In 1775 Percivall Pott described the occurrence of cancer of the scrotum in chimney-sweeps in the following terms:

"It is a disease which always makes its first appearance in the inferior part of the scrotum, where it produces a superficial, painful, ragged, ill-looking ulcer, with hard and rising edges; the trade call it the 'soot wart.'"

In 1875 Volkmann observed the occurrence of epithelioma scroti in workers employed in the distillation of paraffin oil from lignite. At the same time epitheliomata were observed among oil refiners in the shale oil industry in Scotland, and since that time various cases have been reported in the literature of several countries. In 1922 Southam and Wilson published the result of their investigation at the Manchester Royal Infirmary, where they found that, out of 141 patients suffering from cancer of the scrotum, sixty-nine were mule-spinners.

A Royal Commission was appointed in 1925

"to consider evidence at present available as to the occurrence of epitheliomatous ulceration among mule-spinners (mule-spinners' cancer), and to report what measures are practicable for the protection of the workers and what regulations (if any) are required."

It reported as follows:

"On the analogy of mule-spinners' cancer with other forms of occupational cancer (tar workers, patent fuel manufacturers, paraffin workers, chimney-sweeps, etc.), by the evidence of the occurrence of cancer in petroleum refiners, from the results of deliberate experiments with mineral oils, by our knowledge of the conditions under which mule operatives are exposed to the action of such oils, and by the general consensus of opinion expressed by the medical witnesses who appeared before us, we feel bound to come to the conclusion that the evidence is strongly in favour of this disease being due to the prolonged action of mineral oils."

This report has come to be interpreted as proving that epithelioma of the skin, in whatever situation it occurs, in any worker in a mill is occupational in origin and due to the oil used in the work. In addition, medical literature has been so inundated with reports of such cases that an entirely erroneous idea of the relative frequency of this disease in the spinning industry has been given.

Cancer of the skin occurs in two main forms: the squamous-celled tumour, usually termed epithelioma, and the basal-celled type, or rodent ulcer. Hitherto investigation has, however, been confined to the squamous type only, but it would be of more value to include also the less malignant, but commoner, basal type in any statistical survey.

These figures were compiled from the records of patients attending the Manchester and Salford Skin Hospital, which caters for a large and extensive industrial area, and should, therefore, be some index of the incidence of this disease in industry, especially in the cotton trade. All the patients have been examined by me personally, and in any case in which the diagnosis has been at all uncertain it has been confirmed by biopsy. Inquiries have been made into the whole working life of each patient, with particulars of any possible exposure to irritants, whether these be known carcinogenic substances or not.