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ON

THE PSYCHOLOGICAL INTEREST IN GENERAL PRACTICE*

BY

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No one, I hope, will dispute that when there is physical disorder there is always some psychical, and that when there is psychical disorder there is always some physical. This is the true sense of the aphorism, *Mens sana in corpore sano*, which, in this country, is usually taken to mean that mental health is to be procured by middle-aged men playing ball games. Certainly in some cases what is called the physical predominates; or, rather, it is the physical that arrests our attention. We then speak of "organic" disease. In other cases the psychical no less obviously predominates or attracts: we then say that the patient is "mental" or "psychotic."

But there is a vast group of cases concerning which many doctors find themselves in difficulties: in these, psychical and physical disorder are apparently so nicely balanced that it seems impossible to force them into either of the beloved categories. In this group we find the migrainous and the vertiginous, the sufferers with mucous colitis, the asthmatics, the hysterical dyspareunics, the aerophagics, and the subjects of extrasystoles and palpitation. In these, physical shortcomings and distress are generally combined with psychical disorder, as well as with physiological unrighteousness: the migrainous man has astigmatism and practises coitus interruptus; the vertiginous man has some middle-ear catarrh and smokes too much, as well as being in fear of falling, physically and morally; the dyspareunic woman has a misplaced uterus and a husband whom she hates; the aerophagic doctor bolts his meals, is in debt, and has a flabby abdomen; while the subject of extrasystoles and palpitation drinks too much tea, has a congenitally poor heart, and masturbates.

Too often such persons as these are dismissed from our serious attention, being consigned to the limbo of the so-called "functional"—if no surgeon can be found who will operate upon them for something or other! But to call a man or woman a "functional case" does not help anyone very much, unless it be the doctor, who is enabled thereby to conceal his lack of clarity in thought and his bankruptcy in therapeutics, at the same time that he justifies the continued prescription of bromides and luminal.

If these so-called "functional cases" are the despair of the thoughtful practitioner they are the joy of the charlatan, and, often enough, are "cured" by New Thought, Christian Science, osteopathy, and the like. It is principally to them that I would crave your attention to-night, for it is in them that the psychological interest in general practice chiefly abides.

Now it is a study of these "functional" cases that gives us the key to what I will call the rational human study of disease: for it teaches us that we must not divide our patients into two, or even three, hard-and-fast classes—the organic, the functional, and the mental—but that we must always investigate the *individual*, from every aspect, without reference to obsolete and misleading academic distinctions.

These so-called "functional" cases teach us, however, something more. They teach us that, if the patient be

confirmed in his psychological or physiological sins, such organic disease may ultimately develop as only the surgeon—if even he—may remove. This, on which I am anxious to insist, is fundamental, I maintain, if we really wish to understand the beginnings of disease. I do not wish for one moment to underrate the influence of extrinsic factors in bringing about organic disease, but we should never assume, in respect of any case, that there was never a time in which organic change might have been averted if only right functional adjustment had been secured. Cowper put the situation admirably when he wrote:

"Faults in the life breed errors in the brain;
And these, reciprocally, those again."

The poet's lines have really a far wider field of application than he contemplated when he wrote them. For if we inquire how organic changes can possibly be brought about in consequence of conscious or unconscious psychical states we find a link in the sympathetic and parasympathetic systems, their cerebral and spinal connexions, and their control of those vasomotor, secretory, and muscular mechanisms that do undoubtedly lie behind disease processes, whatever be the parts played by micro-organisms or exogenous toxins.

But the play and interplay between what some call mind and body, and others psyche and soma, are so inextricably combined that it becomes wise, and more convenient, the further we pursue our studies, to abandon the theological or metaphysical distinction and to content ourselves with studying the *individual*, in a fashion that I am anxious to discuss with you to-night.

It is, indeed, only when the practitioner leaves resolutely on one side all outworn academical distinctions, and observes what happens, that he begins to be truly a physician, and comes to appreciate the wealth of interest that there is for him in the complete investigation of every patient.

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I now come to a point that is not too willingly conceded by some of our most eminent teachers in the elementary medical schools. It may, perhaps, be otherwise at our new post-graduate school. We shall see!

The practice of our art is, very largely, guided by the views we hold concerning the nature of disease, and these are derived from our attitude towards certain metaphysical and philosophical problems. Time was when doctors of physic studied philosophy, and then systems of medicine were logically justifiable. Nowadays we do not systematically study the foundations of knowledge and belief, and we ignore logic; nevertheless, medical doctrine is always based on belief, and many of our so-called advances are not so much actual discoveries as expressions of a change of attitude towards the fundamental problems of life. Considerations of this sort may not seem very relevant to such questions as, for example, whether a leg should be amputated by a circular or a flap method, and so forth, but become of extreme importance when we have to decide whether or no a patient with "colitis" should be treated by appendicostomy or psychotherapy. One man will call for thyroidectomy at the very onset of what he diagnoses as Graves's disease; his colleague will inquire about what the patient is frightened and, in particular, will examine the sexual complexes. And so on. Put otherwise: the man who does not believe in the supremacy of mind over matter will "go for" material remedies, but he who believes in that supremacy will have something to say in favour of psychotherapy.

In further illustration of my point, let me remind you that in the East disease is generally regarded as the result of the abstraction of something spiritual from the body.

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Western races, on the whole, consider disease to be the expression of something added. In bygone centuries this was very frequently a demon. To-day, this "something added" is often a toxin that no chemist can identify, a filter-passer that no microscopist can see. But when a patient is constipated a dose of castor oil is efficacious, whether we give it to expel a demon or to eliminate a poison!

Now although we no longer believe in demons, official views concerning disease are still of a peculiar order. "A" disease is (officially) something real—an objective entity: different diseases are spoken of as different kinds of natural objects that can be studied in the same way as lions and tigers, postage stamps and coins, Conservatives and Socialists. This sort of talk, once current in science, when laws were supposed to govern the universe, and forces like gravity to keep the heavenly bodies in place, is now obsolete, save only in medicine and in theology; for those who are interested in modern psychology it has little value. This is why in the schools, where science is still firmly embedded in mediaeval metaphysics, there is no clear teaching in respect of the psychological interest. One cannot accept the results of modern psychotherapeutics so long as one believes that the only disease worth bothering about is something that "attacks" the patient, that makes a noise like a murmur, and that can be seen on a plate after death! Those who think thus consider psychotherapy a special method that has nothing to do with really respectable medicine, but which may be employed, like ultra-violet rays or a change of air, for "those wretched cases which have nothing organic the matter with them."

Now, roughly speaking, there are three sets of metaphysical views which may be said to obtain in medicine. And each corresponds to definite views in respect of health and disease, moulding in respect of treatment the attitude of those holding it.

We have, in the first place, those who may be called materialists. Materialists—I am only speaking in the simplest terms—seek to explain the world as composed of one kind of stuff only: that which they call *matter* and which *moves*. The phenomena of *mind* are, for these people, produced by physical and chemical changes in the nervous system: consciousness is a product or function of protoplasm and nothing more. Doctors who think thus come to believe that in disease what is really important is disturbance in fine or gross structure of the tissues or organs; and so, when they meet with "functional" cases, pass by them "on the other side" as did the Levite and the priest pass by the man "who fell among thieves." That is, if they do not take a hand in the spoliation themselves! For, oddly enough, those who affect to despise the "purely functional" case have a firm belief that derangement of function is really the outcome of organic disease, if the patient be wealthy! And so countless operations are performed, and countless treatments are carried through without avail, on patients who *could* be successfully treated by psychotherapy. Sometimes the result of surgical treatment appears successful, it is true; but the method is that of burning down the house to cook the pork chops, or of removing the tongue to cure the use of bad grammar, or of disconnecting the telephone to stop it ringing. For visceral or vasomotor disturbance may be, and often is, as much an expression of emotion as is crying or sweating.

Our second class of medical metaphysicians believe that all we call material in this world is but an aspect, or consequence, of mental perspective, and that mind, or spirit, is the ultimate or only reality. Those who apply such views to the subject of healing, or who derive their practice from such views, comprise not only the

spiritualists (true and false) and the Christian Scientists, but many psychotherapeutical practitioners. They declare that if all is well with the mind, soul, or spirit, all will be well with the body. It is idle to deny that many who think thus, and rule their lives accordingly, do adjust well to their environments, and do escape many of those troublesome "functional" disorders that vex those who seek to allay an uneasy conscience by blue lights or pink pills. It is idle to deny that spiritual experiences of one kind or another do rid life-long invalids, hypochondriacs, and neurotics of troubles for which they have suffered much at the hands of many physicians. I am not even inclined to deny that sometimes what a pathologist would call a case of organic disease may be "cured" by what we call psychological change. It is not good enough—to use a vulgarism—to say that, *because* a case is cured after a visit to Lourdes, it was never a case of organic disease. To speak thus is to beg the whole question. Let me put it in this way. When an unexpectedly good result is obtained after the administration of a simple drug in a confirmed and seemingly hopeless case many surgeons will say: "Oh, yes! But was it not the effect of suggestion?" Perhaps, but the "case" recovered. To say "suggestion" *explains* nothing. We might, with greater justification say "suggestion" when a laparotomy is performed successfully on a hysterical patient. When employing "physical" means we can never exclude a "psychical" effect, and, conversely, we can never exclude a "physical" effect when employing "psychical" means.

If we give an enema we are working on a low physical level; but we admit a psychical effect as possible. If I say "Abracadabra" three times over, most people would say that I am only employing psychical means, and can therefore only hope for a psychical effect. Yet I am physically stimulating the auditory tract and its connexions, just as definitely as does my friend who gives an enema stimulate the rectum and its sympathetic connexions. As between materialists and spiritualists, it seems to be almost six of one and half a dozen of the other. This is, perhaps, why the metaphysical doctrine most popular among doctors is that of psychophysical parallelism, derived from the two-clock notion of Leibnitz. This means that each physiological "nervous" process has a concomitant psychological process as counterpart, and vice versa. The parallelism may be restricted, as many restrict it, to the higher parts of the brain, or may be applied to the whole of the nervous system, in which case we postulate unconscious psychical processes accompanying the physical nervous states of the spinal cord or nerves.

Now this third doctrine, which supposes "mind" and "brain" to work in "harmony," has a rather subtle practical value. Postulating that neither the one nor the other process has the upper hand, and that we cannot explain the connexion between the two, it allows us to say that it is sometimes more convenient to tackle what we call the physical series—to rub in mercury in order that a gumma absorb—and sometimes better to tackle what we call the psychical—to employ suggestion or psycho-analysis. This kind of facing-both-ways leads one kind of case to be treated by drugs or surgery, while another is sent to the asylum or the psycho-analyst. But the "functional cases" again tend to fall between two stools. This is the grave fault in the neurology of Hughlings Jackson and his pupils. (It was an eminent neurologist of this school who recently said that, though he did not understand "functional cases," he earned his living from them!)

A quite different point of view is now assuming importance. Those who adopt this regard mind and matter

as different names given to different aspects of the *individual*, and prefer to make no such "real" distinction between them as is made by others.

It is this view which I commend to you, and on which I advise you to base your practice and your theory.

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If we now turn to what are called practical details, we find that the method derived from this special view is not only found very useful in respect of asthmatic, migrainous, vertiginous, neuralgic, and "functional" cardiac and dyspeptic patients, as well as of mucous colitis cases, sexual sufferers, prostatic cases, and anxiety, compulsive, and hysterical neurotics—in fact, of the whole gamut of the nervous patients—but is also strikingly valuable in dealing with many of what we usually consider "organic" cases.

This is the method. We must, in the first place, institute a complete physical examination, appraising not only type, not only morphological change, but any disorder of function present. While the ordinary clinical investigation is comprehended in this, something more is required. The physician must pay attention, not merely to the so-called signs of disease, but to the presence of what we call organ-inferiority. He will find, for example, that migrainous and neuralgic persons have usually some ocular or facial asymmetry, or other defect; that asthmatics have imperfectly developed nares, epiglottides, and larynges, and, if we dissect them, not only poor chests, but lungs that are imperfectly developed *qua* lobes. Tinnitus and vertigo patients have often poor external ears; our dyspeptics, dilated or ptotic stomachs; cardiac neurotics, small and pendent, or large and pushed-up hearts; hypochondriacs and "colitis cases" may have long mesenteries, mobile colons, mobile kidneys, and the like. Sexual neurotics may have small or misplaced uteri, varicoceles, phimoses, pendant scrotums, and so on. Spinal and other neurasthenics have rudimentary spinae bifidae, and sometimes a tendency to pes cavus and hammer-toe—because the terminal spine is imperfectly developed. Nay, even our rheumatoid and arthritic patients are found to have digits and limbs with which there is something wrong from the point of view of the sculptor, just as do many insane patients exhibit the most extraordinary skin peculiarities—strong presumptive evidence that the epiblast from which the neural tissues are formed is not what it should be. Now these organ-inferiorities (as Adler has called them) which we notice in the neurotic and the psychoneurotic, are of significance either in connexion with the organs that work badly—as are the small penis and long prepuce of the boy who wets his bed—or as inferential evidence of other organ defects—as when the external ear is malformed in a tinnitus patient—or suggest a widespread deficiency, as do the segmentally distributed skin defects found in association with neurasthenia. In the same way many women with a "neurotic abdomen" have a fissured tongue, so that we can postulate a Meckel's diverticulum or something of that sort, while a neurasthenic miner with lumbago has probably a sacralized fifth lumbar vertebra that has been jarred.

Now we have come to learn of late years that constitutional or local organ or tissue-inferiority often enough affords a peg to which may be transferred an affect, or *feeling*, that rightly pertains to something quite else. The actress with astigmatism who desires not to appear on a certain occasion (because she fears her psychical nose will be out of joint) develops a headache (due to eye-strain, she says her doctor says) that gives her an excuse, while satisfying her unacknowledged and unacknowledgeable desire to vindicate her own importance.

We may give her glasses, but her headaches will continue on suitable occasions. Our war experiences help us to understand this. The shell-shocked man with "cold feet," who durst not acknowledge his cowardice, became deaf if he had a perforated drum, blind if he had astigmatism or squint, paralysed in his legs if he had spinal inferiority with hammer-toes, and wetted the bed if he had a varicocele and a long foreskin. So it is the woman who dislikes her husband who, with a retroflexed uterus or a prolapsed ovary, suffers dyspareunia. She has no dyspareunia with her lover. Where there is a will not to do there is always a way of escape from doing what should be done and what we know ought to be done. *The twin doctrines of organ-jargon and organ-inferiority help us to understand the meaning and purpose of neurotic illness.*

But this is going too fast. Having completed the so-called physical examination we still have much to learn about the individual. We need to know his aim in life, his life-plan, his feelings, emotions, habits—his answer in a word, to the demands of life. How are we to acquire this knowledge, and what system are we to use as a guide to the examination of what is called the mind? The old unhelpful psychology, based on introspection by intelligent, normal, and cultivated persons, was governed by the assumption that the mind, like the brain and spinal cord, responds to stimulus in a predetermined sort of way. This was of little use in dealing with psychoneurotics! *Mais nous avons changé tout cela.* The new psychology, based largely upon study of the neurotic, requires and implies a different outlook. Now there are several schools of those who profess the new psychology; but by far the most helpful to the general practitioner is that of Adler, that of Individual Psychology, and it is in terms of this that I have already spoken.

Our first business is to examine the response—that is to say, the behaviour—of the patient, and then to work back, seeking, not for the sort of stimulus that would or should make what we think a "normal" person so act, but for the tendency, the purpose, that *our* patient is seeking to gratify by his, to us, odd behaviour. Thus a busy man complains of strange cardiac sensations, and tells us his wife is irritable. We, simple souls, would once have told him that he was overworked and advised him to take his wife for a week-end to Brighton. Nowadays we find that he is afraid of not carrying through successfully some business enterprise, and so seeks an excuse in the state of his heart for abandoning it. Moreover, he has just spent a surreptitious week-end at Boulogne, and is trying to justify his marital infidelity by finding such fault with his wife as will reconcile his conscience to the acts of which he is ashamed. Probably, too, he left his fountain pen behind him at the hotel, and thinks his memory is failing! But we do not stop at such explanations as these.

Three psychological categories have to be taken into account if we would understand fully the "neurotic" or "functional" patient. There is, in the first place, the acknowledged, or unacknowledged, conflict or perplexity that is apparently unsettling the patient's mind—the present problem, that is. I say "apparently," because we believe that even the hesitation, the doubt, is useful to the patient, and expresses his purpose. Secondly, there is a guiding tendency or life-style, or goal, for which satisfaction is somehow sought in every situation that arises. Thirdly, there is the early life-history, explaining for us why the life-line is as it is, and helping us to understand the circumstances under which it was first adopted. When we have learned all this we form to ourselves a picture of the way in which the patient is facing the three demands of life: those of subsistence, society, and sex. And why? Then only do we know the individual.

Now Adler finds the desire to assert superiority, to gain one's own ends, to attain compensation for real or fancied inferiority, the great motive which receives gratification in neurosis. Goal attainment is the explanation of life conduct: and, for the neurotic, one frequent goal is the avoidance of social duty and obligation at the expense of others and to his own advantage.

There are other theories and techniques, as you know. There is that of Freud, and there is that of Jung. And there is, at present, a great deal of washy and spineless eclecticism that degenerates into clinical opportunism, if not humbug. But for the general practitioner, whether in relation to the class of case we are chiefly discussing or any other, it is the technique and the theory of Adler—the theory and practice of Individual Psychology—that gives the best results.

I cannot to-night attempt even an outline of Individual Psychology, but it is clear that it demands, on the part of the physician, something more than acquaintance with medicine as taught in the schools. Unless there is a pretty wide knowledge of human types, of life-situations, of trends of thought, and of human nature in all its aspects, psychological appreciation is impossible. The wider our own experiences, the greater our knowledge of the human heart and mind as dissected in art and literature; and the fuller our acquaintance with the views held in respect of religious and philosophical, as well as of ethical, problems, the more successful our efforts. Perhaps that is the meaning of the maxim that at 50 one is either a fool or a physician!

The point I stress is that for each neurotic there is not only some immediate problem which is not being decided, and in respect of which there is an apparent conflict, an attempted compromise, or some abortive repression into the limbo of the unconscious, some putting away of what is unpleasant or unwelcome, but there is a special attitude towards life in general which is adopted in face of almost every problem, whether in connexion with the family, the school, the opposite sex, society, one's profession, and religious or irreligious inclinations. This attitude, however coloured, is generally one of indecision, of irresolution, of procrastination and evasion, so that practical adjustment is never made, and compensations for what is denied, satisfactions which are not openly claimed, excuses for what shames, insurances for what is feared—in fact, a whole cloud of "mechanisms" and arrangements are set up. The child complains of stomach-ache when, for some reason of which he guards the secret, he does not want to go to school!

Now while the first object of our inquiry is to lay bare all such mechanisms and arrangements that lie behind the manifest symptoms of which the patient complains, the second is that, after the picture has been made clear to the doctor, the patient himself may come to understand the reason for his or her behaviour in this or that fashion, on this or that occasion. Then the patient assumes conscious control of the disturbing factors and, if the demand is rightly met, well-being returns, all being done that rightly can be done by medicines, by physical agents, or what not, to assist the control by the individual of those disordered visceral functions which have led to advice-being sought.

I would like now to exemplify in some measure what I have suggested in respect of the emotional or affective and purposive aspect of certain neurotic disorders. The man or woman who complains of migraine or of trigeminal neuralgia is, I think, without exception placed in some situation that gives rise to an unexpressed or unrecognized emotion of "rage and humiliation." The vertiginous neurotic is one who has constantly with him the fear of falling—morally, socially, or financially. Patients with

tinnitus are generally those who refuse to listen to some imperative call, and the kind of noise of which they complain often gives a key to the difficulty. Neurotic asthmatics are often obsessed by an urge towards economy (not always in respect of money), and regret expenditure. The miser in a novel always wheezes! Whilst patients with true or false angina are angry and resentful "at heart," the ordinary case of cardiac neurosis suffers from fear, from anxiety, and, very often, from unacknowledged or unsatisfied sexual desire.

It is odd how common phraseology helps us here. We speak of a maddening headache, say we feel sick about something, have sorrow in our heart, or are in a piddling funk. Such verbal combinations indicate psychical correlates of physical states which were perfectly well known to the Hebrew prophets and psalmists. Nay, there is far more truth than we acknowledge in the Graeco-Roman correlations between the bile, black bile, lymph, and blood, and the emotions symbolized when we speak of being liverish, splenetic, phlegmatic, and sanguine.

The flatulent dyspeptic has usually reason to resent, or even loathe, that which he is compelled, or thinks himself compelled, to swallow; constipation is associated with sexual repression and avarice; diarrhoea, sometimes with a desire to be rid of this or that; and so-called "colitis," not so much with a repression of sexuality as with an unsatisfied desire for sexual gratification. (The physiological explanation of this last is that the colon, though not the small intestine, is associated, via the sacral autonomic system, with the sexual viscera.) Sexual neuroses are commonly associated, I think, with remorse or dissatisfaction in connexion with the sexual life. The man who is impotent with a prostitute may so protect himself against sin and infection; the syphilophobic has always, I think, remorse for some past or present wrongdoing in his mind, and is trying indirectly to satisfy his conscience, or protect himself in respect of what he has not the moral courage to renounce. Paralysis of the functional type often carries the same kind of explanation, and the psychical element in sciatica, that is sciatica, is often clear. It is generally the expression of a desire to shirk a duty or avoid a danger, and is associated with a sacro-lumbar organ-inferiority that can be demonstrated by *x* rays.

But now, the individual diagnosis having been made, if not in detail, at any rate in such broad outline as is possible at an early stage, we turn specifically to the psychotherapeutic management of the case. Let the patient understand the nature of his unwellness as we see it; then outline the physical treatment necessary or advisable. This should never be neglected, whatever the psychotherapeutic indications. It may be, of course, and often is, necessary to enlist the aid of a specialist friend. But here a word of warning. A colleague or acquaintance, unless he is sympathetically inclined towards psychological investigation, is only too likely to put the "finger of inexperience into the wheels of complexity." Even if he be sympathetically inclined, by exceeding the limits of his own province he may do more harm than good. I advise you, then, to be careful to ask for just what you want—namely, an opinion on the somatic condition without any discussion of its nervous importance.

But is such psychological treatment as is required to be given by the general practitioner or by a physician who has paid special attention to the subject? I am all in favour of the general practitioner retaining the treatment in his own hands if he feels himself competent and confident, and has had experience, and cares to give the time. A physician consulted as "second opinion" may advise helpfully *once*, but cannot as a rule do much more, unless the psychical treatment is confided to him

as whole-heartedly as is the conduct of an operation to a surgeon. It may be, and often is, advisable that this course be followed. If so, let it be followed without reserve. It is as impossible for a physician to make a complete diagnosis, and to convey to an uninstructed practitioner, within the limits of a single consultation, full psychotherapeutic directions as it would be for a surgeon to explain by letter how to "do" a laparotomy to one who has never "done" one.

Again, it is impossible for intimate conversations to be held with a physician and a practitioner alternately. It is generally unwise for confidences to be repeated; and there is the danger of wearying and frustrating intervention by relatives who, too often, are predisposing and exciting morbid agents. If the patient's confidence is to be gained it must be deserved and kept.

The aim of the physician must be to help the patient to know himself and to understand the mechanisms and arrangements that he has unconsciously constructed, and why. He must be led to see where is the difficulty; that compromise and indecision are no solution. He must be rather led to see that adjustment to the demands of subsistence, of society, and of sex *must* be made. But the solution must not be dictated. The patient must herein minister to himself; he must work out his own salvation. Never is the method of Adler (which involves early diagnosis on the part of the physician and early statement to the patient) more successful than when the patient cries with the Philippian gaoler: "What must I do to be saved?" If, that is, he is really desirous of freeing himself from what as yet he has only partly confessed to himself.

While prolonged attempts at psychotherapy are seldom very useful when the patient is over 50 or 55, something can be achieved sometimes if tried in the right way. But perhaps psychotherapy has its fullest scope between the ages of 20 and 40, and surprisingly good results often attend the quite summary treatment of young people eager to be helped.

With Adler's method the relation of the physical symptoms to a psychical state can be confidently pointed out at once. Again, under Adler's technique, the feeling that the patient comes to entertain towards the physician should be free from embarrassment to either. It may be desirable that the physician should be one who, if not an actual stranger, is at any rate not a participant in the social life enjoyed by the patient. At the same time his attitude should be not that of a pedagogue or a priest, or of one that speaks with authority, but, in Adler's own phrase, one of "comradely benevolence."

One word in conclusion of general interest. Bishop Butler reduced the "authorities in the polity of the soul" to two: conscience and self-love. The term "self-love" covers the superiority-aim of Adler. By "conscience" we may understand the countervailing social impulses that tend in certain circumstances to inhibit self-gratification at the expense of others. This is what Adler has in mind when he speaks of the defectiveness of the social or community feeling, in the neurotic, and in the psychotic. For the neurotic seeks to have dependants and the psychotic has no friends. In great part, then, we are only learning anew, and in a new language, what, in the pride of modern scientific research, we have too carelessly forgotten.

Two further points: the psychological interest in general practice is so immense that nothing could be more deplorable than diffusion of the idea that the investigation of the neuroses means the discussion of sexual topics with young girls; and psychotherapy, the recommendation of fornication. No, when sexual complexes are predominant the patient suffers, because for one reason or

another a wrong attitude has been taken up in respect of the great problems involved in human life.

And this leads towards my second point. Nowadays we are apt to "explain" all aberrations of emotion and conduct as determined by the balances of our internal gland secretions. It is true that, in clinical medicine, by administering thyroid gland we can sometimes effect wonderful changes in mental and physical functioning; but it is no less true that, by persistence in certain forms of conduct, we modify, first, the functional activities, and, secondly, the actual organization of those glands which by so many are supposed to dictate our emotional responses and our conscious endeavours. Frankenstein's monster in the end slew his master. But it was Frankenstein himself who created the monster, and on whom the ultimate responsibility for his own destruction rested. In everyday life it is the monsters of our own creation who slay not only ourselves but our children—unto the third and fourth generation. For the effective gland balance in the child is often enough an expression of the consciously exercised and developed positive or negative psychological and ethical trends of the parents.

"The fathers have eaten a sour grape, and the children's teeth are set on edge."

So I end as I began—by asking you to believe with me that, although some of us refuse to make the distinction (unnecessary, as we see it) between mind and body, yet, if this distinction is made, it is better to allot the responsibility for bodily ills to the wrong use of the mind than it is to put the blame entirely on the body. If we follow the latter course we foul the springs of human conduct at the very source: if with Adler we adopt the former, we shall be surprised at the extent to which conscious effort overcomes weakness in the face of difficulty.

We shall be surprised, too, to find how often the "functional" maladies that have defied drugs, operations, scoldings, expostulations, threats, and vaccines or ultraviolet rays disappear when the doctor really understands the individual and the individual understands himself.

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And now a few words by way of epilogue.

My subject has been the psychological interest in general practice. In discussing this I have dealt, as I promised, with the nature and treatment of those cases which, excluded from the categories of the "organic" and the "mental" alike, are too often relegated to the dustbin of the "functional." In actual practice such are too often either dismissed with a bottle of bromide or bandied from pillar to post—that is to say, from surgeon to specialist. They are not sent, as they should be, to the physician who is also, as he should be, a psychologist. For it is these cases—known sometimes as cases of hysteria, of sexual neurosis, of neurasthenia, of anxiety-neurosis, of psychoneurosis, and the like—that are, above all others, those which, seen in time, are so responsive to psychotherapy. These are the cases with which the general practitioner could so well deal, would he only learn the technique. These are the cases that give the psychological interest in general practice.

I have purposely said nothing of the schizophrenes, the manic-depressives, the cases of climacteric or senile involution, and the other psychotics, or of the subjects of obsessions and compulsions—so near to true psychosis. Yet, oddly enough, it is these cases, more refractory to psychotherapy, that are so persistently sent by practitioners to psychotherapists, with a diagnosis of "nothing organic" and an assurance that psychotherapy will put them right in no time. These cases have their interest, of course, and modern psychology helps us to

understand them, at least, and at any rate to do what can be done for them. But psychotherapy to be successful requires co-operative response by the patient. The psychotics cannot, and the obsessed often will not, co-operate with the physician. Even magic requires for its successful application the belief that in itself implies co-operation.

I repeat, the scope for psychotherapy, in the hands of the general practitioner, is, first and foremost, in dealing with the numerous patients who, not the subject of gross somatic physical change, are yet, with the best intentions and the worst consequences, so often submitted to operations and to useless forms of physical treatment before the true origin and nature of the malady is recognized. Alas! that it should be so. And, again, alas! that the true nature of the case is so seldom recognized before the flush of "functional" vasomotor disturbance has given place to small-celled infiltration and fibrosis or other structural consequences of nutritional change.

Your business and your interest are with the "little foxes that spoil the vines." The little foxes are the emotional disturbances which, finding surreptitious expression in "functional disorders" of viscera, are the true begetters of the dreaded "organic" disease.

CHRONIC NON-TUBERCULOUS INFECTION OF THE LUNGS IN CHILDREN *

BY

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I have chosen this subject for my lecture for two reasons. Firstly, the subject is not dealt with clearly or comprehensively in any of the ordinary textbooks, and secondly, experience at the Brompton Hospital shows that many practitioners have no very definite ideas about it. The cases grouped under this heading receive a large variety of labels—chronic bronchitis, recurrent bronchitis, unresolved pneumonia, recurrent or interstitial pneumonia, and fibrosis of the lung with or without bronchiectasis are the diagnoses which are made. It may be considered that to include all these under one heading is unjustified, but if they are seen in large numbers it will be realized that they have a very strong family likeness. I admit that the physical signs in the chest vary considerably, but observation of individual cases over a period of years shows that those who start with slight physical signs in the lungs may steadily deteriorate and finally show signs associated with advanced destruction of the lung substance. Hence I believe that the cases in which these diagnoses are made are really different stages or minor variations of one condition—rather than several diseases. A great deal of the lack of knowledge about them is due to the fact that they occur mostly in children of the poorer classes, with the result that the same practitioner does not have the chance of following many of them through all their varying stages, as they only attend a doctor during acute exacerbations. The child is considered "chesty" by its parents, but as the degree of illness is not sufficient ordinarily to keep it in bed, and the treatment involved is expensive and tedious, there is a tendency for the parents to pay little attention to the symptoms, and the child is seen by the doctor only on the occasion of the next exacerbation. Again, necropsies are not often obtained, as the children seldom die in hospital:

* Report of a lecture delivered at the Charing Cross Hospital Sunday Post-Graduate Course.

when they are admitted during an acute flare-up, careful nursing usually brings them to convalescence. Even when necropsies are obtained, the disease is in the advanced stages and the destruction has gone so far that any clear understanding of the aetiological process is quite impossible. The experience of those who work in the out-patient departments of children's and chest hospitals is, however, very different. These children come up in large numbers and attend for many years.

The cases present a very definite clinical syndrome, but the history usually takes a good deal of elucidation because the facts in the earlier history of the case have been half forgotten and are only volunteered after close cross-examination.

A TYPICAL CASE HISTORY

The following represents a typical history. The child was perfectly well until the age of about 2 years, when it suffered from an attack of whooping-cough; this was associated with respiratory complications—bronchitis, and probably an attack of broncho-pneumonia. From this date the child has never been the same. At first it had a cough in the winter which cleared up in the spring, and during the summer months no ill effects were noticed. Every now and then the child caught a fresh cold which immediately went to his chest, and an attack of bronchitis ensued. The child more than once became rather acutely ill, and the doctor who was called in found on examination of the lungs what he thought was going to be a patch of broncho-pneumonia at the base of the left lung. When he came on the following day the child was better, and to the doctor's surprise the signs had become markedly less. Recovery took place, but the cough was not lost until the return of the warmer weather. These "colds on the chest" tended to become more frequent, and on each occasion the doctor found signs in the same place. After two or three years the colds, which had been absent in the summer, began to appear at this time also; finally the child was never free from a cough. Apart from the cough, the child was comparatively well between the colds. It was fairly well nourished; there was, however, disinclination to take any violent exercise, and the patient got short of breath. The slightest exposure or diminution of resistance was inevitably followed by the dreaded cold on the chest. At length the chronicity of the disease began to arouse suspicions of tuberculosis in the doctor's mind, and the child was sent to hospital for an opinion.

When considered on a large scale, the points of resemblance in the histories are so marked that the identity of the condition is impressed upon one very forcibly. The differences are matters of degree and of the stage of the disease at which the child is seen. The difference in physical signs depends upon this and upon whether a partial collapse of the lung has occurred. I feel that until the pathology and bacteriology are clearly proved these cases should, for clinical purposes, be grouped together.

AETIOLOGY

1. The commonest causes are *whooping-cough* and *measles*. If care is not taken that the chest completely clears, the syndrome is apt to occur; presumably, in the bronchitis which accompanies whooping-cough or measles damage is done to the walls of the smaller bronchioles, and a chronic infective process is set up. The children of the well-to-do who have had these illnesses severely are usually carefully treated afterwards by extra rest, fresh air, and sun, in the country or at the seaside, till the lungs have completely recovered and normal health has been restored. If this is done ill effects do not usually follow, but in the children of the poor careful after-