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PRACTICAL HINTS IN MEDICINE (PSYCHOLOGICAL).

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(A Fellowship of Medicine Post-Graduate Lecture.)

(Continued from p. 147.)

CONSCIOUS PSYCHIC SYSTEM.

Loss of memory may be total, covering periods of various lengths, or merely pertain to certain events. The term "fuge" is applied usually to wanderings during which behaviour may not *per se* be abnormal, but of which subsequent memory is unavailable by ordinary volition—fuges

and dual personality are sometimes akin. Forgetfulness of recent events as the natural result of failure to concentrate upon them at the time of their occurrence is often hysterically described as "my memory has completely gone"—an idea that is there and then contradicted by a wealthy flow of personal reminiscence. "Blanks" of memory, as during a conversation, "wandering" thoughts, feeling of unreality, obsessing domestic or occupational detail, mental fatigability, emotional displays, or lack of normal emotion, extravagant superstitions, "silly" actions, doubts, indecisions, procrastination—all these psychoneurotics are prone to embrace in some such expression as "I have lost all confidence in myself," reservedly meaning thereby "I am in fear of losing all mental control, and doing something desperate" e.g., suicide or homicide.

It ought to be constantly borne in mind that the final mental factor in suicide may be its choice as an alternative to the supposed inevitability of homicide, the supposition arising from obsessing homicidal thoughts.

SOMNIAL SYSTEM.

Derangements of sleep take a prominent position in nervous symptomatology. Insomnia, "too heavy" sleep, somnambulism, narcolepsy, cataleptic trance, nightmares or "terrors," talking or shouting in sleep, are relatively frequent. Insomnia is rarely so, literally, it seems so because wakeful hours pass so slowly in comparison with the hours of sleep. Insomnia should never be considered a disease entity—it never is. When organic and environmental causes have been excluded, mental causes can only remain, and should be investigated and allayed when possible before hypnotics are even considered. Auto-suggestion plays a powerful part in insomnia; the times, amount, and quality of sleep abide by regulations mentally formulated—he sleeps as he thinks he will. Apprehensiveness as to exaggerated results of want of sleep begets wakefulness; the dread of being unfit for business next day in the case of a man, or of "looking a wreck" in that of a woman, or of insanity in either or both, is not conducive to a morphean visitation. Without touching upon the unconscious sources of dreams it is a useful rule that troubles which are thought out, or told, by day, are the less likely to prevent or disturb sleep; the lad who tells his lassie that he thinks of her all day *and* dreams of her all night, is more romantic than truthful.

Lastly, to the foregoing systemic list, add fits of great variety, irritability to violent temper, sulks and obstinacy, handicapping character traits, crime, drunkenness, drug addiction, all of which can originate psychically.

PRACTICAL HINTS.

Diagnosis.—Organic diseases and psycho-neuroses are not mutually exclusive, nor

does one confer future immunity to the other. Each may be almost pure, or they may commingle in any proportion. No matter how extravagant, bizarre, or atypical of organic disease, subjective symptoms may sound, it should never be assumed that they are neurotic and organically baseless; through this assumption, latent structural conditions with vague and insidious symptomatology are liable to be unsuspected at first, and remain undetected even when developed beyond latency—cerebral tumours, tabes, G.P.I., disseminated sclerosis, tuberculosis and cancer are appropriate examples. A doctor, because he had seen a woman occasionally for years with multiple and kaleidoscopic symptoms, diagnosed hysteria still when she complained that on coughing she got a pain in her left foot. On this occasion the symptom was proved to be due to a mass of pelvic carcinoma causing sciatic pressure—the old story of "wolf, wolf!"

On the other hand, a particular sign or symptom or group of them, should never be diagnosed hysterical negatively, i.e., merely by the exclusion of organic disease. Positive evidences of hysteria should be sought at its *fons et origo*, the mentality. The investigation is a science in itself, requiring long training, experience, and practice, and notoriously difficult to teach. However, the following "hints" may prove helpful:—

(a) Be a patient listener, encouraging detailed description of *present* symptoms as to their how, when, and where, especially as to the emotional state at the time of their inception, e.g., shortly after illness or death in the family, or a fiancé's truancy.

(b) Inquire into all *past* illnesses in the same detail. Thus a history of multiple ailments, doctors, and treatments (including multiple regional operations) is presumptive evidence of hysteria.

(c) Discover the patient's ideas, not alone of the cause and nature of past and present troubles, but of their *future* import and development. Few consult a doctor who

are not foreboding evil, be it but continuance of symptoms. Example: feelings in the head as of pressure, of constricting band, or of something about to "snap" inside, are associated with ideas of the approaching loss of all mental control.

(d) Explore for ideas concerning, and emotional reactions to, domestic circumstances and occupation, and associated individuals. So may be revealed the fact that the symptom in question may obtrude itself at home only, at work only, or under one person's influence only, strikingly unlike the behaviour of organic disease.

(e) Never despise the reality of a patient's symptoms, much less laugh, be jocular, disapprove, be censorious, or accuse; and never tell a nervous patient "there is nothing the matter with you." A breach of this "hint," and the doctor is no longer a confidant. Give time, attention and interest—indispensable confidence is won in direct proportion.

(f) Confidence being won, never refrain from inquiry into sex life. Here lies a hinterland that patient, doctor, or both, are too unwilling to view (till experience teaches), to the detriment of a positive diagnosis of psychoneurosis. For it is in sex life, albeit but in conscious sex life, that either the most unequivocal psychoneurotic manifestations usually flourish, or in which may exist abnormality fruitfully provocative of far-flung hysteria. It is a psychological truism that if the energy Nature has differentiated for the securing of continuity of the species finds outlet in the fulfilling of this purpose directly, or is transmuted in considerable amount to substitutive creation that yields personal satisfaction and social utility, nervousness of severe and persistent degree is impracticable. Conversely, nervousness is prone to appear and variously to persist amongst youthfully ardent lovers deterred or denied matrimonial consummation, ageing celibates, the childless and married in name only, the unproductively

employed or unemployed, the rich and idle dilettanti.

As encouragement against shirking inquiry into sex life, let me say that I have never known it present (with tact) any unsurmountable difficulty, and that it often elicits some such remark as "Doctor, I am so glad you asked me that, for I often wondered if that had anything to do with my case," implying that other doctors were deemed neglectful. Example: A lady in her fifties vomited at 7 p.m. for seven years, complaining of this symptom to innumerable doctors meanwhile. She was highly pleased when eventually asked her sex life, which consisted in an impotent husband during thirty years of matrimony, and said, "Could it be that I get sick at the sight of my husband he comes home at 7 o'clock?" She convinced herself that this had been hitherto an unknown fact to her, when it was further elicited that she never vomited whilst she or her husband were taking separate holidays from home. So she cured herself of this symptom, despite the number and varieties of opinions and treatments she had had for her stomach.

(f) Beware of the fallacy of excluding hysteria on superficial observation. One frequently hears: "There is nothing nervous about him, he is a fine, strong fellow, and plays Rugger," or "She is placid, sensible, and a good sort—there must be something really wrong with her." There are doctors who take as limited views of hysteria as the following lady. She consulted a specialist for a lump in her throat. He informed her it was "hysteria," to which she indignantly replied, "If you take me for one of those women who lie on the floor, kick and scream, and bite whoever comes to help, you never made a worse mistake in your life." The specialist was correct diagnostically, yet sent this lady elsewhere through the breach of a simple rule, peculiarly applicable to the nervous: never use technical terms to, or accept them from a patient, without first ascertaining that

respective connotations agree, e.g., to ask a man "Is he nervous" is generally to ask him is he a coward.

Treatment.—Begin by disabusing your own mind of the fallacy that hysterics are conscious malingerers, or wilfully obstinate, in either case blamable and unworthy of your therapeutic aid. It helps towards this end to seek in ourselves an hysterically "blind-spot"; few of us are without one or more.

Avoid, as far as possible, treating a local manifestation of hysteria as though it were a local disease, e.g., bismuth for nervous dyspepsia or vomiting. Local treatment engenders the idea that local disease exists, thus defeats its own end, and, as time passes, fosters the idea to a conviction that the disease is obscure, serious, and intractable. This process is not confined to the mind of the patient, it is prone to infect that of the doctor; hence, in my experience, it comes about that the majority of cases sent to a general consultant physician consists of organically disguised hysterics who have had at many hands many treatments, drugs, diets, rest, change, massage, electricity, light, immunizations, operations, sundry or all—and quackery galore. By this time it is unpromising material to deal with. For this, blame does not lie with the doctor who is latest in dealing with the case and requests a consultation; rather is he a martyr victimized by him who first failed to recognize that the problem lurked in the mind, not in the body. In most other spheres of medicine, the sooner the appropriate treatment is undertaken the better, and the more certain are the results. For the mind, mental treatment (psychotherapy) is the appropriate one undoubtedly. In any of its forms it essentially needs the confidence of the patient in the doctor, a necessity unattainable unless the latter has self-confidence which, in turn, should be justifiably proportionate to his care and capacity in the exclusion of causative organic disease, to the certainty of his psychological

diagnosis, and to his psychotherapeutic experience.

You may say this implies a large order for one man to fulfil. True, and there are few, if any, of us who do not on occasions need for its fulfilment the assistance of specialism. Formerly, a state of war existed between medicine and surgery; at present, both are inclined to ally themselves against psychotherapy. Do not join any camp; learn what you can of the methods of each; be liaison officers. Time now permits nothing more than mention of some of the varieties of psychotherapy that are in use: explanation, re-education, advice as to alterations of environment or occupation to secure more satisfactory outlet of unconscious forces, abreaction (releasing pent-up emotion), persuasion, suggestion, hypnotism, psycho-analysis. All of these have their uses if skilfully applied to the appropriate case, but the greatest of these is analysis, because the most radical and rational, the most scientific, and, paradoxical as it may seem, the most rests with the patient. This portion of an analysis is so far as it concerned a case of a pain in the neck, tic of the head, attacks of dyspnoea (previously diagnosed "asthma"), phobias of loss of mental control and pregnancy, and a repulsion from meat bears on the point. The lady was aged 28, the above symptoms had become pronounced and persistent, following the normal birth of a normal child, as had pertained to her own birth. How then did she ever come to have the fantasy in action in her unconscious mind, self-revealed after months of analysis, that the mode of her own birth had been to be dragged by the head from her mother, the cord strangling her, and her neck being so torn as to approach decapitation? Approximately, at the age of 4 she had been a secret observer of the abnormal birth of a calf by the aid of such crude obstetrics, but had forgotten the incident soon after, as also her sorrow for the calf when thrown away dead; she had unconsciously identified herself with the calf

for unconscious reasons, one being the unconscious wish that her brother (less than two years younger than herself) had never been born, or been born dead. In short, the unconscious curse upon her brother roosted in her unconscious mind and took shape concerning her own birth, on witnessing that of the calf. On the realization of this much of her hidden mental mechanism, she connected it with the above symptoms, which then fell away from her, and only then; other treatment had but aggravated them.

A last word to concern suggestion. Consciously or unconsciously to himself, for good or for evil, for better or for worse, a doctor is ever suggesting to his patient, except when analysing with skill. Yet he cannot suggest all things to all patients, for suggestibility depends, more than upon any other factor, on the contents of the unconscious mind, an unknown quantity to doctor and patient till analytically discovered. Take the example of the last-mentioned lady: it had been easy for a doctor to suggest to her that a vegetarian diet suited her best, that another pregnancy would be calamitous and that she should not make intellectual effort for fear of mental exhaustion; it had been hopeless for him to suggest to her that the pain in her neck was not of dire organic origin.

The safest all-round suggestion, though curatively very limited, except in mild hysteria, is optimism. Coleridge said, "In nervous diseases, he is the best physician who knows best how to inspire hope"—an observation from the personal experience of a highly intelligent sufferer.

THE HIGH-GRADE MENTAL DEFECT IN RELATION TO GENERAL PRACTICE.

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(A Lecture delivered under the Auspices of the Fellowship of Medicine and Post-Graduate Association.)

LADIES AND GENTLEMEN,—In choosing a subject for this lecture, I purposely selected one about which I knew next to nothing until it was forced upon me in the course of practice. Most of us, I think, find when we get into practice, no matter whether it is general or special, certain gaps in our knowledge which may be traced partly to defects in the curriculum and partly also to the fact that certain aspects of medicine make very little appeal to our examiners, and such aspects we, as students, can safely and profitably neglect. The whole subject of amentia still remains a closed book to the great majority of medical students and practitioners, and yet there is probably not one of us here who has not had occasion to regret his ignorance of the subject at some time or another.

From the sociological point of view the problem of mental defect is of absolutely fundamental importance, and particularly owing to the fact that the defect is a transmissible one. It is especially when one has dealings with the higher grades of defect that we realize the unrestricted opportunities they possess for transmitting their incapacity to the next generation. I do not, however, wish to pursue this aspect of the matter today beyond saying just this, that any legislation that overlooks this essential fact, and seeks to strain the already inadequate accommodation available for aments still further by extending admission to those who, though innately normal, have suffered a retrogression or retardation of mental