Chapter IV.

Some General Considerations.

It is instructive to compare the public attitude towards insanity with that adopted in the case of another serious disease, tuberculosis.

There is nowadays a general conviction, not only amongst the medical profession but also amongst a large proportion of the educated public, that tuberculosis is a curable disease. It may exist in a mild and incipient form in many persons regarded as healthy, and, if properly treated in its early stages, with due regard not only to the actual disease in the bodily organism, but also to the healthy environment of the individual, it is almost certainly conquerable. Not many years ago, however, this happy belief did not obtain. A person "in consumption," especially if "consumption was in the family," was regarded as being in a very serious and almost hopeless condition. The patient, shielded from fresh air, inappropriately and insufficiently fed, often succumbed, supplying one more example to support the unscientific conception then prevalent of the inheritance of the disease. But such conditions axe passing away. In our medical schools and hospitals special attention is paid to the diagnosis and treatment of early forms of tuberculosis; the importance of preventive measures is emphasised; the influence of the patient's environment in favouring or combating the disease is explained; and the future medical practitioner is afforded frequent opportunities for personal investigation of tubercular patients. The old ideas about the "inheritance of consumption" are greatly modified. No longer is a patient's disease explained as "in the family" and left at that. Preventive measures, early treatment, an attempt justly to appreciate the relative influence of heredity and en vironment are the watchwords of the modern medical attack upon tuberculosis.

If, however, we consider the attitude of the general public in this country towards the malady of insanity we find a mixture of ignorant superstition and exaggerated fear. From these there springs a tendency to ignore the painful subject until a case occurring too near home makes this ostrich-like policy untenable. The sufferer is removed to a "lunatic" asylum, neither himself nor his relatives being spared the gratuitous extra wrench to their feelings aroused by this name, which has long struck terror into the uneducated mind. He is taken away by the relieving officer of the district, often under the pretence of being given "a few weeks in a convalescent home at the sea-side," and eventually finds himself under lock and key. Here, as is well known, he is treated with great kindness. Neither public money nor the exertions of the staff are stinted in the effort to render his lot as pleasant as possible - "the asylum to-day has become a model of comfort and orderliness." But the proportion of doctors to patients is on the average, one to 400, and it is exceedingly difficult to ensure that

all patients, once inside the "lunatic" asylums, shall be regularly visited by friends from the outside world. The attitude of the general public is not deliberately cruel, but it appears to be far more benevolent than it really is. The community treats the sufferer well, when, *but not before,* he has become a "lunatic." it allows his delusions to become fixed, his eccentricities and undesirable acts to harden into habits, his moods of depression to permeate and cement together the whole of his life - and then interns him and treats him kindly for the rest of his life, but does not give him facilities for gratuitous treatment while he is still sane. ***That is the British Procedure to-day.***

Lest we should be accused of exaggeration, or worse, we will quote here from published articles and reports.

Dr. Bedford Pierce says.- "Let me state in a few wards the defects of our present system. At present, broadly speaking, no person unable to pay its cost can receive adequate treatment until he is certified as of unsound mind. This practically means that no special treatment is possible until he has utterly broken down, and is so seriously affected as to convince a magistrate that he is decidedly insane. No general hospital will receive such a patient; the public asylums are all closed to any one who begs for protection or treatment, for county asylums cannot receive voluntary boarders even when the cost of their maintenance is forthcoming.

"Consequently there is no alternative but to apply to the Poor Law authorities, who, under certain circumstances, provide treatment for a period of two weeks in the workhouse infirmary. The whole system is radically wrong. When the wife of an artisan becomes depressed after confinement, surely it is cruel in the extreme to make her a pauper and send her to the workhouse infirmary, pending a decision as to whether she is insane or no. it is obvious in such a case that this course will not be adopted until the last possible moment, and consequently much valuable time is lost. Every practitioner will be able to call to mind patients travelling steadily towards insanity in unfavourable surroundings. This question is brought even more prominently before consulting physicians, especially those interested in nervous and mental diseases."

In the words of the report of the Medico-Psychological Association:-

"The present system, which compels all persons, except those able to pay adequately for their maintenance, to apply to the Poor Law authorities in order to secure treatment, is unsatisfactory and unjust. In doubtful and undeveloped cases temporary care can be given only in workhouses or Poor Law infirmaries, which, with very few exceptions, lack proper facilities for treatment.

A system which artificially creates paupers in order to obtain medical treatment necessarily acts as a deterrent, so that too frequently there is serious and even disastrous delay."

This is not exactly locking the stable door after the horse has gone: it is double-locking him thoroughly, expensively and often unnecessarily, in someone else's stable.

Let us, for a moment, compare this state of affairs with that existing in the case of tuberculosis. Nobody now believes that the scientific way of treating this disease consists in waiting until the patient has become a positive danger to others, and then locking him up. This point needs no elaboration. But another fact in this connection should not be forgotten. The tubercular patient usually seeks the doctor *of his own free will,* often obtaining treatment in a relatively early stage of the disease.

There are, however, many reasons that deter the mental sufferer from seeking medical help. One of the strongest of these is the wish to cure himself by his own unaided efforts. This is a laudable desire and one which is extremely helpful and important in mild and uncomplicated cases of relatively recent occurrence, but of which, as we have seen, the gratification is not always possible. Another factor is the natural disposition which the patient shares with the rest of conventional humanity, to conceal his worries, not only from his friends, but perhaps above all from those of his own household. This tendency to concealment, however, often only aggravates his mental distress. Particularly is this the case in adolescents. As is well known, a talk with a kindly, sympathetic and wise person, or even a confession to such an adviser, frequently means the end of many painful mental conflicts.

But in addition to these very natural reasons for deferring recourse to medical help, there are in our own country special causes for delay. These are due to the prospects imagined by the sufferer to be awaiting him if he discloses his troubles. (We have in mind throughout the discussion, not the richer members of the community, for whom a relatively expensive holiday or period spent in the nursing home is easily possible, but the great majority of the public, to whom even the ordinary doctor's bill may be a source of financial embarrassment for months or years.)

The treatment of incipient mental disorder is often a long and complicated process for which the average general practitioner has seldom either the time or the special training. In very few hospitals in this country is out-patient attendance for such maladies practicable. For the mental sufferer whose means are not considerable, there exists nothing, if the efforts of the general practitioners fail, but trying to cure himself, or, if he becomes worse, admission to an asylum. Unfortunately, however, the average asylum, with its one doctor to 400 patients, does not and can not meet his needs. The

successful treatment of mental disease usually requires individual care, often lasting over long periods. When it is remembered that the asylums contain a considerable percentage of patients whose bodily diseases, apart from their mental troubles, require the doctor's attention, and further, that by the time the patient reaches the asylum, his disorder has usually

passed through its initial stages, it is easily seen that our asylum system in its present state - to put it mildly - is far from conducive to recovery from mental disease. Considering that, in spite of these drawbacks, 33 per cent. of the patients are discharged, (R. G. Rows, Journal of Mental Science, Jan. 1912) we can only gladly recognise the efforts made by the asylums; we are, however, bound to ask *: What percentage a/ the inmates need ever have entered the asylum?* It may be objected that it is easy, but unfair, to ask such a question seeing that no satisfactory answer can be given. To this objection there are two replies. first that, judging from the present state of affairs, this question cannot be publicly asked too often; secondly, that materials for an answer are already forthcoming. It is conclusively proved by the experience of other countries that a large proportion of the patients might have been cured without being sent into an asylum. Thus, for example, in Germany, in the province of Hesse, by reason of suitable treatment during the early stages of mental illness the authorities were able to postpone for ten years the erection of a new asylum.

" The Psychopathic Hospital at Boston, Massachusetts, was built by the State expressly to deal with recent acute cases. No fewer than 1,523 patients were received in its first year, and of these 590 were received under a temporary care law, which provides for a week's detention only; large numbers were also received on a voluntary basis, so that during the year *48 per cent. of all patients escaped the usual lunacy procedure.*

"On reading the reports of work done, one is struck with the enthusiasm of the medical staff and the vast field of research undertaken. During the two years eighteen medical men describe their work covering almost every department of psychiatry: juvenile crime, tests for feeble-mindedness, incidence of syphilis, alcoholism, hydropathy in its influence on red blood cells, treatment of delirium, prophylaxis, analysis of genetic factors, salvarsan treatment, tests of cerebro-spinal fluid, and last, but not least, the value of out-patients' departments and after-care. There is a special social service department for the purpose of following up cases in their homes, and it was found that of every100 admissions 20 needed supervision on discharge, 24 needed advice, 3 required assistance in arranging their discharge, and 10 showed a need for prophylactic work in their families.

This bald statement of the activities of the Boston State Hospital shows plainly what an important service it renders in providing treatment apart from ordinary asylum

associations. It shows how it is possible at such a Hospital to organise a medical service which covers all departments of psychiatry; and further, that when the mental symptoms clear up, a patient need not be thrown back into old associations without help or supervision.

This hospital at Boston is but one of many that have been established in the United States in recent years. Some of the others are due to private munificence; in particular, reference may be made to the Henry Phipps Psychiatric Clinic at Baltimore, the medical staff of which consists of a director, assistant director, a resident physician, two assistants, and five resident medical officers. In addition to these are the heads of three research laboratories dealing

(1) with clinical pathology and biochemical investigation,

(2) with neurological research,

(3) with psychopathology.

In advocating the establishment of separate pavilions for nervous and mental disease in direct association with the general hospitals, Dr. Bedford Pierce says:-

"At La Charite Hospital in Berlin, the visitor enters a small park, and Dr. Ziehen's clinic is but one of many detached buildings devoted to special diseases. It is as easy and simple to get advice there for the patient suffering in mind to get advice there as foe another with eye and lung trouble."

Let it be noted that none of these German patients, on returning to their relatives and friends, suffer from the stigma of having been to an asylum. In our country some of those same friends during the patient's absence would often have been engaged in "sympathetically" spreading the news of the sufferer's absence and his whereabouts to everybody in the district. To a certain type of mind there is a ghoulish fascination in gloating over the illnesses and afflictions of neighbours. Even though people addicted to such habits may salve their own consciences by exclaiming "poor fellow" at the end of their narrative, the effect of their conduct is none the less brutal and offensive. This is not the place for the discussion of so remarkable and important a phenomenon of social psychology. Nevertheless it plays a great part in the causation of the prevalent dread of treatment for mental disorder.

For many reasons the psychiatric clinic is not regarded by the public as a "lunatic" asylum. In the Giessen clinic in Germany, for instance, both nervous and mental diseases are treated. The patient afflicted with tremor or a paralysed finger visits this institution as well as the sufferer whose troubles if neglected might develop into

mental disease. Difficult medico-legal cases resulting from such incidents as those arising from the claims by workmen and others for compensation after accident are sent to this clinic for observation and opinion. "Rest-Cures" and similar treatment are also carried out there. The official title of the institution, displayed at the entrance, is "Clinic for Mental and Nervous Diseases." The institution is therefore regarded by most people in quite a different light from the asylum, and it is not spoken of by the general public with bated breath. One of us, while working in the laboratory of a German psychiatric clinic, was introduced to a visitor who made some remark about "when I was here." To the question, "Were you on the staff, then?" the visitor answered quite naturally, "Oh no, I was here as a patient."

With this experience may be contrasted another incident, this time from our own country. Delegates from a certain Board of Guardians paid a visit to the county asylum to inspect the arrangements made for the comfort of the inmates from their own district. In the next week's local newspaper a report of the visit appeared in the form of the chief delegate's speech at the subsequent board meeting. This report consisted of "funny" stories of the eccentricities of the patients the visitors had seen, and of the delusions from which some of the victims were suffering, with sufficient detail to enable many of the relatives, and possibly some of the friends, of these "lunatics" to identify the afflicted ones. The newspaper account of this humorous effort was punctuated at suitable intervals with "laughter."

It is obviously not claimed that these two accounts are typical either of Germany or of England. But what is claimed is that of these two public attitudes the clinic system promotes the one, the "lunatic" asylum the other.

Before leaving the comparison of insanity with tuberculosis we must remind the reader of some other facts that are important in this connection. We have seen that the scientific study of tuberculosis has materially modified the earlier views concerning its hereditary transmission. It is now held that tuberculosis is not inherited as such; but that a child of tuberculous parentage may begin life with a subnormal power of resistance to the disease and perhaps greater risk of exposure to infection. If later he develops the disease, it is traceable directly to his environment. The corollary is that if his environment be improved, and his body's power of resistance increased meanwhile by all the means in our power, he has a considerable chance of living a life free from the disease. Thus the old pessimistic view is replaced by a distinctly optimistic one.

In the mental disorders that are indubitably traceable to organic disease of the central nervous system, heredity doubtless plays a great role. But two points should be remembered in this connection. First, among asylum patients the number of mental disorders which cannot, *Post-mortem,* be traced to organic causes is very great as compared with those that can be so related. For example, of 1,325 patients received at

the Burgholzi Central Asylum and University Psychiatric Clinic, Zurich, Dr. C. G. Jung (Analytic Psychology, London, 1916, p.318) states:-

" . . . in round figures a quarter of our insane patients show more or less clearly extensive changes and destruction of the brain while three-fourths have a brain which seems to be generally unimpaired or at most exhibits such changes as give no explanation of the psychological disturbance.... We must take into account the fact that those mental diseases which show the most marked disturbances of the brain end in death; for this reason the chronic inmates of the asylum form its real population, and among them are some 70 to 80 per cent of cases of dementia praecox, that is of patients in whom anatomical changes are practically non-existent."

In a great number of mental disorders our present knowledge of anatomy, physiology and pathology is of little help as a means of throwing any light upon the patient's condition. While in no way attempting to belittle the magnificent work in these subjects during the past century, it should be pointed out that its very success has brought about, especially in this country, an unfortunate tendency to regard these methods as the only ones suitable for attacking the problems of insanity. But nothing is more certain than that in the psychoneuroses: hysteria, neurasthenia, psychasthenia and the rest, anatomical and physiological knowledge has not yet passed beyond the theoretical stage. But it is equally indisputable - and the statistics of shell-shock cases have strengthened the evidence for this assertion - that the psychological mode of attack, the treatment of mental disorder by mental means, is now firmly established as a practical method.

It appears, therefore, that precisely in those cases of psychoneurosis which yield to psychical treatment, there is no anatomical, pathological or chemical evidence of inheritance. But while the contributions of anatomy, physiology and pathology to the treatment of psychoneuroses have not yet gone beyond theoretical and mutually conflicting suggestions, the psychological method of investigation and treatment on the other hand has proved itself of practical use in restoring patients to a normal state of mental health. What scientific justification therefore have we, when considering the action of heredity, for lumping together the organic and the functional mental disorders ?

The psychoneurosis is often simply a progressive state of mal-adaptation to environment; a mental twist which can be corrected if treated suitably at a sufficiently early stage. Its specific nature is frequently explicable almost entirely in terms of the peculiar educational, family or social relations of the patient's environment. The war has shown us one indisputable fact, that a psychoneurosis may be produced in almost anyone if only his environment be made "difficult" enough for him. It has warned us that the pessimistic, helpless appeal to heredity, so common in the case of insanity,

must go the same way as its lugubrious homologue which formerly did duty in the case of tuberculosis. In the causation of the psychoneuroses, heredity undoubtedly counts, but social and material environment count infinitely more.

To some readers the above argument may seem so obvious as to be superfluous. To ascribe a patient's entangled state of mind to heredity without attempting to discover how far his own personal experiences have tended to bring about that mental condition, would seem as fatuous as attributing to heredity the financial muddles of a son who has inherited from his unbusinesslike father a badly managed estate. The trade-adviser called in to help might for a moment consider the possibility that the son may have inherited his father's unpractical character, but surely his first serious efforts would be to discover where the business methods were wrong or antiquated and to improve on them. So it is with the mental patient; his own history is the important desideratum. That of his parents may cast valuable light upon his trouble, but even then it is often just because their own difficulties have contributed to the making of his environment.

One of the most dangerous and misleading terms in our language is the word "neuropathic;" for it is made to signify so many things that it ends by meaning nothing. Etymologically, it should mean "afflicted with disease of the nerves," a conception the precision of which we shall discuss below. Yet on the return from the front of patients afflicted with "shock" one heard the opinion at first that the cases were those of "neuropathic" men, that the soldiers who became affected by shock were weaklings or were descended from mentally afflicted or nervous parents. It is, of course, unquestionable that in a large army there must be many soldiers with tainted family histories; and it is probably equally certain that such factors play some part in determining the greater susceptibility of certain men to shock. But it would be a gross misrepresentation of the facts to label all the soldiers who suffer from mental troubles as weaklings. The strongest man when exposed to sufficiently intense and frequent stimuli may become subject to mental derangement. It is quite common to find among the patients suffering from shock senior noncommissioned officers who have been in the army fifteen or twenty years (much of which time has been spent in foreign service under trying circumstances, such, for example, as the South African War), and have stood this severe strain. Such men can hardly be called weaklings or "neuropathic".

Even in those cases where there is a definite history of a neurotic parent, it would be a mistake hastily to conclude that when the son of such a man or woman becomes a victim of shell-shock it is due to heredity. For when the detailed history of such patients is obtained the fact comes out quite clearly that the social disturbances in the household of such a nervous person may be amply sufficient to inflict severe psychical injuries upon young children.

Further, in many cases the histories themselves clearly and definitely reveal the real etiology of the mental condition, and point to emotional disturbances in children, due to the cruelty of drunken parents, a rankling sense of injustice, a terrifying experience, which may have been an accident or deliberate maltreatment by some human being, or again, to the appalling conditions created in some of these homes by nervous and irritable parents, as the real trauma which the "shock" has served to re-awaken.

But when we come to ask *what* disease of the nerves, or, more strictly, of the nervous system, is implied in speaking of the "neuropathic" we find no satisfactory answer. Certainly no one disease is regarded as being the causal factor. And the list of theories is over- whelming. Disturbances of the genital, vaso-motor, or digestive systems, demineralisation, chemical disturbances of nutrition of hepatic or cholaemic origin, visceral ptosis, cerebellar disturbance, thyroid disorder, complex disturbances in functioning of the blood vessels, intoxication. exhaustion: these are some of the numerous theoretical suggestions proposed to account for neurasthenia only. Whether the unfortunate neuropath is supposed to be afflicted by one or all of these is a matter which we certainly cannot decide; for the theories proceed from many different sources.

But we must not lose sight of another important fact in this connection. The neuropathic person's mental troubles, or those at least for which he seeks relief from the physician are by no means in the clouds of theory. They are real enough, and as a rule not to the patient only, but also to his relatives and friends, with whom he finds it difficult to live amicably. Those troubles are based upon fear, anxiety, anger, and excessive curiosity concerning matters about which the normal person would not bother his head. They find expression in outbursts of pugnacity or of unusual self-assertion with its emotion of elation, often followed by self-abasement and subjection, inordinate desires either to be alone or never to be alone, floods of tender emotion, possibly following close on the heels of a mood of blatant self-assertion with no regard for the feelings of others. These relatively simple processes of mind, occurring sometimes in comparative isolation, sometimes inextricably blended or kaleidoscopically transient, are the real marks of the so-called neuropath or neurotic. Bodily troubles may, and often are, added to these. But as every physician knows to his cost (and sometimes to the patient's), and as faith-healers know to their advantage, these bodily diseases are usually exaggerated by the neurotic sufferer, and frequently prove to have but a slight material basis. In other words, the real marks of the neurotic are mental. And one need not be a technical psychologist to see that the above list is nothing but an enumeration of the instincts and emotions possessed in common by all men. If then, the neuropath is merely displaying instincts which are common to all mankind, what is the difference between him and the normal human being? The difference is psychologically slight, sociologically immense. While his normal brother

reacts instinctively and emotionally to his physical and social environment in such a way and to such a degree as to promote his own welfare and that of others, the neuropath does not. Nobody calls the townsman a neuropath who before crossing the street waits on the pavement until the stream of traffic has thinned. If he did not wait we should rather call him a fool. But the instinct of fear is largely at the bottom of his so-called intelligent caution - especially if he has ever witnessed a distressing street accident. But what do we say of the man who waits and waits until finally he is too afraid to advance, eventually stealing down to another place so that he may cross in safety? He is very likely to be called a neuropath. Or what shall we say of the unfortunate man whose caution has gone so far that he cannot cross *any* open space whatever, and is said to be suffering from agoraphobia?

Or again, take the case of a man whose personality, family or country is grossly and publicly insulted. If he strikes at the aggressor, do we call him neuropathic? But we seldom hesitate to apply this term to the. man who is inordinately touchy, ever on the watch for the least suspicion of insult towards himself or anything even remotely connected with him. The emotion of fear underlies both the attitude of caution and of "funk," that of anger, the righteous indignation of the stalwart and the querulous, peevish irritability of the neurasthenia. The difference between the behaviour of the normal man and the neuropath lies primarily in the circumstances that provoke emotion in them, and secondly in the violence and duration of the emotion itself.

We should remember also that many varieties of animals display the kind of behaviour we have described, and regard as so unusual, if not utterly eccentric, in our friends. Professor William James reminds us of the chronic agoraphobia of our domestic cats; and the tamer of wild animals has good reasons to respect the incessant touchiness of some species of the genus *Felis.* Do we invoke theories of visceral ptosis, intoxication and the rest to explain the behaviour of the average cat or mule? Scarcely. We say that these animals are actuated by instinct. Our arrogance makes it difficult for us to suppose that our suffering human brothers are also acting instinctively. Yet this is undoubtedly the case.

It has been said of the neurasthenic with aptness and truth that he behaves like a child. But if a child, normal in its behaviour up to a certain day, suddenly manifests fear of being left alone for a moment in a room with closed doors, or in a street, do we rush for our "Liddell and Scott" and forthwith proceed to babble of claustrophobia or agoraphobia?' Do we follow this up by solemnly invoking complicated physico-chemical theories concerning the state of his blood or other bodily fluids? Finally, do we brand him as "insane" or at least neuropathic? What we do in this case, if we have any sense, is carefully to investigate the causes of the emotional outbreak. We try sympathetically to understand and re-educate the child to meet such situations without

fear. In other words, we use a method precisely similar to that which proves to be of such great use in treating the psychoneuroses.

The analogy - if it be an analogy and not perhaps an identity - between the two cases goes still farther. The child who manifests extreme fear at "inadequate" causes, such as we have described, not infrequently agonises his mother - perhaps soon after his outburst of fright - by an exhibition of foolhardiness which, if we did not know of the previous sign of weakness, would cause one to look upon him as fearless. In short, the child's fear is restricted to one or two special situations. So it is with many neurasthenics. Some, for example, may he driven through traffic in a fast motor car without experiencing the slightest fear, though they cannot bring themselves to enter an ordinary slow suburban train; others may surprise us not only by their exhibition of anger at what we should consider an absurdly slight provocation, but by their tolerance and self-control in other (to us) much more annoying situations. Their exaggerated emotional reactions are excited not by general but by specific stimuli; and a little tact, insight and patience on the part of the physician often reveals in their past experience, psychological factors which explain the tremendous personal importance and over- weighting of these stimuli. If for neuropathic we write: "unduly hampered by instinct and emotion" - and this is all we have the right to do - we represent the matter more truthfully.

Among the laity, before the war, the justification of an attitude of inertia towards the treatment of mental disorder (more particularly of the psychoneuroses) was often based upon two statements. The first was that many of the phenomena reported were not real, but were the imaginings of hysterical women. If to this it was objected that men were not immune to hysteria one was met by the retort: "But they are 'neuropaths'." This war has, however, removed from honest people's minds the possibility of regarding these phenomena in such a shamelessly unscientific light. In the military hospitals there have been hundreds of patients suffering from psychoneuroses, who are demonstrably neither women nor neuropaths, in any of the legitimate senses of these terms. And many of these men have suffered intensely. Their fears and other emotional troubles are such as they usually conceal as long as possible, until further endurance is intolerable. Their troubles are real enough to them. "But they are unreasonable," the healthy philistine may object. Some (by no means all) of the fears *are* unreasonable, if by that is meant that the actual danger (as the healthy man estimates it) and the emotion which it evokes in the patient are entirely disproportionate. But who among us has "sized up" life's dangers so accurately that he can say he knows the precise degree of fear which each one *ought* to evoke?

In some country places the inhabitants to-day are more afraid of the presence in their houses of peacock's feathers or of hawthorn blossom than of scarlet fever. Their fears are unreasonable. But we do not call these people neurasthenics. As a matter of fact,

neurasthenia is one of the last diseases likely to attack these rustics. If they vouchsafe any reason for their fear, it is safe to assert that it will be a rationalisation, for its real sources are hidden from them. And if we really wish to discover the cause of their fear we turn for help to the records of folk-lore and ethnology. In other words, we investigate the history of the fear. This history may go back many centuries and the process of recovering it from a series of clues will prove a task of infinite fascination. Now the history of the neurasthenic's fear is likewise obtainable and much more easily, for it is of much more recent date. Its discovery often means the freeing of a mind from torment, the restoration of a useful member to society, and the enrichment of the science whereby other similar liberations may become possible. But how few investigators, as yet, have been attracted by this tremendous untilled field of knowledge

However, our philistine, while agreeing to this, may, and often does, change his ground. He may add: "When I said that the phenomena were not real I had in mind rather the pains and the paralyses from which the hysteric and neurasthenic suffer - or say they suffer." To this we may answer in the words of Dr. Purves Stewart:-

". . . we must recognise that the neuroses are real diseases, as real as small-pox or cancer. A sharp distinction must be drawn between a hysterical or neurasthenic patient and a person who is deliberately shamming or malingering. . . . The hysterical or neurasthenic patient usually has no knowledge of the disease which he or she may unconsciously simulate. The various paralyses and pains from which hysterics and neurasthenics suffer are as real to the patient as if they were due to gross organic disease."

There is a view which, while eminently useful and sensible in so far as it concerns neurology alone, is apt, by virtue of these good qualities, to retard the progress of psychical treatment of the neuroses. For it tends to focus the attention of the medical world on their physical basis alone. Such a view is expressed by Dr. Purves Stewart in the manual from which we have just quoted. In his chapter on the neuroses he says:-

"The old definition of a neurosis as a nervous disease devoid of anatomical changes is inadequate. *Disease is inconceivable without some underlying physical basis.* The lesion need not be visible microscopically it may be molecular or biochemical."

Now from the purely material standpoint such a statement is above reproach. But some important reflections occur as one thinks over the paragraph, and especially the statement: "Disease is inconceivable with out some underlying physical basis" - as applied for example, to neurasthenia. What are the important signs of disease in the neurasthenic, or what unusual phenomena are there which cause him to seek the doctor? Chiefly, as we have seen, the undue dominance in his mental happenings of

instinct and emotion. But we cannot say that this by itself is a sign of disease. Otherwise we shall arrive at the paradoxical conclusion that wild animals, savages and children form the diseased class *par excellence.*

The behaviour of the neurasthenic differs from that of the normal person only in degree, and some sane men might be unhesitatingly regarded as neurasthenia by one class of society, normal by another. (This was seen repeatedly in the treatment of the relatively uneducated soldiers who had become slight neurasthenic as a result of the war, especially of these whose life had been spent in open-air manual work, or in the strict and healthy routine of the regular army. They complained of emotional irritability, minor lapses of memory such as the forgetting of relatively unimportant names or of errands, disturbed sleep, soon "getting fed up" with their amusements (e.g., "jig-saws," or billiards for hours every day, month after month in a converted schoolroom or outhouse!). Not only did these phenomena disturb them, but in a great many cases they seemed to prove to these unfortunate men that they were insane, or rapidly becoming so. They would anxiously ask such questions as, What is it that makes me so irritable at a slight noise, or at being brushed against by another patient? 1 used not to be like that. Their conduct was also regarded as unusual by their companions. Now would not the head of a business firm, an over-worked medical man, a university professor or an army officer in a position of responsibility, confidently expect to be*allowed ex-officio* a certain number of these eccentricities with. out being called "diseased?" But let him drop the privileges and shelter. of his rank, live for a few weeks as a private in a barracks, with a number of high-spirited and thoroughly health soldiers and his behaviour might certainly be considered by them to be queer, if nothing worse.

Moreover, it is perfectly clear that if we adopt any of the usual views as to the relation between body and mind, not only disease, but health too is "inconceivable without some underlying physical basis." Yet of the molecular or biochemical aspects of that basis we know practically nothing which would help us to understand even ordinary mental occurrences. So when a normal, physically healthy mother bursts into tears of joy on her son's return from the front, is sleepless when she knows he is in the trenches, forgets some of her daily duties in perpetually thinking of him, is "on edge" and irritable when she has had no letter, from France - though we may be perfectly justified in believing that there are molecular or biochemical nervous changes underlying her behaviour. we do not dream of invoking these as explanations of her condition, for of them we know little. Neither do we call her neurasthenic. We understand her condition in that we correctly refer it to the action of instinct and emotion. Its cause is clear to us, and if we attempted to treat it we should know beforehand that the best cure would be the restoration of her loved one, the next best, sympathetic help in facing her worries, the removal of unfounded fears and the

production of a serene, outlook on the future. In other words, the diagnosis, the tracing of causes, and the treatment would be entirely mental, with no reference whatever to the physical basis, the existence of which we obviously should not deny. Similarly, if a man is troubled by great moral conflict which produces in him sleeplessness, irritability, abstraction and the rest, the physical basis of his emotional condition may be "materially" treated. His sleeplessness. may be reduced by bromides, his irritability and depression by alcohol; but who, if he knew of the great mental conflict, would dare merely to prescribe these ?

And this, in the case of many of the psychoneuroses is the crux of the whole matter. The root of the trouble is mental conflict, the complete details of which can seldom be found on the surface of the complex of symptom. To palliate them one by one is often to provoke new one. The conflict is sometimes clearly apprehended by the patient, but even then is often jealously guarded from everyone else. Sometimes, however, it is not clearly conscious in all its details, even to him. This is especially the case, if as so often happens, he habitually shuns the thought of it. Faced

with an inability to adapt. himself to his circumstances, he instinctively relapses into a more childish way of meeting the situation - hence the tears, the irritability, the mental distraction and the rest. This phenomenon, we repeat, is not new. We all acknowledge its existence when we say that the "nervy patient behaves childishly," though perhaps we do not realise what a true conception of the matter we are expressing.

To sum up, while it is indisputable that the psychoneuroses, like all mental phenomena, have a material basis, we should clearly distinguish between fact and theory in our existing knowledge. Every doctor will naturally seek to make the fullest use of his learning it building up the bodily health of the neurasthenic. But to sit with folded hands and wait for the advancement of our knowledge of microscopic anatomy, physiology or biochemistry would be fatuous when there are other and more direct means of treating the numerous and often pathetic cases, which urgently call for cure. The view that "disease, like health, is inconceivable without some underlying physical basis" is sound and useful, but must not be allowed to blind us to the vital significance of the mental factor and its corresponding importance in the diagnosis and treatment of "functional" disease.

It is an indisputable fact that many modem physicians are apt to concentrate their attention almost exclusively upon the bodily ills of their patients. Yet the majority of doctors, especially those who in general practice get to know their patients intimately, admit readily, even eagerly, that not a small number of the maladies which come under their notice are seriously complicated, if not dominated, by mental factors. To take a simple and obvious example, insomnia may be caused by distressing mental conflicts quite as often as by physical disease. The doctor, however, even if he

suspects this fact, often hesitates to proceed further in the light of such knowledge. For this there are several reasons. In the first place, his arduous, lengthy and expensive medical course has usually never vouchsafed him five minutes specific training concerning the manifold ways in which human nature may succeed or fail in adapting itself to the complex environment which we call civilisation. Any wisdom of this kind that he has picked up is due to his own interest and insight in social matters. The university's contribution to his psychological knowledge usually consists in showing him a handful of comparatively hopeless caricatures of mentality in his short series of visits to the asylum. It is as if one tried to teach electrical engineering by a few exhibitions of broken-down dynamos, navigation by half-a-dozen cursory inspections of wrecks, finance by a short series of visits to the bankruptcy courts.

The result of this strange conception of medical education is different according to the mental make-up Of the particular physician. There are many whose insight and sympathy enable them to penetrate success. fully for some distance into the Cimmerian darkness of the patient's mental troubles. But do we believe that insight and sympathy alone are sufficient for the successfuldiagnosis of disorder or disease of the heart or lungs? Mental disorder is subtler, more varied than these, but like them it proceeds along definite lines in definite situations, and it is capable of description even as they are. It is therefore insufficient even for the talented doctor to rely entirely upon his natural gifts. But in what other branch of science would it enter his head to do so?

But not all doctors happen to be of the type we have described. There exist many excellent practitioners who are temperamentally so constituted that to them these unaided excursions into the investigation of mental trouble would never suggest themselves. Predominantly objectively-minded, " without a nerve in their bodies," calm and confident, practical and quick to apply their knowledge in the physical sphere, they have no natural inclination towards the study of such disorders as we have mentioned; and their teachers have too seldom done anything to supplement the exclusively materialistic studies of their medical course. When, as not seldom happens, he is faced by a case of hysteria or neurasthenia, such a practitioner is inclined to regard the malady, if it does not prove tractable by rest, change, drugs and diet, massage, electricity, etc., either as "fanciful" and requiring firmness unveiled or veiled, (". . .strong electric shocks, cold douches, and other decorous substitutes for a sound birching."

(W. McDougall, *Psychology*, London 1912.) or as the beginning of a lamentable and grave attack of mental disorder. Unfortunately the number of cases yielding to firmness is not gratifyingly large. The hysterical patient, too, has a will of his own, and frequently proves this fact in a disconcerting manner. The neurasthenic, knowing long before the doctor tells him, that he ought not to worry, that he ought to "buck

up," frequently becomes acutely critical of his physician, and his powers of judgment are all the keener for their frequent whetting. upon his own deficiencies. Not that he should not worry, but *why and how* he should not worry is what he wants to know.

This criticism of the brusque, cheery way in which such a physician may treat mental troubles is not meant to be one-sided or unfair. For some patients, the "firmness" treatment is the right one; others may be so impressed by the doctor's cheery personality that they recover. But it is safe to say that these are seldom serious cases. The intelligent, highly moral, over-worked business man must not be given the same treatment as the society lady suffering from lack of honest labour - and nobody knows this better than the patient.

This objective way of regarding cases of neurasthenia readily tends on the one hand to make the physician underrate their importance (as when he expects to cure them with "firmness") and on the other, when they prove impregnable to such attacks, to cause him to exaggerate their seriousness. For, he may argue to himself, if they are beyond cure in this way, what is to be the future of the patients except permanent eccentricity, or even insanity? Only a deeper knowledge of the subject can save him from this top-heavy oscillation from unfounded optimism to equally baseless pessimism.

We have noted two of the common obstacles which obstruct the path of the physician anxious to treat mental disorder: his own lack of training and, in not a few cases, his temperamental inclination to look exclusively for visible and tangible material evidence of disease. There is, moreover, at present another serious obstacle consisting in a widespread social convention. This is the unwritten law which commands a person to hide any troubles of a mental nature not only from his friends,. but even from his doctor, though he may speak of his physical disabilities to everybody with unblushing frankness. Much could be written on this subject, but the inconsistency of the current attitude has been satirised with inimitable wit and humour by Samuel Butler.

His whimsical fancy has created a civilised country in which this convention does not exist; in which, in fact, the opposite belief obtains. In that land, while a man's bodily ills are counted a disgrace, and not to be mentioned, his mental troubles are regarded as physical illness is with us. The name of that country is Erewhon. In Erewhon, we are told, physical illness is not only considered shameful but is punishable by imprisonment. Mental trouble, on the other hand, even irritability or bad temper, is regarded as illness requiring the attention of physicians, known as "straighteners." And the consequences of this are that a man will dissimulate the existence of indigestion, giving out that he is being treated for dipsomania, while in answer to questions about his general condition another will quite freely and truthfully say that he is suffering from snappishness. We in England, says the explorer, "Never shrink

from telling a doctor what is the matter with us merely through the fear that he will hurt us. We let him do his worst upon us and stand it without a murmur, because we are not scouted for being ill, and because we know that the doctor is doing his best to cure us and that he can judge our case better than we can; but we should conceal all illness if we were treated as the Erewhonians are when they have any. thing the matter with them; we should do the same as with moral and intellectual diseases - we should feign health with the most consummate art till we were found out. . . ."

This convention inevitably influences the "straightener's" attitude towards his patients, as we are told by the traveller in a description of an interview between his host and an Erewhonian doctor:-

"I was struck with the delicacy with which he avoided even the remotest semblance of inquiry after the physical well-being of his patient, though there was a certain yellowness about my host's eyes which argued a bilious habit of body. To have taken notice of this would have been a gross breach of professional etiquette. I was told, however, that a straightener sometimes thinks it right to glance at the possibility of some the slight physical disorder if he thinks it important in order to assist him in his diagnosis; but the answers which he gets are generally untrue or evasive, and he forms his own conclusions upon the matter as well as he can. Sensible men have been known to say that the straightener should in strict confidence be told of every physical ailment that is likely to bear on the case, but people are naturally shy of doing this, for they do not like lowering themselves in the opinion of the straightener, and his ignorance of medical science is supreme. I heard of one lady, indeed, who had the hardihood to confess that a furious outbreak of ill-humour and extravagant fancies for which she was seeking advice was possibly the result of indisposition. 'You should resist that' said the straightener, in a kind, yet grave voice, 'we can do nothing for the bodies of our patients; such matters are beyond our province, and 1 desire that 1 may hear. no further particulars.' The lady burst into tears and promised faithfully that she would never be unwell again."