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THE CASSEL HOSPITAL

FOR

FUNCTIONAL NERVOUS DISORDERS

(Founder: The Right Honourable SIR ERNEST CASSEL, G.C.B., G.C.M.G., G.C.V.O.)

PATRON:

HER MAJESTY QUEEN MARY.

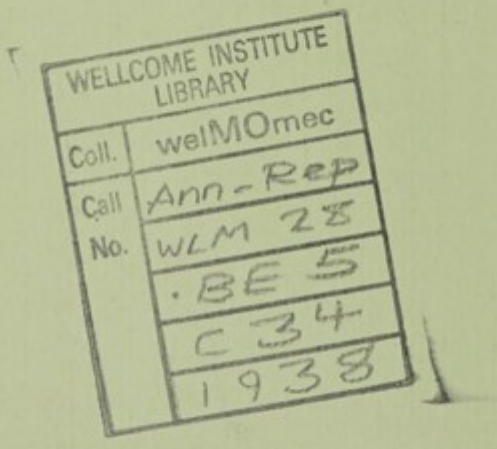
Twelfth Medical Report

TO THE COMMITTEE FROM THE

MEDICAL DIRECTOR

Presented: 31st DECEMBER, 1938.

SWAYLANDS, PENSHURST, KENT.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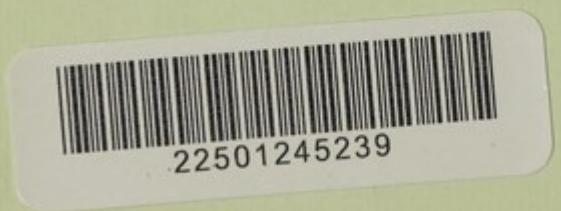
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The Cassel Hospital for Functional Nervous Disorders.

ANNUAL REPORT TO THE COMMITTEE FROM THE MEDICAL DIRECTOR.

31*st December*, 1938

THE TWELFTH MEDICAL REPORT.

THIS Report deals with patients discharged during the year 1938. It has always been the custom of the hospital to follow up by letter all former patients over a period of at least five years. These patients will, therefore, be mentioned again in the next report with a statement of their progress one year after their discharge.

The problem of classification is an important one in the presentation of a report of this nature. Lewis has stated that a classification should have two primary aims. It should be useful and valid. In the present state of psychiatric knowledge no classification can be devised which would be regarded as universally valid. There is not sufficient basis of agreement concerning the fundamental problems of psycho-pathology for this to be possible. A classification can, however, be valid within certain limits which can be defined. It can further be consistent, and its usefulness will depend to a considerable extent upon its consistency. This is particularly true in the case of an annual report in which frequent variations of classification tend to destroy the value of the report. A system of classification was laid down in the Annual Report for 1927. It was based chiefly upon symptomatology, that is to say, upon the observed reactions of the patient. This classification has been followed more or less closely since then ; with minor variations it will continue to be followed.

It may perhaps be opportune at this time to define the headings under which patients are grouped. With a definition of these groups it may be possible for others who may study the report to form a clear judgment of the type of reaction included under each heading. The groups into which patients have been classified are as follows :—

GROUP I. PSYCHONEUROSES. (*a*) PSYCHONEUROTIC ANXIETY STATES.

In the Report for 1927 it was stated " In this Group we have placed all those patients whose chief symptom is either frank mental anxiety or its somatic manifestations of which palpitation, flushing, and tremor are the chief." The problem of the relationship of this group to states of depression has received much attention. Many of these patients show some depression, as also do many patients suffering from other forms of ill health. By paying special attention to the symptom of depression it may be possible to reduce the group to a very small number of cases, and to increase the number included under the heading of depression. This may be done either because on psycho-

pathological grounds it is felt that a state of depression lies at the bottom of the clinical picture, or because of a certain nihilistic belief in the impossibility of differentiating between the significance of depression in one patient or another. In this group, undoubtedly, many patients will be found in whom depression appeared as a symptom at some time or other in the course of their illness. Others will be found who presented hysterical features. The common factor which has caused them to be included in the group of anxiety states is that the anxiety reaction as defined above was the leading feature of their illness. Those cases in which other reaction tendencies were present in a marked degree have been indicated by a bracketed note, e.g. (depressive features).

(*b*) Hysteria.

Under this heading will be found those cases who have presented a dissociative, dysmnesic, substitutive type of reaction or more simply a " dodging " type of reaction (Adolf Meyer). In its simplest possible form this reaction consists of the unconscious production of symptoms designed to enable the patient to avoid a difficulty. The patient does not show much anxiety since his emotional problems have become " converted " into physical symptoms. The Freudian school has stressed the regression which occurs in conversion hysteria to the unsolved difficulties of the Œdipus situation. Whether one accepts this terminology or not, it is certainly true that many hysterical patients show personality adjustments of an immature and childish type. They tend, for example, to make exaggerated and uncontrolled demands upon their environment such as one commonly associates with the behaviour of a poorly disciplined child. When these demands are not fulfilled an outburst of conversion symptoms or anger frequently follows. These are the more complicated hysterical reactions and have been spoken of as " hysterical personalities." Since, however, most of our hysterical patients show both conversion symptoms and personality deviations in some degree, no good purpose can be served by separating them here.

During the course of treatment anxiety symptoms or depression may be revealed in some cases. At times it may become apparent that a mood disturbance is really the leading feature of the illness. Such a case has been grouped accordingly, but wherever the hysterical reaction is the predominant feature the case has been included under this heading.

Sub Group—Anorexia Nervosa.

This small group has always been separated in the Medical Reports of the hospital. It has been strictly limited to those cases in which anorexia and loss of weight have occurred without serious mood disturbance or disorganisation of the personality, and without evidence of primary organic disease. Every case has occurred in a young, unmarried female. All have had amenorrhœa.

(*c*) Obsessive Compulsive Neurosis.

A group of patients showing either recurrent obsessional thoughts or compulsive acts which the patient frequently knows to be irrational but which he or she cannot avoid at least without marked anxiety.

(*d*) Psychopathic Personalities.

Patients whose symptoms suggest a constitutional difficulty in adapting themselves to the demands of everyday life which has been noted from an early age.

(*e*) Unclassified Neuroses.

Patients whose symptoms or behaviour are not readily identified with one of the other groups in this classification.

GROUP II. Alcoholism and Drug Addiction.

This is a small group requiring no further description. It tends to include a number of personality problems of which the addiction is the outstanding symptom.

GROUP III. Mood Reactions. (*a*) Depression.

Under this heading have been grouped those cases in which depression is the leading feature of the illness. In the group, however, are included depressions which are more or less endogenous or constitutional, and those which are more or less reactive. An attempt to separate these two groups would be foreign to the classification adopted. Moreover, its validity would be open to considerable doubt. In every case of depression it is necessary to assess the importance of the constitutional and environmental factors. In some of those which are generally termed reactive depressions much can be done by psychotherapy to shorten the duration of the illness and to prevent its recurrence. In others which appear to be constitutionally determined to a greater extent, it may be that psychotherapy cannot greatly reduce the length of the illness which runs a course in spite of treatment. Between these two extremes, from the psychoneurotic or reactive depression at the one end to the constitutionally determined, manic depressive illness at the other, lies an infinite variety of cases which might be labelled differently by different observers. The fact remains, however, that in all cases the constitutional and environmental difficulties of the patient have to be judged, and treatment has to be modified accordingly. Even in those depressions where little can be done by psychotherapy during the course of the illness, it appears that attention to the patient's subsequent mental hygiene may help to prevent recurrence. The organisation of the Cassel Hospital for psychotherapy is, however, such that it would be wasteful to admit, for treatment, cases where little psychotherapeutic help is possible.

(*b*) Excitement.

Cases in which hypomanic or manic excitement is a leading feature of the illness are not as a rule suitable for treatment in the hospital, though hypomanic features sometimes appear during the course of treatment of depressions and other illnesses.

GROUP IV. Schizophrenic Reactions. Paranoid Reactions.

Those patients whose reaction is predominantly of the schizophrenic type have been few. A number of patients whose illness has corresponded mainly to one of the other reaction types have shown some thought disorders of the schizophrenic type. Apart from these a few mild schizophrenic reactions have been treated in the hospital, but in the majority of cases their transfer to a mental hospital has been recommended. Patients in whom a paranoid reaction is the principle feature of the illness have also been included under this heading.

GROUP V. Organic and Toxic Reaction Types.

These are patients whose symptoms have depended mainly upon an organic or toxic disturbance of cerebral function. These patients are not usually suitable cases for treatment in the hospital though psychotherapy may sometimes prove valuable in assisting a patient with an organic limitation of cerebral function to adjust himself to his restricted capacity.

It will be observed that this classification does not presume to cover the whole field of psychiatry but only to provide a practical working basis for the presentation of the case material of the Cassel Hospital. In its conception it is intended to be sufficiently elastic to allow changes to be made, either because of increased knowledge or because of special interests which may from time to time be developed in the hospital concerning particular groups of patients.

Selection of Cases for Treatment.

The proper selection of cases for admission to the hospital is a problem of the utmost importance. The type of patient for whom the hospital is primarily intended is that in which intensive psychotherapy appears to offer the best prospect for recovery. It must not be inferred from this statement that the hospital has no concern for any other form of treatment. On the contrary, every patient receives a thorough physical examination and any special treatment is undertaken which may appear to be necessary. In considering the suitability of a patient for admission, however, emphasis is naturally placed upon the possibilities for psychotherapy. In addition, the whole environment of the hospital is designed to afford the maximum benefit for those who are able to organise their own daily life to some extent without the need for constant supervision. This type of organisation is very valuable for the majority of psychoneurotic patients, but it may be useless and indeed dangerous or harmful for more severely disorganised personalities, e.g., schizophrenic reactions, severe depressions, etc. Such patients are, therefore, apart from any other consideration, quite unsuitable for treatment in the Cassel Hospital.

Another consideration which limits the selection of cases for treatment is, paradoxically, the very adequate facilities which exist for psychotherapy. No member of the medical staff carries a regular load of more than 14 cases, and it is, therefore, of the utmost importance that as many as possible of those cases shall be suitable patients for intensive psychotherapy, otherwise the essential function of the hospital is wasted. Under these circumstances, chronic psychopathic personalities and other cases in which there is little prospect of improvement are not proper cases for treatment in the hospital.

On many occasions the general practitioner who refers the case for treatment cannot be certain whether it is likely to be a suitable one or not. During 1938, therefore, the Medical Director arranged to see personally in London those patients about whose admission there was some doubt. This interview was always carried out free of charge and was concerned only with the suitability of the patient for treatment in the hospital. The report of a consulting psychiatrist was, of course, accepted as an alternative. The arrangement has worked well and is being continued. It has resulted in a diminution of the number of unsuitable cases admitted into the hospital.

Occupations, Entertainments, etc.

This aspect of treatment is of the utmost importance. The problem of occupational therapy can be approached from a somewhat novel angle in dealing with psychoneurotic patients. It is of small value to insist that patients follow a certain specified activity at a certain time irrespective of their own needs. It is far better to place much more of the responsibility upon the patient's own shoulders and to foster the urge to activity from within. All patients who are able to do so are advised to find an occupation between the hours of 10 a.m. and 12 noon. The golf course, tennis courts, etc., are not available for use before this time. A register is kept in which the patients themselves are asked to enter details of their morning occupation. This may consist of one of the ordinary forms

of occupational therapy in the work-room, e.g., basket making, weaving, etc., or else carpentry or work in the engineer's shop. Many patients prefer to work out of doors where there are innumerable opportunities for gardening, farm work, etc. The maintenance of the tees, greens, etc., of the golf course is placed as far as possible in the patients' hands. This ensures that the more adequate the work done on the golf course the more satisfactory the subsequent game. It also stimulates a healthy rivalry as between the state of one green and another. The entertainments and games are also organised to a considerable extent by the patients themselves in co-operation with the responsible members of the Staff. In this way a convalescent patient is able to play an important part in the organisation of the life of the hospital, and can truly feel that he or she is a thoroughly useful member of the community. When a patient fails to respond to this atmosphere, his defection becomes an important therapeutic issue between himself and his doctor.

Methods of Psychotherapy.

The case material which passes through the hospital is a constant reminder of the need for a widely varying approach to different problems and of the uselessness of a cut and dried formulation. In certain cases methods of analysis of a Freudian type have seemed advisable. In others (and these have been the majority) methods allowing a greater use of constructive synthesis have been employed. In certain respects there is little room for difference of opinion. For example, the need for a thorough psychiatric history at the earliest possible stage of the patient's treatment is accepted in all cases, as also is the need for an adequate and early physical examination. These are essential preliminaries which form the basis upon which some estimation of the patient's assets and liabilities can be reached. They are, therefore, of the utmost importance in deciding the future plans for treatment. They have also a profound therapeutic value in establishing the patient's confidence and belief that his problems, both physical and mental, are receiving their full share of attention.

Treatment is essentially individual. A patient is allotted to one physician and normally remains with that physician throughout his stay at the hospital. The importance of the " transference situation " in treatment cannot be overlooked, whatever methods are employed. The term is perhaps an unfortunate one, since it implies an analysis of the relationship between patient and physician which is certainly not undertaken in all cases. The term " personal relationship " is, therefore, less liable to be confusing when used in this context, since it clearly covers those cases in which the relationship lends itself to analysis and those in which it does not. In either case, however, this relationship serves as a vehicle for the whole treatment and is not lightly to be interrupted. Occasionally it may become the principal problem in treatment and it may then require long and difficult analysis. Under these circumstances the experiment has sometimes been tried of transferring a patient from one physician to another in order that this relationship may receive more objective analysis at the hands of another person. This arrangement has proved helpful at times and has in certain cases considerably accelerated the treatment.

Tables of Cases.

One may now turn to the Tables of Cases discharged during the year 1938. The main table at the end contains a summary of all the cases grouped under their appropriate diagnostic headings. The cases are grouped under each heading according to the length of stay in the hospital. Age and sex are given in the first column ; duration of stay in the second ; leading symptoms in the third, and result on discharge in the fourth.

The term " Much Improved " is used for those cases whose symptoms at the time of their discharge are either completely relieved or much diminished. In addition, they have apparently gained some insight into the nature of their illness and of the maladjustments which have led up to it. The term " Improved " represents some symptomatic improvement without the same increase of insight. All other cases are described as " Not Improved."

In Table A, a numerical summary of this case material is presented. It will be observed that 137 patients were discharged from the hospital during the year. Of these 13 were re-admissions. 17 cases were discharged within one month of their arrival as being unsuitable for treatment in the hospital. This number includes only those for whom it was decided, on medical grounds, that treatment in the hospital would be inadvisable. It does not include any patients to whom treatment was offered but who discharged themselves for one reason or another at an early stage. This point is emphasised because the cases excluded are only those for which the hospital is not suitable. The group of 17, it will be noted, contains 9 depressions, in all of whom the illness was too severe for treatment in the hospital. It contains also 4 schizophrenic reactions, 2 organic reactions, and 2 hysterical reactions. Of the organic cases, one was a cerebral tumour. The patient had been treated in the hospital about 9 years previously for an anxiety state which was not apparently in any way connected with his subsequent tumour development. He was comatose on admission and died 24 hours after his transfer to the National Hospital. Of the hysterias, one was so disturbed that her removal from the hospital had to be recommended. The other was a pathological liar and was suspected of malingering. She was claiming compensation and in this particular case treatment was considered useless until her claim had been settled. Since in all these cases treatment was not pursued, they are not included in Table B.

In Table B, the cases are considered by diagnosis and by sex and the results of treatment are shown under the three headings " Much Improved," " Improved " and " Not Improved." These results must be accepted with caution for two reasons. Firstly, only the result on discharge is shown. It will be possible in future reports, as in the past, to compare these results with the results shown by the periodic follow-up. Secondly, the case material is highly selected. Grounds for the exclusion of certain patients have already been described. These may be on account of the seriously psychotic nature of the illness which renders the patient unsuitable for the environment of the hospital, or the patient may be regarded as unlikely to benefit sufficiently from psychotherapy. The latter factor of selection, in particular, should tend to increase the percentage of good results obtained with the case material accepted for treatment.

On the other hand, many patients come to hospital because their neurotic symptoms have reached such a degree of severity as to necessitate their removal from home and the discontinuance of psychotherapy in an " out-patient " capacity. This is a factor of selection which tends to work in the opposite direction and to counteract the previous factors.

In presenting this table of results, therefore, one must state that the figures given represent the rate of improvement under treatment of a group of cases selected to some extent for their suitability for treatment and to some extent by the fact that the degree and nature of their illness make hospitalisation advisable.

It is now proposed to describe in detail two cases from among those discharged during 1938. These cases are selected, not because they present any rare or extraordinary features, but for the opposite reason. They are samples of the ordinary case material of the hospital, cases which perhaps receive too little attention in the psychiatric literature of to-day. They do, however, illustrate one or two points which are held to be of great importance in the Cassel Hospital. One is the need for

a very broad approach to the problem of psychological illness which shall be formulated as far as possible in simple terms such as the patient himself might use. Another is the need to use all diagnostic terms with caution lest they be permitted to mean too much and to carry an ætiological and prognostic significance which far outruns the facts.

ANXIETY NEUROSIS. CASE NO. 20.

The patient, a man aged 37, was an engineer in a public corporation. His complaint on admission was as follows : " I have a pain in my left temple ; I cannot get my mind off myself. I feel full of anxiety ; noises worry me terribly ; I have fits of sweating ; I cannot do my work properly." He had had the present symptoms for about three years, but there had been two previous attacks. This attack started at a time when his wife had a ruptured ectopic gestation. It began with pain in the ears which was treated in various ways. The patient believed that bad teeth were at the root of the trouble, and tried to persuade his dentist to extract a number of perfectly sound ones. The dentist refused to do so, and later the patient's symptoms grew worse and he had a " nervous collapse " with much feeling of mental anxiety. He was away from his work for a while and on returning to it he began to experience trouble with his eyes. He had a number of careful physical examinations at which only minor troubles were found, and his symptoms continued to increase until he was finally admitted to hospital.

In his previous history it was found that he had been brought up by a fussy, over-anxious mother upon whom he had always been very dependent. As a schoolboy he had the reputation of being a dare-devil who would attempt anything, but at the same time he was always secretly over-anxious. As he grew older his ambition, which was strong, was constantly thwarted by his anxiety and dependence on his mother. He became an engineer in the Mercantile Service, but soon grew to dislike the work. He desired to get away from home yet was not happy when he had succeeded in doing so. He was married in 1926, but his wife did not get on well with his mother, and there were troubles between them. At this time he began to develop attacks of sweating, and he was able to recollect that the first one occurred after a row between his wife and mother. His dislike of the sea grew more acute at this time and he began to fear that the heat of the engine room was affecting his health. One of his shipmates developed tuberculosis and he thought that he too might be suffering from this condition. He consulted a number of specialists and finally gave up his job at sea.

Afterwards, he was well for a time and settled down happily with his wife at home. He was, however, always somewhat childish in his attitude towards her, demanding that she should be more of a mother than wife to him. Their sexual adjustment was not entirely satisfactory and he found great difficulty in asking her to have intercourse with him. He felt that her refusal would be a great rebuff to his pride.

He obtained a good job in which he did well, but in this also he was anxious, feeling that he had to carry it out to perfection and worrying over the possibility of failure.

In 1933 his wife became pregnant and at the same time her mother was taken ill so that she could not devote as much time to him as usual. He became restless and resentful and soon began to develop symptoms of anxiety together with pains in the head. After the baby was born the symptoms improved but when his wife again became pregnant in 1936 and was taken seriously ill with a ruptured ectopic gestation, he relapsed and gradually became worse.

He had never had any serious physical illness except for a supposed attack of chorea at the age of 11. The family history revealed no obvious evidence of mental disorder.

A physical examination revealed no evidence of organic disorder. A study of his mental status showed that there was no serious disturbance of mood and no formal disorder of thought content. A diagnosis of an anxiety neurosis was made. Treatment could be divided into two stages. In the first stage he was given a thorough reassurance on the basis of the physical examination. This had been done before without much effect, but on this occasion it was associated with a detailed explanation of the origin of his symptoms through psychological factors. This explanation was repeated many times with illustrations of actual occurrences of physical symptoms in connection with psychological difficulties in the past and present. The need for repetition is a matter which must be stressed. The same points have frequently to be driven home from many different angles before the patient is able to accept them. He began to assume a somewhat different attitude towards his symptoms and at this stage an analysis of his personality difficulties was undertaken. He was able to discuss constructively his relationship with his mother and to see how the difficulties which had arisen in this respect had been carried over into his relationship with his wife. The whole question of his marital relationship with her was thoroughly discussed, and he realised that he had adopted false standards of pride and had been childish and demanding. A detailed analysis of his ambitions in his work and other fields was also undertaken, and he was able to modify his perfectionistic attitude towards success and failure.

Towards the end of his period of treatment his wife came to stay near at hand, and he found that his attitude towards her had changed considerably. He was less dependent upon her and less jealous, and at the same time able to discuss his feelings with her more frankly and openly than before.

He had a slight relapse a few weeks before leaving, and it was found that this was associated with a feeling that his recovery ought to be such as to render him free from any symptoms of any kind whatever. He had always felt that good health should be absolute and not relative. This was typical of his perfectionistic attitude towards many other matters which had been discussed. He was able to see it in this light and his anxiety symptoms quickly faded into the background. At the end of his treatment he was able to tolerate minor physical discomforts without undue concern.

This case might have been formulated in many different ways. In his attitude towards his work and bodily health the patient had a need for perfection which might be termed obsessional. The occurrence of the symptoms in periodic attacks might lead one to emphasise the importance of any depression which was found. If, however, a longitudinal section of the case history is considered, the gradual development of pathological anxiety upon a background of imperfect personality development is clearly seen. This can be expressed in simple terms which are ultimately satisfying both to the psychiatrist and to the patient. Such a formulation cannot be termed superficial, nor can it be said to deal exclusively with conscious factors. On the contrary, many matters were brought forward of which the patient had not been previously conscious and many of them were reached through dream analysis and free association.

The whole treatment occupied a period of three months and the patient achieved understanding of his personality problems on both an emotional and intellectual plane.

The next patient to be presented is an example of a depressive reaction. The case is of particular interest in that it demonstrates most vividly the danger of accepting without the most searching enquiry the constitutional origin of a recurrent depressive illness. In this case the symptomatology differed sharply from the previous case in that an evident mood disturbance was the outstanding feature of the illness. It is reasonable to assume that this patient had a constitutional tendency to react with depression instead of with anxiety to her personality problems. Her problems were,

however, just as amenable to psychotherapy, and the depression no more came " out of the blue " than did the anxiety symptoms first described. Her treatment occupied a period of five months.

DEPRESSION. CASE NO. 11.

The patient, a woman of 31, was admitted to the hospital with a diagnosis that she was suffering from a form of manic depressive psychosis. From the history this was supposed to be her third attack, and all the attacks were stated to have occurred with little apparent cause and to have disappeared without definite treatment.

When the patient was admitted she had been ill for about six months. She was depressed with a strongly expressed fear of a return of the depression if and when she got better and with a fixed feeling that she was doomed for life. For the first few days she talked only about superficial things or recent events in her life such as her love affairs previous to her breakdown. After about a week she was persuaded to give a detailed account of her life, which revealed at once a deep seated maladjustment.

She was the youngest of a family of five. Her father was the unsuccessful son of a successful and quite wealthy family in England who were very strict and belonged to the Church. In his youth he was sent to South Africa to make his way by farming. He married a girl there who was pretty, vivacious, and feckless, and who was regarded by his family as being " worldly." The family in England did not quite approve of the marriage but undertook to attend to the education of any sons of the marriage. There were three boys and two girls. The marriage was not very successful and the patient's life in South Africa in her early days was unsatisfactory in every way. It was interspersed with one or two visits to England to her relations. It was also disturbed on one or two occasions when her mother left her father, and also on one occasion by the knowledge that her father had been unfaithful to her mother and had been friendly with the mother's sister by whom an illegitimate child was born.

About 1916, after the War had broken out and two of the elder sons had been killed in France, the mother finally returned to England bringing with her the two girls. The father later returned from South Africa and did some war work. Meanwhile, the family were financially dependent on the father's relations, who were very strict, though kind to them in a material way. The patient's sister took up nursing but contracted an illness about 18 months after and died. After the War the father returned to South Africa leaving the mother and patient behind and they never rejoined him. A few years later he died in South Africa leaving no money at all, so the mother and daughter became entirely dependent on his family who undertook the patient's education. She decided, when she was about seventeen, that she would like to take up physical training, but the family for a long time opposed this, as they did not think it was quite a respectable vocation for a girl, but after long arguments they finally relented and the patient went to a physical training centre.

In the third year of her training just before her final examinations there were a series of difficulties with the Head of the College and with the patient's relatives who were interfering. This made her feel it was going to be very difficult to get a job when she finished her training. At this time also her physical health was poor owing to hæmorrhage from piles. She was sent to a hospital to do a course in anatomy, and her first experience of hospital life rather upset her because it reminded her of her sister's death. She became depressed and began to sleep badly. She was seen by a consultant who sent her off for a fortnight's holiday. She improved and came back to finish her work. After she qualified she was quite successful in getting jobs and about two years later she had a post in a school

where she led a very strenuous life, working very hard and playing very hard. She became friendly with a set of people who were better off than herself, and this rather increased her tendency to extravagance which had always been a source of dissension with her relations. She finally helped herself to some money from a Staff Fund meaning to return it at the end of term, but towards the end of term when she found herself unable to do so she became very worried. She got an attack of tonsillitis and had to have her tonsils removed. She became depressed again and was sent to see another consultant who sent her to a nursing home in the country. She had lost much weight and was sleeping badly. After about ten days there she began to tell the doctor in charge about her worry over the money. She felt that at last she was going to find some person who could help her when a relative, a doctor, who was financially responsible for her in this nursing home suddenly came down to see her. Because the patient was not having massage as he thought necessary, he removed her at once and put her into a surgical nursing home in London for a form of Weir Mitchell treatment, which consisted in having the patient kept upstairs in a top room with no visitors and no letters. She became exceedingly depressed and ate very little. She made an attempt to communicate with the outside world by throwing a letter into the street. Finally, after about three weeks there, the Matron of the home sent for her relative and refused to keep her longer as she was not a suitable patient. She was then removed into the acute ward of a Hospital for Mental Diseases. She got gradually better there but received the impression that she was suffering from a form of nervous illness which was recurrent and though she would recover from this attack, there was a fear of it returning several times during her life. She was unhappy at this hospital and insisted on being removed before she was quite well. She went down to the country and in a few months' time was sufficiently well to resume work. After a while she got a job which she liked very much in a massage clinic, and though she was always very happy there, she was frightened that the depression would return and frightened also at the thought of her previous experience of nursing homes. She worked for about 18 months at this clinic. At the same time she was leading a rather gay life with one or two hectic love affairs, and she finally got emotionally attached to one of her chiefs who was married. She became depressed and sleepless and was seen by several doctors in London who diagnosed the condition as a return of the manic depressive illness. She was sent to a nursing home in the country and remained there for several months before she was admitted to the Cassel Hospital.

A superficial view of this history, with the story of depression alternating with periods of extravagance and hectic social activity, might lead to the view that one was dealing primarily with a series of manic depressive mood swings. From this it would be easy to conclude that the mood changes were themselves the determining factors, and that the other occurrences were secondary to these. A diagnosis of manic depressive illness might be permissible provided that it did not carry with it a special ætiological and prognostic significance. When the case history is considered in detail it becomes evident that the mood changes depended to a very large extent upon psychological factors which were capable of modification. Treatment consisted of a thorough analysis of these factors, during which the patient learned to acquire a much better understanding of her illness and of the difficulties which had led up to it. She also came to realise that the attacks of depression were not things which came upon her without warning or reason but were, on the contrary, the result of her difficulties with which she had not learned to deal adequately.

It would be premature to say that this patient is not likely to suffer another attack of depression. It is obviously possible that she may again get into difficulties and react in this way, but at present she is leading a very normal existence, and her whole adjustment to life is now such that there seems to be far less possibility of relapse.

1938

TABLE A.

Total number of Patients Discharged from Hospital during 1938.

CLASSIFICATION.

	New Patients.	Re-admissions.	Total.	Discharged unsuitable within 1 month	Total in which treatment undertaken.
Anxiety States	33	2	35	—	35
Hysteria	20	2	22	2	20
Anorexia Nervosa...	1	—	1	—	1
Obsessional States	9	—	9	—	9
Psychopathic Personality ...	7	—	7	—	7
Unclassified Neuroses	1	—	1	—	1
Alcoholic State and Drug Addt.	1	1	2	—	2
Depressive States	39	6	45	9	36
Schizophrenic States	7	—	7	4	3
Paranoid States	2	—	2	—	2
Organic and Toxic Reaction ...	4	2	6	2	4
Grand Total	**124**	**13**	**137**	**17**	**120**

1938.

TABLE B.

Total number of Patients for whom treatment was undertaken. Classification by Sex, and condition on Discharge.

	MALES.				FEMALES.				TOTALS			
	Much Imp.	Imp.	Not Imp.	Total.	Much Imp.	Imp.	Not Imp.	Total.	Much Imp.	Imp.	Not Imp.	Total.
Anxiety States	21	3	1	25	10	—	—	10	31	3	1	35
Hysteria	3	—	—	3	8	3	6	17	11	3	6	20
Anorexia Nervosa	—	—	—	—	1	—	—	1	1	—	—	1
Obsessional States	4	3	—	7	1	—	1	2	5	3	1	9
Psychopathic Personality	—	5	1	6	—	1	—	1	—	6	1	7
Unclassified Neuroses	—	—	—	—	—	—	1	1	—	—	1	1
Alcoholic State and Drug Addt. ...	1	—	—	1	—	1	—	1	1	1	—	2
Depressive States	8	2	1	11	13	6	6	25	21	8	7	36
Schizophrenic States	—	—	2	2	—	—	1	1	—	—	3	3
Paranoid States	—	—	—	—	—	1	1	2	—	1	1	2
Organic and Toxic States ...	—	2	—	2	—	1	1	2	—	3	1	4
Grand Total	**37**	**15**	**5**	**57**	**33**	**13**	**17**	**63**	**70**	**28**	**22**	**120**
Percentage	**65%**	**26%**	**9%**	**100%**	**52%**	**21%**	**27%**	**100%**	**58%**	**23%**	**18%**	**100%**

1938.

GROUP I.

PSYCHONEUROSES.

ANXIETY STATES.

Sex and Age	Duration of stay	Symptoms	Result on Discharge
1 F. 42	1 year 4 months.	Palpitations, fears. (Some hyperthyroidism.)	Much improved.
2 M. 28	9 months.	Palpitations, headache, insomnia.	Much improved.
3 M. 47	9 months.	Fear of illness, anxiety, feeling of weakness.	Much improved.
4 F. 51	7 months.	Headache, fatigue, anxiety.	Much improved.
5 F. 52	7 months.	Fears of illness, depression, inability to walk (hysterical features).	Much improved.
6 M. 28	7 months.	Pain in face, anxiety.	Much improved.
7 F. 32	6½ months.	Anxiety, indecision, insomnia (depressive features).	Much improved.
8 M. 22	6 months.	Many fears, loss of appetite, insomnia.	Much improved.
9 F. 39	6 months.	Fears of health, panicky feelings, fear of dark.	Much improved.
10 M. 38	5 months	Palpitation, pains, fears.	Much improved.
11 F. 39	5 months	Anxiety, insomnia, depression (depressive features).	Much improved.
12 F. 54	4½ months.	Anxiety, hypochondriasis.	Much improved.
13 M. 40	4½ months.	Anxiety attacks, tremors, fears.	Much improved.
14 M. 40	4 months.	Hypochondriasis, insomnia, depression (depressive features).	Much improved.
15 M. 38	4 months.	Anxiety, insomnia, headaches.	Not improved.
16 M. 42	4 months.	Anxiety, restlessness, fears.	Much improved.
17 M. 36	4 months.	Anxiety, weakness, fears, lack of concentration.	Much improved.

1938.

GROUP I.

PSYCHONEUROSES.

ANXIETY STATES—*continued.*

Sex and Age	Duration of stay	Symptoms	Result on Discharge
18 M. 36	3½ months.	Fears, abdominal pain, hypochondriasis.	Much improved.
19 M. 30	3 months.	Depression, anxiety attacks, lack of concentration.	Improved.
20 M. 36	3 months.	Palpitation, pains in head, anxiety.	Much improved.
21 M. 69	3 months	Fatigue, lack of concentration, insomnia.	Much improved.
22 F. 52	3 months.	Anxiety, insomnia, depression (manic depressive mood swings.)	Much improved.
23 M. 55	3 months.	Anxiety, depression, alcoholism.	Improved.
24 M. 46	2 months.	Giddy turns, palpitation, depression.	Much improved.
25 M. 45	2 months.	Insomnia, anxiety, loss of appetite.	Improved.
26 M. 33	2 months.	Anxiety, insomnia, depression (depressive features).	Much improved.
27 M. 46	7 weeks.	Fears, restlessness, depression, (depressive features).	Much improved.
28 M. 51	6 weeks.	Anxiety, exhaustion, insomnia, weeping attacks (depressive features).	Much improved.
29 M. 61	5 weeks.	Anxiety, depression (cardiac failure)	Much improved.
30 M. 39	4 weeks.	Palpitation, giddiness, backache.	Much improved.
31 M. 30	4 weeks.	Fears, impotence, depression (psychopathic personality and mood swings).	Much improved.
32 F. 34	4 weeks.	Fears, nausea, insomnia (depressive features).	Much improved.
33 F. 35	4 weeks.	Fears, obsessional thoughts, anxiety attacks (obsessional features).	Much improved.

1938.

GROUP I.

Psychoneuroses.

Anxiety States.

Readmissions.

Sex and Age	Duration of stay	Symptoms	Result on Discharge
1 M. 42	7 months.	Anxiety, depression, insomnia (depressive features).	Much improved.
2 M. 35	4 months.	Anxiety, hypochondriasis, grievances (paranoid trends).	Much improved.

1938.

GROUP I.

Psychoneuroses.

Hysteria.

Sex and Age	Duration of stay	Symptoms	Result on Discharge
1 F. 21	1 year 3 months.	Fear of illness, inability to go out alone, insomnia.	Much improved.
2 F. 51	1 year.	Anorexia, headache, insomnia, hyperpnœa (depressive features).	Much improved.
3 F. 36	10 months.	Bedridden, fears of collapse, depression (paranoid features).	Much improved.
4 F. 35	9 months.	Lack of concentration, inability to travel alone, depression.	Much improved.
5 F. 17	9 months.	Fears, hypochondriasis, depression.	Much improved.
6 M. 37	9 months.	Ataxia, amnesia, agraphia, dysphonia (psychopathic personality).	Much improved.
7 F. 45	8 months.	Anorexia, abdominal pain, screaming attacks.	Not improved.

1938.

GROUP I.

PSYCHONEUROSES.

HYSTERIA—*continued.*

Sex and Age	Duration of stay	Symptoms	Result on Discharge
8 F. 27	5 months.	Self mutilation, fears, weeping.	Improved. (Removed by parents)
9 M. 44	4½ months.	Paralysis of legs, tremor, insomnia.	Much improved.
10 F. 50	3 months.	Insomnia, fears, depression, (paranoid features).	Not improved.
11 F. 22	3 months.	Attacks of sleepiness and depression.	Much improved.
12 F. 25	2½ months.	Anorexia, fears, indecision.	Discharged herself. Improved.
13 M. 38	2 months	Spastic paralysis, inability to walk, feeling of of self-consciousness (following severe anterior poliomyelitis).	Much improved.
14 F. 38	2 months.	Inco-ordination of legs, twitching, speech difficulty.	Much improved.
15 F. 17	5 weeks	Difficulty in walking, screaming attacks, becoming more noisy.	Discharged to mental hospital. Not improved.
16 F. 46	1 month.	Anorexia, paralysis of arms and legs (schizophrenic features).	Not improved. Discharged unsuitable.
17 F. 56	1 month.	Tremors, fears, threats of suicide (depressive features)	Discharged to mental hospital. Not improved.
18 F. 27	3 weeks.	Pain in back, inability to move (Compensation neurosis ? malingering).	Discharged unsuitable. Not improved.
19 F. 21	11 days.	Behaviour difficulties. Refusal to co-operate with others. (Psychopathic personality).	Disharged herself. Not improved.
20 F. 30	5 days.	Palpitations, attacks of terror, collapse.	Not improved.

1938.

GROUP I.

Psychoneuroses.

Hysteria.

Readmissions.

Sex and Age	Duration of stay	Symptoms	Result on Discharge
1 F. 49	2½ months.	Fear of noise, depression.	Much improved.
2 F. 36	1 month.	Frigidity, temper outbursts.	Improved.

1938.

GROUP I.

Psychoneuroses.

Sub-Group—Anorexia Nervosa.

Sex and Age	Duration of stay	Symptoms	Result on Discharge
1 F. 15	8 months.	Loss of weight, anorexia, amenorrhœa.	Much improved.

1938.

GROUP I.

Psychoneuroses.

Obsessional States.

Sex and Age	Duration of stay	Symptoms	Result on Discharge
1 M. 20	1 year 6 months.	Obsessional thoughts, compulsive activities (schizophrenic features)	Improved.
2 M.25	1 year 1½ months.	Fears, obsessional phrases, feeling of influence (schizophrenic features).	Improved.

1938.

GROUP I.

Psychoneuroses.

Obsessional States—*continued*

Sex and Age	Duration of stay	Symptoms	Result on Discharge
3 M. 42	1 year 1 month.	Obsessional fears, ritualistic practices, washing and counting.	Much improved.
4 F. 35	1 year.	Fear of dirt, compulsive washing.	Much improved.
5 M. 23	10 months.	Obsessional thoughts, solitary, fear of disease (schizophrenic features).	Much improved.
6 M. 32	4 months.	Fears of improper behaviour, fear of police watching him. (Paranoid features).	Much improved.
7 M. 38	3½ months.	Hand washing, obsessional praying, depression.	Much improved.
8 M. 21	3 months	Obsessional thinking, negative compulsions.	Improved.
9 F. 35	1 month.	Obsessional thinking, feeling of tension, restlessness (schizophrenic features).	Not improved.

1938.

GROUP I.

Psychoneuroses.

Psychopathic Personality.

Sex and Age	Duration of stay	Symptoms	Result on Discharge
1 M. 31	9 months.	Obsessional fears, feeling of worthlessness (obsessional features, mood swings).	Improved.
2 F. 37	6 months.	Temper outbursts, lying, insomnia (hysterical features).	Improved.
3 M. 51	5 months.	Depression, feeling of inadequacy, paranoid ideas. (Paranoid depression, alcoholism.)	Improved.
4 M. 28	3 months.	Apprehensive, self conscious, depressed, impulsive.	Improved.
5 M. 26	3 months	Homosexual assault, general maladjustment.	Improved.
6 M. 33	2 months.	Inability to go out alone, lying, delinquency.	Improved.
7 M. 49	1 month.	Fetishism, anxiety attacks, insomnia, (alcoholism).	Not improved.

1938.

GROUP I.

Psychoneuroses.

Unclassified Neuroses.

Sex and Age	Duration of stay	Symptoms	Result on Discharge
1 F. 49	6 days.	Eczema, probably psychogenic.	Not improved.

1938.

GROUP II.

Alcoholic States.

Sex and Age	Duration of stay	Symptoms	Result on Discharge
1 F. 35	3 months	Drinking, quarrelsome, financial difficulties (mood swings, alcoholism).	Improved.

1938.

GROUP II.

Alcoholic States.

Readmissions.

Age and Sex	Duration of Stay	Symptoms	Result on Discharge
1 M. 41	4 months.	Depression, irritability, feeling of unworthiness (alcoholism).	Much improved.

1938.

GROUP III.

Mood Reactions.

Depressive States.

Sex and Age	Duration of Stay	Symptoms	Result on Discharge
1 F. 23	2 years 4 months.	Tearful, irritable, overactive, hypochondriacal (mixed manic depressive illness).	Improved.
2 F. 22	1 year 10 months.	Depression, unstable and irresponsible behaviour (immature psychopathic personality).	Much improved.
3 M. 32	1 year, 8 months.	Depression, inability to concentrate, food fads (obsessional features).	Much improved.
4 M. 33	11 months.	Unable to concentrate, felt sinful, believed himself damned (paranoid features).	Much improved.
5 F. 45	8 months.	Insomnia, depression, fatigue.	Much improved.
6 M. 42	7 months.	Depression, insomnia, lack of concentration.	Much improved.
7 F. 52	7 months.	Depression, insomnia, noisy weeping (hysterical features).	Much improved.
8 F. 44	6½ months.	Depression, feeling people are antagonistic to her.	Much improved.
9 F. 46	6 months.	Depression, insomnia.	Improved.
10 F. 26	5 months	Depression, feelings of guilt, later over-active, aggressive behaviour (manic swing).	Discharged unsuitable. Not improved.
11 F. 31	5 months.	Insomnia, depression, fears.	Much improved.
12 F. 58	5 months.	Depression, later some over-activity (manic features).	Much improved.
13 F. 54	4½ months.	Depression, lack of concentration, later over-activity (manic features).	Much improved.
14 M. 51	4½ months.	Depression, feeling of weakness, irritability.	Much improved.

1938.

GROUP III.

Mood Reactions.

Depressive States—*continued.*

Sex and Age	Duration of Stay	Symptoms	Result on Discharge
15 M. 53	4 months.	Depression, insomnia, feeling of hopelessness.	Much improved.
16 M. 38	4 months.	Depression, feeling of tension.	Improved.
17 F. 51	4 months.	Depression, insomnia, fears	Much improved.
18 F. 42	3 months.	Depression, agitation, weeping, insomnia.	Improved.
19 F. 21.	3 months.	Depression, feeling of futility and loneliness.	Much improved.
20 F. 68	3 months.	Depression, insomnia, headache (senile arteriosclerotic features).	Much improved.
21 F. 47	2½ months.	Sleeplessness, feeling of anxiety, throbbing in head, depression (anxiety features).	Much improved.
22 F. 76	2 months.	Depression, insomnia, anxiety.	Much improved.
23 F. 42	1½ months.	Anxious, restless, depressed.	Patient discharged herself. Not improved.
24 F. 38	7 weeks.	Refusal of food, depression, delusional development concerning diabolic possession (paranoid features).	Discharged unsuitable. Not improved.
25 F. 29	1 month.	Depression, indecision, emotional ourbursts (hysterical features).	Not improved.
26 M. 46	1 month.	Depression, lack of concentration, insomnia.	Much improved.
27 M. 48	1 month.	Depression (mental defect, ? birth injury).	Improved.
28 F. 32	3 weeks.	Depression, agitation, obsessional recurrence of words (psychopathic personality, alcoholism).	Not improved.
29 M. 48	3 weeks.	Depression, insomnia, self-reproach.	Much improved.

1938.

GROUP III.

Mood Reactions.

Depressive States—*continued.*

Sex and Age	Duration of Stay	Symptoms	Result on Discharge
30 M. 29	3 weeks.	Depression, feeling of unworthiness.	Discharged unsuitable. Not improved.
31 F. 49	10 days.	Depression, insomnia, fears.	Discharged unsuitable. Not improved.
32 M. 33	9 days.	Depression, agitation.	Discharged unsuitable. Not improved.
33 F. 49	9 days.	Depression, agitation (paranoid ideas).	Discharged unsuitable. Not improved.
34 M. 30	8 days.	Agitation, depression, loss of identity.	Discharged unsuitable. Not improved.
35 M. 57	6 days.	Depression, hypochondriasis.	Discharged unsuitable. Not improved.
36 F. 42	6 days.	Depression, agitation.	Discharged unsuitable. Not improved.
37 F. 22	3 days.	Depression, feeling of emptiness, suicidal preoccupations.	Discharged unsuitable. Not improved.
38 F. 39	3 days	Depression, anxiety.	Ran away. Not improved.
39 M. 45	1 day.	Depression, agitation (paranoid ideas)	Discharged unsuitable. Not improved.

1938.

GROUP III.

Mood Reactions.

Depressive States.

Readmissions.

Sex and Age	Duration of Stay	Symptoms	Result on Discharge
1 F. 45	3½ months.	Depression, insomnia, loss of weight.	Improved.
2 F. 63	3 months.	Depression, sleeplessness, agitation.	Much improved.
3 F. 21	3 months.	Depression, tension, guilt feelings (immature psychopathic personality).	Improved.
4 F. 29	2½ months.	Depression.	Improved.
5 M. 36	2 months.	Depression, anxiety, and later some over-activity.	Much improved.
6 M. 46	1 month.	Depression, anxiety.	Discharged unsuitable. Not improved.

1938.

GROUP IV.

Schizophrenic States.

Sex and Age	Duration of Stay	Symptoms	Result on Discharge
1 M. 22	2½ months.	Tense, suspicious, inability to concentrate.	Not improved.
2 M. 19	1 month.	Fears, bizarre hypochondriasis.	Not improved.
3 F. 32	1 month	Breathlessness, weakness, amenorrhea (? adrenal tumour).	Discharged for physical investigation. Not improved.

1938.

GROUP IV.

Schizophrenic States—*continued.*

Sex and Age	Duration of Stay	Symptoms	Result on Discharge
4 M. 22	12 days	Depression, insomnia, delusions.	Discharged unsuitable. Not improved.
5 F. 25	9 days	Anorexia, negativism, thought disorder.	Discharged unsuitable. Not improved.
6 M.32	2 days	Apathy, depression, thought disorder.	Discharged unsuitable. Not improved.
7 F. 31	1 day	Bizarre hypochondriasis.	Discharged unsuitable. Not improved.

1938.

GROUP IV.

Paranoid States.

Sex and Age	Duration of Stay	Symptoms	Result on Discharge
1 F. 49	1 year 9 months.	Pain in face, weeping, depression, feeling others against her. (Depressive features).	Improved.
2 F. 49	9 months.	Quarrelsome, eccentric, dominating behaviour at home.	Not improved.

1938.

GROUP V.

Organic & Toxic.

Reaction Types.

Sex and Age	Duration of Stay	Symptoms	Result on Discharge
1 F. 60	1 year 4 months.	Insomnia, lack of concentration, pains (cerebral arteriosclerosis).	Improved.
2 M. 65	9 months.	Depression, feeling of being despised, insomnia (depression, cerebral arteriosclerosis).	Improved.
3 F. 70	7 months.	Insomnia, restlessness, confusion, tremor (agitated depression, paralysis agitans).	Not improved.
4 F. 62	1 week.	Confused, restless, depressed, sleepless (cerebral deterioration, ? arteriosclerotic)	Discharged unsuitable. Not improved.

1938.

GROUP V.

Organic & Toxic.

Reaction Types.

Readmissions.

Sex and Age	Duration of Stay	Symptoms	Result on Discharge
1 M. 70	1 month.	Depression, agitation, cerebral arteriosclerosis.	Improved.
2 M. 49	1 day.	Comatose (cerebral tumour).	Discharged unsuitable. Transferred to National Hospital.

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