A RETROSPECT ON PSYCHIATRY AFTER 40 YEARS OF GENERAL PRACTICE*

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I was educated in medicine in a school which specialized in teaching the personal approach to medicine as opposed to the purely scientific, detached treatment of disease. In spite of this the teaching of psychiatry was poor. We were given a few lectures on mental diseases, which consisted more of describing psychiatric states than in suggesting any approach to treatment. A patient was either certifiable or not certifiable according to the safety of the patient himself, or to his potential danger to others. Very little was attempted in the way of treatment, except in cases of general paralysis of the insane which were fairly common in those days. When I or other students thought of reading Freud, we were told not to do so, because his theories were more or less quackery.

It was about five years later that I first came in touch with modern ideas on psychiatry. During the first World War I was on the staff of Chatham Naval Hospital which, early in the war, had no psychiatrist on the staff, and Dr Beatson, who before the war had been a junior registrar in a mental hospital and was then a temporary naval surgeon serving at sea, was brought ashore to deal with the situation. He was a personal friend of mine and I learned from him the elements of the psychological approach.

In February 1919, I was demobilized and took over a small general practice from a very good, young doctor who was being treated for a mental breakdown by Dr Crichton-Miller, then one of the leading psychiatrists in London. My predecessor was cured by analysis, and afterwards specialized in dental radiology. I became very good friends with Dr Crichton-Miller, but I still knew nothing of psychology. Crichton-Miller had been ten years in general practice in Scotland and in Italy before taking up psychiatry.

In general practice I soon found I was out of my depth in this branch of medicine, and so I started referring cases to Crichton-Miller, meeting him in consultation on many occasions. An outstanding cure of one particular case impressed me very much.

The patient was a girl aged 16 whose parents I knew well as patients, and who had great faith in me. They had brought her up to rely on my medical care with the utmost faith. She came to me with the story that she had fainting attacks. I could not find any cause. I referred her to a well-known consulting physician, and to a neurologist on the staff of a teaching hospital. They both diagnosed vaso-motor trouble. In spite of this and their suggested line of

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treatment, the girl got worse, was said to have more attacks. At that time I had not seen any of her fits. She went to the coast to convalesce and walked into the sea with her clothes on. Her friends brought her back, but she was said not to have understood the situation—presumably because she was in a light trance. Shortly after her return I was called by a neighbour to a house near the surgery as an urgent call, to see a girl who had collapsed on the pavement. I recognized the girl, and found her in a trance, from which I roused her by speech and stimulation with pins. Next she collapsed in the middle of the road quite near the surgery. Then an attack occurred as the girl walked from the waiting room to the consulting room. She became deeply comatose, her respirations were almost inperceptible, and her heart only flickering. She looked cyanosed and nearly dead. She did not recover consciousness on this occasion for nearly six hours. After this she had several long attacks, until she spent most of the twenty-four hours unconscious. She was cured by Dr Crichton-Miller who considered her an exhibitionist, and she has never relapsed. About twenty years later she ran a coffee stall in London during the ' blitz ' and later became a policewoman. I have not seen her for years now.

After this I sent more cases to Dr Crichton-Miller, and also started reading psychiatry. I read Freud, Adler, Crichton-Miller, Havelock Ellis and others, and I was invited to lectures in London by Crichton-Miller, Rees, Henry Wilson, and later by Graham Howe. When I first read Graham Howe's book *Motives and Mechanisms of the Mind* I did not understand it, but after reading it three times I thought it excellent. So, gradually, I became able to deal with easy cases of psychological illness, and to determine which were suitable for further advice. It was fairly easy in the 1920's and 1930's to get help through either private consultation or the Tavistock Clinic.

Today it is more difficult. Most people expect N.H.S. treatment, and certainly do not want to attend a mental hospital. Consultations can be obtained at the psychiatric departments of teaching hospitals, but I find these not very satisfactory. The tendency is to refer them back to me, (and I have generally tried my ideas before sending them to hospital) or to give them ECT. The latter often fails, in my experience, and, if successful, the patient is very liable to relapse, and many are too frightened to go back for more treatment. ECT is certainly better than its predecessor, convulsant drug therapy. I am wondering if prolonged narcosis is still used; it was sometimes successful. I have no real experience of cerebral leucotomy: one of my acquaintances is a great success but he is not my patient. Analysis does not seem to be used today. The objection to long analysis is its cost in time and money, but why is not rapid analysis, as was often used in the war, employed more frequently. This seems to me more rational than ECT.

The system of certification at present, via the duly authorized officer, is quite unsuited for the patient who has good and bad patches. There is only a chance that the bad condition is seen, and, if it is not, the case is turned down, and the general practitioner is left with a very difficult case on his hands.

Change of occupation sometimes does more for a patient than

hospital treatment. For instance, a patient who was a jeweller and a setter of precious stones became depressed and suicidal. Change of occupation to hospital theatre porter has helped him a lot, and he is now very happy, and although he earns much less money, he now has no thoughts of suicide.

When dealing with children, one has often to treat the mother as well. The following case was referred to me by a local doctor. It was a child of about 12—14 years who took to stealing at school owing to lack of any affection at home. He came from an apparently good family; the mother had been a trained nurse before marriage, but she had a very stern unsympathetic outlook on life, and did not believe in any display of emotion. Her outlook was purely rational. The child was cured chiefly by educating the mother to show love and emotion to her child.

Depressed cases are often thought to be suicidal. For example a woman stored sleeping tablets (barbiturates) and took all of them. I saw her just before death. She told me she would not see me again. I did not believe her at the time, but she was found dead a few hours later. The post mortem revealed death from barbiturates, but the relatives refused to believe it was suicide. I suppose we have all seen cases of depression, before we realized that they were bad enough to commit suicide. I know a case of a young man in a mental hospital who had insulin treatment (and possibly ECT) and, when on parole from hospital, pushed a man in front of an express train without any provocation. This boy was not his father's child, and had had a bad upbringing.

A recent improvement is the encouragement of voluntary boarders in mental hospitals. Years ago it was fairly common to certify patients in order that they might have treatment. This seems to have been abandoned, but I think it served its purpose.

One of the most dangerous cases I ever had to deal with was not certified because his wife would not agree. He had an obsession against catholics, and had bursts of homicidal mania, often directed against his wife, and occasionally against me. He was afterwards legally separated from his wife, largely on my evidence in Court of his cruelty to her. He spent every week-end with her afterwards until her death. I have not seen him since then.

I remember a woman about 50 years of age who was under my care for a long period. I sent her to at least two psychiatrists as probably suicidal. The idea was at first turned down, but later she was admitted to a mental hospital. I do not remember for certain what form of treatment was given. She was sent home as believed cured, and promptly committed suicide. I was made the scapegoat, and discarded as family doctor for not having cured the patient.

Young adults—perhaps schizophrenic—sometimes decide to live in hospital, or go back there frequently. This seems to me very unsatisfactory. In my view, few cases are cured by ECT, but many more were cured by analysis. It is a pity that the latter is too costly in time and money. Cases of advanced arteriosclerosis are sometimes treated with ECT. This seems to me quite irrational and dangerous, but occasionally good results do occur. Insulin and prolonged narcosis are sometimes very useful. Cases treated by ECT are alleged cured, but relapse, sometimes so quickly that they are with us again in general practice at once. ECT seems to be too much a fashion now—very much like ultra-violet light and short-wave therapy were at one time in physical medicine. Patients are often taken off sedatives by psychiatrists. Perhaps this is all right in hospital under control, but in many cases, unsafe outside hospital. I hasten to say, I am not keen on producing drug addiction, even with the tamer types of drugs!

The present system of certification works fairly well for obvious urgent cases, e.g., when assault or attempted murder or suicide has taken place, but not for the cunning or " borderline " cases. We in general practice are better trained to be able to judge whether a case is mental and suitable for hospital than is the duly authorized officer and it seems unprofessional and quite unsound to have to call in a layman to get a case certified, or removed to hospital for mental observation. The duly authorized officer is, in my view, a menace and unnecessary. The general practitioner should be the man, and if he is in doubt a consultant should be called in, as in other specialized branches of medicine.

This short paper represents some of my views, which you will now have the opportunity to pull to pieces. Looking back, I wonder whether I should not have liked to take up psychiatry instead of general practice if I had been given a better start by being taught the elements of psychology as a young student, and then some balanced psychiatry in my fifth year. As it was, I had been qualified for six years before I found out how to start learning.

The Uses of Hypnotherapy in General Practice. KENNETH SANDERS, M.B., CH.B. *The Practitioner* (September 1958), **181,** 329.

Hypnotherapy was undertaken in nine selected patients during the course of one year's general practice. Induction failed in two cases, and two more were not influenced by treatment. Some success was achieved in a case of over-smoking, though there was subsequent partial relapse.

The author describes some successes and concludes that suggestion is useful in allaying anxiety and inducing sleep, and may occasionally be helpful in neuroses.