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"Whither Psychiatry?"

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IN the first place I would like to thank the Association for the great honour they have seen fit to do me in appointing me their President for the ensuing year. It is indeed a great honour and a sobering experience to occupy a presidential chair which has been filled in the past by such illustrious psychiatrists as Conolly, Maudsley, Crichton-Browne, Clouston, Mercier and Mott, to mention only a few. Not least amongst these names, one day I am sure will rank that of my immediate predecessor, Dr. Drury.

Sitting quietly one evening in my study thinking of a possible subject for this talk it came to me that dwelling as I did in a pleasant backwater near the banks of the Solway I was well placed for making a leisurely survey of the roads which psychiatry was travelling on both sides of the border. It seemed reasonable to hope that my survey would show me how psychiatry was tending and which of its many paths were showing the greatest promise. The result of these musings is this present address, which I have called "Whither Psychiatry?"

As I have no desire to suggest that my backwater is stagnant, I have considered it permissible to illustrate the various trends or aspects of psychiatry as far as possible by work carried out at the Crichton and of which therefore I have personal knowledge. My survey will be in no way systematic and still less exhaustive; rather will I follow the roads on which my local illustrations set my feet.

It seems logical to start with the query, Whither preventive psychiatry? Here there are many roads, but to me it would seem that all too many of the

people travelling some of them are talking rather than working. One can appreciate the aim of those to whom I particularly refer, namely, to alleviate the mental sickness not only of individuals, but also of societies and nations, and there is no doubt that some very sound work is being undertaken. Unfortunately, however, the movement tends to be brought into disrepute by those uncritical enthusiasts who give the impression that they have the key to a utopia from which war is banished, crime a thing of the past, and mental illness unknown outside text-books. According to some of them all that would appear to be required is that the rulers of the leading countries should through the personal analysis of themselves or their advisers know themselves and those they rule. I wonder. My own view of this is that while there is undoubtedly a place for psychoanalysis in group as well as in individual psychology, one has reason to ask for caution in its application to human relations, and still more to world affairs.

I am afraid our local efforts in preventive psychiatry have been on a more modest plane. The first example I would like to give is the Mental Health Survey of Dumfriesshire carried out by Dr. Mayer-Gross and Miss Brown, psychiatric social worker. It seems to me that this can certainly be regarded as a worth-while contribution to preventive psychiatry, in that it sets out very clearly the extent of the problem which has to be tackled as exemplified in a typical rural area. Probably the most striking information it unfolds is the very high proportion of backwardness in the school population viz., 11 per cent., and how utter is the failure to tackle this educational problem, to the consequent detriment not only of the dull and backward themselves but also of the normal boys and girls in our schools. It seems quite futile to prolong the schooling of these backward children beyond 14 years when it is apparent that they are incapable of benefiting by the type of education provided in the ordinary classes, which is usually all that is available to them. The fact that, as the Survey shows, these subnormals after leaving school seem to settle down into happy and contented citizens who do comparatively well as agricultural labourers, not only points the way to the practical type of education they need, but is further proof that their transference to this work should not be unduly delayed. While on the subject of education I would like to suggest a contribution our educationists could make to preventive psychiatry. In our materialistic age the emphasis is on such things as higher wages, shorter hours of work, higher standards of living, better housing, etc., and in keeping with this outlook education tends to be all too utilitarian in its aim. I feel strongly that the happiness of the individual is much more dependant on what he is than on what he has, and that accordingly it should be the aim of education to inculcate in the child a sense of values, religious, aesthetic and moral, which would enable him to live a full life in accordance with these values, and to make proper use of the abundant leisure which modern conditions provide. Certainly from the point of view of preventive psychiatry a person so educated should be better equipped to deal with the frustrations and other difficulties which lead to mental ill health in later life.

The Survey also showed that Mental Deficiency at 15·6 per 1,000 is appreciably higher than the 10·49 found in Lewis's Survey in three English Rural

Areas in 1927, which suggests that institutional and other provision for mental defectives may have to be even greater than at present envisaged. Another deduction which the cynic might draw from these figures is that it is probably time to replace the legend about the hard-headed Scot by one about the thick-headed.

Here I would like to suggest that similar surveys could be carried out with advantage by medical officers of health. The work would certainly enlighten them as to the nature and extent of their psychiatric problems, and our experience in Dumfries showed that they already possess much of the information required for such surveys.

Another important contribution to preventive psychiatry to which I would refer is the *education of the public* in matters psychiatric. I would like to relate an example of local activity which I think can claim to be in the nature of a pioneer effort. In 1948 the University of Glasgow in conjunction with the Education Department of Dumfries started an experiment in the holding of extra-mural classes on quite an extensive scale. Short courses in social science, child guidance and psychology proved so popular that last year the Crichton agreed to organize a complete course of lectures dealing with mental health in the community. The course was spread over the full six months of the Extra-Mural Session and consisted of 20 weekly lectures given by 16 different lecturers, all authorities on their subject, and including the Professors of Psychiatry in the Universities of Glasgow and Durham. The course was attended by more than 80 people, including teachers, general practitioners, public health and other nurses, business men and women, mostly people interested in social welfare in its many branches. That interest in the course was sustained to the end was shown by an enthusiastic audience of over 200 at the final session, which took the form of a brains trust. The primary aim of the course was to give to its members a background of knowledge which would enable them to take an active part in fostering public interest in mental hygiene. After each lecture the members arranged themselves in discussion groups of eight to ten under group leaders and proceeded to discuss questions suggested to them by the lecturer. They were encouraged to examine and relate the lectures to their personal and professional experience, so that the group got the advantage of the experience of its various members for practical application at a later date when putting into use what they had learnt at the course. I think it will be agreed that this attempt to interest and educate these influential members of the public in mental health is a contribution to preventive psychiatry worthy of development.

A path closely allied to, if not identical with, that of preventive psychiatry is that of *early treatment*. In England this path broadened out into a public highway in 1930 with the passing of the Mental Treatment Act, and it is hoped that following the Russell Report a similar Act for Scotland will not now be long delayed. Thirty years ago, when our mental hospitals had little better to offer than custodial care, this question of early treatment had not the importance it has to-day, when so much can be done by psychotherapy and the modern physical methods of treatment. Here I think we can congratulate ourselves on the lessening of the schism in our ranks which these two discip-

lines have tended to foster. Always there has been the tendency for the psychiatrist who has not practised psychotherapy to belittle it, while his opposite number with no experience in physical methods has often described them as little short of criminal. Nowadays the number of psychiatrists with experience of both methods is ever increasing, and it is rare for anyone so trained not to appreciate the advantages and shortcomings of both methods. While on the subject of psychotherapy I would like to record my opinion that the more it is appreciated that the fundamentals of psychotherapy, like the skill in their application, belong to the art rather than the science of medicine, the more will be its progress and the greater its scope of usefulness.

Looking ahead on the highway of early treatment, it seems to me that our task as an Association is to encourage the provision of facilities for early treatment, and to make sure that the quality of the treatment provided is of the highest. A great advance in this matter of early treatment will undoubtedly come from the Chairs of Psychiatry recently instituted in several universities both in Scotland and England, and I am sure that psychiatry as a whole will benefit greatly from the psychiatric units and other activities which have been set up by these Universities in their respective regions.

So much for the roads along which preventive psychiatry would appear to be travelling. Some are broad, some narrow and some more promising than others, but it can safely be said that steady progress is being made in their construction and in the journeys along them.

The next roads which I envisage and on which I would now like to linger are those belonging to *Child Psychiatry*. Born across the Atlantic, this child of our speciality is slow to form roads characteristic of British rather than American Psychiatry. It still retains its team attack, which is undoubtedly excellent, but on the other hand its expense has certainly slowed up its expansion. All members of the team, psychiatrists, psychologists and psychiatric social workers are in short supply, and look like being so for a long time to come, yet any form of dilution seems to be anathema to the vast majority of those employed in the work. Surely there is at least a growing place for the highly trained lay psychotherapist willing to work under proper medical supervision. More American than British also is the tendency in child psychiatry for undue emphasis to be placed on the psychoanalytic approach. While fully agreeing with the dictum that the child is a child and not a miniature adult, it is still my strongly held opinion that child psychiatry is not in any fundamental way different from adult psychiatry, and this being so I cannot agree with the psychoanalytic claim that theirs is the only rational approach to the maladjusted child. It is usually claimed that some 70 per cent. of those who attend child guidance clinics are helped by so doing, and I look forward to the day when we will be presented with a comparative study of the results obtained in child psychiatry by the various forms of approach, including that of psychoanalysis. Equally with the psychoanalyst other child psychiatrists appreciate the importance of the early stages of a child's development in shaping its personality, and like them they know that the interaction between biological and cultural forces, between nature and nurture, is all important in this development. I would suggest that this

agreement should give sufficient common ground to allow child psychiatry to develop its different methods of approach and clinical practice with every confidence that its future progress would be abundantly assured. In-patient clinics for maladjusted children are a comparatively recent development in this country. Portsmouth and the Maudsley have had such clinics for some years, and we in Dumfries have recently started the first one in Scotland. It is interesting to report that this unit had its being as a result of a request from the Scottish Division of our Association to the Western Regional Hospital Board. Such units are likely to multiply in the near future, and in addition to the treatment of their patients they should offer valuable opportunities for research into problems of behaviour and the psychoses, as well as being extremely useful for post-graduate teaching in child psychiatry.

Treatment.

The next road I approach is that relating to *Treatment*. It is a wide road with numerous branches, many of which I must leave unexplored. The shock troops, of course, are prominent, a comparatively young body, though some critics would fain class them as direct descendants of others of the early nineteenth century whose armamentarium included such things as revolving wheels, surprise baths and swinging beds. Some of the more vocal of these critics are psychotherapists who are quite genuine in their protests and in their belief in the superiority of psychotherapy even in the psychoses. Unfortunately there are still a few who use the same destructive arguments, not to justify their particular form of treatment, but as far as one can judge largely to excuse their negative attitude to *any* form of active treatment. While on this subject I would like to say that I have little sympathy with those who give lack of nursing staff as an excuse for the withholding of some of these forms of treatment. As far as the supply of nurses is concerned it has been my experience that these treatments do not necessitate any appreciable increase of nursing staff. I find that the staff required to administer occupational, recreational and insulin therapies are largely saved in the greater ease of nursing the patients who have been improved by such treatment. It is usually considered that the heaviest drain on nursing staff is in the admission wards with their unknown quantities amongst the patients. It might therefore be expected that with its high admission rate of over 1,000 patients per year for its 1,200 beds the Crichton would have a high nurse-patient ratio, and particularly as in addition to its 15 occupational and recreational therapists it has 13 nurses engaged whole time in the Occupational and Recreational Therapy Departments, and 9 in the Insulin Department. I am firmly convinced that it is because there are so many nurses engaged in these active therapies that the optimum nurse-patient ratio is fixed so low as 1 to 5·1.

Be that as it may, we can certainly maintain that thanks to psychotherapy and the physical therapies psychiatric treatment has improved out of all recognition in the last three decades, and I think we can claim greater advances during that time than during any other comparable period. It may well be that our present shock therapies will appear somewhat crude to a future

generation. Certain it is that medicine abounds in records of empirical treatments, later replaced by something more specific. For example, cinchona bark was long used in the treatment of malaria before being replaced by elegant preparations of its active principle, quinine, and fresh vegetables only recently gave pride of place to the vitamins in the treatment of scurvy and other deficiency diseases. In the same way more specific treatment may well replace our present shock methods if only we can discover what in fact is their active agent. It is my firm conviction that these various shock treatments differ quantitatively more than qualitatively, and if this be true the future may well see great refinements in their application. These remarks are not meant to belittle the extremely good results which we are presently obtaining. A recent follow-up carried out at the Crichton on all patients who had received one or other of the physical treatments during the years 1939 to 1947 disclosed many interesting facts of an encouraging nature. Like the majority of such investigations, both here and abroad, it provided abundant evidence that clinicians who practise these treatments are fully justified in so doing. I hold very strongly, as I have for many years now, that the facilities for these treatments should at least be available to all psychiatrists who wish to treat their patients by them. If they do not wish to employ such methods they need not, but equally if they do wish to they should have the facilities so to do. As you know, the hypotheses offered in explanation of how these empirical shock therapies work are legion. I do not propose even to enumerate them, but perhaps I will be excused for describing in some detail the biochemical one which I favour. It is of course well known that all shock treatments cause cerebral anoxia, and as in the hypothesis I am putting forward this phenomenon plays an important part, it is probably advisable that I clarify my views about it.

We know that for all practical purposes the only substance which the brain cells can utilize is glucose, and further that its oxidation necessitates the presence of oxygen and the catalyst dehydrogenase. Strictly speaking anoxia means lack of oxygen, but biochemists have extended the use of the term to include conditions where the same results are obtained by inability to use any oxygen present. Thus in the present context anoxia may be due to lack of oxygen, lack of glucose or lack of dehydrogenase. In actual fact one or other of these forms of anoxia takes place in the various shock therapies. Thus in nitrous oxide and CO_2 therapies the available oxygen is used up; in insulin therapy the available glucose; while in prolonged narcosis the catalyst is rendered unavailable by the attachment of the narcotic to it. Electrical convulsion therapy causes its anoxia by excessive cerebral activity using up the available glucose, while at the same time cessation of respiration interferes temporarily with the oxygen supply to the brain. That cerebral anoxia is not sufficient in itself to explain how the shock therapies bring about a cure is shown by the fact that merely taking our patients up into high altitudes or placing them in decompression chambers does not cure them. I would suggest that the various therapies are selective in the site of their cerebral actions and that this may be one factor in their therapeutic results. Thus we have both clinical and *in vitro* experiments to show that different barbiturates

act on different parts of the brain, and there is abundant clinical proof that insulin and E.C.T. act in this selective fashion. In fact various hypotheses of their efficacy claim that this is due to selective action on the autonomic system, the pituitary mechanism or the reticular system of the thalamus, to mention only a few. I feel I have been on reasonably firm ground so far, but fear there is less practical evidence in support of the remainder of my hypothesis. This postulates that in the psychoses cerebral metabolism is acting below its optimum due to a partial upset of its oxidation systems, e.g., by circulating amines not detoxicated by the liver, as suggested by the benzoic acid tests of Quastel in catatonics and the work of Gjessing and others. It is quite possible that this upset may sometimes be the continuing result of a causal agent which itself has ceased to be active, which incidentally might explain the inability of Richter and others to find any toxic amines in the blood of various types of psychotics. The hypothesis further postulates that when the metabolism of the brain is recovering from the anoxia caused by the treatment, at least temporarily it returns nearer to its optimum, and if the treatment is repeated often enough it tends to retain this higher level with a resultant cure of the psychosis. In short it is not the anoxia but the brain's reaction to it that restores normality. I like to think that this latter part of the hypothesis fits in with Cannon's concept of the homeostatic principle, and that a homeostatic centre may even be involved in the operative mechanism. If this hypothesis is correct one would expect a cure to be most likely in those cases referred to above in which the lowered cerebral metabolism is the result of a causal agent which is no longer active. This offers an explanation of the occasional failure of E.C.T. at the beginning of a depression and its success later when, it may be, we are dealing with the end-result of our unknown causal agent. Again, as sepsis can cause cerebral anoxia, we have here a possible explanation of the well-known fact that tonsillar and other forms of sepsis may interfere with the efficiency of insulin therapy and E.C.T. The hypothesis can also be used to explain why the longer and much more frequent anoxia of insulin therapy is required for schizophrenia, whereas E.C.T. is sufficient for the less malignant manic-depressive psychosis. It is quite impossible to prove or disprove these speculations till much more is known of the biochemistry of the C.N.S., and unfortunately this is such a difficult subject that biochemists seem to fight shy of it. We are still largely ignorant of the biochemistry of the healthy nervous system, and accordingly it is extremely difficult at present to carry out really fundamental investigations into the biochemistry of the neuroses and psychoses—in short a knowledge of physiology must precede a study of pathology. I hope I may be excused yet another speculative diversion, this time into a by-way which one day may constitute an important psychiatric highway. Is it possible that the theory of adaptation diseases put forward by Professor Hans Selye in his Heberden Oration for 1950 contains something of importance for psychiatry? Certain it is that many of our psychoses, including schizophrenia, fit in well with his concept of an adaptation disease as a biochemical or metabolic disorder due to physical or emotional stress, and with a reversibility which may occur from some biological change brought about spontaneously, therapeutically or

accidentally. Is it possible that some substance of the nature of cortisone or ACTH may be forthcoming as a therapeutic agent in the psychoses? Professor Selye has described how ACTH failed to cure certain mental patients where subsequent shock therapy succeeded, and he went on to postulate that the latter had caused certain specific changes which had acted as conditioning factors of the pituitary-adrenal discharge characteristic of the general adaptation syndrome. This hypothesis certainly brings shock therapy into line with the adaptation reaction, and advances the possibility of ACTH and cortisone being the forerunners of non-specific shock therapies superior to those we at present possess.

Research.

I would now like to pass from the comparatively straight wide road of physical treatments into the much vaguer and more indeterminate pathways of research, and first I would like to travel the *biochemical* one. I must confess to a partiality for this road, as rightly or wrongly I have always felt that it was the most hopeful of all approaches to psychiatry and the one most likely to repay extensive research. In my Cardiff days I often remarked that if half the time and money spent on cancer research alone were spent on biochemical research in psychiatry, the benefits which would accrue to mankind would be profound. I am still of that opinion.

Even to-day very few laboratories are tackling the problem on the scale started by Quastel at Cardiff City Mental Hospital, and I have always deeply regretted the necessary interference by the war in his pioneer work on the carbohydrate metabolism of the brain. I am pleased to say that Dr. Richter, his successor at Cardiff, has some very promising work in hand from which important results may well accrue in due course. I would like to pay my tribute here to the valuable work that is being done in many small biochemical laboratories attached to our mental hospitals in different parts of the country. From the small Crichton laboratory Mayer-Gross and Walker recently published interesting results on the restoration to consciousness of patients in insulin coma by the injection of glutamic acid and other amino-acids, work which suggests that the brain may when necessary utilize foodstuffs other than glucose. Weil-Malherbe considers that the results are due to adrenaline produced by the hypoglycaemia, but Dawson, working in Richter's laboratory, obtained results which make this a very unlikely explanation. Too little is known, however, to decide if there is in fact a direct utilization of the glutamic acid by the brain cells. At present the Crichton laboratory is investigating the claim of Meduna to have isolated a hypoglycaemic factor in the urine of certain acute schizophrenics. We have been successful in isolating the substance and examination of controls naturally followed. Since finding that he himself is positive to the test Mayer-Gross has doubts as to its complete specificity: and so it goes on. One day the biochemical explanation of such things as schizophrenia is just round the corner, the research continues and the final arrival is not at a terminus but at the siding of some small wayside station. Such is the fate of most research, but so long as it is critically scientific it is a contribution to knowledge and accordingly of definite value.

A well-trodden if narrow road of older date than the one we have just left is that of *Neuropathology*. If the biochemists have been afraid of the nervous system the same cannot be said of the histologists, and as a result a long line of brilliant neuropathologists have thrown light on those less common diseases of the nervous system which bring organic changes in their wake. For help in understanding the commoner psychoses such as schizophrenia and the manic-depressive group it would appear that we must await new methods of approach and the improvement of existing methods. The ever-growing co-operation between neuro-anatomists and neuro-physiologists with their delicate electro-physiological techniques have been corroborating the claims of the former that structural differentiation in the C.N.S. is evidence of corresponding functional differentiation and localization. At present amongst their other activities Professor Meyer and his Maudsley school are guiding us in the dark places where leucotomy leads, and as so often happens in medicine the members of the team, in this case the neurosurgeons and the neuro-pathologists, are providing each other with valuable material for benefiting their respective specialties. It is only recently that the Scottish neuropathological road was re-opened at the Crichton by Dr. Klein, yet another pupil of the German school of neuropathology, and we are hoping that it will be carrying a little traffic, at least, in the near future.

From the highway of *Biophysics* on which the, to me, well-beloved figure of Professor Golla is particularly prominent, probably the most important road as far as psychiatry is concerned is that relating to electro-encephalography, with its use of biophysical methods to amplify and record the small variations of electrical potentials in the brain. While most of its traffic centres on Bristol and London, of recent years much activity has been apparent in other parts of the country. While we are justified in expecting great developments in this sphere of activity, it is unfortunately true that the light thrown on most psychiatric problems is still disappointingly slight. Nothing of fundamental importance has been added to our knowledge and understanding of the major psychoses or neuroses, but on the other hand we certainly continue to receive valuable additions to our knowledge of epilepsy, psychopathic personality and some organic disorders. Special mention must be made of the valuable contributions of Grey Walter, Denis Hill and their co-workers. In continuing my practice of using local illustrations I would point out that it was at the Crichton that Roth did his original work on the changes in the electrical activity of the brain induced by E.C.T. In the paper he is reading to-morrow he brings evidence to show that E.E.G. changes occurring during treatment are due to electrical activity in the frontal lobes caused by the cumulative stimulation of a subcortical pacemaker situated in the thalamic reticular system, and he puts forward the hypothesis that this thalamic stimulation is the causal factor which ultimately leads to the recovery which results from E.C.T. There is no doubt that the E.E.G. changes recorded by Roth do take place, but whether they are merely concomitants of the E.C.T. or the actual curative factors must await further investigation. Certain it is, however, that such work goes to show the intriguing possibilities of E.E.G. research.

Another road which centres on Bristol is that dealing with *Endocrinology*. This is a line of research which held out great promise, but in spite of the painstaking work of such as Reiss surprisingly little seems to have come out of it. One reason for this is undoubtedly our aforementioned lack of knowledge of the biochemistry of the brain, which makes it extremely difficult to correlate cerebral changes with hormonal activities, normal and otherwise. It is certainly work which has great possibilities, and it is to be hoped that one day soon new methods may be evolved which will yield a richer harvest. Is it possible that the plethora of facts so painstakingly collected will one day be found to fit in with the work of Professor Selye already mentioned, and help to further its application to those psychiatric disorders which may turn out to be due to hormonal derangements resulting from maladaptation to stress?

Here we leave Research and approach the last road on which I will take you, that of *Academic Psychology*. This is a wide road, which in former days was probably even more travelled in Scotland than in England.

From the days of Hume more than 200 years ago up to quite recently Scottish psychology had a distinctive national character, thanks to such exponents as Adam Smith, Thomas Reid, William Hamilton, Alexander Bain, and more recently G. F. Stout. Scottish psychology always had a metaphysical background, and there are signs that, invigorated by its recent Freudian mud-bath, psychology in general is returning to its former relationship with metaphysics and moral philosophy, all the better for its incorporation of such concepts as symbolism and unconscious phantasies. This development is likely to be encouraged by the tendency of social psychology to break with the older static psychology, and join with the anthropologists and sociologists in the new discipline of social relations. At the Crichton we have a Psychological Research Department which is affiliated to the University of Glasgow. Much of the work of the Department is carried out in relation to clinical psychiatry, but much relates to the wider sphere of scholastic, industrial and academic psychology.

The measurement of abilities and aptitudes in personnel is playing an increasing role in education and industry, and Raven and his co-workers at the Crichton are making important contributions in both these fields, using along with other methods the various matrices tests which they have evolved.

As some of the papers to be read to-morrow will show, the Crichton psychologists have joined with the psychiatrists in research into such matters as the structure and dynamics of the personality at various ages and the effect of different treatments in the various psychoses. His appreciation of the science of statistics and his training in the treatment of psychological data and methods of psychological research make the psychologist an indispensable member of the psychiatric research team in such problems. The great advantage of having psychological research departments capable of fundamental research attached to such hospitals as the Maudsley and the Crichton is that it is possible to carry out clinical research of a very high standard. Such a department would be failing in its true function if, in addition to research which could be carried out equally well at a University or special research centre, it did not include in its programme an appreciable amount of clinical

research which required material and facilities which only the mental hospital or psychiatric unit could provide.

So we come to the end of our wanderings. I would again emphasize that what I have been offering you this afternoon is not a studied survey of the whole field of psychiatry. For example no mention has been made of such vitally important matters as the recently enacted Criminal Justice Bill and other Acts which embody enlightened psychiatric opinion, and are destined to guide psychiatry in relation to such things as the prevention and treatment of delinquency in the young and crime in the adult. Again I have seen fit to exclude from my survey the National Health Service with its great potentialities to influence, for good or evil, the future of psychiatry. Nor have I given any indication of my opinion on such an important subject as the probable course and ultimate fate of orthodox psychoanalysis in this country.

Apart from any other consideration the time at my disposal this afternoon has precluded the feasibility of a fuller survey, but honesty compels the confession that an even more important reason is my complete unfitness for the task. I always think there is no harm in confessing the apparent. Again it will be noted that in posing the question "Whither Psychiatry?" I have made little attempt to answer it. What I have attempted is to give a few personal impressions of some of the trends in the world of psychiatry today. I ask you to excuse the all too free use I have made of local illustrations. I appreciate that this has inevitably led not only to glaring omissions but to a somewhat unbalanced review.

In conclusion I would like to put on record my confession of faith in the future of our speciality. In my opinion we can look back with justifiable pride on our progress during the past three decades, and we can look forward with equally justifiable optimism to steady progress in the future. Let us be never failing in our co-operation with the great body of general medicine to which of course we indissolubly belong, but let us equally never forget that progress in our speciality, in the future as in the past, will come mainly from the efforts of those actually engaged in the practice of psychiatry and in research into its special problems. In short, let us continue to stand on our own feet. Ladies and Gentlemen, I thank you.