and his assistant, Dr. Jardine, Dr. C. C. Easterbrook, Dr. Neil T. Kerr, and Dr. Dunlop Robertson, as well as to assistant physicians at the Royal Edinburgh Asylum, including Dr. Henry Yellowlees, Dr. William McAlister, Dr. E. M. Johnstone, Dr. Bell Emslie and Dr. Neil McLeod.

(The discussion which followed will be found on pp. 543–6, vol. lxvii, October, 1921.)

The Oxford Clinic.(1) By T. S. GOOD, *O.B.E.*, M.R.C.S.Eng., L.R.C.P. Lond., Medical Superintendent, Ashhurst Hospital, Littlemore, Oxford.

THE Oxford Clinic for Nervous Disorders first came into official being in the beginning of 1918, when the Committee of the Radcliffe Infirmary did Dr. W. McDougall and myself the honour of appointing us as Physicians-in-Charge of this department, and asked us to organise and run it. It was started with an out-patient department one afternoon a week and was entitled the Department for Nervous Disorders. This term was chosen as it was hoped that it would induce all classes of nervous cases to apply for treatment. Particularly for those cases which show mental symptoms was this title chosen, in the hope that such patients would come to the clinic without feeling they were being specially branded as "mental." Opportunity would be given for treatment, and possibly improvement or even cure might be effected, and thus certification, which every one of these cases most dreads, could be avoided.

A case-sheet was designed and carefully discussed, then printed on the loose-leaf system. Dr. McDougall and I considered a case-sheet essential in order that records should be kept of all physical changes in the nervous system. This was more especially necessary, we felt, in that we were hoping to deal with physical and psychic cases, and though in mental cases it is perhaps impossible to design a case-sheet to cover all signs and symptoms, this is not so as regards the physical. The sheet is so arranged that a routine examination of all motor and sensory signs is recorded, both negative and positive, commencing at the head and proceeding systematically through the body, with spaces for family history, past and present, and personal history of the patient. We felt that as we were dealing with mixed cases, in which the diagnosis is often difficult as regards whether the disorder is functional or organic, or both, that it was absolutely imperative to have a record not only of positive but of negative symptoms, and also to ensure, as far as possible, that a routine examination should be conducted in every case. I think we were greatly influenced in this respect by what I may perhaps call the "omissions" which had come under our notice on case-sheets of such

(1) A paper read at the Annual Meeting held in London, July 13th, 1921.

https://doi.org/10.1192/bjp.68.280.17 Published online by Cambridge University Press

patients during the war. We often found that only certain reflexes and signs were recorded, no mention being made as to whether others were present or not. For instance the knee-jerks might be mentioned, but the plantar reflexes were not unless they were extensor.

It is, in our opinion, absolutely essential to record as accurately as possible the state of all reflexes, both superficial and deep, whether normal or abnormal, as it appears probable that many cases which were labelled "functional" might later prove to have some organic basis. Early cases of disseminated sclerosis and tabo-paresis, for instance, often in the initial stages show very little, if any, organic change. At first sight they present all the symptoms of a purely functional nature, but they do not clear up under psycho-therapy. Thus it would appear imperative that careful records should be kept, not only for the reasons already advocated, but also with the idea of helping to solve the question as to whether prolonged functional disorders may eventually develop into organic. A careful examination is also, I believe, in many cases, a great psychic help in obtaining the co-operation of the patient in his treatment.

The Oxford Clinic is held at the County Hospital, and there are many and great advantages in being attached to a general hospital:

(1) Borderland or more advanced mental cases do not object to presenting themselves, or their friends do not mind bringing them for advice; whereas they will shun anything of the nature of a mental institution until so ill that to go there appears the only course left open to them.

(2) At a general hospital there is easy access to every other department, such as eye, ear, V.D., electrical, and massage, and the opinion of another specialist is therefore not only available, but the department now under survey is brought into close touch with other branches of medicine and surgery to their mutual advantage. I feel that in the past there has been too great a cleavage between the mental and organic sides of medicine, to the detriment of both.

(3) It enables team work to be carried out. Many cases in the clinic of a partly organic and partly functional nature would appear to improve more rapidly under two specialists working in unison than under one department: for instance V.D. cases often develop mental symptoms which psycho-therapy will relieve, or orthopædic surgery may be assisted in the after-treatment or *vicê versa*. In fact with proper collaboration there are hardly any departments which cannot be of mutual help. The importance, too, of having access to a V.D. department is immense, and I venture to think a Wassermann blood test might be adopted as a routine in every case in which there is the least suspicion of nervous disorder.

The question of in-patients at the clinic has been considered, and the

https://doi.org/10.1192/bjp.68.280.17 Published online by Cambridge University Press

original plan was to have had about twenty beds allotted at an extension of the Radcliffe Infirmary at Headington. Up to the present, however, owing to lack of funds these beds have not materialised. This question of beds attached to a nervous-disorders clinic is a difficult one. In many of the cases in-patient treatment is not only unnecessary, but in my opinion even harmful.

In the neuroses there is always an unconscious reason, *i.e.*, some decision the sufferer fears to make and wishes to avoid, and the illness is an attempt at adjustment: they fear their own psychic death, their symptoms are an unconscious question. Therefore it would appear that in most cases to take such patients into a hospital would be likely to increase their malady, for the reason that by this step their unspoken question is being answered and confirmed by the physician, *i.e.*, if they are ill enough to be taken into a hospital it must be as they feared, and they are in danger of psychic death, and that the doctor has agreed with this because he has admitted them to hospital. Also unconsciously they have thus avoided for a time making any decision or effort—the very thing which was the primary cause of the illness.

Out-patient treatment for these cases is, to my mind, and in my small experience, the best. As an out-patient the case has at once one question answered, "The doctor does not think me hopeless." This immediately strengthens the transference, and then analysis may unravel the mental tangle and the patient may be possibly improved or even cured.

As an illustration of the great possibilities of out-patient treatment of a case with suicidal tendencies, I may mention I have recently treated a young school mistress who was brought to me by her father and sister, and who, I was told, had made an attempt at suicide, and was threatening suicide, they said, at the time I first saw her. The father maintained that she needed to be under control. I risked the suicide and treated the case as an out-patient by analysis, which proved that the suicidal threats were an unconscious attempt at a solution of her conflict, which was the fear of death, both physical and psychical, the latter being insanity. This started as a child with fear of the mother's fits of rage, and the idea that her mother was mad. The father, for whom she consciously had a great attachment, she despised unconsciously because of his domination by the mother. Fear of her mother forced the girl to withhold all questions on the various sexual problems of a growing girl, which consequently she and her sister attempted to work out for themselves. Undue dependence on the sister was the result, and the death of this same sister caused a severe attack of depression, with, it was stated, an attempt at suicide. The girl partially recovered from this by repressing the whole circumstances. The recent breakdown was brought about by a severe shock to her love affairs through

https://doi.org/10.1192/bjp.68.280.17 Published online by Cambridge University Press

anonymous letters from a rival. She had been loving her *fiancé* as her father on account of her sexual repression due to a forgotten episode, which occurred at a very early age when she had heard a woman shrieking in childbirth. The analysis was prolonged, but I may here state that the girl resumed her teaching, and has lately called expressly to tell me that she has lost all fear of insanity and that she feels she is now well.

Suicide of a patient has its horrors for the physician, but perhaps the risk is much greater in our imagination than in actual fact. I feel sure that had in-patient treatment been adopted in the case above mentioned, recovery would have been jeopardised.

I think I may say that out of the 149 civilian patients whom I have personally treated at the clinic during the last three and a half years, excluding organic cases, I have only been really anxious to find accommodation as in-patients for three children, who would probably have been cured quicker and with more ease had it been possible to remove them from parents or relations, who tended rather to aggravate than to cure their disorder.

Of the adults two cases have required certification, one of senile melancholia and the other an old-standing case of dementia præcox. Both these were of long duration, and were only fit for treatment in a mental hospital. One case of senile melancholia with marked hypochondria, who was an in-patient for bronchitis under one of the physicians, apparently improved under treatment and was discharged, but later committed suicide at his own home.

No acute toxic mental cases (and amongst these I include puerperal and confusional cases) have up to the present applied for treatment. Such cases would, of course, require in-patient treatment, and I am of the opinion that a special ward in a general hospital is the best place for them in the earlier stages until one is convinced that recovery is unlikely. It appears to me that the sooner the general hospital is linked with the mental hospital, by having on the staff a psychiatrist with beds at his disposal, so much the sooner shall we be able to remove from the mind of the public the obstructing idea that mental disorder is a disgrace carrying with it an everlasting stigma. Except where there is a definite organic disease associated with the mental disorder, as in general paralysis, alcoholic, traumatic, and toxic psychoses, as far as my personal experience goes the clinic would tend to prove that manic-depressive, obsessional, impulsive and non-systematised delusional mental disorders are mainly environmental in their origin.

Not only are civilians treated at the Oxford clinic, but discharged soldiers suffering from nervous disorders have from the beginning been sent there by the Pensions Committees of Oxfordshire and the surrounding districts.

https://doi.org/10.1192/bjp.68.280.17 Published online by Cambridge University Press

In fact in the earlier months the pensioner patients were far in excess of the civilians. As I stated at the commencement, we gave one afternoon a week for treatment, but as civilians increased and pensioners continued to come in great numbers, we found it necessary to give two afternoons, and that still continues. The waiting list of pensioners is not so large, but the number of civilians applying for treatment is greatly increasing. When Dr. McDougall went to America his place at the clinic was taken by Dr. A. T. Waterhouse.

Speaking as the Medical Superintendent of a Ministry of Pensions Neurasthenic Hospital, namely Ashhurst Hospital, Littlemore, the fact that I have only taken in three pensioners to Ashhurst from Oxfordshire and district during the last two years is, I think, a very strong proof that in most cases out-patient treatment for a pensioner is far the best. I have treated 344 pensioners at the clinic and I would like to emphasise this point: I consider that to the neurotic pensioner in-patient treatment, except in a very small percentage of cases, is even more harmful than to the civilian. I am, of course, excluding organic and such other toxic cases as I mentioned before would necessarily need in-patient treatment.

With pensioner and civilian the illness is the same though the cause may be different, and yet a greater difference lies in the condition under which each comes for treatment. The civilian comes of his own accord and with everything to gain by recovery: the pensioner comes often only because he is forced, and if he recovers he will lose his pension. The civilian probably has work which he can carry on during treatment: the pensioner has often been in hospital, thereby losing his job or possibly a business of his own, and enfeebling his body, therefore he comes for treatment with the added anxiety of unemployment.

During the last year a large percentage of pensioners presenting themselves for treatment have shown toxic and organic troubles of some kind, such as rheumatism, malaria, V.D.H., neuritis, old head and spine injuries which unfit them to compete with sound men in their work. In these cases the anxiety caused by this incapacity to support themselves often masks the real organic mischief. These men have been discharged from the Army labelled "neurasthenia," and sent to one hospital after another, an unconscious suggestion having accompanied them that all their complaints are but figments of their imagination, and consequently these complaints have been treated with suspicion. Such cases are often confused with the malingerer. Time and patience alone may enable us to find the cause of the illness and they may improve with treatment. Both for their own sakes and also from an economic point of view these cases have a better chance of improvement under treatment at an out-patient clinic, where they

https://doi.org/10.1192/bjp.68.280.17 Published online by Cambridge University Press

can live at home and do some work, than they will ever have in a hospital. Thus it will be clearly seen that the treatment of the pensioner is far more difficult than that of the civilian, as the physician has to cope with the pension and unemployment complexes in addition to the ordinary difficulties in dealing with the neurotic.

I will now briefly mention the methods of treatment used at the Oxford Clinic.

To a certain extent drugs and physical methods are employed, especially with the semi-organic cases, massage being included. This, however, is only used in the cases in which there has been loss of mobility of a limb and as an aid to psycho-therapy. In other words massage is employed to help the nutrition and also to assist relaxation of the opposing muscles, but it is only used with careful explanation of the reason of its employment, and the patient is instructed as to how to co-operate and re-associate the lost movements.

Psycho-therapy: (1) Persuasion, in which the cause of the neurosis is explained to the patient, combined with a stimulation of his interest and determination to recover, and a re-education of his mental and physical processes. (2) Suggestion, which includes (*a*) waking suggestion, (*b*) suggestion under hypnosis. (3) Hypnosis. (4) Analysis. I mention analysis last as being the hardest, the most scientific and thorough of all methods of psycho-therapy, though I think in order of merit it should come first.

There are many reasons why analysis cannot always be employed—time, the number of patients to be dealt with, and last but not least, the fact that only a certain percentage of cases can be treated by this method.

Personally I use any of these methods according as to which I feel may be suitable to the case. Time prevents me from illustrating the results of these different methods of treatment. I should like, however, to state that I have mainly used hypnosis for recovering war-amnesias and for inducing sleep; and as far as possible never do I use hypnosis with deliberate suggestion as a method of cure except as a last resource, as I never feel sure how long the good results obtained by suggestion alone are likely to continue.

In order to endorse any statement I have made as to the result of treatment of pensioners at the clinic, I would like to quote some remarks and read some figures as given to me by the D.G.M.S. of the Oxford Area.

He states as follows: In my opinion, in a large proportion of the cases treated at the clinic there is definite and distinct improvement. Of those patients who have been discharged from the clinic as requiring no further treatment, very few have relapsed. Most of the men are at work, and but for the fact that there is a slight residual trace or undue

https://doi.org/10.1192/bjp.68.280.17 Published online by Cambridge University Press

tendency to neurosis to be detected they appear well, and in 40 or 50 *per cent.* their pension is only 20 *per cent.* or less. The number of high assessments is extremely small.

The following figures give the number boarded and the pensions assessed in the last four months, and in the opinion of the D.G.M.S. the number of high percentage pensions is unduly high in this period as compared with the average for the whole year.

Of total number (65) boarded: 2, or 3 *per cent.*, were assessed at 80; 3, or 4 *per cent.*, at 70; 3, or 4 *per cent.*, at 60; 4, or 6 *per cent.*, at 50; 9, or 14 *per cent.*, at 40; 14, or 21 *per cent.*, at 30; 24, or 38 *per cent.*, at 20; 6, or 9 *per cent.*, at less than 20 *per cent.*

The average percentage of assessment for the whole number during that four months is 30 *per cent.* pension. These figures include patients still waiting for treatment and also some organic cases. During the whole period less than five cases have had to be certified in this area. In the last two years only three cases have been admitted to a neurasthenic hospital:

(1) A case of alcoholic and syphilitic dementia. (2) A case who was waiting for training had depression and a hostile environment. (3) A case from the permanent staff of the Ashhurst Hospital—the only survivor of H.M.S. "Vanguard," who had never mentioned that he had been subject to fugues about the date of the catastrophe.

These figures I submit support the contention that out-patient treatment for pensioners is probably better in most cases than keeping them in expensive hospitals, both from the point of view of the health of the patient and the expense to the State.

As regards civilians, the increasing numbers presenting themselves for treatment is perhaps the best evidence I can produce, that an out-patient clinic for nervous disorders will well repay every member of our branch of the medical profession who gives his time to trying to treat and understand every form of nervous and mental disorder.

(For the discussion which followed see pp. 525–534, vol. lxvii, October, 1921.)

Psychology and Psycho-therapy.[1] By WILLIAM BROWN, M.A., M.D.Oxon., D.Sc., M.R.C.P.Lond., Wilde Reader in Mental Philosophy in the University of Oxford.

WHEN your President did me the honour of asking me to read a paper before this Association, it occurred to me that a subject not lacking in topical interest at the present day might be such an one as the relation between suggestion and psycho-analysis. But, on second thoughts, I felt that this would be giving undue emphasis to a tendency

[1] A paper read at the Annual Meeting held in London, July 15th, 1921.

https://doi.org/10.1192/bjp.68.280.17 Published online by Cambridge University Press