I

PRELIMINARY

By the use of statistical methods it is possible to arrive at an average prognosis for acute disease, especially if this disease is of epidemic nature. Thus it is possible to say that the mortality of a given epidemic is so much per cent., the complete recovery rate so much; the various sequelae also could be given a definite average figure. It is true that the prognosis of any acute disease may vary in different epidemics and at different periods of the one under investigation, that the prognosis of diseases like scarlet fever and measles is different now from what it was fifty years ago; these facts, however, do not invalidate the statement that the prognosis in these disorders is capable of statistical treatment. And on this possibility depends our ability to assess the value of treatment, which must otherwise be a matter of guesswork and prejudice.

In acute non-epidemic disease, if the disease is as definite a condition as, say, lobar pneumonia, the same possibility is present. In all these diseases one may obtain what may be called a natural prognosis, i.e. one unaffected by treatment. The diseases may be merely observed without being treated, and it is of importance to say that they may be so observed without this having any effect on the patient. This may sound a platitude, but indeed, as we shall see presently, one cannot always merely observe a disease process without affecting or altering it.

In chronic diseases factors are at once encountered which make the assessment of their prognosis a much more difficult matter. These are of different kinds. A patient with scarlet fever or measles will commonly be under the same observer throughout the illness and, if he be a specialist in these disorders, and thus can see many examples at one period of time, the requisites for accuracy of statistical results could not be bettered. In chronic disease, on the other hand, the patient will sometimes be under the care of a general practitioner, but not always the same individual, and sometimes he will be in hospital under a specialist. Either of these might
apparently collect reliable statistics, but very soon objections to placing complete faith in them will become manifest. The general practitioner has the advantage of seeing his patients over many years, but he frequently labours under the disadvantage of not seeing a large enough number of examples of the disease in question to make his figures of much value. There have, of course, been exceptions to this, of whom the late Sir James Mackenzie was one of the most recent; but it is usually granted that he was an unusual person. To prevent the total loss of the large mass of clinical knowledge now in the minds of the general practitioners and of them alone, for it is they particularly who see after-results, something can be done by a combined enquiry such as was undertaken a few years ago on the results of operation for peptic ulcer, and it will probably be by such enquiries in the future that many questions of prognosis will be settled. The specialist, on the other hand, sees a large number of cases, but his difficulties in ascertaining what happens to them after they have left his care are very great. If they have done well, he seldom sees them again, for they do not need him, and frequently if they have done badly he does not see them either, for they are apt to go to someone else. He is therefore driven to trust to written reports, or the reports of a social worker; we shall see presently how many fallacies underlie the report of any kind, written or oral, in the absence of personal observation. Sometimes he will be able to interview the patient afterwards, but this will probably be exceptional for many reasons. The specialist, furthermore, because he is a specialist is subject to certain disadvantages which make it difficult for him to arrive invariably at just conclusions. He is apt, for instance, to take a pessimistic view of any treatment which he himself does not practise, for he is apt to see the failures of that treatment, whereas, as has just been stated, he does not see quite so many of his own failures. In parenthesis it might be stated that if this obvious fact were more frequently recognized, some of the heated denunciations of certain forms of treatment, so often heard, would cease, to the great advantage of the progress of therapeutics, which in truth cannot be discussed profitably in an emotional atmosphere. The specialist, however, because of this fact, gets a distorted view in favour of what he himself practises, and against what he himself does not practise.
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He is led into this particular error because in a less degree indeed, but still in some degree, he suffers from the same difficulty as the general practitioner in that he does not see a large enough number of cases if he is trusting to his own experience entirely. No one man, be he specialist or general practitioner, ever sees quite enough examples to be dogmatic; and unfortunately the specialist is the more apt to be groundlessly dogmatic than is the general practitioner. Furthermore, the specialist obtains an unduly pessimistic view, apart from treatment, of the disease in which he specializes, because as a rule he is not asked to see the milder forms of any disease, but is called in only when the illness becomes so serious that the general practitioner wishes further help. Every general practitioner believes that on the whole specialists always take too grave a view; this is in part the explanation of the belief that they see their own speciality in every patient; every specialist thinks that the general practitioner is too light-hearted. Having practised in both capacities, I am inclined to think that the general practitioner is more often right; though when he is wrong the consequences are often more dramatic, and as he is less given to writing papers than the other it is usually he that is made the whipping boy when affairs are not going smoothly. A very obvious example of this kind of error will be found in the history of schizophrenia. The specialist tended to see patients who had already pronounced schizophrenic symptoms, and when he traced back their histories he found that in one way or another they had often had similar though milder symptoms in episodes for many years; under his observation they passed into dementia; but it must be noted that they were more ill when they came to him than they had been in earlier attacks; unless indeed they were of the kind who were deteriorating, he would probably not have seen them at all, but he did not so often see those with one such episode which cleared up and was never repeated. Therefore for years all patients presenting schizophrenic symptoms were looked on by specialists as doomed. It was difficult for the general practitioner to believe this, as he seemed to know people who had formerly fitted into the schizophrenic category, but who were now well. The general practitioner, however, especially in psychiatric matters, does not dare to lift up his voice. The history of the stethoscope is associated with a similar disaster. Many patients
who were dropsical and about to die were found to have cardiac murmurs, therefore anyone with a cardiac murmur was bound soon to be dropsical and moribund.

The clinical research on prognosis which is so necessary could best be undertaken by teams of both kinds of practitioners working together, and having their work correlated by medical statisticians. This is a form of research which might be very fruitful of results, but it is not showy and will probably not be done, except occasionally as in the enquiry on peptic ulcer.

These remarks are applicable to all chronic disease, both organic and functional, but in the latter, that is in the neuroses, there are reasons whereby these difficulties are even greater. As has been stated, it is possible to observe organic disease without treating it, and in this way to establish a natural prognosis for the disease in question. But in the neuroses there is no such thing as a natural prognosis; it is quite impossible to observe psychogenic diseases in vacuo. For good or evil every interview with these patients alters the course of the illness. Every time they are seen by a doctor they are left with either more or less hope, and there can be little doubt that more or less hope profoundly affects the course of their illnesses.

I have seen doctors who proposed merely to observe patients suffering in this way, but in a very short time they began to realize that they were doing nothing of the kind; they were either influencing the patient by telling him that his case was curable, or plunging him into despair by remaining judicially non-committal. To give an opinion that a case is curable may make the patient better or worse; it never leaves things as they are. It will make him better if he desires cure, worse, if, as is possible, he dreads the consequences of cure—which may entail return to a hated environment. To be non-committal is alarming because it is interpreted by the patient to mean either that the doctor does not understand the case or that he has some fearful possibility in his mind, such as cancer; and though the patient might not be averse to a little illness, he does not wish a very bad one any more than the rest of us. It would therefore be truer to say that the prognosis of psychogenic disorders can be only the prognosis of the case as far as that case has been modified by the doctor in charge; in this book it will be a prognosis of the neuroses as modified by contact with
the total environment of the Cassel Hospital for Functional Nervous Disorders, in itself a somewhat complex factor, which must be split up into its component parts if possible. The modifications which this complex induced in the neuroses were sometimes for the better, but sometimes they must have been for the worse. On the whole, it is hoped that they were for the better. Before we go further in our study of prognosis it would be well to give some account of this modifying environment, and also to assess if possible the value either plus or minus of the various factors.
II

THE ENVIRONMENTAL FACTORS

The Cassel Hospital for Functional Nervous Disorders was founded in 1919 by the late Sir Ernest Cassel, and was opened for the reception of patients in May 1921. He had been deeply moved by the pitiable state to which men were reduced by so-called shell shock. On learning that similar conditions were common among the civilian population, and that the means of coping with them were meagre, he expressed the desire to found a hospital which should help to deal with these problems.

In the materialization of this idea he was assisted chiefly by the late Sir Maurice Craig, who had for long wished that there should be a hospital for the special purpose of investigating and treating the neuroses.

Sir Ernest bought a large country house, Swaylands, near the ancient and historic village of Penshurst, Kent—Penshurst Place was the birthplace of Philip and Algernon Sydney, and was also closely connected with Robert Dudley, Earl of Leicester.

After certain alterations had been carried out accommodation was provided at Swaylands for fifty-two, and later with subsequent alterations for sixty-four patients. All the patients except seven have separate bedrooms, but there are also two small wards of four and three beds respectively.

After purchasing and equipping the house there was still a large sum of money left over from Sir Ernest’s endowment. Because of this, patients can be received at a figure which is considerably less than cost price, the standard sum being five guineas a week. The ward patients pay three guineas, and patients who are better off pay seven guineas and upwards. These figures are inclusive of board and lodging, medical attendance, all necessary medicaments; indeed there are no extras of any kind whatever. It was Sir Ernest’s wish to assist chiefly educated persons of slender means, as he knew that they formed a class which received almost less help than any other. The hospital is placed in a very beautiful garden. It has a
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private golf course, tennis courts, a cricket field and all the other amenities of a large country house.

The management consists of a committee for general superintendence of finance, repairs, alterations and so on, and a medical committee for purely medical affairs. The local executive is in the hands of a medical director, but as it was considered most important that his time should be devoted entirely to clinical matters he delegates all the domestic management to the secretary and to the matron.¹

A patient at Swaylands comes into active contact for certain with his doctor. The ratio of doctors to patients has varied: at first it was about one to sixteen or seventeen patients, later it was increased to one to twelve or thirteen. Opinions will differ concerning what is the right proportion; for reasons which will become obvious later, I do not consider that the first proportion need spell neglect of the patients, but I do not expect to find that many psychotherapists will agree with me. Some hold that even the later figures provide too few doctors. With sixteen patients it is not possible for the doctor to see every patient every day; again reasons will emerge whereby this is not always necessary or even desirable. With this number it is to my knowledge eminently possible for the doctor to be a potent influence in the life of each patient, to be quite the most important thing he comes across in hospital. There are three methods of psychotherapy employed at Swaylands—hypnotism, persuasion and analysis. That the neuroses are psychogenic and that their proper treatment is by psychotherapy is a subject which will not be entered into here. I have dealt fully with the question in a previous book—The Common Neuroses—and I have no wish to modify what I there wrote on this head. Of course any concomitant physical treatment which is necessary is carried out at the same time as the psychotherapy, but this is always undertaken for the sake of the physical condition in question in exactly the same spirit as it would have been in a non-nervous person, and not with any hope that physical treatment will modify a neurotic tendency, or remove a neurotic symptom, though indeed it often seems to do the latter.

Hypnotism has been employed only occasionally. On the whole

¹ All information regarding admission of patients etc. can be obtained from the Secretary, Cassel Hospital, Swaylands, Penshurst, Kent.
it is probable that it affects the prognosis adversely: it does not tend to enable the patient to stand on his own feet, but rather to make him more dependent. It is significant that many clinicians, who used it at one time, gave it up later. The names of Bernheim and of Freud occur to one at once in this connection; and this has happened although in the literature there are many records of its lasting beneficial action. No one who has used it doubts its immediate potency, but that is of little importance. Alcohol, cocaine, morphine could all be given with the happiest immediate result in the neuroses, but that does not make their use desirable.

Persuasion and analysis are best considered together. In this connection it must be stated immediately that the word “psycho-analysis” is not being used, as it has become a sort of hall-mark which is the private property of the Freudian school. There was complete belief at Swaylands about the actuality of an unconscious mind, a belief also that it could be explored, but not a complete belief that the Freudian description of it was true in detail. From time to time one or other of us would develop strong beliefs in Freud, and feel for a time that he was very right indeed; and then usually such beliefs weakened. If the word had not been seized on, and, as it were, registered by another sect, I should have said that our belief was largely in an individual psychology, i.e. that the patient’s personal experience was the important thing; some of this when he came under observation was conscious, some of it had become unconscious; we were interested also in trends which had not yet become experience, and often not yet conscious. What we aimed at was to discover what experiences an individual had encountered and how they had affected him. Much of this is often repressed, and the exploring of such repressions is frequently, as it seems to me, of more value than following the development of the infantile mind through the various stages which have been described by the Freudians, but which were possibly invented by them.

The mere existence of the unconscious mind is still denied by many, but this is not the place to give proofs for the beliefs in it. I have given my reasons for believing in it in another book—An Introduction to Analytical Psychotherapy.

One of the things which will emerge from the following studies, however, is that in a considerable number of examples no explora-
tion of the unconscious need be undertaken at all; the proofs of this and further discussion of it will come later.

The word “persuasion” also needs comment. It has nothing to do with suggestion; it is not persuading a patient to become well. The word as used was coined by Dejerine. It connotes a process of history taking at length, during which several things will come out of a limbo of forgotten things. After this comes careful examination by ordinary clinical and, if necessary, laboratory methods, followed by evaluation of the symptoms in the light of this examination, and the demonstration that most of them commonly accompany emotion in everybody. It is then pointed out that the methods of management of life in the past were bad. After this in many instances the patient’s symptoms disappear seemingly spontaneously. Again this method was described in great detail in The Common Neuroses and therefore will not be repeated here; but it might be pointed out that the method has not had a very intelligent trial by the specialist psychotherapists in this country. I have seen it dismissed very curtly in the Freudian literature by writers who to my knowledge have never tried it, who said it could not succeed because all the investigations were conducted on the conscious level, which begs the question twice, once by suggesting that all neurosis must depend on repression, secondly by saying that Dejerine was ignorant of the dynamic unconscious because he did not use the expression.

The next contact for the patients at Swaylands was with the staff. Not all the patients had any contact to speak of with the staff; only those who were too ill or too timid to mix much with the other patients had much to do with the nurses. If a patient was well enough he got up in the morning for breakfast, was occupied one way or another till bedtime, and such a one really never saw the nursing staff. If he was in bed or could not, because of phobias or other difficulties, go down to meals, then he saw more of them. So far as was possible the effect of the staff was meant to be neutral. No one can be quite neutral, but the staff were encouraged not to treat patients themselves at all, but to recommend them always to bring their troubles to the doctor. This precaution was part of the wisdom of Weir Mitchell. In his isolation rest cure the nurses
were instructed not to permit the patients to talk to them about their symptoms or their troubles. If they talked about them to the nurse they did so less to the doctor, and Weir Mitchell wished to keep complete control in the matter of that moral influence which was obviously, in his eyes, the most important thing in his treatment. Even though he described it as the adjuvant to rest, it is easy to see that he himself thought highly of it, and that no course of treatment could be regarded as efficient without it. In a materialistic age this aspect was wholly ignored by his readers and imitators, and Weir Mitchell’s treatment was spoken of and regarded as wholly a physical treatment which rested the exhausted cerebral cells and recharged them with energy. When others more or less followed his detailed instructions, and often thought they were bettering them when they kept patients in the dark in solitary confinement and allowed them to be visited by the nurse, only when she brought their meals, they usually failed to get good results, for they forgot to use his moral teaching; indeed, though it was plain enough in his book, it is probable that they never saw that it was there, but repressed it in the act of reading it. They looked about for materialistic reasons for his successes, and, curiously, so obviously veracious was Weir Mitchell that they never accused him of exaggeration. The most amusing explanation ever given was Osler’s, who thought it must have been due to the excellence of his nurses, the very people whom the master would not allow to do anything with or to the patients. Excellent they must have been, but it was the excellence of the deaf and dumb slave whose tongue has been cut out so that he should not blab secrets, which in fact he had never heard.

The next contact for our patients was with the other patients; here we come across one of the most potent influences in the treatment of these patients, an influence which is sometimes helpful, but which tends often to be baleful. The advantages of contact with other patients may be summarized as follows.

Each patient can relearn the value of co-operation. That is a social faculty that nearly every patient has lost. He has become more and more the centre of his universe; the family has learned that his whims are disregarded at their peril; he assists other people