the other hand, let it not be forgotten that he may see most useful methods and arrive at valuable conclusions long before the slower thinking mind even glimpses them.

Lastly, one word about the introvert. Introverts are ill-suited to mental work. A nurse that after her months of probation is discovered to be an introvert in any marked degree should certainly be dispensed with. She cannot establish contact with her surroundings. Because she appears callous and aloof, she will not get on with her patients, being always suspected by them of ill-will, or accused of wrong-doing. She will not work harmoniously with her colleagues, will quarrel with them, and perhaps be exploited by them. She will be liable to a mental breakdown herself; her subjective life being so stressed already, she will be very susceptible towards her patients' tendencies to phantasy formation; she may easily drift into a neurosis with hallucinations and compulsions.

Enough has been said to outline the importance of the subject, and though the above remarks cannot claim to bring anything new or original to bear on the matter, they will not have been in vain if they assist anyone in mental hospitals to remember the need for a clearer understanding of types, and the possible influence of such knowledge upon the every-day work of the institution.

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*The Formulation of Psychiatric Cases.** By Angus MacNiven, M.B., Ch.B., D.P.M., Assistant Physician, Royal Edinburgh Mental Hospital.

" The disorders of the psycho-biologic adaptive processes must be viewed as the resultants of a group of facts and factors; and, by accepting this view, we get on a natural working basis for our understanding and our dealings with the case." —Adolf Meyer.

In order to obtain a complete account of these facts and factors from every available source, and to get the co-operation on behalf of the patient, it is necessary that the relatives, the physician and the nurse of the patient be presented with the data in a comprehensive form.

As each of these groups varies in intelligence, understanding of psychological matters and point of observation, and differs in what is expected of it, it is essential that the mode of presentation takes these variations into account. With this idea of individual presentation, a case has been prepared as it would be

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discussed with the nurse, the family physician, the relatives and the patient.

This case illustrates the various problems which each psychiatric case might present to the physician.

In considering the mental illness as a reaction of the individual to a situation rather than as a disease entity, it is important that we have accurate histories, so that, when these facts are considered along with the patient's personality, we can have some idea of how the illness came about. We can then consider what factors in the situation played the important *rôle*, and how to modify matters so that the patient can readjust himself once more. To bring this about we have not only to deal with the individual himself, but with his social setting, therefore it is important to consider the bearing of the family situation on the problem.

We are aided in this by the social service worker, whose help we should make use of in giving the patient a fresh start after his recovery.

In treating a case of mental illness, the physician must gain the co-operation of the patient's relatives. Not infrequently, the friends express definite ideas as to the cause of the patient's illness, and the manner in which the treatment should be carried out. To correct erroneous ideas without antagonizing the relatives may at times prove very difficult.

The conception of a mental illness is very difficult for the ordinary person to grasp. To explain that the patient's symptoms need not have any demonstrable physical basis is not always easy, even when one is dealing with well-educated people. The natural desire to find some cause for the changes in the patient's personality leads them to believe that the symptoms must be caused by "something on the brain," or by "poison in his system." Not infrequently they have been encouraged in these ideas by the physician who treated the case before it came to the psychiatrist.

The attitude of the patient's relatives to the mental hospital is often one of suspicion and distrust, and the psychiatrist has to dispel these and win their confidence and co-operation. They wish to know what caused the patient's illness, and how he is to be cured. The physician must explain that a mental illness does not result from the operation of one specific factor, but that the breakdown is closely connected with the patient's personality and his difficulties in life; and that treatment must be directed towards correcting the causes of these difficulties. In explaining to the friends the mode of approach to the case, the physician should make them understand why it should be dealt with in the way he advises, and invite them to co-operate with him Unless such an

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explanation is given, the relatives cannot be expected to aid the physician, and they may even prove a hindrance in the treatment of the case. It is often difficult for them to understand, for instance, why the patient cannot be allowed to see visitors, or why he should have to remain in hospital when, to them, he appears to be restored to health. When the patient is discharged his future well-being is often dependent upon the attitude of those with whom he is most intimately in contact.

The physician must make clear to the relatives what the patient's limitations are, and to what extent he needs protection against particular stresses, so that a future breakdown may be prevented. The conduct of the patient is often a source of irritation and annoyance to members of his family, who, in their attempts to correct matters, may only succeed in making the situation worse. The physician should make the relatives understand that the abnormal conduct of the patient is a symptom of illness, for which he requires special treatment, and that they must not expect him to conform to normal standards. They must be made to realize that they should adapt themselves to the patient, rather than expect the patient to adapt himself to them.

In most cases of mental illness the advice of the psychiatrist is only sought after the case has been in the hands of the family physician. Often the family physician has but a hazy conception of mental illness and the manner in which it should be treated. When the patient comes under the care of the psychiatrist it is the latters duty to give the physician a presentation of the case which can be understood by him, and of value to him in dealing with similar situations in the future. The family physician is usually in close touch with the patient's relatives, and has their confidence. We should, therefore, endeavour to arouse his interest in the case to understand the rationale of our treatment, and support us in gaining the co-operation of the patient's relatives. Relatives will often accept advice and guidance more readily from their own physician, whom they look upon as a friend and adviser, than they will from the psychiatrist, who is a stranger to them.

When the patient leaves the hospital we should inform the physician what we consider the best mode of life for the patient to follow, and how he can best be protected from stress which might lead to another breakdown. If the physician is to carry out our instructions satisfactorily, the important *rôle* played by the psychogenic factors in mental illness must be explained to him. In presenting the case to him, we must remember that we are probably dealing with someone who has been accustomed to think of mental disorders in terms of disease of the brain. It should be our aim

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to show him the part played by the various factors in the life of the individual in bringing about his illness. We would do well to avoid using specific diagnostic terms, and speak rather of the patient's illness as a reaction to a situation. If we use diagnostic terms—schizophrenia, for instance—they probably convey only one meaning to him, namely, that the patient is suffering from an incurable illness. He will thus lose any interest he had in the case.

When a case of mental illness is treated in hospital, the part played by the nurse is an important one. The nurse should not be allowed to play a purely passive *rôle;* she should take an active part, under the guidance of the physician, in the treatment of the case. In order that she may do this, it is necessary that she be given some knowledge of the facts of the case. We should present the case to the nurse in such a way as to arouse her personal interest in the patient. If the patient behaves in an abnormal and erratic manner, we should explain to the nurse that the behaviour is not altogether meaningless, but that everything the patient does has some significance. We should advise her as to her attitude to the patient, and, inasmuch as we need her co-operation in the treatment, we should explain our reasons for adopting it. If the patient is hypochondriacal, we must make it clear to the nurse that, while the patient's aches and pains are fictitious, yet, to him, they are very real, and a source of great distress. It should be pointed out to her that the behaviour of the patient is greatly influenced by the manner in which he is managed, and that if he is unresponsive and uncoöperative she should take herself to task, and consider whether she herself is not in some degree responsible.

If we regard a mental illness as a reaction on the part of an individual to difficulties he has had to face, we may hope to gain some insight into the manner in which the illness came about by making a careful study of the individual's personality and of the environment in which he lived. We wish to know what kind of person the patient was before he became sick, what his capabilities were, what he has done, what difficulties he has had to contend with, and whether they were created by his own constitutional maladaptation to life in general, or whether they were of such a nature as to prove a stress to the average person. By taking the whole situation into consideration and assessing the relative importance of the constitutional and environmental factors, we come to some conclusion as to the method which we are going to adopt in helping the patient to readjust himself once more.

From the point of view of the treatment of the case, an exact verbal, nosological diagnosis is of much less importance than an

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understanding of the way in which the various factors in the patient himself and in his environment have worked together in bringing about his breakdown. In our treatment we must try and explain these things to the patient in such a way that he will be able to grasp them and use them for himself. If we can give the patient some understanding of himself and his difficulties, he will be more inclined to accept the advice we give him, and thus help himself towards recovery. Not infrequently we find that the patients with whom we have to deal in hospital seem to shut themselves off from almost all help and guidance, so that treatment on the above lines seems impossible. In dealing with such cases we must make use of the resources offered by them. We must adapt our treatment to the patient, trying one mode of approach after another until we find something which he is willing to accept, and which will help us in getting into closer touch with him.

Dr. Adolf Meyer emphasizes that we must obtain in each of our cases " the nature and depth of the disorder, the factors at work, and the points of attack for treatment." We should not think of the disease in general, but of the facts presented by the patient. Hence we try to secure the facts concerning " the total reaction, reaction-type or reaction-complex. The reaction-complex is then qualified by the statement of the ætiological or dynamic factors at work; it is next weighed for the possible structural involvement, and especially also the therapeutic opportunities, and the prognosis; and finally, according to whether the case does or does not coincide with a well-defined practical type, it is classed as identical with, or akin to, a standard unit such as we keep for our statistics and for elementary teaching."

One thing is certain: we have to get away from the idea of " one person, one disease." If we consider the personality as the unit which presents itself to us, and study the constitutional make-up, the special psychological and other factors at work, we get the best understanding of a patient. For every patient there is individual treatment, and we try to work with really individual facts. If we try to work from " analytic-synthetic dynamic " viewpoints, the psycho-pathological problems of man lie before us in a form which we can make understandable not only for ourselves, but for everyone who can assist us in the treatment of the patient.

Miss B. C—, æt. 16, schoolgirl. Admitted into the Phipps Psychiatric Clinic February 27, 1926.

The patient is the second of two girls. Her father died of general paresis when patient was two years of age. Her mother is living, she is a somewhat prudish, narrow-minded woman. A great-uncle died of senile dementia, and a paternal uncle was alcoholic and addicted to drugs.

The patient was born in 1910. Her birth was normal, and she walked and talked at the usual ages. She was a healthy child, who did not show any neurotic traits.

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She was an active, sociable, energetic girl. As a child she was rather self-willed, but she was not stubborn, and she was not given to tantrums. She played freely with other children, and was a leader in her group.

She commenced school at five years of age. She was an average scholar. She graduated from grammar school.

As she grew up she took an active part in the social life of her group. She was fond of outdoor sports, and had a great many friends of both sexes, with whom she was a general favourite. She was not shy, was always keen about amusements, and always seemed to be of a bright and care-free disposition. She was fond of dress; she liked the admiration of boys, with whom she was popular. Although affectionate towards her mother, she was not dependent upon her to any extent.

The patient herself was able to give some account of her sex life. Her mother, she said, did not give her any instruction in sex matters, but she got her knowledge from the other girls at school.

She states she practised masturbation for about two months before the onset of her illness. She knew that other girls practised self-abuse, because another girl discussed the matter with her. She could not remember exactly what this girl told her, but "she seemed very worried about it." The patient denies that she thought or worried to any extent about the matter; but she tried to give up the habit, because she "did not think it was the right thing to do." Before the onset of her illness she did not think that any particular harm could follow from masturbation, but she admits that, after she began to feel ill, she worried about the habit. She wondered whether it could cause a displacement of one of her internal organs. She cannot explain how she came to have this idea. With regard to her experience with boys, she says that she had numerous boy friends, but, apart from kissing, she never had any intimate relations with them.

In the summer of 1923, when 13 years of age, she went to Europe. While there she seemed to be run down physically, and her mother noticed that she had a slight degree of spinal curvature. On her return home her mother took her to a physician in Boston, who prescribed exercises and a spinal brace. She continued to have treatment for a year, so that she was not able to attend school during this period. In the fall of 1924 she entered a preparatory school with a view to preparing herself to enter a well-known women's college. She did not work excessively, nor did she appear to worry about her studies.

She seemed to be in perfect mental health until the onset of her present illness. During the Christmas vacation (1925) she was engaged in a continuous round of entertainments. She went to dances and parties practically every night, and often had very little sleep. On the night of January 2, 1926, she went for an automobile ride with two boy friends. An accident occurred; the car overturned, but no one was hurt. The patient did not appear to be upset at the time. On her arrival home her mother rebuked her for having gone out with boys in a car, and the patient seemed to take the scolding to heart. Next day she seemed upset. She cried, and complained that she felt dazed. She said that when out to dinner that night she had difficulty in following the conversation at table.

The following day, January 4, she returned to school; but next day she was found in her room, shrieking loudly, and evidently in a state of panic. She was taken home, and from that time until her admission to the Clinic (seven weeks later) she continued in a state of great emotional instability. She cried frequently for long periods and said that she was "going crazy" and that she had "no soul." She did not sleep well at night, and sometimes she appeared to be in extreme terror. If her mother approached her she shrieked loudly, and told her to go away. She declared that she could not bear to have her mother near her. After a few weeks her condition changed somewhat. She became sullen and preoccupied, and at times she gave the impression of not understanding what was being said to her. Her outbursts of panic still persisted. She would cry bitterly, say that her family did not understand her, and referred to herself as a "high-grade moron."

On her admission to the Clinic on February 27, 1926, the patient seemed depressed and tense. She was clear and orientated. She talked somewhat freely about herself and her condition, but she seemed strained and uneasy. When talking she burst into tears, and gave as the cause of her distress the fact that she had various fears and apprehensions—she feared she was going to be paralysed and that she would lose her mind. Next day she presented a somewhat different picture.

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She wandered about the ward in a somewhat dazed way. While talking to the physician she suddenly began to scribble on a piece of paper on his desk, and when asked what she was writing she replied that she was "making the dot-and-dash sign." While talking she seemed on the point of tears, but she also frequently giggled and smiled. At times she made self-depreciatory statements, such as "The others don't want to have me around. Why should anyone like someone whose growth is stunted?"

When asked what she considered to be the cause of her illness she replied, "Only myself, because it's God's way. He meant for it to be that way. He has control of all people." She said she was worried because she did not "grow up," and she complained that her teeth did not seem to move. She continued in this condition for several days, was quiet in the ward, sat by herself and cried frequently. She asked whether her hands were growing smaller, and whether her eyes were becoming crossed. She wondered whether the stripes on her pyjamas meant laziness. She seemed in a perplexed state. She said, "I feel confused and upset. I don't know what it's all about. I started out a girl, and now I am a boy."

At times she seemed depressed, and she described her own mood as being one of depression; but, as a rule, she could easily be diverted to smiles. She remained in this state for a week, and then began to show considerable improvement. She behaved in a perfectly normal way, seemed cheerful and sociable, and took part in the various activities in the ward with enjoyment. She was able to give a good account of herself and her illness. She said that during the Christmas vacation she felt tired and "done out." Following the automobile accident she felt very worried. The boy who drove the car was slightly under the influence of alcohol at the time the accident occurred, and she worried because she thought that people would talk about him and make uncomplimentary remarks. She had asked him to take her for a ride, and so she considered that she was largely responsible for the accident. On the day after the accident she felt dazed and "far away." She could not now remember what she thought about. When she went back to school the other girls talked about the accident, and said that her friend who drove the car was "dead drunk" when it happened. She was very worried about the remarks, especially as they were a gross exaggeration of the actual circumstances. She said she felt very tired—"I couldn't do things; I couldn't study." She went to her room and cried because she felt "so tired." Asked why she had screamed when her mother came into her room at home she said it was because she felt unworthy of her mother, on account of the fact that she had practised self-abuse.

The period of improvement, during which the patient was able to give the above account of her illness, lasted about two weeks, and then she relapsed into the condition she was in upon her admission. She ceased to take part in the activities of the ward. She seemed distressed and perplexed. She said she was worried because sometimes other patients in the ward seemed to her to be different in size at different times. She complained of feeling at times as if she were "flying away." People did not seem to her to be telling the truth, and she had the feeling that she did not tell the truth herself. At times she wandered around the ward in an aimless manner, and in her behaviour gave the impression that she was in a state of perplexity and apprehension.

Formulation of Case

As regards her endowment, the patient has a somewhat unstable background on the paternal side (paretic father, senile grandmother, alcoholic uncle), and, furthermore, has in her physical make-up a spinal curvature, about which, although it is slight, she is rather sensitive. In spite of the fact that she lived with a somewhat prudish mother, she seemed to lead a remarkably free and outgoing life.

The striking thing about the onset of the illness is its suddenness. Undoubtedly the assumption of the responsibility for asking an intoxicated boy to take her for a ride must have been a severe

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psychological trauma, especially since the drive resulted in an accident. The fact that her mother increased her feeling of blame by scolding, and that the next day the girls at school spoke about it disparagingly, seems to constitute a rather inadequate ætiology for a serious upset, considering the patient's constitutional make-up. Apparently, two weeks before the onset, she was going to a great many parties, and was getting little sleep. This must have resulted in considerable fatigue, and probably a certain amount of sexual excitement. For the first few days the outstanding facts were the emotional instability, with a mixture of depression and terror, and the talk of going crazy and having no soul. The shift to sullenness and preoccupation, with difficulty in understanding what was said to her, is noteworthy. Apparently this state was not constant, because on admission to the Phipps Clinic she seemed quite clear, talked freely about herself, and was fearful and depressed with the idea that she was going to be paralysed and would lose her mind. Many of her utterances suggest an auto-erotic conflict. Her relapse into a perplexed condition again, with frequent alternation of tears and giggling, together with her odd scribbling of the " dot-and-dash sign," might suggest a somewhat schizophrenic colouring. After this her utterances were, for the most part, depressive, although the feelings that her hands were growing smaller and her statement that she " started out a girl, and now I am a boy " suggest a more serious type of body-alteration feeling. It is interesting to note further that she definitely complained of feeling confused and upset. The three-week period of improvement with good insight into her illness, and the explanation of some of her unusual behaviour on a depressive basis (sending her mother away because she felt unworthy of her on account of the auto-erotic activity), argue for benignity. Her relapse into the dazed attitude, with definite perplexity, the subjective feeling of the difference in the sizes of people, and the uncertainty about whether she told the truth, or was being told the truth, spread a more ominous colouring on the psychosis. It is, of course, possible that the relapse was precipitated by a too rapid ventilation of the patient's complex material. One must bear in mind that the patient was brought up under the influence of a prudish mother, and that her auto-erotism and the excitement resulting from the Christmas festivities apparently played an important part in the psychosis.

In summing up the case at this juncture, I should be more inclined to regard the psychosis as predominantly affective, with confusion. In favour of this is the marked depression, the self-depreciatory and self-accusatory utterances; secondly, the sudden

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onset following what was to the patient considerable psychic stress, the rather frank auto-erotic conflict, and the patient's good behaviour and contact in the ward. The more ominous signs are the acute panic attacks, the perplexity elements (which may, however, be affective bewilderment), the talk of body alteration.

Formulation to the Nurse.

Girl of extraordinarily healthy, active, sociable, friendly life. Handicapped by a slight spinal curvature, and quite sensitive about it. The girl became upset because there was an accident during an automobile trip which she had suggested. Apparently somewhat sensitive about sexual self-arousals, much of her talk would allude somewhat to worries and fears about this form of sexuality. The nurse should be cautious in talking with the patient not to push inquiries into the meaning of any sex-references, but should note them down so that the physician may use them at a later date. The patient should be tactfully led away from any discussion of intimate matters, for fear that she may have a subsequent revulsion of feeling. The main energy of the nurse should be devoted to getting the patient to follow routine, undertake some form of hand-work, and to participate in games.

Formulation to the Physician.

As we now see the case, we are very hopeful that, because of the relatively normal life the girl has led, and the fact that this upset came when she was very tired, and on the occasion of what might have been a rather serious accident, for which she might legitimately take part of the responsibility, and, further, because of the degree of depression, the girl may make a recovery. That, on the other hand, we are inclined to present to the family a hopefully guarded prognosis. This, because certain features of the case—namely, the panics, the perplexity and the feeling of body alterations—occur in the more serious types of psychoses. (I should avoid using diagnostic terms, and would try to explain it, thinking of life situations.)

Formulation to the Family.

Tell mother that, on the whole, we are hopeful that the girl will get well, but that, both because of our uncertainty about the outcome and the fact that we cannot predict the length of time that recovery may take, she should make her plans, financial and otherwise, for a long rather than a short illness. Impress upon her the necessity of encouraging the girl, by a sympathetic attitude, to ventilate her problems and future difficulties. The girl will not

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do this unless she feels that her mother is able to look at matters from her point of view. Hint tactfully that it is difficult for older people to see eye to eye with youth, but that she should endeavour to direct the patient's energies into safe and harmless channels rather than suppress them.

The reason for this advice is that apparently the girl is somewhat over-sensitive, and takes her responsibilities seriously; and, although the mother was quite right in her disapproval of the automobile ride, she must, in the future, realize that discipline and condemnation should be tactfully given, and also that adolescent girls are confronted with many problems of their emotional life, which leave them floundering unless they are wisely and carefully instructed.

In regard to our plans for further treatment, we have to take into consideration the fact that we cannot go too fast with an analysis. We have to decide whether we shall attract the patient's attention by occupation, or whether we shall try to analyse as much as possible. It is very important to make clear whether a male or female physician can have better *rapport* with and influence upon her. Some homosexual features which we observe in the patient, and her easily stirred up sexuality, need special attention.

I wish to express my thanks to Dr. Adolf Meyer, Director of the Phipps Psychiatric Clinic, for his permission to use the case material, and for his stimulating advice and unfailing encouragement.

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*Some Points in the Histology of the Globus Pallidus.**

By E. Barton White, M.R.C.S., L.R.C.P.Lond.

There are many references in neurological literature to pathological changes in the globus pallidus in diseases accompanied by muscular tremor and rigidity, such as paralysis agitans and post-encephalitic Parkinsonianism.

Scattered among these references are descriptions of a very striking change in the walls of the blood-vessels of the globus pallidus, seen as a deposit—often in large amounts—of amorphous material in the outer walls of the blood-vessels. The amount of this material laid down in the vessel-walls is often enough to obliterate almost entirely their muscular and elastic fibres. When examined by routine methods, the deposit *resembled* very closely the process of calcification. As more cases were described, and the condition was always relatively gross, easy to detect and very striking, there arose a tendency to regard it as pathological, and as

(*) A paper read at the Quarterly Meeting held at Bristol, February 16, 1928.

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