THE UNCERTIFIED CHRONIC PATIENT.

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Uncertified chronic patients comprise a vast heterogeneous group of cases. Legally, they can be divided into voluntary and temporary patients and normal persons. Clinically, they can be given innumerable diagnoses.

Diagnosis.—The fixing of a diagnostic label is notoriously difficult as in many cases two or more diagnoses could be given. In these series the earliest or the most prominent condition has been used, but other clinicians would, without doubt, have given other diagnoses to some of the cases. The voluntary and temporary patients were diagnosed by Dr. E. Casson and so are definitely comparable with one another. The other groups are also comparable as they were all my own diagnoses. The cases were examined before the collection of the figures for this article and the diagnoses were made without consideration of the diagnoses in other groups. Although many of the depressives and maniacs may have been manic-depressives, they have not been placed in this group as the cyclothyme condition was not the most prominent symptom present at the first interview.

Acute and Chronic Types.—The exact definitions of the terms acute and chronic are not very clear, but I am regarding, arbitrarily, an acute condition as one starting suddenly and persisting for a few weeks only.

Few cases can be termed acute. Sudden onset of anxiety, acute attacks of mania and of alcoholic delirium may occur and approximately one-third of the temporary cases were of this nature. In the other groups the acute cases numbered so few that each series can be regarded as chronic in character.

Type of Case.—A review of the patients attending any one hospital may be entirely fallacious as regards giving a general idea of the nature of the class under consideration. The cases have been selected by those who have referred them and also by the reputation of the hospital in the locality, whether this is small or large. Consequently, in order to determine the nature of uncertified chronic psychological cases, the diagnoses from six groups of cases have been reviewed.

The cases were successive and unselected. The groups consist of voluntary and temporary patients, cases referred to a private psychological practice, patients seen for psychotherapy at the West End Hospital for Nervous Diseases, London, and patients referred from general practitioners and the honorary staffs of the Bristol Royal Infirmary and the Bristol General Hospital. The diagnoses of the voluntary and temporary patients have been taken from the records of Dorset House, Bristol, a nursing home

of 100 beds, of which 30 are approved under the Mental Treatment Act for the reception of voluntary, and, up to 5, temporary patients. My thanks are due to Dr. E. Casson for permitting me to use her figures. At the West End Hospital for Nervous Diseases, the cases are referred by the neurologists to the psychiatrists. If they are considered suitable they are then sent for psychotherapy. To Dr. Blachford, my late senior at the Bristol General Hospital, my thanks are due for permission to cite cases which have come to the department for mental diseases at that hospital.

General Review.—Table I demonstrates some striking points, of which

TABLE I—DIAGNOSES (PERCENTAGES IN BRACKETS).

Diagnoses	Voluntary	Temporary	Private	W. End Hospital	Royal Infirmary	General Hospital
Anxiety ..	4 (8)	0	20 (40)	11 (44)	22 (44)	15 (30)
Confusion ..	12 (24)	7 (28)	0	0	0	1 (2)
Depression ..	11 (22)	2 (8)	3 (6)	3 (12)	11 (22)	13 (26)
Schizophrenia ..	9 (18)	5 (20)	4 (8)	5 (20)	2 (4)	2 (4)

the most prominent is the relatively high and constant proportion of anxiety cases in the private, the West End Hospital, Royal Infirmary and General Hospital groups. This type varied from 30 to 44 per cent of all cases. The absence of these cases from the temporary group and the low percentage in the voluntary group demonstrate that cases of anxiety do not usually require to be under any kind of order. The diagnosis of confusion was seldom made in private, West End Hospital, Royal Infirmary or General Hospital series, but formed about 25 per cent of the voluntary and temporary cases. In the combined temporary and private groups depressives form 7 per cent of the cases, but 23 per cent in the combined voluntary Royal Infirmary and General Hospital groups. At the West End Hospital they occupy an intermediate position (12 per cent), probably because many melancholics would have been eliminated as being unsuitable for psychotherapy. Schizophrenics vary from 16 to 20 per cent in the voluntary, temporary and West End Hospital groups, in the latter being chiefly slight types. In the private, Royal Infirmary and General Hospital groups they form only from 4 to 8 per cent of the cases. Secondary dementia is slightly more common in the voluntary group than elsewhere, and mania in the temporary cases. As these last were mostly acute cases, they can be excluded from this discussion. Hysteria was absent amongst the voluntary and temporary groups. The high proportion of delinquents, 3 of 4 and 2 of 4, in the groups of sexual aberrations and mental deficiency respectively, is of interest. These cases were referred from the Courts.

Sex.—Table II gives the distribution of the sexes. The voluntary and

TABLE II—SEX DISTRIBUTION. (PERCENTAGES IN BRACKETS.)

	Private	W. End Hospital	Royal Infirmary	General Hospital	Total
M. ..	29 (58)	14 (56)	25 (50)	23 (46)	91 (52)
F. ..	21 (42)	11 (44)	25 (50)	27 (54)	84 (48)

temporary patients have been omitted as the Dorset House records are

biased towards the female side. This is partly due to males having been admitted in any numbers in the past three or four years only, and to the number of male beds being less than female.

The remarkably equal distribution of the sexes in the private, West End Hospital, Royal Infirmary and General Hospital groups would suggest that some definite selective action had occurred, were it not known that this were not the case. Table II suggests that either males suffer in a higher proportion than females from the conditions under consideration, or that males come for treatment more than do females, the female population of the country being greater than that of the opposite sex.

Age.—The age-distribution is shown in Table III, the ages being those at which the patients first came under observation.

TABLE III—AGE DISTRIBUTION. (PERCENTAGES IN BRACKETS.)

Age-Group	Voluntary	Temporary	Private	W. End Hospital	Royal Infirmary	General Hospital	Totals
0— 9 ..	0	0	0	0	1 (2)	3 (6)	4 (2)
10—19 ..	1 (2)	2 (8)	8 (16)	0	1 (2)	7 (14)	19 (8)
20—29 ..	9 (18)	5 (20)	13 (26)	14 (56)	13 (26)	6 (12)	60 (24)
30—39 ..	9 (18)	1 (4)	11 (22)	6 (24)	18 (36)	18 (36)	63 (25)
40—49 ..	6 (12)	4 (16)	8 (16)	3 (12)	5 (10)	7 (14)	33 (13)
50—59 ..	11 (22)	5 (20)	7 (14)	1 (4)	9 (18)	4 (8)	37 (15)
60—69 ..	8 (16)	4 (16)	0	1 (4)	3 (6)	4 (8)	20 (8)
70—79 ..	5 (10)	2 (8)	1 (2)	0	0	1 (2)	9 (4)
80—89 ..	1 (2)	2 (8)	2 (4)	0	0	0	5 (2)

At the West End Hospital there is a children's department, so that young persons are artificially excluded from the table.

The voluntary and temporary patients are fairly evenly distributed throughout the age-groups from 20 to 70 years.

In the private group the ages lie chiefly between 10 and 60 years, in the Royal Infirmary group between 20 and 60, and in the General Hospital series between 10 and 50. Of all cases combined 49 per cent were aged between 20 and 40 years.

Summary of Tables.—Tables I, II and III show that the sexes occurred in equal proportions and that the majority of cases coming for treatment were from about 20 to 59 years of age. The most frequent diagnoses were anxiety (29 per cent), depression (17 per cent) schizophrenia (10 per cent), and confusion (8 per cent). The other diagnoses were, in alphabetical order, chorea, cretinism, delirium, delusional psychosis, enuresis, epilepsy, exhaustion, fibrositis, hypothyroidism, hysteria, labyrinthine disease, mania, manic-depressive psychosis, mental deficiency, migraine, neurasthenia, neurosyphilis, paralysis agitans, paranoia, paraphrenia, post-encephalitic conditions, senile dementia, sexual aberrations, spinal hæmorrhage, tic, torticollis, and vocational guidance.

In one of the depressives Pick's disease was present, in another pellagra.

Comments.—Comments are made below on the most common conditions, and, in addition, on a few other conditions which have been specially studied.

(1) Anxiety : This may be shown by obvious signs of fear or by somatic symptoms, such as flatulence, nausea, pain or diarrhœa. In one case,

the last occurred for three days on each of two occasions when repressed memories of an accident rose into consciousness accompanied by fear. Flatulence is a frequent accompaniment of anxiety and pain may be localized in a region already the seat of organic pain. In a woman who had had an illegal abortion performed following illicit coitus unknown to her husband, severe pain developed over the vertex and the occipital region. A slight degree of cervical osteo-arthritis was found on X-ray examination, but it was insufficient to cause such severe pain, which was apparently due to guilt, unconfessed to her husband. The presence of physical symptoms of anxiety may be difficult to detect as in the case of a chronic alcoholic who gave a very detailed account of his past history. It was not until after about forty-five minutes, and then only on questioning, that he mentioned that he underwent attacks of "trembling" which consisted of palpitation and a "sinking feeling in the stomach."

(2) Depression: Although a diagnosis of depression is usually relatively easy, decision as to whether the condition is primary, e.g. a phase of a manic-depressive condition, or secondary or an anxiety or toxic state, may be difficult. The depression may be attached to anything, two very different subjects being a mistake made in buying a house, and a fear that an expected baby would be mentally defective.

Treatment depends upon the cause, but benzedrine, commencing with small doses of mgm. iiss, gives very good results in cases who are particularly depressed in the earlier parts of the day. Many cases improve with general hygienic measures, such as the correction of constipation, increased exercise and feeding, coupled with occupational therapy. The last is important in order to draw the interest of the patient away from the subject to which the depression is attached. The toxic group of depressives should be dealt with by surgical and other suitable physical measures, such as hydrotherapy and the use of ultra-violet rays from a mercury-vapour lamp combined with infra-red rays.

(3) Schizophrenia: The treatment of the uncertified schizophrenic may present several difficulties. The voluntary patient may leave when he has improved slightly after a few injections of cardiazol, before he has completed the full course. The discomfort of both cardiazol and insulin treatment may make the patient protest against further injections, although treatment is apparently less unpleasant with triazol 156. Fortunately, large numbers of schizophrenics show a steady, lasting improvement without these treatments, with good food, cheerful surroundings, and constant occupational therapy. The use of the hands appears to be of great importance. One case, a clergyman's son, was advised to give up working for examinations and use his hands. He entered an engineering works as an apprentice. Although he continued to live at home and no other treatment was given, he improved so much that, within a month, his own doctor considered him normal. In reality, he had not fully recovered.

Psychotherapy may be of definite value in schizophrenia and may modify

and improve the condition, but, in my hands, it has never produced a good remission, even temporarily.

Finally, mental defectives may develop schizophrenic symptoms, the schizophrenia being superimposed upon the deficiency. The proportion of defectives in which this occurs is not high. Dr. J. Lyons and the writer were able to find only about 1·6 per cent of defectives with schizoid symptoms amongst the 600 mental defectives of all ages and both sexes in Hortham Colony. This estimate is, no doubt, low. Many cases would have been sent direct to the mental hospital. It gives an indication of the proportion of defectives, who without being typical schizophrenics, may possess one or two schizoid characteristics. Such cases need the training given to defectives in addition to any chemical treatment or psychotherapy that may be used.

(4) Confusion: The diagnosis of confusion usually presents little difficulty. The amount of deterioration or dementia present can be estimated by means of Babcock's method of the use of vocabulary tests in conjunction with estimates of intelligence.

The causes of confusion may be difficult to determine, but the most common are toxic and arteriosclerotic. Cerebral tumours are a less common cause. Psychotherapy may be of value in certain cases, but I have no personal experience of its use in cases primarily confusional in character. The treatment of the majority of cases should consist of general hygienic measures, the removal of toxic foci, and, possibly, the attempted lowering of high blood-pressure.

(5) Post-encephalitic conditions: In addition to the well-known changes of character that may follow encephalitis epidemica in children, the adult cases often show depression and fear, and are frequently over-emotional. Treatment with some of the standard methods, as tincture of stramonium in 45 or 60 minim doses, improves both the physical and psychological states. My results with the Bulgarian treatment on a few cases, but over periods of up to 500 days, strongly suggest that the method of preparation is the important factor operating in cases reacting well to this therapy. Greater improvements were obtained in patients treated with B.P. Belladonna root prepared by the Bulgarian method than by the use of the Bulgarian mixed Solanceae roots prepared by the same method.

(6) Sexual aberrations: Although the diagnosis of these cases is usually obvious, the causes may be obscure. Quite superficial treatment will correct many cases, but prolonged deep psycho-analysis is necessary in others. A few sessions cured a patient who felt inferior, and, in consequence, exposed himself to prove he was a fully developed man. Another case who exposed himself two or three times a week, required over twenty interviews before he was free from the urges for even three weeks.

(7) Mental deficiency: The diagnosis of deficiency is of importance. Many of the higher grade are missed and break down in their conduct because they are expected to do work for which they are incapable. They

in consequence, feel inferior and so break out in primitive ways, by violence, theft or other methods of showing their importance or of "getting even" with individuals or the community. An early diagnosis gives time for treatment and training so that the defective can be made to feel proud of that which he can achieve and so feel competent, even if in small matters only.

Some modification of the Binet-Simon group of tests is usually used for an estimate of that evasive quality known as intelligence. Burt standardized the American Stanford Revision of the tests for English children, but a revised form of the series of tests was issued three years ago in America. This revised form is at present unsuitable for English subjects as it has not yet been standardized for this country.

A very useful, rapid test for higher-grade defectives is Kent's Oral Emergency Test, C. J. C. Earl's English modification. The test tends to give results slightly lower than those of the original Stanford Revision of the Binet Simon Tests.

Performance test such as Koh's blocks, Healy's pictures, the Manikin and the Porteous Maze test, are valuable, C. J. C. Earl having shown that performance tests do not necessarily run parallel with other tests of intelligence. The testing for Spearman's specific or group factors, the last overlapping one another, may give useful information, and, although the influence of the specific factors is probably of greater clinical importance, an estimate of g. may be of much value for general purposes. The Accomplishment Quotient $\frac{(\text{Educational Age} \times 100)}{(\text{Mental Age})}$ when compared with the I.Q. will give indications as regards school progress, as in reading, spelling, English, arithmetic and writing. Finally, tests for æsthetic sense, which appear to be basic and independent of experience and training, may be used.

When an estimate has been formed of the capabilities of the individual, suitable work can be selected for him, but success or failure will be dependent upon the use made by the defective of his intelligence. He will use it to the full only if his temperament and character are suitable and his emotions are favourably stimulated. Unfortunately, tests of temperament and character have low validities and, at present, the assessment of temperament is an art rather than a science.

(8) Delinquency: Delinquents who do not break the law from conscious motives may do so for many reasons, such as being unable to appreciate the wrongfulness of their actions or feelings.

A somewhat unusual instance of this is that of a man driving with undue care. He drove three motor-bicycles and one horse into stationary objects. He suffered from *petit mal* attacks of a few seconds duration. More common instances are those of rick firing by defectives who like to see a "nice fire," but who cannot understand the reasons for not setting the hay alight.

Compensation for feelings of inferiority is seen in the case of a boy who stole individually nearly 150 keys from house doors and kept a diary with

the place and date of each theft. Sexual crimes of this type are exemplified by a man who exposed himself to women about his mother's age as he, unconsciously, wished to prove he was a fully developed man.

Although many sexual offences can be satisfactorily explained by psychoanalysis, some appear to rest on a more superficial basis. For instance, a boy stole female underclothes from clothes lines to obtain stimulation for masturbation. In another case, a man exposed himself to three strange girls immediately after thinking of coitus with a girl with whom he was greatly in love.

Sexual causes are frequently the origins of criminal acts which apparently have no relation to sex. An instance is that of a man who had lived happily for two years sharing a house with another man, a homosexual. Owing to obtaining a knowledge of the law, he decided to move. Two days after he had transferred his furniture from the house he committed suicide.

Another cause of delinquency is promise of a reward by some more intelligent person. A defective walked into a garden strange to him and openly cut evergreens for selling as he had been told by a companion that he had permission to do so.

Summary.—The nature of the uncertified chronic types has been investigated in 6 groups of cases from two towns. In a total of 250 patients, 31 different diagnoses were made. Of these, anxiety, depression, schizophrenia and confusion were the most frequent. The sexes were equal and the majority of the cases were aged from 20 to 59 years. Comments are made on anxiety, depression, schizophrenia, confusion, post-encephalitic conditions, sexual aberrations, mental deficiency and delinquency.