Thesis

# On the significance of Lack of Courage in the genesis of psychosis and neurosis : and the therapeutic inferences.

by

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The apostle Paul (I), while incarcerated in prison, wrote - 'I can do all things through Christ which strengtheneth me' - which means that he was borne up to face adversity with a splendid courage. According to Adler (2), psychosis and neurosis are modes of expression for human beings who have lost courage. Talking to a young woman who suffered from hystero-epileptic attacks, he said (3) - 'The whole trouble is that you are not brave enough.' She asked - 'Do you mean that if I am courageous I can cure my attacks?', and Dr. Adler answered - 'Yes.'

One of the chief stumbling blocks in psychiatry is the uncritical acceptance of the classification of patients into groups such as dementia praecox and involutional melancholia, and the resultant application of a standardised mode of treatment to the members of any one group. A measure such as this may simplify general hospital administration, but it impedes rational therapy. Adler's aphorism, though not so universally applicable as he would have it, is of the greatest significance, because it lays the emphasis in psychogenesis on a constitutional factor, whereas the main trend of present-day thought is to regard the environmental factor as of chief importance.

Unquestionably one must consider each individual as a biopsychic organism in its milieu (4), but one must apportion accurately the relative importance of constitutional and environmental influences. The

psychiatrist would appear to have especial difficulty in avoiding extremes of thought. The Individual Psychologists have seen the most clearly. Bumke says(5) that there can be no psychology that does not attempt to understand the whole man, and this cannot be achieved with any certainty except through the study of the individual.

Personality is the psychic endowment that comes to the child as a result of the interchange between it and environment(6). Personality is a product of experience. The development of the constitutional endowment is influenced by the environmental conditions. The principal element affecting the urgency to adaptation, in the constitutional endowment, is the individual's courage, whose quality may be more robust or more fragile, and which may develop more vigorously or more feebly. The manner in which the individual will in future life deal with his environment in order to fulfil his ambitions, is determined by the development of courage in his personality. The more strongly developed his courage, the lesser will obstacles in the environment seem to the individual, whereas the more weakly developed his courage, the greater will difficulties appear. In the former group, one will not frequently find psychoses and neuroses, whereas these will occur more commonly in the latter group.

To understand a human being one must understand his relative situation in the human group in which

he moves.(7). The criterion of successful adaptation is social adequacy, which is the quality by which a family is able to preserve its domestic life without unusual aid from the community.(8). A similar criterion applies to the individual, for whom social adequacy is the quality by which he is able to preserve his individual life without unusual aid from others. Psychoses and neuroses indicate unsuccessful adaptation and social inadequacy. Success on the part of the individual in the management of his environment, depends perforce on the quality of his personality, which in turn depends on the development of his constitutional endowment, of which the principal relevant factor is his courage. Failure of adaptation indicates a lack of courage. In every case it is essential, therefore, that the whole life-history of the individual be investigated diligently and his development traced step by step from his earliest years. In this way alone can a full understanding of the individual, of his life-technique, and therefore of his symptoms, be attained. The quality and durability of his courage will then be apparent. Should this be found deficient, the primary indication in therapy is to engender fortitude and to promote its optimum development and to ensure its maximum utilisation.

If the logical application of a hypothesis to therapeutic procedure result in the dissipation of the malady in a series of cases, the validity of the hypothesis is strengthened. The writer has found

this therapeutic principle to be of considerable service in a number of cases with very diverse clinical syndromes.

Of the following illustrative cases, the first five demonstrate the application of the principle and describe the results achieved. The sixth case serves to show that all psychoses and neuroses are not attributable to lack of courage.

Case I.

N.F.C., male, single, aet. 26 years, attended at the Tower-House Out-Patient Clinic, Leicester, on I/9/32, accompanied by his father.

Complaint:- 'Fits.'

Personal History.

Conception, foetal development and birth were apparently normal. Until five years of age, the history was without event. He could recall readily his first day at school, and his feelings of timidity apprehension and fear. He continued to be timid, nervous and afraid, and the other children, realising this, 'made fun of him, teased him, and made his life a misery.' One boy in particular was persistent in urging the others to bully him. This unhappy state of affairs continued until he was nine years old, when the ringleader left the district. The other children then ceased to molest him, and consequently he was much happier. Thereafter he got on well with the other boys, he made several 'special' friends of whom he was fond 'in a boyish way', and he lost his 'self-consciousness.' He did not indulge in any sex-play. At the elementary school he was a successful pupil, and when he was twelve years old he went to a secondary school.

At the secondary school another boy was top of the class, Nevil being second, third, or fourth. After a year at this school, he determined to work hard and surpass his rival. He began to study diligently. One night a few weeks later, while reading

by the fire, he saw a 'sudden, great, flashing light in front of his eyes -- not a real big fit.' He was alarmed, but he neither fell down nor did he experience anything further. A week later he had a similar experience. He reported this to his parents who consulted the family physician. During the succeeding six months he had frequent 'fits.' In some of these he would fall down, but there was no disturbance of awareness. Every time, he experienced the 'great, flashing light.' The 'fits' occurred almost entirely at home. He consulted the encyclopoedia, learnt about epilepsy, and feared that his experiences were unmistakable signs of this dread malady.

His studies were not curtailed, and eventually he became top of the class. The 'fits' then ceased. In the following two terms, he occupied the second place in the class, his former rival again being first. He was not, however, 'much worried by this, as he had achieved his object.' In fact, a friendship now sprang up between the two boys, who regarded oneanother as friendly rivals.

When he was fourteen years old, he went to a senior school, from which he matriculated as top boy. At seventeen years of age, he was operated on for appendicitis, and subsequently developed orchitis followed by atrophy of the right testicle. -- 'It swelled up the size of a hen's egg, and then it went down to the size of a pea.' The doctor told him that the other testicle was quite adequate, but

he remembers 'feeling incomplete.' Following the orchitis he again had 'fits', sometimes with complete awareness, at other times with partial unconsciousness. He now became more certain than ever that this was epilepsy.

At this time he left school and became a pupil-teacher, principally to please his parents. He 'had not much idea to be one -- he wanted to be a B.A., and get a good job as a result of this.' Actually he got a place at College, to go there after a year; but, being a failure as a pupil-teacher, he lost this. He said 'I was very feeble as a pupil-teacher. I would have gone to College the following year, but I had not enough self-confidence to keep the children in order.' The loss of this opportunity was a great disappointment to him. During the latter part of this period he had many 'fits', never at his work, but always at home. When eighteen years old, he abandoned the idea of becoming a pupil-teacher, whereupon his 'fits' promptly ceased.

He then became a clerk in the Education Department, but he found the work monotonous, and was moved from one department to another. He had 'fits' again when twenty-two years old, but now they occurred chiefly in the office. Their frequency became such that in January, 1930, he was asked to resign. Thereafter he assisted his father, who was a market-gardener. He soon began to study in order to qualify for the 'business world.' In these

studies he made rapid and satisfactory progress. He continued to have many 'fits' daily. From the summer of 1930 onwards, he took bromide regularly.

His great hobby until December, 1931, was cycling, and for four years he was secretary and treasurer of an important cycling club. He had to give this up on account of his malady.

He 'had a girl' who was 'fairly fond' of him, and this friendship endured for two years until he gave up cycling. She then gave him up. The termination of this friendship in April, 1931, upset him at the time, but he was then without 'fits' for eleven weeks.

During 1932, he occasionally had nocturnal eneuresis, and the 'fits' were preceded by an aura, which consisted of a 'roaring of voices.'

Family History.

The paternal and maternal grandparents and their collaterals were said to have been quite normal.

His father, aged fifty-four years, was a jobbing gardener, to become which he relinquished the post of hosiery warehouseman thirty years ago. He was a peculiar man, quite unselfconscious, full of quaint mannerisms, and somewhat eccentric in dress. Apparently rather disinterested, actually he was deeply concerned about the health of his son, for whom he had a very sincere affection. He was not strongly religious, but was a reader, and, according to his son, a 'poetic sort of person.' In answering questions he was never positive.

His mother was fifty-two years old, and was a quiet imaginative, somewhat reticent, pleasant woman, of good intellectual capacity, and a capable housewife. Four years ago she became very 'nervy', when her husband feared she would 'lose her reason'. During the past three years she had been quite placid and normal.

His one sibling, a brother aged thirty-one years, was a stone-carver who had a cold, austere, ambitious personality. He had no sympathy to offer his brother in his affliction, and his only visit to the patient in hospital had disastrous effects. He was a man with few friends, a definite aim in life, and a considerable self-respect.

During his first visit to the clinic, the patient began quite suddenly to grin : he averted his head, assumed a grotesque expression, twitched his hands and arms, and emitted a gurgling noise from his throat. His colour did not alter, and in less than a minute the episode ended; and he gaily professed unawareness of the event. Later, however, he said that he remembered its occurrence. During the consultation he displayed many mannerisms of speech, attitude and behaviour, all very similar to those of his father. He described his interests as 'fairly universal', and he said that he was an ardent reader, and that he 'liked to think that a book was of good quality.'

He was admitted to the hospital as a voluntary

patient on September Ist., 1932.

Physically he was an asthenic leptosome. His nutrition was subnormal. The right testicle was atrophied. The only deviation from normal in the central nervous system was supernormal activity of all the tendon reflexes. There was no evidence of any organic disease.

His personality was of the sensitive, timid, Hölderlin type. Intellectually he ranked highly. The somatic demands were not pronounced. He had no mean opinion of himself, and he regarded himself as a 'highbrow.' He tended to be satisfied with himself, and he was eager to vindicate his fits. The urgency to adaptation was but little in evidence.

His general behaviour and his interest were centred entirely about his psycho-neurotic manifestations. The stream of mental activity was slightly retarded, due, presumably, to the prolonged ingestion of bromide. He took more pleasure in reading fiction than in the affairs of everyday life. He was in no way confused, and his memory was excellent. Retention, apperception, thinking capacity, and power of attention were quite normal. In school and general knowledge he was highly proficient. He had insight without understanding, and his judgment was biassed entirely by his symptoms.

Following admission to hospital, he had a spate of hysterical fits simulating epilepsy. He also

had four nocturnal major epileptic fits. After a period of observation, therapeutic talks were begun. His history was traced in great detail from his earliest years, and then it was explained to him that 'fits' had become his technique to achieve his goal of power over his restricted environment. The manner in which fits had occurred at definite periods in his life, when his prestige was threatened, was indicated to him. It was suggested strongly to him that the cause underlying his symptoms was inadequate courage, whereby he lacked confidence and impetus to master his normal environment, and had allowed himself to be seduced into a psycho-neurosis.

He was intensely interested, and expressed wonder that this explanation, which he accepted wholeheartedly, had not previously occurred to him. Thereupon his fits ceased(I9/9/32), and his general behaviour was much more rational and orderly. On 24/9/32 he again had occasional fits, and further therapy stressing the need to display courage was promptly effective in terminating the symptoms. On II/X/32 he returned home.

He remained confident, cheerful, and free from symptoms until 27/IO/32, when he attended a cyclist club meeting, really in the hope of seeing his former lady friend, now married. On his return home, he entered a state of hysterical raptus, followed by a stupor which continued for thirty-six hours. He then became so restless that only the writer's intervention saved him from certification.

On 3I/I0/32 he was readmitted to hospital as a voluntary patient. He was in a dull, retarded state, due partly to sedative drugs. Next day he became more lucid and now was able to remember something of the recent acute symptoms. For a few days he was reticent, unhappy and much disappointed over his failure. Therapeutic talks directed to stimulate his courage resulted in a dramatic improvement, and he was once more active, cheerful, alert and and optimistic.

He remained free from symptoms until 27/II/32, when notice of an impending visit by his brother precipitated a series of typical major epileptic fits, which continued until 9/I2/32. During his brother's visit on 3/I2/32, he had two hysterical fits.

Thereafter he had groups of epileptic fits, both major and minor, separated by intervals of complete freedom from symptoms. Luminal, grains--½, twice daily, has been administered since 5/5/33. Hysterical symptoms did not occur again. His personality was much better integrated, he faced his difficulties with considerable fortitude, and he had excellent insight into his condition. As he himself put it, his whole outlook was changed. On 29/7/33, while at home, he had a typical epileptic equivalent, in which he rose from the dinner-table, removed his trousers, carefully folded them up, unfolded them, put them on again, and resumed his place at table, with complete amnesia upon the whole

episode.

At no time did he show any other feature of essential epilepsy. With the passage of time, the fits in succeeding groups became of less intensity, and minor fits tended to replace major fits.

Discussion.

This patient aimed high. His goal was one to attain which he would require to exercise much confidence and determination in order to overcome the obstacles in his path. But he lacked courage.

Admittedly his environment was loaded against him. An eccentric father and a somewhat spineless mother had but little talent in teaching him the rules of life. He was overawed in childhood by the unattainable superiority of his self-assured and unsympathetic elder brother. Influences such as these tended to stunt the growth and development of courage in his personality; and his feeling of inadequacy became more and more prominent.

Once his enquiring mind experienced the value of sickness as a socially acceptable reason to account for his inadequacy, he was not slow to adopt this technique again when confronted with further difficulties. Eventually the very device came sonto intoxicate him that he began to lose sight of his original goal, and to substitute the life-line of psycho-neurosis.

His history indicates that his childhood experiences and education conspired to cripple the

development of his constitutional endowment of courage. Timidity was prominent in the patterns of his conduct long before he first sought sanctuary by flight into illness. The 'fits' provided him with a satisfactory excuse for failure. When faced with difficult situations, he had 'fits.' At the secondary school, the thought of the possibility of failure precipitated 'fits.' If he had then failed, his excuse would have been that he was so handicapped by his 'fits.' Unfortunately he learnt the details of essential epilepsy, and obsession with the idea of this disease further undermined his courage. Physical defect added to his fears, when his testicle atrophied, and the 'fits' occurred in great numbers.

He did not want to be a teacher : so, to explain this to his parents, he had 'fits' always at home, never at school. As soon as teaching as a career was abandoned, the 'fits' stopped - they had served their purpose. His work in the Education Department was uncongenial, and consequently he reacted with 'fits.' As his psycho-neurosis obtained more and more hold on him, he made less and less attempt to modify his environment. When there was a prospect of being saddled with the responsibility of marriage, he had many 'fits', but as soon as this question was settled he became free from all symptoms. He wanted to marry, but he did not have enough courage to do so.

Unhappily, the fear of epilepsy, and the

conviction that he actually suffered from this malady, coupled with the many hysterical fits simulating grand mal attacks, in some way set in action the mechanism for the convulsions of essential epilepsy.

Something was set in motion, to arrest which is beyond the power of psychotherapy. But much was achieved. By explanation, education and exhortation this patient's courage developed remarkably. The hysterical phenomena were completely eliminated, and his whole outlook became wider and more mature, his life immeasurably happier, and his personality enriched by the insight which he acquired into his way of life.

Case 2.

A.T., male, single, aet. I9 years, admitted under certificate to the City Mental Hospital, Leicester, on II/3/32.

Personal History.

His birth and childhood were normal. He was an average pupil at school, which he left when fourteen years old. Until the onset of symptoms in October, I93I, he was employed regularly, first in an elastic-web factory, and later in the shoetrade. He got on well with his associates with whom he was quite popular, but he was inclined to be solitary. In October, I93I, he had pneumonia and pleurisy, during convalescence from which he developed tuberculosis of the left epididymis. He entered a sanatorium, where he attempted to cut into the tubercular mass in an endeavour to rid himself of it. On his return home he declared that he was dying of tuberculosis, and that he was wicked, but that Jesus was with him. He threatened to commit suicide and he attacked his parents and siblings, saying that they must die with him. He now became more and more reticent, untidy and dirty, and he was eventually certified.

Family History.

His maternal grandmother died of pulmonary tuberculosis.

His father was a working-class man, aged forty-five years, who had been unemployed for three years.

He was a somewhat disheartened, stolid, general labourer.

His mother was a working-class housewife, aged forty-one, the mother of eleven children, of whom the patient was the fourth, - hardworking, honest and phlegmatic. Her physical health was unsatisfactory.

Siblings. - seven brothers and three sisters, all fairly healthy and quite normal.

On admission, physically he was of the asthenic type. His general nutrition was satisfactory. The left epididymis, which was somewhat obscured by a hydrocele, was the site of tubercular disease. There was no other organic disease.

His personality was of the shut-in, easily-hurt, schizophrenic type, His intellectual capacity was mediocre. The somatic demands were but little in evidence. His self-estimate was very unfavorable, and the urgency to adaptation was feeble.

His general attitude was one of reticence, evasiveness and suspicion. There was considerable psychomotor retardation. He was unhappy, sullen and afraid.

He lay quietly in bed, preoccupied with his physical ills. He expressed various unpleasant thoughts, e.g., he believed that he had pulmonary tuberculosis; and that he had sinned against God, to Whom he could atone only by death. His language was colored with Biblical terms, and he said that he could feel the presence of Jesus beside him. About his bodily sensations he had built an edifice of

phantasy, in which he dwelt, and to which he would admit no one. He was well orientated. The various memory, apperception and other mental tests were poorly performed, but his attention was not gripped by them. His discrimination and judgment were gravely disturbed, and he had no insight.

In the course of a few days, he regressed into a state of catatonic stupor. Attempts at exhortation to awaken and stimulate his courage resulted in some improvement, which, however, was shortlived. By I5/4/32 he had become quite inaccessible. He grimaced, he adopted fixed attitudes, he was destructive to clothing and bedding, and he was incontinent of urine and faeces. Frequently he dilated his anus with his fingers. He looked unhappy, lost and bewildered. Ten days later, he explained to the writer that he felt compelled to behave as he was doing. Direct psychotherapy was persevered with, but progress was slow, partly owing to his retardation. On I0/5/32 he developed an acute attack of Bacillary Dysentery, which lasted for ten days. In the meantime the tuberculous disease of the epididymis had slowly extended. On30/5/32 he was examined by a consulting surgeon, who assured him that an operation would cure his disease completely. Explanatory and exhortative talks were persevered with, to stimulate his courage. From this time on he began to improve mentally, and within six weeks he was much happier, quite friendly, and communicative, careful in his appearance, and

occupied in dusting and polishing the ward. On I/8/32 he developed acute catarrhal jaundice, but his mental reclamation went ahead steadily, and on 6/II/32, after having been set progressively more difficult tasks, he was happily employed in the hospital greenhouses. He was well extraverted, sociable and happy, and he had good insight into his illness. His psychomotor retardation had almost completely gone. On 6/I2/32 he was discharged quite recovered. He then went to the Royal Infirmary, where the tuberculous epididymis was excised successfully.

His troubles, however, were by no means over, as he was unsuccessful in obtaining work. His mother died on 8/4/33, and on 8/8/33 his elder brother suddenly died after a short illness. His father and he were soon in poverty. Nevertheless he continued to be of stout heart, and went on looking for employment. He reported periodically at the out-patient clinic, where he was always alert and carefully groomed, but showing unmistakable signs of reduced circumstances. Every effort to procure assistance for him was unsuccessful.

Discussion.

This patient showed no overt abnormality of conduct until physical illness overtook him. Until then his history showed excellent social adequacy and a normal life-technique. But the handicap of ill health, especially of the organ inferiority

feeling associated with the diseased epididymis, was more than his courage could face. He misunderstood the intention of conservative treatment, which, coupled with the sanatorium life and his grandmother's death from pulmonary tuberculosis, signified incurability and a fatal issue to him. In an attempt to explain why he should be so afflicted, he developed ideas of unworthiness, guilt and sin, which led to preoccupation with religion, and so, step by step, into the classical syndrome of catatonic schizophrenia. In this condition he was very unhappy, and in a state of constant terror, besieged by dreadful phantasies and disgusting compulsions.

Attempts at re-education and development of his courage alone were quite unsuccessful and ineffective. It was only when he had reassurance and a promise of cure of his testicular disease, backed by the prestige of a consultant surgeon, that rehabilitation began. The writer is convinced, however, that such reassurance alone would not have effected the recovery. Reassurance of this nature modified his 'environment' considerably, and then it became possible to educate and nurture his courage by therapeutic talks and also by carefully regulated occupational therapy.

The provision of remunerative employment is needed for this individual. His present difficulties are great---bereavement, poverty, lack of occupation and oft-repeated disappointment in his search for work.

Case 3.

F.J., male, single, aet. 20 years, admitted under certificate to the City Mental Hospital, Leicester, on I8/2/3I.

Personal History.

His birth was normal, but he was an illegitimate child. Soon after his birth, his mother married a man other than his father. She had five children by her husband. His mother and step-father did not want him, and he was treated very badly as a young child. Eventually his maternal grandmother undertook his upbringing. He was very timid and self-conscious, and would not play with other children, avoiding in particular those games in which he might be hurt. He was a moderately good scholar. When he left school, aged fourteen years, he returned to his mother's house, where he lived for four years, but he was so badly treated and neglected that at the end of that time he went back to live with his grandmother. He was employed in various situations until January, I93I, but he was not happy as people teased him, and he took things unnecessarily to heart. Soon after leaving school, rheumatic infection became manifest, and his health gradually deteriorated.

He became dull, retarded, sullen, unkempt, and afraid to go out of doors. Eventually he was certified.

Family History.

His paternal ancestry was unknown.
His mother was a normal working-class woman, aged forty-three years, somewhat dull and lethargic.
Her ancestry was healthy.
He had five half-siblings, all younger than himself, who were fairly healthy.

On admission, he was very near to collapse, owing to neglect and uncompensated mitral stenosis and incompetence. He was an emaciated, asthenic leptosome. There was slight hyperthyroidism.

He was in a filthy state. He answered no questions, but muttered unintelligibly to himself. When approached, he showed the helpless terror of an animal at bay, and he struggled against all attention. He was evidently aurally hallucinated. He was incontinent of urine and faeces. Tube-feeding was resorted to.

He was reassured and told that he was now among friends who would help him, but he must be of stout heart and be brave. If he would be courageous, he would become quite well.

The history and subsequent course showed that his personality was of the mimosa-like quality. Intellectually he was of average attainments. The somatic demands were sluggish; his self-estimate was unfavorable; and the urgency to adaptation was absent. He was very deeply regressed, exhibiting the classical clinical syndrome of acute catatonic

schizophrenia.

During the next few days, he began to pay some attention to therapeutic exhortation. Gradually in the course of six weeks, though his behaviour remained very degenerate and depraved, his fear and apprehensiveness subsided, and his attitude became one of pathetic gratitude. His speech was still disconnected and incoherent.

In March, 1931, he developed a severe cellulitis of the thigh, and, later, a contralateral ischio-rectal abscess. In April, he had an acute attack of Bacillary Dysentery. By June, he had become quite rational and communicative, and he showed a good sense of humour. He was somewhat apathetic, and retarded in movement and speech.

A month later he was assisting in wardwork, and he soon became a good out-door painter. He was much crippled by rheumatic disease, but nevertheless he worked diligently. His feeling of inadequacy was much less pronounced, and he had now acquired considerable insight. He had become an ardent reader, finding great pleasure in detective stories.

He continued to make excellent progress, and he was quite adequately adapted to his restricted environment and physical handicaps, when he developed subacute bacterial endocarditis, complicated by pericarditis and pleurisy. This painful illness pursued an irregular but downward course, ending in his death in September, 1932. Throughout, he bore great pain and discomfort with a rare courage. He

found much solace in reading, and he retained his sense of humour until the end.

Discussion.

From his very conception this patient's environment was unfavorable. He was an unwanted child; he was illegitimate; and he was neglected in infancy. As a very young child he came to fear his mother and his step-father, who rejected his advances, and who devoted their attention to his younger half-siblings. He was a Cinderella, but had no fairy Godmother. Naturally he grew up to be timid, solitary, and shrinking from injury. His potential courage had no opportunity to develop. He was so downtrodden at home that he came to fear outside social contacts. The advent of crippling rheumatic disease further accentuated his feelings of inadequacy and inferiority. Every innocent quip of his work-mates hurt him intensely. His work became more and more unsatisfactory. Such courage as he had was insufficient to support him in a very unequal battle, and, hopelessness eventually taking possession of him, he regressed into a schizophrenic psychosis.

Hospital came as a revelation to him. Kindness, sympathy and encouragement were new experiences to him. The constant assurance that he had that courage in him which would restore his self-respect filled him with hope. From the first interview onwards, he was told that he had plenty of courage, but that so far he had not been allowed to show it. He was assured that if he were brave he would soon

overcome his difficulties. Persistent encouragement was eventually rewarded.

As his physical infirmities were very crippling, and he had no suitable home waiting for him, his interest in reading was deliberately fostered, as it proved such a real pleasure to him, and so helped him to face his environment with fortitude. The truly robust nature of his courage so carefully trained and developed, was displayed in the quite heroic fortitude with which he faced his terminal illness.

Organ inferiority played but little part in the development of his psychosis fundamentally, which indisputably was due to his very irregular upbringing.

Case 4.

P.H., male, single, aet. 47 years, admitted as a voluntary patient to the City Mental Hospital, Leicester, on 9/I/32.

Personal History.

His conception, birth and early childhood ran a normal course. At school he was an excellent pupil, but he was very sensitive, easily hurt, and ready to take offence. He was somewhat self-centred, but was full of outside interests. He developed into a well-educated, cultured man, deeply interested in literature, the theatre and the arts; himself a talented musician, painter, writer and linguist.

For many years he was in the pottery trade, and his work took him far afield. He was intensely interested in all his experiences, and he brought an original and provocative mind to bear on all he saw. He was quite an outstanding personality.

He was said to have had nervous breakdowns in I907 and during the Great War, detailed accounts of which were not obtained. He had always been somewhat 'nervy, childish and self-willed,' and was not 'quite like other people'. During the past five years he had held a responsible post in a large petrol concern.

In the summer of I930, he became attached to a girl who became his fiancée in the following November. At this time he developed a corneal ulcer which responded well to treatment. In July, I93I, he went on holiday with his fiancée, and intimacy

took place. During the succeeding months he became unhappy and much given to brooding. In November, 1931, following an altercation with his employer, he resigned his post. Thereafter he became very depressed, restless and sleepless, and his engagement was dissolved. He began to complain of severe backache. Although the corneal ulcer had quite healed, he became convinced that a band traversed his vertebrae from his genitals to the back of his eye and pulled on his brain. He was so depressed that that he spoke of killing himself and his landlady, who was a second mother to him. He was then persuaded to seek hospital treatment, and was admitted as a voluntary patient.

Family History.

His father was a normal middle-class man who died in middle life after a short illness. His ancestry was healthy.

His mother was a chronic invalid, but was said to be quite normal mentally. Her ancestry was normal.

There were two female siblings, both younger than the patient.

On admission, he was tall, well-nourished, with flabby musculature, and of the athleto-asthenic type. He was in good health and he had no organic disease.

His appearance, in spite of his extraordinary conduct, was distinguished. He was of high intellectual attainments, talented and cultured. His nature was very sensuous, but he feared amatory

experience, feeling himself to be sexually inferior. He had a very adverse opinion of himself, believing that his body was rotting away, that he was hopelessly insane, and that he had come to hospital to die. He was quite overwhelmed by his unhappy thoughts, and he felt no urgency to adaptation.

His general behaviour was extraordinary. He was continually restless, wringing his hands, shaking in every limb, and calling on his Maker to attend to his pitiable state.

The mental stream was irregular and jerky, as each new pain and sensation captured his attention, which was fixed exclusively on his hypochondriasis. He was in a state of great misery, distress and agitation. He was constantly reiterating how his body was riddled with disease, and he declared that the outlook was hopeless, that despair enveloped him, and that a foul death would soon overtake him. Orientation and memory were excellent. His judgment was quite unbalanced and he had no insight into his condition.

During the succeeding few days, his hypochondriacal symptoms were protean, and he displayed considerable depersonalisation. Explanatory discussion of his malady and therapeutic essay to foster courage in him were for a time quite ineffective : but after much patience, he began to consider the arguments and exhortations with which he was bombarded. Thereupon his unhappiness began to decline. Soon he had periods of freedom from

symptoms, of which advantage was taken to press forward with therapeutic talks. By I/4/32 he had acquired very considerable insight into the nature of his illness, and his bahaviour was entirely normal. His confidence continued to grow steadily. In June,1932, his mother died, and coincidently he discarded the remains of his anxiety. He benefited considerably under the terms of her will, and he now set about the duties of executor with great vigour. In the knowledge that his financial position was now much more satisfactory, he left hospital on 27/7/32. He continued to enjoy excellent health.

Discussion.

This patient was a man of striking personality, and of a restless, enquiring mind. He had many cultural interests, coupled with a sensuous nature and a taste for good living. He was individualistic, and any restriction of his freedom to follow his desires was abnormally galling to him. He was accustomed to have his way. His mother's precarious health prohibited foreign travel, and consequently he had to change his occupation. His engagement to be married meant further restriction of liberty, and though not taken very seriously at first, he felt that intimacy made the bond more final. Courage had never been very prominent in his personality, as typified by the history of 'nervous breakdowns' during the Great War, by his ready susceptibility to injury, and by his feelings of sexual inadequacy.

To evade the responsibility of marriage, he proceeded to lose his occupation and to become a hypochondriac. This technique led him to freedom from his engagement, and so his immediate purpose was achieved. But now he was in the toils of his psycho-neurotic technique. He was in straitened circumstances; he had experienced hypochondriasis; and he was generally dissatisfied. In the face of all this, his courage entirely petered out, he admitted defeat, and he lapsed into a severe psycho-neurosis.

By careful and persistent explanation, encouragement and exhortation, directed to stimulate and educate his courage, his self-respect was restored, and the completion of his recovery was accelerated by an environmental modification, viz. the timely death of his mother. His was a charming, but not a particularly admirable personality.

Case 5.

S.C.F., male, single, aet. 30 years, admitted under certificate on transfer, to the City Mental Hospital, Leicester, on I/3/3I.

Personal History.

His conception, birth and childhood were without event. He got on well at school; and as a boy, he was sociable and fond of games. He left school when he was fourteen years old, and he became a clerk in a large store. Towards the end of the Great War, he was in the army; and after demobilisation he was unemployed for two years. Eventually he became clerk and verger at a High Anglican Church. He was always deeply religious, very devout, and fond of ceremony and ritual.

For many years he was a scout-master. He had no taste for female society, and he was most happy when in the company of young men and boys.

The first indication of mental disorder was the abrupt onset of nocturnal major epileptic fits in June, I930. Thereafter he had fits every two months, when the following sequence of events invariably recurred. There was no preliminary warning. The fit was followed by confusion and stupor of two days' duration. This state was succeeded by a vivid hallucinosis which lasted for twelve hours. In this he felt that he was dead, and that his spirit emerged from his body and went up to heaven for divine judgment. He saw God and the celestial angels to whose hymns of praise he listened.

God then reviewed his life, rebuked him for his sins, and pronounced him to be unworthy to dwell in heaven. This made him very downcast, but God then said that He would give him another chance, and He held out fresh hope of ultimate salvation. He was now filled with indescribable happiness. His spirit slowly returned to earth and re-entered his body. The hallucinosis then came slowly to an end, and he wakened up to reality.

Family History.

His father had been a normal man who was accidentally killed when sixty-eight years old. His ancestry was quite healthy.

His mother was alive and well. She was stated to be a normal, rational, active and capable woman. Her ancestry was quite healthy.

He had eight siblings, all of whom were quite healthy, both physically and mentally.

On admission he was of the athletic type physically. He was in good health, there being no evidence of organic disease.

His personality was somewhat egocentric, reminiscent of the Pharisee, fond of ritual, ceremony and religious form. His speech was precise and accurate, yet a little grandiloquent. Intellectually he was of average attainment, and he had some musical talent. He was essentially homosexual, and he found much joy in the company of boys.

He held a somewhat inflated estimate of himself.

His urgency to adaptation was fairly active, but he was entirely satisfied with his work in the church. His behaviour was excellent. He was well-groomed and clean, polite, proper and correct. He assisted in the wardwork at every possible opportunity, and he was sociable and agreeable with patients and staff. He was very well-contented with his lot, but his general attitude indicated slight exaltation. He discussed his experiences very frankly. He regarded his fits as the direct influence of God. Since these experiences he felt that he was different from other men, and he likened his commitment to a mental hospital to the denial and eventual crucifixion of Christ. The vision of heaven having been accorded him, he would bear his 'affliction' with courage, hope and fortitude.

This attitude was immediately attacked. While it was admitted that his difficulties were great, it was put to him that he was showing very little true courage in substituting illness for his real problems; that his existing concept of courage was one of a peculiarly effete type.; that to escape from his illness and to solve his basic problems, he must display courage of a more practical and robust kind. Although this mode of therapy had no apparent effect on him, it was persevered with. On 26/4/31 he had two major fits. On the following day there was slight dulness and confusion, which had quite cleared away by evening. There were no other sequelae. No other form of treatment was employed

but this, which was continued until his discharge on 2/6/31.

Discussion.

In this case the explanation of the symptoms was more complex. The keystone was his constitutional homosexuality. This was immutable, and he had to modify his life-technique accordingly. For many years he sublimated his homosexuality successfully, as a scout-master and a church official, but these very activities led him more and more into immediate temptation, until instead of facing his difficulties and finding a satisfactory solution of his indisputably serious life-problem, he adopted a paranoid technique, transforming his love of men into love of God, and eventually, finding this unsatisfactory, substituting the converse, viz., God's love of him, and precipitating this into consciousness, combined with still present guilty feelings, as a hallucinosis heralded by the orgastic ecstasy of an epileptic fit, which indicated his passivity.

This technique was followed because he lacked courage to join battle directly with his peculiar constitutional difficulties. Such an explanation was given to him, the essential weakness of his technique indicated, and his want of honesty in not acknowledging his abnormal constitution discussed. He was exhorted to develop courage. No attempt was made to change his basic homosexuality.

The therapy succeeded beyond expectation, as the hallucinosis did not recur.

Case 6.

J.H., male, single, aet.20 years, attended at the Tower-House Out-Patient Clinic, Leicester, on 6/4/33, complaining of a phobia for thunder, which had been with him constantly since he was ten years old. For a long time it interfered with his social interests, but it did not interrupt his work. More recently, however, he had found it increasingly difficult to concentrate on his studies. The phobia made him feel restless and unsettled. None of his associates was aware of its existence.

Personal History.

His conception, foetal development and birth were apparently normal. Childhood was comparatively uneventful until he was ten years old, when the phobia of thunder first entered his consciousness. Until this event he was sociable, fond of games, quite competent and unselfconscious. With the development of the phobia, he felt 'horribly inferior and shut-off' from his associates. Nevertheless he compelled himself to appear sociable and to play games with other children. He had no intimate friend until he was fourteen years old, when he had a 'chum' for several months. He was a good pupil, and obtained a scholarship to a senior school, which he had to leave prematurely owing to insufficient money. He then became an assistant librarian, and saved his earnings, until, in October, 1932, he had sufficient means to enable him to go to College, where he progressed quite satisfactorily.

His home conditions had been unfavorable. His parents had frequent disputes, and there had never been much financial stability. After puberty, he had many quarrels with his father. Consequently he went to live in lodgings, but continued to have his meals at home. This arrangement proved quite satisfactory. In childhood he experienced no sex-play, nor had he any guilty feelings. At the secondary school he was 'a bit of a prude and conscious of his own virtue.' When aged sixteen years, he fell in love with a woman twice his age, and intimacy occurred several times. When this affaire ended, he was temporarily much upset, but he soon recovered. From time to time he had amatory interludes with further experience of coitus, which was accompanied by anxiety only when contraceptives were employed. Prostitutes did not attract him in any way. He had no desire to marry, or to be burdened with a home. Three years ago he nursed an uncle by marriage through the terminal stages of general paralysis -- ' a very revolting experience.'

From 1928 to 1933 he had attacks of migraine at intervals of two or three months. The attack usually followed a nocturnal emission. Violent frontal headache with nausea, constipation, and sometimes vomiting, was succeeded by loss of speech-coherence, ophthalmoplegia, and a 'yellow, cold, dead' condition of the extremities. After four hours the symptoms began to abate, and on the next morning he awoke feeling quite well. Recently their freq-

uency had been greater.

Family History.

This was obtained from the patient, who requested that his family be kept unaware of his malady.

His father was a chauffeur, aged 50 years, who was a working-class man of a domineering type. The unrestrained exertion of parental authority led him to quarrel with his children when they reached puberty. He did not want the patient to go to College, but eventually he ceased to interfere with his mode of life, whereafter they got on quite well together. When the phobia first appeared, his father treated it with great scorn, and the patient learnt not to disclose his symptoms.

Three paternal aunts had migraine. Otherwise the paternal ancestry was quite healthy.

His mother was a working-class woman, aged 48 years, nervous and easily agitated. She invariably took the part of her children in quarrels with their father, and she supported the patient's academic ambitions. Her collaterals and ancestry were quite healthy.

Siblings:-

The eldest was a sister, aged 24 years, a training college teacher, who lived at home and was quite healthy.

The second was a sister, aged 22 years, a shorthand typist, who left home two months previously following a quarrel with her father.

The patient was the third child.

The next was a sister, aged 18 years, a shop-assistant, who lived at home.

The next was a brother, aged 16, who was at a secondary school.

The youngest was a brother, aged 12, who was at a school to which he had won a scholarship.

The brothers and sisters all got on well together and they were all quite healthy.

Physically he was in good health. He was tall, somewhat spare in build, and of the astheno-athletic type.

His personality was well integrated, and he faced his problems with considerable determination of purpose. Intellectually he was well endowed, and his interests were largely cultural. He was very fond of female society, but he did not let this interfere with his work. He tended to over-estimate his critical faculties and his ability to acquire knowledge, but he did so with a certain humorous insight. He felt strongly that his phobia impeded his advance in life. His behaviour was quite normal. There was nothing in his bearing to indicate the anxiety in which he lived. He had previously told no one of his phobia, and he 'poured out his soul' to the writer, to whom he had come with a request to be analysed.

He was alert, co-operative, and entirely honest in answering questions. The various mental tests

served to demonstrate an active, keen, well-balanced mind working under the handicap of an ever-present phobia, whose source he was unable to find.

He rarely dreamed at night, and he never had thunder-dreams or nightmare. He indulged to a normal degree in day-dreams, in which he would see himself in 'situations in which he would have approved of himself:- e.g., as an author.'

He had complete insight into his condition.

The study of the history together with a general discussion with the patient, indicated clearly that the symptoms were not attributable to any obvious want of courage. On the contrary, he had shown considerable determination and fortitude in his life-technique. The phobia had persistently impeded his progress, and all his efforts to overcome it had proved unsuccessful. No useful purpose could be served by an endeavour only further to stimulate his courage. To expect a successful issue to follow such therapy was unwarrantable. The genesis of the phobia had to be brought into the patient's awareness, and accordingly the method of Jung was adopted. The analysis is still proceeding, but much light has already been thrown on the case, the phobia is only periodically active and is much less intense, and a complete cure is legitimately expected.

Discussion.

This case is described in order to illustrate

that psychic disturbances occur which are not attributable to a lack of courage. The investigation of each case, following the methods of Individual Psychology, reveals the state of the courage of the individual. If this be found to be satisfactory, other methods of investigation of the case are indicated, and the preliminary analysis shows the direction these must pursue. In this patient, the phobia is the manifest product in consciousness of a'forgotten' experience.

General Discussion.

The text of this thesis is that the basic factor in the genesis of psychoses and of neuroses is, very commonly, a lack of courage.

Many psychoses and neuroses are therefore to be regarded as deficiency diseases, the symptoms presented being the product of inadequate courage. Such a deficiency may be inherent in the constitutional endowment of the individual, but more commonly it is due to faulty personality development. In many cases, of course, both factors are operative. If the deficiency be an inherited one alone, the prognosis is less favorable than when it is the result solely of developmental error.

The art of understanding human nature is the art of understanding the dynamic patterns of human conduct(9). These patterns are infinitely variable; and in the individual case, they can be traced only by obtaining a detailed life-history, which illustrates the conduct of the individual from earliest life. Thus alone can the psycho-pathology of the individual case be determined and its genesis discovered. Two cases of schizophrenia may present identical symptomatology, and yet the genetic basis in the one case may be entirely different from that in the other.

Accurate diagnosis, correct prognosis,and rational therapeusis are to be obtained only through wide knowledge and wise understanding of psychopathology, which is individualistic. The methodol-

ogical simplicity of Individual Psychology has itself rendered its teachings suspect to those accustomed to expect complexity in psychological argument.

Painstaking study of the individual's life-patterns is the sine qua non. It is largely due to neglecting to make such detailed studies that so many empirical forms of therapy are employed.

Timme, in discussing the role of physical conditions in behaviour problems, says(IO) that 'while 'there is danger of oversimplifying by searching too 'closely for a simple physical agency, this factor 'must alway be kept in mind. The fact that these 'disorders are not simply organic or simply psycho-'genic, but of a rather complex origin must always be 'borne in mind. In a properly balanced point of view, 'the physical condition is considered the starting 'point---.' The overstressing of one or other factor in the genesis of psychoses and neuroses does much to retard the advance of knowledge. The focal sepsis school regards other schools with no little scorn. To be deplored most of all, is the pronouncement of the leader of a great research into the aetiology of schizophrenia, viz.(II), 'The aspects 'that we regard as most fundamental do not lend 'themselves to ''dynamic'' approach. If one has 'dementia praecox, it is because one was born with 'something that makes one have it.' Careful enquiry into the individual's life-history, reviewed according to the tenets of Individual Psychology, does much to dissipate such biassed views.

An individual's courage may be undermined in many ways. Of these, one which is frequently described is 'organ-inferiority'. This is exemplified in cases I and 2. The role of organ-inferiority has been unduly emphasised. Its effect is usually a secondary one, being a displacement product of the real inferiority, viz., a lack of courage. However, organ-inferiority tends directly further to lessen the individual's confidence in his courage and his ability to exploit it.

Conversely, the awareness of physical perfection may tend to enhance an individual's confidence in his capacity for courageous conduct. This is strikingly exemplified in the case of Toledo's strong boy, aged 6 years, who(I2) 'displayed a very decided 'feeling of superiority. He boasted about being the 'strongest boy of his age in the world.'

In the individual case, whatever be the syndrome presented, an exhaustive life-history alone will demonstrate the presence or absence of a lack of courage. Such a history, obtained by the method of approach of Individual Psychology, enables one to follow the development of the individual's personality. When the courage of the individual is found to be deficient, appropriate therapy must be instituted to correct faults in the personality formation, and to engender, foster, activate and cultivate courageous techniques.

Such therapy falls into three main categories:-

I. Discussion, exhortation and explanation. This

is essentially the work of the psychiatrist, who must be prepared to devote many hours to each case. As soon as the pathogenesis of the psychotic or neurotic manifestations is clearly understood, the weaknesses of his pathological techniques are discussed with the patient, their development is explained to him, the concept of courage is introduced, and he is assured that in due course he will develop sufficient fortitude to enable him to overcome his difficulties, and to take up his place in the community. He is carefully educated in the normal techniques of life, and is exhorted always to be brave.

This treatment can be begun without the active co-operation of the patient.

2. By precept and constant example on the part of psychiatrists, nurses, and convalescent patients, ideas of all manner of obstacles successfully overcome are instilled and cultivated in the patient.

3. Occupational Therapy.

The principle which underlies this procedure is not merely to assist the extraversion of interest. Its real purpose is to educate, develop and exercise the confidence and courage of the individual, by enabling him to experience success in overcoming difficulties. The tasks are made progressively more difficult, and so the individual learns to achieve more and more complex goals. The motive of the procedure is clearly explained to him, and with each success he is praised and encouraged to further

efforts. In this way his courage is strengthened, until he is prepared to resume the rough and tumble of everyday life. There is no more useful form of practical therapy in those cases in which the chief genetic factor is a lack of courage. Such therapy is frequently followed by very striking results.

The chief cause for reproach in alienism in Great Britain is the lack of provision of organised after-care services. The individual who has been painstakingly rehabilitated, on his restoration to the community finds himself unemployed and in impoverished circumstances. Frequently he discovers that any little savings have been appropriated by the public assistance authority to cover his maintenance in the mental hospital. Only too often the employer will not re-engage the individual who has had a mental breakdown. The individual is thus plunged quite abruptly into very adverse conditions. Case 2 illustrates this very well: the converse principle is seen in case 4. Frequently this rude awakening is too much for the individual, and it results in suicide or relapse. Case 3 would almost certainly have undergone mental regression had he been discharged, unless adequate after-care had been available.

Employment exercises the individual's ability to master difficulties ; it whets the appetite of his courage. The effects of unemployment are pernicious ; the individual is not afforded any opportunity of displaying his prowess, and simul-

taneously his environment becomes less attractive. Idleness and want combine to undermine the courage of the individual. While such circumstances prevail in the community psychoses and neuroses will be prevalent also. The provision of clubs, workshops, gymnasiums and organised games, etc.,gives the otherwise unemployed individual opportunity to exercise his courage, and is therefore a factor of immense importance in mental hygiene. Unquestionably it does much to limit the occurrence of mental disorder.

After-care, to be of real value, must be truly practical. Convalescent homes by the sea, and similar provision, are not required for the great majority of cases. The individual does not require to be supported by the community : what he requires is to be enabled to support himself and his family. The guiding principle in after-care must be the provision of remunerative employment for the patient who has been discharged from hospital. After-care should provide the opportunity for, and guide the individual in the exercise of his courage, until such time as he can safely fend for himself entirely. Such organised after-care should be an integral part of the mental hospital work, and not in the hands of charitable organisations. It is best administered in connection with the out-patient clinic, where contact with the individual can be maintained until he has become thoroughly established in the world, and is a normal, self-supporting, independent citizen.

It is during childhood and adolescence that the personality of the individual developes and matures. This is a product of experience, i.e. of the interaction of environmental influences with the inherited constitution. Unfavorable environmental forces tend to deformed personality-formation and to the adoption of unprofitable patterns of conduct, which in later life it is difficult, and often impossible, to correct. Psychosis and neurosis are the manifest indications of these insidious processes : their origins lie in faulty techniques acquired in childhood : they are not a product de novo of adult life.

The environment of children is in the hands of adults(I3), whose bounden duty is to ensure that the environmental influences to which the child is exposed are such as to promote the development of a well-integrated, courageous personality. The subsequent mental efficiency of the individual is largely dependent on this.

Mental hygiene services should instruct parents and teachers how best to achieve this. Where faulty patterns of conduct have been adopted, treatment at the Child Guidance Clinic is indicated, to teach the child to follow a normal, healthy, courageous technique. The cultivation of courage in the child's personality and life-technique should be a guiding principle in any educational system. An individual with a robust courage, is well-equipped to weather the storms of life, without resorting to the meretricious shelter of psychosis and neurosis.

## Conclusions.

Lack of courage is a common basic factor in the genesis of psychoses and neuroses, many of which are to be regarded as 'deficiency diseases.'

An exhaustive life-history is a sine qua non in every case.

Where the courage of an individual is deficient, therapy directed to activate and develop this is to be given. Such therapy takes the form of discussion, exhortation and explanation : precept and example : and graded occupations. Striking improvement frequently ensues.

Such rehabilitation is often neutralised by an abrupt return to an inimical world.

Organised after-care services to ensure the provision of remunerative employment for the discharged patient are required to consolidate and perpetuate the cure. This should be part of the mental hospital organisation.

Mental hygiene services must teach parents and educationists how to develop courageous personalities in children : and Child Guidance Clinics must be provided to correct aberrations of conduct, which, unchecked, may develop into frank psychosis and neurosis in later life.

## Summary.

I. Lack of courage as a common cause of psychosis and neurosis, is discussed, and the therapeutic inferences are considered.

2. Six illustrative cases are described.

3. In a general discussion, the importance of careful personality-training in childhood is stressed; and the lack of organised after-care services, providing remunerative employment for the individual on discharge from hospital, is deplored.

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