She was given sac lac. After some days report came that she was O.K.

SOME OBSERVATIONS ON HOMŒOPATHY IN RELATION TO PSYCHONEUROSIS

DR. D. M. GIBSON, M.B.,B.S. LOND.

THE question of the pathological aspect of psychoneurotic states and the proper handling of these conditions is, of course, a colossal subject. It is one, moreover, in which one can very easily get rapidly lost in a jungle of teachnical and often ambiguous terminology.

Fashions in terminology change, as do methods of diagnosis and techniques of treatment. The "hysterics" of the Victorian era with accompanying unlacing of corsets and applications of the smelling-bottle gives way to Edwardian "neurasthenia" and Weir-Mitchel regimes. Later the "shell-shock" of World War I merges into the present-day "anxiety neurosis". When it comes to treatment, a galaxy of therapies now awaits the victim of this all too prevalent malady—sedation with narcotic drugs of varying toxicity for months on end, insulin shock, deep narcosis, E.C.T. and its variants (prescribed only too often in an almost routine manner), and psychoanalytical techniques.

There are also personality-altering procedures such as prefrontal leucotomy. These may perhaps have a field of usefulness in certain cases, i.e. when the psychopathic state of the patient makes life intolerable for all concerned and in which, indeed, the personality of the individual can hardly be altered for the worse. But to add further trauma to an already damaged nervous system would seem to be very much a last resort.

It is evident, therefore, that there is a wide range of therapies available at the present time for the handling of

these cases. This multiplicity of method inevitably suggests that the results of therapy are none too satisfactory. Further, it cannot be denied that many of these techniques involve serious risk of additional damage to delicate cells and tissues, i.e. superimposed trauma, psychological, mechanical or chemical.

Successes are clamed for one or other of the above mentioned procedures, but it is a fact of experience that one meets a great number of sufferers who have not been benefited thereby, or whose symptoms have been made worse.

To *further depress the already depressed* with narcotics, to *further confuse the already bewildered* with extensive delvings into the past and excavations of somewhat terrifying urges and complexes, to *further intimidate and alarm the already over-anxious and jittery* by incarceration in a mental ward or by the induction of electrical convulsions, would all seem to be procedures hardly calculated to restore to normal poise and serenity the unfortunates whose "nerves" have already "gone to pieces".

Psychoneurosis a morbid state. It is important to realize that a person suffering from psychoneurosis is sick, that mental illness is as much a morbid condition with underlying pathological tissue changes as any other sick state. Mental illness involves a dysfunction of the thought processes, which are dependent on the healthy activity of certain definite bodily cells and tissues. It may be that the triple function of desire, volition (to control desire) and performance (to carry out decisions, conscious or unconscious) is possessed by every cell in the body.

In any case it is more than probable that disturbance in the sphere of the emotions and the will is accompanied by definite cell change of a morbid character. That such changes are not obvious, and cannot be detected by any available device or gadget, does not warrant the assumption that no changes are present. What is of significance, however, from the angle of treatment and cure is that such

early or initial tissue changes are probably in most cases *"reversible"*, that is, they can be corrected with restoration of the "status quo ante" by the natural defence and repair activities of the living body. The aim of therapy, therefore, should be to aid and abet these activities, not merely to obtain temporary control over individual symptoms by the action of drugs which gain their effect by interfering with normal physiological processes, that is by co*ercion* rather than by co-*operation.*

When permanent, irreversible and irreparable cell damage has taken place the therapeutic outlook is indeed grim. This is probably the state of affairs in various types of frank psychosis, not excluding intractable hypochondriasis, despite the fact that in some of these cases the actual tissue damage may be difficult to demonstrate and assess by any known technique.

In many psychoneurotics, however, the outlook is much more hopeful. Any treatment employed in handling this morbid state should surely scrupulously avoid adding to existing cell damage by causing further trauma. Unwise psychotherapy, especially ruthless analysis, may easily in some cases result in *additional emotional trauma;* the employment of toxic drugs may only too readily cause *chemical damage* to cells and tissue fluids and thus interfere with, rather than restore, normal physiological processes; surgical or electrical procedures may cause *mechanical trauma* to delicate and irreplaceable nerve cells. To restore and maintain the health and integrity of the tissues is surely a prime requisite of therapy.

Established disease. There are two main factors concerned in the development of established disease. Perhaps in the past too much attention has been focused on the more obvious of these, namely *the precipitating factor,* the hostile agent or circumstance apparently responsible for the sick state. This hostile agent may be of one kind or another, infective, toxic, traumatic, environmental, autogenous, in-

cidental or persistent in operation. It is not, however, the sole or the whole cause responsible for disease.

There is another all-important factor in the situation, *the personal factor,* namely the ability possessed by the body to defend itself, the capacity of its cells and fluids to deal with any situation that may arise. It is only when this vital reactive capacity of the body is inadequate that a sick state can supervene. Therapeutically, therefore, everything possible must be done to strengthen the natural defences of the body, to maintain the fullest possible health of its cells and fluids, and *nothing should be done that may further impair their efficiency and further disorder normal function.*

Chronic toxicosis. The question naturally follows as to whether anything can be done to correct an existing unhealthy state of the body and to restore sound function where this has become impaired. This query leads directly to another, namely, what was the reason for the inadequacy of the defence reactions that made the development of a state of disease possible in the first instance? One possible explanation is that the efficiency of the cells and fluids had been impaired by the presence in the body of some poison, present at birth or acquired later, and that this state of chronic toxicosis interfered and continues to interfere with the normal carrying out of vital function.

To encourage and enhance the elimination of toxins is therefore of fundamental importance in any attempt to aid in the processes of halting disease, initiating repair and restoring normal rhythm and function. *Among all the forms of therapy available today the homœopathic method is, perhaps, the one that most surely has this aim, and also most sedulously seeks to avoid inflicting fresh trauma on already injured tissues and increasing the stress on already embarrassed function.*

Nature of psychoneurosis. In psychoneurotic states there is a failure in emotional adjustment to the circumstances of life with its strains and stresses, blows and buffe-

tings. This breakdown may be linked to a constitutional predisposition to emotional instability or it may ensue on some form of acute or chronic poisoning by bacterial or other toxins, including drugs. The precipitating factor may be a single isolated untoward event or experience or, perhaps more often, is a set of circumstances or a series of events which prove "too much" for the victim and with which he or she is "unable to cope". A greater or lesser degree of impairment of thought processes and emotional control is the result.

The aim of treatment must therefore be to restore the poise of these disturbed functions. For this it is necessary to take into account both the precipitating factor and the personal factor in the case. This will involve investigation not only of the more obvious symptoms but also of the constitutional type of the patient, and of evidences of toxicosis, e.g. psora, sycosis, tuberculosis, vaccinosis, etc.

Classification of psychoneuroses. The grouping of cases of neurosis is not easy or satisfactory. The basal failure of emotional adjustment and disturbance of thought processes gives rise to a bewildering variety of fears, fancies, aberrations of sensation and somatic distresses. Indeed, the induced disorder of normal functions may give rise to actual dyscrasias of circulation, of endocrine balance, of digestion and other activities suggestive of, or even productive of, so-called organic disease. Every effort must be made to investigate the possible presence of such organic lesions, and to decide whether the said lesion derives from, is the cause of, or is merely associated with the neurotic state. For emotional stress may give rise to actual tissue damage producing an organic lesion accompanied by its own subjective somatic symptoms. Thus one may be confronted at one and the same time by obvious and easily detected pathological changes and by occult, deep-seated and non-demonstrable "pathology" which constitutes the *basal sick state* of the patient. It is this latter, the real

cause of the illness, that must be realized and relieved if there is to be any lasting cure.

It is difficult to find a satisfactory definition of psychoneurosis. For the purposes of this small survey the following definition has been adopted:

"Psychoneurosis is a sick state characterized by a plethora of symptoms associated with an absence or paucity of explanatory pathological findings."

In some patients presenting a symptom picture that is predominantly mental and emotional in content, careful investigation may reveal a mild degree of detectable morbidity, e.g. the presence of slight opacities in a chest X-ray indicating the possibility of early pulmonary tuberculosis. Such findings must, of course, be given due weight when present. But in a great many cases careful physical examination, routine X-rays, and the usual laboratory tests reveal nothing abnormal, and detailed enquiry elicits no evidence of drug addiction or dietetic deficiency. The numerous complaints, often qualified by superlatives such as "awful", "terrific", "unbearable", appear to lack adequate pathological foundation. They are, however, very real to the plaintiff and the probability is that definite morbid changes are present, and also that they are reversible and can be influenced in the direction of cure by suitable medication, especially that provided by the well selected homœopathic remedy. Wise and discriminating psychotherapy may also be of great value, especially if it results in the stimulation of confidence and hope, in themselves powerful agencies for influencing metabolic processes healthward.

Case survey. The cases under review have been roughly grouped in three categories related to the predominating symptom:

Phobic Psychoneurosis—cases with fear or anxiety as the most prominent feature.

Depressive Psychoneurosis—cases characterized by gloom and depression of various types.

Somatic Psychoneurosis—cases in which physical distress of one form or another dominates the picture.

There is, of course, a good deal of overlapping as in almost every patient there is some measure of anxiety, of depression and also of physical distress. The grouping is therefore only approximate and for purposes of convenience in study.

Of 120 patients grouped in this way 21 were listed as Phobic, 35 as Depressive and 64 as Somatic, this latter group thus being larger than the other two together. However, even in the somatic cases one must not be lured into the trap of giving undue weight to the many physical complaints on which the sufferer is apt to harp so loudly and so long. The root cause of the trouble lies deeper and the chief element requiring therapeutic attention is the underlying metabolic disorder.

Sex. Less than a quarter of the total were men. This preponderance of women was found in each of the three groups. Possibly women are more prone to endocrine disturbances than men; possibly women are more exposed to harmful psychological stress than men, or less able to stand up to it; possibly women are more ready or more free to seek advice and treatment than men; possibly psychoneurosis is commoner in women than in men. One cannot say. This series is too small to give a clear indication in the matter. Extremely difficult and intractable cases were met with in both sexes.

(*To be continued*)

for patients to return to me, and keep looking out for others who specially need this form of desensitisation.

—*Homœopathy, Dec. 1954*

SOME OBSERVATION ON HOMŒOPATHY IN RELATION TO PSYCHONEUROSIS

(*Continued from page no. 48*)

DR. D. M. GIBSON, M.B., B.S. LOND.

Quite a number of the patients listed under this diagnosis only appeared once at the clinic or only paid one or two further visits. These were not included in the survey. Perhaps they did not appreciate the homœopathic approach; perhaps like Naaman they expected something more spectacular in the way of treatment than a small bottle of colourless, tasteless liquid, plus a box of insignificant little white pills; perhaps they did not like the doctor, or were believers in the policy, "Try everything once", and expected instant relief. Anyway they failed to afford Homœopathy a fair opportunity or provide valid data for study.

The three groups were reviewed separately and in each a smaller group of fifteen representative cases was studied in relation to the "most prominent symptoms" (M.P.S.), the "relevant associated features" (R.A.F.), the "possible precipitating factor" (P.P.F.), and progress under treatment.

Phobic Psychoneurosis. (21 patients, 7 men, 14 women.)

Age. Seventeen patients were under 40 and four were over 50. Rather surprisingly there were none in the 40-50 decade. An impression was gained that fear as the predominating symptom is likely to be met with more frequently in the younger age groups, and especially in individuals whose childhood experiences of emotional trauma have been aggravated by further mental stress and anxiety in early adult life.

Duration of symptoms. It seems unfortunate that so many patients arrive in the out-patient department complaining of symptoms that have been present for a considerable length of time. In this group 13 patients had been ill for over a year and several others gave a history of several months. This delay in seeking homœopathic help means that much valuable time is wasted, and worse, for frequently the condition has been aggravated by over-medication or ill-advised treatment of one form or another.

Results of treatment. These were encouraging, only two of the patients in this group failing to show maintained improvement. In one of these, the back-ground of mental trauma in childhood was quite appalling and additional causes of anxiety and emotional stress were still operative in force. Of the remaining nineteen patients, nine were listed as "Very much better" and ten as "Definitely better" at the time of review.

Symptoms. In studying this group it became obvious that fear as a distressing and most harmful emotion is a definite symptom just as is pain, pruritus, paresis or any other deviation from normal well-being. Like other symptoms fear may come and go, vary in intensity, or prove very persistent.

Certain characteristic types of fear seem to be frequently met with, e.g. *fear lest one lose control and do someone an injury,* especially a near relative, husband, child. One wonders whether this brand of fear is not fostered and encouraged by modern psychological literature and by lurid accounts in the press of murder and suicide as the result of so-called "irresistible impulse".

There is the *fear of going out alone or crossing the street unaccompanied.* This rather curious form of specialized apprehension often has as a background, some distressing experience in the remote past. It often proves very persistent and difficult to overcome, even though the originating cause has been laid bare.

Another form is *a sudden and unaccountable fear* that

seems to arrive out of the blue and assails the victim with a horrifying sense of impending disaster or of intense panic and terror. It commonly attacks when the patient is alone but in one of these cases, a woman, the cold panic of inexplicable terror would swoop upon her when among friends and when humanly speaking everything in the garden was absolutely, even superlatively, grand.

While the various forms of fear were the outstanding feature in this group the associated features and the causal factor had often to be taken into account before prescribing.

It was noted that the effective remedy varied from case to case. This emphasizes the important fact that psychoneurosis is a highly individual matter and by no means to be dealt with in any routine way by sedation or E.C.T. or other set technique. *Lycopodium* and *Ignatia* were frequently indicated in this group, and other remedies called for were *Arsenicum alb., Dys. co., Opium, Sepia* and *Coffea.*

Depressive Phychoneurosis. (35 patients, 8 men, 27 women.)

Age. All but fifteen of these patients were over 40. Thus depression as the predominating symptom appeared to be commoner in the higher age groups and to occur especially in relation to the menopause.

Duration of symptoms. Many of those in this group stated that their symptoms had been present "for years". In twenty-four cases the length of the history was given as less than one year. Comparing this group with the former it seemed that whereas fear as a symptom tends to be remarkably persistent, depression occurs more in phases and often in association with an inability to cope with adverse circumstances and accompanied by extreme fatigue. Fear is often traceable to a single experience of terrifying nature, perhaps in early childhood, while depression seems to be the outcome of a long series of emotional stresses, culminating in capitulation and characterized by utter weariness and complete lack of zest.

Results of treatment. On the whole, patients in this

group seemed to respond to treatment fairly quickly, eighteen out of the thirty-five being much better within six months. One particularly difficult case only became really well again after steady perseverance for 12 months. Another case with a quite recent history required treatment for nine months before recovery was completed. Twenty of the thirty-five were listed as "very much better", twelve as "definitely better" and only two as unimproved. One of these was a woman of 62 with a most unsatisfactory previous history of nervous breakdowns and probable arterial disease.

Symptoms. A tendency of involuntary and causeless weeping often accompanied the depression. In other cases there was an associated complaint of "feeling in a daze or in a dream."

The precipitating factor in a number of these patients could be traced to some particular occasion of stress, such as bereavement, domestic upheaval *et sic*, but in many it was a matter of circumstances proving beyond the patient's capacity for adaptation.

Several of these depressive patients presented a typical picture of *Sepia*. This remedy undoubtedly takes precedence over all others in restoring such patients to normal poise and cheerfulness. *Ignatia* was of great service in many cases and *Nux vomica* when irritability was marked. *Medorrhinum* was helpful in several patients, also *Lycopodium* and *Natrum mur*, prescribed on constitutional grounds, and *Staphisagria* when there was evident resentment and the "injured feeling".

Somatic Psychoneurosis. (64 patients, 11 men, 53 women.)

Age. Twelve of these patients were under 30, twenty-one were in the next decade, sixteen were in the 40 to 49 period and fifteen were over 50. Thus it would seem that emotional stress is likely to result in physical distress of one kind or another over a wide age range.

Symptoms. This group presented a somewhat mixed

picture. It included the type of case in which a detectable lesion such as a leaky heart valve or fibrositic rheumatism was associated with pronounced psychoneurotic state. It also included cases in which an obvious lesion such as peptic ulcer or dermatitis was accompanied by evident anxiety neurosis and in which the probability was that the obvious pathology was psychogenic in origin. But for the most part this group was composed of patients who complained, often bitterly and in superlative phraseology, of a wide variety of somatic symptoms for which there seemed to be no apparent or detectable pathological explanation.

The extreme example of this condition is the inveterate hypochondriac whose plethora of woes amounts to obsessional insanity and can be classified as a definite psychosis. The underlying morbid changes in this condition are probably irreversible and the hope of recovery remote.

Duration of symptoms. In thirty-seven of the sixty-four patients in this group symptoms had been present for more than one year; in several for a considerable number of years. One is forced to the conclusion that for one reason or another Homoeopathy is a sort of last resort only to be given a trial when all else has failed. The unfortunate result is that too often when the sufferer finally arrives under review one is confronted by a confusing Turneresque or surrealist canvas on which the picture is a blurred medley of original disease symptoms plus drug-induced symptoms. This makes accurate prescribing much more difficult than if the patient had sought homoeopathic treatment at the outset.

Results of treatment. This type of case tends to be like the bad halfpenny and ever with us, but in perhaps about half of these patients there was quite definite improvement in six months or less. Twenty of the sixty-four patients in this group were recorded as "very much better", twenty-four as "definitely improved", ten as unimproved. The other ten failed to maintain temporary recessions of symptoms. As a group these patients appear to be afflicted with a low-

ered sensation threshold. Normal afferent impulses reaching the central nervous system from various parts of the body appear to be projected into conscious awareness as exaggerated or distorted sensations of pain or other form of distress. They are much to be pitied. The attempt to dull this over-sensitivity by barbiturate sedation merely seems to add progressive depression to the already long list of other complaints. The attempt to disrupt the condition by conclusive or subconvulsive therapies adds further trauma to a nervous system already in a damaged state, and the "latter state" of the patient so "beaten up" is likely to be worse than "the former".

Symptoms: Patients in this group provided a great variety of symptoms ranging all over the body and involving most of its functions. They all tended to be severe subjectively and either very persistent or periodically recurrent.

Despite the emphasis which the patient lays on this or that symptom, when it comes to the matter of treatment close attention has often to be given to the relevant associated features in the case and to the constitutional type of the patient. Thus in this group chief reliance was placed on remedies chosen on these grounds. In some of the cases this line of attack was supplemented by the use of a remedy prescribed on the basis of local organ or tissue pathology and given in low potency. In cases showing lack of response the nosodes, e.g. *Psorinum, Medorrhinum, Dys.* co. and *Tuberculinum,* were found of value.

Summary. A series of 120 cases of psychoneurosis have been reviewed and studied in three main groups, viz. Phobic, Depressive and Somatic.

It is suggested as most probable that a morbid state of cells and tissue fluids is present in all these patients. The immediate inability to detect these changes does not prove their absence.

It is inferred that in many cases, especially in the early stages of the disease, the changes present are reversible, and that cure is therefore possible.

It is felt that the process of cure can and should be aided by therapies which stimulate the vital recuperative power of the body. For this reason it is contended that the homœopathic method is preferable to more drastic techniques which inevitably carry a risk of causing further trauma to the already damaged tissues.

The results encountered in this admittedly very small series seem to justify perseverance in the homoeopathic line of approach to this very pressing problem of our age.

A small selection of the cases studied are appended in summary form, the main indications for the remedies used being indicated by italics.

BRIEF SUMMARIES OF ILLUSTRATIVE CASE NOTES

Phobic

Case 1. Woman aged 21. First seen December 13th, 1948.

M.P.S. Since childhood liable to sudden waves of acute fear associated with blanching, palpitation, numbness, tension, burning feeling in nape, blurred vision and sweating. Attacks more frequent and severe for past 11 months, giving rise to thoughts of suicide as "whole universe is pointless and joyless".

R.A.F. *Flags in heat: craves air: likes wind:* likes salt, vinegar, pickles: averse solitude: averse being touched: trifles annoy: *involuntary tears: moods vary: apprehension before ordeal very active alae nasi*: manner diffident.

P.P.F. A bad scare at age of 11 by

a "spectacle seen in a hospital ward". *Ign.* 200 ii

December 29th, 1948. Much better re fears, but *concentration very poor and easily irritated.* *Lyc.* 30 iii

January 25th, 1949. Two attacks of fear one night but able to control thoughts better and less tired in evening. *Phos. ac.* 6 b.d. xxviii

February 22nd, 1949. Much better for two weeks, then depressed with episode of *involuntary tears* at work: *seems to have "no goal".* *Sep.* 200 ii
Phos. ac. 6 b.d. xxviii

April 19th, 1949. No more attacks of fear: *difficulty in settling down to work.* *Lyc.* 1*m* iii

May 17th, 1949. **Feels very much better in every way;** witnessed a car accident recently without being upset thereby.

Continued under observation and treatment for hay fever and other intercurrent troubles up to December 28th, 1951, without recurrence of acute fear attacks.

Case 2. Man aged 30. First seen October 19th, 1949.

M.P.S. Fear lest he become violent, lose control and do an injury to someone: thoughts dwell on unpleasant things.

R.A.F. Irritable, snappy, *very restless, cannot settle down for long: worries about the future: feels the cold badly.*

P.P.F. Pressure at work: financial worry.	*Ars. alb.* 200 ii
November 2nd, 1949. Feels better, but still a bit *strung up* in evening.	*Nux v.* 6 b.d. xxviii
November 30th, 1949. Gets *depressed as soon as it is dark,* but is better on the whole.	*Stram.* 30 iii
December 16th, 1949. Less depressed.	S.V.R.
January 13th, 1950. Not feeling so well.	*Ars. alb.* 200 iii
February 17th, 1950. Feeling better, but room for improvement.	*Calc. phos.* 6 b.d. xlii
March 17th, 1950. **Feeling very much better.**	Rep. *Calc. phos.*
Case 3. Woman aged 30. First seen July 21st, 1950.	
M.P.S. Haunted by fear since childhood: awful fear lest will kill somebody, worse at sight of knife: fear of losing reason.	
R.A.F. Averse heat and being indoors: better in open air: *feels strung up*: *cannot relax*: terrified of heights: fear of closed space: apprehension before ordeal.	
P.P.F. Lost mother at age of 9 and constantly terrified as child. Has been heavily dosed with sedatives and also a great many homœopathic remedies in high potency by a lay prescriber.	*Dys.* co. 200 iii
August 28th, 1950. *"No interest in anything or anybody":* gets in a	

sudden panic: "terrified to be alone".	*Sept.* 200 ii. *Acon.* 12 p.r.n.
September 12th, 1950. "Afraid to be happy as fear likely to recur": *duality sensation very marked.*	*Anac.* 12 b.d. xii
September 19th, 1950. Varies a lot: has "terrible thoughts".	*Arg. nit.* 200 ii
September 26th, 1950. Fear has *persisted since childhood.*	*Op.* 10*m.* ii
October 2nd, 1950. Is *resentful;* keeps asking, "Why, why, why?"	*Staph.* 6 b.d. xiv
October 9th, 1950. Some good days but fear persists.	*Ars.* 1*m* iii
October 16th, 1950. Headache on vertex, worse emotional stress.	*Phos. ac.* 6 b.d. xxviii
November 13th, 1950. Was better for two weeks then bad relapse associated with *"urge to kill* or strangle someone."	*Nux v.* 12 p.r.n.
Things went on like this, sometimes better, sometimes worse, and on	
May 8th, 1951. Again reverted to "fear of committing a murder" with *duality sensation,* and said she was *worse when extremely happy.*	*Thuj.* 1*m* iii *Coff.* 6 p.r.n.
-Again improvement and relapse alternated and on	
July 20th, 1951. Again mentioned recurrence of fear especially when "everything is pleasant and gay"	*Ign.* 12 o.n. vii
September 14th, 1951. Felt fine for three weeks but worse again the last two weeks.	*Coff.* 1*m* ii
Not seen again till	

March 11th, 1952. When came re indigestion and reported that the **fear trouble had "just gone"** a while back: was very cheery and **no talk of further relapses of fear.** The gastric symptoms were accompanied by a desire for cold drinks. *Phos.* 30 b.d. xii

Case 4. Professional woman aged 39. First seen December 7th, 1951.

M.P.S. Persistent fear of failure: liable to sudden panic, accompanied by fear of death at night: loss of confidence in herself.

As result of this had been off work for a long time and had signed on to go into a mental hospital for shock treatment.

R.A.F. Liable to "turns", i.e. paroxysmal tachycardia and at times fainting: *long-standing resentment against circumstances and against certain individuals:* tense, ardent, artistic, touchy: liable to sudden exhaustion from emotional stress.

P.P.F. Surrounded by emotionally trying circumstances from childhood onwards. *Staph.* 200 iii

December 28th, 1951. Under *fresh emotional strain.* *Ign.* 6 b.d. xxviii

January 11th, 1952. Feeling definitely better, "much more on the level". *Ign.* 6 b.d. xxviii

January 25th, 1952. Recent bilious attack, feels "down" again. *Kali p.* 6 b.d. xlii

February 1st, 1952. *"Under the cloud"* again: *weepy: fresh fears re future and re failure.* — *Sep.* 200 ii

February 15th, 1952. Feels much steadier. — *Ign.* 6 b.d. xxviii

March 7th, 1952. Writes to report appointment as trainee for further course of study.

October 10th, 1952. Writes to report, "I was successful in the examination and have enjoyed every minute of my training, and **my health has never been better."**

Case 5. Woman aged 20. First seen November 2nd, 1949.

M.P.S. Gets nervous over nothing: *daren't face people or parties:* off work for three months because too afraid to meet people: would cross road to avoid an acquaintance: wants to pick things up and throw them about: desire to weep or scream.

R.A.F. Right side of face twitches: *feels the cold: flags in heat: prefers hot food: easy satiety: fear of dark, of solitude, of thunder:* irritable, *flies off the handle: irresolute: apprehensive ante ordeal.*

P.P.F. Buried in a bombing raid in 1945 with resultant attack of hysteria. — *Lyc.* 30 ii

November 16th, 1949. Complains of *severe nausea* p.c. with *vomiting of food eaten: nausea persists after vomiting: tongue clean:* is

impatient, irritable, keeps jumping up and down. *Ipec.* 30 t.i.d. ix

November 25th, 1949. Nausea and vomiting very much better: liable to *giddy turns with desire to clutch something for support.* *Phos.* 30 b.d. iii

December 9th, 1949. **Feeling much better: giddiness better: has more confidence:** *face may still twitch at times.* *Ign.* 6 b.d. xxviii

(*To be continued*)

A COMMENT

To

The Editor,

Hahnemannian Gleanings, Calcutta 12.

Dear Sir,

I have read with keen interest "The Letter to the Editor" published at pages 474-75 in December, 1955 issue of the Hahnemannian Gleanings, commenting upon an article "Oral Contraceptive" by Dr. B. C. Chatterjee, M.D. published in August, '55 issue of the said journal. I give below my views on the subject and shall feel grateful if they are given due space in the esteemed columns of your journal:—

To utilise remedies for the relief of ailing humanity can in no way be called as prostitution of the sacred science founded by Samuel Hahnemann. The Founder of Homeopathy lived, worked and died in the service of the people, and to relieve their sufferings should be the foremost aim of his true followers.

Human ailments do not constitute only objective expressions of certain diseases but the disorder of the "*Vital Force*". The "*Vital Force*" being very sensitive to all sorts of influences atmospheric, environmental,

see that every state, nay every city, should have at least one Hospital, one college and a Research Laboratory so that our main object—*service to humanity through homœopathy*—is achieved.

SOME OBSERVATIONS ON HOMŒOPATHY IN RELATION TO PSYCHONEUROSIS

DR. D. M. GIBSON, M.B., B.S. LOND.

(*Continued from page no.* 91)

Depressive

Case 1. Woman aged 18. First seen December 30th, 1949.

M.P.S. In a daze for two weeks after witnessing a Red Cross Film depicting an operation for pneumonectomy. After she came out "something happened" and she "had not been the same since". *Profound depression: "nothing seems important"*, "man's body a a mere machine", *"what's the use of anything?". This train of* thought recurs and recurs.

R.A.F. *Cannot talk without tears:* face quivers all the time: *desire to get away from people:* unwilling to talk. *Sep.* 200 ii

January 6th, 1950. Still marked apathy, but does express a desire to get well: *fear persists.* *Op.* 10*m* i

January 27th, 1950. Was better till five days ago after taking *Arn.* 6 b.d. for a couple of weeks: persistence of unpleasant thoughts with superadded somatic symp-

toms, heat waves, vertigo, dysphagia; this in association with a M.P.	*Nat. sulph.* 10*m* i
February 3rd, 1950. Feels confused and *weeps when talking about it.*	*Ign.* 200 ii *Phos. ac.* 6 b.d.
February 14th, 1950. Is much better, but *unpleasant thoughts still recur.*	*Nat. mur.* 200 ii
March 7th, 1950. *Weepy again:* keeps asking "Why?": *sad, sessile, indifferent.*	*Sep.* 200 ii
March 14th, 1950. Better but feels very tired.	*Ign.* 6 b.d. xiv
March 21st, 1950. Still weepy and depressed: has *stabbing pains in head:* and "frightened feeling in stomach".	*Aur. met.* 1*m* iii
March 28th, 1950. Feeling better: headache better: "thoughts" still recur.	*Phos. ac.* 6 b.d.
April 18th, 1950. Yesterday a sudden blurring of vision accompanied by nausea and vomiting and pain in left eye: *keeps sighing, "can't stop myself sighing".*	*Ign* 30 b.d. vi
May 12th, 1950. Much better on all counts: *M.P. a week late: has lost weight.*	*Bac.* 200 ii

Reported by letter dated July 10th, 1952, **"I am happy to say that I have been perfectly well since my last visit to the hospital in October, 1950."**

Case 2. Man aged 28. First seen October 23rd, 1951.

M.P.S. "Nerves bad" for six months after a nervous breakdown in

May—a sudden terrific pressure on vertex accompanied by *crying and depression:* was off work for six weeks. A further spell of crying in September. Still *terribly depressed: no interest in anything: irritable with his children: everything "too much trouble".*

R.A.F. *Desire to sit or lie down:* scared of heights: averse closed space: throbbing headache in temples and heart "beats like mad". — *Sep.* 200 ii

November 6th, 1951. Feeling happier "definitely". Still gets headache at times. — *Bell.* 3x p.r.n.

December 7th, 1951. Less depressed, but still some headache as result of stress re emergency operation on his wife: *temples feel "in a vice".* — *Lyc.* 30 b.d. vi

January 3rd, 1952. A pack of troubles this month but in spite of this the depression is very much better. Occasional *surgings of heat to head.* — *Glon.* 12 b.d. xiv

February 5th, 1952. *Depressed again with tears,* pounding in head, and pulsating in limbs. — *Sep.* 200 ii
Bell. 3x nocte

March 4th, 1952. Has felt normal for two weeks.

July 8th, 1952. **Has kept well to date** apart from a slight upset when attempted to climb the dome of

St. Paul's and felt an *urge to jump down* — *Arg. nit.* 30 b.d. vi

Case 3. Man aged 33. First seen September 26th, 1950.

M.P.S. Nervous trouble for seven months: pent-up feeling: *life "gets on top of him":* feels like throwing things about: *can't cope: wants to "get out of it".*

R.A.F. Manner diffident: unwilling to talk about himself: feels the cold: flags in heat.

P.P.F. Monotony and pressure of work in factory, turning out bakelite panels at top speed. — *Sep.* 200 ii

October 10th, 1950. Much the same. — *Nux v.* 12 b.d. xiv

October 31st, 1950. Feels better: *tends to catch cold easily.* — *Bac.* 30 ii

November 28th, 1950. Continues better: a long-standing dermatitis on buttock. — *Phos. ac.* 6 b.d. xlii

January 30th, 1951. **"Nerves much better"** and continued so up to more recent visit in November, 1951 when complained of boils. — *Psor.* 200 ii

Case 4. Woman aged 50. First seen November 9th, 1951.

M.P.S. Depressed and when talking of her mother dissolves into tears: just wants to sit and sit: desire to get away from everything: irritable and can't stand noise.

R.A.F. Hot flushes very frequent: occipital headache with blurred vision: *dreams and wakes screaming:* terrified of thunder.

P.P.F. Death of mother in April: can't get her mind off it. *Calc. cm.* i

November 23rd, 1951. Feeling much better: sleep not so disturbed. S.V.R.

December 28th, 1951. Feeling better: sleeping better: complained of *pruritic rash.* *Sul.* 30 iii

February 1st, 1952. Recent upset owing to suicide of neighbour, but despite this feels definitely better. Continued to improve and at last visit on. *Ign.* 6 b.d. xxviii

July 18th, 1952, reported, **"feeling fine."**

Case 5. Woman aged 41. First seen October 10th, 1950.

M.P.S. "Nerves very bad" for four months; longs for quiet: *can't stand noise of children:* dreads going to shops: *wants to sit down all the time:* choky feeling in throat: easy palpitation.

R.A.F. *Depressed but doesn't cry: wants someone to talk to: gets hot in bed and feet sweat:* "got to get things done" feeling: chilly, likes warmth: *likes vinegar and pickles: sweats from weakness, especially on head.* *Sep.* 200 ii

October 31st, 1950. **Feeling ever so much better—"like herself again"** and while attending hospital on and off for various complaints had no return of depression to date, July 1st, 1952.

Somatic

Case 1. Woman aged 21. First seen August 1950.

M.P.S. Torticollis: severe and frequent spasm of right sternomastoid muscle, deflecting chin upwards and to left: also "nerves" bad: two months' duration.

R.A.F. *Easy tears:* reduced to tears by her doctor: fear of dark, of dogs, of "practically everything".

P.P.F. *Driven and chivvied at work* (machine sempstress). — *Ign.* 30 iii

September 5th, 1950. Slight improvement: gets fibrillary twitchings here and there. — *Calc. p.* 6 b.d. xxviii

September 19th, 1950. No spasms, but complained of burning pain in nape: is *jerky at night.* — *Bell.* 3*x* b.d. xiv

October 3rd, 1950. *Constant pain in neck, worse least movement,* and wants to cry. — *Bry.* 30 t.i.d. xviii

October 10th, 1950. Neck less painful, but stiff. — *Rhus t.* 12 b.d. xiv

October 31st, 1950. Neck much less painful, but spasms recur at times, especially when walking or working the machine: *jerky movements at times which cease during sleep.* — *Agar.* 30 b.d. vi

November 14th, 1950. Pain very much better: still some tendency to spasm when walking in street: *feels jumpy if left alone in the dark.* — *Stram.* 6 b.d. xiv

November 28th, 1950. Steady improvement in every way: difficulty in getting to sleep because mind too active. — *Lyc.* 1*m* ii S.L. xiv *Cal. phs.* 6 b.d. xxviii

January 9th, 1951. Still slight tendency for head to turn to left when walking in street. — *Agar.* 30 iii

No further recurrence of the spasmodic tic although attending clinic for minor ailments, to date, March, 1953.

Case 2. Woman aged 35. First seen August 30th, 1949.

M.P.S. Whole body throbs and aches on waking: *feels dreadful in morning:* no energy or vitality: pain in nape with desire for movement but no relief thereby.

R.A.F. *Feels the cold* but *flags in heat: likes hot food: averse oysters:* hates wind: *quick temper: fear of dark; fear of dogs:* not averse solitude but *wants someone around: apprehension ante ordeal: "frightfully tidy": wakes "ugly".* — *Lyc.* 30 iii

September 12th, 1949. **Feels much better in every way.** — S.L. *Bac.* 200 once a month

Case 3. Woman aged 38. First seen February 9th, 1949.

M.P.S. Tight feeling in chest: pain in right breast accompanied by tenderness and pain also on medial aspect of right arm: loses voice if upset.

R.A.F. Very averse solitude: trifles annoy: symptoms vary from day to day: *intolerance for onions which cause diarrhœa:* dreams of burglars. — *Thuj.* 1*m.* ii

March 8th, 1949. Feels better: has a *dry tickly cough.* — *Phos.* 12 b.d. xiv

April 5th, 1949. Has had tonsillitis: feels depressed. — *Bac.* 200 iii

May 4th, 1949. Feels very much better this month. — S.V.R.

June 1st, 1949. Feels **"really well now", "full of energy".**

Case 4. Woman aged 41. First seen January 26th, 1949.

M.P.S. For about a year liable to fits of trembling and feeling as if "stomach turned over", associated with extreme exhaustion, and at times pain in R.I.F.

R.A.F. *Depressed: wants to scream* and *"get away from it all":* fear of "impending disaster". — *Sep.* 200 ii

February 15th, 1949. Feels much better and pain in side is also better: gets *"full of wind", relief from belching:* gets hot in bed and pushes covers off. — *C. veg.* 3*x* p.r.n.

March 16th, 1949. "All of a tremble" this morning. — *Sul.* 200 iii

April 13th, 1949. Was much better till two days ago when had a "nasty turn", and now is so drowsy "could go to sleep on a clothes-line". — *Lach.* 30 q 7 d.

May 11th, 1949. Better on the

whole: says epigastrium "felt like a big hole".	S.V.R.
June 8th, 1949. Feels better: gets empty feeling about 11 a.m.	*Sul.* 200 iii
Improvement was maintained over the period to date September 26th, 1952, with occasional doses of *Sulphur* or *Pulsatilla.*	
Case 5. Woman aged 42. First seen November 3rd, 1948.	
M.P.S. Severe somatic complaints for some years: notably severe pruritus vulvae, urinary distress, sensation of "seething" in abdomen with flatulence.	
R.A.F. Is afraid of everything: can't cope: *very averse heat which causes flushing "like beetroot": symptoms are worse ante M.P.* and *better when flow starts: dreads waking: very averse tight collar.*	*Lach.* 200 ii
November 17th, 1948. I.S.Q. enquiry into background reveals *strong sense of injury and resentment.*	*Staph.* 30 twice a week vi
December 17th, 1948. No better: weeps from "inward rage".	*Sep.* 200 ii *Cham.* 6 o.n.
January 5th, 1949. Sleeping better and seems more cheerful: still complains of *severe pruritus at night.*	*Kreos.* 30 b.d. vi.
February 2nd, 1949. Feels a bit better: pruritus still present.	*Sul.* 30 iii
March 2nd, 1949. Full of rheuma-	

tism, especially in nape: much catarrh with sneezing, *worse in cold air which causes nose to run like a tap.*	*Nux v.* 12 b.d. xiv
March 30th, 1949. Coryza persists.	*Bac.* 200 iii
April 27th, 1949. Catarrh improving.	*Staph.* 30 b.d. vi
July 13th, 1949. **is very much better**	
July 13th, 1949. **Is very much better in every way, including the pruritus.**	S.V.R.
September 19th, 1949. Came again because **"I just want to tell you I'm much better"**: looks a totally different person, quiet, well-poised and sine complaints.	S.V.R.

DISCUSSION

Dr. POLLAK, opening the discussion on the paper, said: The French have a saying, *On revient toujours à son premier amour*, which means in free translation that you will always fall back on your first hobby. Before I started as a medical student I had been an archæologist, and this is the reason why I have been looking at everything from the historical point of view. Psycho-analysis, psychiatry and in particular psychosomatic medicine are the slogans of our day. You cannot open a medical journal without finding at least a few references to this subject; psychological views have invaded almost all aspects of human life and at one of the United Nations Medical Sub-committee meetings it was hinted that spreading psychiatry will mean in the long run preventing wars. Partly, I am proud of what a blessing my speciality will turn out for mankind, yet I am rather sceptical of such an Utopia. I have asked myself sometimes: Is it really true that all this is our invention and privilege? The answer was provided on a Sunday afternoon when I was re-reading Plato. "Do not treat", he says, "the body without giving proper attention to the soul. This is the reason why so many Greek physicians

have no success because they do not know the totality of the human being. For never will a part recover unless the whole is fit." I do not think that the nucleus of psychosomatic medicine could be defined and summarized in shorter, better or more modern terms than here by the ancient sage.

This being so, you would expect that in the course of centuries, we have enriched the psychosomatic doctrine and added a good deal of knowledge to it. But I am afraid you will be disappointed when you look around, and you will find that we are still there where Plato stood. When it comes to treatment, psychosomatic medicine boils down to nothing more than "theoretical lip-service". In this country and especially in America, medicine is nowadays too psychological, apparently due to the influence of Freud; medicine on the Continent and especially in Russia is too organic, apparently due to the influence of Pavlov. Half way between the two another giant stands, Samuel Hahnemann, still unsurpassed because he has succeeded in synthesizing the physical and the psychological. He is the first and, so far, the only one to whom we owe a system by which Plato's demand for treating the whole can be put into practice. In Hahnemann's doctrine equal importance is paid to both phenomena of that great mystery we call life. I have always admired its *Materia Medica* as the most complete textbook of psychosomatic medicine, offering theory and practical advice as well. Although more than 30 years have passed since I first came into contact with Homœopathy through Professor Schultz in Greifswald I am still fascinated by the psychological part of his work. Reading, for instance, the mental symptoms of remedies such as *Arsenic, Gold, Phosphor* and the like I remember immediately all those unhappy men and women who are visiting me daily.

For some years I have been running three psychiatric out-patient clinics, one in Brighton, two in Hove, and it is there I found Homœopathy of invaluable help. I could

treat patients who otherwise would have been hopeless cases or I was able to cut down duration of treatment by many weeks or months. A case will perhaps best illustrate what I have in mind. A man of 32 enjoyed good health until 1951 when his mother suddenly died. He then complained about continuous headaches especially when driving, great depression, inability to work and a feeling as if he would fall over. As the report from the Eye and E.N.T. hospital was negative, the general practitioner sent him to the Neurosis unit, suspecting the underlying cause might be psychological. He was seen by a colleague of mine who summarized the case as follows: "He appears to be suffering from an anxiety state with hysterical symptoms. During my interview with the patient there emerged marked feelings of guilt concerning the way he had treated his mother before her death. He had divided loyalties between his wife and his mother and he wonders whether she died thinking he was a bad son."

Every psychiatrist will agree with me that this case does not offer much chance for a therapeutical approach. He shows symptoms in both the physical and psychological spheres, and especially those of the latter are prognostically not very favourable. The sense of guilt seems to suggest an œdipal situation the ramifications of which might go back into the patient's early childhood. To treat it would mean a great expenditure in time and yet the result is doubtful because the patient might not be able to establish the necessary emotional adjustment.

When I first saw this man I noticed his lips were strikingly dry and cracked. I took a homœopathic history and was pleased to find that he presented the typical *Nat, mur.* symptomatology. He was put on *Nat. mur.* 12 and after the third consultation he said to me: "I don't know what you did to me but I'm certainly another man". All his previous symptoms had disappeared—and his diastolic blood pressure having been 115 before treatment was now down to 90.

Not every neurosis will respond so brilliantly to homœopathic potencies, and other psychiatric cases will require different treatment. Yet I shall be always grateful to Hahnemann, as some of my greatest successes are due to his teachings.

Dr. W. LEES TEMPLETON said that Dr. Gibson had had some amazing results which were, incidentally, a first class presentation to the rest of the profession of the homœopathic method. He would ask Dr. Gibson to rename his paper "What Homœopathy can do in psychiatry" and leave it there. Why did he give certain remedies? He would ask him to state *why* he chose his remedies: this was of the utmost importance. The emphasis placed on exciting events was of great value. How frequently one was struck by the fact that a patient had had previous so-called breakdowns: for example, breakdown after the mother died, breakdown after child very ill; this was the sort of history which was most important in the choice of a remedy for such cases.

It was not the little events which caused the breakdown, and that was why he personally did not find *Ignatia* very helpful; *Nat. mur.* he found more useful. He was surprised to find that Dr. Gibson did not find *Nat. mur.* more frequently indicated as a follower of *Sepia;* one often gave *Sepia* and then switched on to something else, forgetting that *Nat. mur.* was the complement to *Sepia.*

Dr. Gibson had demonstrated the efficacy of Homœopathy in the most intractable cases, but he should leave his presentation there. It spoke for itself when comparing other methods.

Sir JOHN WEIR said he was very pleased he had something to do with Dr. Gibson's introduction to Homœopathy. He had been a hard and successful worker and his results were remarkable.

Sir John mentioned the case of a woman of 29, a Rumanian refugee. She was friendless in London, and came to see him suffering from migraine headaches, and

so depressed she did not want to live. She was given *Aurum met.* 200, single dose. The headaches, which had been persistent, disappeared, and she was a different creature in a month's time ; she could hardly believe it was herself. In these cases one went for the temperamental and psychological symptoms first of all, and then considered the type of headache.

He thanked Dr. Gibson for his paper, and Dr. Pollak for nis introduction.

The PRESIDENT said that Dr. Gibson had given a selection of the cases he met in the out-patient department : they were mostly chronic cases and they were extremely interesting. A case which came into the hospital sometimes presented a feature which was different, an acutely ill patient with strong psychological features. In these cases one found some very interesting things. There was an old man in the hospital now who came in suffering from chronic bronchitis, on the top of cardiac failure, resulting from severe nephritis. His behaviour was absolutely atrocious. He was a dirty old man. When he fed, his food was all over the bed. When he spoke, he used the most filthy language. He upset all the patients and all the nurses. When he was first seen one had the impression that he would be *Anacardium.* It was given to him without any effect. An examination of his electro-physical reactions was carried out and it was found he was in the eighth group. He was given *Nitric acid* and it had an immediate effect in helping to make him feel better. This was given on March 13th. He went on getting steadily better in his physical state until the end of March. He was still a very unpleasant person to have in the ward. He changed to the sixth group and was given *Sumbul* on March 31st, which got him out of his cursing. He made splendid progress but was still extremely distressed in his respiration. He was cyanotic with a bloated, puffy face, and by April 7th he had stopped responding to *Sumbul* and was given *Medusa* 6c in three doses six-hourly which exactly fitted his

physical condition. His whole attitude then changed. He became a pleasant individual. He stopped using filthy language and he became interested in the newspapers for the first time. His response went on steadily until April 17th, when he had a dose of *Ferrum arsenicosum*. He became pleasant and began to be interested in everyone else and in the things which went on in the ward. On April 24th he had *Comocladia* in the 8th potency, and now everyone found him to be a very nice man. Some remedies were unusual, yet each one had its gratifying response.

That was one example in which one could say that Homœopathy had superseded any other kind of psychological treatment. Not once was it necessary to give him any kind of sedative. He was particularly pleased to say that, because in his experience patients who had had barbiturates or repeated sedatives were the most difficult creatures to bring back into good health.

In thanking Dr. Gibson, he hoped he would not go away with the feeling that he was not an expert. His contribution had shown that his fears were unfounded, for he proved so clearly how well fitted were the principles of Homœopathy to psychological medicine.

—*The British Homœopathic Journal, July 1953*

HOMŒOPATHIC NEWS

SOCIETY FOR THE ADVANCEMENT OF HOMŒOPATHY, DELHI

The society for the advancement of homœopathy was inaugurated by Mrs. Lilawati Munshi, M.P., at the Constitution Club New Delhi on the 14th September, 1955 as Shri S. K. Patil, M.P., the President of the Society could not attend owing to indisposition.

The hall was packed to capacity and people had come from all parts of India namely Calcutta, Lucknow, Dehradun, Meerut, Kanpur, Aligarh, Ludhiana, Karnal etc. Shri C. C. Biswas the Law Minister, took the Chair.