Will and Duval (1947) have reported the treatment with unmodified E.C.T. of a patient with pulmonary tuberculosis in whom there was a rapid spread of disease. They quote experiments on rats and cattle which show that E.C.T. causes petechial haemorrhages in the lungs and they say these account for the activation of tuberculosis. They also suggest that curare might, by abolishing the violent movements and post-convulsive hyperventilation, provide a greater degree of safety in the shock treatment of the tuberculous patient. The avoidance of cyanosis with our technique is a further logical advantage.

We would like to stress the absolute importance of having available, and being familiar with, a suitable oxygen resuscitation apparatus before this treatment is undertaken.

Summary

The literature concerned with contraindications to E.C.T. and complications arising from it is discussed.

The technique of E.C.T., modified by *d*-tubocurarine chloride and thiopentone with assisted respiration, is described.

Fifty patients, untreatable by ordinary E.C.T., many of whom have been in a mental hospital for a considerable number of years, are reported as having been successfully treated by curare-modified E.C.T.

Four cases are reported in full.

The advantages of curare-modified E.C.T. in the various types of cases reported are discussed.

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ACTING AS AN AID TO THERAPY IN A NEUROSIS CENTRE

BY

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It has been known for many centuries that drama may effectively release emotional tensions in actors and audience or both. Since 1921 Moreno has been attempting to use drama for psychotherapeutic purposes, and in 1942 he founded his Theatre for Psychodrama in New York (Moreno, 1946).

We started to employ group methods in 1942 at Mill Hill Emergency Hospital, and began using plays for therapeutic purposes. At that time we had no knowledge of Moreno's work, but in recent years we have borrowed freely from him.

The Industrial Neurosis Unit at Belmont Hospital has 100 beds (two-thirds male and one-third female), and the patients stay in hospital for an average of two to three months. The organization of the unit has been described elsewhere (Jones, 1947). The patients suffer from various neurotic complaints, mostly of a long-standing character, and the term "industrial" is used to indicate that the case represents a job-placement problem when the time comes to leave hospital. Patients of this type have usually a poor social adjustment, and may be actively antisocial. It has been found that group methods of treatment are particularly useful in treating this type of case. Only the use of drama will be considered here, although, of course, other types of individual and group treatment are used where indicated.

The Rehearsed Play

The plays are written and produced by the patients with the help of the nurses. About one week is spent in preparation and a play is presented weekly. The three wards on the unit take it in turn to produce one. A patient usually volunteers to present his own problem, but he may, if he chooses, remain anonymous, or even write a play which presents some problem other than his own. The patient, having volunteered, is free to choose his own cast, producer, etc.; in other words, all the resources of the unit are put at his disposal so that he may be given every help to re-enact his problem as realistically as possible. No stage, curtains, or elaborate props are used, and the room is just large enough to hold the players and the audience. This is done to obtain an "intimate" atmosphere and avoid any suggestion of amateur theatricals; we want actors and audience to merge, and as many patients as possible to act or discuss or "act out" during the discussion. All the patients in my ward attend, and with the nurses and visitors about 100 people are usually present. Various production devices may be used—e.g., a whispered voice over the microphone to portray thoughts while the player mimes his anguish, etc., or a divided stage where two separate scenes are acted simultaneously, dialogue and mime being used alternately by each group of players.

Following the play, which represents a social or personal problem but never offers a solution, the group is asked by the psychiatrist to help the players to resolve the problem. The psychiatrist plays a largely passive part, content to allow the discussion to flow freely, intervening only if the discussion is becoming irrelevant or is being monopolized by one or two patients, etc. During the discussion it often helps to ask a contributor to demonstrate his point of view by working it out with the actual players. Thus a girl with a partial hemiplegia, the result of a birth injury, wrote a play around her basic problem of social insecurity. She preferred not to act her own part, but during the discussion after the play found it impossible to remain anonymous. She was glad to re-enact several situations with the players, taking over her own role from the patient who had played it previously; such "acting out" allows the audience to "test out" a point of view much more realistically than by mere verbal discussion. At the end of the meeting, which lasts an hour, the psychiatrist tries to sum up and, if possible, to bring the various views expressed into something approaching a point of view acceptable to the group as a whole, or at least to the majority.

Reproduction of a Psychiatric Out-patient Interview

The psychiatrist simply reproduces an out-patient interview and a nurse usually plays the part of the patient. An old case record is used, preferably one where the psychiatrist has done a "follow-up" inquiry. The psychiatrist and nurse run through the interview beforehand. The psychiatrist knows the case well, and it is enough for the nurse to know the general trend of the interview, as she

gets her cues from the doctor; she must try to act the part of the depressed patient or whatever is called for. If necessary, other psychiatric help can be invoked, and the psychiatric social worker, probation officer, disablement rehabilitation officer, etc., can appear in person.

Experience has shown that only simple situational problems should be raised, and there should be no attempt to develop any complicated treatment situation. At the end of the interview, lasting up to thirty minutes, the patients are asked what they would do if they were faced with this particular problem in the role of the psychiatrist. Again the discussion lasts until the end of the hour period, and the psychiatrist sums up, bringing the various points of view together, if possible, into an integrated whole. As before, there is opportunity for the patient taking part in the discussion actually to play the part of the doctor or patient and develop the interview along some particular line to demonstrate points more graphically than can be done by discussion alone.

Spontaneous Acting in a Small "Analytic" Group of about Eight Patients

Group treatment of an "analytic" type has been developed in recent years by many workers, including Schilder (1940), Wender (1940), and Slavson (1947) in the U.S.A., and Bion and Rickman (1943), Foulkes (1946), and Jones (1948) in Britain. Here a group of six to eight patients of both sexes meet for an hour a day for approximately two months. Patients are selected who have some form of social maladjustment, a good intelligence, and not a severe neurosis. The patients come to know something of each other's backgrounds and emotional difficulties. There is a common purposive goal—i.e., that the group should try to understand and help the individual. The atmosphere is essentially permissive, and the group stands for public opinion, which in time comes to be perceived as a much more friendly and understanding abstraction than when the group was first formed. Intimate confidences begin to be expressed and instinctual needs can be consciously formulated. Guilt is found to be much more universal than was at first realized, and is shared by all members of the group with obvious advantage—e.g., guilt over masturbation or hostility towards parents which previously may have been strongly suppressed. In this setting it is comparatively easy to get people to start "acting out" their problems. Thus a bus-driver who had a difficult domestic situation which he could not deal with satisfactorily was helped considerably by the group.

This man, aged 40, had been fairly happy in his home life before going overseas on active service. He was away from home for six years and returned to find the domestic situation completely altered. His wife had ceased to spend all her energies on her household duties: she now enjoyed the company of various women neighbours and was often away from home. Their son, now aged 17, went his own way, paying scant attention to his father or any other member of the family. Their little girl had been a baby when the father left home, and now regarded him as a stranger: the mother had done nothing to keep his memory alive. He returned to find he had no place in the family hierarchy. Added to this, conditions at work had changed; he now had a conductress in whom he had no confidence and who persistently gave the starting signal as some old lady was stepping off the bus, and so on. He felt tense and apprehensive all day when driving, and began to be quite obsessional about his time schedule. By the time he was off duty he felt exhausted and went home only to feel unwanted and frustrated. Finally he developed digestive symptoms suggestive of peptic ulcer, and was sent to hospital.

In the group this patient showed a good understanding of the other patients and a rare sense of humour. A scene was re-enacted when he returned home to his rather unfriendly wife and children and suggested that the whole family spent his day off on Sunday at Kew Gardens. His son met the proposal with frank derision, and the little girl, taking her cue from the mother, showed a striking lack of enthusiasm. It was painful to witness the patient's suppressed anger, and one could almost visualize his red engorged stomach churning furiously. After this scene the group decided that somehow the patient would have to get to know his wife all over again. Various approaches were acted out, the patient often becoming completely inhibited as his hostility got the upper hand: it was much more difficult than just an intellectual understanding, and feelings seemed to crowd out his thoughts. But he made definite progress, which he began to apply when in the real setting of his home. At a follow-up six months after he left hospital he claimed proudly that he had "worked through" his domestic difficulties, and said that the family had had a most enjoyable outing at Kew Gardens.

Discussion

It is difficult to assess the value of any psychotherapeutic method, and in an in-patient unit such as the one at Belmont, where so many other factors—environmental, social, vocational, etc.—are at work, evaluation is particularly difficult. No critical assessment of our acting technique has as yet been attempted, but we are convinced that, taken in conjunction with other individual methods of psychotherapy, dramatic methods can aid treatment.

The rehearsed plays and the reproduction of a psychiatric out-patient interview are carried out in the presence of the entire personnel, patients and staff, of the unit. The patients are given a common social goal, and are asked to try to help with a real life problem concerning a fellow patient. It must be remembered that the industrial unit is largely composed of unemployed disheartened antisocial neurotic people, and one of our chief aims is to try to achieve some degree of resocialization: we believe that the plays bring the patients together and give them a social responsibility which, being shared, amounts to a group aim. The fact is that the patients are a remarkably good audience, and there is a large degree of participation in the discussion afterwards.

This group has definitely changed during the years we have been using a dramatic technique: the attitude now is one of much greater responsibility than formerly towards the person whose problem is being dramatized, and the group participation in the discussion afterwards is correspondingly greater. The other striking change is from anonymity to personal presentation, the latter now being the rule. This suggests the development of a group culture which is accepted by the group as a legitimate medium for the expression of personal problems. The plays usually raise very intimate problems and often invite censure; the fact that great tolerance and understanding are invariably shown must help to restore social confidence not only in the individual directly concerned but in all the patients who have identified themselves with their fellow patient.

The problems presented by the plays are of general interest, and it is easy for the individuals in the audience to project themselves into the situation enacted. In the discussion following the play various points of view are expressed, and the individual has an opportunity of gaining a more objective idea of the problem.

In the small analytic group of eight patients, meeting daily for up to two months, there is a much better opportunity for more specific therapy. We find it comparatively easy to pass from discussion to spontaneous re-enactment of some incident described by a member of the group. In this way it has been found possible to achieve mastery of a situation which in real life had overwhelmed the individual patient. By re-enactment in a friendly environment, in the presence of the psychiatrist, and with the knowledge that it is make-believe anyway, the individual may feel strong enough to cope with the problem enacted.

I doubt if an exact explanation can be given of the emotional relief felt subjectively on some occasions after "acting out," any more than the exact mechanism for the relief of anxiety following a painful abreaction during an analysis can be wholly explained—it is a fact, however, to which all those who have been analysed can testify. Where emotional "catharsis" actually occurs there is usually a sense of relief similar to the everyday experience of getting something off one's chest.

Conclusion

The various dramatic techniques described all aim at giving the individual an opportunity of expressing his thoughts and feelings in direct action or at least of projecting himself into a situation that is being enacted by others. Some of the advantages from these methods include the increase of group consciousness resulting from the patient's participation in a socially valuable group endeavour, an increased objectivity, the opportunity afforded for mastery of neurotic difficulties, and the liberation of pent-up emotions.

Many other techniques involving the same principles could be evolved, and Moreno has shown how valuable the psychodramatic method can be in many social spheres besides that of treating the neurotic—e.g., in the training of social workers by rehearsing home visits, etc. I have simply attempted to describe our use of psychodramatic methods to date, designed to meet our own particular needs in treating an in-patient neurotic population. No attempt is made to claim any specific therapeutic results by these methods. I do feel, however, that they have real value in supplementing short-term individual methods of treatment, and as the experience grows they may make a serious contribution to that most desirable goal—successful treatment of the neurotic in a reasonably short time.

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Medical Memoranda

Perforation as the First Manifestation of a Gastric Carcinoma

Perforation of a carcinoma of the stomach is an unusual event. We owe a classical description of the subject to Aird (1934), who collected details of 71 cases and described eight others treated at Edinburgh Royal Infirmary during the preceding ten years. It is significant that of the 71 references listed by Aird only five are from the British literature, and the most recent of these was published in 1904. The series of 506 cases of gastric cancer collected by Payne (1939) from the records of St. Bartholomew's Hospital includes six cases in which suture of a perforated carcinoma was performed, but no clinical details are given.

The diagnosis of the lesion may be considered in two parts: (*a*) diagnosis of the perforation, and (*b*) recognition of the presence of a carcinoma.

Symptoms consequent on the perforation generally follow on classical lines, but some cases pursue a more or less silent course, resembling in this respect perforations of the small bowel occurring in typhoid fever. However, in this event the primary growth or its metastases will already have undermined the patient's health, and it is hardly likely that perforation of an early carcinoma will pass unnoticed. As regards recognition of the carcinoma, in a considerable percentage of cases its presence is already known and the perforation is but an incidental and terminal result of its extension. If the pre-operative findings have not already made the diagnosis certain, a laparotomy is nearly always bound to do so, either by inspection of the lesion or by the observation of metastases, which have been present in approximately half the recorded cases. A small residuum remain in which the history is inconclusive, metastases are not seen, and the perforated ulcer itself lacks the stigma of malignancy. It is the latter group which the following case is designed to illustrate. The case is unusual because the first evidence of gastric disease was provided by the perforation, the carcinoma was not recognized at the operation for its closure, and the patient made for a short time a complete recovery to normal health.

Case Report

A man aged 60 was admitted to the Sheffield Royal Hospital on Nov. 26, 1946. He had been in his usual state of health until the day of admission, and although he had suffered from a mild degree of silicosis, due no doubt to his occupation as a grinder in a Sheffield cutlery works, he denied any past history of indigestion or of other symptoms immediately or remotely connected with his stomach. Ten hours before admission he was prostrated by sudden severe generalized abdominal pain which made him fall to the ground. It doubled him up and made him sweat, and during the course of the day pain was also felt at the tip of the left shoulder. After a few hours it decreased in intensity and he ate a little food, which caused him to vomit.

Examination showed an elderly-looking man lying quietly in bed. He had a good colour and was not sweating. The pulse was 100, regular, and of good volume; respirations 20. Generalized abdominal tenderness and board-like rigidity were present. Peristaltic sounds were heard, but the area of liver dullness was diminished. The clinical history therefore made it evident that a hollow viscus had perforated.

The abdomen was opened two hours after admission—12 hours after the attack began. Dirty free fluid containing fragments of undigested food welled up from the peritoneal cavity. Astride the lesser curve of the stomach, near the pylorus, was an ulcer which had perforated in its centre, the perforation admitting the tip of the little finger. An area of induration about 1 in. (2.5 cm.) in diameter circumscribed the central perforation. The stomach was mobile, with no suggestion of fixity, and the visible extent of the stomach wall at a distance from the lesion had a normal appearance. The liver adjacent to the stomach looked healthy, and in view of the apparently simple nature of the lesion the abdominal cavity was not explored. The perforation was oversewn with three catgut mattress sutures and the abdomen closed.

The post-operative course was uneventful. Gastric suction and intravenous infusion were maintained for 48 hours, and penicillin and sulphadimidine were given until the eighth post-operative day. The patient was discharged on Dec. 10, 14 days after admission.

On Jan. 6, 1947, he was examined in the out-patient department and appeared to be in good health. He complained of occasional epigastric pain after meals, and while it was considered that he might eventually be a candidate for partial gastrectomy the possibility of malignancy had not yet been entertained. A further examination on Feb. 17, however, showed a change for the worse. The pain, though still occurring only after meals, had become severe, vomiting had supervened, and he had evidently lost weight. A barium meal showed "chronic pyloric stenosis associated with a large gastric ulcer. The condition is probably due to adhesions arising from the previous perforation of the gastric ulcer, but the possibility of malignancy cannot be ruled out."

In view of the deterioration in his health, the patient was readmitted to hospital. A laparotomy on March 6, 14 weeks after the first operation, showed a carcinoma of the lesser curve of the stomach, fixed to and infiltrating the liver, and numerous tiny seedling deposits of growth scattered over the anterior wall of the stomach and throughout the peritoneum, omenta, and mesentery. The abdomen was closed and he was discharged to his home two weeks later, where he died on April 10, 1947.

Comment

Whatever one's views may be on the frequency of malignant change occurring in a simple gastric ulcer, there is no doubt in my mind that in this case the ulcer was malignant from the beginning. Considering that the primary lesion was so small when first observed, the rapid course of events after the perforation is remarkable. It is tempting to think that flooding of