

Psychiatric Social Workers

In psychiatry more than in any other branch of medicine illness cannot be divorced from its social setting. It is for this reason that psychiatric social workers are playing an increasingly important part in the welfare of the mentally ill. The profession, which had its roots in America, was established in the United Kingdom in 1930 with the formation of the Association of Psychiatric Social Workers. P.S.W.s work mainly in three branches of mental welfare—in child guidance clinics, in psychiatric hospitals, and in the community welfare services.¹

The P.S.W. makes a valuable contribution to psychiatric practice by providing information about the patient's social environment. The patient's relationship with others—relatives, friends, and work-fellows—can contribute to the cause of his mental illness, influence its form and prognosis, and suffer under its impact. Relatives may find it easier to divulge their feelings to the P.S.W. than to the psychiatrist, whose allegiance is to the patient. A home visit, when relatives can be seen *en famille*, may reveal important conflicts and attitudes which might otherwise be missed in the detached setting of the consulting-room. The P.S.W. is thus well placed to supply the psychiatrist with information which, together with the clinical findings, provides a comprehensive view of the patient at all stages of his illness.

A special province for the P.S.W. is the welfare of those patients who are leaving hospital and returning to live in the community. Relatives, as well as reacting with strong emotions such as guilt and resentment to the illness, may have adapted to it by changing their way of life—a wife may have taken over her husband's responsibilities; an eldest daughter may have cared for her siblings while her mother has been ill. If the patient's stay in hospital has been long his family may have closed their ranks and adapted to life without him. The P.S.W. can prepare for the patient's return home in several ways. She can encourage relatives to dissipate disruptive emotions by creating an atmosphere in which they can be aired without fear of censure. She can try to dispel misconceptions about the illness, and she can point out the problems that will occur. She can use her knowledge of local resources to rehabilitate the patient both socially and at work. When it is not feasible or appropriate for the patient to return home the P.S.W. can look for other suitable accommodation.^{2 3}

During the last decade there has been a move towards providing psychiatric care in the community rather than in institutions such as mental and subnormality hospitals. This policy, embodied in the 1959 Mental Health Act, enables some patients to live with their families and to lead as full a life as possible. Local authorities entrusted by the Act with the responsibility for community care are employing more P.S.W.s. Because of the new policy, general practitioners now have patients suffering from chronic schizophrenia, chronic neuroses, and subnormality,⁴ who in the past would have spent their lives in an institution. General practitioners technically have access to local authority P.S.W.s, but this is still a tentative arrangement in most parts of the country. Experience of closer collaboration between P.S.W.s

and general practitioners was described by N. Davis and E. Heimler,⁵ who felt that the experimental attachment of a P.S.W. to a general practice for one year had been a worthwhile venture.

The Social Work (Scotland) Bill⁶ recently introduced brings the many aspects of social welfare, including mental welfare, under the supervision of a single department of the local authority. This legislation will enable the P.S.W. to deal more effectively with the whole problem of the mentally ill patient and his dependants. The organization of social work in England and Wales is being studied by the Seebohm Committee, whose findings have not yet been published, but it is possible that the Scottish Bill foreshadows similar changes.

Mite Infestations

When skin lesions are diagnosed as insect bites the feelings either of anticlimax or of shame which are so often elicited may disguise what is an extremely complex problem. Even in Britain the number of arthropods capable of causing skin irritation in man is very large,¹ and of these by no means all are insects. Too often no precise diagnosis is achieved. Reactions to these arthropods may be due to irritant substances, but in the majority of cases they are due to the host's allergic reaction to an otherwise harmless substance.

In the case of insect bites the different types of antibody formed often give rise to a well-defined biphasic reaction, an immediate weal within the first hour or two and a delayed response after two days, giving the familiar patterns of "heat bumps" and papular urticaria. Of much greater diagnostic difficulty is the problem of mite infestations. The scabies mite is the only one which is a virtually specific parasite for man. Even in a disease which has been so thoroughly studied^{2 3} it is still uncertain how the itching is caused and to what extent it is due to an allergic reaction. That mites can produce powerful antigens is well shown by the recent evidence that they are responsible for some sensitivity reactions to house dust.⁴ The number of adult mites that can be found in burrows in an average case of scabies may be less than a dozen, but the larval forms and males, though unable to produce burrows, cause many of the itchy papules. Other mites are unable to burrow in human skin but may nevertheless similarly be able to cause itchy papules. These mites have a bewildering collection of names and may be derived from sources as diverse as dogs, cats, birds, rodents, and camels, or as an industrial hazard causing such conditions as grain itch and copra itch. Few animals, either domestic or wild, are exempt from mites, and the diagnosis of such infestations in man is fraught with difficulty. The skin lesions may be relatively insignificant—though the itching may be severe—so that there is a temptation for the doctor to dismiss the symptoms as psychosomatic. The unsatisfactory diagnosis of prurigo is the one most likely to cause confusion, but in more florid cases dermatitis herpetiformis may be mimicked. The clinical picture most closely resembles an atypical scabies without burrows. In the present scabies epidemic many such cases will turn out to be scabies.

¹ Jones, K., *Brit. J. psychiat. soc. Work*, 1967, 9, 61.

² Post, F., *The Clinical Psychiatry of Late Life*, 1965, p. 152. Oxford.

³ Kessel, N., and Walton, H., *Alcoholism*, 1965, p. 128. Harmondsworth.

⁴ Adams, M. (ed.), *The Mentally Subnormal. The Social Casework Approach*, 1960. London.

⁵ Davis, N., and Heimler, E., *Brit. J. psychiat. soc. Work*, 1957, 4, 12.

⁶ *Social Work (Scotland) Bill*, 1968. H.M.S.O., London.

¹ Rook, A. J., Wilkinson, D. S., and Ebling, J., *Textbook of Dermatology*, 1968. Oxford.

² Mellanby, K., *Scabies*, 1943. London.

³ Heilesen, B., *Acta dermat.-venereol. (Stockh.)*, 1946, 26, Suppl. 14.

⁴ Maunsell, K., Wraith, D. G., and Cunningham, A. M., *Lancet*, 1968, 1, 1267.

Even when the diagnosis of mite infestation is suspected proof may be hard to obtain. The mites can seldom be found on the patient and must be sought on the animal of origin. On page 93 Mr. L. R. Thomsett explains how the diagnosis may be made in cats and dogs. He found that 50 out of 65 persons who had been in contact with infested animals had themselves had symptoms, sometimes severe and undiagnosed for a long time. When the suspected source is less easily transported to a veterinary surgeon, as in the cases of rodents and birds, it may be possible for an entomologist to identify the mites in sweepings from the house or from the floor of a bird's cage.

Treatment is usually no problem once the diagnosis is established, as the mites are unable to breed or even persist for more than a few days on the human skin. A therapeutic trial of benzene hexachloride, benzyl benzoate, or tetmosol on the pet may in many circumstances be the best diagnostic measure. The same treatments are often used on the patients, often just to be sure that they have not got scabies, but a simple antipruritic like calamine lotion or crotamiton (Eurax), which conveniently is also a miticide, is really all that is necessary.

Cancer Research in 1967

In any field of research, particularly when the answers seem a long time in coming, there is a continuing need to define the questions to which answers should be sought. In relation to cancer this is much more difficult than it may at first seem. Differences in diagnostic criteria, low necropsy rates, and in many instances the impossibility of continuity of observation of patients contrive to make it costly and difficult to obtain reliable information about the natural history and prevalence of particular forms of human cancer. It is quite wrong, therefore, when looking through documents such as the 45th Annual Report of the British Empire Cancer Campaign for Research (B.E.C.C.R.), just published,¹ to dismiss as pedestrian and futureless many projects the main role of which is the better definition of the objectives of research. In Britain the B.E.C.C.R. and the Pathological Society have together organized panels of morbid histologists who collect, discuss, and collate material from cases of tumours of the testis, thymus, and bone. In addition, British pathologists are contributing to a World Health Organization project for the definition of histological types of mammary cancer. In other parts of the Commonwealth, notably Uganda, Nigeria, the West Indies, and South Africa, B.E.C.C.R.-supported cancer registries are collecting basic information about human cancer which provides the data and the justification for much of the sophisticated research that hits the headlines.

A survey of 58 cases of hypernephroma treated at the Westminster Hospital, the detailed analysis of cases of intestinal polyposis and rectal cancer at St. Mark's Hospital, and a study of the natural history and response to treatment of extramedullary plasmacytoma and a series of detailed clinical observations on patients with Hodgkin's disease, both at the Royal Marsden Hospital, all take the process of defining specific problems a stage further. According to Professor D. W. Smithers evidence is growing for an association in man between autoimmune disease and lymphoma, and one wonders if and how this relates to the reports of depression of immune responsiveness in animals infected with lymphoma viruses, or to production of a multi-

plicity of abnormal proteins (Bence Jones) associated with multiple myelomatosis. In the same category of research is an interesting study at the department of genetics at Glasgow University of cases of self-healing squamous epithelioma. It has been confirmed that susceptible individuals are heterozygous for a rare allele, or for some chromosomal aberration not detectable at metaphase in blood leucocytes. The average age at onset is 26 years in females and 35 years in males. When, in a study of 79 siblings, allowance was made for this difference in age of onset the risk of inheritance proved to be equal in the two sexes. Although the total number of lesions was similar in males and females, ear lesions were three times as common in men as in women. This suggests that an external factor such as sunlight may be implicated in the induction of lesions in susceptible individuals.

The distinction between epithelial and non-epithelial tissues is fundamentally important from both an embryological and oncological point of view. Electron microscopy reveals striking changes at the junction between the epithelium and connective tissue following exposure to chemical carcinogens but not to non-carcinogenic irritants.² Similar abnormal appearances have been observed in relation to spontaneous and virus-induced mammary tumours of mice.

A major advance in early diagnosis is the use of a fully automated radioimmunoassay method for the estimation of human chorionic gonadotrophin and luteinizing hormone.³ This method makes possible serial estimations after removal of hydatidiform mole, so that progression to choriocarcinoma can be detected very early and a favourable outcome to chemotherapy is more likely. From King's College Hospital Medical School, V. Parsons and M. Self report that reliable routine methods for the estimation in urine of hydroxyproline, a breakdown product of bone collagen, may help in the diagnosis of metastasis to bone and provide an early indication of the response to hormone therapy.

The benefit to man of many of these exciting discoveries in the fields of molecular biology, immunology, and experimental carcinogenesis lies in the future, but a few have more immediate application to clinical medicine. Despite a long history of knowledge of their dangers carcinogenic mineral oils continue to be used in some industries in such a way that they give rise to skin cancer, in particular cancer of the scrotum.^{4 5 6} There is still plenty of scope for studying the mechanisms by which these complex mixtures of carcinogens and co-carcinogens produce cancer in different species.⁷ It is comforting that ingested asbestos fibres are not absorbed, and it is interesting that the tongue should be especially susceptible to the carcinogenic effects of 4-nitroquinoline-1-oxide. An assessment of the implications for man of the finding that the feeding of bracken induces cancer of the intestinal tract in a variety of species including rat, mouse, guinea-pig, hamster, sheep, and Japanese quail is also awaited with interest.

The development of organ culture techniques is having an impact on many types of cancer research. It is particularly valuable for the study of the mode of action of hormones, and it is reasonable to hope that the application of these techniques will lead to better ways of predicting which

¹ British Empire Cancer Campaign for Research, *Annual Report for the Year 1967*, 1968. London.

² Tarin, B., *Int. J. Cancer*, 1967, 2, 195.

³ Wilde, C. E., Orr, A. H., and Bagshawe, K. D., *J. Endocr.*, 1967, 37, 23.

⁴ Kinneat, J., and Mair, A., *Brit. J. Dermatol.*, 1954, 66, 344.

⁵ Fife, J. G., *Brit. J. industr. Med.*, 1962, 19, 123.

⁶ Roe, F. J. C., Carter, R. L., and Taylor, W., *Brit. J. Cancer*, 1967, 21, 694.

⁷ *Spec. Rep. Ser. med. Res. Coun.*, 1968, No. 306.