BRITISH MEDICAL JOURNAL

LONDON SATURDAY APRIL 28 1956

ON CHEMICAL TRANQUILLIZERS*

BY

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The whole subject of chemical tranquillizers, as they are now sometimes called, is becoming an increasingly complicated one, not only for psychiatrists but for all those general practitioners and consultants in medicine who now seem to have to spend so much of their time prescribing these drugs. Outside hospital they are generally given either to reduce anxiety and tension accompanying an already diagnosed bodily illness or when examination of all bodily systems has shown that nothing is to be found, except perhaps a state of abnormally increased anxiety or depression. Recent propaganda for a so-called "psychosomatic approach" in medicine has also had the effect, paradoxically enough, of increasing the demand for chemical tranquillizers. Many bodily conditions, such as hypertension, asthma, skin disorders, and the like, are now being given highly speculative and theoretical psychological explanations. But psychotherapy alone often does very little to relieve these patients, so that the doctor is forced back on to the most effective sedatives and tranquillizing drugs to deal with excesses of tension, whether operating at a conscious or at a theoretically Freudian subconscious level.

Not only are psychiatry and general medicine now deeply involved in this problem, but big business and politics as well. Enormous sums are being spent under the National Health Service on the ever-increasing amount of sedatives and stimulants being prescribed, and on the infinite combinations and permutations of these being made available to doctors. These drugs are also being advertised extensively in the medical press. Circulars about them come in shoals through the doctor's letter-box, and most doctors' circulars to-day seem, in fact, to be advertisements for such drugs. Big business is beginning to realize the very large profits to be made out of mental ill-health, especially now that the N.H.S. foots the bill. And, unlike the old days, it has become a much more respectable business. There is no longer any need to advertise in the newspapers all sorts of coloured pills suitable for the nerves of all sorts of variously coloured people. All that is needed is to persuade enough ordinary doctors, or psychiatrists, to prescribe these drugs free under the N.H.S. to their patients in the hundreds of thousands each week.

Politics, too, has invaded this very lucrative field. We must realize the fact that the whole economy of Great Britain now rests on our Government being able to balance its budget by extracting over £900,000,000 a year by the taxes imposed on the sale of two other chemical

tranquillizers with strong and sometimes dangerous addictive tendencies—namely, alcohol and tobacco. I think it is important to remember also that these are the two strongly addicting and tranquillizing drugs which the Government allows to remain off Schedule 4. So excellently habit forming are they in fact, from the Government's point of view, that they can now be made to pay for the whole of the National Health Service, including its vast hospital services, and for all the other free untaxed tranquillizers prescribed by doctors. Over £300,000,000 is still left to pay for some of the Army Estimates as well! As a nation we have certainly become dependent on chemical tranquillizers in many more ways than one.

Only the Government's Medical Research Council and the Government's General Medical Council seem, paradoxically, almost entirely uninterested in this particular problem. The Medical Research Council continues to give only the merest and most miserable of pittances out of its very large research funds for urgent physiological research in mental ill-health. And the General Medical Council still allows examining bodies and universities all over the country to permit extremely low standards of teaching and examination of medical students in psychiatry. Both these things are helping to ensure a perpetuation of mental ill-health and the uncritical and plentiful use of both taxed and untaxed tranquillizers for years and years to come.

Some General Considerations

Backward specialties in medicine, like backward nations, have much more spectacular revolutions when they finally happen. This has certainly been true in psychiatry in recent years. When I entered psychiatry from medicine twenty years ago we were being warned by advisers to the Home Office, such as the late Sir William Willcox, that barbiturates were very dangerous drugs indeed for both body and mind. Yet phenobarbitone is now in almost universal use in Great Britain, and enormous amounts of the shorter-acting barbiturates, such as amylobarbitone sodium and quinalbarbitone, are being prescribed under the N.H.S. in addition to all the phenobarbitone and other longer acting barbiturates.

In the matter of chemical tranquillizers in general, however, we must see to it that we do not turn a complete somersault and end up just where we started. My first locum appointment in a mental hospital, in 1934, showed me rows of patients sitting silently along benches with drooping heads and salivating mouths. You could generally tell the heavily drugged patients during a ward round because you could pat them on the backs of their heads while they were sitting in rows. This was because their relaxed heads fell

* A paper given at the meeting of the Royal Medico-Psychological Association on February 9, 1956.

so far forward on their chests. All these tranquillized patients were then on mixed bromides in truly enormous doses. Bromide, in 1928, was also the fifth most commonly prescribed drug in general practice under the old panel system, and some hospitals were also using it literally by the ton each year. Then a means of estimating the blood bromide was discovered. The amount of chronic ill-health caused by excess bromides was recognized. A paper on bromide intoxication by Barbour, Pilkington, and Sargant (1936) and a long discussion on it in the *British Medical Journal* (1936) helped to remedy a deplorable situation. By 1939 bromides were well on the way out both in mental hospitals and in general practice. Barbiturates had started to replace them in popularity, because it was becoming obvious that their dangers had been greatly exaggerated by Willcox and others.

Now we are seeing another revolution in the sedation of patients in and out of mental hospitals. One can again go round wards in mental hospitals and see a new set of patients sitting on benches, with the same drooping heads and salivating mouths. For excited and agitated patients are being placed in the mass on new tranquillizing drugs such as reserpine and chlorpromazine, and in the equally enormous dosages that were used in the past with bromides. Yet, has anybody really shown that some of these patients now do any better than they did on bromides, especially if both are given in the correct dosage? This will almost certainly prove to be the case, and I think we are going to become increasingly impressed with some of the unexpected and gratifying results that are being obtained even in the treatment of chronic schizophrenics by some of the new tranquillizing drugs. But we must at least try to delineate such groups so as to avoid the spending of unnecessarily large sums of money, and we must always remember that both sets of drugs certainly precipitate or aggravate psychoses, as well as relieving them in the carefully chosen patient.

We must not be persuaded by the modern advertising methods of drug manufacturers into using on a mass basis every new drug coming out, at least till it has been shown to be better than the older ones in a selected group. We should be particularly suspicious and careful about using those drugs which are advertised and offered as samples to general practitioners before they have even been tried out and tested in British hospitals and clinics, where proper facilities for such work are available. It is not sufficient just to put any new potentially dangerous chemical tranquillizer on Schedule 4 and think that patients and public are thereby protected. In large areas of London there are still more deaths from suicide than from tuberculosis; some of these deaths are certainly due to the wrong prescribing and sudden withdrawal of the new chemical tranquillizers whose indications and contraindications have not been properly worked out before being put on general sale and into the hands of ordinary doctors. A doctor friend, for instance, has already had to cope with four severe depressions occurring in his general practice and caused by innocently prescribing reserpine to hypertensive patients, and the number of such patients is now probably legion.

Bromides

Although I myself took some part in the work leading up to the recognition of the enormous amount of bromide overdosage in Great Britain, and have been one of the strongest advocates of the increased use of barbiturates in reasonable dosage, in retrospect I do sometimes wonder if bromides were not more valuable drugs than we realized then, simply because they were being used in such excess. In some of the stronger tension states, chronic obsessional neuroses, and other neurotic conditions accompanied by persisting severe anxiety, bromides may still help to keep patients going when barbiturates can lead rapidly to the use of large addicting doses; and we know that many such neurotic conditions are relatively untouched by either chlorpromazine or reserpine. A long experience of bromide

intoxication shows that it usually occurs in the aged, in the arteriosclerotic, and especially in those who have impaired renal function, or confusional states may occur when it is being too abruptly withdrawn. So in passing I would make a plea that this drug, used for so many years by so many intelligent clinicians, should not be totally forgotten as one means of bringing some relief to the chronic neurotic. It must, however, be remembered that the correct dosage of bromide is of the greatest importance. The salt intake, which controls the rate of excretion of bromide, helps to determine what its correct dosage should be.

Pavlov's work on dogs showed that quite different constitutions need quite different doses of bromide to restore nervous stability. Pavlov's "strong excitatory" dogs, for instance, needed eight times the dose of bromide for a dog of the same body weight with a "weak inhibitory" constitution and temperament. This last type was controlled by an eighth of the amount, and made worse if this small dose was exceeded. There is every evidence that in using sedatives in human beings the same differential doses are needed. Strong, tense, and constitutionally aggressive patients may get only a modicum of sedation out of half a bottle of whisky. But we also know the "weak inhibitory" hysterical patient who falls about the floor having been given less than 1 gr. (65 mg.) of phenobarbitone a day. Yet too many doctors, in disregard of all experimental and clinical findings in man and animals, still prescribe standardized doses of chemical tranquillizers and sedatives for all patients coming to them for help, and wonder why better results are not obtained.

Barbiturates

The increased use of barbiturates since the start of the second world war has certainly justified itself in practice. "Front-line" barbiturate sedation, widely introduced towards the end of the last war, probably saved both England and America millions of pounds in pensions. It prevented many acute neuroses from becoming chronic, as had happened after Dunkirk and during the first world war, when no such treatment was available near enough to the front line. When sensibly used in civilians, barbiturates can be equally valuable as a form of psychiatric first aid in preventing aggravation of an acute neurosis or an acute illness from drifting into chronicity. In regard to the chronic neuroses, we are on much more uncertain ground. One must somehow help those with chronic tension states unamenable to ordinary psychotherapeutic methods to keep going. One cannot leucotomize every chronic anxiety neurotic, and most of these have to go on working in order to live. If not placed on barbiturates, they will be trying to obtain something else from the chemist that is not on Schedule 4.

It does seem that until psychiatry improves its present treatment methods and results, some doctors will have to continue to write letters of protest to the *British Medical Journal* deploring what they call the continued "doping of patients" and demanding a greater exercise of spiritual qualities and will-power on the part of the neurotic. But the majority of doctors will sensibly continue to think that a chronic neurotic patient able to work using a modicum of barbiturate is better than the same patient sitting at home being given none, just as a diabetic able to work if given insulin is better than one not working without it. Both patients may, however, get "withdrawal" symptoms of various kinds if their particular drugs are taken away, and may become nearer total incapacitation as a result. We do nevertheless tend to adopt quite different standards in the treatment of mind and body. Some shrink at giving the chronic constitutional neurotic small maintenance doses of barbiturates, but consider it quite proper to give the same drug in enormous doses to an epileptic patient if necessary.

Short-acting Barbiturates

I do, however, think caution is now needed with the more short-acting barbiturates. They are so much more

efficient than the longer-acting ones, such as barbitone sodium and phenobarbitone, in the relief of tension that they are literally craved for by some patients, and, I believe, they consequently show a much greater tendency to create addiction and to produce severe symptoms on too rapid withdrawal. Anyhow, it is unsafe to withdraw barbiturates at once in any patient; it must always be done gradually unless one wants to court disaster and risk a flare-up in both psychoses and neuroses. Barbiturate addicts are not a very serious problem in Great Britain to-day, if only one recognizes and excludes the psychopath and some hysterics who compulsively swallow anything, including barbiturates, that they can lay their hands on, and in truly enormous doses. The obsessional and anxious patients, on the other hand, will generally stick carefully to prescribed doses, and, though they become more anxious if they are taken off them, they do not get into trouble because of their barbiturate-taking.

The hysterical psychopath, however, may rapidly increase his dose, just as he rapidly increases his consumption of alcohol; or he may go on compulsively swallowing his prescribed barbiturates as he swallows alcohol till he passes out, completely unconscious. These are the patients who cannot be trusted with such drugs at all, and form the basis of so many of the articles on drug addiction. They are, however, a very small proportion indeed of all barbiturate-takers, although so much is written around them.

Chlorpromazine and Reserpine

I have no doubt that the manufacturers of these drugs will eventually regret advertising and distributing them to the general practitioner before their psychiatric indications and contraindications had even started to be worked out thoroughly in this country. We now know the tendency of reserpine to cause severe psychotic and suicidal depressions, and yet until just recently it was being advertised in daily newspapers as a patent medicine for the neurotic, and was freely purchasable in all chemists' shops. The dangerous complications of chlorpromazine, such as jaundice, have also had to be learned by the general practitioner at his professional peril and often to his patient's physical disaster; and many doctors have probably abandoned a potentially valuable drug because expectations of its value became exaggerated. It has some very real advantages in selected patients, but not so many of these patients are to be found in general practice. In neurotics it is not likely to replace the shorter-acting barbiturates as the most useful and effective sedative. Chlorpromazine is not even a good relaxer of neurotic tension, and generally it is only the neurotics who have had no experience of the shorter-acting barbiturates who will continue with chlorpromazine in preference to using much smaller amounts of barbiturate sedation. Chlorpromazine and reserpine can, however, be sometimes used synergistically to help cut down the dosage of barbiturates needed if this is rising too much, just as bromide can, and very much more cheaply.

Most neurotic obsessional patients and those with severe anxiety states seem to get little relief from chlorpromazine or reserpine unless these drugs are used in large doses, when treatment becomes very expensive, and depression may then suddenly supervene or near psychotic symptoms occur. Then hospital treatment may be necessary. It is in the more *psychotic* patients that some of the best results from the new chemical tranquillizers are seen. Both reserpine and chlorpromazine have had their greatest claims made for them in mental hospitals, and, it must be noted, often in mental hospitals where other physical treatments may not have been as extensively and as skilfully used as they might have been. For instance, one shudders to hear, even in England, of patients suffering from simple agitated depression or schizophrenia who have been helped by chlorpromazine, and even been able to leave hospital for a time on this drug. First, however, they have had to spend over *ten years* of agitated misery in a mental hospital. Why, one wonders, was not even a modified leucotomy thought

of long ago if the simple reduction of tension, now achieved by chlorpromazine, would have meant the return of such patients to ordinary life and an end to their prolonged suffering and misery so many years ago?

The point I am trying to make is that when all the available physical and psychological methods are used, regardless of any theory on which they happen to be based, there will be much less need for long-continued and often most expensive chemical tranquillizers. Whenever insulin coma, E.C.T., and the newer modified forms of leucotomy have been skilfully and selectively employed, the need has in fact greatly diminished. One can expect fewer reports of good results from reserpine and chlorpromazine in this country than in the U.S.A. and France, simply because all these other treatments are now also provided here under the N.H.S. and are being more thoroughly and skilfully used in most of our mental hospitals. The National Health Service has certainly improved the results of treatment of the average mental patients, both inside and outside the mental hospitals, if only by training and providing so many more well-paid clinicians to carry these out.

It will be found, I think, that chlorpromazine has a real if limited place in the treatment of some chronic psychotic cases, not severe enough for any form of leucotomy, provided they can be maintained for long periods on fairly reasonable doses of the drug. Some almost mono-symptomatic and chronic obsessive and paranoid states in a schizophrenic setting are helped by chlorpromazine. Well-preserved paraphrenics do have their "voices" damped down, and life can become much more tolerable for them. Older patients with agitation are helped. Many psychotic and neurotic patients, after a modified leucotomy but not before, can also have their tension further diminished by chlorpromazine so that a full mutilating operation is avoided, and they can then leave hospital under this combined therapy. Some patients who have had a full operation (rather than a modified one) and also have some persisting tension can be helped by the addition of these drugs.

The post-leucotomy group has been impressive and has shown useful advance in treatment. But chemical tranquillizers have proved no substitute for even modified leucotomy in other patients, and should certainly not be regarded as a routine substitute for insulin and E.C.T. in the treatment of all the acute and early recoverable schizophrenics. Those using them as such will almost certainly allow some of their acute cases to go chronic, and these chronic cases may then have to stay for years in a mental hospital when they could have been outside if all physical methods had been skilfully and selectively employed, and combined when needed. The use of chlorpromazine in intractable pain and as a partial substitute for barbiturates in continuous narcosis treatment has been described in French literature, and confirmed by our own findings. What we do also know is that chlorpromazine has turned out to be a much more useful drug in mental hospital patients, and often in previously neglected hospital patients at that. But it is much less useful for the already adequately treated mental hospital patient and for the neurotic patient outside hospital.

Reserpine, likewise, helps comparatively few chronic neurotics. It certainly relieves tension, but can also produce severe and suicidal states of depression. Again, this drug is going to prove mainly a hospital treatment for tense and agitated patients. I believe that quite spectacular and most heartening results are being obtained with reserpine in the treatment of selected chronic schizophrenics in certain mental hospitals in England and Ireland. These show a better quality of remission and insight than is generally obtained with chlorpromazine; and therefore real hope may be emerging for some chronic schizophrenics where previously it had been entirely abandoned.

A final important point must not be forgotten concerning all these new chemical tranquillizers. When even a modified leucotomy is done in selected chronic neurotic or psychotic patients, it may still take months for the incapacitating symptoms to disperse gradually afterwards.

One can hardly expect the new chemical tranquillizers to work more speedily than a leucotomy, and there may still be a group of chronic neurotics we are overlooking, like some of the chronic psychotics now being reported from mental hospitals, who show improvement on chlorpromazine or reserpine only if they are kept on them for many months at a stretch to allow the illness to disperse itself gradually.

Methylpentynol and Mephenesin

I think methylpentynol ("oblivon," "somesin") and mephenesin ("lissephen," "myanesin") can be excluded from our main deliberations. They do not compare in their sedative effects with the barbiturates, and their only real advantage to a patient was that both could be obtained off Schedule 4. Now methylpentynol has been placed on Schedule 4, leaving only mephenesin, with its alcoholic solvent, freely obtainable by any patient. Both are relatively poor sedatives. They may, however, be of value to persons not yet accustomed to other forms of sedation and therefore sensitive to drugs with even a mild sedative action. As such they have been used by nervous people before taking driving tests and the like. They have also been swallowed in bulk by psychopaths, since they can cause intoxication at a much cheaper rate than by purchasing heavily taxed alcohol. I have seen both methylpentynol and mephenesin used in this way by the economic alcoholic.

"Frenquel"*

I must now go on to my last subject, a preliminary report on a new chemical tranquillizer called "frenquel" (α -(2-piperidyl) benzhydrol hydrochloride), which I have been given the opportunity to test out before it is made generally available in this country. It is an interesting drug. It will cause disappointment to those who have long felt that, if only a chemical antagonist to lysergic acid and mescaline could be found, a key to the treatment of schizophrenia would be in our hands. In frenquel, Fabing (1955), of Cincinnati, claims to have discovered such a drug; in reasonable doses it inhibits the action of both mescaline and lysergic acid on the brain of man; it also abolishes the E.E.G. changes seen with these drugs. Unfortunately, however, our clinical findings agree with those of Fabing that it is certainly not a specific in the treatment of schizophrenia. A few patients, however, do seem to be helped in a quite dramatic manner. Fabing and Hawkins (1956) found that 5 of 14 acute schizophrenics "lost their schizophrenic disorder within two to three days after frenquel. Three others showed definite improvement on frenquel, but of less dramatic suddenness and with residual depressive features. Short courses of electroconvulsive therapy completed their recovery. . . . Four others are considered frenquel failures because they did not begin to respond till E.C.T. was added." Rinaldi, Rudy, and Himwich (1955) have also reported that frenquel has some effects on chronic schizophrenia. Twenty-one of 39 chronically ill schizophrenics in institutions improved with the oral administration of 20 mg. of the drug daily during an eight-weeks observation period.

We have now used this drug in over 60 varied types of patient in the last six months. Doses of up to 60 mg. a day have been given, and some American workers appear to find no advantages in giving greater amounts of the drug than this by mouth. It is prescribed in 20-mg. tablets, 1 to 3 tablets being given each day. No physical complications or undesirable physical side-effects of any sort have been encountered in six months, and none have been reported by Fabing in the treatment of over 100 cases during more than a year's work on this drug. But some patients do appear to become more depressed on the drug when E.C.T. is not used.

Sixteen cases of schizophrenia of various types have been treated, mostly at St. Thomas's and Belmont Hospitals, some for short periods and others for periods of up to two months.

* Frenquel is an isomer of meratran hydrochloride.

One can straightaway say that frenquel is no routine substitute for insulin and E.C.T. in the treatment of early schizophrenia. It may, however, be able to supplement it. We have had patients who have shown no response to frenquel, and none to combined frenquel and E.C.T., but who subsequently made a good response to insulin coma and E.C.T. I make this point since every new chemical treatment of schizophrenia tempts some people to give up insulin coma, combined with E.C.T. if necessary, with possibly unfortunate results for some of their patients. We saw this happen with the introduction of E.C.T. and again with chlorpromazine and reserpine, and it must not happen yet again with frenquel. However, some schizophrenics seem to have had their tension damped down with frenquel alone, while others improve when frenquel is combined with E.C.T. after it has failed on its own.

In only two patients did we find a dramatic improvement which we could possibly attribute to frenquel by itself. Interestingly enough, both were acute and recent schizophrenic illnesses which might well be compared in their symptomatology to a mescaline or lysergic acid intoxication: the patients were being bombarded with voices, but insight into this was coming and going because of the severity of the hallucinatory disturbances being experienced. Fabing has also recorded success in post-operative, alcoholic, and senile confusional states with hallucinosis. We have not yet tested the drug in these groups. Frenquel has some mild sedative effects in anxiety states and obsessional neuroses, but it is not going to have, I think, much place in the treatment of these neurotic conditions.

Use in Depression

We have also given frenquel in over 20 cases of depression of various kinds at St. Thomas's and Belmont Hospitals. Here it has created a favourable initial impression as a possible adjuvant to E.C.T. Fabing makes little mention of its possibilities in depression when combined with E.C.T. At St. Thomas's and Belmont we have many cases of recurrent depression coming for treatment as either in- or out-patients. The majority have had repeated courses of E.C.T. and their individual reaction to this treatment has gradually become known to us. I have been impressed by the action of frenquel on certain recurrent types of depression. In the past they may have needed a large number of fits to bring them into remission. With frenquel they sometimes seem to remit with fewer treatments, and the quality of the remission may be better, if not always sustained. Some patients with depression have not responded to E.C.T. at all until frenquel has been added. Thus one patient who had had 32 E.C.T.s without any improvement at another hospital for depression with obsessional ideas of almost delusional intensity, improved greatly with only three E.C.T.s and frenquel, relapsed again when the E.C.T. and frenquel were stopped, and then improved a second time when three more combined treatments were given.

There has been another interesting group of tension depressions with marked hypochondriacal features, including complaints of persistent pain. These, too, have had previous courses of E.C.T. with little success, but combining E.C.T. with frenquel seems to have helped them also in a much more satisfactory manner. Modified leucotomy seems to have been avoided in at least two of these patients who had been admitted for consideration of this operation, but then responded to combined E.C.T. and frenquel following the previous failure of E.C.T. alone to help them either at St. Thomas's or some other hospital. When E.C.T. is stopped, the drug should be stopped or reduced to one tablet a day.

Assessing the response to any new treatment in psychiatry is a notoriously difficult task. Depressions in particular are always liable to spontaneous remission at any time. Sometimes they respond to E.C.T. only towards the end of an attack and not at all at the beginning. Therefore to make any firm conclusions about the value of a new drug in the treatment of reversible depressions is fraught with danger. My present early impressions may turn out to be wrong.

However, I can only say that as a result of our recent experiences I would be sorry indeed to be without this drug again at the present time. And if frenquel, used alone or combined with E.C.T., helps only a small limited group of cases of depressions and early schizophrenics, and we can learn to pick out these groups clinically, it will still be very much worth while.

Conclusion

May I again stress the importance, with all these new chemical tranquillizers flooding the market, of trying to find the limited and definite indications for any new one used. We must not go on prescribing these drugs at random, replacing one by another without any rhyme or reason. We should always be on the lookout for even the smallest clues to help us in our differential search.

Even several new treatment swallows will hardly yet make a psychiatric summer. Some people, especially in America, have been talking about a new golden era in psychiatry, when it will be possible to give up insulin coma, leucotomy, and E.C.T., and have the chemical tranquillizers as humble handmaidens of universally applicable forms of dynamic psychotherapy for all types of neurotic and psychotic patient. I venture to predict that those psychiatrists who are saying this sort of thing will prove to have been more psychotherapeutically brainwashed than their patients will ever be. What would really happen then is just what was happening twenty years ago. All we had in those days were Freud, Adler, and Jung's psychotherapeutic methods of treatment and the bromides, paraldehyde, and longer-acting barbiturates to help us in the treatment of all types of mental disorder—except G.P.I., for which malaria therapy had become available. Few of the modern physical treatments, such as insulin, E.C.T., leucotomy, the synthetic vitamins, endocrines, and the like, which have made the real difference in actual practice, were then in general use in mental hospitals. The result was that private paying patients and a highly privileged small group of hospital patients got all the psychotherapy, while most of the patients in ordinary mental hospitals were simply kept chemically tranquillized—or “drugged,” as we used to call it in those days—on bromides and paraldehyde. We must not revert to this same old state of affairs by simply substituting new tranquillizers for the old.

A better era in psychiatric treatment is really likely to be achieved only when we start to learn that every method of treatment, empirical and otherwise, not only has its uses but also its very real limitations. There will be no treatment found universally applicable to all groups of patients. Progress in psychiatry will occur gradually and piecemeal, in exactly the same way as has happened in general medicine and surgery. It will certainly not be by the finding of any universal panacea, chemical or psychological. We must therefore go on keeping a very open mind about the value of all sorts of different treatment methods, and try to keep as many of them as possible in *constant* use. Then we shall always be able to compare new methods and new tranquillizers with the old. And it will be found, as elsewhere in life, that “what is new is not always true, and what is true is not always new.”

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ANXIETY STATES*

BY

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The purpose of this paper is to present some findings from the records of Westminster Hospital rather than to give a textbook account of anxiety states, though inevitably something must be said about the nature and aetiology of anxiety. Some years ago a front page to the out-patient notes was devised, and the primary purpose of this was a pragmatic one. It was intended that the essential points of any particular case should be easily ascertainable when a patient was seen for the second or third time. A formulation of the case would have been incorporated in a letter sent to the doctor who had referred the case to hospital, and this front page in effect broke down and analysed the letter. In fact, of course, the analysis came first and the letter was usually composed some hours later. Although this was the primary purpose of the analysis the possibility of future research was in mind, and was encouraged by the fact that the hospital is fortunate in having a records officer complete with a Powers-Samas machine. It was not, however, envisaged that anxiety states in particular would be investigated, and, indeed, the results it presented could have been furnished quite easily in respect of any other syndrome.

These facts are mentioned in so far as it is relatively unusual to present work which has been done without motive, and which has been subsequently computed without any unconscious distortion by the observer, since it was done by a machine. The investigation has revealed one extremely irritating defect in the transcription sheets—namely, that by some strange oversight it does not differentiate between male and female. This will be apparent in what follows in that sex distribution is not available.

Nature of Anxiety

By analogy with the generally accepted definition of depression, an anxiety state may be defined as a clinical condition dominated by an affect resembling fear which is not transitory or slight, and is not secondary to some other condition. By “clinical condition” is meant an illness in the usual sense—namely, that material discomfort is caused by it, or that ability to work and maintain social relationships is materially interfered with. The affect of anxiety resembles fear but differs from it in the following particulars. Firstly, fear is usually related to appreciated danger, and to that extent has the quality of normality. Anxiety, on the other hand, often appears inappropriately and in relation to no particular threat, and to that extent seems to the patient to be pathological. Secondly, fear is more often bodily whereas anxiety is not, and the patient usually shows his appreciation of this fact by saying that in physical matters he is not in the least nervous. Thirdly, fear is for a term and the end of it can be seen, while anxiety may offer no such hope. Lastly, the individual seems to be much more totally involved in anxiety, and the patient does not seem able to survey himself dispassionately as he can in fear.

The other item in the definition which requires brief scrutiny is the primary nature of the condition. Anxiety states are often diagnosed when other conditions are basic

*A shortened version of a Maudsley Bequest Lecture read to the Royal Medico-Psychological Association on November 7, 1955.