REFRESHER COURSE FOR GENERAL PRACTITIONERS

THE ANXIETY STATE

BY

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An anxiety state is nature's way of announcing that life—the common life of mind and body—is disturbed and uneasy. Patient and doctor alike might welcome more precise, more self-evident indications of conflict and discord. The patient may have nothing to show for his illness—how willingly would he change it for a broken leg—and the doctor, having tried everything, may grow impatient. Nevertheless, we have in the anxiety state an authentic illness which creates a vast amount of unhappiness and incompetence.

The medical student seldom receives sufficient instruction about the psychoneurotic patient, and those seen in hospital are often atypical, with inadequate personalities. The physician brushes them aside impatiently or jokes about them. The phrase "Only nerves" suggests that "nerves" is a well-known and at the same time a discreditable complaint, best disregarded, and this is supported by the tags "A flight into illness," "Escapism," etc., which pass from one textbook to another. The student—immature and unaware of the complexities of emotional experience—with no further guidance from his teachers is unable to overcome acquired prejudice. It may be years before he outgrows his cynicism and appreciates the plain fact that reasonable, respected, and successful people are liable to neurosis. Thus he is apt to suspect an obscure physical complaint when he is consulted by a successful business man who complains of giddiness or palpitations. The young doctor learns late that intellectual brilliance and great organizing ability do not give protection against morbid anxiety. Unaware of this, he leads his patient into paths of expensive investigation, useless treatment, and probably into invalidism.

The Attitude of the Doctor

The purpose of this article is to describe the features of the anxiety state and to suggest how it may be handled by the doctor who has no special training in psychiatry, and in particular the lines along which the interview can be conducted.

Each doctor inevitably displays his own attitude of mind towards neurosis and so towards the anxiety state which is the commonest form of neurosis. But the attitude adopted is significant, since it affects the capacity to recognize the complaint. Recognition has two aspects: the knowledge of the characteristics of the condition; and, secondly, an acceptance of the fact that the anxiety state is in itself an illness and entitled to care and attention.

The sick mind, like the sick body, should be helped by considered rather than by casual methods. The doctor in general practice has not the time (and few have the experience) to use formal psychotherapy, but he can acquaint himself with the general conclusions reached by others about the neuroses. Patients should not be referred to a psychiatric clinic or to see a specialist at the first sign of trouble. The majority need never be, provided the practitioner knows how to interview patients with symptoms of neurosis. Technique is of less importance here than in any other branch of medicine. Personal consideration and a friendly approach can make the examination of therapeutic value, for in the relation between patient and doctor lie the essentials of cure or improvement.

Those people who are by nature mentally dull and therefore unable to compete on equal terms in the world are liable to contract the anxiety state. They are much benefited by our support and encouragement and by the simple prescriptions we may provide. Most sufferers with anxiety states, however, are of good intelligence, and they can be given considerable help by the family doctor who recognizes that, though sick, they are reasonable. The understanding of their puzzling illness may well be a first step towards helping them to resume responsibility for their lives. The doctor who stubbornly relies on mere common sense comprehends the anxiety state with difficulty. An unknown factor is ever present in the clinical picture—namely, the unconscious motives and the hidden mental conflict. The patient may be told of this so that he will cease to blame his environment or the shortcomings of his family. Every branch of medicine has its unknown aspects, but medical aid is not therefore withheld.

Features of the Anxiety State

Emotion plays the leading part in every anxiety state and emotion inevitably has its physical counterparts. Accordingly we always get a combination of psychological and somatic elements, although the prominence of one symptom—such as persistent pain—may distort the picture.

The somatic features, usually mentioned first, resemble closely the physical accompaniments of fear: palpitations, flushing, sweating, increased blood pressure and pulse rate, pain, giddiness, tremors, diarrhoea, polyuria. When the anxiety is protracted, headaches, nausea, and other digestive troubles, vaginismus, impotence, and lassitude may be prominent. Blundering jerky movements and restless foot movements may indicate muscular tension due to morbid anxiety. Usually one or two of these symptoms will be to the fore and fluctuations are common. The psychological symptoms include lack of concentration, unreliability of memory, apprehension, and feelings of unreality or of unreality in the external world and, as a consequence, a dread of insanity.

The anxiety may be centred on specific situations. This may become evident when we ask about travelling; whether the patient dislikes going to theatres or crossing the street; whether he has any particular fears, such as a fear of knives, of blood, of poison or diseases—for example, syphilis, cancer. Such morbid fears are usually called phobias. They are often given special labels such as *claustrophobia* and *agoraphobia*, implying wrongly that they have an origin different from other forms of morbid anxiety. The purpose of the phobia is protective, and the situation or eventuality on which it is focused is shunned. If the patient cannot side-step the dreaded situation he is thrown into a panic.

The patient is often in dread of a situation where he is called on to make a direct response. For instance, should he have to drink a cup of tea his hand shakes—a distressing symptom. Again, he is unduly alarmed at being shut in a lift or a railway carriage from which there is no immediate escape. The dread of going out alone, travelling alone, and many similar situations illustrates the subtlety with which an unconscious, unknown problem is projected upon the environment.

The anxiety-ridden patient feels that many of his symptoms are unreasonable and out of proportion to the circumstances. He agrees with his doctor who reassuringly tells him that there is nothing to worry about. But his symptoms are not the result of forethought and are impervious to

logic. Such symptoms, however—palpitations, pain, etc.—alarm the patient, and his demand for medicine seems to him eminently sensible.

Morbid anxiety has a retarding effect on thought and action, and this helps us to distinguish it from normal anxiety—that is, anxiety which spurs us to fitting effort and achievement, as when the student, anxious about his examinations, works harder. Yet morbid anxiety is reasonable, although the reason is hidden, unconscious.

The Interview

The busy practitioner shudders when a patient says, "I'd better start at the beginning, Doctor." He foresees an egotistical and wandering monologue, and so cuts the interview short. The embarrassment and futility of such interviews can be overcome if we make it a rule to examine the minds as well as the bodies of those patients whose symptoms suggest "nerves." A sympathetic relationship, which is at the same time one of detachment, must be established. Without it there can be no appreciation of the patient as a person. The quality and the value of the interview depend on the personality of the doctor, his sincerity, and his capacity for understanding. Having ascertained the reason for the visit and the immediate circumstances—age, marriage, business, general health—a brief chronological survey of the patient's development, noting the personal and family history, school career, and employment record, should be obtained. In a few minutes it is possible to judge how the patient has met the customary demands of life.

We turn next to the present illness and inquire in particular about its onset, duration, course, and response to previous treatment. The emotional climate in which an illness begins is invariably important.

Previous ill-health should be noted and resemblances to the present illness. Special attention should be given to illness of a like kind in a member of the patient's family. His father may have died of cancer; his mother may have had headaches, indigestion, and a "dicky heart." The danger of psychological infection is considerable.

A fear of insanity haunts some patients and they are relieved when the subject is mentioned. They want to know if their illness is "mental." Reassurance should be deferred until the examination is finished, when it can be given with conviction—provided there is no evidence of psychosis. Similarly, the subject of suicide should be raised with the depressed patient, particularly if there is early morning waking and self-depreciation. Such inquiry will not influence the patient towards suicide, nor will he be deflected from it by the (untrue) remark that those who speak of committing suicide do not do so. Nearly all depressed patients have suicidal thoughts; and, in face of the responsibility which the family doctor is called on to bear in the management of a suicidal patient, he is justified if he calls in a specialist.

"How has the illness changed you? Were you a different sort of person previously?" Inquiries of this type are often productive. The doctor's own attitude to the conduct of life will be fully evident by the tone of his questions. If this rings true, the patient will speak freely on any subject.

The physical examination, an essential part of the investigation, is best made when rapport has been established, rather than at the beginning of the interview. The relevance of the state of mind to that of the body becomes evident when seen against the background of personal development and social adaptation.

During the examination the intelligent patient should be given some explanation of his illness: that emotion always affects the functioning of the body and this may become pronounced at times (for example, blushing, tachycardia, polyuria), and that the symptoms are not "diseases" but upset and disturbed normal processes. The patient with palpitations may think he has heart disease. Perhaps he has been told that he has high blood pressure or that his heart, although sound, is not quite healthy. Behind the fear

of going out alone may be the fear of falling down dead. Most laymen believe that life hangs by a thread if there is anything whatever the matter with the heart. The patient with abdominal pain may think he has cancer, but is afraid to ask lest his fear be confirmed. Doctors are often too reticent, too cautious, and even disposed towards a bad prognosis. Optimism is usually more justified than—to the patient—ominous silence. Notice the relief of the patient on hearing: "Your heart is sound, anyhow"; "There is no growth, no sign of cancer." Organic disease may be accompanied by an ill-defined feeling of anxiety arising probably from reduced efficiency, so the physical examination should be thorough. But with the anxious patient it should not be repeated without good reason. Disordered emotions, rather than organic disease, are far more likely to be present, and the danger of treating an anxiety state as an organic illness is considerable.

The number of intellectually dull persons in the community is high, and they often contract anxiety states or other neuroses. Failure to pass routine school examinations and frequent changes of work suggest intellectual and social defect. The doctor will often get a shock if he asks a few simple questions in mental arithmetic or in general knowledge. (A smartly dressed girl of 16 insisted that there were 20 half-crowns in 30 shillings.)

Too much should not be expected from explanation and reassurance. The friendly and genuinely interested doctor increases the patient's self-respect when he listens to him, explains modestly, and gives reassurance only after careful examination. But the anxiety state may well need special treatment, and this should not be withheld in favour of sending the patient for a "complete rest"—a form of management with little to commend it.

Hypnotics and sedatives, as supplementary aids, are valuable. But when given again and again, without any effort at enlightenment, the patient is encouraged to accept "nerves" as a permanent disability. When the patient has some insight into the nature of his illness the sedative is given as a temporary measure to allay tension and not as a "nerve tonic."

Patients may mention the housing shortage and financial and business worries as "getting them down." While these are important, they are usually secondary to the patient's relation to his family and others, which if not central is again and again a crucial matter in the anxiety state. The tireless elder sister, the alcoholic parent, the unhappy marriage, may be linked with the illness although the patient has not observed any association. The doctor should not attempt to sort out family troubles, but his patient will be helped by speaking of them and helped far more than by a tonic and advice not to worry.

An interview conducted on these lines will take perhaps half an hour. But it results in a clear picture of the patient as a whole, and in the long run time will be saved. A patient can get lasting benefit even in one interview, particularly in the early stages of the illness, provided he is given some element of insight into his illness. During the interview the doctor should bear in mind the importance of an affirmative diagnosis in the anxiety state—that is, a diagnosis which rests upon the presence of morbid anxiety. A diagnosis of "functional" or "nerves" reached by the exclusion of organic disease is of little value, as it gives no information about the nature of the illness or the person who is ill.

Relatives quite reasonably ask about their demeanour to the patient: should he be "made to do things" or "given in to"? The cue here—and the same holds for every medical interview—is that the patient should be accepted as being ill and thus entitled to help and encouragement. The patient will lose courage if bombarded by good advice and allusions to will-power.

Psychiatric illness is seldom clear-cut, and so the interview is designed on general lines and is suitable for a wide range of patients. It is well to cast the net wide, for apparent irrelevancies often turn out to be important.