which is given in the form of fluids. This method is of little use in the case of the chronic anxiety state, the patient usually returning to his previous broodings on his health when sedation is stopped.

Conclusion

When the above methods have failed, one is tempted to consider the problem of leucotomy for the sufferer from chronic anxiety. The place of this treatment in the case of the neurotic is still a matter of argument. Although spectacular successes have been reported (Sargant and Stewart, 1947), the result must always be unpredictable. While anxiety is usually relieved and intelligence is rarely impaired, the effects of treatment cannot be undone. The result of the operation might be a bigger social problem than the original illness.

There is a very strong case for a small psychiatric unit in all general hospitals, to provide the above out-patient and in-patient treatments, without the "stigma" of visiting a mental hospital, which deters so many sufferers from seeking help.

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THE NEURASTHENIC PSYCHOPATH

BY

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Full social participation is now commonly regarded not only as a sign of health but as an essential for its achievement. Interest is therefore aroused by those who do not participate in the activity, basic to our society, of work. The findings of a survey and follow-up of a group of psychiatrically disabled men, both employed and unemployed, have previously been reported (Markowe *et al.*, 1955). In the course of the investigation some of the subjects with long-term unemployment asked for psychiatric help, and 28 of these attended a special clinic for twelve months. The present paper offers a discussion of the clinical patterns of these patients.

Clinical Report

In every diagnostic clinic it is often difficult to draw a formal distinction between the illness and the personality from which it springs. The syndromes presented by these patients can be seen in any psychiatric clinic; in the earlier report also it was noted that employed and unemployed subjects had similar symptoms. Twenty patients complained of neurotic symptoms, of which excessive tiredness, back-

ache and headache, hypochondriasis, and a varying mood of anxiousness or mild depression were predominant. Plainly hysterical symptoms and signs were observed in only three patients, but physical symptoms of anxiety were found rather more often. Three patients had major epileptic fits, three were defective, two suffered from involutional depression complicated by organic disease, one developed a mixed depressive psychosis, one was a chronic schizophrenic, and one developed a reactive paranoid state.

These summary diagnostic labels fail to explain the interest provoked by these patients, for they provided a clinical experience of disorders and anomalies of personality not easily gained in out-patient departments, and they afforded a more precise description of the term "inadequate psychopath." The following case history is illustrative.

A man aged 39 when first seen had had neurotic symptoms in his childhood, but did not admit to a family history of psychiatric illness. He served as a regular soldier before the war, but was invalided in 1941. He had several unskilled jobs on leaving the Army, but for the past four or five years had been almost consistently out of work, holding one job for about a month every year or so. He married in 1939 and had one son, but his wife refused to leave her mother to live with him. He was contemplating divorce proceedings when his wife sued him for desertion. He denied any other sexual activity. He lived on his own in lodgings, cooking his own meals, and had no friends. His weekly income from all sources was 69s., of which he paid 25s. for his room and 10s. maintenance for his son. He complained of attacks of anxiety, palpitations, depressions, and dizzy spells since his marriage. He was apathetic and resigned in mood. There were no physical abnormalities. In spite of his poverty he could not get work, although opportunities for employment were excellent in that area. He attempted to get in touch again with his parents: an aunt told him they had removed, but apparently he could not discover their new address.

The ineffectiveness these patients displayed in all aspects of life was also apparent on interview. They waited upon the words of their interlocutor, and rarely ventured to put forward what they wanted in life or what they would like to do. Although some might fairly be described as retarded in speech, they varied in their verbal facility; but when the interview touched on topics which, it might be supposed, would awaken their self-interest, their talk became vague. Their complaints and dissatisfactions, their present difficulties or previous happiness, their hopes and fears for the future, whatever was in question, would arouse no definite affect or point of view which could be seized upon and discussed. A striking feature was their tolerance of the worst conditions and their seeming inability not only to obtain satisfactions but even to desire them. In the case just cited the patient had given up his family and son and had no friends; with the money at his disposal he lived virtually in penury, and must at times have gone hungry. His symptoms were by no means severe, yet he was unable to earn even that little money which he would have found so helpful. With all these troubles he was only vaguely distressed. The lack of a serious disturbance of mood and the long-standing nature of his condition made it unlikely that he was suffering from a chronic depression. None of the basic signs of schizophrenia were present, nor was he cold and unfeeling; on the contrary, he maintained quite a strong affective rapport with the doctor in a dependent and pathetic way.

This lack of drive was well shown by another patient who later developed a reactive paranoid state. He managed to hold a job for a few weeks, and when asked on what he spent his money he replied that he was "putting it by." On being pressed further, he said it was to buy clothes. He neither smoked, drank, nor went to any entertainments, and had no friends of either sex. On giving up his job he forfeited the help of the National Assistance Board and went to live with an uncle, who kept him in the bare essentials of life only.

Apart from defectives, who might be expected to show some degree of inadequacy, this type of personality anomaly was observed in 18 of the remaining 25 patients in varying degrees of severity.

Other types of psychopathy were also observed. Two patients could be classed as contentious and emotionally unstable. One, a qualified laboratory technician, became aggressive and abusive whenever attempts were made to find work for him. He complained that the clinic misrepresented him to prospective employers and prevented their engaging him. He claimed to have many influential friends, but nevertheless he was living in the poorest circumstances. He alleged that a high-level inquiry had been made by the Ministry of Labour into the handling of his employment problems, which had disclosed "inefficiency and muddle all around." The other patient, no less aggressive and paranoid, attempted to borrow £50 at the first interview. At times he showed a hypomanic pressure of talk. While these patients resembled the inadequate personalities in their poor work record and history of failure, yet they were by no means ineffectual in the part they had chosen of acting out a pathological sense of grievance against official bodies.

Another patient, neither inadequate nor querulous, was yet emotionally immature, while the patients with involuntary illnesses and schizophrenia had the personalities characteristic of those conditions.

Treatment and Outcome

It is hardly surprising that in face of such difficulties these patients failed to improve their adaptation as judged by their work record during the time they attended the clinic (Markowe *et al.*, 1955). The progress of some individual cases is, however, worth discussing.

One patient with an involutional depression complicated by pernicious anaemia was admitted to hospital. Adequate treatment of the anaemia and rest in hospital, without further physical treatment, restored a normal mental state, and this patient is now working. Supportive psychotherapy, while available to all patients, was in particular successful in the case of the patient who was emotionally immature. He had found work for himself, but was crippled by heavy debts. With the encouragement of the clinic he succeeded in satisfying a court order and made good progress in straightening out his affairs. A patient who had reached retiring age was settled happily in an old people's home, and a place was found for one of the defectives in an occupation centre. Although this could not be counted as rehabilitation, it represented a much more satisfactory disposal than their previous way of life.

When patients were successfully placed in jobs, this was almost always done by the local disablement resettlement officers, but there were some problems which could not be solved through the good offices of the employment exchanges. One patient, an undischarged bankrupt, was by temperament more fitted to work on his own account. He had trained himself as a french-polisher, and by borrowing money from various sources it was found possible to set him up in business again.

For many patients, however, with the gross deficits of personality already described, treatment was unrewarding. Attempts to place them in suitable employment failed, as their ineffectiveness could not long be hidden from their employers. Vacancies in Remploy were too scarce to be of practical value, but one patient was accepted by an industrial rehabilitation unit. Physical treatments were inappropriate and supportive psychotherapy was without effect. In three instances, where patients presented particularly difficult problems of adjustment, arrangements were made for their admission to the Social Rehabilitation Unit at Belmont Hospital under the care of Dr. Maxwell Jones, in the hope that vigorous social therapy would be more effective than out-patient treatment. The remainder, on the other hand, provided ample opportunities for welfare work. Those without friends were encouraged to join a social club for out-patients. In spite of National Assistance, there were some who lacked clothing and other necessities, and these patients were grateful for being put in touch with charitable organizations which could relieve their needs.

At the end of twelve months four patients had either recovered or were much improved and were back at work. Four others showed symptomatic improvement. In three cases the improvement in health preceded the return to work, in four it followed a return to work or the taking up of an occupation. Relief of financial anxiety, the feeling of again being useful, and occupation in itself were reasons given by these patients for their later improvement. One patient received symptomatic relief from sedatives without any improvement in his work record.

Two patients deteriorated while attending the clinic. One, having developed a mixed depressive psychosis with marked hysterical features soon after his first attendance, was admitted to a mental hospital. The other was an extremely inadequate man who was advised to attend out-patient occupational therapy. After some weeks his behaviour at the occupational therapy centre became disturbed, and he felt that the staff were against him. Later he believed he heard the voice of a neighbour talking about him: she knew all the details of his life and was in touch with the occupational therapy centre. He ceased attending the centre and resumed his solitary existence with his uncle. His delusions still remain, but he does not act upon them, and remains an isolated and eccentric figure.

Comment

In spite of the serious unemployment two decades ago, there are surprisingly few clinical reports of the psychiatric disturbances of the unemployed. Lewis (1935) reported on 52 such patients and found a uniform clinical picture in which hysteria was predominant. In the present series the predominant symptomatology may fairly be described as "neurasthenia." This change in the form of neurotic illness is now a commonplace observation; Mayer-Gross *et al.* (1954) attribute it in part to changing fashions in diagnosis, but Lewis noted gross hysterical phenomena in 23 of his 52 patients, which is to be compared with only 3 out of 28 patients in the present follow-up study. It is possible that the increasing sophistication and self-respect which has accompanied a rising standing of living tends to inhibit the cruder forms of hysterical response: it is of interest that Kalinowski (1950), in his review of psychiatry in the last war, comments that gross hysterical conditions, so common in the first world war, were reported as frequent only in the Yugoslav partisans.

Although the symptoms were plainly neurotic, the gross anomalies of personality suggested the possibility of more serious psychotic disorders, in particular mild chronic endogenous depression or simple schizophrenia. In almost all cases this could be discounted. Except for the one case of declared schizophrenia, thought disorder was entirely lacking and good rapport was obtained. Secondary symptoms were absent, except for the patient who developed paranoid delusions, but this could more accurately be described as a reactive paranoid state, the basic signs of schizophrenia being lacking. Similarly, the cardinal features of depressive psychosis were absent in all except the patient admitted to a mental hospital; one other patient who had lost weight and was slightly retarded was also suspected of suffering from a mild depression. Signs of an organic dementia were not found in any patient. In almost all cases, therefore, a supporting diagnosis of constitutional personality disorder had to be made.

The term "inadequate personality" has come to be widely used, and is now included in the *International Classification of Diseases*. Published descriptions of this condition are not, however, entirely applicable to the cases here described. Henderson (1939) notes that such patients "may show a condition approaching apathy, but it is not so much an apathy as a self-centredness which takes no thought of others, and has for its aim the individual's self-gratification and glorification." Mayer-Gross *et al.* (1954) describe the "unstable drifter" (*Haltlosigkeit*) in similar terms: "His immediate wishes, affections, or disgruntlements rule him completely, and he is indifferent about the future and never

considers the past." These are descriptions of the typical psychopath, unable to steer a steady course, seduced by each passing temptation, and certainly apply to two patients in the present series. No doubt this type of behaviour also occurs in the remaining patients to some extent, but the heart of the matter lies elsewhere. Their characteristic and common feature is lack of drive; the pattern of repeated failure is to be seen as due, not to lack of control, but to a profound enfeeblement.

Janet's (1903) words are more apt: "Presque toutes ces personnes présentent quelquefois depuis leur première enfance un caractère bien reconnaissable: ce sont des mous, des indolents, des paresseux." Janet distinguished his concept of psychasthenia, with obsession and rumination, from neurasthenia: "Certains malades sont très abouliques, ne peuvent plus faire attention et présentent de l'amnésie continue... chez ceux-là les troubles de l'obsession sont peu à redouter." He writes of mental sickness in a context where the term personality disorder is now preferred, but the point to be made is that the ineffectiveness of the patients here described is closer to the older concept of neurasthenia than to that of psychopathy, as now generally understood. Schneider, too, included asthenia in his list of psychopathies.

It is hardly surprising that this type of personality disorder has not caught the attention of writers to the same extent as the more troublesome unstable psychopath: it is of their nature to pass unnoticed. When, however, there is a strong social pressure to work, as in the present period of full employment or in times of war, their disability becomes apparent. The clinical impression of these patients upon me could be compared only with my experience of Army psychiatry, and in both instances patients were often referred for administrative reasons. In discussing the effort syndrome Lewis and Jones (1941) pointed out that symptoms were of little consequence in a man's decision to soldier on; more important was his attitude to military service. This is patently the same problem of adjustment as is presented by the present unemployed.

If, as I am inclined to believe, it is this type of personality disorder which forms the core of the disabled unemployed and not the "unstable drifter," the question of treatment remains. In the Army, group techniques tended to be developed (Foulkes, 1948; Maxwell Jones, 1952), which have since been continued by the Social Rehabilitation Unit at Belmont Hospital. Promising results are claimed—44% satisfactory adjustment on follow-up (Maxwell Jones, 1952)—in patients for whom the criterion for admission was social failure; but it is uncertain whether this outcome applies equally to the type of patient here discussed. By the showing of the present clinic, out-patient attendance alone is not sufficient to improve their level of adjustment. Rehabilitation may even be ill-advised for some patients at particular stages of their illness. Attempts to break down the defensive social isolation were found intolerable by the patient quoted above, who developed a reactive paranoid state when he was exposed to the stimulation of an occupational therapy centre.

The discussion of the differential diagnosis should perhaps have included the lay interpretation of laziness, as a description not of behaviour (as with Janet) but of motive. Nothing could be farther from the truth. The economic sanction of withdrawal of National Assistance benefit did not change the adjustment of the patient concerned, and, even if by these harsh means some were induced to re-enter employment, there is some evidence that they do not become productive workers (Markowe *et al.*, 1955).

When such conditions occur in wealthy men they are regarded as amusing eccentrics, like Goncharov's Oblomov; in poorer men, however, our society takes a sterner view. The possibility remains that, like Oblomov, these unhappy people can be neither treated nor coerced into becoming more productive citizens, but remain a charge on the kindly employer or the welfare services, even requiring the more

able to search them out, for they are as ineffectual in seeking help as in all other things.

Summary

Attention is drawn to a type of personality disorder which was observed in patients attending a clinic for unemployed psychiatrically disabled men. This disorder is characterized by absence of drive and irresolution rather than by emotional instability as in other forms of psychopathy.

The response to out-patient treatment both in occupational adjustment and in mental health was unrewarding.

It is considered that, although these patients may not often be suitable for rehabilitation, they are almost always in great need of social welfare services.

I wish to thank Professor A. J. Lewis, honorary director of the unit, for his advice and stimulating criticisms, and Dr. M. Markowe and Dr. G. M. Carstairs for making available to me observations on patients under their care.

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THE FOOT AS A HALF-DOME

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Although the foot is usually described as having medial and lateral longitudinal arches and a transverse arch, a few writers—for example, Ellis (1889) and Wood Jones (1949)—have compared the foot to a half-dome, the weight being transmitted from the talus to the periphery of the foot, which forms more or less a half-circle as seen in the footprint.

There are three sound reasons why this latter method of regarding the foot should be more widely taught.

(1) The trabeculae within the bones indicate the direction of weight transmission, and in radiographs of the individual bones of the tarsus the fan-like arrangement of the trabeculae in the navicular and their downwards and lateral direction in the cuboid are particularly noticeable. Sections through the bones show the pattern even better; in a longitudinal section through the calcaneum the trabeculae radiate forwards, backwards, and downwards, while in a cross-section of the calcaneum through the sustentaculum tali they splay downwards and laterally. If these trabeculae are projected on to the surface of the bones and the bones then articulated (Fig. 1), a picture is formed of a series of "half-arches" or "quarter-meridians" radiating from the talus to all the peripheral weight-bearing part of the foot (Fig. 2). Naturally there are still longitudinal and transverse arches, depending on how the foot is sectioned, but these arches are of no significance in the function of the foot unless the sections coincide with bony trabeculae.

(2) Most students have obviously, and unfortunately, obtained the ridiculous impression that a person uses only the longitudinal arches when walking, whereas between coming down on the heel and pushing off with the toes a