Comment

The satisfactory progress of all but one of these severely and sometimes desperately ill patients, and their return to good health and to full work, seem to indicate that the method of treatment described is a satisfactory one. The follow-up is admittedly a short one and the series is not large. Nevertheless in no case has the disease flared up in the remaining rectum, and regular proctoscopic examination has shown that resolution of the inflammatory changes existing before the operation has taken place.

Addendum.—Since this article was compiled six other cases have been operated upon. Of these, two have returned to good health and three are convalescing. The sixth patient died during the fourth post-operative week following a burst abdomen. Of the patients reported on in the table, Nos. 11, 13, and 17 now have only one to two bowel actions at night.

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ANXIETY NEUROSIS: TREATMENT BY THE GENERAL PRACTITIONER*

BY

RONALD A. B. RORIE, M.D., D.P.M.

Foundation Member of the College of General Practitioners; Assistant Psychiatrist, Eastern Regional Hospital Board (Scotland)

Between the world wars attention was drawn to the fact that a large proportion of chronic sickness was due to the neuroses. Gillespie (1933), while on the subject of psychotherapy in general practice, mentions the fact that, of 600 cases referred to a special clinic, 436 were diagnosed as neuroses. Halliday (1935) found that psychoneuroses accounted for as much as 30% of the sickness of insured persons in Glasgow, and there is no reason to think that this proportion has since diminished. These figures are borne out by the report of the British Medical Association (1941).

The family doctor, while he has unique opportunities for studying the factors that bear on a case, through lack of training has not the knowledge, and too often not the inclination, to attempt to deal with the obviously neurotic patient. At out-patient clinics one often hears the story that "my doctor says it is just nerves, and gives me phenobarbitone."

The palpitations, choking sensations, and innumerable phobias of the anxiety neurotic are all too real to the sufferer, and can incapacitate him totally for work. The man cannot face the bus journey to work, and, once there, has to leave the crowded workshop because of intense feelings of apprehension. The woman is unable to leave home to shop unaccompanied, and cannot attend church or go to the cinema. In face of the exhortations of the family and friends to "pull themselves together," these patients rapidly lose heart; fears of insanity follow, with suicidal impulses which may have fatal consequences.

During the last decade the general practitioner has become aware that a large part of his time is taken up by patients suffering from psychoneuroses. The coming of the National Health Service Act, leading as it has to

a reduction in the time available per patient, has tended to make it difficult for the practitioner to do more than pass the case on to the specialist, with the result that only a small minority, and only the most patent cases, get treatment at all. The majority, of lesser degree, struggle along unhappily, treated by sedative. A recent analysis of prescriptions issued by practitioners under the National Health Service Act shows that the commonest by far is for sedative (Dunlop *et al.*, 1952).

Before the second world war the neurotic could expect to be treated in one of two ways. By the older school, in whom there persisted a moral disapproval of anyone suffering from a neurosis, he would be dismissed as lacking in moral fibre or as malingering. By the inter-war generations, who, while admitting the existence of an illness in such cases, could do little through lack of training, he would be given sedatives and allowed to drift.

I qualified in 1938 and do not remember ever being shown an anxiety neurosis as such during my training in mental diseases. From contact with colleagues during the war, I found that this did not simply reflect on my medical school as compared with others.

The tendency persists to diagnose neurosis in a negative manner, by exclusion of organic disorder, rather than in a positive recognition of the various neurotic syndromes. This leads to much waste of time and effort on the part of other specialists. It is as though one was afraid to admit that the complaint was functional. In practice even to-day, if a diagnosis of neurosis is made, it is necessary to explain that it implies no derogation or criticism of the patient. Even so, many patients feel insulted by such a diagnosis.

In spite of the community's increasing interest in mental illness, as shown by Press, popular fiction, theatre, and cinema, there still persists the Victorian disapproval of a subject which lays such emphasis on the emotional aspect of man's life. It is partly this disapproval which discourages general practitioners from facing and attempting to treat the vast number of minor neuroses they meet every day.

In this paper an attempt is made to describe the treatment of the commonest of the neuroses—the anxiety neurosis—from the general practitioner's point of view.

The Physician's Reaction

It is obvious that if the general practitioner refuses, consciously or otherwise, to face and treat the neurotic, and depends on the specialist, the vast majority of cases will go untreated.

When he is confronted with the anxiety neurotic, what is the physician's reaction? The complaints are indefinite but insistent; a physical examination is negative; a placebo, usually in the form of phenobarbitone, is prescribed, the only psychotherapy being a word of encouragement. If a diagnosis is requested, too often a hint of an organic condition is given—"a nervous stomach," "a tired heart," "overwork," etc. The patient is unrelieved, and on persistence is referred to one specialty after another, with negative findings. The psychiatrist is often the last consultant called in.

Two factors contribute to this maltreatment of the neurotic. The first is lack of time for proper history-taking and evaluation of the symptoms. Ross (1937), discussing the treatment of such cases, states that at least an hour should be set aside for the initial examination. It is a reflection on the conditions of service under the National Health Service Act that few general practitioners could find this easy to-day. The second factor is the blind spot

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that so many practitioners retain for neurotic symptoms. One hears of the busy family doctor who proudly states that he never sees a neurosis.

Choice of Case

Before attempting treatment of an established anxiety neurosis it is necessary to decide whether the case is one that can be dealt with by the general practitioner or one for immediate referral to the specialist. Several factors bear on this decision.

The age of the patient is one such factor. With increasing age the personality becomes more rigid, and is less open to suggestion and persuasion than in the younger years. Rarely is a neurosis of recent onset encountered at this time, and the symptoms are usually complicated by involutional changes.

A certain degree of intelligence is necessary in the patient for any psychotherapy beyond suggestion and persuasion. As one proceeds to explanation of symptoms and discussion of possible causation a higher intelligence is required, and if anything of a psycho-analytical nature is attempted a higher than average intellect is essential. In an average working-class practice few patients are encountered who could benefit from such advanced treatment.

The nature of the illness itself may decide whether it should be handled by the general practitioner or by the specialist. The illnesses of long duration call for expert handling if more than temporary relief is aimed at. Patients with an apparently stable previous personality may be handled by the non-specialist, while personalities showing any marked degree of deviation from the normal should be avoided.

Probable aetiological factors should be considered before deciding to treat an anxiety neurotic. Deep-seated constitutional abnormalities such as homosexuality, if they are the basis of anxiety reactions, should be referred for specialist treatment. The general practitioner can handle with ease the anxieties resulting from sexual malpractice, domestic stress of all kinds, and marital difficulties. The illnesses resulting from war stress are probably within the specialist's sphere, as they are now of more than five years' duration, and the majority have received some form of treatment in the past and are likely to prove chronic.

A further point to be decided in the treatment of the neurotic is the ultimate aim of the treatment. This has been described as "to cure sometimes, relieve often, and comfort always." Some personalities have been anxious for a lifetime, and it is over-optimistic to promise them more than relief. The obsessional personality cannot be changed to a happy carefree nature. Similarly with the constitutional deviations, relief of the disabling anxiety symptoms should be the aim; whether or not the invert can be re-adjusted to a normal pattern of sexual behaviour is debatable; some authorities are optimistic (Allen, 1940), but Curran (1938, 1947) is of the opinion that few are desirous of cure. The latter states that the aim of treatment should be to make the congenital homosexual a better-adjusted homosexual.

Prophylaxis

The treatment of the anxiety neuroses is both prophylactic and curative, and the general practitioner's role is important in both. In aetiology, the main factors are found to be emotional stress of various kinds in the sexual, social, domestic, and other spheres, and also the stress of war service. While the stresses themselves can rarely be modified or avoided, with the exception of the last, which can be avoided by psychiatric examination on enlistment, the personal reaction to them can be modified by education and instruction.

Any general practitioner of experience knows the immense amount of ignorance that exists among patients of all classes, not only of sexual matters but of all matters affecting their general health. The effects of this ignorance are often aggravated by false enlightenment from parents, Press,

and well-meaning religious instructors. This is often the starting-point of needless anxiety and doubts about health. The family physician has unique opportunities of preventing this ignorance. In childhood he can modify the over-emphasis on health impressed by anxiety-ridden parents. He should do his utmost to prevent the unnecessary branding of a child as "delicate." Many a child is forbidden to take part in games and recreation because of some doubtful illness in earlier years. As time passes it becomes more and more difficult to remove this belief that he is not as strong as his playmates.

Careless talk by the practitioner in front of the young patient is very easy. It should be remembered that many an intelligent child in the early 'teens has just as much interest in its illness as the parents have, and is quick to pick up vague suggestions of "a scarred heart valve" or "a spot on the lung." Reassurance should be given in a simple manner by the doctor and not be left to the anxious parent. The handling of proved organic disorders requires fine judgment of the restrictions necessary: Menninger (1945) describes the way in which overemphasis on rest can lay the foundations of neurotic reaction, and states: "The treatment by rest originated with Weir Mitchell, but, according to modern psychiatry, is entirely false in theory and unsound in practice. It aggravates fears of disease and does not cure neuroses."

In adolescence and early adult life every opportunity should be taken to dispel ignorance and resulting worry about normal sexual manifestations such as masturbation and nocturnal emissions in males and menstruation in females. One still encounters surprising superstitions on these subjects, passed on from parent to child.

Similarly when it comes to marriage, the young couple, even of the educated classes, embark on this phase of life in a discouraging state of ignorance. Few ask spontaneously for advice, and the family physician could prevent an immense amount of unhappiness and anxiety by asking the engaged couple what they know, and correcting any misapprehensions. Marriage guidance clinics are still very few, and until these are developed the role of adviser must fall on the general practitioner.

In a discussion of the treatment of the neuroses in general practice, Guirldham (1947) points out the common errors of approach, the danger of excessive physical investigation, and states his belief that "80% of married couples below the level of the petit bourgeoisie use coitus interruptus as a means of contraception." He states that "there is more to be gained in correcting patients' views on these matters than there is in studies of Freudian symbolism." From experience, in general practice I am in complete agreement with both these statements.

In practice it is very easy to follow inquiries about the family with a question on what the couple are doing to prevent further additions. When these matters are brought up patients are usually very willing to discuss them, but hesitate to do so spontaneously. As Culpin (1935), however, points out, some doctors are temperamentally unable to talk about details of sex life, and simply turn a blind eye to it.

Mace (1947) discusses the problem of marriage guidance, emphasizing the importance of the general practitioner in the treatment of sexual disorders and his lack of training in such matters.

In these fields the general practitioner has great scope for the prevention of anxiety reactions. Little can be done to prevent interpersonality tension, which is the result of modern social conditions, but he can do much to prevent its development into an established anxiety neurosis.

Treatment

Psychotherapy alone can produce lasting benefit in an established neurosis. In the first place this need be only of a superficial nature, and is quite within the scope of the general practitioner. The best approach is a simple

explanation of the bodily symptoms. The familiar elements of the emotion of fear should be pointed out, with its dryness of the mouth, palpitations, nausea, tremors, weakness of the knees, headache, etc. The effects of over-attention to bodily functions should be illustrated by the difficulties in swallowing pills consciously, and breathing consciously, as compared with the ease with which these functions are carried out when the attention is diverted. The reality of emotional "lumps in the throat," "heartaches," "headaches," "butterflies in the stomach," etc., should be pointed out.

When this is accepted the next step is to explain how this emotional dysfunction has come about. Occasionally a patient will volunteer immediately where the emotional stress lies, but it is perhaps easier to give instances of the common factors in interpersonality stresses within the family, sexual stresses in adolescence, courtship, marriage, etc. Stress of work is often proffered as a cause, but it is usually found that the stress lies not in work itself but in emotional relationship between the sufferer and his fellow workers. One does not work with one's emotions.

Admission of such factors need not be insisted on, but if the patient is allowed to go home and think things over he often returns and admits them spontaneously. I used this type of discussion on one patient, but failed to get any response. Finally homosexuality was mentioned—one naturally does not begin with this suggestion—and, although strongly denied at the time, the patient returned several weeks later to admit that this was the prime cause of his anxiety.

As psychotherapy proceeds the technique varies according to the individual case. The lower intelligence group require more persuasion and suggestion to help them regain their confidence. The higher intelligence group may be allowed to talk themselves out of their troubles: any subject with a strong emotional tone should be encouraged, and the patient should be urged to face the reality of his feelings towards his environment.

Every patient wants reassurance that his symptoms are not those of insanity. Many are afraid to ask this question. The differentiation must be quite clear and definite. Confirmation that efforts of will alone are ineffectual in cure is essential. It is often necessary also to point out that in neurotic illness there is nothing to justify shame. Many sufferers are pathetically relieved to find someone who does not describe his complaints as imaginary.

After such simple discussion and reassurance many patients admit spontaneously that they feel better for days afterwards.

In the general handling of the anxiety neurosis the environmental stresses must not be neglected. These may be modified to some degree. The relatives of the patient must be interviewed and instructed concerning their correct attitude to the sufferer. It should be explained to them that the symptoms are real, and that well-meaning advice on their part may only serve to increase the patient's tension. Holidays are often suggested, but these help only if they lead to a removal of aggravating factors. A claustrophobic will feel better after a holiday in the country, but his symptoms will reappear when he returns to his previous environment. When anxiety symptoms are the result of an unsatisfactory sexual relationship, intramarital or extramarital, there will be temporary improvement during separation. In unsatisfactory marriage relationships, either physical or temperamental, both parties must be interviewed and the difficulties discussed.

While the somatic symptoms of anxiety can be expected to abate with such reassurance and discussion, the mental symptoms need special attention. The degree of depression requires careful assessment, as in any depression there is always some risk of suicide. The practitioner need not fear asking the patient if any such ideas are present. They are commonly admitted. What is the best course here? It should be realized that the only effective safeguard against such attempts is certification, but very few neurotics are

certifiable. The relatives should be informed that a certain risk is present, even though small; they would be advised to maintain a certain supervision over the patient, and so far as possible he should not be left for long periods alone. This usually leads to difficulties in the working-class home, as it is not easy to find a relative who can spare the time to supervise the invalid. When sedatives are prescribed they should not be given in excessive quantities. It must be remembered, of course, that any patient can hoard small quantities. In cases of doubt sedatives should be given only to relatives who can be responsible for their administration.

An attempt at suicide, however half-hearted, should be an indication for admission to hospital. Many of these potential suicides would be willing to enter a general hospital, but such hospitals are loath to accept mental cases, and the suggestion of admission to a mental hospital, though theoretically correct, leads to a grave exacerbation of anxiety. Suitable neurosis centres with in-patient facilities are still few and far between. Unfortunately on recovery the uncertifiable patient is returned home and if the neurosis is untreated the danger of further attempts remains.

Of the other mental symptoms the handling of the phobia presents some difficulty. The patient realizes that his fears are unjustified and fights continually against them. This fight should not be encouraged. The fears will diminish gradually with psychotherapy, and until they do the best course is to advise the patient to avoid, so far as possible, circumstances that induce them. As discussed below, sedatives can be used during this stage. Sometimes during treatment the phobia becomes attached to some comparatively non-disabling object, which can be avoided with ease.

Medical Treatment

There is no doubt that the temptation to dispose of a neurosis by prescribing sedatives is great, but in reality they play a very small part in treatment from a curative point of view.

Insomnia must be treated initially by hypnotics. Of these, phenobarbitone, though by far the most popular amongst general practitioners, is not the most useful. Neurotic insomnia usually takes the form of difficulty in falling asleep, and phenobarbitone is a slowly acting sedative. Barbitone sodium in doses of 5–10 gr. (325–650 mg.) is more useful; butobarbitone and cyclobarbitone are also useful quick-acting hypnotics. Phenobarbitone has its place in easing general tension by day in doses of $\frac{1}{2}$ –2 gr. (32–130 mg.).

In the treatment of anxiety symptoms amylobarbitone sodium deserves special mention. In general practice it can be given by mouth both in diagnosis and as treatment. The use of small doses of amylobarbitone sodium in diagnosis is worthy of note: 1 gr. (65 mg.) is not enough to relieve anything but emotional stress. It is the most efficacious drug for relieving anxiety, both generalized and phobic. The patient can go to church or the cinema, or undertake journeys that would otherwise be impossible or extremely uncomfortable. The student can attend classes in comparative ease.

Sedatives play an essential part in the treatment of panic states. Here the patient is quite inaccessible to psychotherapy, and the only course open is prolonged sedation with amylobarbitone sodium, intramuscularly or intravenously, combined if necessary with paraldehyde. Sargent and Slater (1944) describe the various uses of these drugs in detail.

Relaxation

In all cases both mental and physical tension may be greatly relieved by instruction in methods of relaxation. A suitable form of relaxation exercise is one devised by Dick Read (1943). Many of the more intelligent patients benefit from this: muscular tension is reduced and a calm

state of mind induced which often leads to sleep. A summary of instructions to be given to the patient is reproduced below. That this falls within the general practitioner's realm is emphasized by the fact that these exercises are taken from a work on the management of pregnancy, being used to reduce muscular and mental tension in childbirth.

Position.—The patient should lie on the back on a wide couch or fairly hard bed with a small bolster under the head and shoulders, and a smaller pillow or cushion under the knees; arms by the side, elbows half bent, hands half closed, knees slightly separated—that is, all joints so far as possible in semiflexion. Relaxation is obtained as follows: (1) shoulders, by thinking of them "opening outwards"; (2) arms, by imagining them falling out of the shoulder-girdle "as though they did not belong to you"; (3) back—sinking through couch on to the floor; (4) legs, knees, and feet—falling outwards by their own weight; (5) head—making a dent in the pillow; (6) eyelids—half closing by their own weight; (7) face—as though hanging from the cheek-bones; (8) jaw—hanging loose. Give about two minutes to each group, and take them in the same order each time.

Breathing.—Let the chest wall collapse with its own weight on expiration, and pause for two seconds (or until the need for a new breath) at the end of expiration. Get a feeling of general relaxation, letting all the joints give a little more with each outgoing breath. This should be done six times. Note the train of sensation in the limbs—usually heaviness followed by lightness or "floating"; faint, transient pins-and-needles in the hands; feeling of warmth passing up from the extremities. A pleasant, torpid, day-dreaming state generally ensues (as in sunbathing), and any tendency to direct thinking should be deliberately diverted into a day-dream.

Duration.—Half to one hour (the sense of the passage of time is often lost or blunted).

Exercises for the Neurasthenic

Exercises of a different nature are to be recommended for the "neurasthenic" type of anxiety neurosis. Many of these patients believe themselves so incapacitated that they take to bed. Graduated physical exercise is required in such cases. It should be clearly explained to the patient that he must not expect to leave bed and feel absolutely fit. Hill and Dewar (1945), in a survey of effort syndrome, mention that graduated exercise is easily arranged in the armed Services, but in civilian practice such procedures are not possible. However, it is sufficient to get the patient to take gradually increasing daily walks, starting with a few hundred yards, and increasing slowly until he finds himself walking several miles without any discomfort.

It is customary to advise special diets and other measures to improve the general health in all neuroses. In domiciliary practice under present-day conditions this is extremely difficult, but it is important to keep in mind the possibility of avitaminosis. In case of doubt it is advisable to administer vitamins, especially those of the B complex, as psychotherapy proceeds.

It might be objected that the practitioner to-day does not have time to carry out the above treatment. Watts and Watts (1952) give a very good reply to this, showing that the time involved is no more than that necessary for the conduction of midwifery practice. As a result of experience in general practice and in out-patient psychotherapeutic clinics I find that, in suitable cases, six interviews of half an hour each suffice to relieve the sufferer of disabling symptoms.

Hospital Treatment

The treatment so far described is that within the scope of the general practitioner. What symptoms raise the question of admission to hospital?

In the first place, depression of suicidal degree makes it necessary for this to be considered. If home supervision is adequate it is possible to treat the case there, but in the average middle- and working-class home it is difficult to find a responsible relative who can spare the time for constant watch on the patient. The depressed anxiety neurotic living alone can cause more concern to the practitioner than

the flagrant psychotic. The latter can be certified with little difficulty, whereas it is often impossible in the case of the former.

A second group that often require admission to hospital are the cases of extreme agitation. The patient is restless, tearful, and wears out herself, her relatives, and her medical adviser with her demands.

Thirdly, admission to hospital may be necessary in the treatment of the anxiety neurosis with symptoms of anorexia, with or without vomiting. Such symptoms can eventually endanger the life of even a young and physically healthy girl.

Lastly, the phobias can restrict the patient's activities to such an extent that he is unable to undertake out-patient treatment even if he were willing. Cases can be recalled in which the sufferer was completely confined to his house by panics which overwhelmed him at every endeavour to leave.

In all these cases the choice lies between admission to a psychiatric unit of a general hospital or to a mental hospital. In either case admission should be on a voluntary basis; but it rarely happens, in cases which cannot be supervised at home, that the sufferer can endanger his or her life and, being uncooperative, make certification unavoidable.

Out-patient psychiatric clinics have been developing rapidly during the past five years, commonly associated with a general hospital. These help in the diagnosis and treatment of early psychiatric illness. In chronic deep-seated anxiety neuroses, prolonged specialist psychotherapy is often required, lasting several months or even years.

Of the various methods of psychotherapy there is no end. From a continuation of superficial explanation, reassurance, and discussion, methods vary through free association, modified analysis, to full analytical methods. As stated previously, the scope for the latter is very small indeed. The growing numbers of cases referred for treatment have now led to a development of group methods of therapy, in which the patients are instructed as a group in the nature of their troubles, and are encouraged to work their way out of them in the group, by various means.

Various abreactive techniques can be carried out on an out-patient basis, using hypnosis, intravenous barbiturates, ether, carbon dioxide, and other aids. These methods were of particular use in the treatment of traumatic war neuroses; the patient is encouraged to work off his previously repressed emotions.

Out-patient electric convulsion therapy, although primarily of use in the treatment of psychotic depressions, has a place in the treatment of anxiety neuroses. It is almost essential in the case of the depressed suicidal neurotic. Although it may increase agitation while it is being applied, the effect is to lessen the depression and to relieve insomnia, and often an increase in appetite and physical well-being is achieved.

In-patient treatment for neuroses still presents great difficulty. The fear of the neurotic that he might be sent to a mental hospital is quite understandable; in practice a relatively small proportion enter such a hospital on a voluntary basis, and they rarely stay long enough to benefit. While a large percentage of neurotic cases are admitted to general wards, they are discharged as soon as such a diagnosis is made. Few hospitals for purely neurotic patients exist. In hospital, further treatment is available for the anxiety neuroses. Modified insulin therapy can be applied to selected cases. It is specially indicated in the agitated and physically debilitated case. Anxiety can lead to profound loss of weight, and this can be replaced rapidly by the use of insulin in dosage sufficient to induce varying degrees of hypoglycaemia. It also acts as a sedative, and psychotherapy can be carried out concurrently.

Continuous narcosis is of use in the case of the acute anxiety state, and is possible only in hospital. The patient is kept continuously under the influence of hypnotics for a period of a week or more, being roused only for nourishment,

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

W. L. TONGE, M.D., D.P.M.

Deputy Medical Superintendent, Cheadle Royal Hospital for Mental Diseases, Cheshire

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.