TREATMENT OF ANXIETY STATES IN GENERAL PRACTICE

BY

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Recent correspondence in the Press has shown that some practitioners are alarmed and dismayed at the incidence of neurosis in general practice. The figures given vary from 14% to 50% of all patients seen. It is obvious that to many doctors neurotics are the bugbear of general practice, and that means that a substantial proportion of their patients receive grossly inadequate treatment. Anxiety gives rise to more suffering and distress than any other aetiological agent of disease. Its treatment is not as complicated as many imagine, and this paper is an attempt to describe one method by which the problem can be tackled in general practice.

The vast majority of neuroses seen in my practice can be dealt with at the surgery. Only a small proportion of patients need to be put off work for a week or two. Most neurotics can be treated while continuing at work. This is not only better for the community as a whole but it is also better for the patient. It underlines the fact that he is not physically ill. Thus the general practitioner's surgery is in many ways an ideal treatment centre for neuroses.

First Interview

The patient is encouraged to expound all his symptoms. He is encouraged to talk and get everything off his chest. When he can think of no more symptoms I question him about each part of his body to make sure he has missed nothing from his history. Details of previous ill-health are recorded, as well as the family medical history. I ask for the earliest memory the patient can give me. The average person remembers back to about five years. The reason for this question will be seen later. I find out what kind of scholar the patient was as a child, and a detailed history of employment is taken. Habits are recorded, including smoking, drinking, sociability, pastimes, and hobbies. Details of the marriage are taken if these are applicable. If the patient is unmarried romantic situations are discussed. I do not make notes on sexual matters, as I feel it may embarrass the patient. Any points of note can be added later. To determine attitudes to parents I ask such questions as, "When a child of 12 to which parent would you have gone for extra pocket money, advice, and so on?" Most patients name either one or other parent. Very few say they have no preference. Such a bias is useful evidence, and, as Case 206 shows, such feelings can play a part in a neurosis.

To exclude organic illness a complete physical examination follows the history-taking. The above preliminaries sound lengthy, but one picks up speed with practice, and I can usually clear my way for psychotherapy in one or two sessions. If the case is a neurosis the patient is told that his symptoms are due to what is popularly known as "nerves." I stress the importance of both speaking the same language and understanding each other. I explain that the symptoms are due to anxiety, and I point out that worry can produce pain as severe as any toothache. I make sure he doesn't go away with the impression that I think either that there is nothing wrong or that the pain is imaginary.

Psychotherapy

The next session opens with a summary of my previous remarks. If the patient needs convincing that the mind can upset bodily function I ask him what happens if he goes to church without a pocket handkerchief. This usually produces the correct answer, and I point out that just as worry can upset the nose so it can upset the rhythm of the heart, breathing, or any other bodily function. I stress the fact that although worry can cause symptoms, that does not mean the body is diseased. It is sometimes profitable to explain to the patient how fear works, and to point out that anxiety is the same reaction, only it is prolonged in time. Palpitations, dyspnoea, sweating, and an empty feeling in the middle can all be explained in this way. The condition is liable to form a vicious circle. Anxiety causes symptoms, and the symptoms increase the anxiety. Reassurance

helps to break this vicious circle for a time, but by itself it is usually insufficient. It is necessary to go deeper and to work out the mechanism of the neurosis as well. My methods may be summarized as follows:

1. *Direct Approach.*—This means a correlation of symptoms and circumstances. Case 24, described below, illustrates this method.
2. *What Useful Purpose does the Neurosis Serve?*—All neuroses are motivated at a subconscious level. Some useful purpose is served even if the bargain as a whole is a bad one.
3. *What Emotions does the Neurosis Express?*—A case of effort syndrome may be the result of a broken romance. There is such a thing as a broken heart.
4. *Dream Interpretation.*
5. *Free Association.*

One, two, or more of the above approaches may be used in an attempt to discover the patient's real problem and to make him face up to it.

1. The Direct Approach

Sometimes the patient frankly admits he has problems, and these can be freely discussed. More frequently, however, he will affirm that he has no worries. I reply that a person can worry about something of which he is unaware. Here it is often necessary to describe the subconscious mind. I remind the patient of the iceberg, pointing out that whereas only one-ninth sticks out of the water, eight-ninths is submerged and hidden from view. The same applies to the mind. I describe the subconscious as the hidden part. It is in fact the storehouse of forgotten memories. Here the date of the earliest memory comes in useful. Most people readily appreciate that the early life and training of a child are of great importance, and yet these vital years are largely forgotten. The memories are buried in the subconscious mind, and from there are able to influence the individual.

Case 394.—This patient, a woman aged 25, was adopted at the age of 2. She had no conscious memories of her first two years of life nor of the town H. in which she was reared. At 14 she was told by her foster-mother that she had been adopted. She told her mother that she knew already, although she was certain no one had mentioned it. Clearly she had never completely forgotten. The name of the town H. always filled her with forebodings. Once when a van from H. stopped at the door she ran upstairs and locked herself in her room for four hours. She was 7 years old at the time. All this fear of H. went when she knew about the adoption. For the first time she realized she was secure and could not be taken back to H. and to her first home, which she had long forgotten.

A case such as this may be quoted to illustrate subconscious memories. After some such digression I ask the patient to tell me when the symptoms first started. We go over details, not of the feelings but of the background. Something in the circumstances has upset the patient. He is not facing up to reality, and his symptoms are a useful red-herring across the trail. In discussing the first attack one often comes across some clue or something worth opening up.

Case 36.—This man of 24 was suffering from effort syndrome. His first attack came on in Switzerland, where he was awaiting repatriation as an escaped prisoner of war. He remembered that he was then writing to his aunt, but as the letter had been written some eighteen months prior to my interview he had no idea of its contents. I told him that something in his letter had upset him, and that if it was important enough to upset him it could not really have been forgotten. I told him that if we left the subject and talked of other things the memory might return.

"What do you think of your aunt?" I asked him. "I'm very fond of her," was his immediate reply. We discussed the old lady. She was his foster-mother, but, being a maiden lady, she was called aunt. She had been kindness itself to him, but he was anxious to break away and stand on his own feet. After half an hour of discussion I repeated my question, "What do you think of your aunt?" "It's a mixture of gratitude and indifference," was his reply. In his first answer he had given his conscious feelings or the orthodox reply which was expected of him. His real feelings had to be stimulated before they were obvious, especially to himself. We broke off the session at this point, but as he reached the door he remarked, "I know now what was in that letter." He told me he was replying to a request from his aunt. She had made him the generous offer of a farm which she wanted him to take over. If he accepted the offer he would lose the independence for which he was striving. It was not easy to word a letter refusing the offer without hurting her feelings and appearing ungrateful. Syncope came as a

temporary respite from his struggle. The mechanism is often clear to the therapist before the patient has any idea of what it is all about, but it is better for the patient to reason out his own problems. Time will not always allow this process, which is necessarily slow, so that once I feel the patient has a grasp of elementary psychology I am often prepared to elaborate the case as I see it. If he can intellectually accept my suggestions he usually improves, but it is surprising how quickly the mechanism is forgotten from one session to another. Constant repetition and going over old ground is usually necessary.

If discussions as illustrated above do not bring the problem to light there are the other lines of approach.

2. What Useful Purpose does the Neurosis Serve?

This method is well depicted in the following case.

Case 208.—A woman aged 42 had called me in because her only child, aged 4, had developed mannerisms and was unduly afraid of cows. I asked her mother to come and see me at the surgery, and it was soon obvious that she herself had a quite severe anxiety state. She complained of pains in her chest and shortness of breath. She had given up cycling and had cut down all her activities. She was convinced it was only a matter of time before she dropped down dead. So sure was she of this that she always carried her identity card so that her body would be recognized. She even hid a farewell letter to her husband telling him how to carry on. Such precautions are a measure of how bad she felt. To summarize the case, which in all took four sessions: she had a pronounced "Atalanta complex" and was markedly fixated to her father, who had died two years previously from heart disease. As is often the case in neuroses, his illness served as a pattern for her symptoms. So great was her fixation that she was courted for nine years before she would consent to marry at 36. Attracted by her father, she was strongly antagonistic to her invalid mother, who lived at the other side of the town. She visited her mother thrice weekly, but it was an irksome duty and gave her no pleasure. Consciously she strove to be dutiful; subconsciously she hated her mother and resented the attention she had to pay her. This is roughly what must have happened. When she felt tired one day she decided she was not fit enough to make the journey. "I would go if I felt better," was her feeling, and so she stayed at home. The purpose of the neurosis is clear. She gave up cycling, and if she had to use a taxi the visits could be cut down to once a month. As T. A. Ross (1937) put it, a neurosis is always a bad bargain in the end. Her feelings excused her certain duties towards her mother, but in the end they made life almost unbearable for the patient herself. Once all this conflict had been clarified at a conscious level the patient felt much better. After the third session she announced herself as well. She could run upstairs and swill the yard in a way she had not done for months. All her fears had left her, and, what is more, her little girl had recovered too. I don't know much about child psychology, but treatment of the parent often brings about recovery.

3. What Emotion is Expressed by the Neuroses?

Case 24.—This young soldier was referred to me for persistent vomiting. No physical cause for his complaint could be found. He had escaped from a P.O.W. cage in Italy and for a year had lived the life of a bandit. The day after he had reached the British lines—and safety—he started vomiting. I could find no reason at first, so I flung out at him, "What does vomiting express?" He could not see my point, so I told him it could be a sign of disgust. I related the story of an Englishman who, having enjoyed a French dish of frogs' legs, was sick when he heard of what he had eaten. My patient opened up at once. Talking of disgust, he said he had never been so shocked in his life as when he was rescued. The Fascist mayor of an Italian village had entertained him with the object of trying to make a good impression. When my patient heard English voices outside he went out and greeted a tank commander. They smoked a cigarette and arranged a rendezvous, as the tank had to complete a patrol before picking him up. When the tank moved on he returned to the house to find that the mayor and his wife and family had all been butchered by patriots. Their brains bespattered the walls and their bellies were ripped up. He said he had never seen such a disgusting sight in his life. The next day he started vomiting.

The correlation of symptoms and circumstances was very instructive in this case. He had been a bilious child, and with some hesitation he produced this story. His father had died when he was 5. His mother took to drink, but he didn't realize this until he was about 7. He found her sitting at the table so ataxic that she could not hit her mouth with her spoon as she ate. He told me he would never forget the feeling of dismay and disgust that swept over him. So far as he could recollect his bilious bouts came on after this incident, and it looked as if they served a very useful purpose in forcing his mother's attention on him from time to time. Later, as a clerk in an insurance firm, he frequently lost work

owing to his attacks. He did not like the work, and he felt that his talents were being exploited. When the director of his firm visited his office he sought an interview with him. He evidently made a good impression, as he became the private secretary to this man, his salary was raised, and he had no more attacks of vomiting. He had never correlated his symptoms with his environment. The comparison showed how vomiting on each occasion had expressed disgust.

While on week-end leave this man had an unpleasant experience. He was to visit an uncle, but when he got there he found his host had committed suicide and the family were in a turmoil. I asked him if he had been sick. "I felt nauseated," he said, "but after our talks I felt I should be able to control myself, and I never actually vomited."

4. Dream Interpretation

Freud described dreams as the highway to the subconscious. In a paper such as this it is impossible to go fully into the subject, but I find it useful on occasion to explain the rudiments to my patient. Dreams all have a meaning; sometimes it is obvious, but more often it is obscure. Dreams are like cartoons. At face value the picture is ridiculous, but there is a hidden meaning behind it. Frequently there is a wish fulfilment. The hungry P.O.W. would dream of Christmas dinner at home, and so on. Dalbiez's (1941) book gives some very useful chapters on Freud's teaching about dreams, and dreams by their revelations can often considerably shorten treatment. I usually ask patients to write down any dreams they have between the sessions, as the treatment itself often stirs things up and useful information emerges during sleep.

A woman came to see me about a phobia which had troubled her since she was 13. We could find no trigger incident to put the neurosis in motion at that age. I told her I was confident that we would find something, and I asked her to remember her dreams. The next session she came back and said she had dreamed someone had left a brown-paper parcel on the doorstep. She awoke and found herself in an awful state. "I know now what upset me at 13," she said. Then she proceeded to describe how one day when she came home from school she had found a brown-paper parcel on the kitchen table. She was curious and looked inside. It contained soiled linen and a placenta. She did not know what it was, but she felt guilty about the whole affair and associated it correctly with the birth of her youngest brother. Soon afterwards her periods started and the same feelings of guilt assailed her in spite of her mother's meagre assurance that it was a normal event. When I questioned her about these memories she affirmed that, so far as she could remember, she had never given the matter thought since her marriage seven years previously.

The most ordinary dream may have a profound significance. Case 394 reported that she had dreamed she was placing a wreath on the grave of a brother who had been killed in a gravel-pit accident six years previously. My first impression was that this dream was a compliment to that brother whom she fondly remembered in her dreams. I heard her sob and found her in floods of tears. Such an emotional outburst is always most satisfying, as one can be sure one is hot on the trail of something important. In a few minutes the problem was clear. When she could speak she told me her father-in-law owned the gravel pit, and the two families were at loggerheads because of this fatal accident. She could not discuss the matter with anyone—even her husband.

After this session, without any prompting from me, she told her husband all about it. He laughed at her and reassured her; and when I saw her again her troubles were at an end.

5. Free Association

This is sometimes very useful, but I do not often use it. The patient is shown how to relax on a couch and is told to repeat whatever comes into his mind, however strange or out of place it may seem. I must point out that it takes practice on the part of both patient and doctor to achieve proper relaxation. This method is useful in long-term cases or when a resistance is holding up progress, but I do not have many long-term cases. Hypnosis and narco-analysis I have never used in general practice.

Short Cases.—If one is on the look-out for neuroses, and examines the patient as a whole in his environment, one can frequently give considerable help with very little trouble or expenditure of time.

Case 357.—This girl, aged 17, when seen was complaining of loss of appetite and feeling sick. She looked a picture of health after

her seaside holiday. While she was getting into bed upstairs I questioned her mother about her, and learned she was about to go to college. She was leaving home for the first time in her life. She had an over-protective mother, and I knew the girl would feel the wrench. I discussed these possibilities with the mother and then went to examine the patient. Nothing abnormal was found, and I put forward my views to the girl. I felt that the queer feeling in her middle was due to the apprehension about leaving home. When I got downstairs the mother told me she was sure I was right, as the same thing had happened when the girl started school. A follow-up some months later showed that the feelings had cleared after a few days at college. She herself was well satisfied with my diagnosis. In all, this case took about half an hour of my time. It required no medicine and no further attention.

Chronic Cases.—Some patients improve up to a point, but can get no further; these require an occasional maintenance dose of psychotherapy. This is truly tiresome and often disheartening, but in my view, it is far more honest than putting off the neurotic with a bottle of medicine.

Case 142.—This patient was a woman of 40. Her troubles began at 16 when spinal disease was diagnosed and she was put on her back for three months. Since that time she has always had a "weak back," although no G.P. or specialist has been able to explain why. From the psychological point of view she had enough to break anyone's back. She was an intelligent and very capable person, but at 14 all hope of advancement along her own lines went when she was drawn into the family business because of her mother's illness. The family were thrifty and hard-working to a degree of absurdity. Work and money-making were the only things that mattered. Social life was frowned on; smoking and alcohol were forbidden. At 40 her mother still referred to her as a young girl and treated her as such. After a few sessions there was a vast outpouring of hatred against her mother with floods of tears. After that she felt better but never completely well. How can she get well under such impossible circumstances? Every six weeks I see her for a painful three-quarters of an hour, during which time she pours out her woes and her resentment against the family. Until her parents die she is in a hopeless trap. She has not the training, resources, or the courage to go elsewhere; but she can relieve her feelings to me whenever she likes, and on the whole she is better. She at least puts the blame where it rightly belongs and does not waste my time talking about her back.

Other Conditions

I have referred in a previous article (Watts, 1947) to the "feel" of functional cases. The typical neurotic willingly co-operates in treatment and takes a real interest in what is going on. If the patient is constantly difficult and lacks the spirit of co-operation the condition is probably not a neurosis but one of the following:

- (i) Psychotic—chiefly endogenous depression. This condition is quite as common as the anxiety state.
- (ii) Mental defect.
- (iii) Psychopathic personality.
- (iv) When the neurosis is too profitable to abandon. It is almost impossible to cure a neurotic on a pension, where a cure of the complaint spells financial loss.

Mentally Retarded.—While deeper forms of psychotherapy are impossible with the mentally retarded, sympathetic handling can do a great deal to jolly them along. One of my best cases was that of a girl of this type. She had not worked for ten years because she felt too ill. By winning her confidence and with persuasion I made her accept my idea that she felt ill because she did not work and that work itself would make her feel better, not worse. After four months of patient prodding she took the plunge, and in ten months has missed only two weeks of work.

Comment

Drug Treatment.—Drugs play a useful part in treatment. In an article of this type it is impossible to go into details. I fully endorse the views of Sargant and Slater (1948), and the rationale of drug therapy is explained fully in their monograph. The point I stress with patients is that drugs will not cure a neurosis. Recovery will only take place with successful psychological treatment. I explain the situation to them as follows: "If you came to me with a broken leg you would not be satisfied if I handed you a crutch and told you to manage on that. Your objective would be to get the fracture set and the leg made useful again. Drugs to a neurotic are a useful crutch, but no

more. They are only a temporary measure, and in no way replace psychotherapy, which aims at complete recovery."

Results.—In a series of 70 consecutive cases 35.7% recovered, 34% were improved, 18.6% were not helped at all, and the remaining 11.6% have not been traced.

Conclusions

In general practice it is necessary to view the patient as a whole in his family and social environment. I try to locate the stresses and strains he is up against, and endeavour to make him appreciate his real problems. The neurotic tends to turn his back on difficulties and complains about his symptoms. I largely ignore his symptoms and get him to face up to his problems. Above all, I try to make him use his powers of reason in the matter. The intelligence of man has made him more anxiety-prone than other animals, but fortunately intelligence also points the road to recovery.

Summary

The need for psychotherapy in general practice is stressed. The family doctor's consulting-room should see a solution to most neuroses.

Methods used by the author are outlined and illustrated by cases and samples of his "patter."

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INTERNATIONAL LEPROSY ASSOCIATION CONGRESS IN CUBA

The Fifth International Leprosy Congress was held in Havana, Cuba, from April 3 to 11. The previous international congresses were held in Berlin (1898), Bergen (1909), Strassbourg (1923), and Cairo (1938). At the Cairo meeting it was decided to hold quinquennial congresses, and the next was to have been in Paris in 1943. Unfortunately this was prevented by the war.

The initiative in calling this Congress, as also the Cairo Congress, was taken by the International Leprosy Association, a body formed in 1931 at a meeting of leprologists at Manila called by the American Leprosy Foundation. Two of the chief functions of this association are the publication of the *International Journal of Leprosy*, which is produced in America with the assistance of the Leonard Wood Memorial, and the arrangement of periodical congresses. Its office and secretary-treasurer have from the beginning been furnished by the British Empire Leprosy Relief Association in London. In 1946 the Association accepted an invitation from Cuba to hold the fifth congress in Havana, and the Cuban Government invited all countries to send delegates. Two hundred and twenty-nine delegates, including 74 from Cuba itself, gathered from 36 different countries. Important countries not represented were Russia, Japan, Australia, Pakistan, and Indonesia. By far the largest delegations were from the Latin countries: Spain 12, Portugal 4, Brazil 28, Mexico 16, and Argentina 15. There were 31 delegates from the U.S.A., but only 14 from the British Commonwealth. In Cuba itself leprosy is a serious problem, and carefully planned steps are being taken to bring about control.

While the International Leprosy Association was chiefly responsible for arranging the scientific side of the Congress, the Cuban Government made all the local arrangements. The Congress met in a large school building, with dormitory arrangements for 60 delegates in the top story and a restaurant on the ground floor supplying food at or below cost price, while on the first floor there were offices and committee rooms, a post office, and exhibitions, together with a large auditorium with seats for 400 and interpreters for the four official languages—English, French, Spanish, and Portuguese. Delegates were supplied with earphones so that each could hear the speakers in his own native tongue.