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Anxiety Neuroses and Phobic States. III—Referral and Prevention

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When to Seek a Psychiatric Opinion

How much of the treatment of an anxiety state the family doctor undertakes himself will depend on his time and his inclination. There are some circumstances, however, which should make him consider referral to a psychiatrist. The first of these is any severe anxiety state which fails to improve after a few months' treatment. In some patients a severe anxiety state will progress to a disabling phobic anxiety state. This is a development to be forestalled at all costs. It was said earlier that, in general, normal anxiety is self-limiting, pathological anxiety self-exacerbating. Of no instance is this more true than of agoraphobia. Furthermore, social adjustment is severely disrupted, and the patient's demands that she is always accompanied when she goes out, her insistence in some cases that a schoolchild stays at home to keep her company, or her habit of ringing her husband up at work at all times throw a severe stress on family life. It follows from this that there is an even greater urgency about referring patients who are already developing an agoraphobic state which is not responding to treatment. One of the difficulties here is that agoraphobia may develop inconspicuously. The distinction between the housewife who goes out little because of lack of opportunity and the housewife who never goes out because she has agoraphobia may be difficult to detect, particularly if, as is often the case, she feels that her fears are foolish and unjustified and makes strenuous efforts to conceal them. For this reason it is worth making a point of establishing whether any anxious or depressed patient is also agoraphobic. Agoraphobia rapidly becomes entrenched, so that early diagnosis is likely to improve the prognosis.

Another indication for referral is the patient who seems to be on the verge of doing irreparable damage to his social adjustment. The man who during a period of acute anxiety throws up his work or abruptly severs lifelong associations with his friends is likely to prove difficult to rehabilitate. In some anxiety states the patient agonizingly ruminates about the possibility that he may have a grave physical illness. If this is impervious to reassurance, it is worth seeking a psychiatric opinion.

Difficult problems may be posed by patients with attacks of unconsciousness that do not appear to be typically syncopal, in those in whom the illness develops seemingly without adequate cause or relatively late in life, or for whom a neurotic illness appears out of character. Patients with persistent and disturbing depersonalization symptoms may raise difficult problems in long-term management, and a psychiatric opinion may be helpful. Finally some patients remain severely disabled after all forms of treatment have been tried and repeated attempts at social rehabilitation have been made. It is worth seeking

an opinion about the advisability of prefrontal leucotomy in such cases. There is a small but important place for the modern versions of this operation, and some of the best results are achieved in chronic, severely disabling anxiety states in individuals of formerly stable or relatively effective personality.

Prevention

By the time a patient with an anxiety neurosis consults the doctor the underlying process—faulty personality development—may be largely irremediable. Prophylaxis is therefore likely to assume increasing importance, and in this the family doctor will be a key figure. The prospects in this field dwarf the accomplishments; they can best be gauged by examining what is known about the pathogenesis of anxiety states.

We know from twin studies that hereditary factors are important. However, the concordance rate in identical twins is only 41% and in dizygotic twins 4%,⁶ and this makes it clear that environmental and interpersonal factors are also significant. In a sense the family is a school in which children receive a crucial part of their education about the culture of the community. It has succeeded if it produces an individual who can avoid most of the hazards but reap the benefits of being a social animal. This education can fail in one of several ways. It may proceed at a rate unsuited to the child's development. The child may be given emotional responsibility prematurely, as for instance the "child-mother" who at an early age has to care for her younger siblings, or may be made confidant of her parents' emotional problems. Harsh or arbitrary discipline at one extreme and excessive indulgence and permissiveness at the other, or, perhaps even worse, an inconsistent alternation between the two, results in someone who has no reassuring yardstick by which to guide his adult behaviour. There is good reason to believe that some anxiety responses are learnt from the parents. The mother who is preoccupied with a host of unlikely dangers cannot fail to communicate to her children that she is anxious and may well inculcate her actual fears. Thus the children who are hustled into the cupboard under the stairs every time there is a thunderstorm are likely in their turn to become fearful of thunder.

Neurotic personality development during childhood and adolescence may not be accompanied by any very conspicuous disturbances. In particular the continuous and crippling anxiety of adult anxiety neurosis is not usually seen. At this stage the abnormality of such persons and the clues to their propensity lie in the way they conduct their lives, but because this conduct is often countenanced by the culture in which they live it is likely to go unrecognized. That a young married woman visits her mother every day is unlikely to attract much attention because it is probably common behaviour in the neighbourhood. But when mother becomes ill or dies and the daughter develops a crippling anxiety state it becomes clear that her visits were occasioned by an abnormal emotional overdependence.

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However, some advances have been made in identifying the children at risk. Adult neurotics tend, as children, to have been gloomy, unpopular, and submissive and to have had difficulty in adjusting to school. Adult agoraphobics tend often to have been excessively timid and fearful as children. As these observations accumulate and are confirmed so the foundation of preventive work will become more secure.

There are two instances in which prophylaxis and treatment converge. The first is that the early recognition, effective management, and rehabilitation of chronically sick parents is an important prophylaxis against the development of neurosis in their children. The second is the prevention of further neurotic personality development in patients who have developed an anxiety state. Though the critical steps in the development of neurotic personality occur during childhood this process may continue throughout the adult years. Thus recent work suggests that one adult experience which increases neurotic proclivity is living with a neurotic spouse.⁷ The experience of an anxiety state and its attendant events is a stress which the patient, more than anybody else, is ill-equipped to cope with. Thus loss of work ("People think I'm not pulling my weight"); the lingering ignominy that mental hospital admission carries for some patients ("Once you've been in there people think you are mad"); and the panic attacks in public ("The neighbours must think I'm queer") will certainly have a malign influence on the further development of adult personality. The effect of this influence can sometimes be most clearly seen in the way a patient regards himself—his "self-esteem": that collection of assumptions, implicit and explicit, which he makes about himself in relation to the community in which he lives. Many patients, after several years of an anxiety state, will make the type of comment that one of ours made recently: "I'm completely useless now—a rotten husband. I used to be a professional decorator and now I can't even paint a window frame." Even if earlier damage to the personality cannot always be undone, present damage can at least be curtailed.

Concluding Remarks

In conclusion we should like briefly to make two points. The first concerns the desirability of setting limited objectives. These should take realistic account of the sort of personality one deals with. The second is that sensible limits have to be set to the anxieties that should be regarded as medical problems.

As far as the first is concerned the following case history will serve as a good illustration.

Mr. A. B., aged 62, fell ill after he had lifted something heavy at his caravan and developed transient chest pain and dyspnoea. He became anxious, distressed, and at times panic stricken. When seen by a psychiatrist he was very tense, emotionally labile, and his behaviour was histrionic. The E.C.G. showed evidence of mild myocardial insufficiency. He was admitted to hospital, where he was treated with tranquillizing drugs, assurance, and simple explanatory psychotherapy. He showed marked improvement, and in the course of the next few months made an almost complete recovery.

He has worked at a greyhound stadium for 39 years, and now, aged 68, continues this on a part-time basis. He is a man of athletic build, tanned, smartly dressed, and fit-looking. He has always been conscientious and methodical, but rather rigid. His pride in his physical fitness and competence at work has always been profound. He drinks a cup of hot water every morning for "inner cleanliness," followed by exercises and club-swinging. His hobby is his fitness. He does not drink or gamble and considers

that smoking is "a filthy evil." Now five years after the commencement of his anxiety state he is cheerful and well and is proud of the feat, which he regards as unique, of going round the track on his hands and feet.

No attempt was made to influence this man's long-standing personality traits, and his views about health have always been treated with respect. He has not been told about the E.C.G. changes, nor has his blood pressure of 200/120 or the evident mild impairment in his memory for recent events been mentioned to him. Overambitious or indelicate treatment might well have caused a lifelong and crippling anxiety neurosis in this patient.

The second point is that while some anxiety states require formal treatment, possibly with an initial period in hospital, others require simple support and encouragement with some medication, while those with transient anticipatory anxieties in the face of life's ordinary stresses need help to tolerate these feelings as part of a normal life. Ours is said to be an age of anxiety. Life moves at an accelerating pace; changes in its pattern strain man's powers of adaptation. There are ever-present dangers; mounting competition in the scramble for position and material goods and the magnitude of social and industrial organizations tend to dwarf individual human beings into insignificance. However, if we succeeded in subduing into tranquillity all anxieties no matter how transient and understandable it would probably undermine people's capacity and determination to overcome the social and personal problems they face.

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