THE ANXIETY STATE*

By

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The term *anxiety state* attained notoriety in the recent war, as *shell shock* did in days gone by. Each came to be used casually as a label for practically every form of mental disability and for other conditions as well. This had serious results in the 1914-18 war, as many patients, being wrongly diagnosed, were wrongly treated. The aftermath was seen in the heavy burden of pensions with its inevitable concomitant of invalidism. Fortunately this was not repeated in the last war as psychiatry was taken seriously in the Services. The civil mental health service of the country is, however, far from adequate. There is a shortage of trained psychiatrists, a shortage of in-patient facilities and a shortage of social workers. Consequently it falls to the general practitioner to diagnose, manage, and perhaps also to treat many psychoneurotic patients. At least half of this group will be sufferers from the genuine *anxiety state*. It is necessary therefore to use this term with care, otherwise treatment will be haphazard, prolonged, and disappointing to the patient and to the physician. This can only be done when there is a clear picture in the mind of what an anxiety state "looks like" clinically; and it is the purpose of this paper to draw the outlines of such a picture.

I

The clinical picture in the *anxiety state* is a combination of psychological and somatic features. The psychological component is morbid anxiety and the somatic, broadly speaking, one or more of the physiological accompaniments of normal fear. Men and women, children and old people, the wealthy and the poor, the active and the idle, the intelligent and the stupid, the married and the unmarried, are all victims. It is an illusion to think that these patients have adopted their symptoms out of perversity or in order to escape from the demands of life. They have become ill because of mental conflict of which they are unaware. The motivation of their illness is unconscious and so outside conscious control and direction. The hypothesis of mental activity outside consciousness is generally accepted for reasons which can be found

in any modern text-book on psychiatry. The reasonableness of the complaint is its least obvious feature. But unless it be accepted by the clinician, his handling of the patient will be ruined by his own irritation and sense of frustration.

Anxiety is not always morbid. To be troubled in mind about some uncertain event, such as an examination or an illness, is to show normal anxiety. This anxiety is indeed useful—it leads to appropriate activity. In contrast to it stands morbid anxiety which has a paralysing effect upon thought and action. The sufferer cannot account satisfactorily for the anxiety by reference to local circumstances. The home, financial, and business situation may be satisfactory, and yet anxiety dominates the scene—the mind is in a state of anxious alertness. Inactivity rather than activity results and there may be a sub-current of fussiness and restlessness which is liable to focus on almost any triviality. Anxiety of this type is morbid. It is a symptom of importance and it should be looked for in the patient who is repeatedly seeking advice for minor complaints. The simplest method of detecting it is to take a history of the illness, noting the response of the patient to the demands of life at school, in business and in marriage. This should be the first step in the examination. A certain clinical intimacy is established as the history is unfolded, and the confidence of the patient is gained. It is unnecessary to ask a lot of questions for these patients will talk freely. But a few carefully selected questions may be interposed: How do you sleep? Is your memory as good as it was? Are you able to concentrate on your work? Would you regard yourself as unduly irritable or highly strung? Do you find yourself disturbed in any particular situation? Is travelling by train difficult for you? Are you worried about your mental health?

The demeanour of the patient in giving his history, and the answers to the special questions, will make it possible to decide with a fair degree of accuracy whether the patient is or is not morbidly anxious.

The second step in the investigation is to make a physical examination. When bodily illness is discovered and if the symptoms of it are those about which the patient is anxious, treatment should be laid down, reassurance given, and the interview ended. If, however, the physical examination reveals nothing abnormal or at any rate

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nothing which appears to account satisfactorily for the undue anxiety, we should bear in mind, as mentioned above, that morbid anxiety does produce physiological disturbances similar to those which accompany normal fear—the natural and healthy response to a dangerous situation. The difference in the two conditions is that morbid anxiety arises when there is no obvious sign of danger. It is in fact the reaction to an inner, unconscious, and so unrecognised danger to the personality.

II

The psychological symptoms of an *anxiety state* will vary from time to time, but they will usually include lack of concentration, irritability, impairment of memory, apprehension, depression, feelings of unreality and insecurity, sleeplessness and the dread of insanity. The anxiety may be concentrated upon specific situations such as travelling by train or the underground railway, lifts, heights, crossing the street, walking alone out of doors, interviews, theatres, restaurants, open or closed spaces and so on. Certain objects may also cause anxiety, for example spiders, cats, knives and blood. The so-called phobias fall under the last two groups and these are often dignified by special names such as claustrophobia and agoraphobia, implying, wrongly, that these conditions have an origin different from the less specific forms of morbid anxiety.

The purpose of the phobia is protective and the place, situation, or eventuality on which it is focussed is avoided as far as possible. Incidentally, while it is avoided, it is also kept in mind; for a phobia is a curiously double-edged weapon. There may be a phobia of a situation which demands an exact response, for example driving a golf-ball, sitting at a dinner table or drinking a cup of tea. Such situations can be dealt with appropriately only in one way. There are not a dozen ways of taking a cup of tea. It is astonishing and pathetic to learn of the devices which patients employ to avoid the dreaded situation. The phobia is the symbolic externalisation of some object or impulse repressed from consciousness.

Acute panic may arise in the morbidly anxious patient is likely if he is faced with the situation or object for which he has a phobia.

The physiological symptoms or accompaniments of morbid anxiety are numerous. They include palpitation of the heart, raised blood pressure, increased pulse rate, flushing, sweating, respiratory trouble, tremors (particularly of the hands and face muscles), digestive disturbances, diarrhoea, polyuria, bed-wetting, impotence and vaginismus. The general muscular tension may result in stammering or in blundering and jerky movements. It would be unusual of course to get all of these in any

one patient. This applies also to the psychological symptoms. There is usually a ringing of the changes and at times morbid anxiety or the somatic factors may be in abeyance. This should be remembered during the history taking—symptoms absent to-day may have been a cause of distress a few weeks previously. Then again an organic condition may appear in a patient with an anxiety state or vice-versa.

Medical men have a tendency to overvalue the importance of physical symptoms and to undervalue the importance of psychological symptoms. Thus patients with a full-blown anxiety state are treated only for the physical accompaniments and perhaps treated for a long time on the assumption, presumably, that any physical symptom can cause morbid anxiety. They tend to be unrewarding patients. This is hardly surprising as the importance of the symptom for which they asked advice is exaggerated and morbid anxiety—the root of the trouble—is overlooked.

III

A few of the physiological aspects of morbid anxiety may now be noted in more detail. One of the commonest is the so-called "*nervous heart*." Anxiety, whether morbid or otherwise, is liable to affect the action of the heart, but in the normal person the "palpitations" soon pass. When a person is beset by morbid anxiety, however, they persist and may be accompanied by considerable lassitude in doing any work, or even while at rest, by pain in the left thoracic region and by a sighing respiration. This of course is the familiar picture of effort syndrome. The anxiety will become centred upon the heart if it is examined again and again. This was common during the war partly owing to frequent movements of Medical Officers, Medical Specialists and patients. The new M.O., having no case history to go on, started de novo, and referred the patient to the Medical Specialist who repeated the investigations, perhaps for the third or fourth time. Before long the patient was convinced that he had heart disease. While this is less likely to happen in peace-time, it is still true that patients are in danger of over rather than under-examination. It is important, therefore, that the doctor should make a complete physical examination and give reassurance if he finds all is well. When this reassurance is accepted and acted upon, the patient is not suffering from morbid anxiety but from a reasonable misapprehension.

If the reassurance is unavailing and the patient appears again and again it is likely that he has an anxiety state and his attitude of mind should be investigated.

The respiratory system is often involved in an anxiety state. There may be a cough, a shortness

of breath or pain in the chest. The patient may have been seen once or twice before and given a cough mixture. Assuming there has been no relief the doctor, perhaps urged by the patient, will send him for an X-ray examination. If this turns out to be negative, it is probable that the morbidly anxious patient, on his own initiative, will consult a series of specialists. He thinks he has got T.B. or cancer of the lung. It is a wise precaution to ask such a patient, when the chest is healthy, about previous examinations; for he may well say that he has no private doctor and yet claim that he has had the trouble for many months. It then turns out that he has been to many physicians, and that each of them, thinking only of his chest, gave a cheerful report. The patient is really sick—but it is a sickness of the mind.

Impotence, or the fear of it, in men, and vaginismus in women are met as symptoms of the anxiety state and of other psychoneurotic conditions. The shyness or ineptitude of parents—not by any means confined to the Victorian era—in giving instruction to their children when they ask questions on sexual matters is the starting point of much of the anxiety which prevents the normal expression of the sexual instinct. A feeling of guilt becomes associated with the mysteries of procreation in the mind of the child and adolescent. This is ordinarily unconscious in the patients unable to achieve coitus. They disown any distaste for the act and say that they regard it as perfectly normal. The man may report that he has had intercourse before marriage, but that since marriage he has been impotent. The woman, desirous of motherhood, is yet unable to permit, or submit to, the advances of her husband.

The presence of morbid anxiety must not be taken for granted in assessing the significance of impotence or vaginismus. Sometimes it is absent and the worry (or normal anxiety) which the patient feels is based on ignorance of the mechanics of coitus. Women with vaginismus often fear that coitus may be painful. Some believe—mistakenly—that the sexual sensations are heightened by contracting the muscles of the legs and abdomen. Every patient with impotence or vaginismus should be asked, to begin with, about the simplest aspects of coitus. Ignorance of the subject is widespread and much of it can be removed by explanation as it may rest upon a misunderstanding perhaps dating back to some remark overheard in the conversation of adults. It is highly satisfactory when the difficulties can be overcome in this way. But of course there are the many whose symptoms have a deeper meaning. How numerous they are none can say. The impression gained in the practice of psychiatry is that impotence and vaginismus are commonplace. Patients are sensitive about these matters and often the presence of impotence or

vaginismus will only be discovered by tactful enquiry. If morbid anxiety be revealed in the history taking, it is a good plan to mention that the intimate side of married life is at times a perplexity to those in good health, and that to those who are not, it is frequently the main cause of distress. If this is not done and tonics and injections are prescribed for impotence and dilation for vaginismus, the result may be that the patient, having derived no benefit, concludes that the condition is beyond the scope of medical aid. Sexual intercourse, it is assumed, cannot be carried out and attempts to achieve it had better be given up.

The principles which should guide the doctor in his examination of those complaining of cardiac, respiratory and marital disabilities apply also to the other physiological aspects of the anxiety state mentioned in Section II. The individual rather than some hypothetical disease entity should be looked at. It is harmful merely to inform the psychoneurotic patient that he is looking well, that he is as sound as a bell and that any insurance company would be delighted to accept him as an A.1. life. This cheerful attitude may be helpful because the patient feels that his doctor is interested in him. But the help is transitory. The doctor, however good his intentions, is being blind to an important clinical symptom, namely morbid anxiety, which consequently persists.

It may be argued that the taking of a full history is too time-consuming; and that to take the history of a psychoneurotic patient requires training which few possess. But the palliative treatment of the “nervous” patient is also time-consuming and indeed often goes on for years. The general practitioner must be rare who cannot think of at least one patient who could be accurately described as a good steady invalid.

IV

The treatment of the anxiety state is a serious matter “and therefore is not by any to be enterprised, nor taken in hand, unadvisedly, lightly, or wantonly.” Skill and training are necessary in the treatment of neurosis. The successful therapist, in addition to technical skill, must possess an aptitude for this branch of medicine, a knowledge of the world and an appreciation of the spiritual as well as the material aspects of human affairs. This is not to say that every psychoneurotic patient must be referred to a psychiatrist. Apart from the fact that there are not enough psychiatrists to make this possible, it is the duty—and will we hope always be the duty—of the general practitioner to diagnose illness in its early stages. It should be remembered that the anxiety state, like any other illness, has a beginning and also that it can have

an end; nor does it come with the abruptness of a road accident. The onset is usually insidious. In dealing with the illness in its early stages, the attitude of the doctor towards the patient is more important than his technique. Relatives and doctors often ask about the correct demeanour towards the psychoneurotic patient—should it be sympathetic or hard-hearted? Should they be made “to do things” or “be given in to”? The answer is that the patient should be approached with objective sympathy, as in other forms of illness. The possibility of preventing the development of a neurosis is high if it is handled wisely in the beginning. The doctor soon discovers what he can do, and the power he does possess, if he approaches this group of patients as innocent rather than guilty people. Once he is trusted he need not be afraid of being too bracing, or as critical as the situation demands.

Many of course will not respond to these simple measures. They are grateful but uncured. It is then that help should be sought—either by reading or by reference to a colleague. No treatment is better than the wrong treatment, for this helps to establish the condition. It should be remembered that statements such as “it all depends on yourself” do constitute a form of treatment quite as injurious as the injunction given to one patient—“pin your faith to the little white pill and it will cure you.” The correct treatment for every patient is just not available in the present state of the health services. What then can the doctor do? It is recommended that he should be frank with the patient, indicate that the remedies he prescribes are intended to heal or rest the mind which is sick, while pointing out that it is not the type of illness which is popularly called “mental.”

This may seem a small thing, but to neglect it does serious harm. It is a disservice to give treatment only for the physical symptoms. To keep an expectant eye on those arising from morbid anxiety, hoping they may fade away, is not enough. The patient will naturally and reasonably conclude that the symptoms for which he is receiving treatment—that is the physical symptoms—are the cause of the trouble. When hope is deferred and the doctor has exhausted his resources, it is hardly fair to put the blame on the patient, saying that it is “all imagination.”

The personality of the doctor plays a big part in the management of this illness and often it is this which restores confidence and hope in the patient who is tyrannised over by morbid anxiety.

While the use of the various psychotherapeutic measures employed in psychiatry is best left to the psychiatrist, it should be possible for every medical man to acquire some knowledge of the principles upon which they rest. He will find them of practical value in every branch of medicine and surgery, for the anxiety state knows no boundaries.

Summary:

1. The clinical picture in the anxiety state is a combination of psychological and somatic features.
2. The psychological and physiological symptoms are described.
3. The symptomology of cardiac and respiratory factors is outlined. Attention is drawn to the significance of impotence and vaginismus.
4. The importance of the attitude of the doctor in the management of the patient is stressed.