

wide experience by saying what the committee might pass and what they could never pass. In addition their knowledge could result in a better general plan being adopted. If this were done the committee would need to have the final application before it at one meeting only and could pass it or refuse it at that meeting. This single change could result in a saving of up to two months. It is even possible that the College's practice advisory committee might be represented at the assessors' visit.

In retrospect, 10½ months may not seem a long time but it does not include the period during which we ourselves had been searching for a site and considering our plans. Of course one of our difficulties in general practice is that we are used to responding quickly, often immediately, to the calls made upon us in practice and find it hard to appreciate that there are other spheres in which 'in' and 'out' trays and prolonged discussion and correspondence are the breath of existence. Nevertheless, it has been our experience that the officials dealing with our affairs were always courteous and expeditious but that they were defeated by the delays built into the system after the application leaves the executive council. Had we obtained the loan through a building society on such a rapid repayment plan we should not have waited ten months for legal agreement.

If after all this anyone were to ask if he should apply for a group practice loan we should all say, with no doubts at all, "the sooner the better". If his wife were to ask, our wives would agree that while they miss being in the swim of the practice they gladly exchange that for a home which is now only a home and not a medical Clapham Junction.

### **STUDENT PRIZE ESSAY**

#### **A CASE OF MIXED PSYCHONEUROSIS**

**Public Welfare Foundation Competition Prize-winning Essay 1963.**

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MRS M. AGED 35 WAS BORN into a family with no record of mental or physical illness. The fourth of six daughters, her twin brother's stillbirth proved a big disappointment to her mother. Although she

reached the progress milestones at the normal times, this skinny, straight-haired, buck-toothed girl, who readily lapsed into a world of phantasy, was always regarded by her mother as the "odd one out" among her attractive sisters. Her childhood was superficially uneventful; she was never separated from her parents.

She left school at the age of 14, in the same year that her father was killed in the war. It was also the year she reached the menarche, unprepared by her mother, but without obvious distress. Her subsequent work record was satisfactory.

Married at 19 to a sailor, her first experience of intercourse was with a drunken husband and seems to have been crude. She maintains that her relations with her husband were satisfactory, and she bore him two sons, in 1947 and 1952. No neurotic symptoms appeared following either of these pregnancies.

In 1954 her husband walked out. This was a great shock to her. When he was found, three years later, she obtained a divorce on the grounds of adultery.

It was while she was waiting for the divorce that she came to live in this city and is reported to have suffered, in succession, from tension headaches, muscle aches, psoriasis and short episodes of depression. These complaints continued to bring her to the surgery every one to two months after her second marriage in 1958, by which time she was worried over her failure to conceive again. When she did become pregnant, early in 1960, she suffered from agitation and irritability, globus hystericus, nausea and hyperemesis gravidarum. Because of a breech presentation at term she had to be admitted to hospital for delivery. There she claims she was brutally treated, and the fear of "going through all that again" she pinpoints as being at the root of all her present troubles.

Up to this time, she appears to have been a friendly person of fair insight and intelligence. Meticulous in everything she did, she was capable of energetic, if not sustained, activity. Her mood tended more to sporadic gaiety than to depression, although a chronic sufferer from headaches and constipation.

The first hint of the present illness came two months after her confinement when she presented with symptoms of fatigue and irritability. Her haemoglobin level was satisfactory. She was given meprobramate, which helped her temporarily.

Two months later she presented with a skin rash on both legs.

A specialist confirmed the diagnosis of lichen planus, and recommended topical steroid treatment. At this time, on intensive questioning, she confessed to depression, thoughts of suicide and running away, sleeplessness, headaches, muscle aches, aversion to

intercourse and the presence of obsessional trends related to housework. After two long listening sessions, her family doctor reassured her, advised her to stop being over-meticulous with the housework, prescribed the antidepressant drug phenelzine (nardil), and provided her with a contraceptive cap.

With this treatment she improved, although there was some fluctuation in severity of her symptoms. This made her re-appear at least once a month with different complaints.

Seven months after the first attack she came back with a similar florid picture of depression, suicidal thoughts and frigidity. This time the doctor called in her husband for a talk about methods of contraception, again listened and reassured her and prescribed phenelzine.

Now, six months later, she is much less depressed and her suicidal thoughts have gone, but she remains irritable and frigid.

Her physical health is generally good. Her only illnesses have been measles in childhood, diphtheria at 18 and recent menorrhagia. The latter was caused by a large cervical erosion for which she awaits treatment in hospital.

*The social aspects of the patient's problems.* Financially, the patient is more prosperous than she has ever been before, and this seems secure as her husband works in a stable industry, wire-making. She has every modern convenience in her four-roomed, brick council house which is in a new housing estate in the city suburbs. There, however, she does not find the neighbours nearly so friendly as in the centre or in the country towns where she used to live.

Living in a small house on the outskirts this family has few activities outside the home, relying for distraction on watching television and playing 'pop' records. Thus they are closely-knit, constantly being caught up in each other's affairs. They are all nominally Roman Catholic but this means little to them in their family life and certainly provides no barrier to the use of contraceptives.

Although the two oldest sons are of a previous marriage, this causes no friction. Her husband, seven years her junior, is away from home every week-day from 7 a.m. until 9 p.m. He is helpful and understanding but is naturally becoming increasingly frustrated by her frigidity. This has led to an interminable succession of rows which form the major cause of upset to them both and to the rest of the family. The children are Philip (15) who is docile, Roger (10) who is temperamental and Paul (2) who is only a toddler. Towards them she shows ambivalence—one minute tender, the next minute unreasonably angry. Naturally, this also is a source of worry to her.

Her visitors consist mainly of her mother and sister and her

mother-in-law. The two former provide deep friendship in these foreign parts but must necessarily be a constant reminder of her unhappy past. The latter is a crude person who constantly re-introduces in conversation the subject of her own sex performance compared with her daughter-in-law's.

Such are the influences in this extremely rigid and limited working-class community in which this patient lives.

#### **An appreciation of the general practitioner's role**

When this patient became ill, the doctor saw the necessity for prompt and adequate assessment of the illness and for deciding which of the many symptoms had the priority of treatment. His knowledge of her personality and background was invaluable in discussing her frigidity and in giving him some idea of the aetiology and possible prognosis right at the beginning.

He saw the patient twice in the first three days after she came to see him and made direct inquiries about, for example, suicidal thoughts. He decided the priorities were: (1) risk of suicide; (2) frigidity; and (3) skin lesion.

The frank discussion of suicidal thoughts can be, and was, of great therapeutic value. The doctor instructed her to call him whenever she felt suicidal, and prescribed an antidepressant drug. This treatment seems to have been well balanced, combining understanding and assurance of help with a pharmacological mood-lightener. It was successful in so far as the telephone bell did not ring and the sleep disturbance and headaches were eased.

In a woman with such a chequered marital history, it was imperative to inquire, as fully as possible, into her sexual experience. After listening and questioning, the doctor felt justified in giving advice and practical instruction on contraception, and in explaining to her that the root cause of her frigidity probably lay in events occurring before her third confinement—not in the fear of another pregnancy. At this point there was little indication for a talk with the husband as it was hoped that her frigidity would disappear with her depression. Asking her to report back several times served the dual purpose of being of therapeutic value to her (“to get it off her chest”) and of assessing the severity and progress of the illness.

For the skin lesion, she was referred to a specialist. At this point it is convenient to review the dealings with specialists in physical medicine in this case. For both her neurodermatitis and menorrhagia, she was sent immediately to see a consultant. The family doctor was certain of the diagnosis before referring her, but his prompt action both confirmed his ideas on therapy and assured the patient that these major symptoms would be adequately attended. She was never sent to see a neurologist, orthopaedic surgeon or

gastro-enterologist—she was examined thoroughly in the surgery for any symptom and told directly the result of the examination, thus avoiding the additional burden of hypochondriasis.

When the patient appeared for the second time with severe depression and frigidity, the doctor decided that he would see her husband, whom he knew to be a helpful, approachable person. This enabled him to see if any of the fault lay with the husband and to get a more objective account of the patient's disability. As a result, the doctor was able to suggest a change to the sheath method of contraception, and to advise strongly against the use of coitus interruptus. The patient herself had said nothing of this latter method, which may have been a potent factor in producing anxiety over coitus. She was reassured again, and phenelzine was prescribed.

At this point, no doubt many people would have advised specialist psychiatric treatment. The long duration of her symptoms and the lack of success with contraceptives would seem to point to her frigidity having a more complex aetiology, which would require more thorough psychotherapy. However, the cessation of coitus interruptus and the co-operation of the husband seemed important pointers to success without outside intervention, which would be difficult to arrange for a busy housewife.

In many cases of psychoneurosis, improvement can occur on changing the social circumstances of the patient, but advice of this sort was impossible because her social state was so fixed. Now, after another six months, it is necessary to assess the illness and its treatment in general practice in retrospect. She has been successfully steered through the dangers of a depressive illness but little has been achieved with her frigidity, which treatment has shown clearly not to be due to fear of another pregnancy. Events have also shown that, in this highly neurotic person, any further crisis is liable to cause a recurrence of her depression. Thus further treatment is necessary on two counts: to attempt to cure the frigidity, and to prevent further episodes of depression.

Along what lines can this therapy be directed? There are some aetiological clues, her father's death at her menarche, the unpleasant shock of her first coitus, her first husband's disappearance, and so on. Yet on the other hand, knowledge is scanty of her childhood, adolescence and first marriage—and why did her first husband leave her? It is important now to know whether she in fact loves her husband or is married only for security reasons. The possibility of her obtaining secondary gain with these symptoms must also be explored. This kind of investigation is not easy.

With regard to prognosis, factors in her favour are the acute onset of frigidity, its association with neurotic symptoms (i.e. placing its fixation at a reasonably accessible date) and her desire

for cure. Against her are her age, poor intelligence, the long duration of symptoms and her rigid social situation. These factors make psychoanalysis out of the question and hold out only moderate hope of success for deeper therapy.

The question now arises as to who will conduct her therapy. This promises to be a long and difficult task, so that regarding both time and experience, it appears that specialist psychotherapy is more feasible, and has more hope of success, than the supportive therapy possible in general practice.

This is a family problem. In her present state she is no more than a passenger in her dual role of wife and mother—and, for the sake of her husband and children, deeper therapy must be tried if there is any prospect of cure; her two oldest boys are already the victims of one broken home.

Help in the understanding of this case has come from interviews with the patient herself, discussion with the family doctor and reading, especially M. Balint's *The doctor, his patient and the illness* (1957) and Clifford Allen's *Textbook of Psychosexual Disorders* (1962).

#### **Summary**

This patient, with neurotic personality and a stormy marital background, developed a neurotic illness after her only pregnancy by her second husband. The nature of the symptoms were varied—obsessive compulsive acts, neurodermatitis, depression and frigidity.

She was cared for by several long interviews and given concurrent drug treatment. Under this therapy, the obsessional trends disappeared quickly and the skin lesions healed slowly. The symptoms of depression lessened but recurred. Her frigidity remained intractable. The situation now is that, both for the relief of her frigidity, and for the stability of the household, further psychotherapy is required. Present knowledge of the aetiology and prognosis of the illness can, at best, forecast only moderate success.

## **CLINICAL TRIALS**

### **THE TREATMENT OF MENTAL SYMPTOMS IN THE AGED WITH PROTHIPENDYL (TOLNATE)**

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IT HAS BEEN SAID that "In the end all our contrivances have but one object: to continue growth of human personalities and the cultivation of the best life possible". Physicians and welfare workers may