SYPHILOPHOBIA

A PSYCHIATRIC STUDY*†

BY

IDA MACALPINE, M.D.

Associate Chief Assistant in Psychiatry, Department of Dermatology, St. Bartholomew's Hospital, London, E.C.1

Introduction

Psychiatry induces widespread apprehension, and physicians and surgeons tend to steer clear of it as much as possible. Unfortunately, even something seemingly so far removed from mental problems as venereology cannot afford to ignore it. In fact, the more successful the treatment of venereal disease, the more your attention will be demanded by patients in whom neither spirochaetes, cocci, nor viruses are the malefactors, but simply their minds. Thus, while the number of patients requiring treatment from the venereological aspect may be diminishing, those who are really psychiatric patients may well increase.

It is with trepidation that I address you on a psychiatric subject, partly because psychiatry, which has gained so much in popularity, has developed a bewildering array of jargon, words, schools, and treatments which must appear forbidding to the outsider; partly because often the only result of referring a patient to a psychiatrist is a lengthy and incomprehensible report in which therapeutic information is confined to the statement that the patient's name has been added to an interminable waiting list.

Syphilophobia is not only a fascinating manifestation of mental illness, but it also provides an excellent example of how fruitful close cooperation between a psychiatrist and other medical or surgical specialties can be. Patients with syphilophobia may present in the out-patient departments of all specialties with such complaints as headache, backache, stomach-ache, palpitations, or precordial pain. These symptoms are expressions of their morbid fear or conviction of being infected. Frequently, they complain of peculiar sensations—sensations which are not only peculiar to themselves, but peculiar also in that they do not add up to any known disease. Further, though the symptoms may be many, the signs may be none or minimal. Where signs of disease exist at all, they are often on

the skin and, apart from venereologists, dermatologists see the largest number of such patients, the genito-urinary departments attracting the next largest number.

My interest in syphilophobia was first aroused during an investigation some years ago into patients with intractable pruritus ani, in whom no organic cause for the pruritus could be found (Macalpine, 1953; 1954). Half the patients I saw were convinced that their pruritus was a manifestation of venereal disease, a conviction often based on no acceptable evidence of risk or exposure. Often it only became apparent in the course of psychotherapy that many of these patients feared or were convinced that they had syphilis, although some ventured such alternatives as cancer. This condition may be called "masked syphilophobia" in contradistinction to "overt syphilophobia" such as presents at special treatment centres (S.T.C.). By the time patients are convinced that they have syphilis or are sufficiently disturbed by the prospect to mention it to their doctors and so be referred to a S.T.C., they are usually more severely ill mentally than those patients in whom anomalous body sensations arouse a secret fear of having a venereal disease about which they do not volunteer information; the latter group hope the doctor's examination will discover or exclude the disease.

I therefore thought that a separate investigation into overt syphilophobia would be interesting, and Dr. C. S. Nicol kindly referred to me patients from the S.T.C. at St. Bartholomew's Hospital. Before I discuss these and other patients I have seen, I want briefly to consider the incidence of syphilophobia as it appears in S.T.Cs.

Incidence

It is impossible to arrive at a precise estimate regarding the proportion of patients suffering from syphilophobia out of the total who attend S.T.Cs. It varies from centre to centre, and probably also with the psychiatric acuity and interest of the venereologist. An analysis of the published statistics

* Received for publication February 16, 1957.

† Paper read to the M.S.S.V.D. on January 25, 1957.

of first attendances at S.T.Cs. was tried, but no conclusions could be drawn from them. The fact that, in 1951, the column "Other Conditions", comprising all non-venereal conditions, was split up into those "Not Requiring Treatment" and those "Requiring Treatment", does not allow any legitimate conclusions to be drawn regarding the incidence of syphilophobia. Quite apart from the fact that some primarily psychiatric patients may have been missed, those who are spotted and referred to the psychiatrist are in some S.T.Cs. entered in the column "Requiring Treatment", whereas in others they are entered in the column "Not Requiring Treatment".

However, the impression is that, although the figures for the incidence of venereal disease may have declined since the war, the number of psychiatric patients attending S.T.Cs. has not decreased correspondingly, but remains stationary. Figures published by Schuermann (1952) show that the incidence of "venereal disease mania", as he called it, had not declined with the incidence of the disease. If this is correct, it would be expected that the recognition and treatment of psychiatric conditions would become increasingly important as their percentage of the total attendances rises. This trend will continue until such time as venereal disease has lost its significance in the popular mind as the last word in doom and dissolution.

In any case, only a psychiatrist working in a S.T.C. could ascertain the real incidence of psychiatric conditions. This is because there is a fine gradation from patients in whom the mental background of symptoms is not obvious, to those frankly disturbed for all to see. To discover them all, the person examining has to be acutely attuned to psychiatric patients of this kind.

History of Syphilophobia

It appears that the term—like syphilis itself—is transatlantic in origin, for it appeared first in a dictionary of medical science published in Philadelphia in 1848 (Dunglison, 1848). There it was defined as "a morbid dread of syphilis giving rise to fancied symptoms of the disease", and an interesting distinction was drawn between it and "syphilomania, vulgarly called noddlepox", defined as "a mania with which some persons are affected so that they subject themselves to anti-venereal treatment under the notion that they are affected with syphilis".

Thus, although the term syphilophobia is hardly more than a hundred years old, it has, like many other conditions, been known for very much longer and adequate clinical descriptions are to be found in 17th century medical and surgical literature (e.g.,

Wiseman, 1676). Probably it had been recognized even before then, for many medical and religious authors of the 16th century dealt with melancholic persons labouring under a sense of sin who imagined that they were suffering from all kinds of diseases inflicted on them as divine punishment (e.g., Bright, 1586). Mandeville (1711) published an excellent self-description and in the third edition of John Hunter's "Treatise on the Venereal Disease" (Hunter, 1810) there appeared a lengthy account written by a patient.

Syphilophobia had become of sufficient importance to be discussed by Freind (1727) who wrote:

There is one remarkable thing, which often attends this distemper, and which indeed we find in no other: that persons, who have been once infected with it, though never so well cured, take it into their imaginations, that still they are under the power of the disease, and in continual danger: the very reverse of what we see daily in a consumption where even at the last gasp of breath the patient is so fond of flattering himself, that one can hardly persuade him this his case is desperate. But here in this other unfortunate extreme, [i.e. syphilophobia] if but a pimple appears or any slight ache is felt, they distract themselves with terrible apprehensions: by which means they make life uneasy to themselves and run for help to every pretending knave who for the sake of gain never fails to encourage their fears. And so strongly are they for the most part possessed with this notion that an honest practitioner generally finds it more difficult to cure the imaginary evil than the real one.

In the mid-19th century the French devoted much attention to the subject, and by the end of the century it had gained sufficient respectability to be given separate attention in English psychiatric literature. In 1892 Sir George Savage divided patients into two groups: in the first there is an "insane dread of syphilis . . . syphilis acts as the idea around which the melancholic feelings group themselves", often in a patient who has had some form of venereal disease in the past; in the second group the patient interprets morbid feelings about himself and his body as due to syphilis "without the disease ever having been contracted". The former he called syphilomania, the latter syphilophobia. In his experience patients were often solitary and self-conscious young men, some of whom had acne and other "harmless" pimples which seemed to add weight to their delusions. Some of the married men were impotent, and many were suicidal at one time or another. He attributed the preponderance of men not only to bad habits but also to the fact that "young Englishwomen . . . are happily ignorant of the features of the disease" and therefore cannot imagine they have it.

In the last few decades, the condition has once again been lost to sight, and it is scarcely mentioned

in current textbooks of psychiatry, dermatology, or venereology. The reason for this is not because it is on the decline, but because division of medicine into sharply distinguished specialties results in many patients with somatic symptoms who are primarily psychiatrically disturbed, never impinging sufficiently on the psychiatrist's attention because they appear in other departments. Thus patients become distributed among many specialties, which fact also accounts for the magnitude of the problem not being appreciated.

Psychiatric Implications

Syphilophobia considered as a psychiatric symptom reveals all the complexities and confusion in present-day psychiatry: for instance, how are these patients to be classified or diagnosed? Formal psychiatry provides a variety of labels for the condition: anxiety state, anxiety hysteria, anxiety neurosis, obsessional neurosis, hypochondriasis, delusional psychosis, depression, depressive reaction and depressive psychosis, melancholia, involuntional melancholia, paranoia, paranoid schizophrenia, and schizo-affective disorder. This labelling does not help the understanding of the individual patient; indeed it is often a substitute for it, and may actually hinder it by disregarding the transitions from stage to stage of mental illness which are so beautifully illustrated in this condition, and which allow its development from the mild to the most severe to be studied. Equally it is of little importance whether the condition is labelled syphilophobia, syphilomania, venereal disease phobia, venereal disease mania, or anything else—indeed “noddlepox” is perhaps still as descriptive a term as any.

What does matter is what the condition means to the patient, and how he has come to think and feel as he does. It usually means that he is anxious about himself, has a preoccupation, an exaggerated fear, or a doubt, or a conviction that there is serious mischief going on inside him, or that something is growing inside, and this is often accompanied by the idea of rotting or by the thought that a terrible end awaits him or is actually taking place. With it goes a sense of guilt, punishment for sin, and doom. Hence many patients feel that they are a danger to other people, especially to members of their families, and a source of deadly infection to their nearest and dearest. Naturally, anybody suffering from such sinister fears or delusions is likely sooner or later to consider suicide as a way out, if only to avoid what he considers to be a fate worse than death, or to avoid infecting others. Some of these patients do

in fact commit suicide and occasionally take their families with them.

For example, an apparently happily married man aged 50 years, with one child, had a great deal of unnecessary and harmful investigation and treatment for a burning sensation in his penis. When he developed dermatitis medicamentosa, he was sent to the Dermatological Department at St. Bartholomew's Hospital where I saw him at his first attendance, because he told the dermatologist he thought he had syphilis. I could not give him any time that day and so arranged to see him at length the following day. Although I took his case seriously, I must confess I was in no way alarmed about him, nor was there any apparent reason to be. He went home and hanged himself the same night. His widow subsequently told me that he had been extremely depressed for months, he was quite convinced he was suffering from what he called a terrible and incurable scourge, *viz.*, syphilis, and that he lived in constant terror of infecting his family. He would not touch anything in the house without first putting on gloves and every cup and glass from which he drank he smashed afterwards. Latterly, he had had only one thought in mind: how he could save his family from the same fate.

This patient illustrates a valuable practical lesson: the noisiest, most anxious, and most agitated patients are not always the most seriously disturbed. On the contrary, while the patient anxiously seeks help he has not fully accepted his morbid fears. Once he has accepted them and they have become fixed in his mind as delusions, he often appears calm, although he is now more seriously and even dangerously ill mentally than before. In fact, it is in this outwardly deceptive stage that patients most frequently commit suicide, which then seems to occur unexpectedly and out of the blue. The patient I have mentioned was a very typical example of this.

And here perhaps it should be said that as a general rule in psychiatry severity of overt symptoms is no criterion of severity of illness although commonly mistaken for it. The more acutely disturbed the patient the better the prognosis, while patients with few if any overt symptoms may be chronically incapacitated. I need only mention that so-called neurotics are commonly referred to as chronic, while so-called psychotics have a two-thirds spontaneous rate of remission within six months with or without treatment, and may be perfectly well before and after their acute illness.

Patients with syphilophobia are best graded in terms of severity of mental illness according to how tenaciously they cling to the idea that they are suffering from syphilis and what exactly this means to them. In order of severity they may be roughly grouped as follows:

- (1) the mildest patients who have adequate reasons for thinking they have contracted a venereal disease;

- (2) those who have some skin lesion or skin sensation which arouses the idea of syphilis and brings to mind a past exposure;
- (3) those who, at one time, have had a venereal disease and have been successfully treated, but who suddenly develop a doubt about whether they have been cured;
- (4) those who have multiple somatic symptoms which may take the form of localized aches or pains and who without reason attribute them to syphilis;
- (5) those in whom there is no adequate history of risk or infection at any time but who develop the conviction of being infected.

These last are the frank syphilophobes and the most severely disturbed. Their delusion is twofold: it is not only centred on their bodies, but has spread to misinterpretation of past events.

Thus, the condition may be an expression of the patient's morbid or exaggerated but well-founded anxiety about himself and his body, hence the diagnosis of anxiety state or hysteria. Alternatively, it may be an anxiety without any adequate foundation leading to a perpetual doubt in the patient's mind whether he has syphilis or not, a stage at which he may be labelled an obsessional neurotic. This stage merges imperceptibly into one of conviction of having the disease and where depression and concern replace anxiety. The patient is now deluded, that is to say he has a fixed false belief not amenable to reason or reassurance and not shared by other members of the community; hence he may be diagnosed as suffering from hypochondriasis, depressive psychosis, melancholia, or paranoia, depending on the psychiatrist's taste and whether he pays more heed to the depressive or delusional symptoms. The patient now tends to go from doctor to doctor and from centre to centre in order to find somebody who will confirm and so share his delusions.

If such body delusions spread to other spheres of the patient's life, *e.g.*, if he takes them as evidence of persecution by Communists or as the influence of atomic rays, then he is patently mad and will be diagnosed as a psychotic, schizophrenic, or paranoid schizophrenic.

This is the stage at which such patients are found in mental hospitals. There they are no longer diagnosed as syphilophobes because other and more conspicuous evidence of alienation becomes superimposed, and because mental hospital patients are rarely investigated psychologically (Macalpine and Hunter, 1955).

Material

Altogether 24 patients were referred for psychiatric investigation from the S.T.C. at St. Bartholomew's

Hospital: these form part of a larger series including over one hundred other patients classified as syphilophobes seen in the Dermatological Department and in mental hospital practice; details of this larger series will be published elsewhere (Macalpine and Hunter, 1957).

Of the 24 patients, 23 were male and only one female. This astonishing preponderance of males over females coincides with recorded experience, past and present, and I shall return to the psychiatric reasons for it later. In Schuermann's (1952) series there were 65 men and two women.

Patients' ages ranged from 17 to 55; one patient was under 20 years; one between 20 and 30; fifteen were aged 30 to 40; three were 40 to 50; and four were over 50. Thus most cases fell into the middle period of life, which shows that there is no direct relation between syphilis and syphilophobia, as the highest incidence of syphilis is in the third decade. The age distribution tallies rather with the incidence of more insidious and less acute mental illness, often designated as the paranoid form of schizophrenia.

Patients' occupations varied from unskilled manual to skilled clerical work; four patients were professionally unemployed, *i.e.*, vagrants.

With reference to marital status, there was a much higher proportion of bachelors than is found in the same age group in the general population: only eleven of the 23 men were married, and the only woman was unhappily married and childless.

There was a previous history of mental breakdown in nine patients: all had been to mental hospitals for periods varying from a few weeks to a number of years. Another four were so severely disturbed when I saw them as potentially to require admission to mental hospitals, and I know that one of them was subsequently admitted. The only woman had also been in a mental hospital. It need hardly be stressed that fourteen out of 24 is a very much higher incidence of severe mental illness than is found among an unselected series of out-patients attending any department, or in the general population, of whom only about one in 25 or 30 will in the course of their lives require psychiatric attention.

Treatment

It was not surprising that a group of patients with such a high incidence of severe mental disturbance was not uniformly amenable or indeed desirous of out-patient psychotherapy. Thus thirteen patients were seen only once: some failed to attend again after the initial psychiatric interview, some felt that they could not expect to benefit, and one had to be sent to a mental hospital. Those patients who had been in mental hospitals previously were naturally suspicious of seeing a psychiatrist because they were afraid of being returned to a mental hospital. Another group of patients had no social roots or ties and were chronically unemployed: for these there was no incentive to attend for treatment as they had nothing to gain from abandoning their

delusions. Finally, some patients were hovering on the brink of severe breakdown and because of this were afraid of the psychiatric approach. They preferred to go on thinking that they had a bodily illness.

As it was, psychotherapy with the ten remaining patients was more successful than is usually thought or taught to be possible. All were sufficiently improved after three to six interviews for them to be considered no longer acutely ill.

Some attended as often as twelve times at weekly or fortnightly intervals. One patient cured himself during the waiting period between attending the S.T.C. and his psychiatric appointment. He said: "When they told me they wanted me to see a psychiatrist I knew I couldn't have syphilis because they only send patients to psychiatrists who aren't ill". One wonders whether such a result can in all honesty be counted as a psychotherapeutic success.

It was surprising how quickly these patients recovered their pre-morbid state, although it is impossible to say how long they will remain well. One avoids speaking of cures because it is by no means established in what circumstances one is justified in speaking of cures in psychiatry, but these patients were no longer depressed or concerned about venereal disease and returned to work and domestic happiness. Four of them still report to me from time to time.

Clinical Features

Certain characteristic clinical features emerge from this series. All patients had previously been to other S.T.Cs. or hospitals for investigation of anomalous body sensations or of a declared belief that they were suffering from syphilis. On the average, they had had six negative Wassermann reactions before I saw them: one had had 22 at various centres in 12 months—he certainly could not take no for an answer and, needless to say, only came to see me once.

If patients are confronted with the fact that they are known to be unconvincible and that it is taken for granted that they have attended other doctors and centres previously, they usually reveal a lengthy history—a characteristic feature which may escape notice unless specifically and sympathetically inquired after. Patients are chary of mentioning their other attendances because they somehow realize that it may make them appear odd or ungrateful. Fresh cases of recent onset are seen only rarely.

All patients gave a history of exposure, but on close questioning well over half of them revealed this to be either delusional or fictitious. Delusional exposures were recounted in terms of strange looks, drinking or eating from utensils that may previously have been used by a syphilitic, the inevitable lavatory seat, and sleeping in strange beds. Others recounted hallucinatory experiences such as voices which told

them that they were infected. These fictitious accounts of exposure were given by the patients in the hope that their cases would be taken more seriously and would be investigated more intensively. In fact, four patients who had given lurid accounts of contacts with the opposite sex were later found to have been impotent at all relevant times. In these patients ideas of exposure derived from and followed their delusional conviction of having syphilis.

Case Histories

These clinical features are best illustrated in case histories selected from those seen in the Dermatological Department as well as those referred by the S.T.C.

Case 1, an intelligent married man of 33, a printer by trade, is an example of the less severely though acutely disturbed group, in whom the idea of having syphilis fluctuates between a fear and a conviction. At times he could see it was quite irrational to think he had syphilis, but mostly he could not get the thought out of his head. He was an anxious frightened man who trembled and sweated a good deal when interviewed. He complained of pains in the head, the left chest, the right arm, and in the groin. These had made him very depressed. Four years previously he had extra-marital intercourse once while his wife was in hospital with an ectopic pregnancy. He immediately felt very guilty and was convinced he must have caught a disease. He felt he had changed in some way. A doctor told him he had non-specific urethritis although he was really only suffering from a guilty conscience, and he took this to mean he was suffering from an as yet unknown and therefore particularly vicious type of venereal disease. Subsequently, every ache or pain he felt he took as evidence of the disease, and abstained from intercourse for fear of infecting his wife and producing tainted offspring. He continued to work but both he and his wife lived solitary lives, spending most of their spare time brooding over their bodies and visiting doctors and hospitals. It is of interest that his wife developed a belief that she had a tumour growing in her abdomen, with various other symptoms characteristic of phantom pregnancy or pseudocyesis. Whatever symptoms she developed he suffered from also, and *vice versa*. Once previously, during his Air Force career, a pimple on his thigh had been followed by similar ideas which at that time did not take root. The first and second interviews consisted entirely of the patient pouring out his story and giving vent to his pent-up feelings, in other words sympathetic and extended history-taking in which the patient shared. At the third weekly interview he reported that he felt very much better, was hardly depressed, and accepted that his ideas about having syphilis were unfounded. He said, "I cannot understand how one can develop a kink in one's mind as I have done". After a few more interviews he reported that his improvement had reflected also on his wife and that they were both much less concerned about their health and were busy attempting to produce a child. This couple are an interesting

example of a not at all uncommon psychiatric condition known as *folie à deux* in which anomalous body sensations as well as irrational ideas are transmitted between persons who live closely together (Greenberg, Hunter, and Macalpine, 1956). That another person shared his false beliefs and aches and pains of course clinched the diagnosis that they originated in his mind.

Case 2, another example of *folie à deux*, was a patient from the slums who was convinced he had syphilis, to which he attributed his presenting symptom, pruritus ani. He believed he had contracted it by having a bath in the same bath water as a coloured lodger. His mother followed him as the third person into the same bath water and developed the same delusion. To them syphilis represented a general idea of contamination.

Case 3 was a patient whose delusion of having syphilis arose from an hallucination, *viz.*, that a bad smell emanated from his penis—also a not uncommon symptom. He thought this made people in buses and confined spaces, and sometimes even in the street, pass remarks about him. All attempts to discuss his ideas with him in terms of their possibly being false impressions failed utterly; he always countered any such suggestion with the statement that surely they could not be in his imagination seeing that his wife had also noticed his smell. He had accepted his hallucinations so completely that he had taken a job in a rubber factory where there were so many bad smells about anyway that his own would not make him conspicuous.

Case 4 was a medical student, a very disturbed and suicidal patient, who had always been a solitary, nervous sort of chap, with mental illness on both sides of the family. He had never had any contact with girls and developed the delusion that he had syphilis when he was working very hard for his final examinations. He complained of pains in the head which he took as a sign of impending general paralysis of the insane, eye strain which he was sure was due to commencing optic atrophy, and pain in the shins which he took as evidence of tabes; in fact, he acquired all the symptoms of syphilis the moment he read about them. He was seen half a dozen times and persuaded to continue his studies and delay decisions about his future until after qualification. Doubtless the immediate precipitating cause of his breakdown was overwork; that he had fixed on syphilis was because he considered it punishment for masturbation. Once successfully qualified he never looked back.

Case 5 was a middle-aged man, a typical chronic patient, who had never held a job longer than for a few weeks. He had spent many years tramping all over the British Isles in quest of somebody who would agree with him that he had hereditary syphilis. This conviction dated from an incident in his adolescence when he had seen a pimple on his father's chest. From then on he was convinced that his father had syphilis and that he had inherited the taint from him. He was neither particularly anxious nor depressed, but had spent his whole life in pursuance of his delusion. Needless to say, no attempt was made to

substitute the delusion that he was really all right for the delusion that he had syphilis.

Cases 6 and 7 had syphilophobia which was associated with exhibitionism, and one of them also feared that an impulse he had of murdering his mother might become irresistible. Such patients require very careful psychiatric handling as out-patients, but both did well.

Discussion

The explanation of the enigmatic preponderance of male patients with syphilophobia, whereas the incidence of mental illness is much the same for both sexes at all ages, can only be found if it is borne in mind that syphilophobia is a symptom, not a disease. There are two analogous complaints in which women predominate, *viz.*, in the delusion of parasitosis and the delusion of growing or losing hair. These two conditions are in a way complementary and belong together psychopathologically and clinically. But for the reversal of sex incidence, they correspond in all features: they develop in the same way and are often precursors or concomitants of severe mental illness: and, in expert hands, the chance of helping them by psychotherapy is much the same and much better than is generally held.

In both, the development of delusions and the progression of mental illness from mild to severe can be followed. They differ only in the content of the delusions. Part of the answer to the question why analogous conditions produce different ideas in men and women, lies in the fact that men know a good deal more than women about the signs and symptoms of venereal disease. This is not, perhaps, in our time, so much through experience as through educational influences, especially in the Forces. More important is the anatomical difference which hides from women what men can freely observe and about which they can more easily brood.

Management.—Before giving in outline the psychiatric management of these patients, it is necessary to dispel some misconceptions about psychotherapy. First, psychotherapy is not the endeavour of someone who knows better to talk a patient out of a faulty notion. In fact the essence of the procedure is sympathetic, patient, and extended case-taking in which the patient shares and the therapist says very little. Care must be taken to avoid a barrage of personal questions reminiscent rather of obtaining evidence than of taking a clinical history. All symptoms must be noted and inquiry made for others than the presenting ones. The precise time at which they started, how they developed, and any connexion with other events in the patient's life to which they might be related are very important. A picture

should be obtained of the whole person, his work, his friends, and his interests. Often the patient's behaviour may betray emotion where none is expressed in words. Inaccuracies or hesitations in the patient's statements can be valuable because they give a clue to his innermost thoughts and feelings, sometimes called unconscious. It is not so important to discover what happened as to find out what a particular incident meant to him. Inconsistencies may reveal delusional interpretations or hallucinatory experiences where these are not obvious, and must be continually looked for. The patient's fears and fantasies about his body, what he thinks has happened in the past and what he fears in the future should be traced out. The only way to appreciate how the patient feels and to show that you understand his condition, is by really understanding him. Once he feels that this is so, one can hardly imagine a more grateful and loyal patient.

It is essential never to reassure. When a patient asks whether he has syphilis or not, the answer is: What makes you think it may be; or, what makes you think it is; or, what do you anticipate would happen if it were? Such a patient is extremely sensitive and may easily interpret reassurance as meaning that you do not understand his case, otherwise you could not brush it off so lightly; or that you have not enough time to spend on him; or, sometimes, that you are lying, because in point of fact his condition is very much more severe than you would like him to know, and reassurance is all that can be done in his desperate plight.

All this is not theory but facts learned at my cost in dealing with patients. Reassurance and an appeal to reason are in any case doomed to failure in patients who are convinced that they have syphilis, because a delusion by definition is an unshakable belief which cannot be corrected by this means. Such patients simply cannot accept the fact that their Wassermann reaction is negative. It is this which often makes patients so very trying, particularly to non-psychiatrists who may feel how easy they would be to handle if only they would see sense, and who may even take it as a slight on their professional ability if patients do not believe them. The incapacity to accept evidence is also the explanation why patients go from doctor to doctor and from centre to centre in quest of somebody who will confirm or share their delusions.

One of the difficult points in management is that patients often ask for just one more blood test. I tell them that they would not accept a negative report, or if they did the relief afforded would only last them a short time. Often they accept this explanation, but some quite understandably ask

"Why have I had so many tests if there is no question of my having syphilis?" Every test to them means that the doctor who ordered it must at least have suspected they had a venereal disease. Indeed, how little they are reassured by a negative report on their blood is shown by one patient whose face fell when it was shown to him, and who said resignedly, "I suppose that means I've got leprosy".

Even greater difficulties occur in psychotherapy when a course of penicillin has been given in the hope of assuaging their fears or pacifying their delusions. Such a procedure is always fraught with danger because a delusion shared by the doctor means a delusion very much reinforced by an unbiased objective authority. I know of one patient who had to be sent to a mental hospital after the third injection and who remained there. Various forms of somatic treatment designed to placate the patient merely add the weight of reality to budding delusions.

Feelings of guilt often play a large part and are closely linked with depression in which the patient feels he is no good, if not positively dangerous. If he is allowed to ventilate these feelings instead of being talked out of them, he will at once become less depressed. With the depression of course goes the sense of isolation that nobody understands him and nobody has ever had anything like it before. Therefore at a suitable moment, I sometimes tell patients that I have seen many similar cases, all of whom have felt the same. This can be surprisingly effective because it makes the patient realize that his case is not so unusual as to make him unique and a mystery, a belief which naturally isolates him from his fellows. After all, the essence of insanity or alienation is having experiences which other people do not, will not, or cannot share. This is at once lessened when patients realize that others can understand or have felt the same (Macalpine and Hunter, 1956).

Detachable Delusions.—Syphilophobia is one of the conditions in which the development of mental illness can be traced and the development of delusions and hallucinations followed: it illustrates how patients may advance from anxiety and fear to doubt, from obsessive rumination to an unshakable conviction of disease. Stages in the development of delusions shade into one another, although the condition may be arrested or disappear at any time. There is a stage at which delusions are still only loosely held and the patient is depressed by his insight: patients still have spells of knowing they are wrong, a stage which may be described as one of fluctuating delusions. This is a great help in

psychotherapy and when I observe it I always draw the patient's attention to it and tell him it is a healthy sign. So long as delusion is not yet fixed, it is much easier to get the patient to relinquish it.

All this makes these patients so fascinating, because it contradicts the general assumption that once they are deluded, *i.e.*, mad, they must go to a mental hospital and be past psychotherapeutic help. It seems that there is an incipient stage in which the mind is wrong yet still right enough to recognize that it is wrong. At this stage severe and perhaps chronic mental illness can be prevented, whereas a false psychotherapeutic move may foster it. Dr. R. M. B. MacKenna jokingly suggested that they might be called "detachable delusions", and nothing expresses the psychotherapeutic possibilities better than this excellent term.

How do these patients give up delusions? This is a problem hardly ever discussed or studied by psychiatrists. Occasionally, a patient recovers on insight and may mention that he cannot understand how he came to think as he did. More commonly delusions gradually recede and patients never refer subsequently to having had false beliefs or state that they can now abandon them. They may stop talking about them altogether and, when asked, say that they do not think of them so often, or that they do not seem so urgent, or that they have other things to occupy their minds, particularly since resuming former activities. It is almost as if they had lost interest in whether they had syphilis or not—the problem simply vanishes. Although so much is talked of recovery with insight, I am not at all sure that insight is always necessary or indeed beneficial. It is apparently equally sound for patients to forget about their false beliefs; this may even be sounder because the sudden relinquishment of a delusion may be as delusional as the original delusion.

Summary

These patients are not just dead wood but a fascinating field for psychiatric investigation and treatment.

Syphilophobia is a psychiatric symptom which may accompany or precede all stages of mental illness, and is analogous to all features to the delusion of parasitosis or hypertrichosis in women.

The severity of these patients' mental illnesses can be roughly estimated by how far the history of the

risk of or exposure to infection is removed in time and from fact, and by the degree of tenacity with which they cling to the idea that they have syphilis.

The noisy and most troublesome patients are not necessarily the most severely disturbed. On the contrary, those who are quietly resigned to what they think is their fate are really more seriously ill psychiatrically speaking and potentially more suicidal.

The most important points in their management are the uselessness of reassurance, the danger of repeated testing to oblige the patient, and the grave danger of placebo treatment.

Finally, much can be done to help patients by careful and sympathetic history-taking without much being said by the psychotherapist. Indeed, much more can be done by psychotherapy, even to the point of detaching delusions, than is usually considered possible even by psychiatrists. These patients exemplify the dictum that in psychiatric practice one does not necessarily have to be doing something to patients in order to do something for them; in fact, the reverse is more true.

I thank Dr. C. S. Nicol for kindly allowing me to study patients attending his department and for his interest in this investigation; Dr. R. M. B. MacKenna in whose department I work, for his sustained appreciation and encouragement and for the many patients we have seen together; and Dr. Richard A. Hunter with whom I have had valuable discussions and who placed his mental hospital experience at my disposal.

REFERENCES

- Bright, T. (1586). "A Treatise of Melancholie". Vautrollier, London.
- Bumstead, F. J. (1879). "The Pathology and Treatment of Venereal Diseases", 4th ed., p. 784. Lea, Philadelphia.
- Dunglison, R. (1848). "A Dictionary of Medical Science", 7th ed. Blanchard, Philadelphia.
- Freind, J. (1727). "The History of Physick", 2nd ed., Part 2, p. 385. Walthoe, London.
- Greenberg, H. P., Hunter, R. A., and Macalpine, I. (1956). *Brit. J. med. Psychol.*, 29, 294.
- Hunter, J. (1810). "A Treatise on the Venereal Disease", 3rd ed., p. 416. Nicol, London.
- Macalpine, I. (1953). *Psychosom. Med.*, 15, 499.
- (1954). "Modern Trends in Dermatology", 2nd series, p. 18. Butterworth, London.
- and Hunter, R. A. (1955). "Daniel Paul Schreber: Memoirs of my Nervous Illness". Dawson, London.
- (1956). "Schizophrenia, 1677". Dawson, London.
- (1957). To be published.
- Mandeville, B. de (1711). "A Treatise of the Hypochondriack and Hysterick Passions", p. 42. Leach, London.
- Savage, G. H. (1892). "A Dictionary of Psychological Medicine", 2, p. 1253. Churchill, London.
- Schuermann, H. (1952). *Hautarzt*, 3, 296.
- Wiseman, R. (1676). "Severall Chirurgicall Treatises", book 8, p. 4. Royston, London.