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Good personality breakdown in patients attending venereal diseases clinics

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It has long been recognized that fear of venereal disease may provoke psychiatric illness, but the impression has grown up that in many instances there is a predisposition to such illness. However, it is thought that in some cases fear of venereal disease may alone be responsible for breakdown in patients of good personality well able to weather the ordinary stresses of life. No definite investigation of this possibility has been made hitherto. The present study indicates the incidence, psychogenesis, symptoms, diagnosis, and treatment of psychiatric illness occurring in patients at a venereal diseases clinic who were selected because they were of good personality before 'breakdown' occurred. The term 'breakdown' is used for convenience to infer the occurrence of psychiatric symptoms of sufficient degree to cause serious interference with the patient's normal life and work (Stallworthy, 1961).

Stokes, Beerman, and Ingraham (1944) pointed to the special psychological management necessary for the normal patient with syphilis and recognized that the mental state of the finer types of patients was a reflection of the stigma so long applied to sexual problems. Bankoff (1949) described a number of psychiatric states in patients of good personality which appeared to have been solely reactive to venereal infection, or to the fear of it.

It was many years before 'good personality breakdown' became recognized as an entity. In the middle of the 19th century, Bernheim, who had set out to study the sane in order to understand the insane, concluded that we are all *hallucinable* or *hallucinė* (Zilboorg, 1941); but it was not until the world war of 1914 that direct observations were made of psychiatric illness in normal servicemen. Mott (1916) thought a third of 'shell-shock' cases occurred in sound individuals, and Harris (1916) considered that mental strain, hard work, and shell fire could break the nervous stability of the hardiest soldier. Freud, Ferenczi, Abraham, and Jones (1921) confirmed that because of the universality of narcissism, no one was exempt from a traumatic neurosis. Little was heard of good personality breakdown between the wars, so much so that Darrah (1939) remarked that most psychiatric textbooks did not even list the word 'normal' in their copious indexes. Nevertheless, Tredgold (1933) in the inter-war period had studied previously normal personalities suffering from 'acute neurasthenia'. He thought that it might result from excessive work and mental strain, and it was characterized by good recovery with rest. In the second world war good personality breakdown came to receive its full recognition and formulation, and was described in servicemen by Sargant and Slater (1940), Garmany (1944), Weinberg (1946), and Tredgold (1948) and in civilians by Gillespie (1942) and Ling (1944). Finally, Appel and Beebe (1946) showed that almost all men in rifle battalions became psychiatric casualties if they remained in a combat area for more than 200 to 240 aggregate combat days, and that a man reached his effective peak in 90 days. As a result of this study the rearrangement of combat duties and periods of leave greatly conserved man-power by reducing the psychiatric casualty rate. Menninger (1948) remarked that it was not a question of who would break but when, and that not enough had been known about the good personality. The modern concept is stated by Saul and Lyons (1952), that every normal individual has vulnerabilities and may break under stress on his specifically vulnerable spot. The acute reactive psychiatric state, as in war, is not a matter of individual neurosis, latent or otherwise, but of the individual's 'fit' or adaptation to the particular environment. This accords with the 'chink in the armour' theory of breakdown in servicemen of good personality put forward by Tredgold (1948).

Method of study

(1) MATERIAL

69 consecutive old and new psychiatric cases, male and female, from the general attendance of the V.D. department at Guy's Hospital from 1959–60 were

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studied over a period of one year. The following cases were excluded:

(a) Organic psychiatric illness;
(b) Incidental psychiatric states bearing no relation to the fear of V.D.;
(c) Male sexual inversion, considered to be a personality risk in its own right (Garmany, 1956);
(d) All cases of psychiatric illness in which there was some form of predisposition.

There remained 23 psychiatric patients of good personality who formed the subject of this study.

(2) EXAMINATION

After physical examination, patients were examined by interview only. Formal personality tests were not used lest they upset rapport. Patients of good personality proved sceptical of too early psychological measures and it was the aim not to make psychological examination too obvious. Curran and Partridge (1963) think that the interview is still the most satisfactory way of investigating personality. Interviews lasted from 30 minutes to 1 hour or longer, either within or outside clinic hours.

(3) CONCEPT OF GOOD (NORMAL) PERSONALITY

For clinical psychiatric purposes a standard of normality was sought. The necessary criteria were:

(a) Good social adjustment shown by the work or service record;
(b) Sustained interests and personal relationships;
(c) No evidence of previous psychiatric illness or of psycho-neurotic traits in childhood;
(d) No family history of psychiatric illness;
(e) The presence of good conscience and sentiment formation.

(4) SENTIMENT FORMATION

Sentiments are closely linked to attitudes in certain areas of thought and action (Young, 1946) and good sentiment formation conduces to multiple mental conflicts (Pailthorpe, 1932).

Sentiment formation was estimated in four main fields of thought:

(i) Social and moral;
(ii) Religious;
(iii) Altruistic;
(iv) Self regard.

If well formed in three or more of these fields it was considered good. If poorly developed or present in only two or less, it was marked poor or absent. Pseudo-sentiments were distinguished. They occurred occasionally in any individual or were derived from a distorted ego as in some psychopaths. Mental conflicts about V.D. in relation to these four fields of thought were recorded:

e.g. mental conflicts = 3 (social, altruistic, self-esteem).

(5) CRITERIA FOR BREAKDOWN

These were that there was an incapacity in one or more important aspects of living, such as work, and social or domestic life, or a persistence of anxiety or depression without adequate cause.

Results

(1) INCIDENCE

Among 887 new patients at the V.D. clinic, there were twenty (2·2 per cent.) who were cases of psychiatric illness with fears about V.D. occurring in good premorbid personalities (Table I).

TABLE I *Good personality breakdown in new patients at V.D. clinic, by sex*

Sex	*All new Patients*	*Psychiatric illness in good personality*	
		No.	*Per cent.*
Male	689	14	2·0
Female	198	6	3·0
Total	887	20	2·2

Of all 69 new and old psychiatric patients seen at the clinic during the study period, 23 (33·3 per cent.) had good premorbid personalities (Table II).

TABLE II *Good personality breakdown in all patients (new and old), by sex*

Sex	*Psychiatric patients*	*Good personality breakdown*	
		No.	*Per cent.*
Male	45	16	35·5
Female	24	7	29·1
Total	69	23	33·3

These 23 patients formed the material for this study and only these are referred to in the following text.

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(2) AGE

The average age of the men was 34 years and of the women 24 years. The youngest men were two aged 22, both with reactive anxiety states: the oldest men were aged 55 and 54, both with reactive depressions. The youngest women were two aged 17, one with a reactive anxiety state and the other with a chronic anxiety neurosis; the oldest woman, who was aged 37, also had a chronic anxiety neurosis.

(3) REASONS FOR ATTENDANCE

Eighteen (78 per cent.) presented with non-venereal conditions. Seven (30 per cent.) presented with only worry, and eleven (48 per cent.) had physical signs which worried them. These were the sweating of anxiety in four men and non-specific vaginal discharges in four women. Simple balanitis, blepharitis, and tinea were three additional non-venereal findings. Five patients had venereal infections; gonorrhoea in two and nongonococcal urethritis in three.

(4) PSYCHOGENESIS

(i) Fear of venereal disease

This was the sole cause of breakdown in twelve patients (52 per cent.). There were five cases of acute anxiety state, three of chronic anxiety neurosis, three of reactive depression, and one paranoid state.

(ii) Additional causes

In eleven cases fear of V.D. was not the sole cause. Associated factors in three women were a disappointment, a sexual assault, and a mental conflict after premarital coitus. In eight men the factors were marital or consort difficulties in four, business worries in two, overwork for an examination in one, and worry about masturbation in one.

(iii) Marital status

Twelve patients were married and eleven single. In the married the average duration of psychiatric illness was 19 months but in the unmarried only 4 months. Psychiatric illness of over 6 months' duration was found in eight of the married but only four of the unmarried. The average duration of doubt and fear before seeking advice was estimated at 4 years in the married but only three months in the unmarried. Eight married men (50 per cent.) admitted to extra-marital risks and three had conflicts about premarital coitus.

(iv) Occupation

In one patient with a reactive anxiety state the change from army to civilian life had led to fears and anxiety during surveillance for gonorrhoea. He thought, as surveillance was not ended on going home, that he had infected his family. Wessel and Pinck (1947) noted 'V.D. anxiety' under such circumstances in U.S. servicemen.

(v) Delay in seeking advice

In thirteen cases (56 per cent.) the period of delay was more than 6 months. Of these, ten were chronic anxiety neuroses, two reactive depressions, and one a paranoid state. In eight chronic anxiety neuroses a transition was traced from reactive anxiety state to chronic neurosis. Fears and doubts about V.D. had remained unresolved and chronicity resulted with phobias about V.D. in three cases.

(vi) Length of attendance and number of attendances

The persistence or recurrence of symptoms or repeated infections were associated with breakdown in three men with nongonococcal urethritis and two women with trichomonal vaginitis. In another man repeated attacks of herpes progenitalis were associated.

(vii) Anti-V.D. propaganda

In fifteen cases (65 per cent.) anti-V.D. propaganda was given as the cause of worry. Three of the patients had a past history of V.D. and had been discharged as cured, but fears were reawakened by what they had read or heard. Frank (1946) reported psychiatric complications in cases of schistosomiasis which arose from conflicting prognostic advice given on the radio. In two men fear provoked by anti-V.D. poster campaigns had been the sole cause of breakdown (Kite and Grimble, 1963). Posters and slogans were blamed by nine, television by two, and army lectures and films by four.

(viii) Mental conflicts

These were estimated in four main areas of thought (social and moral, religious, altruistic, and self-regard). The average number of such conflicts was four in females and 3·8 in males, two males having no religious conflicts. Feelings of guilt were aroused in 83 per cent. of cases.

(ix) Sentiment formation

Good sentiment formation was present in 100 per cent. of cases. This compared with 63 per cent. in 53 maladjusted personalities not included in this study; of the latter 25 per cent. had poor sentiment formation.

(5) DIAGNOSIS

Seventeen patients (74 per cent.) had anxiety states: seven acute or subacute and ten chronic. The relationship of these two groups was important in that eight cases of chronic anxiety neurosis had originally been

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reactive anxiety states to the fear of V.D. alone. There were also four reactive depressions, one obsessional state, and one paranoid state (Table III).

TABLE III *Diagnosis in good personality breakdown, by sex*

Psychiatric reaction type	*Psychiatric syndrome*	*No. of cases*		
		Male	*Female*	*Total*
	Reactive anxiety state	6	1	7
Affective	Chronic anxiety neurosis	6	4	10
	Reactive depression	4	–	4
Obsessional	Obsessional state	—	1	1
Paranoid	Paranoid state (situational)	—	1	1
Total		16	7	23

(6) SYMPTOMS

(i) Acute anxiety about V.D.

This was the *presenting* symptom in 22 cases (96 per cent.), *i.e.* in all psychiatric syndromes except one of depressive illness. Physical concomitants of anxiety were present in 83 per cent. of cases.

(ii) Depressive illness

Three presented with acute anxiety resembling an anxiety state, and only one with depression.

(iii) General symptoms

Those not confined to any particular psychiatric syndrome were: insomnia, loss of appetite, lassitude, loss of libido, sweating, genital pain without physical cause, loss of confidence, loss of concentration, difficulty in making decisions, and feelings of guilt.

(iv) Fainting and panic attacks in the street

These occurred in one woman with an acute anxiety state.

(v) Suicidal ideas

These occurred in one case of depressive illness.

(vi) Temporary delusion about V.D.

This was a feature of one paranoid state.

(vii) Irritability

This occurred both as a sign and as a symptom. As a clinical psychiatric sign it could be defined as a resentful, argumentative, or hostile expression of dissatisfaction with the clinic doctor's reassurance that no infection was present. It was seen in five cases (21 per cent.), including one of acute anxiety state, two of chronic anxiety neurosis, one of chronic depression, and one paranoid state. In the acute anxiety state it represented a protest by a patient of good personality unable to accept psychological illness; a phenomenon described by Garmany (1944) in wartime service personnel. In the cases of chronic anxiety neurosis and depression it was an anger/anxiety reaction (Laughlin, 1967) against attempts to remove, too soon, the long-held morbid beliefs about V.D. which were, in fact, defences against deeper anxiety. Laughlin has explained that the degree of anxiety in such cases varies inversely with the success of the symptom. Two of these patients defaulted.

Irritability as a general symptom, such as having rows at home and feeling 'on edge', was complained of by two other (female) patients. These were anxiety neuroses. The symptom did not have the same significance as the sign.

(vii) Venereophobia

Each patient with this symptom had a persistent fear of V.D.; knowing the fear to be unreasonable could not ward off the anxiety. It occurred in eight patients (34 per cent.) being essentially absent in the reactive anxiety states. Six cases resulted from partial repression of originally reactive fears about V.D. Two women had 'non-venereal' mental conflicts, one about a disappointment in love and one about premarital coitus.

The diagnosis in patients with venereophobia is shown in Table IV, which also gives the average time for the development of the phobia and the results of treatment.

TABLE IV *Significance of symptom of venereophobia*

Psychiatric diagnosis in good personality	*No. of cases*			*Average time for development of phobia (mths)*	*Result*
	Male	*Female*	*Total*		
Chronic anxiety neurosis	2	2	4	10	2 improved 2 relieved
Obsessional state	–	1	1	2	Relieved
Reactive depression	2	–	2	7	Relieved
Paranoid state	–	1	1	12	Relieved
Total	4	4	8	—	—

(7) TREATMENT

Seventeen psychiatric patients of good personality (74 per cent.) were relieved, five were improved (four defaulting and one continuing attendance), and one was not improved (Table V, opposite).

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TABLE V *Results of treatment (asterisk indicates overlap of cases)*

Psychiatric diagnosis	*No. of cases*	*Results*				
		Relieved		*Improved*	*Defaulted or lost trace of*	*Not improved*
		No.	*Per cent.*			
Reactive anxiety state	7	6	86	1*	1*	–
Chronic anxiety neurosis	10	5	50	4*	3*	1
Reactive depression	4	4		–	–	–
Obsessional state	1	1		–	–	–
Paranoid state	1	1		–	–	–
Total	23	17	74	5	4	1

Discussion

Cases of good personality breakdown in patients at the V.D. clinic formed 33·3 per cent. of 69 psychiatric casualties (Table II) in 1960. Recent work by Pedder and Goldberg (1970) suggests this problem may not have decreased. Nor is it known if 33·3 per cent. represents a decrease in cases of good personality breakdown from former days as no figures are available. It compares, however, with studies of the effects of severe mental stress where Weinberg (1946) found 39 per cent. good personalities among his cases of neurosis in the U.S. army. The incidence of good personalities *per se* among the general attendance at a V.D. clinic is unknown, but the present work showed 2 per cent. of new patients to be cases of good personality breakdown. These figures are evidence that fear of V.D. is a powerful mental stress (Seale, 1966; Kite and Grimble, 1963). It is multifactorial by reason of good sentiment formation. It was the sole causative factor in twelve cases of psychiatric illness in good personalities (52 per cent.). Such individuals had no predisposition, nor would they ordinarily have been regarded as being at risk of psychiatric illness.

The most important psychiatric syndrome was the reactive anxiety state. The delay of such patients in seeking advice about fears of V.D. led to chronic anxiety neuroses in eight cases, the latter being the most prevalent condition in the series. The reactive anxiety state has been largely studied in war, and Garmany (1944) showed that early diagnosis was the mainstay of treatment. Prognosis was good but small errors of management made all the difference between recovery and chronicity. In his series of naval personnel, 88 per cent. were relieved. In the present very small series at a V.D. clinic, six of seven cases were relieved.

While the importance of early diagnosis has been stressed, a busy V.D. clinic did not lend itself to this, without a psychiatric service. Most cases in this series would not have been diagnosed by a short interview. Special interviews for any probable case were essential. The first difficulty in diagnosis was a consequence of the acute anxiety with which all but one patient presented; anxiety is so common at the V.D. clinic and its normal range of intensity there closely resembles the psychiatric range, so that the non-psychiatric patient with anxiety presented a problem in differential diagnosis. Secondly, the patient of good personality often denied that he was anxious or psychologically ill. He was conscientious about not taking up the doctor's time in a busy clinic, and might say he felt silly to ask advice. Some patients, particularly women, said they felt too ashamed or embarrassed to talk (Rees, 1964). More at risk of passing unrecognized was the confident individual, anxious about fixed but false ideas about V.D., perhaps misinterpreted from a textbook and taken for granted in silent resignation.

Encouragement to discuss the patients' views on V.D. were essential to resolve these doubts and false ideas and to prevent chronicity. It was a fallacy to equate long-standing neuroses or chronic depressions, necessarily, with a maladjusted personality. As long as the patient was ill the personality would be abnormal. One case of chronic anxiety neurosis and one of chronic depression, for example, had lasted on and off for 5 years. In all cases, however, the premorbid personality and the prognosis were good.

Psychotherapy took the form of discussions aimed at disclosing long-held doubts and fears, often erroneous, and uncovering near conscious conflicts in chronic cases. A broader philosophy of life was an important aspect, in which religion sometimes played an important role, being discussed by the patient of his own accord. Seventeen (74 per cent.) of all patients were relieved. Good personality breakdown illustrated the need for assessment and psychotherapy

in the V.D. clinic itself. Here the ideal doctor/patient relationship existed and free discussion of sexual problems was possible. Suggestions of referral to the psychiatric department for patients to tell their story over again were invariably unwelcome (Pahmer, 1949). By treatment at the V.D. centre they were also unaware in most cases that they were undergoing psychiatric procedures.

The patients in this group were investigated in 1960, and further studies of psychiatric illness in the patient of good personality at the V.D. clinic are now required to determine whether the mental stress of fear of V.D. has diminished with the recent major changes in the climate of public opinion in sexual matters.

Summary

An investigation of psychiatric illness in 23 patients of good personality was carried out at Guy's Hospital V.D. clinic in 1960. Attention is drawn to the prevalence of 'good personality breakdown' at the V.D. clinic and the risk of the development of chronicity if diagnosis and treatment are delayed. Of 69 psychiatric patients, 23 (33·3 per cent.) had good personalities and two in every 100 new patients were cases of good personality breakdown. The patient of good personality seemed specially vulnerable to the fear of V.D. which was a sole cause of breakdown in twelve cases (52 per cent.). Good sentiment formation, present in all cases, aroused multiple mental conflicts, and made the fear of V.D. a multifactorial mental stress. Eighteen (78 per cent.) came to the clinic with non-venereal conditions. Thirteen (56 per cent.) had worried for over 6 months before coming to the clinic. Married patients showed a longer average period of doubt before seeking advice and a longer duration of illness than the unmarried. Anti-V.D. propaganda was given as a cause of fear in fifteen cases (65 per cent.). Reactive anxiety states and chronic anxiety neuroses predominated, with the risk of the former merging into the latter. Depressive, paranoid, and obsessional states were also seen. All psychiatric syndromes except one depressive illness presented with acute anxiety. Venereophobia was a symptom in eight chronic cases, being essentially absent in reactive anxiety states. The resolution of early reactive anxiety states was essential to prevent chronicity. The V.D. clinic was considered the ideal milieu for unobtrusive psychiatric assessment and psychotherapy; particularly in cases of good personality breakdown. Seventeen cases (74 per cent.) were relieved.

Further studies are needed to determine whether changed attitudes to sex and V.D. in the past decade have influenced the incidence of 'good personality breakdown' caused by fear of venereal disease.

I am much indebted to Dr. A Grimble for his encouragement with psychiatric work while I have been working in venereal diseases at Guy's Hospital. Interviews with patients were possible only by his help in making opportunities despite many difficulties. My thanks are due to Dr. N. Rosedale for helpful comments.

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Effondrement des bonnes personnalités psychiques en vénéréologie

SOMMAIRE

Une recherche sur les maladies psychiâtriques survenant chez 23 malades de bonne personnalité psychique fut entreprise à la clinique vénéréologique du Guy's Hospital en 1960. On attire l'attention sur la prévalence de l'effondrement de la bonne personnalité psychique (good personality breakdown*) à la clinique vénéréologique et le risque de chronicité si le diagnostic et le traitement sont différés. Parmi 69 malades psychiâtriques, 23 (33 pour cent) avaient une bonne personnalité psychique et 2 pour cent des nouveaux malades présentaient un effondrement de cette personnalité. Le malade avec une bonne personnalité psychique semble spécialement vulnérable à la peur des maladies vénériennes, seule cause de sa dépression dans 12 cas (52 pour cent). Une bonne formation sentimentale, qui fut présente dans tous les cas, réveille de multiples conflits mentaux et fait de la peur des maladies vénériennes une aggression mentale plurifactorielle.

Dix-huit (78 pour cent) vinrent à la clinique avec des affections non vénériennes. Treize (58 pour cent) s'étaient tourmentés pendant plus de six mois avant de venir consulter. Les malades mariés hésitaient plus longtemps que les célibataires avant de solliciter un avis et la maladie durait plus longtemps.

La propagande antivénérienne a été indiquée comme une cause de peur dans 15 cas (65 pour cent). Des états d'anxiété réactionnelle et une névrose anxieuse chronique prédominaient, avec le risque que la première se transforme en la seconde. Des états dépressifs, paranoïdes, obsessionnels, furent aussi rencontrés. Tous les syndromes psychiâtriques, sauf une maladie dépressive, présentèrent un état d'anxiété aigüe.

La vénéréophobie fut rencontrée pour 8 cas chroniques mais était généralement absente dans les états d'anxiété réactionnelle. La résolution de ces états d'anxiété réactionnelle récents fut primordiale pour éviter la chronicité.

La clinique vénéréologique apparut comme le milieu idéal pour une évaluation psychiâtrique discrète et pour la psychothérapie, particulièrement en cas d'effondrement d'une bonne personnalité psychique; 17 cas (74 pour cent) furent rétablis.

Des études ultérieures sont nécessaires pour préciser si les modifications, dans les dernières décennies, des attitudes devant les questions sexuelles et les maladies vénériennes, ont influencé l'incidence des effondrements de la bonne personnalité dûs à la peur des maladies vénériennes.

*Cette traduction de 'good personality' est donnée sous réserves, après consultation de psychiâtres éminents qui hésitent également (N.D.T.)