THE
JOURNAL OF MENTAL SCIENCE

[*Published by Authority of the Royal Medico-Psychological Association.*]

No. 394 [NEW SERIES No. 358] JANUARY, 1948. VOL. XCIV

Part I.—Original Articles.

THE TWENTY-FIRST MAUDSLEY LECTURE: NOSOPHOBIA.

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"Fear is more pain than is the pain it fears."
SIR PHILIP SIDNEY.

IN the opening chapter of his *Body and Mind* (1873) the physician and philosopher whom these lectures commemorate wisely insists that our inquiries into human faculties should begin with the elementary and proceed only later to the elucidation of the complex. "Surely," he says, "it is time that we put seriously to ourselves the question whether the inductive method, which has proved its worth by its abundant fruitfulness wherever it has been faithfully applied, should not be as rigidly used in the investigation of mind as in the investigation of other natural phenomena. If so, we ought certainly to begin our inquiry with the observation of the simplest instances . . . " In the chapters which follow he applies this principle, and—or so it seems to me—provides a number of healthy correctives to much modern thinking and writing, and not least to the opinions of those who have allowed too little or assumed too much in their appraisals of the body-mind relationship. If we have for too long separated psyche and soma, past and present, organism and environment, individual and society, in our attempts to fathom Man, may not an extension of interest in a primitive emotion such as fear, in which the interdependence of all of these is manifest, have value?

My concern to-day will be with some very common and understandable fears and their effects—fears which scarcely one of us escapes, which may be trivial and transitory, but which may also assist the perpetuation of much unhappiness and of both physical and mental illness. For the most part they may be regarded as relatively "simple instances." At least they are elementary by comparison with some of the other mental and emotional conflicts which the physician and psychiatrist encounter in their work. If any less

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https://doi.org/10.1192/bjp.94.394.1 Published online by Cambridge University Press

simple, the fears which I have in mind are certainly more accessible for study than the immediate fears of present danger.

From the primitive phase of man's history, with its alarms created by pestilence or personal illness—long viewed as the inflictions of gods or devils—we can trace the story of disease-fears throughout the Christian era. Alike in the pre-Christian and Christian periods the fear of pain, disablement or death was buttressed by the fear of unseen agencies believed to be in some way responsible for them. Until quite recent times physical disease was still regarded by many as a punishment for sin, and mental illness as demoniac possession. Modern man, more sophisticated than his ancestors, suffers from an abundance of half-knowledge where they suffered from ignorance, and from enslavement where they more readily enjoyed release by the emotions.

Fears of disease may also be accepted as among the simplest instances of body-mind disturbance in that, once their ubiquity is recognized by the physician, they can be fairly readily unmasked; or, alternatively, without actual unmasking, their effects can often be anticipated or relieved by direct and simple psychiatric methods. And yet we should not, I think, be wide of the mark in suggesting that medical men in all branches of the profession constantly miss opportunities of reassuring scared or anxious patients, and of removing or mitigating the associate symptoms which fears of disease or its consequences create or aggravate. Furthermore, while primitive superstition has declined, there are still numerous customs and traditions and other social influences assisting the prevalence of disease-fears in the community which need not be deemed unalterable to-day. There are thus various actions based upon better individual and social understanding which could, by concerted endeavour, make a genuine contribution to curative and preventive medicine and to individual and communal health. Whether I make an exaggerated claim in respect of the importance and prevalence of disease-fears in our modern world, it remains for others to decide on the basis of the arguments here assembled and their own experience.

Although, for the most part, clinical teachers and the text-books of medicine touch rather lightly upon this subject, it has an evident interest for the world of patients and their relatives, and it should therefore be seriously presented to every student. Geraldine Coster, in her understanding little book, *Psychoanalysis for Normal People* (1932), opens her chapter on adult fears as follows: "Fear of disease is one of the commonest causes of adult neurosis. The ordinary man without medical training is often curiously ignorant, and as it were superstitious, about heredity and infection in connexion with disease. Foolish newspaper articles and half-understood fragments of conversation heard in youth prey upon the minds of people who would shrink from admitting their anxiety even to a physician." This general unwillingness to admit to fears is a particular reason both for their perpetuation, and for the too frequent failure on the part of our profession to give them the full consideration that is their due. In studying fears of disease, we can trace the whole gradation from the natural reactions of healthy people and the physically sick or injured, through the anxious preoccupations of the neurotic, to the morbid obsessions of the insane.

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The Occasions of Fear.

Fears and anxieties in a modern society are of many kinds and they have many causes. Most of them are personal and private, and are so rarely or so slightly accompanied by objective manifestations that the assessment of their frequency in any selected population must, for the present, remain beyond computation. Their effects are more apparent in medical practice than their nature or their causes, and yet the last named, on the whole, are the more readily understood.

After excluding contagious fear or panic and all those major and more urgent fears of injury and loss which may come to us in times of war or civil disaster, there still remain countless day-to-day anxieties which affect both children and adults in varying kind and measure. All of these are apt in civilized man, with his highly organized nervous system, his more retentive memory, his power of foresight, and his tendency to repress the outward display of emotion, to lead to more obtrusive and less transitory mental, visceral and vascular disturbances than may be presumed to obtain among primitive races and animal species. Some human fears are related to the known and the natural, some to the unknown, the half-understood and the supernatural. Common observation tells us that the occasions for these prevalent fears include, for example, ideas relating to admonition or punishment; to ridicule or social censure; to loss of employment and earning capacity. Others are connected with the uncertainties of new undertakings, of new jobs or of sexual experience; and others again with the problems of sin and the hereafter. And yet the physician's experience may well lead him to suppose that none of the fears traceable to these specified occasions exceed in frequency those which are born of ideas and misconceptions connected with physical or mental illness.

Every present physical pain or discomfort and every evident injury or outward sign of broken or threatened health which compels, or should compel, a visit to the doctor is capable of promoting anxiety. The more anxious by temperament the patient, the more readily will it do so, but the steady and courageous are not immune. It is true that injuries, if not too grave or trivial, may also be accompanied by a sense of resignation, resentment, relief, or (in youth) even of pride and importance, which can replace or over-ride present anxiety and the fear of the circumstances which caused them. War wounds in the first world war were never, in my experience, accompanied by the manifestations of "shell-shock." There are also invalid persons who "enjoy" their sickness for the sympathy and escape from responsibility which it secures; their fears lie in other directions. In grave conditions of surgical shock and haemorrhage or advanced illness, fear would seem to be largely eliminated by the altered sensibilities accompanying these states, so that conditions of extreme danger are often, at the time, not appreciated as such by the patient. The anxieties due to frank physical illness or trauma are, however, less common than those due to ideas of physical disease prompted by hearsay or by minor symptoms of passing functional derangement. Of all these anxieties, however initated, the vast majority go unspoken, and a

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small proportion only, let it be repeated, are recognized at their true worth when medical advice is sought.

Some years ago I had occasion to ascertain the frequency and order of frequency of the common diseases seen by me up to that date in a general consulting practice. I found that among the twelve diagnoses which scored highest in my card index, *Anxiety* came second on the list. This diagnostic label was employed only when I judged it to be the main basis of a patient's symptoms and the physical examination revealed no sign of serious organic trouble. In the aetiology of four of the remaining conditions, including the first on the list, mental stress and anxiety are now believed to play at least a contributory part. In what proportion of all these cases the symptoms were due to or buttressed by specific disease-fears, as distinct from or additional to other causes of anxiety, I cannot say, but I am satisfied that it was a large one. Apart from the cases included under this generic label of *Anxiety*, a much smaller group were specifically indexed under such headings as "Cancer Phobia" and "Syphilophobia."

Even among ostensibly healthy persons unspoken fears are common. My colleague, Dr. R. W. Parnell, has analysed for me his findings in the case of 155 university students (representing some 60 per cent. of a group accorded the opportunity of a free health examination) who were not at the time under medical care. Twenty-two admitted to anxieties, and of these ten were harbouring anxieties about disease.

Physical pains and fears are, after all, the two primary dis-eases which our patients bring to us; and the latter are generally brought to us in the guise of the former.

The Recognition of Fears.

It may reasonably be asked how fears to which patients do not openly admit can be recognized as operative or assessed as contributory to illness. The first essential is that they should be thought of. The evidence is otherwise generally indirect. It is seldom such as to carry the conviction at once of objective signs, but it may be more important than objective signs, and we do well to remember that many of our most accurate diagnoses in practice are, and always will be, based upon history and subjective symptoms. The recognition of fears, improving with the growth of experience, is usually based upon (1) the history of the patient and his family; (2) the nature of his symptoms, whether they be physical or mental, or both; (3) observations on his temperamental qualities and present demeanour; and (4) the response, in the form of immediate relief and subsequent improvement, to treatment consisting of simple explanation and reassurance—where these are possible—and of a reasoned optimism, encouragement or comfort where they are not. The less such treatment is confused by other measures, the more reliable will the conclusions be. In some cases it is appropriate to inquire, at a selected stage in the association of doctor and patient, whether a specific fear of disease has, in fact, been at work. In others it is wiser to assume its presence and to emphasize, after a careful examination and without the leading question, that "there are no signs of organic disease" or no signs of tuberculosis, appen-

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dicitis, cancer, or such other condition as the symptoms may have seemed to suggest. The outward features of acute fear are rarely observable in the more restrained portraiture of chronic or recurrent anxiety. The pallor, tremor, sweating, dry mouth and tachycardia of the former—although present on occasion—tend to be replaced in the latter by intermittent gastric, oesophageal, colonic or cardiac discomforts or pain and by vasomotor instabilities. The face is marked rather by the stigmata of care than of alarm. At the time of a consultation we must accept that apprehension regarding the interview and the examination can be as potent as the fear of an adverse verdict, and allowance must be made for this in interpreting signs of agitation.

Definition and Varieties of Nosophobia.

The word "nosophobia" means neither more nor less than "the fear of disease." It has been applied more particularly to obsessional fears relating to a particular malady, but there is no sound reason for this restricted usage. Such fears differ from the others only in that they are graver in their degree and consequences and more persistent. They are an expression, in part, of inherently unstable personality. I shall here apply the term to all forms and degrees of fear or anxiety, whether rational or irrational, connected with disease or ideas of disease. These may be held to include:

1. Fears about an existing illness or injury and its possible import; about the tolerability of anticipated pain; and about confinements, anaesthetics and operations which are, for the patient, an occasion of trauma and a common cause of dread and apprehension.

2. Fears of inheriting a disease, particularly epilepsy, insanity, cancer and tuberculosis.

3. Fears of acquiring diseases, particularly those due to well-known types of infection.

4. Fears connected with a non-existent disease which a patient nevertheless imagines or suspects (usually on the basis of some subjective symptom) that he has already acquired.

5. Fears of death or dying considered as the final malignity of illness and, in the latter case, too widely suspected of involving painful or distressing experience.

In all of these, and particularly the last, popular ignorance or the factor of the "unknown" plays a part. In any one of them the fear may be related to ideas of personal suffering or disability associated, whether in fact or imagination, with the disease in question, or to its consequences for others. A fear about disease, whether real or imagined, in a near relative, and especially in a consort or child, constitutes another kind of nosophobia. In this case anxiety can be transferred from one person to another, may react unfavourably upon the patient, and may even come to involve a whole family. The timid and neurotic child of over-fond and protective parents is a familiar product of habitual anxiety or recurring domestic panic.

Nosophobia is to be thought of both as an individual and, by reason of its prevalence, as a social problem. It is traceable in part to social influences,

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and it lessens communal efficiency. In common with other social diseases, its extent and influence fluctuate within the community and vary from community to community. It would almost certainly be found to be commoner in the town than in the country, and among mental rather than manual workers. It has, I suspect, reached a high degree of prevalence in the urban populations of the United States, where disease-consciousness is more assiduously cultivated by the press and other agencies than in our own country. Although panics due to the major epidemic diseases have largely disappeared from the western world in concert with their increasing control, there are signs that popular nosophobia of a less patent type is widespread and contributing to much of our present-day neurosis; and this notwithstanding that we command more instruments for the protection of life and the prevention and relief of sickness than in any previous age.

Where treatment and prevention are concerned it is therefore necessary to think not only in terms of individual but also of social psychiatry and appropriate public actions. To these ends the first essential is an advancement of our understanding of the varieties, manifestations and causes of what it is desired to counter.

Varieties of Nosophobia.

The varieties of nosophobia could be variously determined and classified by such factors as the severity of the disorder or the degree of specificity of the operative fears, or in other ways. We should, in all probability, find that the most grievous varieties are the least frequent and the lesser varieties the most frequent and tractable; that the specific fears in a modern society are more common than the non-specific; and that the causal influences are always multiple. The manifestations would include both changes of mood, in the direction either of agitation or depression, and physical symptoms. The latter usually have a visceral or vascular notation, a rather indefinite character and time-behaviour and show a relatively slight connection with physical events, and often a reference to several systems or somatic areas—a feature usually inconsistent with a diagnosis of organic disease (*vide* Cases 1, 2, 7 and 8 reported hereunder). The symptoms, in brief, do not differ from those attributable to other anxieties, excepting in so far as a relation between the part affected and the specificity of the fear may be discernible.

For simplicity of description, I propose to consider some types and examples of nosophobia under the three headings of (*a*) obsessional nosophobia; (*b*) nosophobia accompanying structural disease or injury and certain alarming episodes; and (*c*) nosophobia occurring independently of these.

Obsessional Nosophobia.

Victims of this form of the malady are usually psychoneurotic or psychotic persons. Their fears are irrational or slenderly based. They may be superimposed upon emotional disorder having other origins. They become firmly implanted, and are not readily uprooted even by examinations of the most searching kind in concert with the fullest assistance of psychotherapy. Syphilo-

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phobia is a familiar example. It may affect those who have never been exposed to infection in the ordinary way and yet the sense of guilt or taint —sometimes referable to a faulty, puritanical upbringing—is strongly operative. Serious mental breakdown is common. Obsessions in regard to tuberculosis, cancer, appendicitis and heart disease are also encountered, but in my experience have usually appeared more manageable.

CASE 1.—*Syphilophobia.* A nervous man, aged 31, married and with children, developed warts on the hands and a friend told him that they were venereal. He was terrified and began to be physically "sick with worry." Pains in the joints followed and then he thought he had a stricture. He lost energy and all interest in his business and dropped two stone in weight.

CASE 2.—*Syphilophobia.* A man, aged 35, who had been a prisoner in German hands during the first world war for four years, was treated during that period for a urethritis, but denied exposure. After his return he was pronounced free from infection, and his blood W.R. was also negative. In the course of the next few years he had much sorrow and loss, his first wife dying in childbirth and his second from a cerebral abscess. A year before I saw him his urethral discharge reappeared. He was treated without a bacteriological examination. My notes state that "he has developed a persistent obsession that he has syphilis. He complains of pains in the sacrum, the perineum, the neck, the eyes, and under the finger-nails, of flatulence and insomnia and has lost a stone in weight." I discovered a to-and-fro aortic murmur (which was rather disconcerting), refrained from discussing it with him, and admitted him to hospital for further investigation after giving a reassuring forecast. There we obtained another negative blood test and also a negative urethral smear, and, in explanation of the murmurs, a history of three attacks of rheumatic fever in boyhood. He was at the time much comforted by these reports and by a further explanation and strong reassurance, but I have not heard how he fared subsequently. The background of a long imprisonment and his domestic tragedies probably played a large part in maintaining his anxiety of mind and conditioning the phobia into which it had crystallized.

CASE 3.—*Infection phobia.* A student contemporary of mine, now dead of a disease which he probably never feared, developed what amounted to a compulsion neurosis in regard to the possibility of infection. Having washed in the hospital he would wash again in the students' club before his meals, open the swing doors with his elbows, eat his College lunch, and then flame the end of his cigarette before putting it in his mouth. The unhygienic condition of the kitchens and dining-hall in those days and the fact that the food and the utensils must have passed through many unwashed hands before they reached him did not seem to worry him. The fact that hundreds of men risked dining in College year after year, took none of his precautions and yet acquired no fell disease had also failed to impress him.

Although we may assume an inherent liability in each of these cases, in each effective extraneous influences precipitated the mental sickness or unbalanced behaviour.

NOSOPHOBIA ACCOMPANYING PHYSICAL DISEASE AND CERTAIN ALARMING SEIZURES.

An episode such as an haemoptysis or haematemesis, an anginal attack, labyrinthine vertigo, a vaso-vagal attack (Gower's syndrome), fainting, an asthmatic attack and the aphasic or hemiplegic varieties of migraine, may very naturally cause acute anxiety, both in the victim and those about him. Here, prompt action can often be taken by the doctor, and his very presence

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is reassuring. It is never, however, superfluous to make positive, comforting pronouncements, even while medical judgment is still hampered by uncertainty. Situations familiar to the physician and not conveying ideas of too grave a risk to him may, it must be remembered, be infinitely alarming to the lay mind. If we exclude a few incurable diseases, the moribund state, and certain crises accompanying the extremes of age, optimism is, in fact, far more frequently justified than pessimism, even in many of the more hazardous situations.

In recurring conditions like *angina pectoris*—although it is often consistent with many years of useful life at a reduced level of output—the name and nature of the disease, the frequent physical reminders of the pain, and sometimes the distressing "sense of dying," may between them give rise to haunting anxieties and unnecessary modifications of living. Here we may witness a return of mental peace, a resumption of interests and other physical and mental improvements as the immediate consequence of nothing more than explanation and a more reassuring prognosis. Cardiologists, like other specialists, are sometimes preoccupied rather with the organ than the person; with physical instructions and treatments rather than with intimate human understanding. Their intellectual caution and desire for accuracy in the matter of prognosis, while frequently supported by reason and experience, need not be betrayed to the patient, nor made too explicit to relatives. Reputations are not lost by preserving hope, even when the hope is falsified.

In *labyrinthine vertigo* patients are not infrequently afflicted with the dread of strokes or death in an attack or of attacks while crossing the street. Few things, after all, can be more provocative of anxiety than states of complete instability and incapacity arriving "out of the blue." Here again I have seen simple explanation and vigorous reassurance do great good. Although the opinion is insusceptible of proof, it has even seemed to me possible that resultant improvements in general and mental health may sometimes lessen the liability to the attacks. Sensible, direct psychotherapy and counsels of patience in such cases should usually be considered preferable to modern surgical procedures which involve no small risk and may introduce yet another anxiety.

Petit mal, especially in intelligent professional men and women, can be a cause of serious apprehension, particularly in relation to loss of skills and earning power and the possible supervention of major epilepsy. Here, too, I have seen patients, including colleagues, greatly assisted by explanation and by a good prognosis, later fully justified by history and performance. *Fainting attacks* in young people, and innocent palpitations or undue awareness of normal cardiac action at all ages, are frequently feared as manifestations of organic heart disease. Here reassurance and explanation are almost the whole of treatment. In many other diseases, acute and chronic, rapid improvement follows so often upon a more favourable forecast than had previously been allowed, and upon the resulting change of atmosphere in the house and sickroom, that it is difficult to doubt the reality of unexpressed fears as a retarding factor in recovery or the uses of optimism in treatment. In the more chronic conditions, such as arthritis and the dyspepsias, the physical

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symptoms, never long in abeyance, both aggravate and can be aggravated by anxiety. Even in these tiresome conditions a better prognosis and encouragement to " live more normally with a view to feeling more normal " may bring help. May not the quick recoveries of children, their frequent happiness during long hospitalization and their immunity from some of the commoner chronic diseases of adults be due not only to their shorter exposure to adverse influences and to the relative resilience of their youthful and growing tissues, but partly also to their freedom from foreknowledge and foreboding ?

Nosophobia Without Definite Disease.

This is by far the largest category. In a high proportion of cases the fears are related to cardiac or abdominal symptoms.

My case-records include those of a number of medical men and women who came in fear of cancer or other organic disease, a fear frequently based upon symptoms which would scarcely have given them pause in the case of their own patients. Personal anxiety inevitably hampers judgment. For this reason alone we are, or should be, reluctant to treat ourselves or our own kith and kin. If we look back upon experience—and how easily we tend to shelve it!—we can scarcely fail to recall instances, pronounced or trivial, of personal nosophobia in times of fatigue, sickness or stress, on the eve of an operation, or in the presence of an unexplained symptom. Medical students and graduates have their disease-fears like other people, and have been grateful for their mitigation by understanding colleagues. The more reason why, in the course of practice, they should allow no other preoccupation or exigency to excuse the additional time needed for one of the simplest and most salutary of all psychiatric exercises.

Prevailing Causes of Nosophobia.

In the individual an operative nosophobia—by which I imply a state of fear or anxiety too frequently engaging consciousness or giving rise to symptoms—has clearly, in common with other diseases and especially those of a chronic or recurring kind, a multiple factor aetiology. Within the complex of causes we may separate such factors as the temperament of the individual, moulded to a state of susceptibility by a combination of genetic and environmental influence ; antecedent stress or anxiety of another kind increasing sensibility and promoting bodily sensations, which in turn evoke the new specific fear ; a half-knowledge of the disease feared due to reading, acquired through gossip, or prompted by public pronouncements or actual aquaintance with a sufferer from the disease ; the usual native unwillingness to confess the fear to others, including the doctor, even when he is consulted for associated physical disturbances ; a consequent inappropriateness and ineffectiveness in the treatment prescribed ; and finally, the uncommunicativeness of medical men, their failure otherwise to inspire confidence, and, more rarely, their indiscreet pronouncements. A physical symptom or finding may create an anxiety, and an anxiety may create a physical symptom. The traffic of impulses between body and mind is a two-way or circular process. Mind

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and body cannot—as Maudsley always insisted—be conceived as separately existent or functional, nor can they, with optimal results, be separately treated.

Popular fears of disease are variously propagated. Vulgar errors may be less numerous and less fantastic than they were in the days of Sir Thomas Browne, but they are still very common and a cause of much timid living and neurosis. Errors of belief and practice are passed as old wives' tales from neighbour to neighbour and mother to daughter, when they relate especially to pregnancy, childbirth and the supposed necessity for habitual purgation. Ignorance of the most elementary anatomy, physiology, psychology and pathology is still prevalent even among the otherwise well educated.

Fears of disease are widely engendered through the advertisements of proprietary medicines; by the outpouring of ill-judged medical articles in the lay press, of a type even more familiar, perhaps, to American than British readers; and by unorthodox practitioners. All of these make the appeal to fear a part of salesmanship, even though they seek simultaneously to inspire hope by promises of cure, promises which give them a competitive advantage over the honest doctor. The latter, by the more frequent recognition of fears and the employment of simple explanations and rational optimism, could, without doubt, enhance the value of his own treatments and, in the process, do much to shake belief in the unorthodox. Educationally, much could be done along the lines sponsored by the Central Council for Health Education and the personal and publicity services of the public health departments—not by mere condemnation, but by the appeal to reason and to the health rather than the sickness interest—to counter the evil effects of ignorance, superstition, and the traffic in proprietary remedies. Whatever part the various agencies cited above may play in promoting popular nosophobia, we must also reluctantly admit that the very people—doctors and nurses—who should do most to relieve disease-fears often fail to do so and sometimes inadvertently accentuate them.

The Doctor as an Aetiological Factor in Nosophobia.

In contradistinction to the welfare doctor, the Service doctor, and the physician in charge of a student health service (who start with the health perspective, and are mainly concerned with keeping mothers or others informed and hopeful and babies or other young people well) the practitioner, the consultant and the specialist start with the disease perspective, and are under the constant necessity of looking for or not overlooking organic disease. They, too, labour under an anxiety. They often encourage fears unwittingly through their partiality for prescriptions and operations; through their use of generic labels such as gastritis, neuritis, rheumatism, tired heart, and debility, all of which tend to suggest physical disease and chronicity or slow recovery to the patient's mind; and through their caution or their silences. Specialists in the physical branches of medicine too often err through concentration on a part of the body to the neglect of the whole person. The psychiatrist must frequently reduce his powers through failure to make a proper examination of the body. The general physician who gives the time requisite for a careful

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history and a complete overhaul and a sympathetic explanation of his findings holds a very real advantage over those who do not or cannot afford the time, or who confine their interest to parts of the body or the mind. In our specialist age it has, in fact, become a major function of the general physician to examine thoroughly, to explain simply, to reassure as far as may be, and to protect his patients from unnecessary medical or surgical interventions. The routine functional inquiry and physical overhaul will again and again reveal some circumstance which directs attention to an unspoken anxiety. The age and sex of the patient or a casually mentioned symptom or physical finding may suggest the likely fear. The patient past middle life is apt to be concerned about cancer, his heart, or his blood-pressure; the young patient about tuberculosis, venereal disease, his mental state or impotence. Phosphaturia in young men is misinterpreted as spermatorrhoea and may be the occasion of a sexual neurosis. Loss of weight from one cause or another is variously interpreted at different age-periods. "Arthritis" is the nightmare of many people with muscular pains or creaking or clicking joints having no such significance. Even the discovery of a normal anatomical landmark may create anxieties; thus I have been consulted about the ensiform cartilage, which had been taken by the patient for a tumour. There is no end to the fears initiated by trifles, but they are not necessarily trifling fears.

A word about the uncommunicative or inexplicit doctor may not be amiss. He is to be found in all professional groups and among both young and old, but my own experience would suggest—and I have the testimany of many lay and medical observers—that he is, perhaps, more commonly to be found in hospitals than elsewhere. Again and again patients discharged from hospital, when asked what the doctors have told them, say, "Oh, they didn't tell me anything." Often they have spent long periods in the ward and been elaborately investigated, all the time waiting and wondering and uninformed. Could anything be more conducive to the initiation or aggravation of anxiety than experience of this kind? Probably the divided responsibilities which obtain in institutions and the inexperience of house-officers are partly to blame, but the mechanistic, objective character of modern investigations also tends to distract the doctor's from the patients' thought and to direct attention away from private sensibilities and present needs. I have even watched air-raid victims being admitted, examined, X-rayed and transfused without a word of comfort or reassurance being given to them by those concerned.

The pessimistic doctor can also prove singularly unhelpful, however careful and able he may be in other ways.

CASE 4.—A very gallant senior officer in the regular army complained of an attack of faintness and of a recurrent "surging sensation" in the region of his heart. Although he did not openly admit or show it, I had no doubt that he was labouring under considerable anxiety. His father had died suddenly from heart-failure at the age of 59. With the help of consultations at intervals I was able to keep him reassured and he continued to indulge in out-of-door pursuits, including golf, shooting and gardening. Later he had occasion to consult a physician in another city (now no longer living), who was well known to me for his diagnostic ability and his gloomy outlook. He examined my patient cardiographically,

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revealed evidence of myocardial damage not present on a previous occasion and gave a very guarded prognosis. This was followed by a recurrence of anxiety and a further visit, at which I had to pit my assessment against a less favourable opinion backed now by the revelation of a defect of which I had been happily unaware. The patient continued to lead an active life ; six years later he indulged in winter sports, and he was still alive 16 years after the adverse verdict.

We are all fallible, and I have not the slightest doubt that my own errors and missed opportunities have been numerous. But one hears all too rarely of past mistakes, and I am thus compelled to go to my notes of cases illustrating others' failings. If these can teach us something of practical value, they are surely worthy to be placed on record.

The faults of doctors, it will be seen, are mainly faults of omission and due to lack of time or patience or proper training, and, sometimes, even to a dogged belief that it is " better for patients not to be told too much." It is not so much that their knowledge of a simple human frailty is gravely lacking, as that they fail to apply it regularly and to make its application a main feature of their " cure of souls." But there are faults of commission, too, for which even distinguished leaders of the profession must sometimes accept blame. The teacher at the bedside who drifts too easily into pathological discussion is doubly at fault, for he may at once puzzle or disturb his patient and set a bad example to his class. Sometimes the public utterances of doctors show too little thought for the susceptibilities of the public, who are apt to take as gospel all they say. A distinguished surgeon no longer with us, called upon at a large dinner-party to inaugurate a collection of funds for cancer research, was reported as saying to his audience who were seated at small tables, " Do you realize that in ten years from now one person at each of these tables will be dead from cancer ? " Even if he had statistical justification for so dramatic a pronouncement, it was not psychologically justifiable. The same surgeon advised a young man in his twenties, whom I had advised against an operation for cholecystitis, to have his gall-bladder removed lest it might later undergo cancerous change. The pathological opinion was dubious, the expressed opinion indefensible. On both occasions, a public and a private one, he employed fear as a weapon of persuasion. There are rare occasions on which this weapon may be employed in order to compel a patient to submit to an immediate life-saving treatment, but they are very rare.

The Special Case of Cancer Phobia.

Apart from its high mortality and, in many cases, its relentlessness, cancer has inspired fear in the lay mind because of its supposedly inevitable association with grave pain. We would do our patients and the public a real service if we were to remind them more often, firstly, that cancer in its early stages is to-day more readily recognized and eradicable than ever before, and, secondly, that even when intractable it is by no means always a painful disease ; that carcinoma of the stomach, the liver, and the bowel, for instance, at times may run a painless course, and that when the disease is incurable and accompanied by pain a great deal can be done to relieve it. There are causes of death more miserable than many of the cancers which have become a major

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cause of public dread. What to tell the patient who is found to have a cancer and how to tell it is, we well know, a matter calling for the most judicial and humane reflection. The decision varies from case to case, with sex and age, the psychology of the individual, the tractability of the condition, and the estimated prognosis. The manner of the explanation given to relatives also requires the most thoughtful consideration. There are many ways of softening necessary blows, but it is well to insist at all times that there is no case of cancer in which there is " nothing to be done."

Cancer phobia without cancer is, however, far commoner than cancer phobia with cancer. I have carefully perused the notes of 31 cases in which cancer phobia (without cancer) was the specific diagnosis. These must be a mere fraction of the patients seen who harboured the fear in some degree. There were 21 women and 10 men. The average age was 50, the youngest 33 and the oldest 75. Thirteen were described as nervous, very nervous, or as having had a nervous breakdown on one or more occasions. The physical symptoms complained of were generally of a kind associated with emotional disorder. Thus 14, with or without a specific mention of neurosis, were the victims of colonic spasm or other discomforts, of flatulence, globus or rectal spasm, or had had an abdominal exploration. Two patients had duodenal ulcer, and two cholecystitis. One had hyperpiesia. In six cases, all women, there was a complaint of sore or dry tongue or mouth or of altered taste, with no evidence of a local cause for the symptom. In such cases it would seem proper to suspect or enquire for a cancer phobia. In one of these, after completing my examination and while still wondering what could be suggested in the way of treatment, I began by saying, " I am glad to tell you that there are no signs of cancer or any serious disease." " Thank you," came the prompt reply, " that is all I wanted to know." Twelve patients in the series had lost a near relative or friend or neighbour from cancer or had intimate knowledge of a case or cases. Two were in the habit of reading articles in the papers or other literature bearing on cancer.

CASE 5.—A very intelligent middle-aged layman, with expert knowledge of hospital administration, developed a troublesome lumbo-sacral pain after a blow in the back. On a basis of his medical half-knowledge and a vivid imagination, his age, the persistence of his symptom, and a contrast of his present state with his normally good health, he built up an association which seemed to support his fear of cancer. He slept badly and lost a stone in weight. He saw several doctors. He was cured by a single explanation and reassurance. Two years later he was seen for a much slighter anxiety about his heart and again relieved. Later he developed a duodenal ulcer which caused him no serious anxiety and responded to orthodox medical treatment.

CASE 6.—A spinster, aged 70, had twice been treated successfully for rodent ulcers. Her brother had died of cancer of the gullet. Her friends told her that she was getting thin. She had lost a stone in weight, but had taken four years to do so. She was given to reading literature about cancer. There were thus several good causes for her fears.

CASE 7.—A married woman, aged 61, suddenly developed a bitter taste in her mouth, and later cold feelings in the body and slight pains in neck and shoulders. She worried more and more about these symptoms and slept badly. Two distant relatives had recently died of cancer. She had seen a doctor, but had not been

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given a complete overhaul or a reassurance of the kind she needed. Eight months later her daughter reported that she had been well from the day of the consultation.

CASE 8.—A nervous, unmarried woman, aged 47, and passing through the climacteric, had twice had a nervous breakdown in earlier life. Her mother and paternal grandfather had died of cancer. Two months previously she had begun to worry and to sleep badly because a friend of hers was dying of cancer. Her symptoms included pains in the throat, rectum, and vagina. Three years previously she had had a disease phobia in association with abdominal symptoms.

It will be seen from these histories that the fears which we unearth in our patients are often by no means unreasonable, and that multiple factors are usually at work.

THE FEAR OF DYING.

I have written elsewhere (1940, 1941) of fears of death and dying. In an earlier age when doctrines relating to the after-life conjured grim visions of purgatory and hell, these were, we may presume, an added cause of apprehension. They have their lingering influence still. But to-day people do not on the whole fear death itself so much, excepting in so far as it carries with it the idea of separation from loved ones and of impending hardship for those left behind. Fears of the process of dying, however, are far from rare and are sometimes very real. It is quite commonly supposed that the experience must inevitably involve urgent suffering or pain. This is due largely to the appearances and associations of the moribund state, the " Groanes and Convulsions, and a discoloured Face, and Friends weeping " of Bacon's essay. It is a false inference that such scenes must involve distress for the central player. We have good reason to believe—not only in conditions directly affecting the brain, but also in surgical shock, haemorrhage, pneumonia, congestive heart-failure, septicaemia and many old-age deaths—that the last minutes, hours, and often days, are usually a cloudy period, at the most a time of twilight consciousness. Medical observers who have themselves narrowly escaped death from such causes, and also from sudden accident, rarely admit to any recollection either of bad physical suffering or of fear at the time. The popular view, however, still goes uncontroverted, and novelists and dramatists continue to portray death-bed scenes in a most incorrect way, falsely exaggerating suffering, and generally depicting a clarity of mind in their victims which is quite outside medical experience. No opportunity should be lost, therefore, of explaining to patients discovered or thought to be fearful of the end, and to the relatives of most patients nearing the end, that physical pain and mental anguish, or at any rate keenly appreciated pain and anguish, in this phase are exceptional and, when present, in large measure controllable by appropriate management and drugs. Where good medical and nursing care are available, the occasions which justify euthanasia are infrequent.

The strange and intensely alarming " sense of dying " which accompanies certain nervous and physical states must be clearly distinguished from the " fear of dying." It is—as Clifford Allbutt insisted (1915) and my own numerous observations (1928, 1935) confirm—an organic or physical sensation,

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and it may be accompanied by well-defined objective phenomena. It is encountered in a small proportion of cases of angina pectoris and labyrinthine vertigo, in anaphylactic shock and after too large a dose of adrenalin, or perhaps after a proper dose accidentally given into a vein. It is the major presenting symptom in the vaso-vagal attacks of Gowers. It is associated with abrupt changes in blood-pressure such as commonly obtain in all of the above-named conditions, and there are reasons for regarding it as due to a vasomotor disturbance at the medullary level. It is possible that it may sometimes precede death from angina pectoris and anaphylactic shock, although these are, as a rule, so instantaneous that there would scarcely be time for its appreciation. Otherwise, it is consistent, however frequently it may recur, with long life. This aura of mortality is therefore a deceptive omen, and knowledge of this can help to buttress reassurance and assist the treatment of cases. We may not be able to persuade the world so to adapt itself as to believe, with Spinoza, that " a free man thinks of nothing less than of death ; and his wisdom is a meditation not of death, but of life " ; nevertheless, the liberation of many from needless fears of dissolution and terminal agony is well within our power.

SUMMARY.

1. The fears engendered by disease and ideas and misconceptions relating to disease and its consequences are widespread, and a potent cause both of mental fret and more serious neurosis, often accompanied by physical symptoms.

2. They are, to a large extent, dependent upon ignorance, encouraged by reticence and stimulated by gossip and by widespread commercial enterprise and ill-considered magazine articles, and by fiction and the drama.

3. The medical profession is in part responsible for their frequency. Through inadequate or ill-balanced psychiatric training in the student period and undue reliance on physical remedies, opportunities of relieving minds and bodies are constantly missed. Specialists, whether in organs or in therapeutic methods, tend to distract their own attention from the patient and his total need. More rarely, nosophobia is positively encouraged by unwise medical pronouncements, whether made in private or in public.

4. The extension of simple health education for the general public, especially in early life, could do much to counteract, by promoting an intelligent interest in healthy living, the prevalent disease-consciousness of the present day. Periodic health examinations in youth and afterwards can have a high " reassurance value."

5. A better editing of medical articles for the Press, whether written by doctors or laymen, would be salutary. Recent enactments to ensure a better control of the abuses of the proprietary medicine " racket " have made their contribution, but a more complete control is needed. Few forms of profit-making enterprise are more despicable than those which trade upon fear and unjustified promises, which pander to ignorance, and lead all too frequently to the postponement of accurate diagnosis and appropriate treatment.

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Conclusion.

Clinical and sociological studies in the natural history of disease should generally give full scope to objective and numerical methods of enquiry. For this occasion, however, I have chosen a subject not readily adapted to such handling, excepting in so far as careful physical assessments must always be involved. I have done so deliberately, partly because I have so often seen the fears of the sick and injured, in peace and war, go sadly under-estimated, and partly because it is to-day more than ever necessary to strike a just balance between our materialist science on the one hand and our humanist science on the other.

If it were possible to make a survey and a follow-up study of all the cases of nosophobia—major and minor, rational and irrational, of short and long duration—in a given community or practice, we should probably find that a considerable proportion, especially of those developing in young people, undergo resolution with the passage of time and the growth of experience. Others would be found to be relieved by the illness, injury, anaesthetic, or operation which had been feared—the original anxiety often appearing foolish in retrospect. Others again would be quickly cured by the doctor. Only a small proportion would be found to be chronic and incurable. There would still, however, remain another category of cases, possibly exceeding all the rest, in which fears passing undetected would continue at intervals to promote distress of mind and physical symptoms. We cannot, in fact, calibrate the sensations of fear with those of pain, and we should never under-rate the latter, but if frequency and duration rather than degree were the measure of the influence of fears, Sir Philip Sidney's dictum—quoted at the head of this lecture —would, surely, not be extravagant.

As a profession we are losing, in the process of developing our technologies, something of the philosophy, humanism and courage of the older physicians. Our loss of philosophy is shown in our inability to piece together the components of an illness or an individual, to assess the roles of mind and body in morbid experience and to balance the needs of both—in brief, in our inability to see things "whole." Our loss of humanism appears in our too partial success in assessing the psychological needs of the individual and the social needs of the community. Our loss of courage is chiefly manifest in our present-day unwillingness to make pronouncements without subjecting our patients to elaborate investigations. These, while often necessary and valuable, can also prolong anxiety, and leave our own doubts and questions still unanswered. Without courage to accept clinical responsibilities we cannot impart courage to our patients. Without a reasoned clarity in diagnosis and a reasoned hopefulness in prognosis we cannot properly counter fear. In the majority of cases it is possible to give to patients a simple interpretation of symptoms; a simple idea as to how they should be regarded; a set of sound reasons should further inquiry become necessary; a provisional prognosis, in which the emphasis should be on the better chance whenever possible; and an intelligent plan of action. For the busy practitioner or hospital surgeon or physician, it may well be impossible to devote time and thought to the more profound

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psychiatric methods, but there should always be time to examine carefully, to explain clearly, and to reassure as fully as the circumstances allow.

Among the simplest instances of body-mind disorder are states of fear attaching directly to the body and the mind and their mischances. To prevent and treat them effectively in the individual, it is chiefly necessary to remember their existence and ubiquity. For their better control in the community we shall require the aid of education and the law.

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