"Anxiety: A View Point of the OB/GyN"

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Madam Chairman, Fellow Panelists, Ladies and Gentlemen:

When I was asked to speak this afternoon on a subject related to obstetrics and gynecology, I was under the happy illusion, or perhaps I should say "delusion", that I would be speaking largely, if not exclusively, to other obstetricians and gynecologists. I was overjoyed to learn that the subject about which I was to speak was "Anxiety" because as soon as I found this out I assumed that an audience of my colleagues in obstetrics and gynecology would share not only my interest in this important subject, but also my ignorance of the more recondite aspects of psychodynamics. In other words, I thought it would be a piece of cake. I would hardly have to look up any words, and I didn't expect too critical an audience.

When I got the program, however, I observed that this panel discussion was included not only in the program of the section of obstetrics and gynecology, but also in the program of the section of psychiatry. What could be more unnerving than to unburden one's self before a psychiatrically oriented -- by definition, a sophisticated -- audience? Bad enough to make one's confession to one's psychiatrist in private, but to project one's thoughts before a room full is indeed sufficient to produce a good deal of anxiety.

Confronted with this situation I immediately sought the easy way out, and it occurred to me that I might help myself by twisting the subject a little out of its psychiatric connotation into one which was more comfortable by discussing not so much "Anxiety" but "Anxieties" -- and indeed, I think that is a fair enough distinction, because while I, and most others of you in this room, doubtless have to deal often with the anxieties of our patients, nevertheless when that multiplicity of worries, aggravations, concerns and frustrations, focuses itself into a single overpowering, disabling syndrome of anxiety we call in our psychiatrist friends and quietly withdraw from the scene.

I think the key to this matter is the question of disability, or perhaps I should say, the degree of disability, which patients experience as a result of their stresses. Those who are socially immobilized as a result of their anxiety fall into the purview of the psychiatrist, whereas those whose anxieties produce various degrees of distress short of serious disability are far more numerous and more familiar. Indeed, they constitute all of the sick and many of those whom we think of as well.

In speaking to you today, then, about the anxieties of patients that one encounters in obstetrical and gynecologic practice, I hope simply to categorize this rather familiar subject and to indicate some of my ideas and experiences in relation to the problems of these patients.

I think it would be well to approach this subject chronologically, beginning in childhood. Speaking from a limited experience with children in 15 years of practice of obstetrics and gynecology, I would say that in the pre-adolescent girl, the chief expressions of anxiety I have seen have been triggered by marital conflict between the parents. In the prive practice of gynecology I see relatively few young girls in my office. Most of those whom I do see are brought in because of persistent vulvo-vaginitis. I think it is a rather interesting observation that of 4 of these youngsters whom I have seen in the past five years, all have been children of mothers separated or divorced from their husbands. In none of these children was a foreign body implicated as the cause of the vulvo-vaginitis, and while they responded very well to topical estrogen as a means of controlling the symptoms of discharge and irritation, I have wondered what role other factors, such as perhaps energetic masturbation, might have played in the onset of their symptoms. I

make this observation since 2 of these children, both, incidentally, the daughters of professional men, were receiving psychiatric treatment because of emotional problems. While we recognize that masturbation in young girls is a normal practice, I raise the question as to whether or not it may be related, in an excessive degree, to the exhibition of anxiety on the part of young girls particularly in situations of parental discord.

Moving on to adolescence, we have observed in our community a startling increase in pregnancy among adolescent girls. Dr. Clark, of Howard University Medical School, has spoken earlier this week about some of the experiences with this group at Freedman's Hospital. The increase in adolescent pregnancy, as well as the earlier commencement of active sexual life, which is widely regarded, and I think rightly so, as a sign of the disintegration of the puritanical social and moral culture we inherited, no doubt had its origins in the explosive forces which characterize our age, and in the anxieties those forces produce. The situation is analogous to that which is said to have existed in the bomb shelters of London during World War II, where the imminence of destruction produced at times an hysterical display of sexuality.

In a world in which nothing is sacred, where the very existence of God has been called into question, where national enemies become, in a decade, allies, and allies, enemies, where marriage and family life are in dissolution, and where the fear of universal death prevades the atmosphere, we are fast approaching a state of barbarianism, in which the elemental satisfactions of sexual contact provide momentary relief from the tensions and anxieties of a life we dare not project beyond this moment. Pregnancy out of wedlock, promiscuity, abortion, and an increasing incidence of venereal disease, are results with which obstetricians and gynecologists are

all too familiar.

The management of anxiety in the adolescent girl, as in the pre-puberital child, is most difficult, because the sourses of anxiety are inescapably bound up with familial and cultural phenomena which to a large extent are beyond our control, or even our significant influence. I am convinced, however, that an enlightened and cooperative attitude on the part of both parents, and their joint efforts to create a milieu of resonably stability is the key to success in helping these youngsters.

The phenomenon of dysmenorrhea, again, is, in my view, largely an expression of anxiety. All of you are aware that dysmenorrhea runs in families. Older women teach girls at menarche that menstruation, which after childbearing is the most dramatic evidence of femininity, is painful. To those who are cursed with dysmenorrhea it is part of the burden of womanhood, the lot of suffering women must bear in a man's world. That there is a certain degree of physiologic discomfort in menstruation, and that there exist significant pathologic causes for dysmenorrhea, is no less certain than that disabling dysmenorrhea, in most instances, is an emotional disorder, I believe this although I treat primary dysmenorrhea in my practice on a physiologic basis -- with anodynes and at times by ovulatory suppression. To a degree, this is not medicine but necromacy. The pills I prescribe constitute a professional acknowledgment of my patient's ailment, and having established her feminine right to pain, my patient graciously allows me to relieve it.

The other day, I chanced to walk into an operating room where a colleague of mine was performing a hymenectomy for dyspareunia. If I had expected to see a leathery hymeneal membrane, thick, resistant, and with only the smallest perforation, I was mistaken. The hymeneal opening was as wide as I have seen in parous women with well-repaired episiotomies, and the tissues about the

introitus appeared to be entirely pliable and soft. One would have thought that the scar tissue produced by the operation would be a greater source of difficulty than the hymen itself, except that here again the mere performance of the operation confirms the existence of a problem, and the lay on of professional hands may have the effect of a curative rite. What are the problems of fear, of anxiety, of rejection of role, and where is the source of anger, and hostility which is the root of this symptom? In gynecologic practice, we do not unearth these causes, but in most instances, dyspareunia has its source in these emotional areas, rather than in an organic cause. For every case of endometriosis or retrodisplacement with dyspareunia, any gynecologist will see, I think, many cases with similar, or more serious pathologic involvement who have no pain on intercourse. It would be stupid to advance the opinion that hymenectomy on anatomic grounds is never required, but in fifteen years I have not performed the operation. In most instances, a word of reassurance to the patient, counsel of patience to her husband, and the liberal use of lubricating jelly will solve the problem.

The casual approach of a friend of mine in general practice is most helpful. Confronted by a tearful patient who complained of her husband's "size", he blandly replied, "You'll get used to it."

The anxiety that accompanies pregnancy is one of the most familiar aspects of obstetrical practice. There are three sources of anxiety: fears about the well-being of the child, fears about the mother's own well-being, and fears about assuming the role of motherhood.

In early pregnancy, these sources of anxiety are not well differentiated and the patient usually thinks herself as being simply afraid of pregnancy.

Excessive vomiting of pregnancy is clearly related to these apprehensions, and its essential relation to the patient's social situation is clearly revealed by hospitalization. I have demonstrated to my own satisfaction the significance of social and emotional factors in hyperemesis by hospitalizing patients and giving them no special medication or treatment whatsoever. In private practice, however, this is impractical, since a far more rapid -- hence less expensive -- response can be obtained by the institution of elaborate therapy. It is seldom necessary to treat a patient with intravenous fluids more than 24 hours. I do not know of a patient's having required termination of pregnancy for excessive vomiting since the days of my internship.

In the middle trimester of pregnancy, apprehensions about malformations and defects appear, usually precipitated by the patient's awareness of foetal movements. Soon after the pregnant woman feels her baby kick, she begins to worry whether it will have all its fingers and toes. Such anxieties are all the more marked of late, since the tragedy of thalidomide, with its attendant publicity. Parenthetically, the anxieties in reference to the taking of medication aroused by thalidomide have had the beneficial collateral effect of reducing the demands of patients for medication to relieve the varied annoying discomforts of pregnancy, most of which, fortunately, are transient and inconsequential.

In the last trimester of pregnancy, the anxieties I have just spoken of are heightened, and as well, the patient feels increasing anxiety about the pain of labor. Moreover, she experiences an increasing fear for her own health and survival as well as for the life of her baby.

Although these anxieties seem to be most marked in women having their first babies, they are present in parous women, who may, indeed, be all the more distressed because of a feeling that, having borne a child, they are expected to have overcome such worries.

The single most important element in controlling these anxieties, in my opinion, is the development on the part of the patient of a feeling of confidence in the ability and especially in the empathetic concern of the person who will attend her confinement. If there were no other reason for women to receive prenatal care, the opportunity for them to develop, over a period of months, a degree offamiliarity with their physician would be, in my opinion, a sufficient justification, since it determines in such large measure the degree of confidene and serenity with which women undergo childbirth.

Let me comment briefly on an aspect of anxiety which is a phenomenon of relatively recent times; the anxiety of women that they will not deport themselves well in labor. Among the more sophisticated, this fear is the greater since the vogue of the cult of so-called "natural" childbirth. Such women, whether or not they have availed themselves of special attentions in relation to physical and mental preparation for labor, believe that the exhibition of fear and pain are evidence of inadequacy and they feel anxious and guilty about this.

I have no quarrel with the proponents of the theory that labor is not of necessity painful. I am sure that many women have relatively painless labors with or without special preparation, as I am sure that the avoidance of minimal use of systemic analgesics and of anaesthetic agents is by and large desirable.

Yet it is inescapable, I think, that in our culture, childbirth is for the majority a painful experience. The women who seek to condition themselves against the pain of labor and delivery are a select group -- in general, of

greater than average intelligence and education. They are, as we say, highly motivated, which I take to mean, in this cultural context, deeply anxious. The severe emotional reactions such persons may experience should they fail to measure up to their own expectations of themselves under the stress of labor have been described in obstetrical literature. Let me emphasize that it is not my intention to derogate conditioning programs, but only to point out the relation of such programs to anxiety in pregnant women.

In the immediate puerperium, a brief period of recovery and relaxation from the ordeal of childbirth, with attendant joy over the newborn, gives way, a few days later, to a phase of reorientation in which the awesome responsitilities of motherhood become a focus of maternal anxiety. When pueperal patients were detained in the hospital for seven or eight days, this period was a familiar one on the maternity service and the emotional reaction was often spoken of as the "fifth day blues". Now that we send patients home in 3-5 days, it is less commonly observed, yet surely the anxiety still evidences itself. Judicious reassurance by the physician, preparation during pregnancy and in the hospital through reading material, patient's classes, and in-hospital discussions and demonstrations go gar in helping the parturient to overcome this anxiety. At the Woman's Medical College Hospital, maternity nurses conduct daily demonstrations of techniques of bathing babies, formula preparation, care of breasts, puerperal exercises, and the like, which most mothers, even those who have had several children, enjoy and find helpful.

The anxieties precipitated by impending surgery are well known to us all.

The operations of mastectomy and hysterectomy are almost invariably causes of severe anxiety in women.

Those who undergo mastectomy are confronted not only with mutilation, but also with fear of death from cancer. I believe these women should be encouraged to verbalize their anxiety, and supported by a firmly confident attitude on the part of the physician. For my part, I seek to minimize their consideration of the ultimate prognosis, and to focus attention on what is being done medically to get them well. This is at best a difficult task, but it constitutes, in my view, a rational and encouraging approach and one whicb is realistic.

Cancer, more than any other disease, produces severe anxiety in all patients. Fear of pain, fear of lingering, fear of death combine to induce a degree of anxiety which is demoralizing and at times utterly disabling. Whether this anxiety is increased or lessened by telling the patient she has cancer depends on a multiplicity of factors. In general, however, it is my feeling that for most patients, an evolutionary disclosure, where it is possible, of the nature of their illness is less shocking and allows a less difficult adaptation. By and large direct questions should be answered directly and briefly, but terminal patients seldom ask direct questions, and in cancer patients who are not terminal, questions about prognosis can usually be diverted into discussions about therapy. Therapy should in my opinion be the essence of the physician's communication with the cancer patient. Continuous and scrupulous attention to the details of treatment is imperative. Adequate preparation for the expected effects and side-effects of treatment should not be neglected. Radiation sickness, for example, is much better tolerated if patients are told in advance that it may occur.

Radiation therapy, I believe, produces the most severe anxieties in gynecologic practice because of the patient's awareness of the potentially lethal character of the therapeutic agent as well as of the disease being treated. In the modern world the word "radiation" suggests death, individual and universal. Nevertheless, the anxiety of patients undergoing radiation therapy is to an extent relieved by an implication of enourmous potency of the therapeutic mechanism. Moreover, to a certain degree anxiety in patients undergoing radiation therapy is helpful in that it secures their cooperation despite the discomforts of their treatment.

I think the most tragic anxiety is that which the patient feels when she appreciates that she has been psychologically abandoned, that the physician has given up. To my mind, in terminal patients, it is more important to prevent bed sores than it is to correct anemia, and dusting powder and deodorants are of greater help than intravenous fluids. In any event, we must avoid the attitude that nothing can be done, and focus our attention unremittingly, on the patient's comfort. The essence of the physician's duty is not the patient's recovery, but her comfort. It is the responsibility of the physician, and not only of the nurse, to attend to the patient's comfort, and his constant attention to her comfort, does as much as anything can to alleviate her anxiety.

Much has been written about the emotional effects of surgery. Dr. Elam of Meharry yesterday conducted a round table discussion on this important subject. Surely no patients are more susceptible to emotional problems in reference to surgery than women who undergo hysterectomy. These women

offer an opportunity for most fruitful effort by the physician to allay anxiety. In my opinion it is a fact that hysterectomy does not itself adversely effect sexual gratification, and I believe that reassurance on this point alone is of paramount importance in enabling these patients to sustain themselves.

Fortunately, most women who require hysterectomy are beyond the childbearing age, and the surgical loss of childbearing function is not an issue. That is to say, the anxieties of these patients in relation to hysterectomy are not centered on the reproductive function, although, of course, the loss of reproductive function is a source of anxiety in menopausal women.

By and large, I believe, the greatest fears of women subjected to hysterectomy relate to a possible loss of sexual responsiveness, consequent inability to achieve orgasm, and the like.

Such fears are deeply rooted in our culture and are difficult to allay. One basis for this difficulty is the fact that women in the forties, the usual age group of hysterectomy patients -- often have deteriorating marriages to begin with. Their husbands not infrequently employ the fact of hysterectomy as a weapon in marital conflict. For this reason alone, it is important for the surgeon about to subject a woman to hysterectomy to explore the status of her sexual life. I have found that most women who are having problems of sexual satisfaction, or of marital discord for other reasons, accept a candid explanation in advance that while the operation of itself has no damaging sexual effects, when considered in the context of a particular marital or sexual relationship, it may well be a destructive influence. When the male partner, for example, has a firm conviction that hysterectomy is ruinous, it may well be so. For what it is worth, I usually have an interview with these

husbands prior to surgery, when I seek to dissipate their misconceptions. These interviews seldom accomplish that objective, but they are valuabe nevertheless in that they substantiate the woman's concept of her own physical integrity, and allow her to accept her mate's rejection without guilt.

Happily, those couples who have a satisfactory marital relationship often find that it is better after hysterectomy, because of the elimination of fear of pathologic symptoms, menstruation, and fear of pregnancy.

Where strict indications for hysterectomy are applied, there is less anxiety, because the pathologic derangements of function which demand correction are generally obvious and troublesome, and the need for surgery, readily appreciated by the patient and her relatives, tempers her sense of loss.

The same awareness of the necessity for surgery is, I think, responsible for the relatively low levels of anxiety which are produced by the diagnosis and treatment of carcinoma in-situ of the cervix. Despite the fact that these women are young and asymptomatic, they accept hysterectomy very well, for the most part, feeling, with some justification, that they have made a good trade -- their reproductive function for their lives.

I should like to treat the anxiety of menopausal and senescent women as one because in both groups the primary basis is loss of function. The treatment in both groups, I think, is appropriate activity. It is not sufficient, however, simply to tell a menopausal woman she should busy herself. The hypochondrical fears these women experience should be combated by firm counselling based on careful study and adequate medical treatment. The annoying symptoms of sex hormone depletion should be corrected. This requires judicious

use of estrogens, tranquilizers, diuretics, and at times, mood-elevating drugs. The severely depressed, sleepless, withdrawn, or apathetic patient should have psychiatric evaluation.

I am firmly convinced that the anxieties of the menopause, though they are not related to changes in role -- to a sense of defimminization -- are precipitated by physiologic changes. These women do not feel well, and the restoration of their feeling of well-being is a medical problem of primary importance. This above all helps dispel their anxiety, because a feeling of physical well-being counteracts their ideas of imminent dissolution and enables them to orient their thinking toward the pursuit of happiness in a healthy middle age.

Again, in senescence, the maintenance of the best possible standard of health is the sine qua non of activity, and activity is the best remedy for anxiety.

Finally, may I say that in consideration of this important subject one must recognize that it is neither possible, nor indeed desirable, that patients be entirely rid of their anxieties.

Anxiety of reasonable degree is a spur to meaningful activity; in excess, it tends to immobilize. Fear, the excess of anxiety, is our target. Our weapons, as I have indicated, are competent medical treatment and a clearly communicated empathetic concern.