Brit. J. vener. Dis. (1963), **39**, 173.

PSYCHIATRIC ASPECTS OF VENEREAL DISEASE*

BY

E. de C. KITE AND A. GRIMBLE

Guy's Hospital, London.

With the increase of venereal disease in Great Britain it is appropriate to record the problem which arises from the fear of venereal disease and its psychiatric *sequelae*. Anxiety about venereal disease may occur in "venereal" and "non-venereal" patients including those who have never taken a risk. The anxiety may be normal or abnormal and may also precede or accompany psychiatric illness.

It is important to mention that in popular usage the term "venereophobia" is applied to all cases of undue anxiety about venereal disease. Lewis (1950), however, stressed that the term "phobia" should not be used unless the characteristics of an obsession were present as well as fear. The term venereophobia in this study is therefore used in this sense. It accounted for half the anxiety symptoms about venereal disease, the remainder being due to simple anxiety and sometimes to delusions or hallucinations. Venereophobia accompanied nine different psychiatric syndromes.

The actual incidence of psychiatric illness related to venereal disease in the general population is not known. In the venereal disease clinic it is not recorded to the Ministry of Health since it falls under the heading of "non-venereal conditions not requiring treatment".

Such illness may however, carry a serious prognosis and two cases of suicide have recently been reported in the *British Medical Journal* (Faull, 1961; Thyne, 1961). The way in which fear of venereal disease presents makes many of these cases look alike and the psychiatric diagnosis is seldom obvious. The present study seeks to determine the incidence, psychogenesis, and diagnosis, and the results of observation and treatment of psychiatric illness in a venereal disease clinic. The patients all attended the venereal disease department of Guy's Hospital.

Macalpine (1957), who studied patients at St. Bartholomew's Hospital Special Clinic, thought that although figures for the incidence of venereal disease may have declined at the time, the numbers of patients attending with psychiatric disorder had not decreased. Their correct recognition and treatment was important and a study of the actual incidence was necessary for a further understanding of the problem. Wessell and Pinck (1947), in a U.S. Military General Hospital in Europe, found that 50 per cent. of urological patients and 30 per cent. of neuropsychiatric patients were cases of "venereal disease anxiety". Campbell (1951), addressing the M.S.S.V.D., stressed that cases of venereophobia constituted one of the major problems in the Sheffield clinic. Similarly, Rogerson (1951) pointed to an increase in the number of cases of "venereophobia" in the Norwich area. He considered that the increase was confined to male patients. Gibbens and Silberman (1960), in a psychiatric study of 230 males from different special clinics who were the "clients of prostitutes" only, found that 30 per cent. had no venereal disease, but suffered from fears and anxieties, and that 5 per cent. had actual nervous breakdown or attempted suicide.

Comparing the incidence of "venereal disease mania" in the two sexes, Schuermann (1952) found it in 65 men and only two women in his series. Macalpine (1957), in her study of "venereophobia", found only one female among 24 psychiatric patients referred from the special clinic and remarked on this "enigmatic preponderance of males" (but see Table II).

Graciansky and Stern (1953), however, had 14 males and 10 (42 per cent.) females, in a series of 24 cases of "syphilophobia", and Terhune (1949), studying phobias generally without specific mention of venereophobia, found them twice as common in the female, which agrees with our findings.

* Received for publication April 22, 1963.

Material and Methods of Study

This series of 76 consecutive psychiatric cases among old and new attendances at the venereal disease department included 52 males and 24 females. An abnormal fear of venereal disease was associated with a wide variety of psychiatric illness.

Patients attending the clinic who were suspected of psychiatric disorder were given special interviews. Some showed unequivocal evidence of disorder, such as delusions or depression, on which an early psychiatric diagnosis could be based. In others, more prolonged observation was necessary and it was in this group that it was difficult to separate the normally anxious from the psychiatric. In the anxious group some patients defaulted before diagnosis could be established. All the psychiatric patients were examined by interview only, and the information was recorded on a specially compiled proforma, which included full psychiatric and medical history, history of venereal disease, influence of propaganda, details of sexual history, and past risks of venereal disease. The patient was also submitted to a full physical examination. 44 of them were new patients, attending for the first time, and the category under which they attended is shown in Table I. Of the 32 patients with psychiatric disorder who had previously attended, or were still attending the clinic, 29 were in the non-venereal group, two were cases of syphilis under surveillance, and one was a female with gonorrhoea.

TABLE I

TOTAL NEW AND OLD PATIENTS WHICH FORMED THE GROUP OF PSYCHIATRIC CASES

Sex	Psychiatric Patients		
	New	Old	Total
Male	31	21	52
Female	13	11	24
Total	44	32	76

Incidence.—In the present study the incidence of new psychiatric cases was 5 per cent. of 887 consecutive new attendances (4·5 per cent. male and 6·5 per cent. female). A number of probable psychiatric patients did not reattend for a full history and the overall incidence may therefore have been higher than 5 per cent. The incidence among males in this department for a previous 18-month period was 4·2 per cent. The 76 psychiatric patients are divided into their respective groups (Non-Venereal, Gonorrhoea, and Syphilis) in Table II. Over 86 per cent. fell into the non-venereal group, confirming a generally-held clinical impression, and 56 per cent. had no abnormal physical signs of any sort.

TABLE II

GROUPS UNDER WHICH PSYCHIATRIC PATIENTS ATTENDED, AND THE RELATIVE FREQUENCY OF THE FEMALE SEX

Sex	Incidence of V.D. in Patients who attended						
	Total		Non-venereal		Non-specific Urethritis	Gonorrhoea	Syphilis
	No.	per cent.	No.	per cent.			
Male	52	4·5	45	86	5	0	2
Female	24	6·5	21	87	0	3	0
Total	76	5	66	87	5	3	2

It is interesting to compare the incidence of emotional upset with that among patients in other out-patient departments. In one study this was determined by means of the self-administered "Cornell Medical Index" Health Questionnaire (C.M.I.) comprising 195 questions (Culpan, Davies, and Oppenheim, 1960). It was found that "the incidence of emotional disturbance among out patients attending various clinics can be considerable, especially in gynaecology, physical medicine, and female surgical patients, who would appear to need further psychiatric investigation. No definite diagnosis of a neurosis or psychosis was at present possible by means of the C.M.I. however". These authors made no tests in a venereal disease department and in the present study the psychiatric diagnosis was established by means of interviews only. Written questionnaires were not used, and it would appear that some of the contraindications to their use, *e.g.* alcoholism, obsessional states (Pollitt, 1960), are especially common in the V.D. clinic.

Jacobs and Ritchie Russell (1961) found that 5 per cent. of their neurological out-patients had functional disorders only.

Diagnosis.—In 59 patients the psychiatric condition arose before attendance at the clinic, and in seventeen patients (including only two females) during the time of attendance. Whereas some patients presented with unequivocal signs and symptoms of psychiatric illness, in others abnormal anxiety or depression resembled that seen in normal individuals subjected to the stress of the fear of venereal disease. The resemblance of strong emotional expression to psycho-pathological symptoms has been emphasized by Cobb (1950). In all cases certain criteria of psychiatric breakdown were fulfilled, such as incapacity for work or satisfactory social relationships, besides the specific criteria for the diagnosis of each

individual syndrome. In these the most useful criterion of abnormality was the persistence of anxiety or depression in the absence of an adequate cause.

In the depressive illness a distinction was on traditional lines between endogenous, reactive, and involutional depression, as advocated by Sargant and Dally (1962).

The most frequent psychiatric conditions were the anxiety syndromes and depressive illnesses (Table III). Compared with the frequency of psychiatric disorder in one Psychiatric Out-Patients' Department (Garmany, 1956) this study showed that the incidence of depression, hysteria, and psychopathic personality was similar, while obsessional states were more frequent (10 per cent. as compared with 2 per cent.).

Symptoms.—The principal symptoms seen among the different psychiatric syndromes were anxiety (45), true phobia (37), genital pain or itching without organic cause (27), genital pain with organic basis (3), depression (26), delusions (8), auditory hallucinations (2), panic attacks (6), suicidal ideas (6), impotence (6), frigidity (4), phantom genital swelling (2).

Anxiety.—This was regarded as abnormal when provoked by an inadequate cause or abnormally persistent. In each case it was accompanied by physical concomitants. It could be classified as simple, secondary (for example to a delusion), or facilitated by organic cerebral changes. It disguised an endogenous depressive illness in five cases.

Venereophobia.—In this series a true phobia about venereal disease occurred in 37 patients—24 males (32 per cent.) and thirteen females (52 per cent.). Criteria for the use of the term "phobia" were those given by Lewis (1950) and Massermann (1955). Venereophobia was seen in nine different psychiatric syndromes, being most frequent in endogenous depression. It also occurred in anxiety neurosis, obsessional states, hysteria, and reactive depression, but was essentially absent in all reactive anxiety states. It was also seen in schizophrenia, and paranoid and organic syndromes. In four cases the phobia developed into a delusion.

Depression.—This was regarded as a psychiatric symptom when an affect of sadness prevailed without adequate cause. It was prominent in 34 per cent. of cases, of which just over half were depressive illnesses.

Delusions, or false beliefs about infection which were impervious to logical argument.—These occurred in eight cases. In one case of simple schizophrenia the patient believed that there was a large hole in his stomach due to syphilis and he threatened suicide.

The delusions in cases of endogenous depression were of unworthiness and of venereal disease. One patient with endogenous depression threatened and another actually committed suicide.

Macalpine (1957) remarked upon the particularly favourable milieu of the venereal disease clinic for witnessing the interesting transition of phobia to delusion. This was seen in two obsessional states which

TABLE III

DIAGNOSTIC CATEGORIES OF PATIENTS

Reaction Type		Diagnosis	Sex		
			Male	Female	Total
Obsessional		Obsessional state	4	3	7
Hysterical		Hysteria (sensory)	1	2	3
Psychopathic Personality		Psychopathic personality	1	3	4
Affective	Anxiety Syndrome	Reactive anxiety state	9	2	11
		Anxiety neurosis	7	6	13
	Depressive Syndrome	Endogenous depression	15	3	18
		Reactive depression	4	1	5
		Involutional melancholia	1	0	1
		Hypomania	0	1	1
Schizophrenia		Simple	1	1	2
		Catatonic	1	0	1
		Paranoid	0	1	1
		Pseudoneurotic	2	0	2
Paranoid		Paranoid state	1	1	2
Organic Cerebral		Cardiovascular degeneration	2	0	2
		Syphilitic paresis	1	0	1
		Post-concussional syndrome	2	0	2

became a paranoid psychosis and a schizophrenic illness respectively. It was also seen in two cases of endogenous depression one of which had cerebrovascular degeneration and the other acute alcoholism.

Suicidal Ideas.—These occurred in six cases, five in endogenous depression and one in simple schizophrenia.

Hallucinations about Venereal Disease—These occurred, as auditory and accusatory, in two patients, in one case of general paralysis of the insane and in one schizophrenic.

Symptoms of Impotence and Frigidity.—These were present mainly in depressive illness.

Other physical symptoms such as genital pain or itching without organic cause were present in a variety of syndromes. Genital pain masked endogenous depressive illnesses in nine cases (50 per cent.). Andratschke and Rogerson (1943) found that mild endogenous depression presented with physical symptoms in 58 per cent. of their cases.

Discussion

Psychiatric illness associated with fear of venereal disease is not uncommon in a V.D. department. It is a wider problem, however, and cases are also to be seen especially in general practice and psychiatry. Other patients do not seek advice and examples of the latter were seen in three different mental hospitals. One of these had attempted suicide, and another had concealed a primary penile chancre. Examples of serious psychiatric effects of a fear of venereal disease could be given by many practitioners, yet it is doubtful if many could give examples in relation to other diseases, particularly in young people. It must be asked how psychiatric illness with serious consequences can occur when the prognosis of treated venereal disease is usually good, and when there is greater frankness about "sex". Stafford-Clark (1962) reminds us that the aetiology of any illness is necessarily multiple. This was illustrated in the present series, where the fear of venereal disease was always a multifactoral mental stress apart from the physical factors which might also be present. Fear of venereal disease acted often as both cause and effect, because it was prone to appear both as an external mental stress and as a symptom in the resultant psychiatric illness. In 66 cases (87 per cent.) fear of venereal disease had caused mental trauma before the breakdown. In twelve of these cases it played a unique causative role. Here it is necessary to recognize that harmful sentiments about venereal disease are widespread in the population; that it is a sin or a disgrace is the traditional view. Many other unwonted ideas were brought to light by our inquiry, especially doubts sown by anti-venereal disease propaganda (Table IV). 74 patients (97 per cent.) had morbid sentiments about venereal disease before the onset of illness. Conflicts aroused were social, physical, altruistic, religious, egoistic, marital, or sexual; one or more.

The factors which appeared to be related to psychiatric breakdown could be classified as venereal and non-venereal.

(1) *Venereal.*—Extra-marital risk or promiscuity occurred in 84 per cent. of cases; a previous history of syphilis or gonorrhoea was found in 31 per cent.; treatment for non-specific urethritis was not an important factor although attendance for acute gonorrhoea contributed to breakdown in three female patients; observation for syphilis became the subject of a phobia in one melancholic; another male developed a reactive anxiety state during attendance for clarification of a non-syphilitic serum reaction; two females later developed a psychiatric illness during their period of observation for persistently positive serological tests for syphilis; misinterpretation by the patient of signs of venereal disease occurred in 16 per cent. of cases; and lastly the role of anti-venereal disease propaganda.

TABLE IV

TYPES OF ANTI-VD PROPAGANDA WHICH WERE SOURCES OF ANXIETY

Sex	Type of Propaganda						
	Anti-VD Posters Alone		"Service Lectures"	Mixed Sources Pamphlets, Books, Conversation	Television Alone		None Elicited
	No.	Per cent.			No.	Per cent.	
Male	20	38	12	7	3	6	13
Female	12	50	0	5	0	0	4
Total	32	42	12	12	3	4	17

Anti-venereal disease propaganda was given as the main source of fear in 78 per cent. of the psychiatric cases, and was considered to be the most important source of fear and of morbid sentiments about venereal disease, being usually associated with other venereal factors such as promiscuity or a past history of infection. In two cases however, it was the *only* source of fear and the mental stress related to breakdown, neither of which would in fact have been regarded as a psychiatric risk. This factor was thought to be very significant, since in 62 per cent. of cases official sources of propaganda were implicated and this cause should be largely preventable. The Figure shows an anti-venereal disease poster of recent exhibition typifying the phrases and presentation which had inspired fear, shame, and doubt. It appears to be no coincidence that among the 31 per cent. of psychiatric patients who worried about previous venereal disease, the average interval since the infection was over 12 years, although all had been pronounced cured at the time. They had been made to think that "infection can last for years", and the clinic doctor's reassurance was often countered by the patient with something noted from a poster or other propaganda.

Clarke (1936) stated that, in the reduction of syphilis in Scandinavia, emphasis was merely on treatment facilities and on complete frankness about venereal infection. Others have also expressed doubts of the usefulness of posters and propaganda in preventing venereal disease (Vonderlehr, Bundesen, Moore, Nelson, Pelouze, Snow, Stokes, Wile, and Usilton, 1936; Willcox, 1946; Buck and Hobbs, 1950; Moore, 1951). In Poland, however, Capiński (1960) found that nearly a third of attendances at the special clinic were due to intensified venereal disease education. But no study has yet been made of the psychiatric casualties related to various types of

FIGURE.—A cautionary poster inspiring feelings of guilt and shame (by the hand and shadow) and doubt of curability (by the words).

anti-venereal disease propaganda. It is considered that the present findings weigh heavily against presentations which in any way inspire shame, doubt, or fear of dreadful consequences directly or by implication.

(2) *Non-venereal.*—Previous psychiatric illness was recorded in 59 per cent. of cases. It is equally important to state this the other way round; that 41 per cent. of cases had had no previous psychiatric illness of any kind. Good personality, and particularly good sentiment formation, which favours multiple mental conflicts (Pailthorpe, 1932), were important attributes to breakdown in relation to fear of venereal disease. Thomas (1961), in a survey, asks "Should we insist on wider education of the public on the dangers of venereal disease and risk being landed with a population of neurotics . . . are we making it clear that prevention is better than cure and that the mental aspects of venereal disease are as important as the physical?"

Finally, it was sometimes observed that the fear of venereal disease or of visits to the venereal disease clinic had been concealed by the patient from a psychiatrist, or from his doctor, because of social stigma, and that fears of venereal disease had thus remained unresolved. Other patients were reluctant to reveal their psychiatric history at first to the venereologist, either because of the stigma still attached to mental illness, or because the fear that their fear of venereal disease would be regarded as "madness", or again because they did not wish to be referred back to a psychiatrist and to divulge their sexual history over again.

These fears on the part of the patient raise the problem of where the psychiatric treatment should take place. A particular doctor-patient relationship is built up in the venereal disease clinic by the divulging of intimate details of the patient's sexual life. Pahmer (1949) points out that such patients are reluctant to be referred, and it is our opinion that they should be treated in the V.D. clinic where practicable. Twelve cases were referred in this series, one a psychiatric emergency.

Of the referred patients, four returned to the clinic and three were lost to observation. Pahmer advocated the use of psychiatric services in every clinic, and Mayer-Gross, Slater, and Roth (1954) considered that psychiatric advice should always be readily available in the clinic itself. The advantage of the special milieu would not then be lost.

Most (64) of the patients in this series were treated in the clinic. Treatment was by superficial psychotherapy aimed at resolving the conscious or near conscious conflicts (Garmany, 1956) which aroused guilt and other feelings. Macalpine (1957) pointed out that reassurance is not helpful in the face of deep convictions about venereal disease, and it has been stressed that detailed history taking with sympathetic interrogation is worth many hours of attempted reassurance (Puig, 1946; Grimble, 1961). Guilt was the predominant conflict, associated most often with promiscuous sexual intercourse, but also with masturbation and sexual inversion. Sometimes it had a religious basis. Occasionally the basic conflict was one of sexual inadequacy or of repressed aggressive urges. In three females disappointment in love led to "venereophobia". Two of these were obsessional illnesses and one a reactive depression.

Pain represented a defence against anxiety and guilt, which was sometimes accompanied by the desire to suffer a penalty. Hart (1947), has said that "Man is less able to endure guilt than pain". In one patient an endogenous depressive illness was found to have remitted spontaneously with the development of a urethritis (see also Harkness, 1948). At first, patients were seen for up to half an hour once or twice a week. It was noted that they found these attendances welcome and that the interviews helped to restore their confidence. "Obsessional patients require much encouragement by praising whatever can be praised" (Boyle, 1945). Many endogenous depressives benefited by such supportive psychotherapy while remission was awaited; and in the case of the more chronic psychotics it helped "to keep them on an even keel" (Allison and Gordon, 1948). The overall results of therapy showed complete relief in 89 per cent. reactive anxiety states, 80 per cent. of reactive depressions, 61 per cent. of endogenous depressions and 53 per cent. of anxiety neuroses. Of eighteen patients who relapsed, fourteen were suffering from the more chronic illnesses, obsessional states, hysteria, schizophrenia, and organic cerebral syndromes. Of the 37 cases with true phobias (venereophobia), 62 per cent. were relieved; the rest improved but were found to have relapsed in a follow-up of 3 months to 1 year.

Conclusions

In a study of the incidence, clinical picture, and causes of fear of venereal disease it has been shown that this occurs as a symptom of psychiatric illness with significant frequency. Often it is of a serious nature and may lead to suicide.

Unreasonable fear is by no means always phobic. A true phobia (venereophobia) was present in only 50 per cent. of cases of varying psychiatric diagnoses and the general use of this term is therefore misleading and indeterminate. The root of fear, whether

simple anxiety, phobia, delusion, etc., should be elicited together with the underlying psychiatric diagnosis. Upon this the correct treatment depends.

Eight different psychiatric reactions were encountered in this series. Of these a mild endogenous depressive illness was the most frequent, in which the prognosis had always to be guarded.

Assessment and diagnosis is fraught with difficulties. Insufficient time for interviews in a busy clinic and the reticence of the patient at first together with his or her withholding of information, are but two factors. Furthermore, main symptoms, *e.g.*, pain and anxiety, do not by any means always point to the diagnosis.

Of the main factors immediately related to breakdown, the fear arising from anti-V.D. propaganda (as at present publicized) seems to be the most powerful. If this is so, then it would seem advisable to make any discussion about V.D. as clear, straightforward, and factual as possible, and without implicit moral overtones in its public presentation.

In assessing the *prognosis* of these patients as a whole, 46 per cent. of the total were relieved, 24 per cent. relapsed, 21 per cent. were relieved of their fears only, 13 per cent. were improved, 9 per cent. were not improved, and 9 per cent. were not traced. The prognosis in reactive anxiety states and reactive depressions was excellent, and in endogenous depression and anxiety neuroses it was good. Remission in depressive illness seemed to be hastened by the use of mono-amine oxidase inhibitor drugs; Librium and Nardil were used where anxiety was a prominent feature, and phobic symptoms in some neuroses were benefited by Librium alone (Sargant and Dally, 1962).

Summary

In a study of the incidence, pattern, and causes of psychiatric illness related to fear of venereal disease, it has been shown that psychiatric illness occurred in 5 per cent. of patients attending a venereal disease clinic. It was more frequent in females (6·1 per cent.). The Table shows that all the main psychiatric syndromes were met with. Mild endogenous depression was most frequent, occurring in eighteen cases, nine of which presented atypically with genital pain, and five with anxiety. In all syndromes it was significant that the main symptoms did not always point to the diagnosis, and the prominence of fear of venereal disease made many different conditions appear at first alike.

Causes of breakdown were considered. Fear of venereal disease alone caused breakdown in twelve patients of good personality and sentiment, two of these cases being directly related to anti-venereal disease propaganda. Fear of venereal disease was shown in itself to be a multifactoral stress arousing many different conflicts which it was necessary to elicit by psychotherapy. The venereal disease clinic was considered the best milieu for their treatment, except as an emergency, or where the patient wished to be referred. Treatment was by superficial and supportive psychotherapy; drugs were sometimes used.

Figures are given for the results of treatment in the clinic. Relief was obtained in 89 per cent. reactive anxiety states, 80 per cent. reactive depressions, 61 per cent. endogenous depressions, and 53 per cent. anxiety neuroses.

Of the chief factors immediately related to breakdown, the fear arising from anti-venereal propaganda seemed to be the most powerful. If this is the case then publicised discussion about venereal disease should be clear, straightforward, factual, and reassuring without implicit moral overtones in its presentation.

REFERENCES

Allison, D. R., and Gordon, R. G. (1948). "Psychotherapy", p.97. Oxford University Press, London.
Andratschke, R., and Rogerson, C. H. (1943). *Brit. med. J*, **1**, 780.
Boyle, A. H. (1945). *In* "Psychology in General Practice", ed. A. Moncrieff, p. 62. Eyre and Spottiswoode, London.
Buck, C. W., and Hobbs, G. E. (1950). *J. vener. Dis. Inform.*, **31**, 204.
Campbell, D. J. (1951). Presidential Address, M.S.S.V.D.
Capiński, Z. (1960). WHO/VDT/270., p.7.
Clarke, C. W. (1936). *Amer. J. Syph.*, **20**, Suppl. 2, p.7.
Cobb, S. (1950). "Emotions and Clinical Medicine", p.107. Norton, New York.
Culpan, R. H., Davies, B. M., and Oppenheim, A. N. (1960). *Brit.med. J.*, **1**, 855.
Faull, D. C. (1961). *Ibid.*, **1**, 1247. (Letter).
Garmany, G. (1956). *Ibid.*, **1**, 943.
Gibbens, T. C. N., and Silberman, M. (1960). *Brit. J. vener. Dis.*, **36**, 113.
Graciansky, P. de, and Stern, E. (1953). *Sem. Hôp. Paris*, **29**, 2911.
Grimble, A. S. (1961). *In* "Textbook of Medicine", ed. J. Conybeare and W. N. Mann, 13th ed., p.124. Livingstone, Edinburgh.
Harkness, A. H. (1948). *Brit. J. vener. Dis.*, **24**, 66.
Hart, H. (1947). *Psychoanal. Rev.*, **34**, 259.
Jacobs, H., and Russell, W. Ritchie (1961). *Brit. med. J.*, **2**, 346.
Lewis, A. (1950). *In* "A Textbook of the Practice of Medicine", ed. F. W. Price, 8th ed., p.1964. Oxford University Press, London.
Macalpine, I. (1957). *Brit. J. vener. Dis.*, **33**, 92.
Masserman, J. H. (1955), "The Practice of Dynamic Psychiatry", p.164. Saunders, Philadelphia
Mayer-Gross, W., Slater, E., and Roth, M. (1954). "Clinical Psychiatry", p.155 and p.449. Cassell, London.
Moore, J. E. (1951). *Lancet*, **1**, 707.
Pahmer, M., (1949). *Brit. J. vener. Dis.*, **25**, 124.

Pailthorpe, G. W. (1932). *M.R.C. Spec. Rep. Ser.*, No. 170, p.20.
Pollitt, J. D. (1960). *J. ment. Sci.*, **106**, 93.
Puig, J. M. Simarro (1946). *Rev. clin. esp.*, **21**, 97.
Rogerson, H. L. (1951). *Brit. J. vener. Dis.*, **27**, 158.
Sargant, W. and Dally, P. (1962). *Brit. med. J.*, **1**, 6.
Schuermann, H. (1952). *Hautarzt*, **3**, 296.
Stafford-Clark, D. (1962). *Guy's Hosp. Gaz.*, **76**, 236.
Terhune, W. B. (1949). *Arch. Neurol. Psychiat. (Chicago)*, **62**, 162.
Thomas, C.G.A. (1961). *Brit. J. vener. Dis.*, **37**, 33.
Thyne, G. G. (1961). *Brit. med. J.*, **1**, 206 (Letter).
Vonderlehr, R. A., Bundesen, H. N., Moore, J. E., Nelson, N. A., Pelouze, P. S., Snow, W. F., Stokes, J. H., Wile, U. J., and Usilton, L. U. (1936). *Amer. J. Syph.*, **20**, 1.
Wessel, M. A., and Pinck, B. D. (1947). *Ment. Hyg. (N.Y.)* **31**, 636.
Willcox, R. R. (1946). *Brit. med. J.*, **2**, 825.

Aspects psychiatriques des maladies vénériennes

Résumé

Une étude de la fréquence, du développement, et des causes des psychoses associées à la peur d'infection vénérienne révèle que 5% des malades (y compris 6,4% des femmes) qui fréquentaient une clinique anti-vénérienne furent atteints de maladie psychiatrique.

On trouve chez ces malades tous les syndromes principaux psychotiques, dont la dépression endogène légère est la plus commune; 18 malades se présentèrent ainsi—neuf avec une douleur génitale atypique et cinq avec une inquiétude exagérée. On observe que les symtômes principaux ne conduisent pas toujours au diagnostic véritable et que la sévérité de la vénéréophobie domine très souvent tout autre aspect de la maladie.

La vénéréophobie fut la cause principale des crises nerveuses. Chez 12 sujets de personalité et sentiments autrement bien équilibrés, cette peur d'infection vénérienne fut la seule cause, et chez deux d'entre eux ce fut la propagande anti-vénérienne qui précipita la crise.

La vénéréophobie évoque de nombreuses luttes diverses qu'il faut éliciter par la psychothérapie. La clinique anti-vénérienne semble être le meilleur rendez-vous pour ce traitement, sauf en cas d'attaque imprévue ou si le malade veut absolument visiter la clinique psychiatrique.

On emploie ordinairement une psychothérapie superficielle de soutien, et quelquefois les médicaments oraux.

Un bon résultat fut obtenu dans 89% des cas d'inquiétude, 80% de dépression réactive, 61% de dépression endogène, et 53% des cas d'anxiété nerveuse.

Des causes les plus directement associées aux psychoses, la vénéréophobie évoquée par la propagande anti-vénérienne paraît la plus forte. Il semble donc que toute description adressée au public doit être simple et franche et doit se borner aux faits scientifiques sans insinuation morale.