

While such complications are most commonly seen in the severe hypertensive, they are not infrequent in the less severe hypertensive and this probably explains the presence of the chronic pattern across both groups of hypertensives, but to a lesser extent in the less severe group. It is worth while mentioning that the typical depressive pattern for the chest patients was the chronic one. This form of depression is therefore most likely a reflection of the illness and could best be called an 'illness effect'.

The views expressed by Schwarz and by Bulpitt & Dollery can now be drawn closer together. It appears that reserpine and methyl dopa are still causing depression biochemically. However, with the smaller doses of these drugs used today, the severity of the depression is limited, while the incidence remains much the same. The bulk of the depressions occurring in hypertensive patients are felt to be reflections of the illness itself and these are now occurring in greater severity and are more numerous than the so-called 'biochemical depressions'.

## Personality and Premenstrual Tension

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Since the premenstrual syndrome was first described (Frank 1931), and more recently clearly delineated (Greene & Dalton 1953), extensive studies have been made in several populations and in various age groups. A number of physiological and psychological factors have been investigated but there are few detailed studies on the relationship between these symptoms and the personality structure of the sufferers. The present investigation was prompted by the observation, among others, that premenstrual symptoms were rare in young patients who subsequently developed anorexia nervosa, even when menstruation had been normal in time and character before the onset of the illness. We therefore attempted to discover associations between personality traits and the frequency, nature and severity of premenstrual symptoms.

### Method

One hundred and fifteen women whose menstruation was still regular were interviewed. Of the patients included, two-thirds were seen consecutively in psychiatric out-patient clinics, a quarter were psychiatric in-patients and the remainder were from the general wards of St Thomas'

Hospital. Approximately two-thirds were married and a third single, there being only six patients either widowed or divorced. Variation in the above statuses had no significant effect on the results to be discussed later. The mean age was 33 (range 16–54).

Patients with endocrine or uterine pathology, anorexia nervosa, active psychoses, those receiving steroid hormones and those with language difficulties were excluded.

The presence or absence of the premenstrual syndrome was assessed by recording each of seven well-recognized components of the syndrome. These are: headache, tension or irritability, emotional lability, depression or elation (in all cases under review the effective change was depression), abdominal swelling, breast symptoms such as pain, tingling or swelling, and sleep disturbance. If a symptom was present a score of 1 was given, if absent a score of zero. The total score for this assessment therefore varied from 0 to 7 and is referred to as the 'symptom score' as shown in the left hand column of Table 1. A weighted score was then added, as shown in the right hand column of the same table. This provided an estimate of the severity of each of the symptoms and whether the symptom was volunteered or elicited by direct questioning. A mild symptom admitted on questioning would score 1; a mild symptom volunteered or a severe symptom on questioning would score 2; a volunteered severe symptom would score 3. The total for this weighted assessment was therefore a possible score of 21, referred to as the 'complaint score'.

The symptom scores were used to assess the symptoms of the premenstrual syndrome as experienced by the patient on the one hand, and the complaint scores measure the freedom and intensity of complaining about these symptoms on the other hand. The distribution of the symptom and complaint scores are shown in Table 2.

It is noticeable that 85% of these patients had symptoms. This figure is higher than that generally found in the normal female population but is in accord with some studies including large proportions of patients with psychiatric illnesses.

Personality was assessed by using the self-rating Hysteroid-Obsessoid Questionnaire (HOQ)

Table 1

Methods of scoring premenstrual symptoms

	Symptom score	Complaint score
Headache	0-1	0-3
Tension or irritability	0-1	0-3
Emotional lability	0-1	0-3
Depression or elation	0-1	0-3
Abdominal swelling	0-1	0-3
Breast symptoms	0-1	0-3
Sleep disturbance	0-1	0-3
Total	0-7	0-21

**Table 2**

The distribution of symptom scores and complaint scores in 115 patients

Symptom score	No. of cases	Complaint scores	No. of cases
0	17	0	17
1	4	1-3	15
2	14	4-6	22
3	24	7-9	26
4	25	10-12	23
5	21	13-15	10
6	9	16-18	1
7	1	19-21	1

**Table 3**

Scores of 115 patients on HOQ

HOQ scores	No. of cases
0-5	0
6-10	4
11-15	10
16-20	35
21-25	39
26-30	20
31-35	6
36-40	1

devised by Caine & Hope (1967) (Caine & Hawkins 1963), and this was given to all patients. The stage of the menstrual cycle in which the HOQ was given had no effect on the consistency of the HOQ on retesting. This personality test score distribution is illustrated in Table 3.

The distribution of the HOQ scores was normal with a range from 9 to 39, a mean of 21.5 and a standard deviation of 5.5. The medical in-patient group had a mean score of 23.4, the psychiatric in-patients 21.1 and the psychiatric out-patients 21.2. The differences between these means were not significant and compared closely to the means for in-patients on general hospital wards who had been referred for psychiatric treatment as described by Caine & Hope themselves.

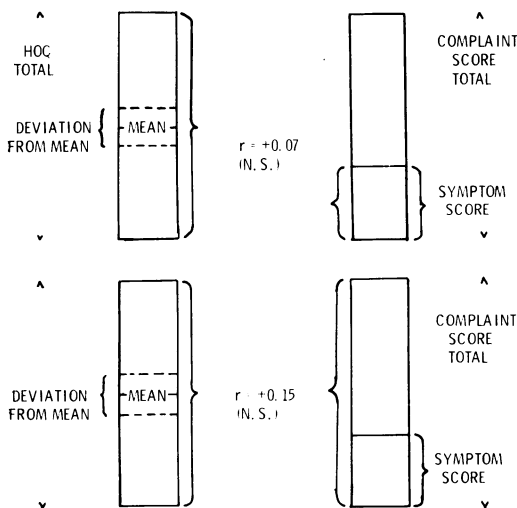
**Results**

The associations between the patients' HOQ scores and their symptom and complaint scores for premenstrual tension were investigated by calculating the product-moment correlation coefficients between them. Fig 1 shows that the HOQ score correlated neither with the symptom

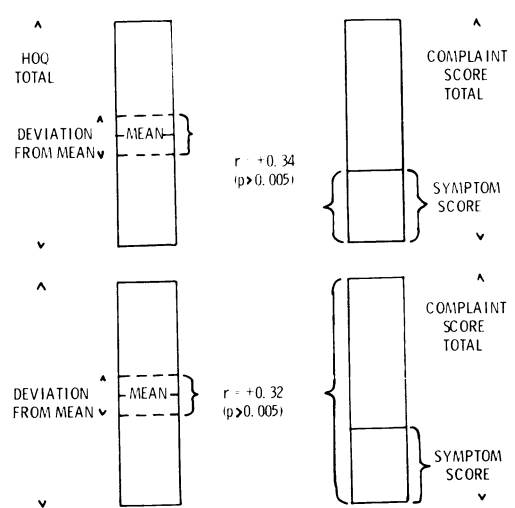
nor complaint scores. However, as shown in Fig 2, the correlations between the deviation from the mean HOQ scores for each patient and symptom and complaint scores are both significant at  $P < 0.005$ :  $r = +0.34$  and  $r = +0.32$  respectively.

It is seen therefore that the greater the departure from the mean score on the personality test, the greater is the increase in symptom formation and in complaints rendered. The relationship between symptom score and the deviation in HOQ suggests that the tendency to develop the actual syndrome is related to personality type, and moreover to extremes of obsessiveness and hysterical tendencies rather than with one specific personality type. The complaint score also showed a positive correlation with personality extremes but since the former relates also to the symptom score, an attempt to differentiate the effects of these two components was made.

Firstly, the score for premenstrual symptoms was subtracted from the complaint score for each patient. This measurement of 'complainability' did not correlate with total HOQ score, but again, as shown in Fig 3, there was a positive correlation between this measurement of complainability and deviation of HOQ,  $r = +0.29$  ( $P < 0.01$ ). Thus the partial removal of the effects of the score due to the actual symptoms still indicated a positive though smaller correlation between the tendency to complain and to have a personality removed from the normal. In order to remove the interference of the symptom score still further, the ratios of the complaint to symptom scores were calculated where possible and compared with HOQ and deviation of HOQ, as shown in Fig 4. Again the correlation with total



**Fig 1** Correlation between hysteroid-obsessoid questionnaire scores and complaint scores for premenstrual tension



**Fig 2** Correlations between deviations from the mean of hysteroid-obsessoid personality score and premenstrual syndrome symptom and complaint scores

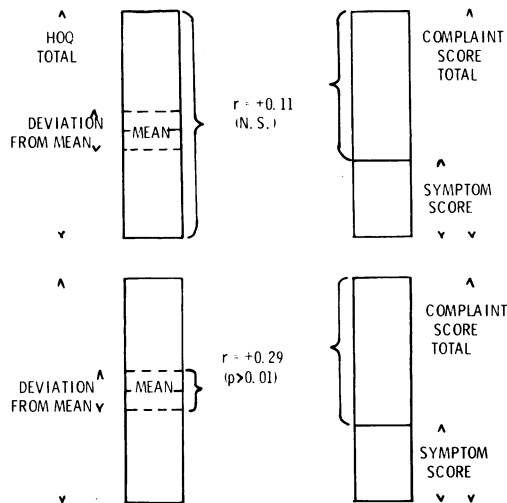


Fig 3 Correlation between HOQ score and deviation from the mean with the complaint score minus the symptom score for the premenstrual syndrome

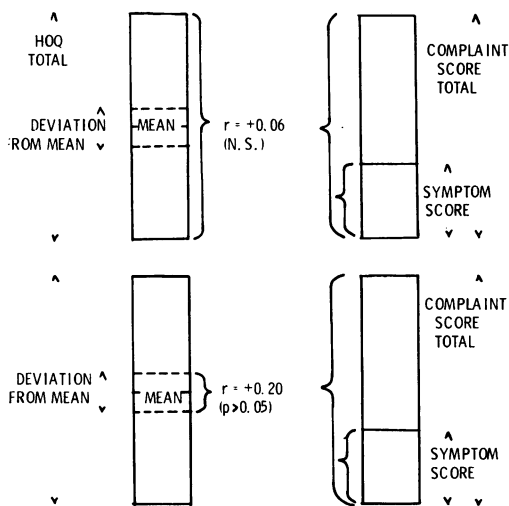


Fig 4 Total HOQ score and deviation of HOQ score compared with the complaint/symptom ratio for premenstrual syndrome

HOQ was not significant but the deviation of the HOQ correlated positively with the complaint score/symptom score ratio ( $r = +0.20$ ;  $P < 0.05$ ). This correlation is much lower, being barely significant, suggesting that complainability is less strongly related to extremes of personality than is possession of symptoms.

**Discussion**

It can be seen from the results that it is probable that either personality extreme is related to complaining tendency in part, or that possibly the tendency to complain was measured by both

the HOQ test and the premenstrual calculations, thus giving common factors. However, it seems apparent that although there is a relationship between complainability and personality deviation, there seems also to be a stronger nonspecific relationship between personality extremes and the possession of the actual symptoms of the premenstrual syndrome as such, and that efforts to minimize the effects of the tendency to complain lend support to this conclusion.

**REFERENCES**

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**Mental Hospital v General Hospital 1972 Scottish Statistics of Psychiatric Care**

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The recent Report (1973) of a Working Party of the Royal College of Psychiatrists (Scottish Division) on the 'Future of the Psychiatric Services in Scotland' recommended increase in the provision of psychiatric service at all general hospitals; but it did so primarily for the treatment of the extensive psychiatric morbidity which presents there and which it believed would continue to remain relatively untreated without such development. The Working Party Report also recommended that for the provision of comprehensive psychiatric care in any area, there should be the opportunity for flexibility between the type of service provided from its mental hospitals and from the psychiatric units at its general hospitals. Hence the Working Party recommended firmly not only the retention of mental hospitals, but also the development of in-patient facilities at all general hospitals.

**Results**

These are displayed in Table 1 and Fig 1. Contrasts in the distribution of diagnosis, duration of stay and age are readily apparent.

A higher proportion of patients were admitted to Psychiatric Units in General Hospitals (57%) for the first occasion than to Mental Hospitals (41%). A considerably lower proportion of patients admitted to Psychiatric Units (1%) were there by an order of the Mental Health Act than