

# **The Age of Anxiety: a Reassessment**

**Malcolm Lader**

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This text is the author's own complete revision and updating of I.C.R. Monograph No. 14, *The Age of Anxiety*, which it replaces.

# The Age of Anxiety: a Reassessment

## Introduction

The word “anxiety” is nowadays part of everyone’s vocabulary and our times have been dubbed “The Age of Anxiety”. Remedies for anxiety, in particular the tranquilliser group of drugs, are widely used and rather disturbingly over a million people in the U.K. take these drugs every day. Is anxiety a major health problem or does it reflect an increasing introspection in our society? The problem is surely great in subjective terms of human suffering and it concerns not only doctors but other members of the caring profession such as clinical psychologists, social workers and nurses. Indeed, as concern has mounted over the widespread use of tranquillisers, the importance of non-drug approaches and hence of non-medical practitioners has become more apparent.

The most important reason for attempting to assess morbidity in the community is to provide information for Health Authorities so that adequate treatment services can be provided. This is a realistic aim where major illness is concerned. For example, schizophrenia in its acute form presents problems of medical management and treatment which are most efficiently solved by admitting the patient to hospital, be it to the psychiatric wards of a general hospital, to a specialised university clinic or to a large area mental hospital. The problem arises when minor or minimal psychiatric disabilities are assessed and epidemiological data amassed. The choice of “cut-off” point between the “ill “ and the “not-ill “ is crucial; too high a cut-off point and individuals who would genuinely welcome and benefit from medical and social help will not be catered for; too low a cut-off point and one can jibe that mentally healthy people are merely those who have not yet had the misfortune to encounter a psychiatrist. As will be seen later, astonishingly high prevalences of mental illness have been claimed. Psychoanalysis also has an important influence in this context as many schools emphasize the inevitability of maldevelopment of some part or other of the “psychic structure”.

Medicine has had its greatest successes in developing preventative rather than curative measures. This is often forgotten by the layman who is more impressed by heart transplant operations, which prolong life by a few months in a few patients, than by the eradication of malaria from a whole province, saving hundreds of lives and improving the general health of thousands. Indeed, a developing country with limited medical resources can

do more from the cost-benefit point of view by concentrating entirely on prophylactic measures than by setting up a few hospitals. The prevention of mental ill-health is much more difficult because so little is known about the causative factors in the onset and maintenance of such conditions. In particular no necessary factors, the removal of which form the basis of the public health prophylactic approach, are apparent. For example, smallpox epidemics, although often associated with insanitary conditions, overcrowding, etc., can be terminated by vaccinating enough of the population so that the virus can no longer find susceptible hosts. There is no equivalent situation in psychiatry so that more non-specific measures such as a general improvement in living and working conditions must be resorted to, especially in the attempted prophylaxis of minor psychiatric conditions such as the anxiety states.

### **Definition of anxiety state**

Anxiety has two main meanings. To be anxious can mean “full of desire and endeavour to effect some act”. For example: “I am anxious to keep your interest and attention”. The low-key emotional tone attached to this urge is directed towards the act to be effected. The second meaning is “being troubled in mind about some uncertain event, being in disturbing suspense, being fraught with worry”. The first type of anxiety is goal-directed and controllable; the second type is diffuse, causing the person to feel passive and helpless.

The latter meaning is relevant to the clinical situation as the ineffable feeling of foreboding is the core of anxiety. It is irreducible scientifically, which means that ultimately one must rely on subjective reports of this state. However, observations and inferences from those observations come close to allowing objective detection of anxiety.

Anxiety as part of everyday experience is a normal emotion. Fear is also a common normal emotion; the distinction between anxiety and fear is quantitative not qualitative. If the cause is clear, the emotion induced is labelled “fear”; if the cause is clouded, or, although readily identifiable, its potential impact is unpredictable, the more diffuse emotion experienced is termed “anxiety”. But anxiety may also be an abnormal emotion, and distinctions between normality/abnormality and normal/clinical can be difficult. It is best to regard clinical (morbid, pathological) anxiety operationally as a need of the sufferer to seek relief from his or her anxiety. Such anxiety may be too severe, too persistent or too pervasive for the person to tolerate. He or she seeks medical advice, thereby becoming a “patient” and the condition an “anxiety state”. Normal anxiety may thus

refer to an emotional state for which the subject does not seek help, although the anxiety levels might actually be greater than those of the patient who welcomes help.

Another distinction of normal anxiety involves the nexus between the intensity of the emotion and the magnitude of the apparent cause. If the anxiety reported by the person and conjectured from the person's behaviour is commensurate with the apparent precipitating cause, it may be deemed "normal". If, by contrast, the anxiety seems disproportionate to the cause, or, as often transpires, no cause is detectable, the anxiety is abnormal. This type of anxiety may also be termed "neurotic", as the emotion reflects symbolic, nonconscious interactions and processes. That, of course, is a separate, vast topic.

Yet another distinction is between state and trait anxiety. State anxiety refers to anxiety felt at one particular time, the moment of study. Trait anxiety is the habitual tendency to feel anxious. Some individuals have such high levels of trait anxiety that they are chronically in a condition of state anxiety.

### **Anxiety States in Psychiatric Practice**

The problem of clinical anxiety as seen by the psychiatrist is not large. In many countries, psychiatry developed in big isolated mental hospitals so that the bulk of the patients were psychotics, often with a poor prognosis. Psychoanalysts working outside these hospitals provided great impetus for the study of neurosis. Indeed, Freud (1894) first delineated anxiety neurosis as a separate disease.

Among psychiatric out-patients anxiety states are diagnosed in less than 10% of cases. The figure is tending to fall a little over the years as general practitioners become more expert and refer fewer patients to specialists.

### **Anxiety states in general practice**

Studies vary enormously in their estimates of psychiatric illness in the community. A one-year morbidity study by eight doctors scattered throughout the U.K. revealed that psychiatric illness was responsible for less than 4 per cent of all consultations (Logan, 1953). However, a group of six practitioners working in collaboration with a psychiatrist reported that about one-fifth of patients seen in anyone day in an urban practice are suffering from "stress disorders" (Finlay *et al.*, 1954). Quite obviously such figures depend enormously on the definition of mental illness. As an example, Kessel's (1960) figures from one London general practice are very

revealing. Using criteria based on the International Classification of Diseases (ICD), 50 per 1,000 of the population were diagnosed as psychiatrically ill. If the criteria were loosened to embrace all patients who showed “conspicuous psychiatric morbidity” (i.e. overt psychological disturbance regardless of diagnosis), the prevalence rate rose to 90 per 1,000. If patients who presented with physical symptoms for which no organic cause was detectable were included, the figure became 380/1000. And if all patients with psychosomatic disorders such as peptic ulcer and asthma were added, the final prevalence reached 520/1000.

Similar total prevalence studies have been carried out in the United States. Again, the wider the criteria and the more intensive the methods used for ascertaining cases, the larger the proportion of the population regarded as “ill” or needing help of some sort. In a survey in Stirling County by Leighton and co-workers (1963), trained assistants administered a long structured interview to over a thousand heads of households or their wives. The complete schedules were assessed by psychiatrists. A prevalence rate of 577 per 1,000 was obtained for subjects judged as being “genuine psychiatric cases”. The Midtown Manhattan Study (Srole *et al.*, 1962) suggested that 23 per cent of the population could be regarded as suffering from serious psychiatric symptoms and some degree of impaired functioning. In both these studies it appeared that less than 20 per cent of the population studied were devoid of symptoms of emotional disturbance, an astonishingly low figure for “normality”. However, this reflects the wide nature of the criteria used, far beyond the bounds of usual psychiatric diagnosis.

A careful and extensive study was carried out by Shepherd and his collaborators (1966) using case-records of general practitioners in London as their source of information. The prevalence-rate over one year of adults consulting for psychiatric problems was the main statistic of interest. Problems arose both from the difficulties of defining psychiatric illness as seen in general practice and in the differences among practitioners in their criteria for diagnosing such illnesses. Furthermore, because the practices studied covered a wide range of socio-economic circumstances, real differences in prevalence rates were to be expected.

Psychiatric morbidity was one of the commoner reasons for consultation: among female patients it came second to respiratory conditions; among males, it ranked fourth after respiratory illnesses, orthopaedic and traumatic conditions and gastro-intestinal morbidity. Psychiatric morbidity referred only to those conditions with a psychiatric diagnosis – “formal psychiatric illness”. “Psychiatric associated conditions”, which included organic illnesses in which the practitioner recognized psychological and emotional

disturbance as playing an important role, constituted a further source of morbidity of about half the formal psychiatric illness rate. The data by diagnosis and sex are set out in Table 1.

TABLE 1 Patient consulting rates over one year per 1,000 at risk (from Shepherd *et al.*, 1966).

<i>Diagnostic Group</i>	<i>Male</i>	<i>Female</i>	<i>Both</i>
Psychoses	3	9	6
Neuroses	56	117	89
Psychosomatic	25	35	30
Others	14	14	14
Total Psychiatric Morbidity	98	175	139

The great majority of patients with *formal* psychiatric illness were diagnosed as neurotic whereas the psychoses accounted for less than 1 in 20 of this group. There were wide differences in the psychiatric morbidity reported ranging from a consultation rate of 25/1000 at risk to 300/1000; the mode was 125/1000. True differences in prevalence related to social class and mobility of the population were discerned. Differences in attitude of the general practitioner were very important, practitioners sympathetic to emotional problems having a high prevalence rate. Other factors which lead to disagreements and difficulties of communication in this area stem from three main sources:

1. Differences at the level of observation.
2. Differences in the conclusions drawn from such observations.
3. Differences in the classificatory systems used by the individual general practitioner, i.e. in the "labelling" process.

It must be emphasized that the treatment of symptoms constitutes a large part of general practice and diagnosis is often difficult or even irrelevant to the management of the anxious patient (Raynes, 1979). Perhaps the most practical approach is to use a tri-axial system with assessment of

physical disorders, psychological symptoms and social problems, as suggested by the World Health Organization.

### **Anxiety states in the community**

The project which best exemplifies the method of using trained psychiatrists as identifiers of psychiatric cases in the community is that at Lund, a rural area in the south of Sweden with a total population of 2,500. Every member of the community was interviewed by Essen-Möller or one of his three colleagues (Essen-Möller, 1956). Individuals were not classified into psychiatric categories but were arrayed on a continuum which ranged from definite psychiatric illness through personality disorders to complete normality. The chance of developing a psychosis during one's lifetime was 1.7 per cent and for neurosis 5.2 per cent. A follow-up study was carried out by Hagnell (1959, 1968) who asked more pointedly psychiatric questions. The figure for psychosis remained at 1.7 per cent but that for neurosis was reestimated at 13.1 per cent. Hagnell also calculated the risk of developing a mental illness over a ten-year period. This was 11.3 per cent for men and 20.4 per cent for women. The estimated cumulated risk of developing psychiatric symptoms (up to the age of 60) is 43.4 per cent for men and 73.0 per cent for women. These are alarmingly high figures, but it should be noted that the risk of contracting a mental illness associated with severe impairment of function is 7.9 per cent for men and 15.4 per cent for women. A substantial proportion of this morbidity relates to neurosis.

A large-scale study, perhaps the most germane to our examination of anxiety in the community, is that of Taylor and Chave (1964). The prevalences of various types of mental illness in the community-at-large, in general practice and in hospital practice in a satellite New Town were recorded, and compared with data for a dormitory suburb and for a decaying area of London. The New Town (dubbed "Newtown") was a socially planned community with full local work opportunities; the dormitory housing estate ("Outlands") had good living accommodation but poor social planning and no local work-places; the old area ("Oldfield") had poor housing usually with shared bathrooms, multiple occupancy and a somewhat above-average number of elderly women.

The purpose of the survey was to delineate the influence of environment on mental health. Does a "good community" promote mental well-being or are genetic and constitutional factors far more important influences? In the field survey, a 1 in 14 random sample of households in Newtown was selected and 1,422 interviews were obtained. In Outlands a survey had been carried out a few years before in which 1,485 people were interviewed. In

Oldfield, a pilot study was carried out on 218 people. A great deal of data was amassed, but the salient points with regard to anxiety and anxiety states were as follows:

TABLE 2 Prevalence of nervous symptoms (from Taylor and Chave. 1974)

<i>Symptom</i>	<i>Percentage of adults reporting</i>		
	NEWTOWN	OUTLANDS	OLDFIELD
“Nerves”	18	22	24
Depression	17	17	12
Sleeplessness	10	12	10
Undue Irritability	13	11	8
At least one of the above	33	35	31

Nervous symptoms were reported by about a third of the subjects, this figure being the same for the three samples (table 2). The percentage of females reporting such symptoms was about twice that of the males; the percentage increased with age in the males but not in the women. The percentage of positive respondents tended to be highest in the lowest social class.

This group of respondents was regarded by Taylor and Chave as suffering from what they called the “sub-clinical neurosis syndrome”. These subjects were more concerned about their health, and actually more ill, both psychologically and physically.

Hire-purchase commitments and short-time working were particular sources of anxiety. Nearly 20 per cent of both men and women described themselves as life-long “natural worriers”.

All the doctors in Newtown took part in a year-long survey of general practice. The prime finding was that formally diagnosed anxiety states constitute at least half of the psychoneurotic conditions. The conclusion of the authors with respect to the general practice survey “is that between 7 and 8 per cent of adults in the new town were treated for neurosis during the year, and this took the form mainly of anxiety and tension states”. Anxiety

states were more prevalent in women than in men, and in the over-45's than the younger groups. In women aged 45–65, the one-year prevalence rate was 83/1000.

As well as these formally diagnosed psychoneuroses, milder conditions were classified by the general practitioners among the group of psychiatric symptomatic conditions. However, in general, the more a practitioner was prepared to make a formal diagnosis, the lower was the figure for psychiatric symptoms, and vice-versa. Only 4 per cent of the patients with neuroses were referred to a consulting psychiatrist.

Clearly apparent is the very high prevalence rate for mental ill-health, with anxiety being an important component. Taylor and Chave were themselves astonished that the incidence of sub-clinical neurosis “would be virtually the same in a decaying London borough, in an out-county estate without local work or social life, and in a planned new town.” About a third of the population show this syndrome; it is not related to length of residence nor to income; it is age- and sex-linked. This minor disease entity must presumably stem from the constitutional factors in the individual, “in the sense that it represents a deeply embedded pattern within the nervous system”. The step from this sub-clinical syndrome to overt neurosis occurs when the patient takes note of the subjective symptoms and consults a doctor. This overt neurotic group varies in size according to the quantity and quality of general practice and specialist psychiatric services available.

Before accepting these and further implications of the data from Taylor and Chave's study, it must be emphasized that such a survey *may* have been subject to bias, special conditions *may* have been prevailing or the results *could* have been wide of the true figures due to a statistical freak. However, there has been a second study with equally startling results.

Salkind (1973), dissatisfied with currently available rating scales for anxiety, painstakingly developed his Morbid Anxiety Inventory (MAI). The instrument eventually took the form of a multiple choice questionnaire, with 21 questions dealing with various aspects of anxiety to be answered by the subject. The inventory was shown to be sensitive to changes in anxiety level and to be an effective instrument in screening subjects for anxiety.

Clinical validation studies suggested that a score of 14 adequately separated non-anxious and anxious subjects. The range 14–17 was a twilight zone in which there was difficulty in deciding whether an individual was anxious or calm. Above 17 there was less difficulty as the misdiagnoses were almost all false negatives, due to denial of symptoms by overtly anxious patients.

Armed with these clinical data, Salkind commissioned a quota sampling of the population of Great Britain by the Gallup Poll Organization. The

Registrar General's Demographic Regions, 12 in number, were all studied and representative samples with respect to age, sex, social class and employment sought. Forty-four interviewers were used and obtained full data on 420 people. Subjects were directly questioned regarding treatment for "worry, depression or any other nervous complaint": 29 per cent answered positively, and about half of this group had received treatment in the past year. Hospital treatment accounted for a quarter.

Taking an MAI score of 14 as the criterion, no less than 44 per cent of the adult population were anxious. If one uses the more conservative criterion of 17 then 31 per cent fall into the anxious group, a figure very close to that of Taylor and Chave for "sub-clinical neurosis". Women tended to have higher MAI scores than men, means of 15.05 and 12.67 respectively. Scores increased with advancing age and in the lower social groups. There was no difference between the anxiety levels of the urban and rural population samples but baffling regional variations were found, the highest values being obtained from East Anglia, West Midlands and South Wales.

An American study evaluated over three thousand members of the general public with respect to "psychic" distress, mainly anxiety (Mellinger, Balter and Uhlenhuth, 1984). Half the subjects were low in psychic distress, 27 per cent were medium in psychic distress and the remainder, nearly a quarter, were high in this factor. Many of the last group suffered multiple health problems, especially musculoskeletal and cardiovascular disorders.

## **Implications**

Do 10 million adults in Great Britain have symptoms of anxiety, insufficient to cause them to seek medical aid yet great enough to cause them discomfort, distress and suffering? The evidence from both Taylor and Chave's study and Salkind's survey is too consistent to ignore. What hospital psychiatrists are seeing is the tip of an iceberg; what general practitioners see is similarly but a fraction of human "dis-ease". Firstly, how should such data influence the specialist psychiatrist in his view of neurosis in general and anxiety states in particular? It seems that about a third of the adult population suffer constantly from nervous complaints, especially anxiety. This proportion is lower in males and the young, higher in females and the elderly. This condition is generally a product of a constitutional substrate. Some of these subjects develop overt anxiety states, but the conditions which govern this step are not clear. To label these conditions "stress" is tautologous. Probably, attitudes to neurosis on the part of the general practitioner and of the general public are the most important factors

in determining the incidence of overt neurosis. A kind, sympathetic doctor with time to listen will find many of his patients with a sub-clinical anxiety state becoming overt. When this happens he will no longer have time to listen.

A sub-group of anxiety states are those with life-long anxiety of an almost entirely constitutional nature. This is present in about 5 per cent of the population; the symptoms may vary but are rarely absent and the outlook is poor. Another sub-group are those patients who do not have any predisposition towards anxiety, but who have developed neurotic reactions to overwhelming environmental factors. The extreme examples of this syndrome are the traumatic neuroses occurring in war conditions and following natural disasters. The prognosis is good.

The implications of the size of the sub-clinical group are frightening. The case-load of psychiatrists and particularly of general practitioners could expand almost indefinitely. In the U.K., the average general practitioner would have about 500 sub-clinical patients on his list, for whom he is contractually obliged to provide treatment. If they all insisted on their rights and he allocated them each only 15 minutes per week for a supportive psychotherapeutic interview, he would be working 125 hours per week with this one condition. Patients are becoming more demanding and expecting effective medical treatment not only for major acute illnesses but for minor chronic conditions as well. The potential for over-loading the health services is great. At the present time, the patients who do come to their general practitioners with vague somatic complaints, "nervousness" and worry are sometimes receiving sympathetic support but more often, because of the limitations of time are treated symptomatically with anxiety-allaying drugs such as the benzodiazepines (e.g. diazepam).

### **Prescription of Tranquillisers**

The ubiquity of anxiety is mirrored by the extensive use of tranquillisers, in particular, the benzodiazepine group of drugs such as diazepam (Valium) and lorazepam (Ativan). The tranquillisers are still amongst the three or four most commonly prescribed groups of drugs in clinical use. A recent study showed that 11 per cent of adults in the U.K. had used tranquillisers at some time in the previous year (Balter *et al.*, 1984). The age and sex distribution is shown in table 3.

TABLE 3 Past-year prevalence of anti-anxiety/sedative drug use: percentage of each sex-age group using medication

<i>Age</i>	<i>Males</i>	<i>Females</i>
18–34	5.3	10.3
35–44	7.9	11.8
45–54	8.9	23.7
55–64	8.3	22.0
65+	5.1	14.9
All	6.7	15.3
Both sexes	11.2	

A disturbing feature is the extent of longer-term usage (table 4):

TABLE 4 Duration of regular daily use: percentage distribution

<i>Duration</i>	<i>All persons</i>	<i>Drug users</i>
No use	88.4	–
Less than 1 month	4.2	37.2
1–3 months	2.7	24.3
4–11 months	0.9	8.4
12 months or more	3.1	27.4
No answer	0.3	2.7

It can be seen that over a quarter of users are chronic users, i.e., they take tranquillisers every day of the year. This represents nearly 1½ million

adults in the U.K. The possibility that some of this usage, perhaps a half or more, reflects physical dependence on the tranquilliser rather than a continuing therapeutic need is exciting a great deal of comment both among doctors and lay men. This may well represent a dependence problem of similar proportions to alcoholism.

## **Conclusions**

Are we really living in an “age of anxiety”? Are we more prone to develop anxiety? Are the stresses of life greater? Or are we more ready to complain and to seek medical advice, less tolerant of “dis-ease”? It is impossible to know because our data are so recent. However, let me quote from Cheyne’s treatise (1733) engagingly entitled: “The English malady: or a treatise of nervous disorders of all kinds, as spleen, vapours, lowness of spirits, hypochondriacal and hysterical distempers, etc.”

“The Moisture of our Air, the Variableness of our Weather (from our situation amidst the Ocean), the Rankness and Fertility of our Soil, the Richness and Heaviness of our Food, the Wealth and Abundance of the Inhabitants (from their universal Trade), the Inactivity and sedentary Occupations of the better Sort (among whom this Evil mostly rages) and the Humour of living in great, populous and consequently unhealthy Towns, have brought forth a Class and Set of Distempers, with atrocious and frightful symptoms, scarce known to our Ancestors, and never rising to such fatal Heights, nor afflicting such Numbers in any other known Nation. These nervous Disorders being computed to make almost one third of the Complaints of the People of Condition in England”.

In this way, Cheyne expresses some of the pervading notions about mental illness which have persisted to this day; that these disorders are increasing as a result of our decadent, sedentary, unhealthy mode of life; that they are associated with dampness, the climate and over-crowding; that they are more common in England than elsewhere; and that they are much more common than they were. His estimate of prevalence has a familiar ring to it in view of the studies cited earlier.

What is needed is a re-appraisal of ways of helping anxious people cope with their symptoms. We should no longer resort to the facile prescription of tranquillisers, of chemical crutches. Instead, people (for they are people, not patients) should be helped to cope with everyday problems by developing realistic strategies of self-help and group help. Methods of lessening tension need promulgating among the general population so that the “Age of Anxiety” becomes the “Realm of Relaxation”.

## BIBLIOGRAPHY

- Balint, M. *et al.* *Treatment or Diagnosis: a study of repeat prescriptions in general practice.* Tavistock Press, London, 1970.
- Balter, M.B., Manheimer, D.I., Mellinger, G.D. and Uhlenhuth, E.H. "A cross-national comparison of anti-anxiety/sedative drug use". *Curr. Med. Res. Opin.* 8, Suppl. 4, 5–18, 1984.
- Cheyne, G. *The English malady; or a treatise of nervous diseases of all kinds, as spleen, vapours, lowness of spirits, hypochondriacal and hysterical distempers, etc.* London, 1733.
- Essen-Möller, E. "Individual traits and morbidity in a Swedish rural population". *Acta psychiat. Scand., suppl.* 100, 1956.
- Finlay, B., Gillison, K., Hart, D., Mason, R.W.T., Mond, N.C., Page, L. and O'Neill, D. "Stress and distress in general practice". *Practitioner*, 172, 183, 1954.
- Freud, S. The Justification for detaching from Neurasthenia a particular Syndrome: *The Anxiety Neurosis (1894).* *Collected Works*, Vol. 1, pp 76–106. Hogarth Press and Institute of Psychoanalysis, London, 1894. Paper reprinted in 1946.
- Hagnell, O. "Neuroses and other nervous disturbances in a population living in a rural area of Southern Sweden, investigated in 1947 and 1957". *Acta psychiat. Scand., suppl.*, 136, 214–219, 1959.
- Hagnell, O. "A Swedish epidemiological study: the 24 Lundby Project". *Social Psychiat.*, 3, 75–77, 1968.
- Hare, E.H. *Triennial Statistical Report.* Bethlem Royal and the Maudsley Hospitals, London, 1968.
- Kessel, W.I.N. "Psychiatric morbidity in a London general practice". *Brit. J. prev. soc. Med.*, 14, 16, 1960.
- Leighton, D., Harding, J.S., Macklin, D.R., Hughes, C.C., and Leighton, A.H. "Psychiatric findings of the Stirling County Study". *Amer. J. Psychiat.*, 119, 1021, 1963.
- Logan, W.P.D. *General Practitioners' Records: An Analysis of Eight Practices During the Period April 1951 to March 1952.* Studies on Medical and Population Subjects, No. 7, H.M.S.O., London, 1953.

- Mellinger, G.D., Balter, M.B. and Uhlenhuth, E.H. "Prevalence and correlates of the long-term regular use of anxiolytics". *J. Amer. Med. Assoc.*, 251, 375–379, 1984.
- Raynes, N.V. "Factors affecting the prescribing of psychotropic drugs in general practice consultations". *Psychol. Med.*, 9, 671–679, 1979.
- Salkind, M.R. *The construction and validation of a self-rating anxiety inventory*. Ph.D.Thesis, University of London, 1973.
- Shepherd, M., Cooper, B., Brown, A.C., and Kalton, G.W. *Psychiatric Illness in General Practice*. Oxford University Press, London, 1966.
- Srole, L., Langner, T.S., Michael, S.T., Opler, M.K. and Rennie, T.A.C. *Mental Health in the Metropolis: the Midtown Manhattan Study*, 1962.
- Taylor, Lord and Chave, S. *Mental Health and Environment*. Longmans, London, 1964.