CARE OF THE PSYCHIATRIC PATIENT IN THE HOME*

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There is an 'old Chinese proverb: "Those who know, do not say: Those who say do not know." I have a strong feeling that there are many wiser and kinder general practitioners than myself in this area, and that we should have secured one of them to enlighten us tonight!

Although this is a discussion on care, I feel it is important to state the obvious: namely that there is a considerable variation in the amount of psychiatric illness between Wensleydale and St. Pancras; and a still greater variation among general practitioners themselves regarding their attitude to illness. Family doctors have estimated the amount of psychiatric illness of all kinds in their practices as varying from seven to 70 per cent. This variation is due to more than a geographical factor. My own comment on this situation is to hope that a dualistic viewpoint in regarding illness will soon be a thing of the past. It never did make sense to judge an illness either somatic or functional (the old derisory term we used to hear), especially to good general practitioners, who have always treated the individual rather than the illness. Every illness has a psychic component—even such things as a broken leg, or a shot through the back of the head. "For this is the great error of our day... that physicians separate the soul from the body", was said not yesterday, but by a Greek philosopher who died in the year 347 B.C.

Nocturnal enuresis or buzzers for bedwetters

Nowhere does the unfortunate dualism that still prevails show itself more clearly than in our treatment of this juvenile disorder.

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This is a classic example of a mainly psychogenic disorder which also contains a somatic aetiological factor. My early efforts to deal with nocturnal enuresis were relatively ineffective because they were based on the idea of its being a wholly organic disorder. It was only when I started to look at the family as a whole that enlightenment came, and I realized the disorder for what it is—a juvenile protest. There is a constitutional factor in these cases: some immaturity of nerve cells, a tendency for the child to sleep unduly heavily in the first part of the night that benefits from the exhibition of dextedrine at bedtime; but what always sticks out a mile after thorough investigation is the basic unhappiness of these families. If the doctor will assume (for a while) the role of a good parent, and gain the affection of these lonely little children, they often get better as if in an effort to please him, and at the same time his attitude and help may ameliorate the domestic situation. A pleasantly Irish attitude to the problem will help the mother to abandon her would-be perfectionism for the child—an attitude often concealing hostility. One reason for my early ill-success in this trouble was that I regarded the whole problem, and that included the patient, with a certain fastidiousness that was felt by the child. Now I make an immediate effort to gain their affection and confidence in what I hope is a natural and sympathetic manner, usually placing the child on my knee if it is small enough, always touching or stroking them. Their ready response to gestures of affection often suggests to me that they don’t get enough in their own family circle.

Discussions with a parent—usually mother—may bring the causes of unrealized hostility to the surface, and this realization will in time help the whole family problem. I suppose that experience teaches most of us a lot of things through forms of conditioning, but the idea of buzzers for bedwetters fills me with horror. I have no doubt at all that they work, in the sense of banishing the enuresis, but I feel that they act at some risk to personality development. If, as I consider, these children are in the main lonely and unhappy then the main task is to improve the family atmosphere.

The principal way the family doctor can help is not by trying to be an amateur psycho-analyst, although he is in an ideal position to bring to the surface unrealized hostility, but by a sympathetic and almost casual handling of the domestic situation that helps to make it more sensible, placid, and loving.

**Children with recurrent abdominal pain**

_The little bellyachers_ as our American cousins irreverently call these cases are almost all behaviour problems—often related to their
scholastic careers. Whilst the interested parties, doctor and parents, seek the relevant problem, the child can be kept comfortable by a mixture of sedative and antispasmodic. Syrup of merbentyl and phenobarbitone is excellent for this purpose.

These children are often using illness as a weapon, and the factors are usually complex. Mother is often over-anxious and perfectionist, but father's social ambitions may enter into the problem. My last case centred round father's persistent wish for his little boy to do well in examinations, to succeed in which he was not by nature very well equipped. The family problem will vary in every case: the quick way to deal with them is to appreciate them for what they are, and not to be so unwise as to order unending investigations, and start the dreary round of specialist opinion.

**Child psychiatrists**

It is rather a sad reflection on our society and the National Health Service it has created that there should be such a great need for child psychiatrists. If general practitioners had time (and inclination) they could show themselves to be family doctors in the truest sense by dealing with most of the cases that are now sent to various clinics. Child welfare clinics should be run by family doctors.

It is unfortunate that mothers and their infants should come under three different parts of the health service at this important time. Preventive medicine is greatly hampered by this division.

In saying these things, it must be understood that I consider there is, and always will be, a particular field for child psychiatrists, but an excessive development of this field to deal mainly with simple problems of human behaviour seems unnecessary.

**How does the general practitioner treat neurosis?**

How often in the past did a consultant's letter end with the words that no organic disease was present, and all that was required was reassurance and the exhibition of one quarter of a grain of phenobarbitone three times a day.

It is the fashion among psychiatrically orientated folk to poke fun at this advice as useless, and unscientific, but it often worked. Placebos often work, as does any treatment given with assurance and emphasis. Today, with the difference that a tranquillizer is usually prescribed instead of phenobarbitone the situation is only different in that the specialist often shares the enthusiasm of the drug firm. I agree with those who think that this is usually inadequate treatment, but I also consider that in many cases sedatives and tranquillizers give the disturbed personality a chance to acquire stability and greater maturity and diminish psychic and physiological
tension. It may be a synthetic rest among stormy seas, but it is a rest nevertheless.

The way to use tranquillizers (and sedatives) is to use this time profitably by encouraging the patient to talk freely of his life and problems, and help him to see them with greater serenity and wisdom. We should beware of always trying to ‘cure’ the patient. His psychosomatic illness may be the best personal solution to his difficulties. Ill-considered or uninvited probing of the psychic origins of disease is always wrong. We must always ask ourselves why the patient is complaining and what the significance of his complaint is, but we must be patient. Before leaving sedatives and tranquillizers, I should like to quote what to me is the best statement of their modus operandi. It occurs in A. Guirdham’s recent Christ and Freud:

"The aim of the sedative is to enable the patient to take the first step towards reducing his heightened self-awareness to normal. All medicines are artificial re-educators of the psyche. They are necessary to individuals, who, because of their tension are unable to initiate this process themselves. Prayer and fasting were necessary to medieval man when he wished to pass from self-awareness to self-annihilation. Sedatives are necessary for modern man when he wishes to reduce his hypertrophied self-awareness to normal proportions."

What are my own methods?

Almost always a complete physical examination should be done. Taking off one’s clothes is part of an essential process of self-revelation and often seems to encourage a patient to unburden himself. All human beings need one person to whom they can turn. Physical examination partakes too of the ancient magic of laying-on of hands and adequately done always adds to confidence in the doctor. A surprising number of patients have unexpressed fears of cancer, tuberculosis, hypertension, and coronary disease. The greatest fear in the general practitioner’s mind is that he should, in his examination, miss a serious organic condition. If he dithers about, uses imprecise diagnostic terms, and orders numerous unnecessary examinations, he will not diminish the incidence of neurosis. He must be clear and definite, and not equivocate.

I find ordinary folk (of mature personality) speak freely enough—when encouraged—of their personal and work problems. I am sure that family doctors everywhere deal very adequately with these reactive stresses and situational problems. It is a constant surprise, nevertheless, to find so many people in the world who apparently have never unburdened their souls of their load of worry, sorrow, and stress. People with recurrent functional dyspepsias are very ready—perhaps too ready—to associate them with antecedent stress. In cases of difficulty or where I wonder if anxiety symptoms or somatic complaining mask a psychotic depression I make an evening
appointment with the patient and listen to him for an hour. Subsequent interviews need not be so long.

I am not suggesting that general practitioners should become amateur psycho-analysts; merely that my experience leads me to think that there are countless people who would welcome the opportunity of talking out their problems with a sympathetic listener.

**Depressive illness**

The recognition and treatment of endogenous depression is one of the most important tasks of the general practitioner. Here he can add considerably to the total of human happiness. He must look for the many involutional cases, realize that much insomnia is really endogenous depression, look twice at many of his chronic and aged patients, and, in fact, always bear this possibility in mind—not least in cases of purely somatic complaints like intractable neuralgias, and in cases of hysteria and hypochondriasis.

**Treatment**

The general practitioner must decide whether he is going to treat the case himself or refer it to a psychiatrist. The two obvious points on which to base his decision are... (1) the depth of the depression and (2) the risk of suicide. These two do not always coincide, suicide often indeed occurring during a phase of improvement. Judging from personal experience, a useful mental exercise is for the doctor to imagine himself in the place of the depressed person and to consider his total life situation. In a number of suicide cases—not regarded by anyone previously as depressed—the life situation was cold, lonely, and hopeless. There are large numbers of cases of endogenous depression: probably five per cent of the population suffer at some time—very many unrecognized.

There is a general tendency to avoid ECT as a treatment and in consequence the general practitioner treats more of these patients by himself.

Many moderately severe cases of depression respond very well to drugs like nardil or niamid, with or without a sedative like fentazin. Even a relatively mild drug like deaner has value in some.

I have three cases of ischaemic myocarditis (recovered coronary thrombosis) who are true depressives and insist on taking marsilid year after year with apparently great advantage to their health and happiness.

Many of our severer depressives are happy on tofranil, a treatment
usually initiated by psychiatrists; but the general practitioner is now beginning to start this treatment on his own responsibility.

One of our problems is how to maintain and vary these drug treatments over the years. Another, strangely enough, is to get somebody to give one of our patients ECT, when we are convinced that thymoleptics and antidepressive agents are inadequate.

Prescription "Doctor" is always required in depression, and the need for it perhaps more necessary today when the antidepressive drugs are so successful and the general practitioner tempted to avoid any consideration of the inner life of the patient. I find it impossible to judge whether any one case is one hundred per cent endogenous without any reactive factors at all; and even though I am convinced that all cases of endogenous depression inherit or develop a specific kind of brain cell metabolism (which is favourably influenced by our new drugs) they still need and benefit from simple, psycho-therapeutic handling.

“Work thus a salve against the elfin race and nocturnal visitors, and for the women with whom the devil hath carnal commerce; take the ewe hop plant, wormwood, bishopwort, lupin, asshthroat, henbane, harewort, vipers bugloss, heathberry plants, cropleek, garlic, grains of hedgerife, githrife, fennel; put these worts into a vessel, set under the altar, sing over them nine masses, boil in butter and sheeps grease, add much holy salt, strain through a cloth, throw the worts into running water. If any ill tempting occur to a man, or an elf or night visitor, smear his forehead with this salve, and put it on his eyes, and where his body is sore, and cense him with incense, and sign him frequently with the sign of the cross; his condition will soon be better.”