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Discussion

Dr Yellowlees: I want to ask Dr Fraser if there is any system in Aberdeen, being a fairly compact place with its central medical school, for group discussion like the Tavistock scheme.

Dr Fraser: There was a pilot scheme some years ago which very few general practitioners attended and so the short answer to that is "No", although of course the psychiatric staff are always at hand and we know them quite well in a small town such as Aberdeen.

***Chairman*:** We are hoping to get something going for senior medical students this year and perhaps rather more next year. The plan we have worked out is for tutorial groups in which members of my department will discuss with senior students the purely personal and personality aspects of illness.

Dr Laing: Does dealing with neurosis increase the incidence of neurosis in psychiatrists and general practitioners?

Dr Walton: That is an important and interesting question. Most people who work very extensively with neurotic patients and disturbed people are brought face to face with some extremely trying and upsetting emotional conflicts and these can often rouse very intense feelings. One gets into special problems when, for instance, the patient begins to develop quite a marked emotional relationship with the doctor, the jargon for that being 'transference'. As transference develops the doctor inevitably develops a responsive reaction, a so-called counter-transference. There is little doubt that if one is interested in producing real changes in behaviour patterns, these patients need to experience considerable feeling. Freud said "Reminiscence without emotion is useless"; in other words, it does not help for a patient just to be prattling about the past unless the feeling is revived. If the doctor is at all sensitive or responsive, he, to a large extent re-experiences the patient's feelings. If the patient becomes morbid, he very often begins to make claims on the doctor which are relatively difficult to tolerate. A woman may act in a way which clearly indicates she is very fond of the doctor, and that the fondness is even becoming disproportionate. The doctor then has to work out all the problems of responding to this behaviour. I would say that psychiatry, for a doctor, is a stressful procedure; he cannot help the patient unless he is prepared to accept that stress. To my mind he is helped very much by one technical point: nobody gets people better just by empathy. Psychiatry demands a step towards the patient in which one puts oneself fully in the patient's shoes and experiences everything I have spoken about, but equally necessary is another step when the doctor detaches himself and goes away from the patient and considers everything that's occurring in the patient and in himself, objectively. The doctor can get into serious trouble and develop neurosis if he cannot take this detaching step, which is a necessary part of handling patients. It is important for a doctor beginning to work in psychiatry to objectify his treatment behaviour by reporting to some other person. A psychiatrist in training does this by talking to a supervisor, so that it is extremely rare for psychiatrists under proper training conditions to become neurotic as a result of their work.

Dr Richardson (*Aberdeen*): I am concerned about the difficulty in defining certain simple words like neurosis. Is there any way in which general practitioners can be assisted towards a clearer, more standardized use of this term 'neurosis' and its recognition in patients? I have recently been obliged to fill up the Maudsley Medical Questionnaire. Is this kind of method

useful for screening outpatients in the early stages of mental illness and can it be used to enable us all to use psychiatric terminology with a certain amount of uniformity?

Dr Walton: Whenever one gives a test of this sort to a group of patients of various types, one gets such considerable overlaps that I do not place reliance on the results. To my mind they become useful when a particular test like the Maudsley personality inventory is used on a large sample of patients so that we can generalize about proportions and categories. About the word 'neurosis', I am sorry that there is such discrepancy of opinion. Most British psychiatrists would use the word to describe an illness consisting either of an anxiety state, an hysterical psychoneurosis of the conversion or dissociative type, an obsessional psychoneurosis, a phobic state or a reactive depression; five conditions beautifully enumerated in all reputable textbooks. One way to get agreement on terms is to make films of patients (which is now being done by the World Health Authority on an international basis) and show them to doctors and see whether they can clarify the areas of ambiguity. We are not going to be helped by any screening test that I know of. Tests like the Maudsley personality inventory are not designed for and not very efficient in, giving information about individuals; they tell you about groups of people. There are tests such as the Cornell Medical Index, which is a whole list of symptoms on which you obtain a score and say what the chances are that this person is neurotic. For a practitioner who is busy and wants to identify a psychosomatic disorder, a person filling this up in the waiting room might come in with some quite useful information. It just possibly has an application, but the days of computer diagnosis are approaching when it will be possible to make diagnoses on just this sort of basis.

Dr Richardson: What you really seem to be saying is that we have no reliable methods of early identification so we must wait until patients come to us. But don't patients come to medical care after passing through a number of screens? I had the experience some years ago of watching a member of my own family develop serious mental illness over a two-year period and I saw the protective family at work, the elaborate rationalizations that were put up to explain what had become very bizarre behaviour indeed. I heard the excuse "He's overworking" used to delay going for medical care. Now, how much do we know about these screens and how much are we likely to be able to intervene in the future? I can remember as a young general practitioner getting into the most ghastly trouble because I raised the question of mental illness in a patient who had never mentioned it. The family were not at all pleased. Are there certain risks involved in going out to discover mental illness early? Must we just wait until it comes to us?

Dr Walton: I myself find one of the interesting implications of your remarks is the fact that a great many people come to doctors with what we call cover stories. Mallison has shown this, especially with university students in London—they come with a somatic complaint, but they know perfectly well this somatic complaint is the initial entrance ticket that they must give the doctor. If he has the appropriate skills he can rapidly get the patient to amplify the complaint so that, for example, a headache or a backache can be revealed for what it is, a difficult burden imposed on the patient. A skilled practitioner does not accept the initial presentation of the patient at all. Especially in psychiatry it requires extremely deft detective work and coaxing of the patient—a sort of obstetrical job—before the patient delivers himself of what is really troubling him. One often needs to go further and guess what the patient is really troubled by and, with skilful timing, put it to him that this seems to be the real problem.

About the question of seeing illness before our eyes and not knowing what to do about it, this is one of the topics about which medical students get most concerned. What is the doctor's duty if in his social activities he sees somebody whose excessive drinking has crossed the border into dangerous addiction? Should he go up to that person, diagnose him as an alcoholic and tell him that if he does not have treatment he will deteriorate and there will be serious sequelae. It seems to me that there is a great conflict between a doctor's social and professional rôles. Are we entitled to diagnose and treat only when approached by a patient or should we act as a sort of screening mechanism in the community at large.

I am reminded of a story about the great psychiatrist Esquirol. He went to see the King of Spain and the King's son was produced for him, the King saying "Don't you think he is handsome?" One can imagine the sort of tussle Esquirol had before he said to the King, "He is extremely handsome, but his eyes are the eyes of madness". This visiting doctor did what no

courtier could do and pointed out to the King that his son was schizophrenic. Another complex problem is: When has the doctor the right to make a diagnosis of a condition that has not been brought to him for his professional attention? Whenever we pass people on a pavement and see thyrotoxicosis or myxoedema, we feel a similar unease within ourselves.

Dr Annis Gillie: Dr Sainsbury has told us of the benefits of community care for certain patients, and the satisfaction of the family in conferring those benefits and keeping the patient at home even when they find it wearing and exhausting. An obvious answer is to give the family a rest by admitting the patient for a short time. But how much does that cancel out the sense of security that being treated in the community has produced? Obviously if the mother of the home, the daughter probably, goes down with 'flu there is a clear explanation, but if she is still running the home, and the elderly person is admitted purely because the mother is getting a bit threadbare in energy, is this a serious setback to the advantages of the system?

Dr Sainsbury: No, I don't think so, in our own service this is what we do, particularly with elderly people. Many families like looking after their elderly member rather than have them spend the rest of their life in a mental hospital, and they are prepared to accept this burden with apparent willingness. We find that it makes it much easier for the family if we say that we are always prepared to admit a particular patient, if we are informed when she begins to get too troublesome, or when the family goes on holiday. This is quite often done to give them a month or a few weeks' holiday. I do not think, particularly with the demented patient, that they suffer. On the whole and particularly with non-demented patients the situation can be explained and hospital is often well tolerated. One must certainly not think of community care as always preferable to the hospital; there are many occasions when hospital is preferable for all concerned.

Dr Sainsbury: It is sometimes to the advantage of the family as well as to the patient to go into hospital. We have to weigh up each case on its merits, on the merits of the family situation and on the characteristics of the patient. There are some people who become very dependent on hospital life because it offers an easy way out, and they are difficult to discharge. There is another group for whom temporary separation will be of mutual benefit. There is no hard and fast rule, we have to attempt to find a solution in each individual case.

Dr Kuenssberg (*Edinburgh*): Dr Walton seemed to infer that surgeons, physicians and other specialists had a very large proportion of neurotic patients referred to them prior to seeing a psychiatrist. Our present thinking and teaching as general practitioners is to eliminate the organic disease before coping with the other side.

There is another point which I would like to make. You showed us the characteristics of four groups of final-year students, and what their estimated capacity for dealing with neurotic and psychotic patients would be. Why is the selection of medical students done in a vast number of universities, such as Aberdeen and Edinburgh, by adding up 'A' levels grades and so forth, because this obviously has no bearing whatsoever on the quality with which you would concern yourself in treating these patients?

Dr Walton: Psychiatric training aims to make doctors diagnose positively, psychiatric illness is not diagnosed by exclusion. One finds the positive evidence of a particular disorder and makes the diagnosis on the basis on those criteria. But, what interests me is that if you ask a class of students who have been taught psychiatry whether neurosis is diagnosed by exclusion when there is no physical disease detectable, or positively by the discovery of actual psychiatric symptomatology, you find a schism in the class. Some prefer diagnosis by exclusion and a personality test to go with it, a so-called test of neuroticism. This does not test whether a person is neurotic, it tests what his anxiety level is, and students on this test are more anxious. In other words, the sort of people who are aware of their feelings and have feelings somewhat similar to their patients, are often prepared to make positive diagnoses. The students who do not have anxiety and presumably do not have feelings like those their patients are describing often say they would not diagnose neurosis until they have excluded all the organic factors. If psychiatry is to be adequately practised it should be by making positive diagnoses, not by exclusion.

Chairman: It strikes me too that you may have to include certain organic diseases, not

exclude them. Taking our own referrals as an example, something like one third of all the patients whom we see have established organic disease in association with their psychiatric disorder. Both sides have to be looked into. The psychiatrist should occasionally diagnose an organic disease.

Dr Richardson: I do not know where Dr Kuenssberg found his evidence that in Aberdeen we select students by adding up grades at 'A' level, because we add up much more than performance in school examinations, including such information as we can get about the personality of the applicant from the headmaster of his school. That is our only source of information and we have never advocated interviews because the evidence points fairly clearly to their unreliability.