

if I may get back to my stage. On the stage of Christendom, in seeking guidance to these profound problems of personal and national life which I mentioned so briefly, the people traditionally put at the centre of their stage, the man of God, the preacher in his pulpit. Even if both preacher and audience failed hopelessly down the centuries to live up to the message that was preached, nonetheless in all walks of life formal recognition was given to an optimistic divine purpose and to the active presence of the devil. But over the last 200 years the audience has become increasingly bored with this kind of sermon, and the reason for their distraction has been the dramatic entry of a flamboyant character, the wizard. In the *dramatis personae* of this fantasia the wizard is described as a "technocrat or technologist who believes in human salvation through scientific and industrial advancement: despises the preacher". The wizard's performance has been impressive and he deserves the thunderous applause he has been given as act follows act, moon rockets and monoamine oxidase inhibitors, atomic fission and television, jet propulsion and juke boxes, computers and contraceptive pills, no wonder the preacher has forgotten his words, but the wizard has become so pleased with himself—he knows not the meaning of the word humility, and is a chap of endless conceit—that he has pushed the preacher into the wings, put on his robes, mounted the pulpit and started preaching sermons. I am sad to note that sometimes our later-day psychiatrists are not loathe to play the wizard in the pulpit. Now a pulpit is no place for a wizard, and his elevation there is a dangerous thing, dangerous because his sermon is based on a rather nebulous Freudian doctrine that the chief end of man is the pursuit of personal wealth and pleasure and touches not at all on the inescapable knowledge of good and evil. I make no apology for raising these issues, they cannot be ignored in any discussion on the prevention of neurotic breakdown, and I end by suggesting that if we are to look forward to a society which has stability and purpose, and therefore mental health, we must think seriously of putting the wizard in his proper place before the curtain is run down in chaos and darkness.

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Some concepts of domiciliary psychiatric practice

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Visiting patients in their homes is a tradition of British medicine, of particular relevance to general practice, with its accent on the family physician and the holistic approach to the patient. For many medical generations it has been the custom to invite the specialist to visit the home, consult, and distil the recommendations for treatment. It is understood that awareness of the emotional needs of patients is important in any doctor-patient relationship and it is paramount in the field of psychiatric medicine. The literature on domiciliary psychiatry is still sparse, but American sources have begun to examine the home visit in the setting of private psychiatric practice, and also to con-

sider the merits of domiciliary examination of the patient as opposed to hospital reference.

In recent years there has appeared the changing legal concept of psychiatry, as expressed in the Mental Health Act of Scotland (1960) and the equivalent act for England. Emphasis has been placed on informality, admitting patients to hospital is now easier, and there is the increased responsibility of local authorities to provide community services. These changes have been mirrored by the open-door policy, and the accent on community psychiatry which often houses individualistic conception and interpretation. That domiciliary examination of a patient may prevent admission to hospital is not a new idea. It has been studied in Holland for many years; a community approach to the mentally disordered person has been operating in Belgium for centuries; and in Scotland, too, the placing and supervision of mentally-handicapped persons has been practised for decades.

It is now necessary to explore in greater detail the many facets of a domiciliary visit paid by the psychiatrist to the home of a patient who is allegedly suffering from some form of psychiatric disorder. In an attempt to clarify what is always a complex situation, the domiciliary examination will be described as it affects the referring doctor, the patient and his family, and the examining psychiatrist.

The referring doctor. The factors underlying the referral of the patient may be many. There has frequently grown up a professional relationship between the practitioner and some particular consultant in the local psychiatric services; as a result there is personal communication on the substance of any clinical situation. The ability to work verbally through the problems of an individual patient with a psychiatrist may even preclude the need for a domiciliary consultation. In essence this is a comment on the psychiatric sophistication of the practitioner and touches on the question of what allows a doctor to decide that a person is psychiatrically ill. Clearly some physicians decide this much earlier than others. A request for a visit may have a number of reasons; the patient may be confined to bed and too emotionally or physically ill to attend an outpatient department; the problem may be one of diagnosis; or the family may be 'on to him' with the 'something-must-be-done' phenomenon, irrespective of the fact that the problem has been present for 25 years. This raises considerable emotional pressure within the general practitioner.

Some consideration should be given to the kind of patient that gets referred for psychiatric consultation. Clinicians are all aware of the patients who disturb them, who worry them; and these conscious and preconscious processes may play a part in leading to a request for a psychiatric visit. Anxiety by the practitioner about the subject of psychiatry itself may be important in requesting examination. In this day and age this can be taken as a backwash from the poor medical education in psychiatry that doctors received in the past. Improved teaching and more sophisticated knowledge of psychotherapeutic processes should benefit future doctors and patients alike. There is also the other side of the problem;—What about the physician's personal psychological blind spots and resistances to recognition of psychiatric problems in his patients? A medical education need not necessarily give emotional maturity and clinical empathy. These may have to be learned and learned the hard way, though one hopes that by teaching students and by group discussions this side of the problem will improve. One factor should never be forgotten by the visiting psychiatrist; the family doctor's background knowledge of the family dynamics, the particular patient and his particular psychology, and his local knowledge of the community pressures. These are extremely important, and a thumbnail sketch of 15 seconds can be worth many words.

The patient. The patient himself may not consider that referral to a psychiatrist is necessary, and may feel that a visit in his own home is even less necessary. To him a psychiatrist may seem a threatening figure who means admission to a psychiatric hospital,

with the implication that this is the end of the road, that his condition is hopeless. All of us like to avoid the unpleasant and for some patients the psychiatrist and fantasies about him may convince the patient that there is no future. Examples of this kind of disordered reasoning are sometimes seen in the depressed patient who commits suicide in the interval between the decision that a psychiatric opinion is required, and the visit itself. The expressed wish of a patient not to see a psychiatrist may be a projection of the desires of the family, who, particularly if they are of the older generation, see the psychiatrist and the 'asylum' as a stigma of disgrace and shame. Fortunately, this attitude is changing, but it still exists. It must at times be a difficult decision for the family doctor to over-rule a patient, when treatment generally means the willing acquiescence of both parties, patient and doctor, in attempting to produce a change for the better. The patient may be willing to have a psychiatric examination, but express a wish for this to be in the security and privacy of his own home. There are occasions when such a wish must be respected, and the psychiatrist as well as the referring physician must not be so rigid as to insist that a domiciliary consultation can take place only if the patient is unable to come to the clinic. Often patients with psychiatric disorders are physically able to attend outpatient departments, but emotionally and even diagnostically this may not be to their clinical advantage. In certain diagnoses, such as chronic phobic states or chronic depression, the initial home visit may set the stage for increased motivation to move out of their 'prisons' and see again the pleasures and contacts of the external world.

The patient can at times make demands on his physician. He may not feel that enough is being done for him as far as the exploration of the psychological components of his illness are concerned. If so, the request for psychiatric help may come from the patient.

In some disorders the patient may have limited insight into the fact that he is ill, and may either resist such knowledge or support his practitioner when the need for help is explained. In contrast, the patient with psychotic illness protests frequently and at times vehemently that he is not ill, and rejects out of hand that there is anything wrong with him. This leads to the precipitation point at which the family has had enough and the cry for help emerges.

The family. Family dynamics may result in an early request for psychiatric referral or in long drawn out delaying tactics which defeat any move by the physician to seek outside assistance. Evidence concerning the intra-family factors which underlie the admission or non-admission to hospital of patients suffering from serious psychotic illness have been described in various reports. The family may appear to agree with the physician's suggestion of a psychiatric examination, but be deeply resentful, frightened and hostile, wrecking the psychiatrist's attempts to explore and understand the interpersonal relationships within the family unit. To a bystander such things are crystal clear; to the participants they are more clouded. The family members can be easily bewildered when mechanisms of this nature are explained to them.

The toleration temperature of any family is a complex phenomenon, it obeys no defined rules; what would be intolerable for one family group is accepted without demur in another; the most bizarre psychotic behaviour may be tolerated without question; the appearance of incontinence may be the breaking point in another setting. As examples of this, consider the mother who regarded the psychotic behaviour of her son in running out of the living room, upstairs to his bedroom, standing in the dark and talking to himself, as a wish to be alone; and the farmer who viewed the signs of depression in his wife as laziness and incompetence and impatiently wished her away to hospital. There are occasions, too, when the domiciliary visit acts as a catalyst, setting in motion a chain reaction of various conflicts and long-pent-up emotions. The psychiatric scapegoat emerges, and difficulties arise between the family, the family physician and the visiting

psychiatrist, in which the family make critical comments about the quality of assistance they consider they have received from the practitioner. ("He didn't examine her the last time he came". "He didn't have time to listen"). This aggressive mechanism is not infrequently found. The appellation 'doctor' gets dropped, the family physician being referred to as 'Smith', or 'Jones', or 'Brown'. Such incidents highlight the importance of 'working through' patients' aggressive conflicts.

The examining psychiatrist. Some psychiatrists feel more at home dealing with patients either in the security of the hospital atmosphere or in the seclusion of the consulting room; this was certainly the general conception of the average British psychiatrist even in the years immediately following the Second World War. As already discussed, there is still reluctance to consider the psychiatric domiciliary consultation as a necessary part of psychiatric practice in the United States and of course family physicians there, have the same reluctance to visit patients in the home. But the importance of domiciliary visiting is increasingly recognized; the present day consultant psychiatrist must, however, accept that domiciliary visits are a necessary part of his professional life, and indeed it is an area of extreme fascination supplying information and insights into human behaviour and functioning that are never seen in the sterility of the hospital ward, or the outpatient clinic, where the best frock has been put on, where the hair has been tidied, and the Sunday suit is worn.

It must be realized, too, that an academic discussion of a problem and a treatise on the psychopathology of a symptom or condition is much more appreciated in the teaching situation of the hospital or clinic than in the pressing 'here and now' of the patient's home. There is no point in talking about the symptom complex when you clearly see a depressed patient in front of you.

In past years the request for a specialist to visit a patient at home had a certain tradition and ritual. The family physician was always in charge of his patient, the consultant was there by request, the examination took place in consultation, decisions were made and the patient and family informed. The specialist then departed from the house prior to the family doctor who 'sealed off' the visit. Unfortunately, in this day and age, this cannot always take place. New generations have new ideas, and in the experience of the writer, it is rare in city practice for a domiciliary psychiatric consultation to be carried out along with a particular practitioner. There are various reasons for this. At times it is realistically difficult for the practitioner and specialist to meet at a mutually convenient hour, each having their individual responsibilities. There are times, too, when the family physician feels that co-operation would be better if he was absent, and the stage left to the psychiatrist.

In the country scene, the situation differs. Frequently the patient's residence may be difficult to find and the practitioner is necessary to act as a guide and also fill in the history and background. It is, therefore, more than likely that country domiciliary visits still fit the traditional pattern of consultation and are valued by practitioner and consultant alike.

Problems of the transference situation may be operating between the family doctor and the patient before the examination in the home setting is requested. The doctor may see his patient as one of his difficult patients—"He is one of my difficult ones. He's always on the 'phone, he wants to know about his drugs, he exaggerates" and so on. On the other hand there may be a positive transference in the picture and this too, can make problems for the psychiatrist entering the scene.

Communication difficulties between the family doctor and the psychiatrist may be important. Descriptions of patients' symptoms can be given in terms which mean completely different things to the participants. Commonly the words 'demented', 'confused', 'excited', 'hysterical' are used to describe clinical situations which are not

interpreted as such by the psychiatrist when the patient is seen. This is not a measure of the family physician's incompetence, but frequently an indication of his lack of formal psychiatric training, a situation which it is hoped, present teaching methods will rectify in time. It is important to be scrupulously honest both with the family and with the patient. To be introduced as a nerve specialist or other half truth does not help the clinical situation or promote confidence between patient and examining doctor. Patients, even the most psychotic, are not 'fools', and react badly to any attempt to deceive.

Having set the scene, and bearing in mind that psychological defences and psychopathology are not the prerogative of the patient, but exist in the referring doctor and examining psychiatrist, the method of carrying out the domiciliary examination becomes an individual matter.

Possible stages of the domiciliary consultation

1. *The nature of the presenting problem—(a) the acute emergency.* The sudden appearance of acute psychotic disturbance is an alarming experience in the patient's family and it is not uncommon to find the room filled with various relatives, near and distant, as well as interested neighbours. The patient's disturbance may be noted prior to entering the house by the noise or sound of raised voices, or singing, or the playing of the piano, or even silence. In the majority of cases it is imperative to clear the room and see the patient and see the problem. It may be difficult to be alone with the patient; relatives and friends want to be helpful, to be involved in the situation, as the drama of the disturbance is attractive as well as frightening.

The acutely psychotic patient is rarely difficult to diagnose as far as psychiatric symptomatology or signs are concerned, but the diagnosing of a physical aetiology can produce a problem due to the lack of co-operation and the psychotic belief that perhaps the examination itself is a threat to their person and a danger to be avoided at all costs. Even with the acutely-disturbed patient, however, patience, and perseverance can in the main result in adequate physical examination to allow a complete formulation to be made. In most situations the next action is the admission of the patient to psychiatric hospital, under recommendation (compulsion) if necessary.

(b) *The subacute or chronic situation.* It should not be considered that only the psychotic constitutes an emergency psychiatric situation. The majority of psychiatric syndromes progress in severity over a period of time and the psychiatrist may come in on an acute crisis in a chronic neurotic adjustment, or in a long-term depressive illness.

From the above description, it can be seen that the basic problems of the psychiatric domiciliary visit are in no way different from consultation in other branches of medicine, namely, the obtaining of history, the examination, the resultant diagnosis and the line of attack. In the field of psychiatry, however, there is that added quality of anxiety, the problem of interpersonal reaction, and the thought of unpredictable behaviour—'the what-might-happen' situation.

2. *Obtaining the history.* The information previously obtained from the family doctor can be expanded upon by relatives or friends. It is important to remember that apparent differences in the history may occur, certain features may be played down by the family, others elaborated, and often at this stage of the examination, any tension and disharmonies within the family circle become apparent. Allowance must be made for inaccuracies in the time sequence of symptoms—it is difficult to remember events in the heat of the moment and a particular symptom or piece of behaviour may have become accepted insidiously over a period of time.

The patient is in most cases the main source of history. The patient has one advantage in the domiciliary scene. This is his house, his territory, you are the stranger, and he can as a result feel generally more relaxed and in control of the situation. The history

given at this psychiatric contact may differ considerably from that obtained later should admission to hospital occur. In the new environment, other problems may emerge and the focal point shift. It is always instructive to compare histories obtained by different physicians from the same patient and in psychiatry this is of particular importance in that differing interviewing techniques, or a change in the sex of the interviewer can elicit varying symptomatology, all of which has relevance to the individual patient.

3. *The physical examination.* The necessity of physical examination in the psychiatric evaluation of a patient need not be elaborated upon. What requires to be considered is how the wish of the psychiatrist to examine the patient physically may be in itself a surprising situation for the patient. The response may vary from "I thought you would only want to talk to me", through, "there is nothing physically wrong, I am not prepared to be examined", to, "I refuse". For the patient the physical act of examination may have considerable psychological import, both negatively and positively. It can be at opposite extremes, either yet another examination, or the expression of the opinion that "I've never had such a thorough examination". What is certain is that the physical contact between psychiatrist and patient results in some change, which may be of value in later psychotherapeutic contact in persuading the patient to accept a recommended regime.

4. *The formulation (diagnosis).* Psychiatric patients are interested in what you may have found wrong with them. The phobic wishes to be reassured, the hypochondriac awaits confirmation of his worst fears, the depressed often hopes for something to be found, those with organic disease want to know what you think (and compare what you say with what they have been told elsewhere), the dementing patient is often pathetically grateful for the interest you have shown.

The formulation implies the treatment, and a good part of the visit may be spent discussing the pros and cons of a treatment regime, the magical tablet versus hospital admission. Still in this day and age, this is tied up with the attitudes of relatives towards psychiatric treatment, hospital admission, physical methods of treatment, the fear of electroconvulsant therapy and the many fantasies that this procedure engenders. The discussion between the patient, relatives and psychiatrist after the formal examination is over can be the most rewarding or the most exasperating part of a domiciliary visit.

From the diagnostic point of view, the syndromes to be found in domiciliary psychiatry differ in no way from those found in outpatient departments or the wards of the psychiatric hospital; only the setting is different, and this setting is of considerable importance in leading to the diagnosis.

In neurotic illness can be seen the acute crisis that so frequently occurs—the anxiety depression, or the acute panic in long-standing personality problems. Chronic neurotic maladaptations can be seen often in surprising clarity with the manipulations of the family environment and the emotional blackmail that so frequently occurs. All grades of depression may be seen encompassing all ages from the tempestuous adolescent depression, through to the serious agitated depression of the elderly. It is important to bear in mind the depressive illness which in the middle-aged woman can present with a predominantly hysterical component. Non-recognition of this, and acceptance of hysterical acting-out in the home as evidence of an hysterical personality may produce a surprise with an attempt at suicide.

Acute psychotic illness has already been mentioned, but it is important to recognize the chronically psychotic patient with damaged personality functioning, and the rather bedraggled domesticity that can result from the low-grade psychotic illness operating over many years. Then there are other 'special' problems that can be found in domiciliary practice. The marriage guidance problem in a home that can drag an examination out over several hours, as when the problems of the chronic neurotic interaction in the

marriage are paraded in front of the psychiatrist. Consider too, the pathetic domestic scene of the chronic alcoholic; or a chronic paranoid personality, who shows in the surroundings evidence of his delusional system.

The evaluation of the suicidal risk in any patient is a not uncommon task in domiciliary visitation, and there is the mental totting up of a positive and negative balance of suicidal intent. In hospital practice to be wrong in this assessment may not be disastrous; in the home, the result may be fatal.

Finally, it should be clearly understood that the psychiatrist of the present must be aware of the psychological presentation of organic disease. The depressive, paranoid or confused reaction in the setting of subthyroidism, the diverse presentation of intracerebral lesions, or the psychiatric symptomatology in a patient with masked pulmonary carcinoma, are examples to be borne in mind.

5. *Additional information from the home visit.* Much useful information can be gathered if the domiciliary visit is taken as having started when the door of the house is approached. The state of a garden may give indication of what you will find. The neglected over-grown garden, the ash bins with rubbish lying scattered around may point to an elderly demented person. Close curtained windows with newspaper or cardboard stuck up or odd signs may suggest a chronic paranoid disorder.

On admission to the house, the smell may give a clue to neglect. The external appearance of the patient can give valuable evidence as to the psychiatric problem. The nature and number of clothes, the filth and neglect of the demented patient or the chronically psychotic person, the kitchen without food, moulding contents of tins or excessive quantities of a particular item may point to a dementia. Non-verbal communication can be of extreme importance.

6. *Treatment regime advocated.* Following a domiciliary examination, there are a number of treatment regimes that may be suggested and the success or failure of these in psychiatric practice is not due to one factor. Certain treatments may be suggested to the patient which are psychologically incompatible. At the simplest level, if a patient is suffering from an acute psychotic illness and is disturbing the family, there is little resistance to his being admitted to hospital, either informally or compulsorily. With the patient who is depressed there may be a situation of rumination and doubt and ambivalence about treatment, but this can almost always be resolved. On the other hand, in patients with long standing neurotic difficulties there may be much argument and discussion about proposed treatment regimes, and these get built into the neurotic problem. So, there can ensue long discussions about what admission to hospital may or may not do to them, that drugs are no use for them, they have all been tried, and in the home setting, patients can often call on their manipulated allies to obtain support for their expressed views.

In addition, the patient's family may be against certain proposals made, especially if the question of admission to hospital for observation or investigation has been raised.

Conversely, the psychiatrist may decide that removal from the home is not required and may support the patient by either further visits or arranging for visits from a psychiatric social worker or mental after-care officer. Resistance to such proposals can also be found, and if the family thermostat is set at the level which says 'remove' then there is generally little point in trying to fight this, as failure frequently occurs. The family physician may not be in favour of the patient remaining at home, and so another pressure can arise.

The above discussion has raised the possibility of a domiciliary treatment service and this has been tried in various centres. It is difficult to compile a list by diagnosis of psychiatric illness which might be treated in the home by drug therapy and supportive services. One could visualize the mild depression being so treated when there is family

support, the senile patient who responds to medication and even an acute psychotic reaction when the patient was willing to take an antipsychotic drug. Bound up with any proposals to retain a patient with psychiatric illness under treatment in the home is the question of the anxiety present in the psychiatrist and the family's physician. What might be the risk of suicide? What is the effect on other members of the family? This is the reverse in a way of the factors underlying the retention of long-term psychiatric patients in the community following discharge from hospital.

In the field of domiciliary psychiatry there are many features, there are many problems—some overt, some covert in the contact between the patient, the family physician, and the consultant psychiatrist. There is a great deal involved when a psychiatrist's telephone rings, and a doctor says, "I wonder if you would see a patient of mine?"

Alcohol in the Highlands and Islands

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It is perhaps too trite to say that the history of the Highlands and Islands of Scotland would have been different without alcohol; for so indeed would the history of mankind—and womankind.

It was a Jacobite volunteer, Mr Hepburn of Keith, who urged Lord George Murray and Prince Charles on to the attack at Culloden by saying, "I never expect to find the Red Coats asleep but they will be drunk after solemnizing the Duke of Cumberland's birthday". This error in estimating the effect of alcohol on others was not only a cardinal one but was to become a monumental blunder commemorated by history itself. The lesson should not diminish in impact with the passage of time for it is never easy to predict the effect of alcohol, or the lack of it, on other human beings.

The word alcohol appears to have originated far indeed from the Highlands, in fact in the Arabic words Al-Kohol, meaning the fine powder of sulphide of antimony used for darkening the eyelids. It is rather difficult to understand how, in the course of time, the word should become associated with the spirit produced in the processes of fermentation and distillation of sugars or starches. It is perhaps not so difficult to understand, however, why the word has always had a stimulating aura of pleasure and pain.

The consumption of alcohol has long and widely, wrongly or rightly, been associated with health—a word which is sounded on and in many tongues whenever a glass is raised to human lips.

Neil Gunn in his book "Whisky and Scotland", dedicated to "Those beyond the Pale", depicts the experimenter who first distilled whisky. "The man was not a little weary with the dullness of social life, including the looks of women and the ambitions of fools." But then his head went up for clearly it was not "water he had drunk—it was life."

Whisky, of course, has a special association with Scotland and indeed with the

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