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

*In receipt of a Research Grant from the Scottish Hospital Endowments Research Trust.

Highlands and Islands. The Statute of Iona, 1607, forbade the Islanders to import it but they were allowed to distil it. This early encouragement to "do it yourself" is now an anathema in a modern democracy where the word 'publican' has virtually regained its biblical meaning of tax-gatherer.

Highland history records that the use of whisky was regarded as a corrective to the climate—a climate which seemed to be remarkably similar and in need of correction in Lewis, Mull and Skye and many other parts of the country as well. It has to be conceded too that our friends, the Irish, who share with the Scottish Celts a reputation for convivial drinking are patriotic enough to refer to Scotch whisky as the best of all the soft drinks.

Perhaps it is that the home of whisky—the Highlands and Islands—have an unjust reputation for alcoholism. It may be that the music hall impression of the Highlander in kilt and 'Balmoral' with bagpipes and haggis (Lowland though the haggis may be) is also associated with at least one bottle of whisky. This already widely implanted cartoon has been, of course, fixed in the minds of our Southern neighbours for ever by Compton Mackenzie's delightful exaggeration, *Whisky Galore*.

And alcohol figures in the Scottish pastime of seeing sin and deploring it in others. Cunninghame Graham's Scotsman after all was a man who sweatingly went about preaching teetotalism—that was for others, but himself "taking his dram" for the reasons so cogently set forth by St Paul the Apostle to the Caledonians. It cannot be gainsaid that some people regard alcohol as the "milk of the devil". But many more regard true temperance not as the churlish rejection of one of God's gifts to man but rather as a reasonable moderation in its use. Not that all is black and white. The differences between "Taking a dram", "Having a refreshment", "I'll hae a suppie o' whisky—nae water nae lemonade", "Just a little drop of Spirits for the occasion—if you say so", "I usually take a nightcap for the good of my health", ordering "a half and a half pint", asking "Will you have wine or would you like something to drink?", and consuming "a sensible modicum of whisky", forms subtle nuances and separate associations in the tutored ear of measurement. It has been said that the man who has never taken a dram or smoked is well worth the watching. Among those who share this opinion might be found not an inconsiderable number of doctors and policemen.

The medical profession's link with alcoholism was never tenuous. It was the *idée fixé* of the older generations that two of the wonders of the world were a sober doctor and an honest lawyer. This maxim may well not be so true nowadays for other reasons than that advanced by the cynics, namely that there are far more old drunks than old doctors. Yet in truth alcohol is never far from the mind of the practising doctor because it is a very practical problem. One knows he will regard it in a balanced light despite the fact that alcohol will claim a number of his patients as victims, for so also will the motor car, the pursuit of gluttony, of power and ambition, and so indeed will the worries and anxieties of everyday life.

The term 'alcoholic' does not brook of easy definition. What he is suffering from is not the same thing as drunkenness. It is probably not the same thing as excessive drinking. It is probably not the same thing as excessive drinking over a long period of time. Possibly the practical definition is—"A person beaten by alcohol". The hard social drinker does not always become an alcoholic. We do not really know what percentage of them do and how long it takes them. The estimate that six per cent of all people who take alcohol will in time become problem drinkers and 1.5 per cent will become alcoholics may or may not be soundly based. Perhaps those who practise medicine in smaller communities may, by the privilege of their position, get nearer the real answers than those who practise in the conurbations.

Inpatient admission figures do not necessarily tell us much about the true overall

incidence of alcoholism in a community. In the Highlands and Islands the admission figures are relatively high, 2.7 times the Scottish rate, but the significance of this is doubtful. The opinions of the family doctors in the area regarding the real incidence of alcoholism and their comments on it are set out in appendix I.

Nor is cataloguing the ingredients of an alcoholic or potential alcoholic an easy matter. The one thing they have in common is that they like the stuff or its short-term effects, or they grow to need it. Beyond this there are multitudinous variations. For example the innocent 'hair-in-a-bun' teenager who leads a youth club astray by smuggling in a half bottle of gin in her handbag may merit the nickname of 'fruity owl', but she may or may not be a potential alcoholic. Different is the problem of the tinker, who never really works in the definitive sense of the term, but who intersperses his nips of whisky with the cheap wines from what was once our Empire, before embarking on the almost inevitable tribal conflict that lands him in court. A different problem too is the alcoholic man who in the last ten years has been in hospital on 66 occasions but has successfully worked for a total of eight years between his spells in hospital. Different also is the 'king-size' man of 6 ft. 3 or 4 inches and 16 stone who was drinking three bottles of whisky a day and yet drove up safely to hospital in his own car, not having quarrelled with anybody, having no domestic worries, and none financial, for he owned his own distillery.

It is difficult to ascertain what is the real drinking pattern of any community. Enquiries in this regard, however discreet, must rarely produce anything like the real undiluted truth. A 100 ladies who were consecutive patients in a ward of a general hospital in this area gave their views (*see* appendix II). Although this is not an attempt at a statistical evaluation of magnitude the appendix may merit consideration.

It must seem to many of us that the rôle of medicine in the treatment of the alcoholic is merely supportive. There is no doubt that hospital treatment is effective as far as arefaction or 'drying out' is concerned with bland fluids, sedatives, tranquillizers and vitamin B, but the forms of treatment which come after the acute stage whether they be aversion therapy, groups, special drugs, individual psychotherapy and so on can really only be classed as helpful but not as curative. It is also true that hospital treatment often gives the patient a chance to keep his job, a chance to keep his wife and family, and it may help him over and out of his troubles for the time being. It may give him a jolt. It certainly gives his family a rest. It may give the family doctor and in some cases the police a rest but it is not really true to speak of it in terms of cure. Not that hospital treatment is by any means straight forward. One of the difficult problems is to persuade an unco-operative and unadmitting alcoholic who needs treatment to accept it; if he accepts it unwillingly the continuity of his treatment is by no means ensured. Forced entry to hospital except in an emergency, raises its own problems.

There are hazards too when alcoholics are gathered together in hospital. A realistic colleague of mine wrote to a family doctor about a patient who discharged himself, "I do not know how drunk he was when he came into this hospital but he was certainly drunk when he left." It must be admitted, moreover, that there is a corner of the shrubbery surrounding most of the hospitals and nursing homes which treat alcoholics that may not be 'forever England', but is certainly likely to be an empty memorial to the products of our distilleries. Such statements will come as no shock to those who have borne the heat of the hospital day in having to take the inevitable risks in allowing an increase in freedom to the convalescent alcoholic prior to his discharge to the community. But in any case the community may well have in store for the patient exactly the same quota of problems, and things that cannot change or be changed, as obtained before he went to hospital.

The real problems of the alcoholic have in all probability started long before, go

deeper than, and will remain after any spell he may have in a hospital or special unit. If, as quite often happens, he is the product of a home where drink flowed like water or bigoted teetotalism prevailed one is entitled to assume that nature and nurture are both involved to the gunwales.

Yet there comes a time in the life of a number of alcoholics when for some reason or another (probably best known to themselves) they come to terms with the problem. It may or may not coincide with medical treatment (outpatient or inpatient) as we know it, but nevertheless, this fact alone should encourage us to keep on trying to help the alcoholic to survive his recurring bad patches, and if necessary to haul him back from the very brink of the Gadarene precipice itself.

Such a supportive organization as Alcoholics Anonymous (surely the club with the highest entrance fee in the world) knows all about 'slips' and is prepared to keep trying. Their basic tenets are now widely acceptable and accepted even by those who do not attend their meetings. The basic approach of A.A. to the problem is tersely expressed by the slogan which the B.B.C. borrowed, namely, "Not so much a programme—more a way of life"—A way of life which accepts that for the alcoholic one drink is too many and 50 not enough. Yet the message of A.A. to medicine and to the medical man really is "If at first you don't succeed try, try, try again." A colleague of mine absorbed this lesson well; so well that a man of the cloth who had given a certain relative seven chances with regard to drink was surprised and somewhat taken aback when the doctor said: "Well, Sir, by your reckoning as well as mine that leaves you 483 other shots".

It is said that one alcoholic directly and indirectly, at home and at work, affects the lives of, on average, roughly some 200 other people. It is equally difficult to estimate how many people are influenced directly and indirectly by the 'recovered alcoholic' (if such a term is allowable) but certainly the 'recovered alcoholic' has a great deal to contribute to any community. He has after all achieved more than most of us in conquering not only a ruinous weakness but he has also shown he can conquer himself. Therefore we should learn as much as possible from him. Appendix III deals with details of ten 'recovered alcoholics' who have been off alcohol altogether for an average of more than ten years. This appendix may in a small way help to indicate to us what they can and cannot tell us.

There is no reason to assume that the alcoholic problems in the Highlands and Islands differ from elsewhere. There are some hard drinkers who can stand it and some who cannot. In an area of good 'closed circuit' communication more is known than in the cities. But after all, there are as elsewhere, a great number of sensible people who have as reasonable and responsible an attitude towards alcohol as they have towards other aspects of life. Admittedly there is one hostelry in the Islands where you can view, or sample, if you wish, 100 different brands of whisky. But when whisky or any other alcoholic drink is put into anybody's glass other than your own, you cannot see through the glass but darkly whether in the Gaelic or in the English.

The problem of a person being beaten by one particular thing, namely alcohol, may seem easy. Yet we as doctors all know a little about alcoholism, but, not surprisingly we do not know much. Because in truth our patient who is swallowing the stuff to excess is a larger affair than any single method of minute inquiry be it chemical, physical, pathological, microscopical, psychological or statistical is ever likely to unfold.

Thus the problem is simple, it is complex; alcoholics are all the same, they are all different; they all love the stuff, some don't even like it; alcoholic's wives are wonderful, alcoholic's wives drive their husbands to drink; alcoholics are decent fellows, alcoholics are psychopathic rogues; alcoholics cost the country a lot of money, alcoholics pay their way in taxes; alcohol is the oldest and safest tranquillizer, alcohol is a dangerous curse; alcoholics are born and not made, alcoholics are victims of their environment; alcoholics

have 1,001 excuses for drinking, non-alcoholics have 1,001 excuses for anything; alcoholics have a physical craving, alcoholics have a mental compulsion; alcohol brings people into hospital, alcohol keeps people out of hospital.

These contrasting conceptions delineate the portals of controversy surrounding the dim awareness of the inebriated mind. Portals through which the family doctor, the consultant, the research worker must tread warily and cautiously, but humbly and zealously, in pursuit of the fragments of alcoholic truth.

These very portals are in fact the same in the Highlands and Islands of Scotland as anywhere else in this imperfect world.

Acknowledgements

Table I is taken from "Highland and Island Psychiatric Reflexions". *Brit. J. med. Phychol.* (1967). **40**, 1, by the same author.

I am grateful to Dr R. M. Campbell, Mrs Judith E. Davenport, B.A. (Admin.), Mr Ian Forbes, M.P.S., Miss Flora Green and Dr Andrew B. Hay.

APPENDIX I

Answers to questionnaire by the family doctors in the Highlands and Islands (1965).

	Highland Mainland			*Islands*			*Total*			
	Yes	*No*	*Not sure*	*Yes*	*No*	*Not sure*	*Yes*	*No*	*Not sure*	*Total*
1. Does alcoholism in your practice present a great problem?	31	54	3	9	21	—	40	75	3	118
2. Do you think it is in general on the increase?	33	51	4	13	15	2	46	66	6	118
3. If you have been in another practice outside the Northern Region, do you find it a greater problem here?	31	14	43	8	9	13	39	23	56	118
4. Is there an increase in the consumption of alcohol among young people?	71	11	6	22	6	2	93	17	8	118

Comments:

"Alcoholism is no great problem in my practice because the alcoholics neither seek nor accept advice."

"The chief change, I think, is in the amount of social daily drinking, especially among the younger group."

"New industry has brought people from outside the North and the drink and crime has increased."

"There is a good deal of drinking but not more than years ago, except that the younger wage-earners do more of it."

"Alcohol was used in the West as a cross between an anti-depressant and a tranquillizer, and on the whole it worked very well."

"People drink less nowadays". "Alcoholism is not the problem it was in the olden times." "Drink is the curse of this Island."

"I am fed up with the young teenage groups getting blamed for everything. I hear older

folk say, 'We never took a drink at a dance when I was young'. In my experience this is false. I remember the piles of bottles outside the village hall."

"Alcoholism. This is the most difficult problem I have to deal with; more difficult than cancer. Even in the most untreatable and incurable cases of cancer there is a good and kindly co-operation and symbiosis between the patient and the household and the community. With the alcoholic it is otherwise and as the condition progresses the deterioration of the patient is so often accompanied by growing hostility in place of sympathy. It is certainly an outstanding example of the work of the devil."

APPENDIX II

Observations of 100 wives (1967)

Social class	*I*	*II*	*III*	*IV*	*V*	*Total*
	4	12	56	19	9	100
Age groups	20–29	30–39	40–49	50–59	60+	*Total*
	15	35	31	14	5	100

Drinking habits	*Husbands*	*Wives*
1. None taken	6	21
2. At "weddings and New Year" only	22	35
3. "Rarely"; "Once a month", etc.	16	22
4. Every Saturday night	18	11
5. A "pint" most nights	7	—
6. "Socially", or "For business", several times weekly	5	5
7. Heavy intake, especially weekends	15	3
8. Severe drinking	7	3
9. Probably alcoholic	4	—

Comments:

"He very rarely ever has alcohol. . . . Just a pint (beer) every night".

"Just a few times in a fortnight (*i.e.* he stops by the pub every night on the way home)".

"The poor man has nothing else to do in his spare time".

"Oh just socially. . . . He is probably on the bash while I'm in here".

"My husband never drinks! He can look out. I could have a night out with girls".

Doubtful if beer is regarded by some wives as alcohol. Alcohol=spirits.

It seems that in social classes I and II it is customary for the husband and wife to go out together for a convivial evening. This appears to happen less often in group III and less still in groups IV and V.

SOME EXAMPLES OF SOCIAL CLASS ALLOCATIONS

(H.M.S.O. Classification of Occupations, 1966)

1. Medical and dental practitioners
   University teachers
   Chemists
   Physical and biological scientists
   Civil, mechanical and electrical engineers
   Company secretaries
   Accountants
   Architects
   Clergy
   Judges, barristers, solicitors

2.	Farmers Nurses Shop proprietors Social workers Teachers Pharmacists, dispensers Members of parliament	Authors Journalists Actors, entertainers Musicians Painters, sculptors and "related creative artists"
3.	Draughtsmen Typists, secretaries Clerks, cashiers Commercial travellers Drivers (road, rail, etc.)	Foremen Cooks Athletes, sportsmen Butchers
4.	All agricultural and forestry workers Fishermen Coal miners Construction workers Bus conductors	Fishmongers Warehousemen Milk/bread roundsmen Maids, valets, waiters Chimney sweeps
5.	Labourers in { Chemical, Engineering, Foundries, Gas works, Building and contracting } trades Messengers	Window cleaners Charwomen Stevedores and dockers Lorry drivers' mates Porters Ticket collectors Kitchen hands

APPENDIX III

Detailed observations from ten 'recovered alcoholics' (1967)

Social class	*I*	*II*	*III*	*IV*	*V*	*Total*	
	4	4	0	2	0	10	(M=8; F=2) 7 married; 1 widow; 1 spinster; 1 bachelor married since his "recovery"

Numbers of admissions: Average 2.3 per person. Range 0–7 times.

Times in hospital	0	1	2	3	4	5	6	7
	2	3	2	0	1	1	0	1

	Average (years)	*Range (years)*	
Elapsed time since indulgence	10.7	4–17	(4; 8; 13; 14; 6; 7; 12; 17; 10; 16 years respectively).
Age at which drink first taken	20	16–28	
Age upon first drinking to excess	34	18–55	(All drank spirits to excess).
Age at time of survey	57	46–76	
Elapsed time of excess intake before help sought	8.5	2–16	

Reasons for starting (to take excess)		
Gradual insidious development—it snowballed		4
Following bereavement		3
To build tough, external image		1
No known reason		2
Why stopped?		
Shame; realization of future; fear		4
Turning to A.A. to recover health		3
To recover health		1
Shock of hospitalization		1
No known reason		1
What agencies helped?		
Hospital		8
A.A. practice		6
Doctors		6
A.A. (principles only)		2
Ministers		2
Medical aid—Sought or compelled		
Sought		8
Because of accident or brush with law		4
Compelled		2
'Last straw' which led to treatment?		
Realization of helplessness; fear		5
Accident—heavy bout		4
No known reason		1
Sense of inferiority present before drinking habits developed	Yes	6
	No	4
Family history of alcoholism		
Positive (including 2 known deaths)		6
Negative		2
None known		2
Attitude to drink in parental home		
Drink in moderation		7
None allowed		1
Heavy drinking		1
A house divided (mother T.T., father over-indulging)		1
Drink now kept in the reformee's own home:		
	Yes	9
(Qualified 'yes' in five of nine, e.g. 'but it's under lock and key')		
	No	1

Did 'cutting down' attempts precede final reform?		
(Usually several attempts quoted)	Yes	9
	No	1
Did lapses occur during final reformation period?	Yes	6
	No	4
Does temptation recur?		
	Never	8
	Sometimes	2

Was drink taken:

(*a*) For its effect?	6
(*b*) For its taste?	1
(*c*) Both?	3

Was oblivion the desired end-product?

Yes	5
No	3
Don't know	2

Drinking patterns:

1. (*a*) Solitary	2	2. (*a*) Continuous drinking	4
(*b*) Convivial	0	(*b*) Bout drinking	2
(*a*) Following (*b*)	3	(*b*) Following (*a*)	3
(*a*) and (*b*)	5	Could not say	1

	Yes	No
Were drugs taken also?	—	10
Trouble with law, police, authorities?	4	6
Suicide ever contemplated?	7	3
Did blackouts occur?	6	4
Was food neglected?	7	3

Note:—Eight out of the ten stressed the difficulty of regaining self respect and facing up to their fellow human beings.

Discussion

Dr Reid (*Auchterarder*): I should like to ask Dr Yellowlees about his leading lady—his unstable diabetic with marital stress. Was she stabilized by psychotherapy, or by the chilly advice of the physician to re-adjust her insulin, or does the instability still prevail?

Dr Yellowlees: She was stabilized by the death of her husband. The poor man had a series of cerebrovascular accidents and eventually passed out with a coronary, and I was sure the lady would be all right, which indeed happened. She became much more stable until one day about two or three months after her husband's death when she suddenly went off into a deep coma. I discussed this with her and she said, "I have just heard that some of my husband's relatives are coming to visit me".

Dr Forth (*Cromarty*): What would be the feeling of the consultants regarding the possibilities of consultant–general-practitioner discussion groups, where the general practitioner could gain insight into his own handling of certain patients' situations? I understand that within hospital practice this is almost routine.

Dr Henderson: Yes, indeed; I would actively encourage this. We certainly do it routinely in hospital, at case conferences, and by encouraging the most junior house physician in psychiatry to disagree with his consultant. This is something that is not accepted in many branches of medicine, but the junior man's opinion about an interpersonal situation is just as important and perhaps more valid at times than the consultant's. I would be strongly in favour of any family physician wishing to take part in this kind of group discussion, and I am sure that I speak for my colleagues by saying that, if a group wished to establish itself, we would be very interested to hear of it.

Dr Patterson (*Edinburgh*): For two years recently I attended a once-weekly Tavistock Clinic-