Priest, W. M. (1962). *Lancet.* **2,** 1,043.
Rawnsley, K. and Loudon, J. B. (1962a). *Brit. J. prev. soc. Med.* **16,** 174.
Rawnsley, K. and Loudon, J. B. (1962b). *The attitudes of general practitioners to psychiatry.* Sociological Review Monograph, No. 5. University of Keele.
Reid, J. C. (1954). *Lancet.* **1,** 822.
Ryle, A. (1960). *J. coll. gen. Practit.* **3,** 313.
Sandler, J. (1958). "Some notes on delegate analysis". In Tacon, S. F. *An investigation of some psychoneurotic symptoms in adult neurotic patients.* Ph.D. thesis. University of London.
Schumacher, C. F. (1964). *J. med. Educ.* **39,** 278.
Shepherd, M., Fisher, M., Steinl and Kessel, W. I. N. (1959). *Proc. roy. Soc. Med.* **52,** 269.
Shepherd, M., Davies, B. M. and Culpan, R. H. (1960). *Acta Psychiat.* **35,** 518.
Taylor, S. (1954). *Good general practice.* London. Oxford University Press.
Walton, H. J., Drewery, J. and Carstairs, G. M. (1963). *Brit. med. J.* **2,** 588.
Walton, H. J., Drewery, J. and Philip, A. E. (1964). *Brit. med. J.* **2,** 744.
Walton, H. J. and Drewery, J. (1964). *J. med. Educ.* **39,** 545.
Walton, H. J. (1965). *Brit. J. med. Psychol.* **38,** 63.
Walton, H. J. (1966). *Brit. J. Psychiat.* **112,** 1,097.
Walton, H. J. and Hope, K. (1967). *Brit. J. soc. clin. Psychol.* **6,** 43.

Community psychiatric services and the general practitioner

Dr P. Sainsbury, M.R.C., B.A., M.D., M.R.C.P., D.P.H. (*M.R.C. Clinical Psychiatry Unit, Graylingwell Hospital, Chichester*)

It is the general practitioners who are experienced in providing medical services in the community; psychiatrists have only recently ventured beyond the hospitals' boundaries. Never-the-less, community psychiatric services are something of an innovation to both you and me, and my excuse for being the speaker is that my research unit has been interested in their evaluation. To get the problem into perspective, it is first worth seeing how the care of mental illness in a community is divided between general practitioners and the psychiatrists.

Professor Shepherd and his colleagues (1966) have estimated the prevalence and inception rates of psychiatric illness in 46 London practices, which they did by taking a 12 per cent random sample of the practice-populations. They reported an annual prevalence rate (that is the number of patients consulting with psychiatric illness per 1,000 patients at risk) of 140 per 1,000; the inception rate for the population (that is new cases of illness consulting during one year) was 52 per 1,000. This important study is the most thorough attempt so far made in Britain to assess the amount of psychiatric illness for which the local services must provide. A difficulty in any survey of this sort is the definition of psychiatric morbidity. The method Shepherd used was to include a case if the general practitioner's diagnosis was listed in Section V of the I.C.D., or if the general practitioner considered the illness had an important psychological component. With this classification Shepherd obtained the following diagnostic rates: six per 1,000 for psychoses, 88 for neuroses and 46 for psychosomatic disorders. Chronic cases, defined as those whose illness had a duration of at least one year, accounted for over half of the morbidity. A practice of 2,000 will, therefore, be caring for about 280 psychiatric patients during any year, 140 of whom will have been ill for more than a year, and about 100 will be new cases. What proportion of them does the general practitioner refer to the psychiatric services? Shepherd found that only 3.5 per cent of

new patients were referred; and that only 7.5 per cent of the chronic ones were under psychiatrists' care.

In Chichester the annual referral rate to our community psychiatric service was 6.8 per 1,000, so if we assume that the prevalence of psychiatric illness in Chichester is as in London, then the general practitioner asks us to see only one in 20 of his patients and treats the other 19 himself. Were his attitude to psychiatric referral to change, the services would be swamped.

These observations raise many questions: Why is so small a proportion of cases referred and is this a tacit criticism of the adequacy of the services offered?

What determines whom the general practitioner refers and when he refers a patient?

What characteristics of the patients then determine whether they are admitted, or allocated to community care, which often means the general practitioner shares the problem?

What are the effects on the community of this large reservoir of psychiatrically-ill people?

Is the general practitioner able to deal satisfactorily with those patients he does not refer? If not, how do psychiatric services need to be reorganized in order to improve their efficiency, to encourage collaboration with general practitioners and to divide the work more appropriately?

Insufficient research has been done to provide definitive answers to these questions, and Shepherd's book deals with many of them more adequately than I can; but as a number of projects undertaken at the Clinical Psychiatry Research Unit have also made a start in this direction, I would like to tell you about some of them.

A community psychiatric service was introduced in Chichester and district in 1957 (Carse *et al.* 1958). This service anticipated the recommendation of the 1959 Mental Health Act, which statutorily encouraged the treatment of psychiatric patients in the community. Dr Grad and I therefore decided it would be valuable to attempt to describe and assess some of the effects of this form of care.

The aims of the Chichester service were to relieve overcrowding and diminish the incidence of long-stay patients in the mental hospital, Graylingwell, by greatly extending the extramural services. This practical purpose was further nourished by the notion that treatment given in a normal social and familial environment would be therapeutically more effective than admission to an institution (Morrissey 1966).

The one feature all community-care schemes share in common is their endeavour to treat a larger proportion of patients extramurally than hitherto—and that will serve as my operational definition of a community psychiatric service. The type of organization set up and the kinds of facilities provided to do this vary enormously; and are what distinguish the different community psychiatric schemes from one another.

Thus, in Chichester, at the time we began our evaluation in 1960, the service was organized by the staff of the mental hospital; there was little liaison with the local authority at that time. From the start, however, collaboration with the local general practitioners and their easy approach to psychiatrists, was a cardinal feature. Before the scheme was introduced it was discussed with them; they were asked to discontinue referring patients directly to the hospital, but instead to contact the local day-hospital where a psychiatrist was always on duty. They would then decide together whether the patient should be seen at home immediately, or later at the day-hospital, or be given an outpatient appointment. Only after this initial screening was a decision taken whether to admit the patient or treat him in the community. Home treatment, for example, with the psychiatrist calling much as a general practitioner does, was the disposal commonly used with geriatric patients. The emphasis of the care provided by the service

was much more clinical than social and the consequences of the rather meagre social support given to the family and patient became evident when our assessments of the service were analysed.

And that brings me to those aspects of the service that we evaluated and to mention briefly the method by which it was done (Sainsbury and Grad 1962, 1966).

The aims of our research were first, to see how the introduction of a community psychiatric service affected the rate of referral and the type of patient referred; secondly, to see which patients are treated in the community and which are admitted; thirdly, to examine the effects of the service on the community—and the patient's family seemed the representatives of the community most worth studying; fourthly, the effects on the outcome of the patient's illness; and lastly, the general practitioner's attitude to the service.

The method we used was to record, during one year, some 50 items of clinical and social information on every patient referred both to the Chichester community service and to a control psychiatric service in Salisbury whose policy was more conservative—the majority of patients being referred directly to the hospital for admission.

The effects on the family and on the patient were examined by visiting the families of every third referral. The patient and his family in this sample were then followed-up for two years. All contacts with the services were recorded and the outcome assessed on the basis of ratings made by their family doctor, by two psychiatrists, by the family and by the patient himself. Social workers rated the social outcome. They also rated the effects of the patient on defined aspects of family life: on the occupation of family members, for example; on their income, health, time they spent with the patient, and so on. Each item and the overall burden were rated as none, some or severe: first at referral and again at follow-up so that the change in burden could then be measured.

We found the reliability of our data to be satisfactory (Kreitman *et al.* 1961, Grad 1964). Finally, comparisons between Chichester and Salisbury were facilitated because the two areas are very similar demographically and because the patients, when first referred, were well matched on diagnosis, on two measures of severity of illness and on their social characteristics.

I will now describe some findings that bear on the problem of psychiatric services and the general practitioner; and begin with the effects that the introduction of a community service has had on whom he refers (Grad and Sainsbury 1966, Sainsbury and Grad 1967).

TABLE I

AGE AND SEX. RATES PER 1,000 POPULATION FOR MEN AND WOMEN IN TEN YEAR AGE GROUPS IN CHICHESTER AND SALISBURY

Age group (years)	*Male*		*Female*		*Total*	
	Chichester	*Salisbury*	*Chichester*	*Salisbury*	*Chichester*	*Salisbury*
15–24 ..	5.3	3.3	4.9	4.5	5.1	3.9
25–34 ..	6.0	5.1	10.3	8.4	8.2	6.8
35–44 ..	5.9	3.4	10.2	7.5	8.2	5.5
45–54 ..	4.6	4.8	5.0	5.4	4.8	5.3
55–64 ..	5.1	3.5	6.8	6.1	6.0	4.9
65–74 ..	5.6	4.6	7.1	5.9	6.5	5.3
75 and over	8.4	5.6	12.8	6.6	11.3	6.2
TOTAL ..	5.6	4.2	7.8	6.3	6.8	5.3

The community service had a higher referral rate than the hospital one; and as the higher rate was found for nearly every social and clinical category examined, this may fairly be assumed to be a consequence of the new service (table I). The social character-

istics of patients who had significantly higher rates of referral were the aged, those living alone (table II) and those of lower social and economic status. The clinical categories with significantly higher referral rates in the community service were the depressive and organic psychoses (table III).

TABLE II

LIVING ALONE. RATES PER 1,000 POPULATION (ALL AGES) FOR ONE, TWO, THREE, FOUR AND FIVE OR MORE PERSON HOUSEHOLDS IN CHICHESTER AND SALISBURY

Household size	*Chichester*	*Salisbury*
1 person alone	12.3	9.5
2 persons	7.2	5.5
3–4 persons	4.4	3.5
5+ persons	3.6	2.8
Total private households	5.2	3.9
Hotels, boarding houses and institutions ..	23.5	22.5

I mentioned previously that the patients referred were well matched in the two services, so the effects of the Chichester service had been to mop up the serious mental disorder in the community rather than to attract more cases of minor illness; furthermore, these referrals—the old, the poor and the lonely—are patients who, in the past, tended to be the most easily neglected. As a much higher proportion of patients were also referred by their general practitioners in Chichester —85 per cent compared with 63 per cent in Salisbury—we have grounds for supposing they are making greater use of the new service, especially for the elderly. Previously, they knew that the prospect of finding them a bed in hospital was slight, but when the services are able to offer some assistance with geriatric patients in the form of home care there is then a basis for collaboration with the psychiatrist.

TABLE III

DIAGNOSIS. RATE PER 1,000 POPULATION AGED 15+ YEARS IN FOUR DIAGNOSTIC GROUPS IN CHICHESTER AND SALISBURY

Diagnosis	*Male*		*Female*		*Total*	
	Chichester	*Salisbury*	*Chichester*	*Salisbury*	*Chichester*	*Salisbury*
Organic psychoses	1.2	0.6	1.4	1.0	1.3	0.8
Functional psychoses ..	2.2	1.5	3.5	2.7	2.9	2.1
Neuroses ..	1.4	1.5	2.3	2.3	1.9	1.9
Personality disorders and other	0.9	0.6	0.6	0.3	0.7	0.5
TOTAL	5.6	4.2	7.8	6.3	6.8	5.3

A third significant finding was that nearly all categories of patients were referred earlier in Chichester; nevertheless, the duration of illness prior to referral was still unduly long in Chichester—47 per cent having been ill for more than six months and 31 per cent for more than two years, which confirms Shepherd's observation that general practitioners preferentially refer chronic cases.

Turning next to our second aim, which was to see what factors determine which

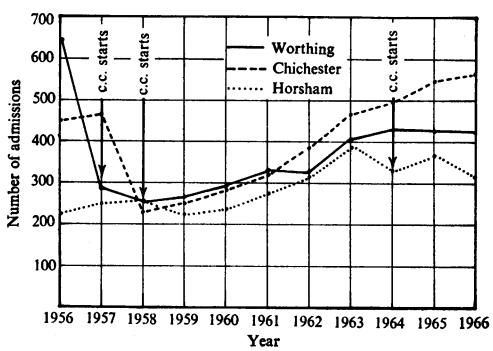

Figure 1.

patients are treated in hospital and which at home (Grad and Sainsbury 1966, Sainsbury and Grad 1967). First of all, it was clear that the community service was successful in achieving its initial purpose of reducing admission to the mental hospital. Figure 1 shows the substantial decrease in the proportion of patients admitted when the community centres in Worthing, Chichester and Horsham were opened. Moreover, in Chichester the mean duration of stay in hospital was shorter than in the control service, mainly due to the geriatric patients being discharged earlier.

TABLE IV

INITIAL DISPOSAL OF ALL PATIENTS REFERRED TO TWO SERVICES DURING 1960–1961

	Chichester Percentage (N=823)	*Salisbury Percentage (N=585)*
Mental hospital ..	*14*	*52*
Other institution ..	*8*	*5*
Admitted	*22*	*57*
Day hospital	*15*	—
Home care	*16*	*3*
Outpatient	*34*	*35*
Discharged to general practitioner	*13*	*4*
Not admitted	*78*	*43*

The extramural character of the Chichester service is more clearly shown in table IV. In Chichester only 14 per cent of referrals were initially admitted to mental hospital, compared with 52 per cent in Salisbury, and this difference in disposal was maintained, though to a lesser extent, throughout the two-year follow-up. During the two years, 62 per cent were treated exclusively in the community in Chichester, whereas only 41 per cent were in Salisbury. It is interesting to notice the greater extent to which nursing homes were used in Chichester. Nursing homes were prepared, it seems, to admit elderly patients with senile psychoses when there was an assurance that the psychiatrist was available for advice and to take over care of the patient if necessary.

TABLE V

BURDEN ON GENERAL PRACTITIONER DURING TWO-YEAR FOLLOW-UP OF COHORTS IN CHICHESTER AND SALISBURY

	Percentage causing problems			*Percentage causing problems*	
	Chichester (N=178)*	*Salisbury (N=100*)*		*Chichester (N=75*)*	*Salisbury (N=30*)*
Patients aged 15–64:			Patients aged over 65:		
Some problem ..	*20*	*22*	Some problem ..	*23*	*10*
Severe problem ..	*9*	*7*	Severe problem ..	*4*	*3*
Total causing problems	*29*	*29*	Total causing problems	*27*	*13*

*Numbers followed-up including those who died and excluding 27 not known.

Further comparisons enabled us to distinguish two other trends in the community service. First, that social factors rather than clinical more often determined admission in this service; a finding which emphasizes the importance of assessing the social and other stresses acting on the family if the most appropriate disposal is to be chosen by either general practitioner or psychiatrist (table VI).

Secondly, the extramural facilities most likely to be recommended in the community psychiatric service were different for the various groups of patients: nursing homes were preferred for elderly dementing widows; home treatment was also used for the elderly, especially if they were married; at the day hospital on the other hand, affective psychoses predominated, usually single people living with their relatives. In both services the

young and neurotic were most likely to be treated as outpatients or discharged back to their family doctor.

As many patients who are admitted in the more traditionally organized service are at home in the community one, we were interested to know whether the general practitioner found them an encumbrance. At the two-year follow-up, therefore, we wrote to the general practitioners of all patients in both the Chichester and Salisbury cohorts. We asked whether the patient had caused any special problems and whether he had taken up a disproportionate amount of the general practitioner's time. They rated their replies 'no special problems', 'some difficulties', or 'very difficult to cope with in general practice' (table V).

For patients below the age of 65 there were no differences between the services: 29 per cent in both were rated a problem of some kind to the general practitioner. The geriatric patients in Chichester, however, caused him more problems; twice as many were found to present difficulties as in Salisbury. In spite of this, the doctors in West Sussex have shown an enthusiastic support of the psychiatric services, but the only statistical evidence I have for this belief is the number who protested when its survival was threatened.

We also wanted to know whether these patients, whose mental illnesses were of all degrees of severity, placed an undue burden on their families, and whether the mental health of the other members of their households was impaired because of it (Grad and Sainsbury 1963, 1968).

TABLE VI

PERCENTAGE OF GERIATRIC REFERRALS ADMITTED

	Community service percentage	*Hospital service percentage*
Social class: I & II ..	*38*	*73*
III ..	*36*	*84*
IV & V ..	*58*	*70*
All geriatric referrals ..	*42*	*76*

TABLE VII

EFFECTS ON FAMILIES WHEN THE PATIENTS WERE FIRST REFERRED

	Chichester (N=271) percentage	*Salisbury (N=139) percentage*
Problem scores:		
0–1	*38*	*32*
2–3	*25*	*24*
4–5	*14*	*15*
6+	*23*	*29*
Burden ratings:		
None	*40*	*29*
Some	*42*	*46*
Severe	*18*	*25*

Table VII shows that when the patients were first referred there was no difference between problems incurred by families in the two areas. About two thirds of them were suffering some hardship because of the patient and in one fifth the burden was rated as severe. For example: the social and leisure life was restricted in a third of the families; 29 per cent had their domestic routine upset (housework, shopping, etc.); and in nine per cent the family income had been cut by more than half (table VIII). Moreover, families were having to give the patient a great deal of care and attention: one third described the patient as importunate and requiring constant companionship; a third were also providing nursing care. These figures represent a serious amount of social disability which becomes more striking when one recalls that the majority had had the ill patient at home for over a year before they were referred by their doctor.

When the families who had been suffering these problems were followed-up, the burden was relieved in 60 per cent of Chichester families compared with 82 per cent of Salisbury ones. But in spite of admitting fewer patients the community service ap-

proached the hospital-based one in the help it gave to the *severely-burdened* families after two years, but it was not so helpful to those families who were less severely burdened (table IX). Thus, conspicuous social disability, such as a relative having to stay away from work, was relieved equally in both, as also were the families of patients with

TABLE VIII
FAMILY PROBLEMS

Effect on	*Percentage of families*		
	Some disturbance	*Severe disturbance*	*Total burden*
Health of closest relatives:			
Mental	40	20	60
Physical	28	—	28
Social and leisure activities of family	14	21	35
Children	24	10	34
Domestic routine	13	16	29
Income of family	14	9	23
Employment of others than the patient	17	6	23

the more socially serious symptoms, such as nocturnal restlessness, dangerous or markedly-bizarre behaviour. It was evident that the community service, as developed in Chichester, was recognizing and dealing with the more obvious family burdens, though not the less serious ones.

TABLE IX
PERCENTAGE OF FAMILIES RELIEVED OF BURDEN TWO YEARS LATER

	Percentage relieved	
	Chichester	*Salisbury*
***Some burden at referral	59	86
**Any burden at referral	60	82
Severe burden at referral	66	68

**p <0.01 ***p <0.001

TABLE X
RELIEF OF FAMILY BURDEN TWO YEARS LATER BY EVER ADMITTED TO MENTAL HOSPITAL DURING THE PERIOD

	Percentage of families relieved	
	Chichester	*Salisbury*
**Admitted patients	59	87
Extramural patients	62	71

**p <0.01

Further examination of our data provided an explanation of this. Failure to admit to hospital was not the responsible factor because the families of those patients who were treated exclusively in the community during the two years, were equally relieved in the two services (table X). When the family burden was analysed by patient's age, however, the families of patients under 65 were relieved more in Salisbury, whereas those with elderly patients were relieved equally in both. So the group who had affected their households worse in the community service, were the younger, less seriously ill patients—mostly neurotics and depressives—who had been admitted, albeit briefly, some time during the two years. When we then compared the social work needed with that done in the two services we found far more visits and items of service were given in Salisbury, so the Chichester service was failing to give adequate social support to families and after care to discharged patients.

These findings draw attention to two problems in organizing community psychiatric services: the first is the relative ease with which patients can get lost, if, for example, they fail to keep an outpatient appointment; and the second is the need to supplement

clinical care of the patient with adequate social support to his family. Nevertheless, considering how haphazard the social care provided in Chichester was at that time, it is remarkable how well they did. Our psychiatric social workers were impressed by the family's readiness to cope with a really burdensome patient. Undoubtedly, many families prefer to care for their own sick; and we have some preliminary data which seems to show that the disposal recommended in Chichester was more in keeping with the wishes of the family than was the case in Salisbury and that opting for home care is not due to a fear of the stigma of the mental hospital. Nevertheless, does the family's health suffer?

When the patient's home was visited we rated his effect on the mental health of both the closest relative and of the children. The relative's health at referral had already been affected to some degree in 60 per cent and severely affected in 20 per cent. Two years later, twice as many relatives in Chichester as in Salisbury still ascribed symptoms, such as insomnia, headache and depression, to worry about the patient. Children, on the other hand, were adversely affected in one third of households, and at follow-up about ten per cent in both services had developed frankly neurotic symptoms.

These observations obliged us to ask whether the continued presence of the patient at home is leading to more mental illness in the community. Studies by Dr Kreitman, then with my unit, indicate that living with a neurotic patient is likely to potentiate or even produce neuroticism. He found, for example, that the spouses of patients have an incidence of mental illness above expectation; that they score higher on a neuroticism scale than do healthy control married pairs; and that with increasing duration of marriage the concordance for neuroticism between the patient and his spouse increases, whereas in the control pairs it decreases (Kreitman 1962, 1964).

Dr Kreitman's findings clearly supplement ours and again stress the need for a careful appraisal of the family situation: further work must be undertaken to assess this risk to the family of community treatment whether it is provided by the psychiatrist or by the general practitioner.

As the comparisons between the outcome of the patient's illness in the two services are still incomplete, I would like to end by considering just the most extreme outcome—suicide; because the management of the suicidal patients directly concerns the general practitioner: one per cent of all his patients and 15 per cent of his depressed ones can be expected to die in this way.

A criticism of extending the extramural care of patients is that the risk of suicide is increased. But we have some experimental evidence that with improved services it may be possible to prevent, or at least reduce, the incidence of suicide (Sainsbury *et al.* 1966). I have already said that one striking effect of the Chichester service has been to provide treatment for many more old people in the district, because closer collaboration with the general practitioners has enabled them to refer cases with some prospects of their receiving psychiatric supervision, though this will often be given at home. Dr Walk wanted to find out what effects this policy has had on the incidence of suicide. He therefore calculated the proportion of suicides occurring in our district who were known to a psychiatrist at some time in the year preceding death. He did this for a five-year period before the introduction of the service and again for the five years after. He found the suicide rate in patients over 65 had decreased significantly, and this had occurred in spite of the number and rate of referrals having increased in the second period. For the under 65's, however, the suicide rate for the two periods had not changed appreciably. Increased extramural services, therefore, certainly do not appear to increase the risk of suicide; they may well be prophylactic.

Dr Barraclough and Miss Nelson are also interested in suicide prevention (Barraclough *et al.* 1968). They are visiting the homes of all suicides in West Sussex soon after the event, in order to get a detailed history of his clinical state and social circumstances.

What has so far emerged from a pilot study is worth mentioning, if only tentatively. Eighty per cent of the suicides had a readily recognizable depressive illness—the diagnosis was validated by three independent psychiatrists; two thirds of the suicides had visited their general practitioner in the week preceding the event; and 20 per cent were currently attending psychiatric outpatients. Since depression is a treatable condition, these findings also indicate that it should be possible to reduce the incidence of suicides by improving community services. On the one hand, the psychiatrists are not providing an efficient procedure for following-up those patients known to have a high risk for suicide; the depressives, alcoholics and patients who have attempted suicide. And on the other hand, the impression gained from interviews with the suicides' family doctors is that they are failing both to recognize depressive illnesses and the patient who is a risk for suicide.

To summarise; first, general practitioners care for most of the psychiatrically-ill people in the community without psychiatric help; were they not to do so the services could not cope. Secondly, they preferentially refer chronic cases, but with improved community services they refer earlier, and particularly those patients for whom little psychiatric provision was previously available: notably geriatric patients. So it is likely that if services were directed towards, say, neurotics, their referral rate would similarly increase. Thirdly, in a community service, social and family factors rather than clinical ones determine whether treatment is given at hospital or at home. In the latter event, responsibility for treatment is shared with the general practitioner and so his work increases, but like the families and nursing homes, he appears to find it less burdensome. Fourthly, the social and personal effects of mental illness on the members of a patient's family are considerable and often prolonged. Serious burdens are relieved as well by community care as by admission; but the neurotic who inflicts a less obvious burden may, in the long run, have more harmful effects on the mental health of his relatives. Both the general practitioner and the community psychiatric services have to be able to recognize these situations in order to be able to recommend the appropriate disposal or adequate social and clinical support. Fifthly, general practitioners and psychiatrists are already over committed, so I believe a realistic approach to improving psychiatric services to their mutual benefit is by devising practical measures for improving communication and collaboration between them, namely:

Easy and informal contact with the psychiatrist, such as consulting one another on the telephone;

invitation to general practitioners to conferences on their patients on discharge;

psychiatric seminars for general practitioners—the psychotherapy seminars are well attended in Chichester; suicide and depression are topics which might have a high priority;

much greater use by both general practitioners and psychiatrists of the social, welfare and ancillary medical services.

The practical and supportive help that nurses, social workers and health visitors can give are often sufficient to enable a family to cope with the elderly or to carry a patient until his condition remits.

REFERENCES

Shepherd, M., Cooper, B., Brown, A. C. and Kalton, G. W. (1966). *Psychiatric illness in general practice*. London. Oxford University Press.

Carse, J., Panton, N. and Watt, A. (1958). *Lancet*. **1**, 39.

Morrissey, J. D. (1966). *Milbank mem. Fd. Quart.* **44**, No. 1, part 2, 28.

Sainsbury, P. and Grad, J. C. (1962). Evaluation of Treatment and Services. In *The burden on the community*. London. Oxford University Press.

Sainsbury, P. and Grad, J. C. (1966). *Milbank mem. Fd. Quart.* **44**, 231.

Kreitman, N., Sainsbury, P., Morrissey, J., Towers, J. and Scrivener, J. (1961). *J. ment. Sci.* **107**, 887.

Grad, J. C. (1964). *Brit. J. psych. soc. Work*,**7**, 147.

Grad, J. C. and Sainsbury, P. (1966). *Milbank mem. Fd. Quart.* **44**, 246.

Sainsbury, P. and Grad, J. C. (1967). *Psychiatric disorders in the aged.* Symposium. Geigy.

Grad, J. C. and Sainsbury, P. (1963). *Lancet*, **1**, 544.

Grad, J. C. and Sainsbury, P. (1968). *Brit. J. Psychiat.* **114,** 508.
Kreitman, N. (1962). *J. ment. Sci.* **108,** 438.
Kreitman, N. (1964). *Brit. J. Psychiat.* **110,** 159.
Sainsbury, P., Walk, D. and Grad, J. C. (1966). *Milbank mem. Fd. Quart.* **44,** 243.
Barraclough, B., Nelson, B. and Sainsbury, P. (1968). Proceedings IV Int. Congress for suicide prevention, 1967. Los Angeles.

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