backgrounds (Roberts and Lawrence, 1973; Murray, 1974). About half of patients with analgesic nephropathy have had psychiatric treatment, but unfortunately their psychiatrists have rarely detected their analgesic abuse. Enquiring about analgesic ingestion when taking a history from patients can provide psychiatrists with an unusual opportunity to practise preventive medicine.

ROBIN M. MURRAY

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CORRESPONDENCE

PSYCHIATRY FOR PSYCHIATRISTS

DEAR SIR,

The letter by 'A Colleague' (*News and Notes*, July, p. 11) is to my mind timely and important. Speaking from the other side of the fence as I am at the moment treating two medical colleagues, I think it is fairly safe to conclude that psychiatrists remain aloof from their colleagues' difficulties because of the stress involved in taking them on.

Another unspoken aspect of this situation is that psychiatrists 'cannot have problems'. Anyone who has been a group member with other psychiatrists will soon realize that this is just not so and that there clearly is a need—a very great need—for greater self and other acceptance by psychiatrists as a whole. Such acceptance clearly facilitates both one's ability to go to one's colleagues if one has a difficulty and one's ability to accept and respond to the difficulties of one's colleagues.

I agree with 'A Colleague' when he says there needs to be a channel through which one's colleagues can find help as well as give it. This channel should be national with a formalized structure so that help can be obtained quickly, smoothly and efficiently, and also so that the person obtaining help does not feel (or be expected to feel) everlastingly indebted to the helper.

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DEAR SIR,

I welcome this opportunity to comment—if I may—upon 'A Colleague's' interesting letter. I should first like to establish my own credentials—so to speak—by saying that I have experienced several depressive illnesses, and that I am, as a consequence, familiar with the terrain over which 'A Colleague' has (I think it may be presumed) travelled even more painfully than he implies. One cannot but help sense the irony which, I venture to think, was not intended by the writer when he described the realization that he too had become subject 'to those same symptoms of anxiety and depression which we hear described by the patients in our everyday practice'. The letter immediately strikes a note one so often hears from psychiatrists: a note of bewildered and painful surprise that the separate worlds of psychiatrists and laymen should become so confused. I agree entirely that the question of where to turn for help and advice is a neglected one; it serves a discussion to which the letter makes a commendable contribution. Yet underlying this neglected area there is much else to be looked at. It is not simply a question of what can be done to help those of us 'who might find themselves in a similar predicament' (much as a good map should be available to those who 'find themselves'—quite by accident, of course—in the wrong part of town); but also it is a question of what we learn of ourselves, and others, whilst in that predicament.

I have learnt a great deal. I have discovered, for example, that to have found myself in 'a uniquely isolated position' (and I agree that it has been as bad as that) is to have denied the myth which says that: (1) psychiatrists should not—if at all possible—become psychiatrically disturbed; (2) that if they do it must be understood that they have fallen victims to an illness not of their making—that is to say, they must be made to feel by the therapist they eventually find 'you're depressed, old chap—it could have happened to anyone'. In other words, the possibility that the depression, or whatever, has anything to do with one's adjustment to life is repudiated as too disturbing and threatening to the essentially collusive relationship between psychiatrist-patient and psy-