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-

chiatrist-therapist. Such, at any rate, has been my experience. I have learnt that within the world of the mental hospital psychiatric illness amongst the staff is felt as a threat to the necessary myth that only 'patients' can be ill. Certainly, I have experienced the shame of disloyalty in being ill: one has in a very real sense let down the side. I hope that 'A Colleague' and his family have been spared the hurtful social isolation that within the psychiatric hospital seems to follow from the closing of ranks amongst those not yet struck down.

Clearly, the illness of a psychiatrist tests very severely the deeper attitudes of his colleagues, most of whom are discovered to be incapable of coping with one of their fellows at a personal level: when confronted by the plight of a colleague, the accustomed defences promote nothing more positive than the isolation of the person most in need of help. Collusion comes later. I discovered that my therapists —there have been several—seemed bent upon rendering me harmless by insisting that my depression was 'endogenous' (for example), or at any rate an illness to be expected from the high level of responsibility and professional anxiety to which I was exposed. I soon learnt to present my case—to discuss my symptoms—in a way most likely to accord with my perception (and a heightened perception it soon became) of what my psychiatrist preferred, or 'needed', to believe. I was at the same time sparing myself the pain of looking at myself directly and honestly. The unspoken contract benefited both of us: the psychiatric game was played to rules mutually advantageous. I got my treatment and symptomatically improved. A more fundamental progress in personal terms was achieved principally with the help of my wife.

Isolation, then collusion. What else? Other therapists are given to denial when it comes to treating a colleague. According to this outlook there is really no difficulty. A mental illness is really like any other—to be treated in an open matter-of-fact manner. This approach is seductive, and is usually practised by the kind of psychiatrist whose insensitivity makes him highly unsuitable and even dangerous.

I can speak too of others. The amount of personal misery, confusion and anxiety in the home of the afflicted psychiatrist is a sad commentary on the way we relate—one to another—communicate and order our affairs. To whom shall he turn? Will his job be in jeopardy? Will the esteem in which he supposes he is held suffer? He struggles on; he pretends; becomes irritable, inefficient, and difficult (or even downright impossible) to live with. Relationships within the family deteriorate. Untold harm can be done. The writer of the important open letter is perfectly correct: there really is nowhere to go; no one to turn to. If the illness is a severe one—a psychotic one—then the uncertainty, the confused arrangements, the unintended but frightening breaches of confidentiality, the personal humiliation—all these can be appalling. I have seen arrangements made that were simply disgraceful in their disregard for the feelings of both the doctor and his family. I am sure that psychiatrists everywhere will know of such cases.

The anonymous Samaritan approach would be excellent, but the provision made should not be too complicated. It must provide the doctor with a direct line to a sympathetic, neutral colleague. The main outline of such a scheme could be as follows:

1. Initiative could come from the Regional Health Authority who could help to establish within a University Department an experienced psychiatrist whose designation might well be that of psychiatric counsellor and co-ordinator of the Samaritan-type group.
2. There could be local members of the group in each district or other convenient area.

The role of the local member would be to afford immediate support and advice to the doctor and his family. Thus, the doctor in difficulty could:

1. Ring the counsellor-co-ordinator directly, and according to the contingency of the moment arrange an interview at the Regional Samaritan headquarters to discuss long-term treatment, admission to hospital, etc.
2. The doctor could be referred, if he so wished, to the local member if a crisis demanded prompt help and intervention.

I think that counsellors or group members should be psychiatrists who have themselves experienced what it is to be in such a predicament. This need not be the only 'qualification' but it should be an essential one.

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DEAR SIR,

Referring to the letter by 'A Colleague', I suppose I qualify on the first count in that I did at one period consult a psychiatrist about my problems, although this was in war time but none the less real for that. Presumably I will qualify on the second count as a psychotherapist of quite long experience. In theory, of course, any psychiatric colleague under stress could appeal to any other psychiatrist of his own choosing