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†*Reading about. . .*

Liaison Psychiatry

by Z. J. Lipowski

In 1929, George W. Henry published a paper on 'Some Modern Aspects of Psychiatry in General Hospital Practice' and thus became the founder of what later came to be known as liaison psychiatry. He described his work as a psychiatric consultant at Cornell Medical School and advised that 'On the staff of every general hospital there should be a psychiatrist who would make regular visits to the wards, who would direct a psychiatric out-patient clinic, who would continue the instruction and organize the psychiatric work of interns and who would attend staff conferences so that there might be a mutual exchange of medical experience and a frank discussion of the more complicated cases'. This quotation spells out the essence of psychiatric liaison with medicine. The work of Henry and a few other pioneers bore fruit: psychiatry was at last brought into general hospitals and the mainstream of twentieth century medicine. This was a development of far-reaching consequence for both clinical disciplines, and a major landmark in the history of modern psychiatry.

By 1932 eight medical schools in North America had developed psychiatric liaison with the clinical departments of teaching general hospitals. These early efforts were given a boost with the funding by the Rockefeller Foundation of five general hospital psychiatric units in 1934, one of which was named 'The Psychiatric Liaison Department' (Billings, 1936). Its objectives revolved around 'sensitization' of physicians and medical students to psychological and social problems presented by 'medical' patients so as to achieve 'betterment of the patient's condition' (Billings, 1936). Psychobiology was to become an integral aspect of medical practice, thought and training. The term 'liaison psychiatry' first appears in this context in a paper by Billings (1939). Although he gave no formal definition, the author implied that the term referred to clinical, didactic and research efforts aimed at integration of 'the principles of psychobiology and psychiatry with those of general medicine' (Billings, 1939). An early evaluation of liaison work concluded that it reduced diagnostic and therapeutic errors and shortened hospital stay, and thus saved money for the hospital, patient and community (Billings, 1941).

'Liaison psychiatry' refers to that area of psychiatric practice which involves consultation to and collaboration with non-psychiatric physicians and other health workers in all types of medical care settings, but especially in general hospitals. 'Liaison' in this context is sometimes used more narrowly to imply regular contact maintained by a psychiatric consultant with a particular medical or surgical ward or clinic for the purpose of early detection, prevention and advice on management of behavioural disorders. Its general goal is to strengthen psychosocial aspects of patient care. Liaison, or consultation, psychiatry comprises clinical activities, consultative and therapeutic, as well as teaching and research pertaining to psychological responses to physical illness or injury and the related psychiatric morbidity. Furthermore, patients who seek medical attention for somatic complaints yet exhibit no relevant pathology also fall within the orbit of liaison psychiatry.

Between 1945 and 1978 a phenomenal growth of general hospital psychiatry in the United States took place. In 1945 there were 75 psychiatric units in general hospitals; by 1978 their number had grown to about 1,000. A body of knowledge has accrued that enriches general psychiatry and at the same time demands specialized training for liaison psychiatrists over and above that expected of the general psychiatrist. The whole area of psychopathology causally related to physical illness and its treatments, to hospitalization, and to various diagnostic procedures, has become a major focus for liaison psychiatry. Somatic manifestations of psychological and social stress are another focus. Liaison psychiatrists have contributed observations on such topics as doctor-patient relationship, illness behaviour, interpersonal dynamics on medical wards, and the impact of physical illness or injury in a family member on family dynamics. By the mid 1960's the

† An occasional feature in the Book Section where contributors give their personal choice of important, memorable or informative literature.

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field of liaison psychiatry was ready to emerge as an area of special interest, if not a subspecialty, within clinical psychiatry. What was needed was to bring together in a coherent framework the data, techniques, guidelines and premises pertaining to the work of psychiatric consultants to medicine. This task was undertaken in 1967/8 in the form of a tripartite review of the salient material defining the scope of consultation-liaison psychiatry (Lipowski, 1967a, 1967b, 1968). Its growth since then has been considerable.

Liaison psychiatry is viewed currently as an integral yet distinct component of general psychiatry. It is taught in most training programs for psychiatrists in the United States. Some 50 American psychiatrists hold post-residency fellowships in liaison psychiatry every year. Most psychiatric units in teaching general hospitals in this country feature an organized liaison service functioning as a link with all the other clinical divisions of the hospital. Such a service typically consists of one or more psychiatrists, and psychiatric nurses, social workers or clinical psychologists. As psychiatry in this country tries to talk its way into the ambivalently open arms of general medicine, liaison psychiatry has found itself at the growing edge of this intellectual and political courtship.

Much of the literature on liaison work is clinical and anecdotal. Not a single fully adequate textbook on liaison psychiatry has yet appeared. Volumes edited by Pasnau (1975) and Strain and Grossman (1975) are both of uneven quality, but taken together they offer a comprehensive overview of the field. A recently published book by Faguet *et al* (1978) is a refreshing and useful addition to this literature. It deals with aspects of liaison psychiatry seldom written about, such as consultations to the neonatal intensive care unit or to rape victims brought to hospital emergency departments. A particularly useful recent review of the history of liaison psychiatry as well as of its current state is offered by Greenhill (1977). He argues cogently that the recent rapid development of critical care medicine and of such areas as oncology has brought with it a rich crop of clinical problems whose diagnosis and optimal management would benefit from the input of liaison psychiatrists. An example of growing collaboration with critical care medicine is offered by Cassem and Hackett (1971), who report on their work as consultants to a coronary care unit. One-third of the patients admitted to the latter had been referred for psychiatric consultation.

A recently published annotated bibliography on psychosocial and psychiatric aspects of various medical specialities offers a useful guide to the literature directly related to the work and interests of liaison psychiatrists (Wilder, 1978). Several older papers stand out as classics of the generally rather mediocre literature on liaison psychiatry. Bibring's (1956) application of psychodynamic concepts to the understanding of behaviour of the physically ill is a pleasure to read and a rich source of clinically useful insights. Her paper represents anecdotal and didactic writing at its best. A different focus, one on interaction rather than on individuals, is illustrated by Meyer and Mendelson's (1961) unusually perceptive article on the interaction between patients and medical staff, and the role of the psychiatric consultant as a mediator trying to forestall disturbing patient behaviour by reducing interpersonal conflicts and tensions. Sandt and Leifer (1964) examine the process of psychiatric consultations in medical settings from the vantage point of communication theory. Finally, Payson and Davis (1967) illustrate the difficulties encountered in trying to evaluate the effectiveness of psychiatric consultation.

This brief survey will hopefully encourage a few readers to look up the works referred to. Once their interest is stimulated, they are likely to find plenty to challenge them in this recently revived and still very young area of psychiatry.

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Book Reviews

Psychosomatic Families: Anorexia Nervosa in Context. By SALVADOR MINUCHIN, BERNICE L. ROSMAN and LESTER BAKER. London: Harvard University Press. 1978. Pp 351. £10.50.

This book gives a general outline of the theory and practice of family therapy as practised by Minuchin and his colleagues and documents the application of this approach to a series of 53 young people with anorexia nervosa. They characterize the disorders of the dysfunctional family in terms of enmeshment, overprotection, conflict avoidance, rigidity and the involvement of the psychosomatic child in detouring conflict. The authors have developed a method for a reliable assessment of the variety of interactions used to maintain family dysfunction and this aspect of their work will appear in a separate publication. Comparing families with and without psychosomatic children, Minuchin *et al* find important differences in family interaction. Their earliest work was devoted to brittle juvenile diabetes and their demonstration that the rise of free fatty acids in their serum consequent upon a family interview is strikingly higher than in a control group, thus providing a clear psychophysiological basis for the variability of their diabetes.

The bulk of the book is devoted to the author's experience with anorexia nervosa. Their therapeutic results are outstanding not only in terms of weight gain and healthy psychological function but in the way that these results have been achieved with minimal periods of hospitalization and often with no hospitalization at all. The willingness and ability of both parents to participate in family therapy is already a major distinguishing feature of Minuchin's patients. In the general run of anorexics, parents are not always willing to become involved, particularly with older adolescents and in such cases problems of management are far greater. There are more zealous family therapists who are reluctant to initiate therapy unless the complete sibship is willing to attend. How pleasant it must be to work with such a highly motivated family but a double misfortune to the other patients let down by their family and without access to the services of this therapist. Such considerations may create strains and rivalries between those who practise family therapy exclusively and their colleagues who feel an obligation to provide a more generally applicable service.

The authors are less than fair to the early awareness of other workers in the field of the need to modify family dynamics in anorexia nervosa and to the legitimacy and effectiveness of methods other than conjoint family therapy for the achievement of this aim. To deny that conjoint family therapy is a panacea is not to detract substantially from the value of understanding the patient in the context of his

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