Section Meetings

Sir Aubrey Lewis chaired the meeting of the Research and Clinical Section held at the Maudsley Hospital, at which the following papers were presented: Measuring Social Characteristics in Patients and their Environment, Dr. Jacqueline Grad; Referrals by General Practitioners to a Psychiatric Service, Dr. Brian Cooper; Distribution of Alcoholism in Northern Scotland, Dr. C. McCance; Epidemiological Study of Drug Addiction in Crawley New Town, Dr. N. Rathod; Trends in Attempted Suicide in Edinburgh, 1962-1967, Dr. N. Kreitman.

At the Joint Meeting of the Child Psychiatry Section, the Mental Deficiency Section and the Forensic Psychiatry Sub-Committee Dr. P. Sykes read a paper on Delinquency from the Point of View of the Mentally Subnormal and Dr. W. L. Walker read a paper on the Role of the Child Psychiatrist in Delinquency. Dr. T. F. Main presented a paper entitled **"Demonstrations of Seminar on Psychosexual Problems"** at the meeting of the Psychotherapy and Social Psychiatry Section.

At the Film Show Mr. David Norris introduced the discussion following the viewing of **"Play and Development—The early education of the mentally retarded"**. The film **"Drugs and the Nervous System"** was also shown.

Adjourned Annual Meeting

The Minutes of the Adjourned Annual Meeting held on 8 February, 1968 will appear in a later issue of the *Supplement*.

ANNUAL MEETING, 1967

"The Place of Psychoanalysis in Psychiatry"

In opening the discussion on the papers by Dr. Main and Dr. Sutherland (see pp. 501 and 509) Professor Sir Denis Hill said:

One evening late in September, 1939 I was marooned in Crewe Railway Station owing to a missed connection. The station bar was filled with young soldiers, and there was much smoke and loud talk. It was here, on the 9 o'clock news, that I heard the announcement of the death of Sigmund Freud. The news was greeted with ribald laughter by the soliders, who did not wait to listen to the short account of Freud's life which followed. At the time I felt angry and contemptuous; but later, thinking it over, I asked myself whether there was any other physician, scientist, writer or philosopher of this or any other century who could have commanded such instant recognition, albeit with imperfect and prejudiced knowledge, from 30 or 40 young soldiers drawn from all walks of life.

Many people have attempted to assess the influence of psychoanalysis on psychiatry. There are those who believe that this influence was greatest in the years between the wars, and continued in the United States during the decade which followed the Second World War, but that it is now less than it was. Others believe that the influence has been greatest on art, literature and morals—that is to say on Western culture—less on sociology and biology, and least of all on psychiatry itself. Ernest Jones (1956), however, when he attempted an assessment of this influence on the occasion of the centenary of Freud's birth, said that it would be many generations before the full impact of Freud's work on psychiatry would be appreciated. In speaking of Freud I am, of course, speaking of the psychoanalytic movement itself, but I must differentiate sharply between the influence of psychoanalytic theory and the influence of psychoanalysis as practice. In this country—and in this we differ from the United States—the majority of psychoanalysts have in the past spent most of their time in the active practice of their technique for the alleviation of mental suffering, and were not able to make more than a slight impact on psychiatry in respect of therapeutic application. Only in recent years have a few psychoanalysts been appointed to Teaching Hospitals, and then, of course, to teach and practise psychotherapy—not specifically psychoanalysis.

Whatever the future holds for psychoanalysis as a specific form of intensive and prolonged treatment, there can be no doubt that this period of seventy years since 1895, thanks to the influence of psychoanalytic theory, has witnessed a revolution in medical history, comparable with the discovery of bacteriology. A large proportion of the sick population, previously regarded as suffering from obscure degenerative or hereditary disorders, previously the curse and also the source of income of neurologists and general physicians, have been firmly and finally recognized as disorders of psychological and social development. The revolution created by psychoanalysis, itself unable to cope with the consequences, has landed the burden heavily in the lap of psychiatry, the practitioners of which again for the most part have been wholly untrained to bear the load. The patients are very numerous, the amount of chronic invalidism and incapacity due to neurotic and personality disorder is only now being appreciated, and the demands on the Health Services, particularly the general practitioners, increase each year as the population becomes more sophisticated, better

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educated and progressively larger. The expectation of "psychological cures" by the public is very high —thanks to the publicity given to the changed prognosis for acute psychosis; but the hard fact is that the Mental Health Services of the country are very poorly equipped, intellectually, technically or numerically to deal with the huge problem of neurosis.

The number of trained psychoanalysts in the country has slowly increased, and is now over 300; consultant psychiatrists to psychoanalysts are therefore in the proportion of 3 to 1. Some analysts have tried to work in the National Health Service and have developed centres where special psychotherapy clinics and psychotherapy training, as opposed to formal psychoanalysis, have been developed. Dr. Main and Dr. Sutherland have spoken to us as senior representatives of two—in fact the only two—psychotherapeutic institutions within the N.H.S. in England which have developed from a basis of psychoanalytic theory and understanding. The influence of these two institutions on psychotherapeutic practice in the country has been far greater than their physical size or the number of psychoanalysts working in them would have led one to expect. Yet listening to them one realizes how far, in their hands and those of their colleagues, psychoanalytic *practice* has moved from the classical image of a diadic relationship between the couched patient and the analyst behind him, and sessions proceeding into the indefinite future. Gradually it seems to have changed to psychotherapy oriented towards the patients' interpersonal and social relationships, but using the insights derived from a stricter concept of psychoanalytic practice. At the Tavistock Clinic, training in psychotherapeutic skills rather than psychoanalysis has been offered to general practitioners, social workers and psychologists. The Cassel Hospital is the only purely psychotherapeutic National Health Service hospital in England. The hospital is manned by psychoanalysts, but I understand that psychoanalysis is not practised there. Analytically oriented psychotherapists of one persuasion or another are to be found on the staffs of teaching and non-teaching hospitals throughout the country, but in very small numbers and mainly in London.

Psychiatry itself in the last twenty years has experienced its own revolution, and psychiatrists now have greatly increased demands made upon them—in the community, in the general hospital wards, in the courts, in all areas of medicine where continuing care of the chronic sick, the defective, deformed, disabled or maladjusted is needed. The numbers of psychiatrists has now increased almost to a ceiling which is imposed by the shortage of medical manpower; but the numbers are still too few. In the medium-term future all that can be done will have to be done with existing resources. With an expanding population, expected to increase by 40 per cent. in 25 years, the proportion of the population who in the future can be recruited to the "caring" professions will be proportionately fewer than at present and the proportion of the population for whom care will have to be provided will be proportionately greater. This is inevitably so as far as the two ends of life are concerned, for invalidism here is dependent upon relatively unchangeable biological factors. It may not be inevitable in that large area where chronic distress and invalidism are the consequence of psychological and social factors, if science can provide radical answers to the major problems of *prevention* and/or *effective short-term* treatment. Neither psychoanalysis nor psychiatry seem to be within hailing distance of this. Are we then to be satisfied with a policy of attempted containment of these problems—to assess the numerical need, to dispose our limited resources of professional personnel to best effect, to give tranquillizers and psychotropic drugs when they seem appropriate, to provide some social and psychotherapeutic help—until the number of patients requiring it outstrip its availability—and by mutual support and mutual help within the professions and groups concerned make it emotionally possible for us as individuals to do this sort of work?

We have all listened with great interest to our two speakers this afternoon. I was particularly interested in Dr. Main's dissection of the psychoanalyst's skill—what he called the coenaesthetic function of deliberate and controlled empathic identification with the patient's inner emotional life, a form of visceral perception quite foreign to the physical and biological sciences, and eschewed by them as being too uncontrolled and too subjective. Then he has contrasted this type of perception with what he called the "diacritic" perception, which consists of the conscious logical evaluation of the resultant data and the formulation of predictions or hypotheses to be tested by the therapists' interpretations. This diacritic function is what clinical medicine and psychiatry call *diagnosis*, but psychiatry itself, as taught in most of our teaching centres, eschews the coenaesthetic or empathic function and relies for its hypotheses and predictions on the verbal communications and overt behaviour of patients. Psychoanalysis criticizes, and I think rightly, psychiatry's total dependence on its limited sources of data. Psychiatry in its turn on the other hand, criticizes psychoanalysis for its overdependence on the coenaesthetic function and for ignoring the sources of data which it, psychiatry, can make available and use. It goes further, and says that

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predictions based on coenaesthetic perception alone, and tested by the method of interpretation alone, are very difficult or even impossible to validate. Nevertheless, speaking as a psychiatrist, I think if we are honest we will admit that the best clinicians among us are those who use both forms of perception of their patients, and that the empathic skills to which Dr. Main has referred are very important. Those who find themselves able to accept and to use the main concepts of psychoanalytic theory may regret that in psychoanalytic practice no other method for the validation of hypotheses than the interpretative method has been evolved.

Ernest Jones once said that of the first generation of psychoanalysts there were only four who had had a psychiatric training. In England this situation has certainly changed—perhaps 20 per cent. have entered psychoanalysis from psychiatry, and in America the majority have done so. The opposite situation—to enter psychiatry from psychoanalysis—must be very rare. The most vocal opponents of psychoanalysis have always been psychiatrists. Those psychiatrists who have become psychoanalysts for the most part abandon their previous medical and psychiatric training; they are usually no longer willing to examine patients physically or indeed to use any of the medical or psychiatric skills they have previously acquired. It often seems that this long period of medical education has been wasted. We know there are ideological reasons for this.

Dr. Sutherland has outlined how, working from the models which the Tavistock Clinic and the Institute of Human Relations have developed, it may be possible to provide psychotherapeutic facilities for the community. The psychotherapeutic clinic and the psychotherapist, who would be an expert in human relations and in "psychological disorder", would be a component in a comprehensive Mental Health Service. This means, since such a service will undoubtedly be organized from a psychiatric base, that psychiatrists and psychotherapists will have to work together, actually and ideologically; otherwise two separate services would develop. But the truth is that there is no hard and easy line to be drawn between incapacity which is wholly due to psychological or social disorder and that which is due wholly to physical incapacity or physical disease. The problems of diagnosis are now complex, and increasingly many skills are needed to unravel them. Unless diagnosis is as complete as it can be, the therapeutic goals can be mistaken or unrealistic. Yet within the total setting of diagnostic appraisal, the approach to the patient or to the family's problems must, I believe, be essentially psychotherapeutic. There is no other language for this than a psychological language, and I would agree with Dr. Sutherland that for this purpose the vocabulary of everyday life is adequate, but all professional persons, be they psychiatrists, psychotherapists, social workers or psychologists must "share the framework" in which their work is done.

If this common "framework" is necessary for all, how can it be created? It will be necessary for more psychoanalytically trained workers to enter the N.H.S. and to give most of their time to it. The majority of those who enter psychoanalysis from a previous background of psychiatric training must be encouraged to return to the psychiatric scene, to seek hospital appointments, particularly in Teaching Hospitals, where one day the majority of future psychiatrists will receive their education, if not their training. We psychiatrists must also look to our training programmes to make sure that our priorities are right. Psychiatry is now a vast subject, with many sciences contributing to its body of knowledge, and there are valuable and worthwhile careers for many sorts of psychiatrists, differing by interest and temperament. Psychoanalysis has failed to provide psychiatry with immediate short-term therapeutic answers to any of the major problems of psychiatry applicable to the two million or so patients whose neurotic burdens the N.H.S. has somehow to bear. Nor has psychoanalysis any clear charter, as yet, to offer preventive medicine. In the decades to come it is improbable that pharmacological agents and experimental psychology or behaviour therapy will provide means of supplying relief from many symptoms. Nevertheless the common "framework" of understanding and insight which dynamic psychology offers, and which is necessary for all those in the "caring" professions, must have a central place in our educational system. Psychiatrists who lack this in the future will be poorly equipped to do their job.

If the future, looked at from the point of view of our Mental Health Services, gives rise to anxiety, and if the numbers of professional people who will be needed to man them fall far short of what will be required, it is clear that the greatest impact of psychoanalysis has been and is being made on those who enter the "caring" professions from the background of social science rather than from medicine. I have no doubt that such people, working with general practitioners, will carry the main burden of treatment of neurotic patients in the future. It will be odd if general practitioners and social workers should come to have greater skill and understanding of these problems than psychiatrists.

Psychiatry needs psychoanalysis now as much as psychoanalysis needs refreshing with modern psy-

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chiatric knowledge, if the future of both is not to run into the byways of disillusion or to start a regressive process. Psychiatry, beset by its vast numerical responsibilities, is in danger of abandoning the traditions which were started at Cos 2,500 years ago and of reverting to the Cnidian practice of treating symptoms by specifics—becoming the technical servants of the pharmaceutical industry. Empiricism will replace logic, and the patient as an individual suffering a crisis in his psychosocial adaptation will be ignored. Psychoanalysis needs psychiatry because, unless its practitioners become willing to take a long and open-minded look at the psychiatric scene as it exists in 1967, rather than as it existed fifty years ago, they will never know what are *now* the important questions to answer.

SCOTTISH DIVISION

The Winter meeting of the Scottish Division was held at the Royal College of Physicians and Surgeons, Glasgow, on 1 December 1967, under the Chairmanship of Dr. A. K. M. Macrae.

The Division noted with regret the death of Dr. D. Ewen Cameron.

The report from the Committee of Management was read, and it was agreed that the March meeting be devoted to a discussion of the Report on the Organization of Medical Work in the Hospital Service in Scotland.

The following were elected Members of the Association:

PRIMROSE, DAVID ALEXANDER ANDERSON, M.D., Consultant Psychiatrist, Lennox Castle Hospital, Glasgow; Greenways, Kirkintilloch, Glasgow.
Proposed by Drs. R. C. MacGillivray, G. E. Swinney, J. Sinclair.

TAYLOR, KATHLEEN, M.B., Ch.B., Medical Assistant in Psychiatry, Murray Royal and Murthly Group of Hospitals; Eastfield, Murthly, Perth.
Proposed by Drs. T. A. Wylie, H. Stalker, W. McClatchey.

WILSON, THOMAS SCOTT, M.D., D.P.H., Deputy Medical Officer of Health, Glasgow; 76 Stewarton Drive, Cambuslang, Glasgow.
Proposed by Drs. M. P. Menzies, R. C. MacGillivray, J. Campbell.

Dr. W. A. Elliot read a paper on **"Recommended Admissions—A review of Recommended Admissions to Gartnavel Royal Hospital from 1962–1967".**

Dr. J. McCurley read a paper on **"Mental and Physical Illness in Elderly Patients in South-West Glasgow".**

Both papers were followed by questions and discussion, and the Division is grateful to the speakers for their contributions.

A Historical Exhibition concerning Dr. John Moore, prepared by Dr. A. Allan Bell, was on display in the College Library.

THE RICHMOND FELLOWSHIP

By MISS ELLY JANSEN, *Director and* PROF. D. A. POND, *Hon. Psychiatric Adviser*

THE RICHMOND FELLOWSHIP was founded by the present Director in May 1959, and is a registered Charity. Its aim is two-fold: to help people who are emotionally or mentally disturbed to make a better adjustment to life, and to promote understanding of people and their relationships so that society may become better equipped to help its disturbed members and also to prevent breakdown. To further these aims the Fellowship provides facilities for community life and individual support on a short- or long-term basis, and now has twelve half-way houses, four of which provide for particular groups: adolescents, students, alcoholics, and mothers with small children. It is envisaged that, with increasing experience and knowledge of different requirements, there will be increasing differentiation in the selection of various groups: for instance, it is recognized that many schizophrenic residents need more intensive care over a longer period than is usual in the present houses, and that students and adolescents need the company of others of the same age and interests, and in order to share the specific problems of growing up and adjustment to adult life. For this reason most of the houses at present in the planning stage provide for a particular group, and it is hoped that the projected schizophrenia unit, the Manchester house for students, and the London houses for adolescents and for those addicted to drugs will be realized in the near future.

The Fellowship has now acquired a house in central London as administrative Headquarters and College, where many of the educative aims are carried out. The success of the houses clearly depends on the quality of the staff, most of whom need special training in principles of group work in a psychiatric setting. A two-year in-service course in group work

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