A Socio-Psychological Study of a Community

in the

North of Scotland

by

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Preface

Practising in a small community leaves one in little doubt of the results of one's therapy. This and certain personal factors were the stimuli which have culminated in this thesis.

Owing to the relative isolation much has been learned the hard way, nevertheless it is a pleasure to record my thanks to those who have helped me in various ways, and in particular I would like to mention:-

Dr Michael Balint, The Tavistock Clinic, London.

Drs Martin Whittet and Ronald F.Caddell,
Craigdunain Hospital, Inverness.

Professor T.Ferguson Rodger, The University, Glasgow.

H.M.Registrar General for Scotland, Edinburgh.

H.M.Registrars of the parishes of Clyne and Kildonan, and the Burgh of Inverness.

Dr G.F.M.Braid, Rogart, for statistical help.

Brora,
1960.

E.J.R.Primrose.

Introduction

Most of the investigations of mental ill health in communities have been by psychiatrists using official statistics. These studies have used different methods and have had differing objects (Reid(1)). The methods by and large fall into two groups; the first, by population census with case finding from official sources such as hospital admissions and clinic attendances, suicide and police records, education authority classifications etc., (Lemkau et al.(2), Roth & Luton(3), Øedegaard(4), Sjogren(5), Mayer-Gross(6), Øedegaard(7), Carstairs & Brown(8), Hollingshead & Reddlitch(9)); the second, by longitudinal study of a number of births followed up over a long period (Klemperer(10), Fremming(11)).

The differing objects have included demonstration of genealogical factors (Sjogren(5)), the effects of social class (Hollingshead & Reddlitch(9)), of social factors in contrasting communities (Carstairs & Brown(8)), and of social attitudes in relation to the forms of illness (Eaton & Weil(12)).

It is generally accepted (Report of Working Party of Council of College of General Practitioners(13)) that approximately one third of patients receiving medical attention from their doctor suffer from illness whose origins are psychological. Most of this illness does not go beyond the general practitioner and so does not reach the official statistics of the hospital psychiatrist. For a more comprehensive assessment of mental illness in the population, field work is necessary and such studies have been few in number and varying in intensity. The more intense include those of Bremer(14) who as general practitioner to a village in Northern Norway during World War II, described the community and its psychic exceptionals over a period of five years; Eaton & Weil(12) who as psychiatrists investigated the strictly religious sect of Hutterites in North America; and Lin(15) who investigated three different communities in Formosa.

A World Health Organisation Report(16) calls for further socio-psychological studies and this thesis by the general practitioner of a small community is a further contribution in which the social factors, community attitudes and prevalence of mental disturbance are described and discussed. A final chapter on psychotherapy is

included as it is the author's belief that this form of therapy is an important facet of general practice.

Living in a small relatively isolated community as sole practitioner, one readily gets to know everyone and their problems and illnesses which they can rarely conceal. In addition, as the practice is entirely National Health Service there is no financial barrier to treatment. The intimate contact with the community also has considerable influence on psychotherapy which will be discussed under that heading.

It is fortunate that the practice comprises almost all of one civil parish for which census and other official records are available.

Chapter I

Description of the Community

Social Factors

Geography The Parish of Clyne is situated in the North of Scotland in the East coast of the County of Sutherland. (See map overleaf)

Most of the population live in or near to the village of Brora which is situated at the mouth of the River Brora. The trunk road and railway from Inverness to Wick run through the village and provide limited public services - so limited that the ownership of private cars is at a high rate compared with the rest of the country.

The climate is temperate and there is little natural shelter; strong winds and snowstorms are common in the winter. The average rainfall is about 30 inches per annum. There is a small harbour at the mouth of the river and an excellent beach and golf course which serve to attract some summer visitors. The inland part of the parish consists mostly of moors and mountains forming parts of various sporting estates which depend on deer, grouse and salmon.

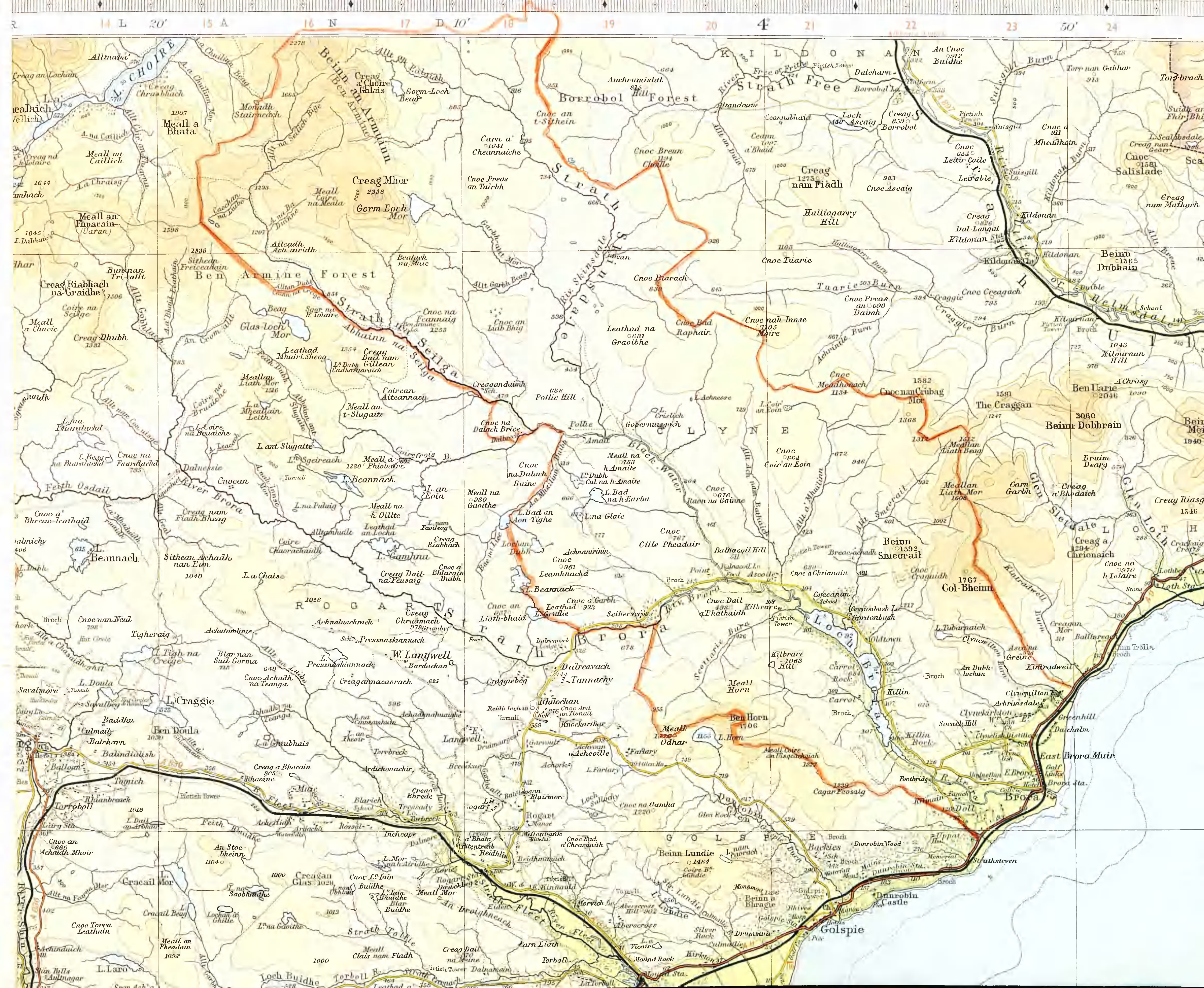
History As far back as records go the parish has been dominated by the Earldom of Sutherland whose seat, Dunrobin Castle, in the neighbouring parish of Golspie is some five miles south of Brora.

At the time of the First Statistical Account of the Parish in 1794, the greater part of the population was in the inland part of the parish - 960 persons, compared with 700 in the lowland coastal area.

In the second decade of the 19th century the "evictions" or "clearances" took place during which most of the inland population was driven off the land by the Earls of Sutherland in order to make room for sheep. Bitter resentment for this is still expressed by many natives of the parish. Some of those evicted went abroad but many were able to fit into the lowland part of the parish around Brora, where a coal pit, saltpans, a brickworks, stone quarries, a distillery and fishing, helped to provide employment. The coalpit and its attendant industries (saltpans and brickworks) closed from 1828 to 1872 when the mine and brickworks reopened and since then have been in more or less continuous operation, now employing about 50 persons. A wool mill started in 1890 has flourished and now employs about 100 persons. Seafishing formerly active, now supports only two small vessels, partly due to the formation of a sandbar at the

PARISH OF CLYNE

OUTLINED IN RED.



K I L D O N A N
Borrobol Forest
Strath Free
Auchrumistal Hill
Beinn an Armuinn (Ben Armine)
Creag Mhor
Gorm Loch Mor
Meall a Bhata
L. Choire
Strath Skinsdale
Cnoc Breun
Creag nam Fiadh
Halligarry Hill
Cnoc Tiarie
Tuarie Burn
Kildonan
Beinn Dubhain
Ben Armine Forest
Strath Seilga
Abhainn na Seilga
Glas-Loch Mor
Creag Riabhach na Graidhe
Creag Dhubh
Cnoc Biarach
Leathad na Graoibhe
Cnoc Bad Raphain
Cnoc nan Innse Moire
Cnoc Meadhonach
Cnoc nan Craibag Mor
The Craggan
Ben Uarie
Beinn Dobhrain
Kilournan Hill
Pollie Hill
C L Y N E
Black Water
River Brora
Cnoc Dail a' Bhathaidh
Loch Brora
Beinn Smeorail
Col-Bheinn
Meallan Liath Mor
Meallan Liath Beag
Glen Loth
R O G A R T
Strath Brora
W. Langwell
Dalreavach
Tannachy
Ben Horn
Meall Horn
Meall Odhar
L. Horn
Kilbraire Hill
Carrol Rock
Killin
Clynekirkton
Clynelish Distillery
East Brora Muir
Brora
Brora Sta.
Golf Links
Doll
Cagar Feosaig
L. Craggie
Ben Doula
L. Doula
Gracail Mor
Creagan Glas
Rogart
Rogart Sta.
R. Fleet
Strath Fleet
Strath Tollie
Loch Buidhe
G O L S P I E
Beinn Lundie
Dunrobin Wood
Dunrobin Castle
Golspie
Strathsteven
Backies
Mound Sta.
Mound Rock
Aberscross
Tamich
Torroboll
Lairg Sta.
River Shin
4°
50'
20'
10'

harbour mouth and partly to deterioration of the fishing grounds. The distillery makes a fine malt whisky and now employs about 20 persons.

A Government radio station established in 1939 has brought many incomers to the community, many of the operators having married local girls. These incomers have had a beneficial influence in the community helping to broaden its outlook. Two County Council departments, five hotels, various retail shops, small workshops and garages provide other employment. In spite of this seasonal unemployment exists particularly in the hotel and building trades.

Agriculture is represented by a few farms and many crofts (smallholdings).

Education is traditionally held in high regard by the Scots and this parish is no exception. The parish school provides a good education up to the age of 15 and scholars of ability can go on to 18 years in one of the county high schools and with the aid of generous financial grants, from there to University. No child of ability is nowadays prevented by financial considerations from obtaining a higher education.

Other social educational activities include a well patronised public library, Boy Scouts, Girl Guides, country dancing, badminton, Women's Rural Institute and classes in sewing, baking, art, woodwork and piping. There is also an active Red Cross Division, a Masonic Lodge, a struggling dramatic club and an Amenities Association which runs the local cinema which is now falling on evil days. B.B.C. television has been available since 1955 and many households now have a set. Coincident with spread of TV throughout the community there has been a marked decline in attendance at most of the clubs and night classes and it appears that the community is becoming, like the rest of Britain, more "home centred" (Abrams(17)).

In discussion with older members of the community it is apparent that until the recent war, passions would be easily roused on such subjects as religion, politics and sport. For instance it was quite usual for 200 persons to support the football team when it played away, now 20 supporters would be considered a crowd. Since 1945 passions have been less and less obvious. The last event which revealed a strong community spirit was the Coronation in 1953. Probably a strong community spirit still exists but is dormant.

Health Services The general medical services are provided by the author, sometimes assisted by a trainee

assistant, a district nurse, two visiting dentists and a resident chemist.

The hospital services consist of a 20 bed surgical unit 6 miles from Brora where there is a resident surgeon, and consultants from the main hospital centre in Inverness attend periodically to hold clinics. The mental hospital is also in Inverness which is 75 miles from Brora.

Public Health measures are well supported by the community. Inoculation and mass miniature X ray schemes are well attended. Two negative attitudes however exist, in respect of teeth where conservative dentistry is not indulged in by a considerable number and in respect of breast feeding which is also not favoured.

The Housing of the community is generally good there being 204 council houses and 12 radio station houses. Generous Government grants have enabled many others to improve their houses.

Crime is not a serious problem. Nearly all of it is associated with excessive consumption of alcohol, in the forms of assault or drunken driving. Poaching is prevalent but few regard it as criminal.

Religion is represented by four churches in the community. The great majority of the population being nominally presbyterian either Church of Scotland or Free Church. There are also a few Roman Catholics (13 over 18 years) and Scots Episcopalians (12 over 18 years). Church attendances average about 140 in the Church of Scotland and 160 in the Free Church for persons over 16 years of age. There is a strong tradition of Calvinistic puritanism which is gradually dying out although it still retains a strong influence in local affairs. A local author (Charteris(18)) has described somewhat satirically but with considerable insight the conduct of local affairs and also several "types" from this and neighbouring parishes.

Social Attitudes The customs associated with the major emotional stresses of life vary from one society to another. They are of interest because they illuminate and sometimes determine the pattern of mental illness (Volkhart & Michael(19)). In this parish in addition to the common emotionally intensifying situations attached to reproduction, death and severe illness, there are significant attitudes related to New Year Celebrations, Alcohol, mental illness and winter storms.

Reproduction Very few parents in the community give their children any sex instruction although they welcomed a talk to their daughters given in the school on one occasion. In spite of the apparent success of this it has

not been repeated, probably because of unconscious resistance by those in authority.

Childbirth normally takes place at home and is generally regarded as a natural event. Emotional difficulties during labour are infrequent and analgesia is often declined. It has been found possible to trace every pregnancy and its termination and the date of marriage for the five years 1955 - 1959. Reference to the Registrars of Births, the District Nurse, the practice records and other sources, reveals that of a total of 155 pregnancies 68 were first pregnancies and of these, 24 were conceived out of wedlock. Expressed otherwise 35.3% of first and 15.4% of all pregnancies were conceived out of wedlock. 24 of these pregnancies ended in abortion of which 7 were first pregnancies. None of these aborted pregnancies were conceived out of wedlock and in no case was there any evidence to suggest illegal interference. This contrasts strongly with Bremer's (14) experience in Norway where 35.8% of 123 pregnant women wanted, attempted or carried out an abortion. He ascribed this high rate to the unfavourable economic factors in their lives.

All but two of those who conceived out of wedlock married before the birth of the baby. In most cases they had been courting for some time and a reasonable outcome is expected, however a few of the "shotgun" marriages seem particularly illmatched. The two mothers who did not marry were confined away from the area but have returned with their babies and have been accepted into the community and their homes.

Prostitution is non existent and homosexual practices are thought to be rare; coitus interruptus is widely practised both before and after marriage.

Marriage Almost all of the weddings take place in church although in many cases the couple are not normally churchgoers. The reception after the wedding is frequently an occasion for excessive consumption of alcohol.

Death The usual attitudes to death differ according to whether the death is expected or unexpected. In an older person it is expected sooner or later and when the end approaches the relatives gather round in a friendly way, happy and expectant, and when death comes they speak of the "happy release". In a younger person however there is considerable distress amongst the relatives, as one would expect, but in addition a blight is cast over the whole community and an exceptionally large attendance at the funeral can be expected. Also during the following weeks it is quite common for a few patients to appear at the surgery with symptoms arising from fear of having the same

disease as the deceased.

The funeral customarily is attended only by the men of the community. It is a point of honour to attend and some of the more puritanical believe they gain unction thereby. Very little emotion is shown by the men and the women show some but in a restrained manner.

New Year As elsewhere in the North of Scotland the great annual celebration is the New Year and although it is gradually losing ground to Christmas it is still the more important celebration. During the last fortnight of the year the housewife prepares for entertaining and the husband for drinking which starts in earnest on Hogmanay. Most families see in the New Year at home and for the first day or two of the year they "first foot" their friends. This visiting is done mostly by the menfolk, each being armed with a bottle of whisky. In each house a dram is given and taken and there is a great spirit of cordiality and good fellowship.

The signs of stress at this time are seen mostly in the housewives during the period of preparations and they appear to be associated with the additional work and expense and more especially with the uncertainty of the results of their menfolk's celebrations.

Snow Storms Each winter in January or February there is usually a severe snowstorm with drifting which disrupts communications. The older croft houses with their smaller windows suffer a "closing in" by reduction of the already poor light by snow formation round the windows and by reduction of sound and draught as doors and ventilators are sealed off. This has been observed to have a depressing effect particularly on older people probably by its reduction of their normal level of stimuli. Younger people who are not so confined to the house have not shown this state.

Alcohol In the Highlands of Scotland whisky has had an important place in the lives (and deaths) of the people. This community is no exception. By tradition whisky is the water of life and it is still widely thought to have valuable medicinal properties. It is kept in almost every home for emergencies and it is even given to sick infants and animals. It is always proffered at confinements and its importance at New Year and weddings has already been noted. It is little wonder in such an environment that alcoholism is not looked on as an illness nor is it condemned by the community who are more likely to treat the matter as a joke. What condemnation there is comes from the suffering relatives and occasionally from the sheriff when police action arises.

There are five public bars and one licensed grocer in the village. The public bars are "men only" establishments

as is customary in Scotland. The usual drinks are neat whisky washed down with beer. Considerable drinking by both sexes occurs in connection with dances; this precipitates most of the crime in the community which takes the form of drunken violence or drunken driving.

At the distillery the workers receive a generous ration of strong raw whisky once or twice a day. This is given to try to reduce the pilfering of matured whisky but in spite of this considerable pilfering goes on. The effects of this continual drinking are reflected in the ill health of the workers and there is no doubt in this author's mind that the distillery is the most dangerous place in the community in which to work.

The nearest branch of "Alcoholics Anonymous" is in Inverness which is too far away for attendance by any of the few alcoholics who have recognised that their behaviour requires help. To help in this problem the mental hospital in Inverness has offered to accommodate anyone wishing to attend Alcoholics Anonymous; in spite of this only one person in eleven years has made use of this offer.

It is considered that the high cost of alcohol is the only effective deterrent in this community.

Mental Illness The nearest mental hospital, in Inverness, is 75 miles away and during the last eight years has come under enlightened new management and has been transformed from an asylum into a pleasant modern mental hospital. Previously it was very difficult to persuade patients to go in, but in recent years a great change has occurred and now it is not uncommon for patients to come and ask to be sent there.

There is still some evidence however of old fashioned attitudes especially amongst the more ignorant and amongst the older people who still tend to think of it as the madhouse.

The attitude to senile psychosis is generally tolerant; neurosis is often described as "the nerves". Of the few neurotics who have been to the mental hospital several have experienced difficulty in meeting people on their return to the community - they feel they are being looked at and talked about. This arises because it is impossible to prevent their admission to the mental hospital from becoming common knowledge and because of the deprecatory attitude of some of the community. It is thought that this attitude is changing for the better probably because of the propaganda to this end which has been evident for some years in the press, magazines and from the B.B.C. in such programmes as "The Hurt Mind" and "Lifeline".

Community Statistics

1. The AREA of the parish is 74,504 acres.

2. The POPULATION DENSITY at the 1951 census(20) was approximately 2 persons per 100 acres.

3. The FLUCTUATIONS of POPULATION are shown in Table I. The figures are from the official censuses except for 1960 which are the authors count.

Table I

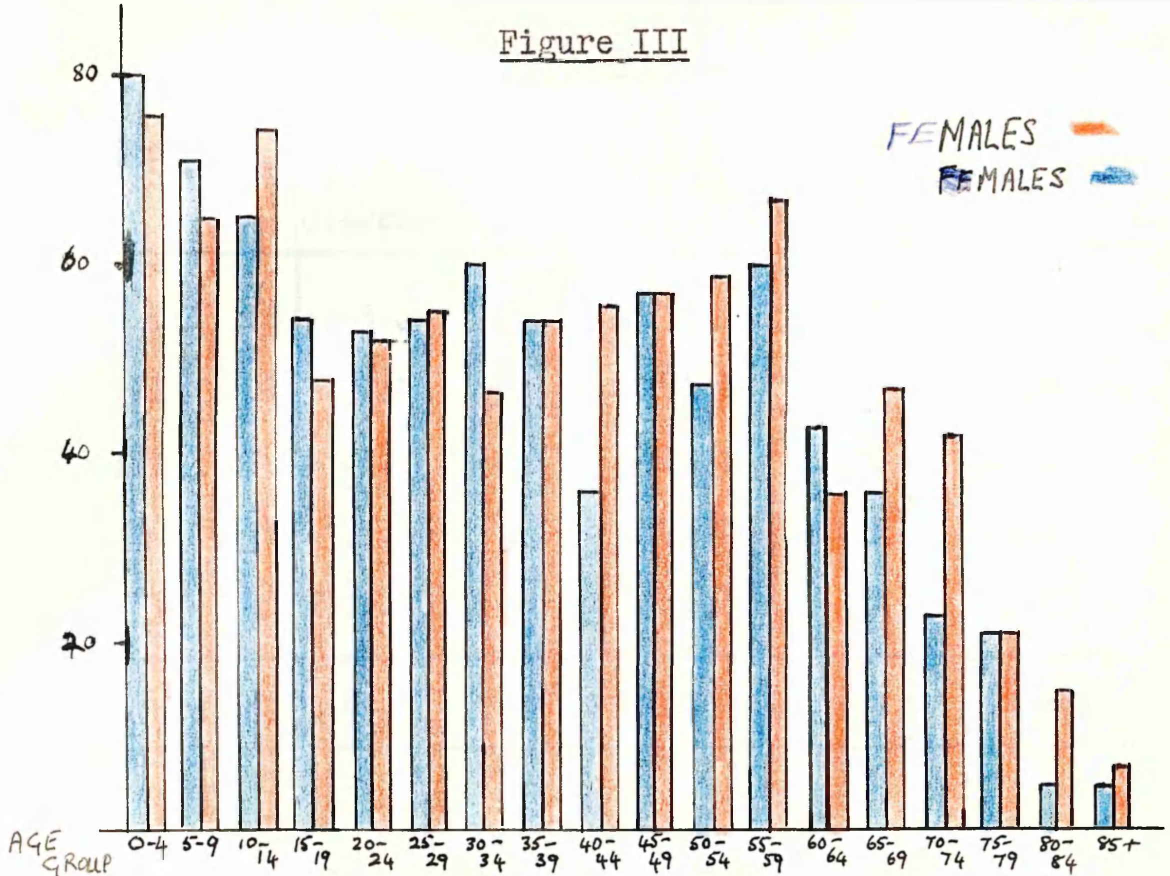
Census Year	Population
1801	1643
1811	1639
1821	1874
1831	1711
1841	1765
1851	1933
1861	1886
1871	1733
1881	1812
1891	1713
1901	1724
1911	1749
1921	1616
1931	1723
1951	1730
1960	1701

4. A QUINQUENNIAL AGE AND SEX DISTRIBUTION of the parish was made by the author as nine years had elapsed since the last official census. Included were residents temporarily away from home on holiday, on courses or in hospital; excluded were visitors and those on national service. The count was made from the practice files and checked where necessary against the National Health Service records in the offices of the local Executive Council, a few ages were obtained direct from the persons concerned and a few more from the registrar of births. The effective census day was made 29th February, 1960 and the results are shown as a table in Figure II and as a histogram in Figure III.

Figure II

Age Groups and Years	Male	Female	Both Sexes
Under 1 yr	15	9	24
1 - 4	65	67	132
5 - 9	71	65	136
10 - 14	65	74	139
15 - 19	54	48	102
20 - 24	53	52	105
25 - 29	54	55	109
30 - 34	60	46	106
35 - 39	54	54	108
40 - 44	36	56	92
45 - 49	57	57	114
50 - 54	47	59	106
55 - 59	60	67	127
60 - 64	43	36	79
65 - 69	36	47	83
70 - 74	23	42	65
75 - 79	21	21	42
80 - 84	5	15	20
85 & over	5	7	12
Totals	824	877	1701

Figure III



5. The LANGUAGE of the community is English but it has not always been so as is shown by Figure IV derived from the 1951 Census. Gaelic is no longer taught. In 1951 the total number of Gaelic and English speakers was 156.

Figure IV

All Gaelic speakers as percentage of population.

Year	1881	1891	1901	1911	1921	1931	1951
%	73.9	69.8	69.0	49.3	41.4	24.8	9.0

6. The SOCIAL CLASS statistics were kindly supplied by the Registrar General for Scotland and they are shown below in Table V. Although nine years have passed since the census from which they are derived it is thought that as the employment structure of the community has changed little they will still be applicable for this study. Of 837 males 602 were classified and of 893 females 187 unmarried gave an occupation which was classified

Table V

Class	Males		Females		Both Sexes	
	No.	% of all classified	No.	% of all classified	No.	% of both sexes cl'f'd.
I	18	3.0	0	0	18	2.28
II	108	17.9	41	21.9	149	18.8
III	284	47.2	90	48.1	374	47.4
IV	127	21.1	48	25.7	175	22.2
V	65	10.1	8	4.3	73	9.25
Totals	602	99.3	187	100	789	99.93

In SUMMARY we have a moderately prosperous and stable population of Calvinistic traditions with tendencies to shotgun weddings and excessive consumption of alcohol, in transition from harder times to the sophistications of modern gadgetry.

Mental Ill Health in the Community

In an attempt at comprehensiveness various methods were employed in order to discover as many cases as possible of mental illness in the parish. All cases which were active at any time during the year ending with the census day (29th February, 1960) were recorded. Most cases were encountered during the routine of the practice but reference was made to the District Nursing Officer of the parish and to the Medical Officer of Health and to the Educational Psychologist of the County of Sutherland in order to confirm the list of defective and backward children. Likewise communication with the Medical Superintendent of the Mental Hospital serving the area confirmed the list of those of the community who were resident there. Some alcoholics were not encountered professionally during the year but the continuance of their previously known addiction was observed "en passant". Finally, the practice records were scrutinised to discover cases seen by holiday locum and trainee assistant.

All the cases were recorded on cards to show age, sex, marital status, social class, diagnosis, and whether given long interviews. Social class was assessed according to the Registrar General's Method (21), dependant relatives being given the class of their breadwinner and retired persons that of their occupation prior to retiral. Diagnosis was made in terms of the International Classification of Diseases (22) which although not entirely satisfactory is, of the 58 current systems of classification of mental disease (23) the only international system and is sponsored by the World Health Organisation. Psychomatic illness was only diagnosed where the somatisation was clearly dependant on emotional factors.

The figures shown in the various tables for the illnesses are for persons and the rates are shown as period prevalence rates (Reid(1)), the period being one year.

The PSYCHOSES

Table VI

International Class Number	Diagnosis	Male No.of Cases	Male Rate/1000	Female No.of Cases	Female Rate/1000	Both Sexes No.of Cases	Both Sexes Rate/1000	Both Sexes Mod'f'd R/1000
300	Schizo: phrenic disorders	2	2.4	1	1.1	3	1.8	3.0
301	Manic - Depressive Reaction	1.	1.2	5	5.7	6	3.5	7.1
302	Involutional melancholia	0		1	1.1	1	0.6	
303	Paranoia	0		0		0		
304	Senile Psychosis	2	2.4	4	4.6	6	3.5	40.0
306	Psychosis with cerebral arterio: -sclerosis	2	2.4	0		2	1.2	
308.2	Other Psychosis	0		2		2	1.2	
	Totals	7	8.5	13	14.8	20	11.7	

Table VI shows the numbers of the different types of psychotics encountered during the year. The modified rates are calculated by Weinberg's method (Reid(1)) which is fashionable in these studies and is designed to allow for the differences in age structure between populations so that the prevalence of diseases which occur chiefly in certain age groups can be more readily compared. For example the schizophrenias arise most commonly during the years between 16 and 40. The rates here have been calculated on the following age groups:- schizophrenia 15 - 39; manic depressive reaction 20 - 49; senile and arteriosclerotic psychosis 60 - 100. In the manic-depressive group one patient was hypomanic and the remainder were depressed. The two patients with psychosis secondary to organic disease suffered respectively

from disseminated sclerosis, and afferent loop syndrome following anastomosis for bowel obstruction originally thought to be malignant.

According to Lin (15) the commonly accepted ratio of schizophrenic to manic-depressive illness in civilised communities is about 3:1. He quotes the ratios in other countries as Formosa 2.5:1, Thuringia 3.4:1, Bornholm 1.7:1, Sweden 1.4:1, Norway 2.6:1, Hachijo Island 3.2:1, Japan (Komoro) 1:1.7, New Zealand Natives 1:2 and Taiyal Tribe in Formosa 1:3.

That the standard of diagnosis can affect these figures is shown by Bremer's (14) figures. He classifies 6 cases of schizophrenia and 2 as manic-depressive but of 18 other cases shown as "Constitutional psychosis" 11 were depressed and 2 in exalted states, and of the 6 cases classified as "psychosis of uncertain origin" he states they are mostly schizophrenic. If these cases had been diagnosed according to the International Classification the number of schizophrenics would probably have been about 10 and the number of manic-depressive reaction about 15 which would alter his ratio of schizophrenia to manic-depressive from 3:1 to 1:1.5. Reference to TableXXI on page 28 will show that most other workers have a lower proportion classified under "other psychoses" which suggests they had less rigid ideas of the diagnoses of the schizophrenic and manic-depressive reactions.

Eaton & Weil (12) have suggested that a possible factor in the direction in which psychosis develops, is the extent to which the religious environment enhances the sense of sin and guilt in the members of a community. They studied the puritanical sect of Hutterites and found a ratio of 1:4.3. In this Parish of Clyne the ratio is 1:2 and study of the latest report (24) of the Mental Hospital which serves the Northern Region of Scotland (Counties of Inverness, Ross and Cromarty, Sutherland and Caithness and the Western Isles), shows both in outpatient and hospital admission data a marked preponderance of depressive illness over schizophrenia with an overall schizophrenic to manic-depressive ratio of 1:3.2 for admissions. Admittedly these figures are based on all depressions including neurotic depressions but it is thought that relatively few neurotic depressions would be admitted. The religions of this area are on the whole guilt ridden and the high proportions of depressions may well be a reflection of this.

<u>Senile and Arteriosclerotic psychosis</u> rates are likely to be much affected by the proportion of old people in a population and as it is known that this proportion is increasing in many countries the rates will be best compared when adjustment is made to them to allow for this. The modified rates shown in Table XXI on page 28 vary from 2.2

to 14.7 for studies other than Bremer's whose figure is 25.2, and in the present study the figure is 53.3. These last two are the only general practitioner studies and it is reasonable to expect them to show higher rates because of the non-hospitalised cases which they include. The considerably higher rate in the present study probably can be explained by the longer life which these cases enjoy with the considerable advances of treatment of recent years.

Table VII Age and Sex Distribution

Age Groups	Male	Female	Both Sexes
20-24	-	1	1
45-49	-	2	2
50-54	-	1	1
55-59	-	2	2
60-64	-	-	-
65-69	1	1	2
70-74	-	2	2
75-79	3	2	5
80-84	1	-	1
85-100	2	1	3
Totals	7	12	19

It is remarkable that there is only one psychotic under the age of 45 years (TableVII). In Bremer's study there were 23 under the age of 40 out of a total of 38 cases. What significance there may be in the paucity of young psychotics in this parish is not known. It would however be most interesting to know whether there is any similar scarcity of young psychotics elsewhere or whether this is merely a normal variation here due to dealing with small numbers.

Social Class It will be seen from Table V on page 13 that the percentage distribution of social class is roughly equal between the sexes. It was thought that the occupation structure of the community had changed little since the census of 1950 on which these figures are based and it is therefore proposed to use the distribution of social class of all those classified in that census as a basis on which to compare the distribution of the diseases by social class.

The percentage distribution of the 789 classified by the Registrar General is shown in the following table VIII.

Table VIII

Class	Number	Distribution per cent.
I	18	2.3
II	149	18.9
III	374	47.4
IV	175	22.2
V	73	9.3
Totals	789	100.1

In the tables for the diseases by social class, the numbers of cases in each class are shown as rate per hundred for the total population (1701) and the ratio of these figures to the corresponding figure in Table VIII for the Social Class Distribution, gives a figure of the prevalence rate per hundred of the disease in the social class.

The psychoses by social class (Table IX) although not statistically significant show a similar distribution to the findings of Hollingshead & Reddlitch (9) in that the psychoses are more prevalent in the lower social classes.

Table IX

Class	Male	Female	Both Sexes	Rate/100 of Population	Prevalence/100 of Social Class
I	-	-	-	-	-
II	-	3	3	0.1765	0.935
III	4	4	8	0.4706	0.992
IV	3	4	7	0.4118	1.856
V	-	2	2	0.1176	1.271
Totals	7	13	20		

x^2: 2.308 p = 0.5

Table X

International Classification Number	Diagnosis	Males		Females		Both Sexes	
		Cases	Rate/ 1000	Cases	Rate/ 1000	Cases	Rate/ 1000
310	Anxiety Reaction	5	6.1	47	53.6	52	30.6
311	Hysterical Reaction	2	2.4	16	18.4	18	10.6
312	Phobic Reaction	4	4.9	12	13.7	16	9.4
313	Obsessive Compulsive Reaction	1	1.2	-	-	1	0.6
314	Neurotic-Depressive Reaction	1	1.2	6	7.8	7	4.1
315.1	Psychoneurosis with somatic symptoms - circulatory	-	-	1	1.1	1	0.6
316.0	-do- - digestive system mucous colitis	-	-	1	1.1	1	0.6
316.1	-do- - irritable colon	-	-	1	1.1	1	0.6
316.2	-do- - gastric neurosis	8	9.8	8	9.2	16	9.4
316.3	-do- - other digestive	7	8.5	6	6.8	13	7.6
317.0	-do- - respiratory	-	-	3	3.4	3	1.7
317.1	-do- - genito-urinary	1	1.2	7	8.0	8	4.7
317.2	-do- - pruritus	1	1.2	-	-	1	0.6
317.3	-do- - other skins	3	3.7	5	6.7	8	4.7
317.4	-do- - musculo-skeletal	-	-	3	3.4	3	1.7
318.0	Hypochondriacal reaction	1	1.2	1	1.1	2	1.2
318.3	Asthenic reaction	2	2.4	1	1.1	3	1.7
318.4	Psychoneurotic disorders - mixed	-	-	1	1.1	1	0.6
	Totals	36	43.6	119	135.7	155	91.1

The prevalence of the different neuroses is shown in Table X and as with much other illness encountered in general practice many cases were mildly and some seriously ill, two of the latter requiring admission to a mental hospital. The overall rate of 91.1 per thousand is the highest recorded (see Table XXI on page 28) the nearest being Bremer's with 45.2 per thousand over a 5 year period. The other surveys are mostly from hospital, consultant and official statistics and it is unlikely they would pick up the minor neuroses which are usually dealt with by the general practitioner.

Anxiety Reaction is most prevalent with a rate of 30.6, second is psychomatic conditions of the alimentary tract with a rate of 18.3, Hysterical Reaction at 10.6 is third and Phobic Reaction fourth at 9.4.

Females are more affected than males by three to one, which is about the usual finding in the neuroses, but the rates for gastro-intestinal psychomatic ailments are similar in the sexes.

The high overall rate of 91.1 per thousand is not thought to be exceptional for this community. The recognition of mild neurosis does not come readily to many of the medical profession because of the great emphasis on organic disease in their education. Balint (25) has shown how some patients present their emotional problems to their doctor in the form of symptoms commonly associated with organic disease, or sometimes even more indirectly through a "sick" child. These symptoms can be accepted for investigation along purely organic lines and treated symptomatically and left at that, and the doctor may be only vaguely aware that important emotional factors are present. If the doctor rejects the illness because the symptoms do not conform to any organic disease, the patient is likely to present further symptoms. On the other hand the doctor's acceptance of symptoms as probably denoting some possible organic disease, is liable to fix them in the form of chronic ill health with, in consequence, frequent calls for attention.

Reference has already been made to the accepted estimate of $\frac{1}{3}$ of general practitioners' patients as suffering from mental illness most of which will be neurotic (13). That doctors can be taught to diagnose and treat their patients' psyche as well as their soma has been shown by Balint among others.

Tables XI and XII overleaf, show the neuroses by age and sex and their frequency by age.

Table XI

Age and Sex Distribution

Age Groups	Male	Female	Both Sexes
0-4	-	-	-
5-9	1	1	2
10-14	-	1	1
15-19	2	1	3
20-24	2	13	15
25-29	5	11	16
30-34	-	10	10
35-39	5	10	15
40-44	2	5	7
45-49	2	11	13
50-54	5	21	26
55-59	6	7	13
60-64	3	8	11
65-69	1	5	6
70-74	1	8	9
75-79	-	3	3
80-84	-	3	3
85+	1	1	2
Totals	36	119	155

Table XII

Frequency in Age Groups

Age Groups	Number of persons in Age Group	Number of neurotics in Age Group	Frequency per cent
20-24	105	15	14.3
25-29	109	16	14.7
30-34	106	10	9.4
35-39	108	15	13.9
40-44	92	7	7.6
45-49	114	13	11.4
50-54	106	26	24.5
55-59	127	13	10.2
60-64	79	11	13.9
65-69	83	6	7.2
70-74	65	9	13.8
75+	74	8	10.8
Totals	1168	149	12.76

$X^2 = 20.8_{(21)}$ $p = 0.05$

In Table XII the rate of 24.5 in the 50-54 age group is statistically just significant. Of the 26 cases in this age group, 21 are female which is about one third of all females in this age group. Among possible reasons for this high prevalence, the effects of paternal separation in World War I were considered but on investigation, only about one half of the cases had been separated from their fathers by war service. However, on examining their histories, there was in 15 considerable stress in their relations with their love objects. This age group in women also suffers the peak incidence of involutional melancholia (26) and it seems likely that involutional pressures influence neurosis at this age too. In Bremer's study the peak prevalence is in the 30-39 ages. The circumstances of his community were very different, with strong economic pressures against repeated pregnancies and with high rates for psychopathy.

The Distribution of the Neuroses by Social Class is shown in Table XIII below.

Social Class	Male	Female	Both Sexes	rate/100 of population	prevalence/100 of social class
I	3	3	6	0.3529	15.47
II	12	12	24	1.41	7.46
III	17	60	77	4.53	9.56
IV	1	26	27	1.588	7.16
V	3	18	21	1.235	13.24
TOTALS	36	119	155		

Table XIII

$X^2 = 8.073$ $p = < 0.10$

The differences of prevalence in the social classes here are not significant which implies that in this community the neuroses are not affected by social class. This is to be expected in a society where the children have been subjected to a common educational and religious system.

TABLE XIV

International Classification Number	Diagnosis	MALES Cases	MALES r/1000	FEMALES Cases	FEMALES r/1000	BOTH SEXES Cases	BOTH SEXES r/1000
320.4	Antisocial personality	3	3.6	0	-	3	1.8
320.6	Sexual deviation	1	1.2	0	-	1	0.6
322.1	Alcoholism, Chronic	16	19.4	1	1.1	17	10.0
324	Primary childhood behaviour disorder	5	6.1	1	1.1	6	3.5
325.0	Idiocy	1	1.2	2	2.3	3	1.8
325.1	Imbecility	3	3.6	0	-	3	1.8
325.2	Moron	6	7.4	3	3.4	9	5.3
325.3	Borderline intelligence	7	8.5	4	4.7	11	6.5
325.4	Mongolism	1	1.2	0	-	1	0.6
326.1	Stammering of non-organic origin	2	2.4	0	-	2	1.2
326.2	Other speech impediment of non-organic origin	1	1.2	0	-	1	0.6
	TOTALS	46	55.8	11	12.5	57	33.5

The character disorders are more than four times more prevalent in males. The figures for Borderline Intelligence are for school children only, as it was not found possible to assess the rest of the community for this condition. The rate for alcoholism is high and would have been higher if three alcoholic psychopaths and one alcoholic hysteric had been included in this category. The social factors regarding alcohol have already been discussed and this high rate for persons whose drinking is out of control is not surprising. The rate for Mental Deficiency (Idiots, Imbeciles and Morons) is 8.8 which is similar to the rate of 8.56 found by Lewis (27) in an extensive investigation in England.

Table XV shows the Age and Sex Distribution of the Character Disorders.

TABLE XV

Age Group	Males	Females	Both Sexes
0 - 4	6	-	6
5 - 9	4	1	5
10 - 14	7	4	11
15 - 19	3	1	4
20 - 24	5	-	5
25 - 29	3	-	3
30 - 34	3	1	4
35 - 39	1	1	2
40 - 44	-	1	1
45 - 49	3	-	3
50 - 54	2	-	2
55 - 59	4	1	5
60 - 64	1	-	1
65 - 69	2	-	2
70 - 74	1	1	2
75 - 79	-	-	0
80 - 84	1	-	1
85+	-	-	0
TOTALS	46	11	57

The figures for the Character Disorders by Social Class (Table XVI) are highly significant and show a peak in Class V.

TABLE XVI

Social Class	Male	Female	Both Sexes	Rate/100 of whole population	Prevalence/100 of social class
I	2	0	2	0.1176	5.07
II	6	3	9	0.5294	2.80
III	10	2	12	0.7059	1.50
IV	7	3	10	0.5882	2.65
V	21	3	24	1.41	15.2
TOTALS	46	11	57		

$X^2 = 74.2$ $p = < 0.000001$

The diagnoses of Character Disorders by Social Class is shown in Table XVII below and shows that most of the Class V cases are mental defectives. In any competitive society one expects mental defectives to drift down to and to stay in Class V.

TABLE XVII

Social Class	Diagnosis and International Classification Number				
	Pathological Personality 320	Alcoholism 322	Primary childhood behaviour disorder 324	Mental Deficiency 325	Other 326
I	1	-	-	1	-
II	-	4	2	2	1
III	1	3	3	3	2
IV	-	4	1	6	-
V	2	6	-	15	-
TOTALS	4	17	6	27	3

Several cases were related as siblings and one group of 5 from three generations are related, and several abnormal stillbirths have occurred to different members of this family.

Hollingshead and Reddlitch (9) in their study of social class and mental illness divided their cases into psychoses and neuroses. In the neuroses they included most of the diseases classed as character disorders in the International Classification. The exception is the group of the Mental Deficiencies.

Their cases were derived from hospital and private consultant sources and their scheme of social classification differs from that of our Registrar General. In order to make a fairer comparison with their results the figures have been worked out for the neuroses including all the character disorders except the Mental Deficiencies and the results which are statistically significant are shown in Table XVIII overleaf.

TABLE XVIII

Social Class	Neuroses plus part of Character Disorders	Rate/100 of Population	Prevalence/100 of Social Class
I	7	0.4118	18.06
II	31	1.823	9.65
III	86	5.058	10.67
IV	32	1.88	8.46
V	29	1.705	18.43

$X^2 = 12.75 \qquad p = 0.02$

Hollingshead and Reddlitch's results differ in that they show highest rates in Class I and II and lowest rates in Class V, viz.

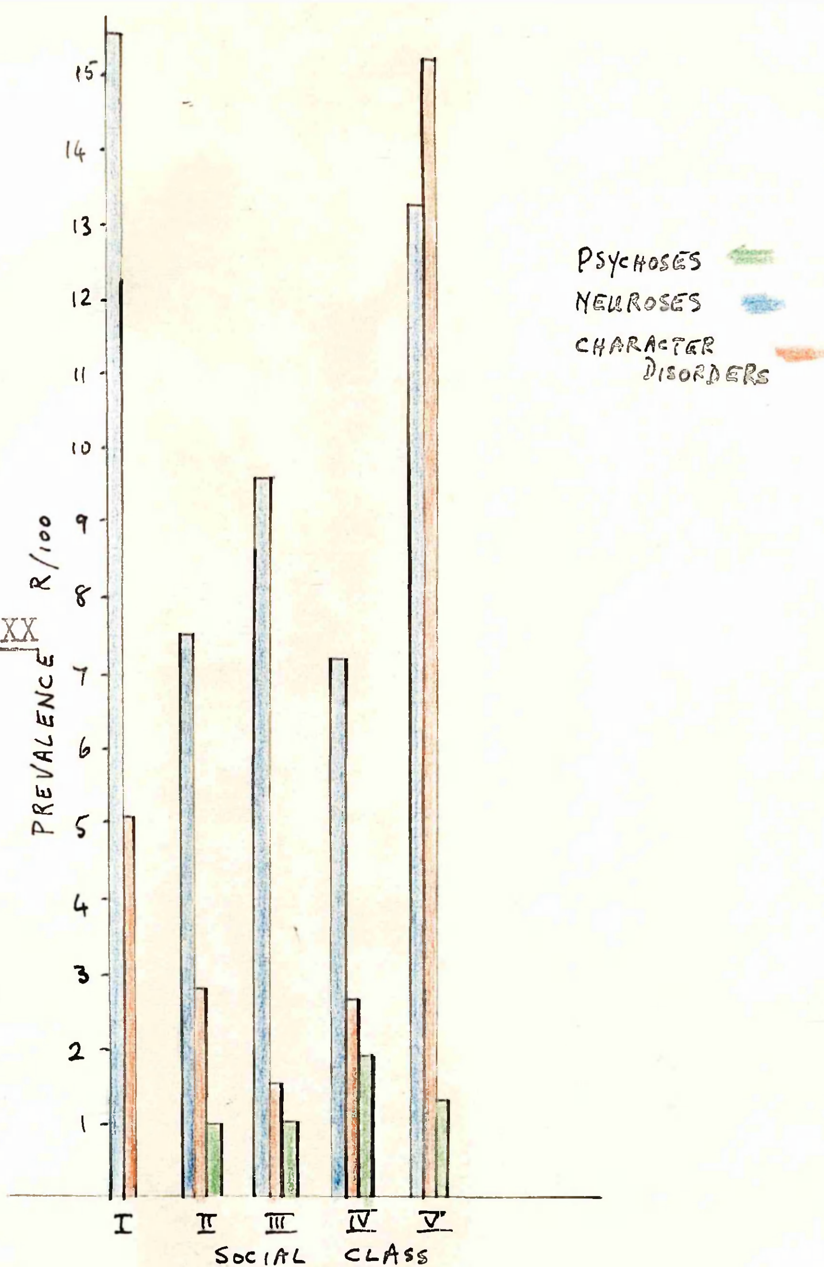
TABLE XIX

Social Class	No.	Percent
I	10	52.6
II	88	67.2
III	115	44.2
IV	175	23.1
V	61	8.4

It seems likely, although they discount this, that in their population the upper classes could better afford to take their illness to hospital or private consultant, whereas the poorer lower classes would not be treated above general practitioner level.

For comparison, the prevalence by Social Class of the diseases in this parish is shown in Table XX.

TABLE XX



Comparative Rates derived from different surveys are of limited value because of the differing standards of diagnosis and of sources of information. However for interest Table XXI has been compiled, partly from that of Lin (15) and with additions from other sources. The New Haven figures are approximations calculated by the author.

TABLE XXI Summary of Psychiatric Data from Various Countries

Country	Investigator	Date of Investigation	Type of Area	Population Studied	All Mental Disorders Total No of Cases	All Mental Disorders Rate per 1000	Psychoses Total No of Cases	Psychoses Rate per 1000	Schizophrenics	Manic Depress.	Senile incl. cer. arteriosol.	Other psychoses	M.D.	Psychopaths	Neuroses	Alcoholism	Adjusted: Schizophrenics	Adjusted: Manic Depress.	Adjusted: Senile incl. arteriosol.
									Rates per 1000								Rates adjusted by Weinberg's method		
U.S.A.																			
Baltimore	Lemkau	1936	Urban	55,129	3337	60.5	367	6.7	2.9	0.7	0.7	1.9	6.8	4.5	3.1	-			
Tennessee	Roth	1938	Rural	24,804	1721	69.4	156	6.3	1.7	1.7	0.9	2.0	8.2	24.2	4.0	-			
New Haven	Hollingshead & Reddlitch	1950	Urban	236,940	1891	7.8	1452	6.1	3.5	0.6	0.7	1.3	-		1.9				
Hutterites	Eaton & Weil	1950	Rural	8,542	199	23.3	53	6.2	1.1	4.6	-	0.6	5.9	0.7	8.1	-			
JAPAN																			
Hachjo Island	Uchimura	1940	Rural	8,330	65	6.8	52	6.2	3.8	1.0	0.2	0.8	0.6	0.4	-	-	9.1	2.8	2.2
Komoro	Akimoto	1941	Small town	5,207	138	26.5	44	8.5	2.1	2.5	2.3	1.0	10.0	2.5	2.5	0.6	5.0	8.7	6.3
Tokyo	Tsugarva	1941	Urban	2,712	82	30.8	25	9.2	2.2	0.7	0.4	5.2	9.6	8.5	-	0.4	4.9	2.3	14.7
FINLAND	Kaila	1936	Rural & Urban	418,472	3026	7.2	2510	6.0	4.2	0.3	-	1.7	4.4	-	-	-	9.1	-	-
SWEDEN																			
A:bo	Sjogren	1944	Rural	8,736	397	45.4	94	10.8	4.6	2.9	0.6	1.7	5.7	2.4	0.5	0.2			
DENMARK																			
Bornholm	Stromgren	1935	Rural	45,930	716	15.6	409	10.9	3.3	2.7	0.2	4.6	4.2	-	1.5	0.2	6.3	6.4	2.8
GERMANY																			
Thuringia	Brugger	1929	Rural	37,561	479	12.8	143	3.8	1.9	0.5	0.5	0.7	5.4	0.7	1.3	0.4	3.8	1.1	9.3
Bavaria	Brugger	1930-31	Rural	8,628	517	59.9	48	5.6	2.5	1.4	0.6	1.0	34.2	2.8	0.8	2.5	4.8	2.8	10.9
CHINA																			
Formosa	Lin	1946-48	Rural Small town Urban	19,931	214	10.8	76	3.8	2.1	0.7	0.3	0.7	3.4	0.5	1.2	0.1	5.9	2.3	10.7
BRITAIN																			
Wales	Carstairs & Brown	1951-56	Mining Valley	19,722	414	3.8	Persons over 15 yrs only												
			Rural	4,621	66	2.6													
South Scotland	Mayer-Gross	c1947	Small town & Rural	56,231	5105	90.7	900	16.0	4.2	3.5	6.0	2.2	15.6	19.4 (Psychopaths and Neuroses)		3.9			
NORWAY																			
North Coast Village	Bremer	1940-44	Rural	1,325	259	195.5	38	28.7	4.5	1.6	2.3	21.1	45.2	76.2	45.2	Incl. with psychopaths	10.0	3.8	25.2
BRITAIN																			
North Scotland Village	Primrose	1959	Rural	1,701	232	136.5	20	11.7	1.8	3.5	4.7	1.8	8.8	2.3	91.1	10.0	3.0	7.1	53.3

Note: The figures for disease rates in the New Haven series are approximate.

In SUMMARY we find in this parish in the psychoses a tendency to depression rather than to schizophrenia; and a distinct shortage of cases under 45 years with a very high modified rate for senile and arteriosclerotic illness.

In the neuroses we have a high overall rate approximating to 9% of the population with three females to every male and a peak age incidence in females in the 50 - 54 years age group. There is no correlation with social class.

In the Character Disorders males predominate and the rate for alcoholism is high at 10 per thousand. The majority are in the lower social classes.

Chapter 3

Treatment

For the 232 psychic exceptionals many different forms of treatment were used. Seven were admitted to hospital, six voluntarily and one by certification. Of these, four were psychotic, two neurotic and one a psychopath. Of the remainder many were given drugs sometimes in association with psychotherapy. The drugs most frequently used were Sodium Amytal and Chlorpromazine, but other sedatives, tranquillisers and antidepressants were also employed.

The year of this study commenced immediately after a course of seminars in psychotherapy and from the beginning of this study a determined attempt was made to use the psychological approach in an exploratory manner, both as therapy for the patient and as an educational process for the author. During the year a technique was gradually evolved largely by trial and error and the following description of some aspects of the use of psychotherapy in general practice may be of interest.

In psychotherapy history taking is frequently therapeutic, and when a neurotic was encountered in the run of the practice a decision had to be made whether or not to arrange for a "long interview" with the patient with a view both to improving the diagnosis and to the concurrent possibility of therapeutic activity. In urgent cases the decision was easy, and in some curiosity was the motive, e.g. in two cases of migraine; in others an opportunity was awaited for a situation where it was thought that the patient would more readily accept the idea of their illness being "nervous"; in some others too, the patient's nuisance value was such that anything was worth trying.

Table XXII shows the sex and diagnosis of the cases who were given long interviews of one hour or more. With the experience now gained some of these cases would not now have been taken on because of their unsuitability for such treatment. This applies particularly to older people and to some cases where the neurosis is a less distressing solution of the patient's difficulties. Some of the cases diagnosed but not taken on during the year have been taken on subsequently.

Int. Class. No.	Diagnosis	Males	Females	Both Sexes
	PSYCHOSES			
301	Manic Depressive Reaction	0	1	1
302	Involutional Melancholia	0	1	1
	NEUROSES			
310	Anxiety Reaction	3	17	20
311	Hysterical Reaction	0	6	6
312	Phobic Reaction	0	6	6
314	Neurotic-depressive	0	1	1
316	Psychosomatic-Alimentary	3	4	7
317	Psychosomatic - other	2	8	10
	CHARACTER DISORDERS			
320	Pathological personality	1	0	1
322	Alcoholic	2	0	2
324	Primary childhood behaviour disorder	1	0	1
	TOTALS	12	44	56

Table XXII. Diagnosis of Cases given Long Interviews.

The Social Class of those given long interviews is shown in Table XXIII below.

Some reluctance was felt at taking on the more intellectual members of the upper social classes, possibly because of a greater degree of social relationship with them; and in Class V the difficulties of communication with some of the less intelligent was a definite deterrent. All the patients were National Health Service so that financial considerations did not affect the question of treatment.

Social Class	Male	Female	Both Sexes	No. of patients in class	% of patients in class
I	0	0	0	8	0
II	3	6	9	36	25
III	7	24	31	97	32
IV	0	11	11	44	25
V	2	3	5	47	11
TOTALS	12	44	56	232	23

Table XXIII. Long Interviews by Social Class

Most of the important features of the therapy have been related to the intimate nature of social life in this closely knit community. The relationship between the community and their doctor is much more than just professional. Over the years of living and working together, a social relationship of some sort has been established with every family. The author has an intimate knowledge of the patient in health and sickness, and the patient knows the doctor, his home, family and interests. To some extent all general practitioners have a social relationship with at least some of their patients; in this type of semi-isolated single doctor practice where the relationship extends to almost everyone, we have a situation entirely different to the practice of the consultant. This was clearly seen when, during the first three months of this study, the psychiatric outpatient Clinic in Inverness was attended once a week and through the courtesy of the Physician Superintendant the opportunity of interviewing cases was given. There one was hindered by lack of knowledge of the patient's background and by not being able to judge easily the patient's probable reaction to discussion of delicate matters. Also one could not afford to risk stirring up much resistance lest the patient should discontinue treatment. In one's own practice, on the other hand, one starts off halfway up the ladder with doctor and patient talking the same conscious and ~~more of the~~ unconscious languages (Meares 29). The doctor too has much knowledge of the likely stresses in the patient's environment, and in addition he may have the pointers which local gossip may give, the information from relatives either directly or indirectly by their attitudes, and indeed so much knowledge of the patient as a person that getting him or her to unclothe the mind for examination may be almost as easy as doing the same for the body.

In this practice the patients have no effective choice of doctor which has made it possible on occasion to use quite forceful psychotherapy in the knowledge that the patient could not escape from treatment as a form of resistance. For example, one patient forgot to keep appointments from time to time and had to be called for and brought to the consulting rooms. The forgetting was due to unconscious resistance to further therapy. The author too has no choice of patient and this has emphasised the necessity for dealing intensively with the bad doctor-patient relationship which existed in some of the cases.

Those who have lived in the country will readily understand how inquisitive are most people about others and how every hint and observation is used to construct a hypothesis of the other's business; how too, straws may be thrown in the wind for confirmation or denial of suspicions. Because of this it is not possible to describe in detail all the cases treated, as members of the community could readily identify many patients from their case histories unless they were so disguised as to lose their value as clinical material. In the cases described jargon is used deliberately but reluctantly to assist concealment of identity.

The long interviews were mostly conducted in the consulting rooms by appointment, with patient and doctor seated in full view of each other. Usually the symptoms were first fully explored and then a biographical history of the patient's life was built up. Gaps in this were noted and if necessary explored, and other resistances were similarly looked for. Emotionally "hot" subjects were usually sought and release of emotion was encouraged. Recurrent attitudes or patterns of reaction were looked for and studied. Explanations were kept as homely as possible. At all times the patients were encouraged to talk freely and their attitudes in their significant relationships - family, love objects and doctor, were assessed. Any emotion felt by the author in relation to the patient was observed for personal study (Ewing 28). In this connection Balint repeatedly reminded the doctors in his seminars "When the doctor feels something he stops and thinks".

After the first interview most patients were booked for a second interview at which the effects of the first interview were assessed. In several cases further sessions were deemed unnecessary and this was particularly the case where there had been much emotional release at the first interview. Some early successes of this kind, the so-called transference cures, raised hopes of the simplicity of the treatment which were soon dashed by cases with little display of emotion in which rapid improvement did not occur.

In most cases significant disturbance of childhood home relationships was evident and sexual repression and guilt were very frequent. Other mechanisms commonly noted were those of childhood insecurity and inferiority feelings, and parental domination and dependency.

During attendance at Balint's seminars, the temporarily

unpleasant process of undergoing the limited personality change arising from examination of one's personality in the doctor-patient relationship - in effect the group psychotherapy for the doctors in the seminar, was undergone. The necessity for this was soon realised when patients were treated. Having dealt in the seminars with the worst of one's own anxieties, it was much more difficult for patients with knowledge of their doctor's personality to embarrass him as a form of unconscious resistance. It was also easier to admit and talk freely about one's defects where necessary - particularly to improve rapport where the doctor-patient relationship was unhappy due to a previous condemnatory attitude to the patient's neurosis. Additionally the revelation in the seminars of how one had succumbed unawares to the unconscious manipulations of certain patients was so salutary that the danger of future recurrence was greatly reduced. Indeed, without some method of achieving personal insight, the practice of psychotherapy in the intimate relationships of general practice would be fraught with danger.

The ways in which patients present their neurotic illnesses have been adequately described by Balint (25) and there were no important differences in this study. It was, however, occasionally possible for the author to initiate contact with the patient - in one case on a hint from a friend where a character disorder had been suspected. At the risk of a brusque dismissal the person concerned was sought out and offered help which was accepted, and after several sessions was helped successfully to overcome a difficulty which otherwise would have led to serious consequences. Had this approach not been made, it is unlikely that the patient would have sought assistance, at least before getting into a dangerous mess. Sometimes too it has been realised that an important person, parent or spouse, in their circle, is mentally ill and an approach has been made to this other person, partly for their own good and partly to help the treatment of the first patient.

In three families husband and wife were both treated; initial reluctance due to fear of falling between two stools was not justified by the results. Naturally, care had to be exercised in dealing with information which either party wished kept from the other. One couple presented through a child whose neurotic behaviour reflected parental disharmony due to sexual maladjustments. In the second couple, the wife's repressed sexuality was an important stressor to a husband with a psychogenic character disorder.

The third couple were a wife with classical hysteria and a husband with severe anxiety hysteria. The husband made a good recovery after nineteen long interviews combined with drugs and a consultation with a psychiatrist. During his treatment his wife was taken on for a few sessions to try to reduce her unconsciously motivated interference with his treatment. After his recovery a more definite attempt at treating her was commenced.

During the earlier months the absence of contact with more experienced colleagues was keenly felt. The only opportunities for discussion of cases arose with a trainee assistant who sat in at most interviews and with a consultant psychiatrist who visited the practice once a month. Much had to be learned by reading and by far the most useful books found were Freud's "Introductory Lectures on Psychoanalysis" (30) and Balint's "The Doctor, His Patient and the Illness" (25).

A case which dragged on until sufficient theoretical knowledge had been acquired was a woman who complained of feeling sick, faint and trembly and who had a phobia of going into populated buildings. Her story revealed sexual repression, mother domination and inferiority feelings, with previous trouble from the phobia when living elsewhere. At the earlier interviews, there was considerable emotional release but in spite of this, the phobia continued until the meaning of symptoms was being studied in Freud's Introductory Lectures. An analysis then of her phobia showed that its function was to prevent her making a scene in front of people. With the knowledge of her home and the community, it was fairly easy to trace the origins of the illness back successively to four years previously when she had fainted at a public meeting thus "making a scene". On enquiring for previous occasions when she had made a scene, she remembered when she was nine years old she had been sick at church and had been hustled out during the service. She could not remember any previous occasions until, knowing the family's then poverty, she was asked whether she had been humiliated at school for perhaps ragged clothing. She replied at once "No", paused, and then burst into tears at the previously forgotten memory of being taken out in front of the class and humiliated because of the holes in her shoes. This marked the turning point of her illness and she has made an excellent recovery. Neither free association nor dream analysis were used to reveal the repressed emotion - only the knowledge of her environment and a construction

from it of the sort of home circumstances of her childhood. In addition, during the sessions she worked out a considerable amount of her feelings of inferiority and sexual guilt. Had it been possible to attend a seminar, the case would not have dragged on for three months, as the protective function of the phobia would most likely have been brought out in discussion.

The abrupt change in the method of treating neurotics was expected sooner or later to become the subject of comment in the community, particularly as it involved frank and detailed examination of patients' intimate lives. Balint (25) describes as the doctor's Apostolic Function the attitudes and reactions which the doctor expects from his patients, and how patients tend to live up to these expectations. The expected disturbance due to the change in the author's apostolic function reached a climax rapidly at the beginning of the fourth month through a hysterical patient who, at her first interview, kept up a barrage of repartee as a form of resistance. At the second session when she was being shown the connection between her symptoms and her repressions she suddenly departed in tears and then started a minor campaign of vilification of the author for asking her all those questions about sex. She also studiously ignored her doctor when they met in the street. After a week of this, she was sent a letter giving her a further appointment and explaining the significance of her actions. Not unexpectedly, she did not keep the appointment, but appeared at the surgery later that day when rapport was regained and it was agreed not to continue treatment. Her symptoms have not recurred. The result of all this for a time was that several patients who were advised to come for long interview were reluctant, but those who did agree were rather surprised to find that the woman had been making a fuss about nothing. The author too learned to use more finesse in his approach. This period of gossip rapidly subsided and was the most serious difficulty encountered. Some earlier difficulties arose from overenthusiasm, particularly in the deliberate rapid provocation of emotional release with insufficient explanations. For instance a young person of lowly origins with a troublesome psychosomatic ailment for which many forms of treatment had been tried with only partial symptomatic relief. At the first interview, considerable tension was observed over painful memories of childhood inferiority. The same evening the mother came to the surgery to complain that the patient was very upset. At the next interview the upset and tension were resolved

largely over the point that the father had in past years opened a letter about himself from the author to a consultant in which his humble origins were noted with a word which to some has derogatory implications, and yet to others is regarded as a not ignoble profession. The patient's knowledge of this and the feeling attached to it and directed at the author was dragged out and explained. The psychosomatic condition resolved and did not recur until a year later when there was a mild relapse when under some emotional strain. Although so much improved, the patient still regards the treatment as having been very unpleasant. The high emotional pitch of these two sessions was very successful clinically, but with so little experience to control it there was danger of things going wrong.

In the early months, a frequent problem was what to talk about at the second and subsequent interviews. It was found helpful to start off with asking the patient what they had thought about, and, since, the previous session. As more experience has been gained this difficulty has receded.

Another difficulty arose in cases where a bad relationship existed because in the past the author had treated the patient, in his ignorance, with an attitude of impatience and contempt for their being "neurotic". These bad relationships had first to be examined in order to improve rapport as previously noted. This led on to examination of the patients' attitudes to the author and these were usually seen as an expression of their neurosis. The working through of these attitudes was the most effective treatment found for hysterics.

The attitude of condemnation of neurotics is common amongst doctors and may arise from their guilt and frustration at not knowing how to understand and treat them. The author remembers vividly how he used to shudder when neurotics appeared at the surgery; now he rather welcomes them.

The time factor is usually brought up as a major difficulty whenever it is suggested that practitioners should do psychotherapy. Admittedly, it is time consuming but in the long run it should be time saving. Two, three or four hours spent in psychotherapy on a neurotic may well effect a degree of cure which no amount of time in repeated surgery attendances for symptomatic treatment with pills and potions will effect. In any case, lack of time would not be accepted as an excuse for

evading the proper treatment of any other type of illness. Nor can the hospital services cope with the mass of minor neuroses. The time occupied by psychotherapy in this survey period has been considerable for two reasons, and is expected to decrease in later years. Firstly, there was a backlog of neurotics who had been having only symptomatic treatment and secondly, several cases were taken on to gain experience.

A case which illustrates the limitations of organically oriented practice and the possibilities when dealt with psychotherapeutically is described with the permission of the patient.

She was a young married woman and some years before this survey she developed an acute positive transference for the author who was alarmed at this unprovoked condition, expecially as it was not practicable to transfer her to another doctor. A consultant psychiatrist was called in and he obtained a history of a very disturbed home during the patient's childhood, and his advice included, to quote his letter, "if she lived nearer a clinic, one would naturally recommend regular psychotherapy". The transference trouble was resolved by explaining the state of affairs to the husband, but this did nothing to help her neurosis. Towards the beginning of this survey it was decided to try some psychotherapy and in three sessions a great deal of harrowing emotion was worked out from the memories of the traumatic situations of her childhood. This produced considerable improvement, but she still had some neurotic symptoms. A year later, having gained more experience, she was taken on again and her bad old reaction patterns are being worked through in her relationship with the author and with the co-operation of her husband. For instance a hard word from author or husband would make her "freeze up" for up to two days, as it revived her childhood feelings under parental ill treatment. In this she behaved like a whipped child retreating into hiding. Fortunately she had a strong desire to be good, probably deriving from the desire for the paternal love she should have had but did not receive - hence the earlier transference to the sympathetic medical father figure. She also had difficulties in bringing up her own children due to the inadequate standards of her own upbringing, and this provided a readily acceptable hook on which to hang explanations. There has been no recurrence of the positive transference difficulty and with once weekly sessions and concentration on the

negative transference aspects, it is unlikely to arise. This complies with the recommendations of Alexander & French (31) for the economical use of psychotherapy. Her progress with this regime has been considerable.

The results of treatment have been very satisfactory. As far as is known no-one has been made worse, some are no better and most are very much better. A rough assessment at the time of writing (July 1960) is presented in Table XXIV below, every opportunity having been taken of following up cases by enquiry from patient and relatives.

Condition	Male	Female	Both Sexes
Worse	0	0	0
Unchanged	6	2	8
Improved	2	12	14
Much improved	3	24	27
Cured	1	2	3
Not known	0	2	2
TOTALS	12	42	54

Table XXIV. Results of Treatment by Long Interview.

Two psychotics also had interviews but as they were mainly treated by other means, they have not been included.

Preventive Aspects.

The psychological treatment of neurosis should do much to break the "infective" link which passes neurosis on from parent to child. If the frequency of neurosis in this parish is at all representative of that of the nation, the benefits of reducing this neurotic "infectivity" would be considerable and not only in the medical field. The neurotic person is to some extent alienated from the community and is apt to act antisocially and unpredictably, and can be troublesome to others as well as their physicians.

One advantage of psychotherapy at general practitioner level would be earlier treatment before serious disease or antisocial acts were established.

The preventive possibilities of deliberate intervention have been illustrated in the case on page 34 and although this method would have to be used cautiously and occasionally, there should be a place for it.

The manipulation of public attitudes carefully planned, might well be used. For instance, in this area some alteration is required regarding the attitudes to alcohol. In the author's opinion too, the most important single factor in the production of neurosis in this community which could be dealt with is the repression of sexuality. Removal of the taboos on discussion of and education in this subject in home and school should be aimed at.

The Role of the Family Doctor.

One hears from time to time of the importance of the doctor to the family in the old days. How he was a help in affliction and that at a time when he had fewer effective drugs than nowadays. How these doctors swore that the basis of good general practice was midwifery and how, if one attended the mother in labour, a deep relationship with the whole family was ensured.

Nowadays the trend is for the general practitioner to do less and less midwifery and the opportunity for strengthening his relationships is suffering. Also many doctors, especially since the introduction of the National Health Service, are so busy that they have little time to listen to more than the briefest synopsis of their patients' histories and again the doctor-patient relationship suffers. Coincident with these trends has been the drift away from the Church, once the other great source of help for people in trouble. Filling to some extent the demand for advice in disturbed human relationships is the popular press - newspapers and women's magazines - in their personal advice columns. What it is like for a newshound to be pitched into action as an adviser is described by West (32) and Timperley (33).

That the medical and clerical professions are awakening to the need to return to the field of human behaviour is slowly being recognised, and suggestions are repeatedly made for more undergraduate and postgraduate psychiatric education (34, 35, 36, 13), and Bourne (37) has shown how successful such instruction can be, even in preclinical years. Lin (38) describes the introduction of 330 hours of clinical psychiatry into the medical student's curriculum.

The overlap between the fields of neurotic alienation and the separation from the love of God of the irreligious is increasingly recognised (Tillich (39)) and the extent to which religious pastoral counselling resembles simple

psychotherapy has been shown by Oates (40). It is the author's belief that the future development of this pastoral trend in general medical practice and in the churches will be of major benefit both to these professions and to our Western Civilisation. Indeed Freud (41) in 1919 "looked forward to a free medical service with psychotherapy for the masses, and if necessary modified to include suggestion and hypnosis". We have the first of these now and the second should be encouraged to follow.

REFERENCES

1. Reid, D.D. (1960) Public Health Paper No. 2. World Health Organisation.

2. Lemkau, P. Tietze, C. & Cooper, M.(1941) Mental Hygiene 25, 624.

3. Roth, W.F. & Luton, F.H. (1943) Amer. J. Psychiat 99,662.

4. Øedegaard, O.(1946) Psychiat. Quart., 40, 380.

5. Sjögren, T. (1948) Acta psychiat et neurol. Suppt. 52.

6. Mayer-Gross, W.(1948) Eugenics Rev. 40, 3.

7. Øedegaard, O.(1952) Psychiat Quart. 26, 212.

8. Carstairs, G.M. & Brown, G.W. (1958) J. Ment.Sci., 104,72.

9. Hollingshead, A.B. & Reddlitch, F.C. (1958) Social Class and Mental Illness. New York.

10. Klemperer, J. (1933) Z.Neurol. 146, 277.

11. Fremming, K.H.(1947) Morbid risk of mental diseases in an average Danish population. Copenhagen (English Edition, 1951).

12. Eaton, J.W. & Weil, R.J.(1955) Chap.XV in Mental Health & mental disorder. Edited Rose, A.M. New York.

13. Report of working party of College of General Practitioners. Brit. Med. J. 1958. II, 585.

14. Bremer, J. (1951) Acta psychiat et neurol. Suppt. 62 (English edition).

15. Lin, Tsung-yi (1953) Psychiatry 16, 313.

16. World Health Organisation, (1959) Technical Report Series No. 177.

17. Abrams, M. (1959) The Listener 62, 914.

18. Charteris, H (1954) Punch 228, 415.
(1955) Punch 229, 232.
(1956) Punch 230, 288.
(1956) Marching with April. London.

19. Volkhart, E.H. & Michael, S.T. (1957) Chapter IX of "Explorations in Social Psychiatry" edited by Leighton, Clausen & Wilson. London.

20. Report on Fifteenth Census of Scotland (1954) Vol. I Part 32. H.M.S.O.

21. General Register Office - Classification of Occupations (1950). H.M.S.O.

22. World Health Organisation. International Classification of Diseases (1955).

23. The Lancet (1960). I, 158.

24. Statistical Summary for Craigdunain Hospital, Inverness (1958). Unpublished.

25. Balint, M. (1957). The Doctor, his Patient & the Illness. London.

26. Garmany, G. (1958). Brit. Med. J. II, 343.

27. Lewis, E.O. (1929) Report of the Mental Deficiency Committee. H.M.S.O.

28. Ewing, J.A. (1960). Practitioner 184, 70.

29. Meares, A. (1960) Lancet I, 663.

30. Freud, S. Introductory Lectures on Psycho-Analysis. 2nd edition. London 1952.

31. Alexander, F. & French, T.M. (1946) Psycho-analytic Therapy. New York.

32. West, Nathanael (1957) "Miss Lonelyhearts" in Collected Works. London.

33. Timperley, R. (1960) The Listener 63, 1058.

34. Brit. Med. J. (1958.) II, 602.

35. Tizard, J.P.M. etal. (1959) Lancet. II, 195.

36. Finlay etal. (1954) Practitioner 172, 183.

37. Bourne, H. (1959). Lancet II, 1952.

38. Lin, Tsung-yi (1960). Brit. Med. J. II, 345.

39. Tillich, P. (1955). The Courage to Be. London.

40. Oates, W.E. (1958). Anxiety in Christian Experience. London.

41. Freud, S. Collected Papers Vol. II. pp. 401-2.