Occupational Agoraphobia

PETER J. HARDWICK, Consultant in Child and Adolescent Psychiatry to East Dorset, The Health Centre, Saxon Square, Christchurch, Dorset

Chance meetings in public between psychiatrists and their clients are not usually relished by either. At its least embarrassing, the encounter can pose to both parties the dilemma: Should we greet each other and risk revealing to the public our special, but stigmatised, relationship? Or, should we ignore one another and risk one (or both) of us feeling rejected? The more embarrassing encounters are well known in psychiatric covens and sometimes even revealed to outsiders in the course of ethanolic abreaction at intimate dinner parties. However, hitherto they have not found a place in conventional psychiatric literature, with its scientific emphasis and basic assumptions in the journals of smoothly flowing professionalism and the normality of the psychiatrist.

Imagine the embarrassment engendered by these chance meetings, multiplied by four or more. Such may be the lot of the modern child psychiatrist, who often treats whole families that may include disinhibited children. Young, relatively inexperienced child and family psychiatrists, grappling with their new status and living in provincial towns with large 'Arndale' shopping centres are most likely to be affected by such encounters. Some may go on to experience a variety of agoraphobia, described below. This condition is not to be confused with varieties of malingering practised by basically agoraphilic doctors, who are also male chauvinists and do not wish to lose time from the golf course to participate in family shopping expeditions.

Case example 1

A 36 year-old married, recently appointed child psychiatrist, Dr A, of somewhat status-conscious and retiring premorbid personality and subject to excessive feminism at home, was doing the Saturday shopping accompanied by his toddler son in his local shopping precinct supermarket. He had at last found his wife's emphatically specified brand of cat food on a low shelf, when he was startled to hear the word "Shrink" uttered in a child's voice. Looking up, he was horrified to see careering towards him two shopping trollies laden and surrounded by children waving and shouting his name. Haggard, preoccupied parents followed but appeared to have not yet seen him. Dr A recognised this as a problem family that was seeing him erratically for family therapy. Instinctively he dived behind the tinned fruit counter and scrutinised a tin of pineapple to escape further recognition. His active son, however, rushed forward to cheerfully greet the entourage, blocking its progress. To Dr A's embarrassment he overheard the "problem" parents exclaim, "Why can't some people look after their kids!" as they removed his son from their path and rushed him as lost to the nearest checkout point. Moments later Dr A sheepishly reclaimed his son from the cashier, a teenage girl who also looked horribly familiar.

Dr A began to develop a condition resembling school phobia, particularly on Saturdays with an exacerbation on Thursday evenings, the time for late shopping. The condition, characterised by a marked fear at the prospect of mingling with the general public, soon became accompanied by psychosomatic symptoms. Dr A began suffering nightmares. In one he and his son were trapped in a lift with one of his families in treatment. In the dream Dr A was unable to control his son, who kept pushing the buttons for the wrong floors. He awoke just after his son had snatched one of the 'treatment' children's ice-cream and was ramming it in the latter's face. In another nightmare Dr A found himself doing his out-patient clinic in his pyjamas, surrounded by team and clients too polite to comment.

Attempts to explain conventially his high social anxiety to his wife failed. Her view was that his new difficulties were of minor importance compared to her far more arduous task of bringing up the family and so he should pull himself together. However, Dr A could not manage this. Instead, on Saturdays and Thursday evenings Dr A suddenly developed an unprecedented interest in 'research'. His previous years' journals came out of their cellophane wrappers for the first time. Avoidance of shopping expeditions and soon other public outings was successful on most occasions and an agarophobic-like condition developed. There followed a period of marital strife, during which Dr A was obliged to take up Do It Yourself, as compensation to his wife for no longer helping with the shopping. Unfortunately this new activity also proved ego dystonic.

A psychiatrist is basically appointed by a Health Authority to enhance the normality of a region. Therefore his professional image is particularly vulnerable if he is observed to behave in an eccentric, indiscreet or flamboyant way in public and nowadays, for the child psychiatrist, a whole family (or families) may be witnesses. Young psychiatrists are seldom poised enough to detoxify the situation with humour. It is often their spontaneous attempts to extricate themselves that greatly compound the problem. Also young enthusiastic psychiatrists may be more likely to set themselves up to be noticed, as in the following illustration.

Case example 2

A young child psychiatrist, Dr B freshly appointed from the capital, enthusiastic to introduce family therapy to the provinces, had organised a role play demonstration of a family therapy session in a local health centre. Of a somewhat inventive and impulsive nature, he had found a large teddy bear to play the part of a baby in the family session

https://doi.org/10.1192/S0140078900017247 Published online by Cambridge University Press

that was to be acted by his colleagues and himself. As he walked carrying the large furry actor through the shopping precinct en route to the health centre, the smiling faces around him led him to muse pleasantly on the friendliness of his new home town. Suddenly he realised that the faces belonged to a large family he had recently seen in his clinic. The teenage children were pointing and giggling at the teddy bear, which he instinctively tried to hide under his coat only to look more ridiculous, especially when the bear slithered to the ground. As the portly Dr B stooped to retrieve it, he experienced a ripping sound followed by a cold air blast from behind. His trousers had just split in their most vital area. Seeking refuge in an adjacent hardware shop, he purchased a tube of Bostick glue, which he used to effect a desperate and temporary repair. However, one's imagination would suggest how this solution ultimately proved more painful than the original embarrassment. The incident heralded a period of severe agoraphobia, coupled to an aversion to bending that many confused with sciatica.

Psychiatrists coming to the provinces from London must be prepared to lose the anonymity they had enjoyed in the capital and which had given them a good deal of immunity from the types of social embarrassment referred to. Even more so the agoraphilic single psychiatrist, the frequenter of Hampstead parties and rakish clubs. One such provincially installed colleague attempting familiarity with a very attractive young lady at a local party, used that cliché, fatal to psychiatrists, "Haven't I seen you somewhere before?", to which she replied, "Yes, I was your patient before you cured me of anorexia!"

As yet there are no recommendations from the Royal College of Psychiatrists on how to handle impromptu encounters between psychiatrists and their clients. Nor is this issue dealt with in training. As regards the uncomplicated 'brush against' shopping-type encounter, observation of many senior colleagues reveals their use of the perfunctory ambiguous nod, a mild greeting barely discernible to most unless they are looking for it. Such a nod leaves the initiative for any further social intercourse to the client. However, it can sometimes be confused as a tic, especially when used continuously by the well-established psychiatrist who is beginning to experience everyone looking familiar. Perhaps the nod (in pre-tic moderation) could be cultivated in psychiatric trainees. There is, as yet, no controlled research to determine whether such a strategy leads to fewer feelings of embarrassment or rejection in clients. Moreover no-one has researched the effects of complicated highly embarrassing incidents of the type described on the psychiatrist/client relationship. The rationalisation sometimes ultimately used by the victim psychiatrist that clients benefit from seeing him as "only another ape like us all" and thus denying the importance of status, has yet to be validated.

Preventative measures to reduce the risk of occupational agoraphobia include avoiding lifts, elderly trousers, taking toddlers shopping and the deliberate cultivation of a reputation for an appalling memory for faces. Of course occupational agoraphobia can be precipitated by unfortunate encounters in settings other than shopping precincts. Home video shops come immediately to mind. Those colleagues who secretly frequent bingo halls and Butlin holiday camps should pay particular attention to a good disguise.

Although occupational agoraphobia can be experienced as socially crippling and lead to marital complications and the need for expensive or unenjoyable compensative measures to the spouse, a number of psychiatrists settle for living with it. They may indeed benefit from the secondary gains. Some rationalise their anxiety into a distaste of modern shopping centres on aesthetic grounds. Others take refuge in the countryside where they establish self-sufficient economies and thus deny the need for shops altogether.

Where treatment is desired, whilst administering a course of psychotherapy the psychiatrist may improve in his own self-confidence and feel more able to cope with seeing his clients in public. Such effects may generalise. However, again there is to date no research investigating to what extent psychiatrists themselves are helped by their treatments and the old adage that they are in their trade to cure themselves has never been put to the test.

Electroconvulsive Therapy

The editors of *Convulsive Therapy* will provide citation lists for individual topics in convulsive therapy and electroconvulsive shock on request. For enquiries, the use of descriptors from standard scientific databases is encouraged. This service is provided without charge to authors and subscribers to the journal under an educational grant. Enquiries may be directed to Max Fink, MD, Editor, *Convulsive Therapy*, PO Box 457, St James, New York 11780, USA; or the university electronic mail address MFINK @ SBCCMAIL. BITNET.

Management Course for Senior Registrars in Psychiatry

The National Health Service Training Authority are funding another two-day course at Keele University from 16–18 September 1987. The course will again be directed by Professor Roger Dyson. Those wishing to apply should write to Mrs Vicky Steventon, Department of Adult and Continuing Education, University of Keele, Staffordshire ST5 5BG (telephone 0782 625116).

https://doi.org/10.1192/S0140078900017247 Published online by Cambridge University Press