TEACHING LIAISON PSYCHIATRY TO MEDICAL STUDENTS

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Consultation-liaison psychiatry has emerged as a significant area of special interest within clinical psychiatry in recent years. It seeks to enhance the quality of psycho-social care of medically ill patients and of their psychological reactions to illness; to provide effective consultations not only with regard to patient management, but also to the complex problems arising where serious medical and psychiatric illness overlap, and to deal with the personal difficulties arising in members of the clinical team caring for the patient. It has an essential contribution to make to the actual practice of holistic, comprehensive health care; rather than just to the airy rhetoric by which whole-person medicine exists in the medical school's prospectus and objectives but not in its wards. We do not teach mere vapid sympathy, but competent psycho-physiological understanding of the patient, and sound communication skills.

The liaison psychiatrist is especially well placed to teach psychiatry as it applies to the regular, daily, practice of medicine, and in a context which is unusually convincing to those students who do *not* appreciate the importance of our subject, and who so often show a stubborn tendency to believe of psychiatry only what the surgeon says, if not vice versa.

Examples were provided of the problems encountered in establishing and developing such services, including the nature of the stereotypes of the 'typical' psychiatrist held in other Departments (and often reinforced by our own 'different' behaviour and dress) and the importance of being able to talk in pragmatic and understandable terms, and avoiding unhelpful jargon.

The wide range of clinical problems seen were discussed, with illustrations. The liaison psychiatrist deals with psychiatric illnesses presenting as medical and physical problems, and with medical problems presenting psychiatrically; with the various psychosomatic and stress disorders; deviant sickness behaviour; and with serious, self-destructive non-compliance, excessive dependence, or gross denial of illness. Such difficulties as the unduly angry patient, the seductive patient, the violent or absconding or lying patient, are not adequately discussed in traditional textbooks, or classifiable in traditional nosologies. Problems in the management of the dying patient and his relatives are dealt with in collaboration with the oncologist and haematologist, for example; and while of undeniable importance, often lie beyond the scope of traditional psychiatric therapy.

Far from being an extra super-specialty, liaison psychiatry represents the most appropriate general psychological medicine to teach the medical undergraduate.

ACUTE PSYCHOTIC REACTIONS IN IMMIGRANTS

By Dr Roland Littlewood,
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Studies of West Indian and West African immigrants have consistently shown high rates of diagnosed schizophrenia, although they differ in the extent to which the illness is seen as atypical. A retrospective examination of hospital notes at an East London Psychiatric Unit showed that although total admissions were similar in different ethnic groups there was an excess of schizophrenia in Caribbean and West African migrants similar to that found previously. These patients also showed an increase in two pathoplastic features, religious and paranoid flavour and an increased proportion of women, formal admissions and short admissions.

A prospective study of patients with religious delusions (a criterion chosen to yield a high proportion of atypical reactions) using the Present State Examination, a Religious Interest Questionnaire, videotapes and interviews with their families, isolated 24 West Indian and West African patients. Sixteen of them who did not have first-rank symptoms of schizophrenia differed from the eight who did in being more likely to be female, to come from a religious family and have had continuous religious experiences acceptable to the family since childhood, to have migrated more than five years before first psychiatric diagnosis/referral, and to have changed church, often to a more charismatic sect, although not participating in church social life. Judged by their family to have been quite well in the week preceding admission, following an event such as a threatened eviction they became excited and violent, assulting people and damaging property, and were taken to hospital under Section 136.

The full PSE could not initially be rated, the patients being suspicious and angry, emotionally labile, often refusing to speak or making delusional misinterpretations. There was no hypomanic affect, thought disorder, clouded consciousness or underlying organic disorder. They complained of auditory

hallucinations, expressed a belief that they were in communication with God and that witchcraft had been practised against them by relatives or neighbours. Depressive symptoms of a somatic nature became more apparent during the admission of 2–3 weeks and in subsequent admissions.

Emphasizing that (i) the beliefs expressed were endorsed by the relatives who saw the patients as ill because of their *behaviour*, (ii) the patients never relinquished their beliefs, (iii) affect was appropriate, (iv) the content of the delusions and hallucinations were intelligible (in Jaspers' sense of Verstehende psychology), the acute psychotic reaction was contrasted with mania, Leonhard's affect-laden paraphenia, the anxiety-elation cycloid psychosis, the Scandinavian psychogenic psychosis, paranoid and oneroid psychosis. The possibility that this reaction was a classical Kraepelinian syndrome with a cultural flavour was considered, but it was felt that there were considerable affinities with the 'hysterical' (culture-bound) psychoses such as the Caribbean bouffées délirantes and the acute paranoid reactions of West Africa, although the typical clouding of consciousness was absent. The semiological aspects and the association with the dominant culture were related to the subsequent depressive phenomenology.

PUERPERAL PSYCHOSIS

Post-abortion Psychosis and its Implications for the Aetiology of Puerperal Psychosis

By Dr Colin Brewer,
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The aetiology of puerperal psychosis remains controversial. Because of the obvious psychological and emotional implications of childbirth, there is a school of thought which regards it as largely psychogenic and therefore relies heavily on a psychotherapeutic approach.

The other school points, in contrast, to the major hormonal and biochemical changes which follow delivery, and suggests that these could well precipitate mental disturbance even without the intervention of psychological factors. Adherents of this view may tend to treat the psychosis rather as they might treat a severe endogenous depression, believing that if medical treatment is successful there will be little need for psychotherapy.

Neither school has yet produced any direct evidence for the importance of particular psychological or biochemical disturbances, and research from both standpoints is difficult since the condition is relatively uncommon. However, certain inferences may be drawn from the relative incidence of psychosis following childbirth and that following induced abortion.

Two recent studies have shown that the incidence of post-abortion psychosis is no more than 0·3 per 1,000-abortions, while the incidence of puerperal psychosis is of the order of 1·5 per 1,000 deliveries. It seems difficult to argue that an abortion is five times less psychologically stressful than childbirth, but it is a reasonable supposition that the biochemical changes after abortion are much less than those which follow delivery. Even when abortion is done after foetal movements have been felt—which must be about as stressful as an abortion can be—serious mental disturbance remains exceedingly uncommon.

This suggests that physiological factors are of greater importance in the genesis of puerperal psychosis—and possibly of lesser puerperal disorders as well—than psychological factors. It follows that 'medical model' treatment may be regarded as of prime importance in such cases. Comparisons may be made with the rare but theoretically interesting post-thyroidectomy psychoses. I do not imply that psychological factors and psychological treatments should be ignored.

A Clinical Study of Puerperal Psychosis

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The case notes of 85 patients admitted to the Mother and Baby Unit and 50 non-puerperal women of the same age group, admitted to Withington Hospital, Manchester, were studied. All case notes were abstracted and all information about their mental state, stripped of contextual clues, was noted. The abstracts were reviewed by two social workers and two psychiatrists, all of whom were ignorant as to the number of patients with puerperal psychosis.

Fifty of the patients began their illness within two weeks of delivery. The two psychiatrists were generally able to identify these patients to within a significant level of 0·01, while the social workers were unable to do so beyond a chance level. Of the 50 puerperal psychotic women 36 were identified by one or other of the psychiatrists ($P = 0·0001$).

An analysis using Wing's 'PSE Syndromes' showed that clouding, lability, agitation and loss of reserve were significantly associated with the puerperal state. These results do not support the prevalent view that puerperal illness is non-specific. They are compatible with the hypotheses that this illness is *either* a specific psychosis *or* a manifestation of manic-depressive illness.