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Correspondence

Letters for publication in the Correspondence columns should be addressed to:
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HISTORY OF BRITISH PSYCHOANALYSIS

DEAR SIR,

I too have been puzzled by the absence of response to Dr. Schmideberg's article (*Journal*, 1971, **118**, 61–9). Her paper is not the sort of contribution that one can read and quietly ignore. It is either an unjustified attack on some of the most respected figures in British psychoanalysis, or it is the first exposure of machinations that owe more to the teachings of Machiavelli than those of Sigmund Freud. Such an article demands reply, and the comments of Dr. Glover and Karl Menninger (*Journal*, 1973, **122**, 115) only increase our curiosity about what really went on.

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DEAR SIR,

Dr. Melitta Schmideberg expresses surprise that her article 'A Contribution to the History of the Psycho-Analytical Movement in Britain' brought forth no comment from readers. But should she really be so surprised? Her article would be of undoubted interest to those historians who are deeply concerned about the intricacies of the British Psychoanalytic Society; it may serve as a corrective to those who idealise the Society and its prominent members to know that at least one former member does not share their view; and it makes fascinating reading for those who (like me) simply enjoy hearing uninhibited comments on these matters, whatever we think of the rights and wrongs of the situation. But is it an important contribution to our understanding of psychotherapy? It is significant—but not very significant—if a certain psychotherapist says 'I don't, on reflection, think much of psychotherapy', just as it is significant—but not all that significant—if he were to say 'I think psychotherapy is a very good thing'.

There is surely no more vexed question in the field of psychiatry than 'Does psychotherapy work?' The statistical criteria that have so far been offered for such an assessment are insufficiently appropriate to satisfy the majority of psychotherapists, and the case against these criteria has been well argued by the phenomenologists. It may be that psychotherapy will, in the end, be judged on the quality of the experience of the general public at the hands of practitioners; and, to a lesser extent, on the cogency and integrity with which psychotherapists report their work.

There is one point in Dr. Schmideberg's article which does, I think, merit comment: her observation that psychotherapists tend to report their successes rather than their failures. I think this is true and something to be deplored. The reasons are many, and unhappily include a fear of exposing one's personal weaknesses in public. But there is also a legitimate reason. Our successes are usually of more importance than our failures. As Simone Weil put it: nobody is very interested if we add 2 and 2 and make 5.

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THE 'GASLIGHT PHENOMENON'

DEAR SIR,

C. G. Smith and K. Sinanan (*Journal*, June 1972, **120**, 685) should be commended for bringing the 'Gaslight Phenomenon' to the attention of the profession; 'subtle and disguised attempts to get rid of a spouse or relative by labelling him or her 'mentally ill or demented' may well occur more frequently and go unrecognized unless this possibility is kept in mind. However, the sub-title, 'A Modification of the Ganser Syndrome' is puzzling, as the paper does not seem to contain the slightest hint of any relationship or analogy between the 'Gaslight Phenomenon' and the Ganser Syndrome. Whether one regards the latter as a form of malingering, hysteria, or psychosis,

it is clear that the patient's behaviour shows his intention to appear irresponsible. In the 'Gaslight Phenomenon', on the other hand, 'mental illness' exists only in the reports of a party interested in getting rid of a person whose presence at home has become undesirable, under the false pretence that this person is mentally ill. Labelling the 'Gaslight Phenomenon' a modification of the Ganser Syndrome is apt to confuse the issue rather than clarifying it.

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THE PROBLEM-ORIENTED MEDICAL RECORD AND PSYCHIATRY

DEAR SIR,

The necessity for psychiatrists to become acquainted and comfortable with the problem-oriented approach to medical records is likely to become important in the near future as the advantages of this approach are recognized and it comes into widespread use. It is, therefore, unfortunate that Hayes-Roth *et al.* (*Journal*, July 1972) have published an article that is likely to convince psychiatrists that this approach has only a limited application to psychiatry.

First of all, the article is confusing to a psychiatrist who wants to apply this system in a practical straightforward manner. It initially describes a way of dividing problems into psychiatric, social and organic subgroups and numbering the problems of these subgroupings separately. Then the article does an about face, admits that such a system of organization 'results in tremendous duplication' and goes on to describe an alternative approach which 'is more efficient' and requires that a series of 'necessary questions' (the data base) be asked of each patient and that the responsibility for asking each of these questions be relegated to various members of the psychiatric team. The answers to these questions are evaluated at a planning conference in order to define the patient's problems, and out of this planning conference a single problem list is developed.

Besides being extremely cumbersome, the systems as described are useless to the private practitioner, the psychiatrist based in a general clinc, and even to a psychiatrist in a psychiatric hospital where a fast turnover of patients makes extensive psychiatric conferences on each patient impracticable. Such psychiatrists are likely to read Hayes-Roth's article with the thought that problem-oriented records might be useful for intensive psychiatric-hospital-based practice but have no value for them.

Because their article fosters such an attitude, it subverts the intent and purpose of the problem-oriented medical record, which is a means of organizing data for all medical personnel in a clear and comprehensive manner, with all the benefits that accrue from such a systematic organization (ability to audit medical care, the necessity for the physician to organize his thoughts more clearly, ultimate computerization, etc.). The article illustrates that psychiatry has strayed so far from the medical model that it has difficulty in formulating problems simply and clearly; that is, difficulty in achieving diagnostic consistency and reliability, although there are systems where clear objective means of making psychiatric diagnoses based on the medical model do exist (for example, see Feighner *et al.*).

Utilizing such a consistent system of diagnoses would allow the psychiatrist to take advantage of the problem-oriented approach to medical records in a comprehensive manner, comprehensible to him and his medical and paramedical colleagues, no matter whether he worked in a psychiatric hospital, general clinic or private practice. He could easily gain the essentials of the problem-oriented method by reading such basic source material as Weed's *Medical Records, Medical Education and Patient Care* or Bjorn and Cross's *Problem-Oriented Practice* rather than having to resort to such special systems as those offered by Hayes-Roth. If more idiosyncratic notes are thought necessary (relating to intrapsychic processes, for example), they could and should be kept separate from the main body of medical records. As long as the psychiatrist keeps in mind that the ultimate goal of the problem-oriented medical records is the integration of a patient's various medical, emotional and social problems in a way that is comprehensible to all those who must deal with the patient, he will not feel himself forced into a mould by the problem-oriented record, but will regard himself as a necessary part of a system working to provide the patient with comprehensive, complete and intelligent medical care. To operate otherwise would be to isolate psychiatry further from medicine to the ultimate detriment of medicine, psychiatry and the patient.

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