MCV/Q

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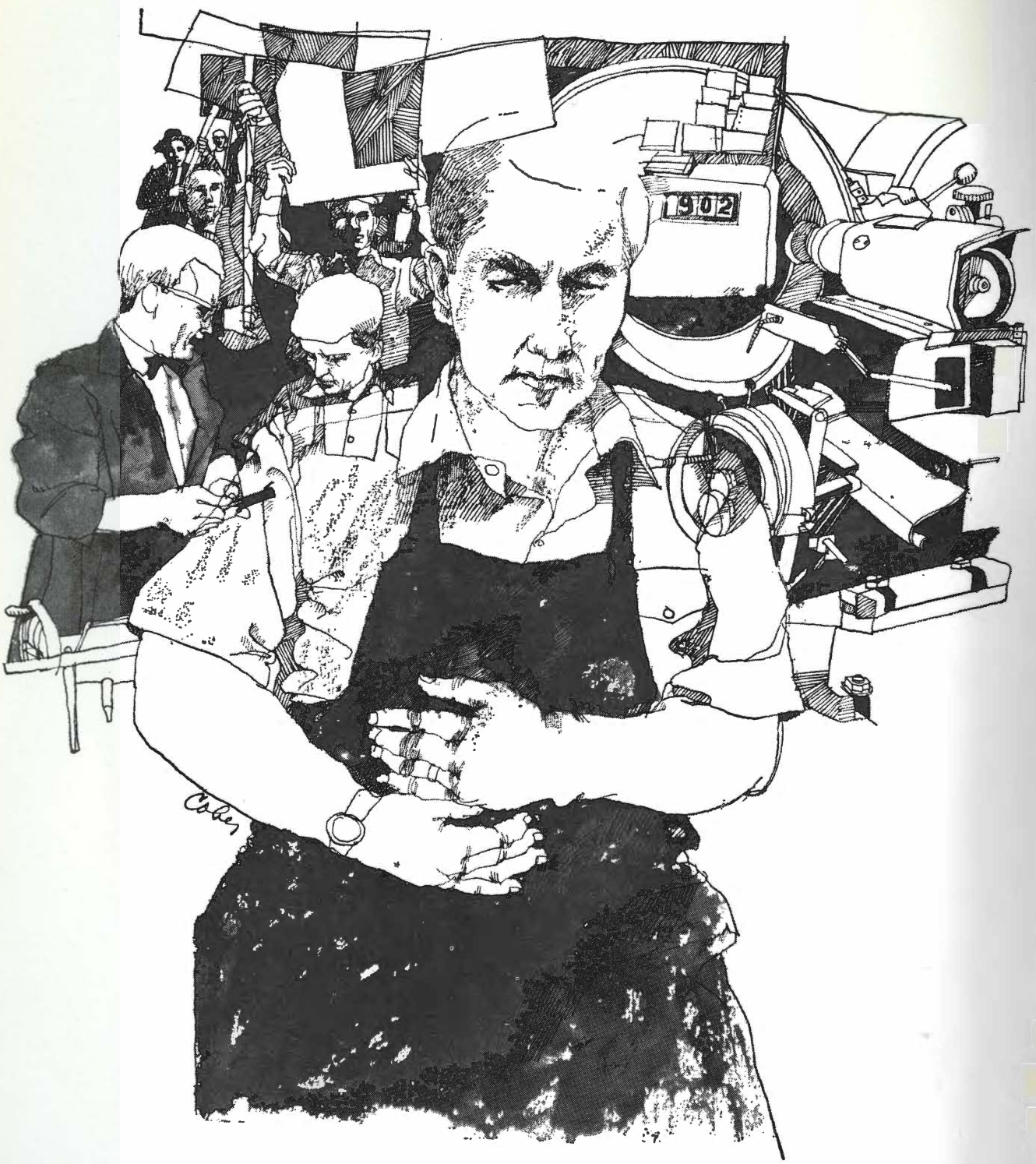

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MEDICAL COLLEGE OF VIRGINIA QUARTERLY

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CONTENTS

The MEDICAL COLLEGE OF VIRGINIA QUARTERLY is designed primarily for the postgraduate education of physicians. The QUARTERLY will publish results of original research in basic and clinical sciences, and report on seminars and symposiums held at the College. Contributions from outside the MCV faculty are invited.

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Psychiatry in Medical Practice*

The Twenty-Second Annual Stoneburner Lecture Series was designed to share with our medical colleagues some of the psychological knowledge applicable to their own medical interests which the field of psychiatry has accumulated. Additionally, we hoped to clarify and illustrate some of the areas in medical practices in which greater collaboration and integration could be established. The program included topics which we felt were most pertinent to the medical practitioner—both at the present time and in the future. Beginning with the two Stoneburner lectures, the papers are presented under four sections: communication in medical practice; the family as a factor in medical practice; psychophysiologic conditions; and psychosocial management.

—G. K.

** The 1969 Stoneburner Lecture committee was made up of Jules Arginteanu, Richard H. Armstrong, Charles F. Christian, Gilbert N. Ferris, F. Paul Kosbab, George Kriegman, Henry D. Lederer, Sherman Master, Barbara A. Munjas, E. C. Paarfus, Douglas Powers, and Morton D. Schumann, all of the department of psychiatry at MCV. Dr. Kriegman served as chairman of the committee.*

Changing Concepts of Deviance

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As I look at the list of distinguished Stoneburner Lecturers, I see I am honored by being the first psychiatrist. This is a tribute to the Department of Psychiatry.

In thinking about this paper, I at first considered giving a kind of history of psychiatry. What seemed to me more interesting, however, was an examination of our whole perspective on deviance, in general, and what we call "illness"—an example of a certain kind of deviance, or, perhaps more accurately, a certain way of looking at deviance.

Concepts of Physical Health

It is clear that if one talks about deviant behavior, one must have some concept of a norm from which to deviate, and yet normality is a tricky concept for which we have either slippery or banal definitions. We have practical definitions, so that if someone says he feels fine and he looks all right to us, we say he's normal. Such definitions have very little theoretical value, however. Certainly our definition of normal has changed as our knowledge about the workings of the body has increased. We now signify changes in cells as being abnormal or deviant, when only a very few years ago one would never think of even examining them. To define health one must think of certain balances that maintain the safety of the organism, protect its life, and maintain the possibility for the fullest use of its various functional capacities. In this framework, all illness tends to hamper or threaten the organism's existence or functional capacity. Health, or the normal, has never been of much interest to physicians. The absence of disease has always seemed dull. The physician who has just examined a patient in which there are no "positive" findings will say the patient has "nothing." Even the word positive is peculiar here, but so accustomed are we to the search for disease, that to change it to "negative" would be a wrench.

This disease orientation of the physician has had great advantages. The imbalance brought by disease to the functioning of the organism has been used to study the balance of health. Where would medicine or, indeed, biology be had we surveyed the size of livers, for example, and concluded that since some people have big livers, some have small, and some are in the middle, this is the natural distribution? The concept of natural distribution has carried with it the tacit set of acceptance or of inevitability. The concept of pathology—of disease, of something being wrong and needing to be changed—has been basic to medicine, to research and to treatment. This whole disease orientation is now under attack. The physician is condemned for his narrowness, and many people want something more—something in the area of increasing potential and happiness. In biology we have certainly moved beyond the need for an illness, which one can view

as an experiment of nature, to point the way for the investigator.

The direct approach in the biochemical and biophysical mechanisms in the organism is at hand, and direct intrusion into the mechanism will prove infinitely fruitful. But before we leave the subject of disease orientation, I would like to point out that Pauling's Nobel Prize in medicine was awarded because of interest in two diseases—sickle cell anemia, a common illness, and paroxysmal nocturnal hemoglobinuria, a most uncommon one—but studies of these two illnesses led to the most fundamental discoveries on the shape and structure of the hemoglobin molecule. The single helical formation inspired the double helical formulation for genetic material and brought a second Nobel Prize.

This direct approach to the study of disease will result in a future generation of physicians having a different and more modern outlook. We have certainly crossed a barrier when we now do research on the aging process and can get grants to study it—hopefully, to cure it. What brave new world do we enter here? Will it be normal some day to be only a certain age, a certain height or a certain color? Will the increase in control that scientific knowledge gives tend to standardize us, to narrow the spectrum of what we now think of as normal? Can we stand these decisions? What constant controversy could maintain when the possibility of control is further realized? Man was spared decision and controversy when superstition reigned and it was the gods or nature who determined practically the whole environment as well as the character of man himself. What arguments one could have with one's wife, parents and in-laws over the ultimate size, color, sex and I.Q. of a blessed event!

The maintenance of life and functional capacity demands an adaptation to the environment, because no living thing is self-sufficient. It always takes from and gives to the environment. In physical terms the lack of adaptation leads to death. Let us look at the mental and the social aspects.

Concepts of Mental and Emotional Health

If we have difficulty in dealing with or developing the concept of physical health, we have even greater difficulty with the concepts of mental and emotional health. We can see many of the same dilemmas in definition, and we see even hazier borders. But if we go about our definitions in the same way, we may get somewhere. To be normal mentally for one's age, there are certain prerequisites. One must have some understanding of the world outside; this we call reality. It is immediately clear that reality varies with the culture and with the understanding of it, but, nonetheless, one cannot be normal or be able to adapt without a grasp on it. Once one has some grasp of reality, some kind of adaptation is absolutely necessary in order to be self-sufficient. We can see that the most difficult part of our environment to adapt to is other men. We can see that there are certain requirements in the environment for the adaptation to be normal. Adaptation to an environment like a concentration camp or a prison, for example, might be heroic for a spell, but quite abnormal if preferred. In other words, the environment must provide the opportunity for the full use of one's mental capacities and the satisfaction of one's emotional drives, or such an environment will prove as restrictive to the mental sphere as the desert to a water bird.

If one were to caricature the psychiatrist's, psychologist's, social worker's or physician's role in past years, one might say that it was to get those who were out of step with the society back into step with it, to help them adapt to it. This is not the same as conforming to it. Now the young and the disenchanted are saying, "Examine your environment; you will find *it* sick—not the people who refuse or cannot adapt to it. Replace your efforts to adjust the individual to this sick society with social action that will modify the society so that it better fits the individual's requirements." There is nothing new in this idea except that, because of modern science and medicine, this problem enters the health field in a philosophical way. Every great political and religious movement had some environmental change in mind. The various communist revolutions all have had at their core a desire to change the human environment in order to enhance the hope of individual realization and opportunity. The tremendous revolution in labor practices of the last 35 years has changed the lives of millions for the better.

In the interface of the society and the mental functioning of the individual, there is a new and confusing twist in our scientific attitude of inquiry into the cause of things and the relationship between forces. We have undermined an older moral view. This conflict gives many of us great concern and is at the heart of much of our turbulence. Not long ago, the idea of free will and individual moral responsibility was widely accepted and, indeed, still underlies most of our legal foundations and social processes. It is based on church law, from which civil law was derived, and is basically an attitude that a great many people still hold. The idea is simple, namely, that an individual knows right from wrong and is responsible for his actions. It was and is a simplistic view. There were no exceptions to this rule at first. Then only those persons who were most deviant were excepted—deviant in the way that they did not see reality the way others did. Until recently this view of human behavior was, in general, satisfactory. Now there is an explosion of discontent and disorder in this area. Under the impact of

psychoanalysis, modern psychology and sociology, the idea of individual responsibility has decreased, and a kind of determinism has taken hold. It is interesting that the assassination of Robert Kennedy, for instance, was met with sadness, but no great public outcry for revenge. As Sirhan Sirhan's own personal history unfolded, one envisioned a miserable little boy, a brutal father and great adversity, and one compounded these into some kind of a partial explanation that did not whet the appetite for revenge, but simply revealed another tragedy.

Similarly, alcoholism has graduated from being a moral defect to being an illness. An illness in this instance is a deviance one cannot help. Not long ago an unmarried girl having her second abortion was considered a psychopath (i.e., a bad girl); now she is more likely to be looked upon as having suffered two traumatic events. In all these instances it is clear that one is moving away from moral judgments toward explanations for behavior that put the individual more in the position of victim than of perpetrator.

The opposition to this modern trend has its rational base in the fear that the lack of individual accountability for one's action will degrade individuals and society as a whole. There are always cases that cause public ire, e.g., when there is no question about the act, but the defendant is judged not guilty because of insanity. In these instances the law, as I see it, turns a partial explanation for a bit of behavior into an excuse. The law says, in effect, that this man's or woman's deviance is so great that he or she can no longer be held morally accountable for any action. As modern knowledge about formation of man increases, we see greater complexity—particularly in the interplay between the environment and the growing mind of the developing individual. It is exactly analogous to the tremendous increase of the biological complexities that biochemical advances have brought in the knowledge of the body. Just as they have made a quick definition of health impossible, so has the knowledge of the developing mind and the complexities in the determination of behavior made a quick and simplistic differentiation of normal impossible. To ask one of us if someone at a given moment in the past knew right from wrong and was able to adhere to the right sounds simple, but to answer the question in an honest and intelligent way is almost always impossible. Our minds are too complex and too inconsistent.

Dilemma of Conceptualizing Deviance

It seems to me that we have a major dilemma here but one which can be solved if we approach it properly. We should divide the concepts of explanation and excuse. For instance, there may be many reasons which determine, or at least partially determine, a man's act when the act is detrimental to society and, therefore, should be deterred. I know a woman who shot an eight-year-old neighbor through the head, buried the gun in some hamburger meat in the freezer, dumped the body in a field, and then went shopping. A large number of people asked me, "Is there anything wrong with Mrs. C.?" The only answer I could give was "How normal can you get? Any suburban housewife ought to shoot the neighbor's child." The act itself, in a case like this or Speck's, speaks more loudly for senseless deviant behavior than anything else one could find out about it. The verdict of not guilty because of insanity in Mrs. C's case does not sit well with any of us. In her instance, guilty because of insanity would make more sense. The depth of penetration of moral concepts into our legal system is clear here, because the law literally maintains that if one had no moral responsibility for the act by reason of derangement, one in effect did not commit the act.

I talk here of an extreme of deviant behavior, which showed its abnormality by being determined not by an external provocation from reality but by distorted inner drives unmodified by a grasp on reality. It may be true that environmental pressures in the distant past were influential in distorting these drives, but, if so, they were important in the developmental process. Let us turn to deviants who are more obviously influenced by the society around them.

Societal Attitudes Toward Deviance

How a society handles and even identifies deviants is an important hallmark of that society. We probably delude ourselves into thinking that times are different in the very ways in which they are not. For instance, student protests and riots, rather than being an innovation of the 20th century, are as old as universities. Student demands for authority started, in a way, at least as early as the Middle Ages when students were the authority. Both in Spain and Italy universities grew out of bands of students hiring men to teach them and firing them when they were displeased. Riots of students in England and Paris progressed to pitched battles in which multiple deaths occurred on each side. In this century, with the great growth in knowledge that has occurred, particularly in the sciences, and the tremendous increase in the number of people and the demand to attend universities, we have had to evolve a more complex structure. This structure is now seriously threatened by student criticism and questioning, actively supported by many faculty—most of them young.

Although many of these criticisms are rational and just, because our structures, like all structures,

have become encrusted, there is great danger that the impatience and sharpness of the demands may make much good disappear. In the excitement of this mounting battle, extraneous motives are included: the working out, or at least the expression of personal hatreds toward an authority that arise out of attitudes toward one's parents; the simple excitement of battle; the support of some cause, no matter what, that gives the shy and the lonely an excuse for companionship. Again one sees the tendency to move responsibility for failure one step away from oneself. It is becoming increasingly popular to say that it is not the student that fails, but the school. The man does not fail; the society fails. In *Time* magazine, an English psychiatrist is quoted as saying that mental patients are not sick; society is sick. It is a reversal of what we had taken as obvious before. We are now almost saying that it is up to the school to see to it that a student is happy and successful and up to society to insure success. The conservatives among us have a point. Is it not degrading to remove all sense of personal responsibility? Does it not remove a valuable pride if one has to say the school or society did it—not I? But the conservatives have gone too far in the past. Starvation is no incentive; hunger may be. The interweaving complexities of our society no longer leave any one of us "free" in the old sense. Prejudice against a man's skin, nationality, or religion still takes a horrible toll, and this must be fought. Societal changes that move toward fairness are the good things that our protesters are protesting for. The deviant serves us well here. The man or woman, girl or boy, who defies convention, who moves out of the establishment to look at it with personal courage and clarity saves us from the perpetration of the wrongs that have gone before. But the older ones of us, who, I suppose, are members of the establishment, wish that the young reformers would realize that once some of us were young reformers, that we are not personally responsible for the world as it is. We inherited a good part of it, and we have been tolerant enough to let them have their strident say. I hope they realize also that the deviant's tragedy is his success, because with success, which entails a following, he no longer is deviant.

Handling of Deviancy, the Hallmark of a Society

In the handling of deviants a society brands itself. A society that demands conformity stagnates at best. A society that allows destructive deviation destroys itself. A compromise between these two extremes is needed. There seems to be an inertial force in society that swings to excessive motion first one way then another, yet it is the middle ground we seek. At this time we are rather at a loss in our control mechanisms which we used to think so firm. To whom do we go to deal with the educational problems in our cities? For all kinds of services? Our demand for service has far outreached our supply, and the demands of men seem to have an infinite capacity to grow. Our welfare and social systems are hopelessly inadequate. Our teacher supply in quantity and quality is hardly better. Our courts and the availability of legal services come nowhere near meeting the need. The distribution of medical care is hardly better. Even the distribution of food in this country of plenty leaves shocking pockets of starvation. These defects demand solution, but how?

The deviant fixes on the weak points in the establishment and forces attention on them—perhaps too shrilly—but he knows there is enormous inertia where change is involved and, accordingly, pushes hard—harder and far more impolitely than many of us wish. The danger he faces is that he must gauge the strength and speed of his demand or he will create a counterforce against him. He already has the conscience of the establishment on his side; once pricked, this conscience can be a strong force, but no one likes looking at his own conscience for too long. I hope we all can manage this so that the reforms may come with deliberate speed with acceptance of the need to act yet without the violence born of frustration.

Tempers are becoming short on both sides. This is not a good sign. We must pay attention to our methods. They are a safeguard. The only difference between a democracy and a totalitarian government is the difference in the methods that are used. Freedom of speech has to do fundamentally with the freedom to express ideas. We should be careful that it does not too readily encompass sheer invective or character assassination. The use of force for either repression or revolution is a dangerous tool; force breeds counterforce, and that, in turn, breeds war. Revolutions have been wrought in the thinking of men without force. Jesus Christ, Ghandi and Martin Luther King accomplished such revolutions. Exercise of true force can bring revolution of another sort. Nazi Germany, Russia, China and Cuba—perhaps even our own country a long time ago—are examples of countries that have seen revolution through force. I doubt that we want that type of solution to our problems. The conditions which existed in Germany and Russia, and possibly China, are not similar to the conditions which confront us now. If we are going to progress, we must realize that all change is not progress; that men still have the capacity for evil or destruction; and that adherence to the method of debate and compromise, heated but softened by reason, is still the steady road to improvement. It is enormously important that motion be evident in the right direction for, as President Kennedy said in his inaugural address,

"Those who oppose peaceful revolution make violent revolution inevitable!"

Summary

I have tried to speak of deviance in a very broad context but have, perhaps, done so confusingly. I was anxious to stress that it is a concept not only deserving broad treatment, but also requiring reevaluation of our stereotyped ideas. I have tried to make three points: 1) Our concepts of health and disease are changing as we move toward a detailed interest in the biological process and the mechanisms that control it. We see that our older classifications are too rigid and too simple. We are caught up in the intricacies of cause and effect and are losing interest in the description—almost moral judgment —of health and disease with illness connoting bad and health good. Furthermore, the increasing control over our lives will provide us with more and more complex decisions. 2) This same kind of cause and effect thinking has penetrated to the mental and emotional sphere —due in the beginning to psychoanalytic findings. Here we have an even more revolutionary problem. Due to the original moral base of our law and the assumption of individual free will and moral responsibility as well as the discovery of a host of genetic and environmental factors in the development of the individual and his behavior, we have fallen into the trap of regarding explanations of behavior as an excuse for it. These concepts must be separated, because society must deter certain actions, regardless of their origin or the degree of our understanding. 3) Deviance, biologically, has been a window through which we have learned much about the more hidden balances of homeostasis. Because deviance is an exaggeration of the usual, its study has brought a greater understanding of the workings of biological organisms and their adaptation to the environment. Through this study we have learned many of the requirements for prolonging life and identified the agents threatening it.

Deviance in the mental and behavioral sphere has likewise been a window, because it, too, is an exaggeration of the usual. It has led us to a better understanding of the human mind. In society it has led us to the greatest reforms for the preservation of the "body politic," but has also led us to the brink of the greatest disasters. Disaster in the body politic equals "illness" in the biological body; both are life threatening. The hallmark of a society and the judgment of a physician are measured in the same way—by the detection of those forces that threaten and those that enhance the life of the organism. As far as society is concerned, I have little to offer but homily virtues: reduction of prejudice, adherence to free debate, determination to be fair, and everlasting humility with regard to the human condition.

Perspectives in the Behavioral Sciences

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Modesty Becomes Us

Those of us who study human behavior are in a maddening position. On the one hand people think we know more than we do, and on the other, people think we know nothing. It is probably safer that we support the latter group, because it is safer to be smarter than you look rather than looking smarter than you are. At this time in our social development when we are conscious of great inequalities and disturbed about ourselves, experts in the behavioral sciences are in a dangerous position, because their advice may well be sought and possibly even followed. Most of us are not well equipped to give practical advice on a broad scale. Physicians may do pretty well with a single patient in a single situation, but overall advice, except in the form of public health measures, is notably less successful. Not many of us in the behavioral sciences are really in the front lines, but we are great Monday morning quarterbacks. Those of us who are in the front lines may well display courage but not always good judgment. The point I am trying to make is simply that those who try to study and deal with the human condition would do well to have great humility about their capacity to do so and be willing to accept information about man, whatever the source; from history, novels, plays, poems, monks, the military, biology, psychoanalysis, psychology, the social sciences, and, I suspect, as important as any, from politicians. The politicians have to "put it all together and make it work" somehow—so they have the hardest jobs and yet in many ways are the most learned.

May I say that many of us interested and working in the broad community let our little communities fall apart. How many leaders in this movement have the greatest difficulty in talking with their own colleagues, let alone their families? How many communication experts won't talk or listen to their wives? It would be hard, indeed, to prove that the children in the families of the psychologically- and socially-oriented are better off than others. Now I don't want to wear a hair shirt over all this, because many divorced men and women can be knowledgeable and helpful about someone else's marital problems. Many weird and difficult people can have unique universal insights. But there are few of us who put it all together, and putting it together is what we are after. Our danger is that with the words to diagnose and, thus, sound scientific, we can condemn another point of view out of prejudice and never know it. This can escalate in pure culture in psychoanalytic circles, so that no time is wasted on issues. The diagnostic terms really fly when there are two well-matched analysts duelling. These terms are never complimentary; no diagnostic term is. Academic people need the perspective that, by and large, they are not "doing in the real world," and the "real world" people need to know that study, away from doing, enlightens.

What We Think We Know

To those of us fortunate enough to be in the general field of behavior, this seems an ideal time, because we feel we know enough to ask some answerable questions and have the tools with which to work. Most of the tools were developed far outside our fields, we must remember, and although I suppose the majority of us think spending money on a moon shot foolish at this time, it is from NASA and exploration of space that telemetering and miniaturization have come.

What do we know? And what are the big questions? Several things are clear. As one goes up the phylogenetic scale, the influence of environment upon the developing individual increases. An insect is entirely instinct bound and needs no education. Its behavioral array is small and predictable. This is undoubtedly true with invertebrates and many lower mammals. But in the mammalian scheme this changes rapidly as one goes higher, and we can see that those organisms that we call high on the scale are the ones that are taught, by their parents at least, and that either exhibit or are capable of exhibiting very wide arrays of behaviors.

The human is the epitome of

MCV QUARTERLY 5(3): 90-92, 1969

early environmental influence. It seems an extraordinary evolutionary precaution to have the brain, and, thus, the mind, develop after birth, so that environmental influence can have its play and the mind can develop around the environment that stimulates it. This allows for the development of what one might call a "fit" between the challenge of the environment and the adaptive tool of the mind. We know that the lack of development at birth demands that the human infant be dependent during its development; hence, the need for a family. Strikingly, those animals that seem highest on the scale have the longest dependency and the latest puberty—dolphins, chimps, baboons, elephants, and men. From another view, these late developers are forced into a position in which education is inescapable. What we do not know about all this is how it happens biologically. There must be some biophysical event that fixes information inside, and there is certainly an emotional coding on this information. Psychoanalysis, in particular, has taught us that. To solve this puzzle in some way would open possibilities that at least seem unlimited. In addition, we think we know that there is a postnatal timetable fixed, just as there is a prenatal one which controls the steps of development, so that stimuli have different effects at different times and the absence of stimuli at one stage cannot be made up later. Certainly this seems true in the nervous system. The monkey who is raised in the dark for a period of six months after birth develops an optic atrophy that is permanent, and even the kitten deprived of patterned light suffers degeneration of cells in the medial geniculate. We do not know the boundaries of the postnatal timetable, nor do we know the mechanisms that control them.

Although there are many controls within the genetic structure of organisms, it would seem that genetic structure sets the limits of possibilities and the environment determines the development within these limits. Many behaviors that we had taken for granted as being entirely genetic in origin now are known to be at least partially taught. Quite a few of the higher mammals, including cats, are sexually incompetent unless taught. Long known in animal-raising circles is the need for perineal stimulation in kittens and puppies in order for elimination to take place.

It is certainly clear that the structure of the environment—the pattern of its demands and the values it impresses—is going to be enormously important in shaping an individual. We, therefore, need pay great attention to this milieu. Never has our attention been so evenly divided. Enormously impressed by the biochemical revolution and the possibilities of manipulating the genetic code, we are equally appalled at areas in our society that have always existed but for which we have not felt responsible. As these areas come into focus, many of us are consumed with guilt. Evolution in the social sciences has at once fed this greater insight and has been promoted by it. Sociology has stressed broad generalities and trends in society as a whole; much of anthropology has been naturalistic or clinical. As time goes on, however, methods of investigation become less distinguishable, not unlike the melding of techniques in the traditional sciences considered basic to medicine. None of us need to be told what a turmoil most of our societies are in. We do need to be reminded of man's history, however, lest we lose perspective. There is one new thing that adds urgency to our seeking for solutions—the great increase in our destructive capability.

Broadening Sense of Our Social Responsibilities

In 1953 French author Jean Briller ("*Vercors*") wrote a novel called *You Shall Know Them.* In Australia a missing link was found which proved to be a docile and highly trainable great ape or man. Naturally, other men exploited these creatures because of their docility and their expertise in carrying out certain tasks. The hero of the novel killed an infant and was brought to trial. He did this in order to protect the newly found creatures from exploitation, hoping it would be decided that he had committed murder—not just the slaughter of a lower animal. It was an intriguing theme with a denouement that was delightful. The trial necessitated many anthropological arguments about the opposable views, e.g., whether an African pygmy had more in common with the apes than with Einstein, and so on. It was finally decided that the creatures were human and that the killing of one constituted murder. The hero was saved, however, by the judge's opinion that whereas any future case would be considered murder, this could not be; because the only meaningful criterion for being a member of the human race was acceptance by other humans. At the time of the killing such acceptance had not been granted; hence, murder was an impossible verdict.

This book has remained persistently in my mind, because so many of our social problems, it seems to me, have something similar at their core. This theme pertains to fundamental identifications one makes as a child as well as the problems the child experiences in differentiating himself from the outer world and from others. One needs only to read about how children were treated in the past to become aware of something not at all unlike the theme of Vercors' book. It is only recently that children have been thought of as anything but little adults, toys, or laborers. Children were simply not protected in the Middle Ages and the Renaissance. Nineteenth century England and America had a ghastly history for cruelty to and neglect of chil-

dren. Not until 1912 were child labor laws passed in this country. On the Eastern Seaboard, trains were filled with unwanted children and taken west to be indentured to farmers, where many were horribly exploited. I doubt whether anyone to this day has been charged and convicted of the murder of his or her child, yet even today in this country more children are beaten to death by their parents than die of leukemia. In other words, a child is not yet fully adultly human. It is peculiar that this is true in what we caricature as a child-centered society. We have gradually and slowly admitted children to the human race and, in fact, have identified with them to the point of feeling responsible and protective. This is not true in many parts of the world today, where brutality to and neglect of children is just as bad as in 19th century America.

The poor have had a similar fate. It is really a new concept—very, very new—that someone else's poverty is your problem. This has been attributed to the Judaic-Christian ethic that says you get what you deserve, but I suspect it is basically something else. This attitude is even more pronounced in India, China, and Indonesia than it is in Judaic-Christian countries. It concerns with whom you identify and with whom you do not.

I once saw a great deal of raw footage taken by an anthropologist studying a particular tribe of Eskimos. A major part of this was of a four-year-old boy helping his father kill and butcher a caribou calf. In the next episode the father was shown snaring a sea gull. The little boy spent four solid hours beating the tethered sea gull on the head with rocks. The Eskimos are very gentle with their children —never hit them, for example. After this little boy's exploits, his parents praised him heavily. I was greatly impressed by the fact that, in a hunting culture, it is most important to avoid bringing up the child so that he identifies with the animals; otherwise he cannot kill them. Also interesting was the fact that no animals—not even dogs—are pets.

Somehow I have the feeling that this phenomenon should be incorporated into the understanding of prejudice. It is somewhat different than our usual explanations. When Marie Antoinette said, "Let them eat cake," she wasn't being sarcastic; she was merely uninformed. When an Indian prince drives through a starving horde and curses people for blocking the way, he somehow doesn't think they get as hungry as he does and feels they are really so different that he cannot have sympathy. Certainly this kind of thing enters into the race problem. The deeply convinced segregationist feels that "they" are just not like us, and somehow the people with whom one identifies and from whom one separates oneself in childhood have a great deal to do with this dangerous problem. The attitudes of the parents are critical here, and if you convince the child that the soft little bunny is just like him, he'll believe you and have a hard time eating it.

It is clear that we have at this moment two major thrusts. The first is the unlocking of the biological secrets surrounding the potential for development and the fixing of learned material in the biological matrix. The second is the careful examination of the culture that will be learned. Here, not only every social scientist but every citizen need be concerned. The present emphasis upon the importance of culture can hardly be exaggerated unless it crowds out our interest in the biological. Man remains an enigma; reason, a personal control of prejudice, and a continuing spirit of disciplined inquiry are our methods for not only achieving a better world but the perpetuation of this one.

SECTION I

Aspects of Communication in Medical Practice

Problems of communication are important in all phases of human existence. One needs only to pick up the local newspaper, a magazine, or listen to and view television to realize the confusing bombardment of widely different concepts to which we, as human beings, are daily subjected. Unfortunately, the same confusions exist in our professional relationships and interactions. Doctor to doctor misunderstandings and lack of communication are not only unnecessary, but particularly need to be, and can be, prevented; because they are a detriment to the medical care of the patient. The first two papers deal specifically with this problem. The third paper deals with patient-doctor communication, for the prime need in emergencies of a psychiatric nature is the appreciation and recognition of what the patient is communicating. He is desperately attempting to convey his profound distress and seeking to be reassured that the doctor understands and will, thus, be able to help him in this profound moment of distress.

—G. K.

Whom, Why and How to Refer

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When a medical practitioner decides that the time has come to refer his patient to a specialist, certain psychological problems arise which may, at times, interfere with the smooth accomplishment of the referral. These problems can and do occur daily in medical practice, and it often makes little difference whether the specialist is a thoracic surgeon, a neurosurgeon or a psychiatrist. Referrals create certain anxieties and fears in the mind of the patient. Some of these anxieties are common to all referrals. The patient asks himself, "What's going on? What does the doctor think I really have? How serious is it? Will I come out of this alive, incapacitated, disfigured? Is this referral necessary? Why can't I go on as I am? Is the specialist he's sending me to really good?"

When good communications exist between the physician and his patient (and also between the physician and the specialist), the level of anxiety drops, and referral is much more easily accomplished. In some instances the intelligent and perceptive patient may sense the situation and may himself suggest the possibility of referral to a specialist. In most other instances, however, the preparation of the patient for a good referral takes time, patience and skill. In fact, the making of a good referral is one of the great unsung arts of medical practice. When all goes well, the patient is grateful to you for making the referral to a specialist, who, in this frame of reference, becomes only an extension of your therapeutic efforts. In other instances the fears and anxieties which are caused by the mere mention of a referral interfere seriously with the patient's future progress. It is in an effort to understand, allay and, possibly, prevent these fears and anxieties that this paper is being presented.

Whom to Refer

Since 50% to 75% of patients seen in general practice have symptoms which are completely or largely of emotional origin, the medical practitioner will have to be highly selective in deciding whom to refer to a psychiatrist. Even if we were to triple the number of psychiatrists in the country, it would never be possible (nor would it be advisable) to refer all patients with psychogenic symptoms for psychiatric treatment. Fortunately, the majority of patients with such problems can be effectively treated and, in fact, *are* being so treated by the family physician, with or without an occasional assist from a consulting psychiatrist.

Who are these patients? Which ones can be best treated by the medical practitioner, and which should be seen by a psychiatrist? Patients with psychiatric symptoms seen in doctors' offices can be divided into three main groups: 1) those with minor disorders; 2) those with major disorders; and 3) an intermediate group.

Due to the increased teaching of

MCV QUARTERLY 5(3): 94-100, 1969

psychiatric principles in our medical schools and the increased sophistication of our medical school graduates, most physicians now feel fairly comfortable in treating patients who fall in the *first group.* They will be suffering, for the most part, with minor anxieties, situational stresses and mild depressions. The time-honored techniques of ventilation, reeducation, reassurance, and persuasion are well known and skillfully used by most practitioners. Judicious use of the newer psychopharmaceuticals plus full employment of the doctor-patient relationship can help the majority of such patients in a relatively short time. Rarely do such patients require a referral to a psychiatrist.

In the *second group,* consisting of those with major mental disorders, psychotic reactions, suicidal depressions and persistent personality disorders, the indications for psychiatric referral are quite clear. Patients having psychotic reactions, whether schizophrenic, manic-depressive or organic, should be promptly referred to a psychiatrist. The exception is the patient suffering from transient delirium or confusional state, which is often associated with an infectious or toxic condition. In general, if any of the following symptoms are present, a psychiatrist is probably needed.

1. The persistence of incapacitating psychoneurotic symptoms, such as phobias, compulsive behavior, anxieties, obsessions or hysterical manifestations.

2. The persistence of psychogenic sexual problems.

3. The persistence of serious psychophysiologic (psychosomatic) symptoms. These are often best treated *jointly* by the psychiatrist and the referring physician at the same time.

4. The presence of psychotic symptoms such as active hallucinations, delusions or thinking disorders.

5. Sudden changes of personality or judgment.

6. Exaggerated swings of mood and motor activity.

7. The development of retardation, depression and preoccupation with self-destructive thoughts. (Sometimes a suicidal gesture which brings the patient into the hospital emergency room may serve a useful purpose by bringing psychiatric help to a reluctant patient.)

The *third* or *intermediate* group of borderline patients will cause the greatest difficulty to the physician making a decision as to referral. In some cases, factors relating to the patient will be of greatest relevance. For example, we often see the patient with frankly psychiatric symptoms who stubbornly refuses to consult a psychiatrist no matter how skillfully the idea is presented. In such cases it is unwise to force the patient. Supportive and symptomatic treatment by the physician should be continued in the hope that he may eventually change his opinion. A patient who consults a psychiatrist under duress or against his will has little to gain from the experience. Another group of patients in this intermediate group may be intellectually, culturally or psychologically unsuited for prolonged psychotherapy, and the doctor's decision not to refer such patients is most often in the patient's best interest.

In other cases, factors relating to the physician himself are of paramount importance. For example, the background, education, aptitude, interests and time availability of the physician himself play an important role in whether he continues to treat the patient with psychiatric symptoms or refers him immediately to a psychiatrist. Some physicians, as is well known, have little background, interest or patience for people with psychiatric problems and give them short shrift. Other physicians with different backgrounds may be unusually interested in such cases and may delay referral to a psychiatrist until it is dangerously late. Obviously no set rules can be laid down, and each case in this intermediate group must be judged on its own merits.

Why Refer

The obvious answer to why a patient is referred to a psychiatrist is to provide that patient with specialized help in order to restore his health as quickly as possible. If this thought can be communicated honestly and openly to the patient—often so much depends on this—then the patient will understand the reason for the referral and cooperate with his physician.

In this connection it is of crucial importance to avoid vagueness in making the referral. Vagueness on the part of the physician only leads to increased anxiety on the part of the patient. Unless you are specific, he is likely to think, "I wonder why the doctor is referring me to a psychiatrist. . . . Does he think I'm insane or something?" Select a specific symptom as a reason for your referral. For example, you may tell your anxious patient something like this: "Your fears of speaking in public have not responded to medication and our attempts at treatment. I think it would be quite helpful for you to see Dr. X, a psychiatrist, who is skilled in these matters." The physician, by focusing on a specific symptom, can help the anxious patient understand and accept the need for psychiatric consultation.

In most instances patients are referred to psychiatrists for consultation and treatment. The psychiatrist continues to see the patient in therapy and may report on his progress to the referring physician from time to time. (The reporting process is not always as complete as it should be, I regret to say. The psychiatrist owes the referring physician an initial report, and there should be continued communication whenever it is to the patient's benefit.) There is now a growing tendency to utilize the

psychiatrist as a consultant only. Very often a psychiatrist, by means of a single interview, may gain sufficient data to make significant suggestions regarding medication, management or type of treatment which may have beneficial effects on the patient's course. In such instances the patient continues to see his family physician on a regular basis until the situation is resolved.

Under no circumstances should the patient be sent to a psychiatrist in order to "get rid of him." If the patient senses that his physician is referring him for this purpose (and most patients are extraordinarily sensitive in this regard), the referral is off to a very poor start. If, however, the patient senses that the referral to a psychiatrist is made with his best interests at heart, the likelihood is that the physician's suggestions will be accepted in the spirit in which they are offered.

In general, a patient should be referred to a psychiatrist because, for a variety of reasons, the treatment he has been receiving has been of no avail in relieving his condition. This is not a negative reflection on the physician or on the patient but rather a realistic appraisal of a frequently encountered state of affairs in clinical practice. If this situation is promptly recognized by the treating physician and the why's of the referral carefully explained to the patient, the referral is accomplished without incident and to the benefit of all concerned.

How to Refer

In considering the question of how to refer, I should like to start by telling a story of how *not* to refer a patient to a psychiatrist. This is a true story of a case I had referred to me some years ago. I have told this tale to many medical audiences, but the lessons to be learned from it are so important that it bears repeating.

Several years ago a successful young physician with a large general practice called my office. I was with a patient at the time and, therefore, unable to speak to the doctor; but I returned the call at the next break. He told me that he had sent a patient to my office and wanted to be sure to talk to me before I saw him. I told the doctor that I was solidly booked for the rest of the day and that it would be impossible for me to see him. However, if the matter was really urgent, I would make time for him as soon as possible or get someone else to see him. At that time I asked him the nature of the problem.

He replied as follows: "Here's the situation. This patient, Mr. Smith, is a taxi driver, 28 years of age, single, and has always been in good physical health. He came to my office a few days ago complaining about lice which were causing him to itch all over. He had used several ointments and lotions which had been suggested by friends and druggists but got no relief. The situation was driving him frantic. I had an office full of patients and was too busy to examine him personally, but I gave him a lotion to apply locally and told him to come back in three or four days. He was back the following day. He said the lotion helped for a while, but the itching returned worse than ever. This time I sent him to the examining room and had my nurse go over him with a bright light. She couldn't find anything at all, but I assumed that the lice had disappeared because of the lotion, even though the itching had remained. So I gave him another preparation with complete directions and told him to return in about three days.

"Well, he was back the following day, this time complaining that the itching was much worse. He was so bothered this time that I took him into the examining room and went over him myself with a fine-toothed comb. I was then convinced that he never did have lice. I told him that I thought the lice were only in his mind, and I suggested he see a psychiatrist.

"At this point he really got upset and said, 'I was afraid you were going to say something like that. . . . I know what I've got, even though you can't find them!' "

The doctor continued, "At this point I was more convinced than ever that he needed a psychiatrist, so I told him, 'Okay, here's what I want you to do. I want you to see this doctor, Dr. Lebensohn. He is a specialist, a specialist in lice. He has a special microscope, and he may be able to see these lice where I can't.' So that's why I gave him your name, and that's why I wanted to give you the background story before you see him, so you would know what to do."

At this point in the telephone conversation there was a long and pregnant pause. I asked the doctor what he really expected me to do when Mr. Smith came to the office, and when he hesitated, I spent the next 20 minutes on the telephone explaining all the reasons why his referral, even though it was made with the best intentions, was doomed to misfire and could only end in catastrophe.

What actually happened? The taxi driver arrived about an hour later without an appointment, as instructed, and noticed that the waiting room and office did not seem to go along with a "lice specialist." After introducing himself, he asked my secretary what kind of a doctor I was. She, of course, told him I was a psychiatrist, whereupon his face took on an expression of disgust. He cried out, "So that's the game!" turned on his heel and walked out.

One can hardly blame this patient for behaving in this way after being tricked into seeing a psychiatrist, even though the doctor had the best of intentions. As a result of this well-meaning but unwise ruse, the patient was now more distrustful than ever of all physicians and became much more difficult to treat.

Lessons to be Learned

It may be helpful to go back over this story, study the various errors, and see what can be learned. The first question is: Should the referring doctor call the psychiatrist before the patient comes in? At times, such a call may be extremely helpful, but if the psychiatrist is called, it should be done with the knowledge and consent of the patient. Some patients, many of them paranoid, would prefer to see the psychiatrist without the benefit of a report which precedes them, a report which they fear may prejudice the psychiatrist. Often it is necessary for the referring physician to call the psychiatrist in order to obtain an appointment, but in such instances it is best, as always, to inform the patient.

Phone Calls

Except for emergencies, most psychiatrists do not accept phone calls during the treatment hour, for obvious reasons. Breaking into a therapeutic session may be like interrupting a surgeon in the middle of an operation. If a message is left, however, the psychiatrist will return the call at his first free moment. Sometimes it is a good idea to make the appointment with a secretary and to write a brief note to the psychiatrist, giving the central facts and the reason for the referral. It is often helpful to give the patient a copy of this note so that he knows exactly what has been said about him.

Getting an Appointment

A frequent and important complaint in recent years, voiced by many of my good friends in general practice, runs somewhat as follows: "Here I work on a patient to the point where he or she will accept psychiatric treatment. Then I call your office and find you're all booked up for the next one or two months. What's a man to do?"

This is a serious problem, and the only way to solve it is to give the medical practitioner a greater familiarity with the nature of the psychiatrist's work. He then can pass this on to his patient as a part of the work-up or referral process. Due to the time-consuming nature of psychiatric practice, the number of patients any one psychiatrist can treat is necessarily limited. One psychiatrist can rarely see more than seven or eight patients in his office during the day, each interview lasting from 30 to 90 minutes. If he is conscientious, he knows that overloading his schedule results in fatigue and inferior work. Therefore, if you respect him as a psychiatrist, it is also important to respect his decisions regarding his ability to see a new patient.

If he is not able to see a patient immediately and you think the patient can wait, it is helpful to explain this to the patient and advise him to do so. After all, the patient has probably had his difficulty for many months, and sometimes for years. On the other hand, if it is something more urgent, send him to another psychiatrist who has free time or ask your psychiatric colleague for other names. Ordinarily, a psychiatrist's schedule is made up some weeks in advance, and he can usually tell you when he will have an opening. After all, many other specialists, particularly ophthalmologists, have waiting lists of two and three months. It is important to emphasize that, other than arranging for emergency hospitalization, it is almost impossible for the psychiatrist to do anything helpful for a new patient who is squeezed in between appointments. It takes a full hour, and sometimes three or four hours, in order to find out what the problem really is. Hence, it would have been of little or no help to see such a complicated case as the taxi driver for only a few minutes. This would only have antagonized him further. There is no substitute for time in the handling of delicate psychiatric problems.

The Medical Work-Up

There is nothing more dangerous, in my estimation, than the premature psychiatric referral with an inadequate medical work-up. This holds not only for psychiatric, but for all other specialty referrals as well. Had the taxi driver in our story been given a careful examination on his first visit, perhaps our story would have had a happier ending. By prescribing treatment for a condition which did not actually exist, the doctor unwittingly reinforced the patient's delusions. When he finally examined the patient and found that he never had any lice, he was placed in the embarrassing position of having to reverse himself. It was perhaps because of this embarrassment that the doctor reversed himself once again and participated in the patient's delusions by suggesting treatment for a condition which did not exist.

In the course of a long and varied practice, I have found myself seeing patients who had been sent to me for psychiatric treatment, only to discover that the basic problem was medical. On one occasion the patient was referred to me for treatment of a depression. In the course of obtaining her history during the initial interview, I noticed that her skin was thick, her hair coarse and her whole appearance suggested hypothyroidism. I was placed in the embarrassing position of sending her back to her physician for further investigation. The PBI turned out to be 2.6, and she responded beautifully to thyroid medication.

On another occasion, a well-known internist referred me a patient who was experiencing peculiar sensations throughout his body. Numbness and paresthesias were present which he could not explain. The man held a responsible government position but was worried

because of a sick wife, many job difficulties, and a retarded child. The doctor gave the patient a Sodium Pentothal interview without any significant change taking place. The patient was referred to me because of a hysterical conversion reaction which persisted in spite of the doctor's efforts. On examining the patient during the initial interview, I was impressed by the organicity of the patient's complaints. He noted that when he shaved the left side of his face was numb. However, there seemed to be numbness on the right side of his body. Careful neurological examination revealed that this patient was suffering from a thrombosis of a branch of the posterior-inferior cerebellar artery. Naturally he was greatly relieved to learn that his symptoms had a physical base and that he did not require countless months of psychotherapy, which he could ill afford in either time or money.

Honesty

In psychiatric referrals the old adage "honesty is the best policy" still holds. There is no exception to this rule in referring a patient to a psychiatrist. Since honesty is important in all human relations, it is all the more important in dealing with the psychiatric patient, who has usually suffered from dishonest handling in the past and is particularly sensitive to dishonesty.

All deviations from the truth, no matter how innocent or well-meaning, invariably lead to disaster for the doctor, the psychiatrist, and —worst of all—the patient. In the story of the lice specialist, it would have been far better had the doctor stuck to his guns. After discovering his first error, he should have told the patient that he was recommending psychiatric treatment. Even if it meant the loss of a patient, it would have been worthwhile, for ultimately enough physicians would have arrived at the same conclusion to have made some impression on the patient.

In spite of education in the field of psychiatry, certain doctors—particularly those of the old school—still regard the word psychiatrist with fear. For this reason they continue to use such euphemistic and, presumably, less shocking terms as neurologist, "nerve specialist," and "nerve doctor." If the problem is psychiatric and the patient is being referred to a psychiatrist, the doctor should say so. If the patient is deceitfully referred to any competent psychiatrist, he will learn his true identity in short order, and his confidence in the referring physician will be shaken. From my experience I find that much of the anxiety in this matter stems from the doctor rather than from the patient.

Another form of dishonesty in referral—and an example of what *not* to do—is illustrated by the following problem presented to a psychiatrist by a family physician. "Doctor, I have a patient who needs your help badly, but she hits the ceiling when I mention the word psychiatrist. Couldn't I simply tell her that you are just a diagnostician and let it go at that? Or better still, couldn't you just come to the house as a friend of the family? Or perhaps you could come to the house ostensibly to see her husband but really to see her? I would be glad to arrange it for you." Of course, yielding to any such deception is sanctioning the worst sort of medical practice. Under no circumstances should a psychiatrist ever be asked or permit himself to see a patient in any role other than his true one.

In addition to being unethical, ineffective and actually harmful, such a ruse may get physicians into serious legal difficulties. As an example of this, several years ago a high ranking Army officer consulted a psychiatrist about his extremely paranoid sister. He was anxious to have her safely hospitalized before he left on an overseas assignment, because he did not wish to be called back for some psychiatric emergency, as he had in the past. The patient had been mentally ill for many years and had once seen a psychiatrist but had refused to return to his office. She apparently suspected that her brother was attempting to have her committed. Her brother finally prevailed on two psychiatrists to join him in the cocktail lounge of a large Washington hotel where, by prearrangement, he was to meet his sister. The sister arrived and was quite shocked to find her brother accompanied by two psychiatrists. They spoke to her briefly and filled out the necessary commitment papers, which enabled the police, waiting outside, to escort her to the hospital.

Needless to say, the courts took a very dim view of the whole matter, and although the patient was very much in need of treatment, she was released by order of the Court, and the doctors were severely reprimanded.

When to Refer

The interrogative adverb "when" is missing from the title of this paper that was assigned to me. However, timing of the referral is often of crucial importance. As indicated earlier, it is most important to do a careful medical work-up, even in cases which are obviously psychiatric. As in the case of the taxi driver, such a medical work-up not only is good medicine but also prevents the possibility of future embarrassment. On the other hand, it is unwise to subject the patient with psychosomatic complaints to an infinite barrage of laboratory and X-ray examinations. Continuing this for too long a period will only reinforce the concept of organic etiology in the mind of the patient. In recent years there has been a tendency to refer patients to psychiatrists a bit prematurely—sometimes, as in the case of the taxi driver, before the medical work-up is completed. Often the

physician underestimates his own ability to manage and treat the numerous emotional problems seen in the course of his practice. It rarely does any harm, and often helps greatly, for the physician to continue to give the patient support and reassurance while waiting to see how the process is going. Very frequently, the physician will be surprised to find that he is treating a transient situational disorder which did not require referral to a psychiatrist.

It is also wise to continue seeing the patient until he is accepted for treatment by a psychiatrist. Not every heart case needs to be seen by a cardiologist, nor does every person with an emotional disorder need to be seen by a psychiatrist. In each instance the knowledge of general cardiology and general psychiatry equips the general practitioner to treat many of the problems himself.

Obviously, the best time to refer the patient to a psychiatrist is at that moment when the physician has satisfied himself that he is no longer being helpful to the patient and that specialized techniques are needed.

To Whom to Refer

In order to make a good psychiatric referral, it is imperative for the medical practitioner to know the psychiatrists and psychiatric facilities in his area. The best information can be obtained from personal acquaintance with a psychiatrist. It is well to recognize that in psychiatry, just as in medicine or in surgery, there are many different schools of thought and many subspecialties within the specialty. For example, there are some psychiatrists who are specifically qualified and trained to give long-term psychotherapy or psychoanalysis; some who are equipped to administer the various forms of shock therapy; some who are primarily interested in psychopharmacology; others who limit their practice to office patients and do not have a hospital practice; and still others who limit their practice to those conditions which respond to intensive, brief psychotherapy. It is best to become acquainted with a psychiatrist who is well trained in *all* the accepted techniques of therapy and rely pretty much on his judgment.

In this connection it is unwise to tell your patient that he is being referred to a psychiatrist for the sole purpose of any one specific type of therapy, such as electroshock therapy or psychoanalysis. The selection of the most effective treatment modality is often a difficult and time consuming task, even for the psychiatrist. If the consulting psychiatrist should decide against recommending the specific treatment mentioned by the referring doctor, the patient is understandably bewildered. In the field of neurosurgery for example, the referring physician does not customarily tell the patient that he is being sent to the surgeon for a suboccipital craniotomy. The patient is simply told that he is being sent to another specialist for examination, diagnosis and recommendations for treatment. The same excellent principles should apply to a psychiatric referral.

Special Techniques

There are some special situations in which special techniques are indicated. In the case of the patient who is hospitalized because of a medical or surgical condition and who then develops psychiatric symptoms, one of the best techniques consists of the attending physician arranging to meet the psychiatrist at the bedside of the patient. The psychiatrist is introduced to the patient and remains while the attending physician relates the history of the problem and the nature of his concern. Very often such an initial interview is all that is needed to establish excellent rapport and eliminate the anxiety which would otherwise accompany a trip to the psychiatrist's office.

In certain situations (relatively infrequent, I must confess), the attending physician has accompanied a timorous patient to my office and has remained for the first few minutes of the interview, to make the introduction and give the background of the case. Such a maneuver, although costly in time, can be exceptionally reassuring to the frightened patient.

Preparing the Patient

A patient who has never consulted a psychiatrist before is often quite concerned about what to expect from his first interview. A few words of reassurance from the family physician can go a long way toward allaying this anxiety. The patient may be concerned about the expense of psychiatric therapy; therefore it is probably helpful to give the patient some idea of the prevailing fees in his community. If there is a serious economic problem, special arrangements may sometimes be made with the psychiatrist or the psychiatric clinic utilized.

A frequent source of misunderstanding on the part of both the referring physician and the patient is the length of time required for psychiatric treatment. Some physicians, in their efforts to allay the patient's anxieties, tend to minimize the difficulty and imply that, if he agrees to see a psychiatrist, he will be completely cured in a few sessions. This, as you know, is totally unrealistic, and there is no experiential basis for the physician making such a judgment. As you also know, it is very difficult to estimate the time required to treat any given condition. Other physicians err in the opposite direction and tell the patient that he will probably require two or three years of psychiatric treatment. This, understandably, tends to frighten the patient away. It is best to explain to the patient that psychotherapy

usually extends over a period of time which can only be determined by the treating psychiatrist. Rapid changes are the exception rather than the rule.

In general, the more a patient knows about what to expect from his first interview with a psychiatrist, the better it is for all concerned.

Summary

I have suggested ten points as aids to the physician in referring a patient to a psychiatrist.

1. Always do a careful work-up, even in the presence of obvious psychiatric illness.
2. Time the referral. Take enough time to establish a good working relationship with the patient before referring him to a psychiatrist. When you have done that, it becomes a meaningful measure and not a way of "getting rid of" a patient.
3. Never underestimate the ability of the sincere family physician to help the emotionally ill patient.
4. Be completely honest with your patient and with yourself. Tell him the specific reasons for which you are calling in a psychiatrist.
5. Avoid displaying needless anxiety or appearing to be in a rush. Remember that there is nothing more contagious than fear itself.
6. Know the psychiatrists and the psychiatric facilities in your area.
7. If you communicate with a psychiatrist before the referral, get the patient's permission and tell him what you have said.
8. Don't oversell psychiatry, any particular psychiatrist, or any particular form of psychiatric therapy. Let the treating psychiatrist orient the patient as he sees fit.
9. A single consultation with a psychiatrist is often very useful. He may enable you to continue more effective treatment with the patient.
10. Tell the patient as much as you can about what he may reasonably expect from psychiatry.

What Referring Physicians Can Expect From the Psychiatrist

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Introduction

I reread the title many times as I began work on this talk, all too promptly and uncritically agreed to many months previously. Since that occurred shortly after a *tricky* paraphrase of a well-known quote from a famous inaugural address, I could not help the thought, "Ask not what referring physicians can expect from the psychiatrist; ask what the psychiatrist can expect from referring physicians." That seemed facetious at first, but I realized that Dr. Lebensohn would be addressing himself, among other things, to the latter question. He has been discussing the task of the consultee half of the consultation team, and my assignment is to discuss the consultant's role.

As I looked again at my idle paraphrase, I realized that both parts could be answered partially by, "colleagueship, communication and counsel." To be effective the consultation must evolve out of a sense of mutual respect and mutual goals. Proper communication, which must be a two-way operation, as I will detail later, is the key to a successful consultation. Counsel or, perhaps more appropriately put, teaching is a major contribution the psychiatrist can make to his colleague at this point in time, though he, too, can learn much from the referring physician and the patient. In fact, not nearly enough is known about the psychological problems of illness and medical management so that non-psychiatrist and psychiatrists working closely together have the potential for acquiring new knowledge and teaching the medical community.

I asked a wise, sensitive, experienced internist what he thought the referring physician can expect of the psychiatrist. He thought carefully for a moment and then said, "You ought to emphasize what the referring physician *cannot* expect of the psychiatrist." The point was, he then went on to elaborate, that the referring physician should not expect the psychiatrist to take every problem patient with emotional difficulties off the physician's hands. He said, "The referring physicians need to know that they will have to care for the bulk of patients with psychological problems themselves and expect the psychiatrists to take care of the complicated or the severe psychiatric problems. I hope you emphasize this very strongly."

He then said, "Now, let me ask you a question. Is it right to expect the psychiatrist to spend some time clarifying for the referring physician how he should understand what is happening to the patient and provide ongoing advice as to how to deal with him? Can the referring physician keep asking the psychiatrist more questions about what is not clear to him?"

At this comment, I was excited and elated and responded, "That's exactly what I think referring physicians should expect and request from the psychiatrist!"

I was much reassured by this exchange with my internist friend, for in my initial thinking about this paper I had been inadvertently interpreting the title as "What Referring Physicians *Expect* of the Psychiatrist." That paper would have been better presented by a non-psychiatrist. However, my friend's question had emphasized "What Referring Physicians *Can* Expect of the Psychiatrist." I now knew that the answer to that should come from a psychiatrist who had experience in consultative work with medical colleagues.

Now, it would be easy for me to fall into the trap of discussing what the referring physician *should* expect from the psychiatrist, that is, what the ideal psychiatrist consultant should do for his consultee. I will certainly emphasize that in this paper, but a word of caution is in order. Psychiatrists are human and fallible.

Difference Between Psychiatrist and Referring Physician

An important point that must be emphasized is that the referring physician may have expectations about the psychiatrist that are not exactly appropriate. In many ways, the psychiatrist is similar to his non-psychiatric colleagues. He has shared a common professional education to the point of specialization. This is an enormous advantage for colleagueship and communication and may lead the referring physician to expect the psychiatrist to think and function in the same manner as he does. However, this is usually not accurate.

I am reminded of the year I worked in England as a research fellow. As an English-speaking

person, I had expected that I would have no trouble in communication. I soon learned, however, the meaning of the expression "the common language that divides." One often has fewer misunderstandings in communicating with someone whom he anticipates to be different than in communicating with someone who superficially seems just the same but has subtle differences.

The average psychiatrist has been shown to be somewhat different not only in his beliefs and interests, but especially in his attitude toward patients. How much he was a somewhat different person to begin with, for which there is some evidence (Funkenstein, 1968), and how much his specialty training is responsible for, no one knows. However, there are differences, and these seem to make for mutual lack of understanding at times, as I have discussed at more length in a paper called "The Gap Between the Psychiatrist and Other Physicians" (1962).

Briefly, the physician traditionally has been oriented to taking over responsibility from the patient and being authoritarian and decisive. The psychiatrist tends to play a much less active directing role and, after clarifying a situation, leaves the decision up to the patient.

The non-psychiatrist tends to think in precise physical and chemical terms in his approach to human biology. The psychiatrist is generally concerned at present with somewhat imprecise psychological and social issues.

I emphasize some of these differences to forewarn the non-psychiatrist not to be upset or annoyed if his psychiatric colleague doesn't function exactly the way he does.

The Consultation

Now, let us turn to the consultation proper. First,the referring physician can expect a quick response to his request. However, even more than many physicians, the psychiatrist is apt to be overbooked and, because of the nature of his practice, has a less flexible schedule than many physicians. Hence, he can give more satisfactory willing consultation if he is given advance warning. When the situation is a real emergency, of course, it is appropriate for the individual to expect immediate help.

One of the major problems for the consulting psychiatrist is to ascertain exactly why a consultation is being requested. Therefore, the more precisely the referring physician poses the problem with which he wants help, the more likely it is that the consulting psychiatrist can be useful.

The referring physician should expect a prompt, clear, relevant communication from the psychiatrist after the consultation. He should expect it to be reasonably free of jargon.

For most consulting psychiatrists, putting the report into plain clear language is the most difficult task. Psychiatrists often surpass other physicians in the tendency to use overcomplicated pseudoscientific jargon. However, there are some technical terms in our field which, on occasion, need to be used, and the referring physician should be willing to learn some new terms if he has not had previous adequate training in the psychological and behavioral areas. In most instances, as well as in diagnosis, formulation and definition of the overall problem, there should be some precise suggestions as to the course to be followed. Here, again, the consulting psychiatrist is apt to find himself in trouble. It is infrequent that step-by-step instructions, including drugs and certain prescribed activity, will be sufficient. Instead, subtle attitudes or modes of psychological support often may be in order. These are extremely difficult to detail in a short, simple statement, particularly if the consulting psychiatrist does not know the referring physician well and is unfamiliar with the degree of his psychiatric understanding.

For the above reasons it will usually be a more useful consultation if the psychiatrist, in addition to preparing a written report, has direct verbal contact with the referring physician either by phone or in person. This creates the optimum opportunity for all concerned to be sure they are communicating appropriately.

I indicated above that few psychiatrists can live up to the ideal, and many of the reports the referring physician receives will neither entirely satisfy his need nor be completely understandable. In this situation, I most strongly urge the referring physician to call the consultant for clarification instead of griping to himself or other colleagues about these "fuzzy-thinking, obscure psychiatrists." He should get back to the psychiatrist, make clear his questions and confusions and see whether he then receives help. Only if that fails should he write him off and find another psychiatric colleague to consult in the future.

Who is Responsible for Continuing Care of Patient

Sometimes the referring physician will expect the psychiatrist to take the patient off his hands and then be disappointed if this doesn't work out. On occasion, the psychiatrist may hold on to a patient the referring physician wished returned.

Proper communication will go a long way to clearing up these difficulties. First, the referring physician should make clear his expectations. Difficulty frequently arises not only because psychiatrists are scarce, but also because their treatment time is usually entirely committed. There are not now enough psychiatrists, nor are there going to be any time in the foreseeable future, to provide continuing care for all the patients with emo-

tional difficulties. Indeed, there is no more reason to think that all emotionally disturbed patients should be treated by a psychiatrist than that all patients with congestive failure should be treated by a cardiologist or all diabetics managed by an endocrinologist.

In my opinion, the average practicing psychiatrist should keep a major portion of his time available for consultations, management of emergencies and severely psychiatrically ill patients; the remainder should be reserved for ongoing patient care. Since the amount of time available for ongoing care is never going to match the need, it is appropriate that the psychiatrist be selective in those patients that he works with regularly and extensively. Ongoing psychotherapy by a skilled psychiatrist has much to offer certain patients. The time involved cannot be significantly compromised, or the process may not be worth carrying out. Moreover, there is major educational gain for the psychiatrist in intensive work with some patients. Through keeping in close touch with the subtleties of human behavior, he will become more skilled in the evaluative process and, hence, a more useful consultant.

Therefore, I am asking the referring physician to be understanding and refrain from pressuring his psychiatrist colleague to keep under his management all or even most of the patients who have psychological difficulties.

Psychiatrist's Role as Educator

A corollary of the above is that the referring physician can expect education and ongoing support from the psychiatrist. Unless he has graduated relatively recently from one of a select number of medical schools, the referring physician will not have a background of sufficient training in psychological medicine to care for a number of his patients. He should expect to be able to learn, by working side by side with the psychiatrist, to be more effective with psychologically disturbed patients. While this can be accomplished through informal contact about continuing care of patients, there are two models for doing this even more effectively.

Grotjahn and Treusch (1957) have developed a technique whereby the psychiatrist goes to the referring physician's office as a guest and consultant and both he and the referring physician interview the patient. The psychiatrist then discusses the case with the referring physician or occasionally may make his recommendations in the presence of the patient. In every instance, the primary physician concludes the interview with the patient. In recent years Treusch and Grotjahn (1967) have extended the technique to include, in many instances, close family members of the patient. This technique, while seemingly expensive of professional time, affords better patient care and can be professionally instructive to the referring physician. It might even be a more profitable use of time for the referring physician than listening to a talk like this.

Balint (1957) in London has for many years met regularly with small groups of general physicians to participate in ongoing discussions of their own problems in dealing with the psychological difficulties of their patients. The success of such a program is highly dependent on the motivation of the physicians and the skill of the leader. During the year I spent in London, I became convinced of the success of this program as I witnessed the interest and sophistication in psychological medicine manifested by many general practitioners in a variety of different settings.

What the Physician Can Expect from the Consultation

Let us consider the substantive things the physician can expect from the psychiatrist.

1. Confirmation or precise diagnosis of major psychiatric disorder, such as schizophrenia, depression, mania and severe neuroses. In these instances, the referring physician can ordinarily expect the psychiatrist to take over care of the patient or help and advise with regard to appropriate hospitalization.

2. Help in diagnosis and formulation of the problem in complicated cases presenting with obscure somatic symptoms. In this situation joint discussion of the case may be extremely important. The referring physician, who has concluded the obscure symptoms must be neurotically based because all of the usual and unusual laboratory tests are negative, should be prepared on occasion to have the good consulting psychiatrist inform him that no positive evidence of neurotic or psychologically determined illness can be found and that ongoing observation of the patient will have to continue until the underlying etiology becomes manifest. The diagnosis of psychological illness should no more be made by negative findings than any other.

3. Help in the clarification and diagnosis of patients with organic brain disease and advice in the management of such patients.

4. Counsel in the management of previously psychotic patients usually being maintained on drugs. The number of these cases which must be treated by the non-psychiatrist is increasing greatly.

5. Help in the management of seriously somatically ill patients the stress of whose illness has decompensated them psychologically or whose response to the stress has led to behavior which may compromise the proper care of the basic condition. A prime example of this sort of problem is the care of the patient immediately following a coronary infarction. Grete Bibring (1956), in an elegantly lucid paper replete with examples, has shown how an understanding of the personality structure of the

medically ill patient can permit the physician to much more successfully manage the patient during a period of critical illness. In a subsequent paper she and her colleague, (Kahana and Bibring, 1964) outline seven types of behavior patterns that may be recognized and give general guidelines for the appropriate strategy in management of each type of patient.

6. Help in the care of patients with chronic illnesses in which psychological factors may play an etiologic or exacerbating role. The so-called psychosomatic disease would fall in this category.

7. Improvement in communication and the disjunctive social situation whenever there is major difficulty in management of or communication with a hospitalized patient —particularly the patient displaying aberrant behavior. This category includes the situation in which a physician finds himself unduly uncomfortable or puzzled in his relationship with a specific patient. Problems in this category have been particularly well clarified by some of the psychiatric liaison services in university general hospitals. Meyer (1962) and Meyer and Mendelson (1961) write clearly about these problems.

8. Support in his attempts to handle difficulties both in and out of marriage as well as other difficulties of a psychological or behavioral nature within families. Antisocial behavior and drug problems in adolescents are increasing in frequency. Grief in the family members who have lost a close relative needs attention.

9. Help in more fully understanding the patient with pain and support the physician in the arduous task of long-term care of such a patient. Pain is too complex an issue to discuss here, but it is important to remember that pain is an intensely subjective experience and that the general set of the individual determines how pain is experienced and dealt with.

10. Collaboration in the care of dying patients. The problem of the dying patient is one which the medical profession all too often fails to meet directly. The psychiatrist is generally not involved unless behavior becomes blatantly abnormal. Those psychiatrists who have dealt with significant numbers of dying patients—usually because of making a special study—have demonstrated that the suffering of many can be greatly alleviated by intelligent, individualized treatment. We need to learn much more about this area of the physician's responsibility.

Psychiatric Consultation-Liaison Programs

Before closing, I would like to make some comments about general hospital-based psychiatric consultation-liaison programs which have made major contributions to the psychological understanding of medical practice and to indicate some different points of view toward the consultation process, especially as it pertains to the hospitalized patient. These programs have been especially meaningful, since with rare exceptions other psychiatrists do not get significantly involved with the mainstream of medical practice. Generally consultations are requested for the very disturbed, those with obvious psychiatric problems, and those patients who create serious difficulties in communication for the physician.

The better psychiatric liaison programs have developed an approach which makes members of the psychiatric groups integral members of the medical team on other services in the hospital. This permits psychologically well-trained physicians to come into direct contact with the totality of medical problems, at least as they present themselves in the general hospital. I will not detail all the references in this area but suggest that those of you who are interested in pursuing this further read two articles by Z. J. Lipowski in *Psychosomatic Medicine* (1967a, b). His extensive bibliography will permit you to read as widely as you wish in this area. A number of excellent books have been written on this subject. A useful one, particularly because it is the most recent, is that by John Schwab entitled *Handbook of Psychiatric Consultation.* It also has an extensive bibliography and, while it is addressed to psychiatrists primarily and is somewhat less profound and comprehensive than some others, it is quite readable and would provide a good source for the non-psychiatric physician.

Approaches to Consultative Process

Over the years, chiefly from work of psychiatric liaison psychiatrists, a number of approaches to the consultative process have evolved. The first approach has been called patient-oriented. This approach is that of the traditional medical consultation. Gradually, we have become aware that this approach in the psychological sphere can be somewhat limited. In this approach the psychiatrist focuses primarily on the patient and responds only to the explicit questions raised by the referring physician. This approach is primarily oriented to patients with obvious psychopathology. It doesn't fit the frequent circumstances where some other difficulty, such as the patient's behavior, difficulty in management, etc. becomes the reason for the consultation. Moreover, as psychiatric consultants worked closely with their colleagues in the general hospital, it gradually became apparent that the concerns of the referring physicians, both covertly and overtly, were often more complex than the usual explicit requests would indicate.

The next approach to be developed was the consultee-oriented approach. It follows from some of the things I have said earlier about the lack of training of the physician in psychological medicine in the past and the problems raised

in the physician by certain types of patients that the psychiatrist would become oriented in helping the referring physician to understand his part in the difficult situation. The notion of the consulting psychiatrist having a role which included teaching and an ongoing relationship with the referring physician was an integral part of the development of the consultee-oriented approach.

As an outgrowth of careful attention of the general hospital-based liaison-psychiatrist to all the problems concerned with patient management, the situation-oriented approach developed. Gradually it became apparent that, in many instances, in order to understand the difficulty in patient management it was necessary to know the total social or ecological circumstances of the hospital ward and medical care team where the patient was hospitalized. Some patients, for example, have the capacity to create difficulties between the attending physician and the nurse or between members of the house staff and the attending staff; on occasion, inherent difficulties in communication among the staff may light up certain problems in the susceptible personality characteristics of the patient. The point is that a hospital service is a complicated small social unit, and, to insure the best medical management for some patients, it is necessary to understand the total complex of all the forces in action, that is, the patient and his interaction with all those immediately concerned with his care. A collateral extension of this has already been referred to above, namely, that in some instances one cannot appropriately care for and treat some patients without an involvement of the total family of the patient. The need for the situation-oriented approach becomes increasingly great as we develop special care units, coronary care units, renal dialysis units, and others. In fact, some of the special medical situations now developing lead to such significant stress for the emotional lives of the physicians, nurses and other staff that the psychiatric member of the team becomes essential.

Summary

I hope that I have persuaded you that the psychiatrist can be a very useful colleague to non-psychiatric physicians. He can be most useful if the referring physician works at developing a mutual learning relationship with him and keeping all lines of communication open.

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Recognition and Management of Psychiatric Emergencies

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The recognition of psychiatric emergencies would seem to be easy. This is certainly true if one thinks of the intoxicated alcoholic who is threatening to kill himself or someone else, or the patient on a surgical ward who reports that persecutors are out to get him. However, we may be dealing with just as much of a psychiatric emergency when confronted by the little old lady who does not wish to bother the doctor but wants something for vague complaints behind which hides deep depression; or the teenager who seems to be just a little bit excited right now but, a little later, is overwhelmed with anxiety.

Emergencies are simply unforeseen occurrences which present themselves to physicians in a variety of ways. Indeed, a physician is not the first person on hand for most emergencies but may merely be called upon for appropriate intervention. Any of us can be presented with an emergency, psychiatric or otherwise, at any moment. However, each of us has his own particular probability of sampling psychiatric emergencies, depending upon who he is and what he does. In actual fact, psychiatric emergencies more often confront people *other* than psychiatrists, for example, the policeman, the social worker, and the general practitioner (Ewing, 1965). As in most medical matters, prevention is preferable to cure. Thus, anticipation of complications and the early detection of pending emergencies are skills to be cultivated—something I will talk about later.

Hospital Emergencies

First, let me make a few comments about the specific kinds of emergencies which are known to me through the emergency room of a large general hospital. Such data are, of course, not typical for all physicians but are fairly typical for similar hospital settings.

Table 1 shows the diagnoses made in a series of patients seen as psychiatric emergencies in such a setting. It is interesting to note that the major psychoses do not predominate in psychiatric emergencies, although they account for the majority of chronically occupied psychiatric beds. Instead, the conditions which present as psychiatric emergencies tend to be exaggerations of normal human emotions.

Everyone feels low in spirits at times, but the depressed patient feels so much lower that life does not seem worth living. He may make a suicidal attempt and be brought to the emergency room because of this, or he may present himself because of a sense of impending doom which, if we are astute, we will detect and deal with accordingly.

Conversely, everyone feels happy and elated at times. However, an extreme degree of elation is presented by the manic phase of a manic-depressive illness; the patient is extravagant in word and deed, very excited and uncontrolled. Likewise, all of us have felt worried and anxious at times, but an overwhelming degree of this feeling may present as a most legitimate psychiatric emergency. The type of patients seen depends to some extent on the location of the hospital. In areas with a severe narcotics problem, hospitals see certain psychiatric emergencies that are unknown, or almost so, elsewhere.

The main reason for undiagnosed patients is the absence of an outside informant when dealing with some patients. In spite of the absence of a definitive diagnosis, a disposition has to be made. Sometimes more understanding develops during further study.

TABLE 1
300 Consecutive Psychiatric Emergencies Seen in a General Hospital

Presenting Reason	Percentage
Alcoholism and use of drugs	38
Affective disorders (including 11% suicidal)	29
Organic brain syndrome	6
Personality disorder	9
Conversion reaction; anxiety reaction	8
Schizophrenia	2
Undiagnosed	8

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Directions of Change

By comparing the psychiatric emergencies seen in the same setting at a ten-year interval, I thought that we would have a chance to observe directions of change (Tables 2 and 3). The comparison shows that the emergency room is being used more frequently for psychiatric emergencies and that there are more teenagers utilizing these facilities. To some extent, this reflects increasing numbers of students in the geographic area, but, in addition, there is a real increase which is probably associated with the greatly increased use of drugs by teenagers over the ten-year period. The move toward community psychiatry and less use of hospitalization is also reflected in the figures. Another modern trend is shown by the higher proportion of patients who have previously had contact with a mental health center or mental health personnel. So far, it is not possible to say with certainty that such people are presenting themselves for less severe emergencies, but this may be the tendency.

If these trends continue, we can predict the need to develop special facilities, including, perhaps, overnight accommodations, more day hospitals and night hospitals, more experts to deal with adverse drug reactions, and more professionals to communicate with teenagers.

Classification of Emergencies

Table 4 shows five categories for classifying virtually all psychiatric emergencies. *Acute and overwhelming anxiety* includes states of panic—homosexual or otherwise—and certain types of hysterical behavior.

Under the category of *confusion* are included certain cases of schizophrenia, brain syndromes (including those associated with drugs and alcohol), cases of amnesia, fugue states, and some aspects of depression.

Psychotic states include schizophrenia, certain profound depressions, postpartum psychoses, manic-depressive psychosis, some toxic reactions to drugs, and the delirious states associated with the withdrawal syndrome of depressant substances, including barbiturates and alcohol.

Conditions involving violence include suicidal and homicidal threats or attempts, some cases of mania, general aggressive behavior, and the excitement associated with catatonic schizophrenia.

The *miscellaneous* group includes such conditions as the manic patient who is on a spending spree, the patient showing other acute manifestations of schizophrenia, and various more bizarre presentations of emergency which appear from time to time.

It is interesting to note that alcoholism may be placed in any one of these categories. For example, the alcoholic patient may present at one point with overwhelming anxiety; the next time he may be confused; still another time he may show psychotic symptoms or become violent. Indeed, it is worth mentioning that suicidal tendencies and successful suicide are the most frequent and serious complications of alcoholism from the psychiatrist's point of view.

Crises

In recent years, psychiatry has had a lot to say about what has been called "crisis intervention." The aim of such intervention is to help to restore the patient to a preexisting homeostasis. Hopefully, more than that can be accomplished. John W. Gardner (1964) has pointed out that certain major expansions of human capacity and knowledge have occurred only under the circumstances of catastrophe. Thus, we must ask ourselves if a crisis can be utilized as a stimulus for further growth, whereby the individual might become better able to deal with himself and his environment (Caplan, 1961). We, as physicians, may also grow personally and professionally at these times. As I look back on my own involvement in a variety of psychiatric emergencies, I feel that each one has taught me something. Thus, I suggest that we try to see these occasions not as irritating interruptions of our planned activities, but as challenges and opportunities. Successful resolution of a psychiatric emergency can give us an increasing capacity to deal with future episodes, a greater sense of awareness, more sensitivity to cryptic communications, and more understanding of what constitutes a crisis for our fellow man, even though it may be insignificant to ourselves.

TABLE 2
Comparison of Psychiatric Emergencies in 1958 and 1968

	1958	1968
Six-month total	121	164
Age 18 and under	35	74
Age 19–39	31	34
Age 40–65	26	31
Over 65	29	25

TABLE 3
Comparison of Psychiatric Emergencies in 1958 and 1968

	1958		1968	
Sex	♂	♀	♂	♀
	41%	59%	42%	58%
Previous psychiatric contact	47%		65%	
Suicide attempt	9.5%		10.9%	
Hospitalization recommended	63%		46%	

Principles of Management

These comments lead me to set forth three basic principles of management (Table 5) for all psychiatry, but particularly for the psychiatric emergency. By saying that we should do the minimum *to* the patient, I mean that we want to gain his cooperation as rapidly as possible. Thus, we should not just accept the role of administering medications, advice or orders, but rather should try to establish a partnership as soon as feasible. Often there are indications to do things *for* the patient, and much of what I say will deal with this. Eventually, though, we want to be doing things *with* the patient.

The first general requirement is to establish human contact. Any person can be of assistance to another if he remains calm, offers support, and accepts the communications of the disturbed person. Occasionally, the patient will insist on being left alone, and then withdrawal to a tactful distance will be appropriate. Generally, however, it is better for someone to stay with him. Clearly, this other person should not be excitable or overtalkative.

Now, let's assume that you as a physician have been called in on some psychiatric emergency. First, where should you see the patient? Much depends upon the individual circumstances. Ideally, the patient should be visited where he is, if at all possible. Whatever happens, he should be seen by you in person, and he should be offered help without delay.

Anthropologists have surmised that the habit of shaking hands developed from the need to demonstrate that one was unarmed. The handshake means more than that today, being both a greeting and the means of saying, "I want to be your friend." As physicians, we should identify ourselves to the patient and greet him with a handshake, if at all possible. Of course, physical emergencies may have to be dealt with, such as persuading an agitated person to hand over his gun, stopping a hemorrhage or performing a gastric lavage in a case of poisoning.

As soon as possible, however, sit down with the patient and try to get him to sit down also. Little can be accomplished as long as he, and perhaps his relatives, are talking excitedly. On the other hand, it is often helpful to have a member of the family or a friend close by. Many patients will talk to a physician if a calm member of the family remains in the room.

Getting the patient to talk is the prime essential. Careful listening must be directed to try to answer our own questions which are: "What does he feel is going on? What does he fear? Why is he overwhelmed or upset?" Unless he starts to give you these facts spontaneously, you may find it necessary to ask leading questions, giving him plenty of time to reply. For example, say, "What has happened that is upsetting you?" If he appears angry and threatening, you should ask quite openly, "What are you so angry about?"

Whatever you do, under no circumstances talk in whispers behind the patient's back. I can think of nothing that needs to be said that the patient should not be allowed to hear. Even the conclusion that he is acutely disturbed or feeling suicidal and requires hospitalization is much better discussed openly. Many of the complications which develop in such situations are due to mishandling by people who act as if the disturbed person can and should have no part in decision making.

It is vital to be absolutely truthful with the patient, never reassuring him inappropriately. For example, it is ridiculous to say, "Everything is fine," or "Nothing is the matter." Statements of this kind which ignore the patient's predicament are bound to make him lose confidence. What we must do is to show him that we understand that he is in a state of panic, depression, or confusion. We should show we are trying to understand his problem, using simple language and persisting even if he does not seem to follow. In other words, we need to say such things as: "You seem to be frightened"; "I can see you're afraid you will lose control"; "These awful feelings you have are part of an illness. You will feel much better when we arrange some treatment for you."

Once you are ready to make some recommendations, discuss them forthrightly with the patient and his family. Although I have emphasized the importance of working *with* the patient, this does not mean that we should hesitate to make specific proposals. It is not reasonable to ask a depressed patient to choose between staying at home with a relative or going to the hospital, or to ask an anxious person to choose between being alone or being with a friend. Instead, we must talk in positive terms of what will be done. For example, say: "We will take care of you"; "We'll see that your children are all right"; "In the hospital we can help you with this problem"; "This medicine will help you feel better."

TABLE 4
Categories of Psychiatric Emergencies

1. Acute and overwhelming anxiety
2. Confusion
3. Psychotic states
4. Conditions involving violence (including suicide)
5. Miscellaneous

TABLE 5
Principles of Management

Do minimum	TO	the patient
Do something	FOR	the patient
Do maximum	WITH	the patient

Controls

Sometimes, you will have to make a decision about whether or not to apply controls to a particular patient. Here, I mean such things as administering tranquilizing or sedative drugs, actually holding him physically, placing him in a hospital, or even putting him under lock and key. To reach a realistic decision about this, you must ask yourself: "What seems to be the patient's need?" Some patients talk of their fear of disaster, explosion, the end of the world, their own death, and the deaths of other people. By so doing, they are actually expressing a fear that they will go out of control. Under these circumstances, firmly applied controls with suitable explanation can be reassuring and calming. For example, you might say: "I am going to place you in the hospital and have someone stay with you all the time. Then you need not be afraid of these things you are feeling."

Remember that emotionally disturbed patients tend to use violence only when they are frightened. The presence of hospital personnel alone may be enough to convince the patient that his impulses will be checked. Personnel should be taught not to offer physical control initially, but to be present as relaxed bystanders who will only intervene if forced to do so.

Watch for the patient whose panic has its origin in homosexual fantasy. You can surmise the presence of homosexual panic by the way the patient talks and behaves, as well as from the history. For example, if he indicates persecutory fears of men, says that his roommate is a queer or that men are going to abuse him, these are warning signs. When you recognize these, you can avoid stimulating more panic. Such a patient should not be left alone with one person of the same sex. Appropriate use of nursing personnel can be very helpful. A man in homosexual panic with paranoid thoughts can calm down quite quickly when placed in the care of a supportive and understanding nurse.

Keep explaining to the patient what you are doing and why. Remember that what may be a simple matter of routine to us may be misinterpreted and, therefore, frightening to him. Here, I am thinking of such things as taking a blood sample, giving an injection, or calling the emergency room of the hospital.

As far as possible, enlist the help of people who are known to the patient. For example, have his family or friends or fellow members of Alcoholics Anonymous stay with him. Place him in a hospital if such care is necessary and avoid using law enforcement agencies except as the very last resort. Sick people do not belong in jail.

The psychiatric emergency should also be seen as a learning experience for people other than the patient and the physician. We should try to involve the person who called us in the first place, particularly if this is a public health nurse, policeman or social worker who is liable to meet with similar cases in the future. Hopefully, this person will be better able to handle such patients next time.

Disposition

Try to detect, if you can, the precipitating factors, whether these spring from within the patient or from his relationship to his environment. What you can understand about this may give you important clues for preventive measures.

It is also essential to take the patient's social environment into consideration. Is the family able to tolerate and cope with the patient's behavior? If the signs are that such tolerance is not present and is not developing with reassurance, this may be a good indication of the need to hospitalize, however briefly. However, if the family shows the desire and ability to adapt, the patient may be able to enter treatment while at home or attending a day hospital facility.

In this last regard, the development of mental health centers is a significant one which, hopefully, will prove useful to many physicians in handling psychiatric emergencies after the acute crisis is over. In our hospital setting, we have offered a 72-hour hospitalization plan for the last year, which has been remarkably successful in some instances. Although it is possible for a patient to be continued into more prolonged hospitalization, we have found that in about 60% of cases, the patient can be helped to find stability during a maximum of three days. This involves intensive care by a team which focuses on bringing the family into the treatment picture and on planning for a rapid rehabilitation and return to family and work. The use of psychotropic medications in such settings is often appropriate and may similarly be considered for the patient who is getting over an acute emergency without hospitalization. The minor tranquilizers are most suitable for the patient who does not need to enter a hospital. By indicating your wish to relieve his distress and by showing that you can help him with something which he can take away with him, you may be able to offer very significant assistance.

Before your handling of the emergency can be considered finished, you should arrange a further relationship with the patient. For example, if he is to go home with his family, your responsibility has not ended there. Make a specific appointment, write it down, and hand him the paper. Everything that you do for emotionally disturbed people should be on a simple level and should involve concrete acts. It is not enough to say to the patient, "Give me a call next week and arrange to see me." Much more effective and supportive is handing him a piece of paper with the specific time and place written on it.

One of the most gratifying things

about working with psychiatric emergencies is that results appear rapidly, sometimes within a few minutes and usually within a few hours. Indeed, almost all emergencies are over within 48 hours. Then we can seek to reduce the likelihood of recurrence. Any physician should be able to see a patient through a psychiatric emergency. Often it is not until later that he may find it appropriate and necessary to make a referral to the mental health center, a day hospital, or a psychiatrist.

My last table (Table 6) summarizes the specific principles of management for psychiatric emergencies. We must establish warm human contact with the patient directly; evaluate the situation calmly and with the patient's help; avoid planning or discussing his problems behind his back; be absolutely truthful and always explain what is going on or what will happen; use controls judiciously when these seem essential; and arrange for further help now as well as offer further contact with yourself in the future.

Prevention

Now, a few words about prevention. There are two aspects to the prevention of psychiatric emergencies. In the case of a specific patient, can we prevent his exposure to the same overwhelming circumstances in the future? This may involve such things as arranging for better physical care for some illness, dealing with his primary alcohol problem, or keeping him on antidepressants for many months. One patient may need help to talk about his anxieties on a regular basis, while another may require assistance to express pent-up grief over some unassimilated bereavement. Of course, in many instances the end of the psychiatric emergency is the indication to start a full diagnostic work-up. For example, only when violence has subsided does it become possible to search for basic causes. This would particularly include brain tumor and temporal lobe epilepsy as well as toxic factors, such as drugs or alcohol, which may have reduced impulse control.

TABLE 6
Psychiatric Emergencies—Principles of Management

Establish human contact
Listen to the patient
Avoid secrets
Be truthful
Discuss plans
Control when necessary
Explain what you are doing
Utilize others
Arrange further contact

Then, there is the question of preventing similar emergencies in other people. When I was a psychiatric resident, I did many emergency consultations in a hospital setting where old men and women had recently had cataract surgery. In those days, such patients with their eyes bandaged were left very much alone on the principle that they required absolute peace and quiet and total rest. Many of them developed acute psychotic episodes under these conditions. Research on sensory deprivation had not yet been done, but nevertheless, we were able to take a series of obvious steps of a preventive nature following which psychiatric emergencies became practically nonexistent. This included better preparation of the patient, more personalized nursing, more visits by family, and less isolation from other patients.

Similar opportunities for general preventive measures present themselves in a variety of medical settings. All illness represents a threat, but particularly to the young and old. When you have to hospitalize someone who is a known risk for psychiatric breakdown, some careful preplanning, especially thoughtful nursing care planning, may be significantly preventative. Most important of all is the prior existence of a good relationship with the physician.

Finally, although the psychiatrist has a role in some psychiatric emergencies, in general I would say that he cannot and should not replace the nonpsychiatrist-physician. He may be useful in arranging for treatment later on. Right now, while an emergency exists, you are perfectly capable of handling it and should do so. One family doctor in the anxious patient's home is worth a hundred psychiatrists in the hospital ten miles away.

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SECTION II

The Family as a Factor in Medical Practice

The growing development of divisions of Family Practice in medical schools and the creation of the new subspecialty in medicine, Family Physician, attest the significance of the three papers in this section. The first paper illustrates how family interactions influence the development and course of physiological conditions. The second paper spells out the effect of serious illness on the family and the physician's role in abating and preventing family distress which, in turn, profoundly affects the patient. The third paper covers the broad community aspects of the delivery of health care services and the future role of physicians, particularly in the mental health area.

—G. K.

Family Tension and Psychophysiological Illness

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As a result of spending a sabbatical year visiting psychiatric centers throughout the world, in addition to trying to figure out what is going on in my own department in this time of turmoil, uncertainty and rapid diffusion of professional roles, I have arrived at a philosophical formulation of what a modern psychiatrist needs to maintain his identity, his integrity and, perhaps, even his sanity. First, he needs a sense of humor; second, he needs a deep sense of humility; and third, he must commit himself to do the best he possibly can for his patients without believing that what he does *is* the best. But perhaps the most helpful advice I can offer colleagues and students as to how to proceed in these perplexed times is that given me some years ago by a Bronx citizen of whom I asked directions to the Yankee Stadium. I stopped my car and asked the citizen what I would now consider a rather silly question, namely, "Pardon me, Sir, could you tell me how far it is to the Yankee Stadium?" The citizen replied, "So you have to know how far it is? What difference is it to you how far it is? Just keep on going and don't worry about how far it is."

The title of this talk, "Family Tension and Psychophysiological Illness," in itself implies that physiological changes may result from psychological forces connected with interpersonal as well as intrapersonal factors. This I firmly believe. For the most part, people do not become ill solely as the result of physiological changes. Illness usually occurs within the context of difficulties in interpersonal relations which, in the majority of instances, means the family. This does not mean that, once the patient becomes ill, he cannot be treated individually, or that, once the illness starts, the intrapsychic conflicts unleashed by it will not run their course despite favorable changes in the family situation which precipitated the illness. Actually the real test of the clinician is in coming to a decision as to where he should focus his therapeutic interventions when dealing with a patient in whom family tension is clearly playing an important role.

Not long ago I asked myself a simple but basic question, namely, "Would I handle certain cases of a psychosomatic nature today in the same manner that I did 15, 20 or 25 years ago?" After I posed this question, I looked over some old papers and, in order to honor the chairman of our host department, selected two cases from a paper "The Treatment of Psychosomatic Disorders by the General Physician," written with him and Robert Crede (1950).

The first case was as follows:

D.Z., a 23 year old white housewife, entered the hospital with severe headaches (typical of migraine) and attacks of pain in the right lower quadrant of three years' duration. Physical examination revealed persistent hypertension (blood pressure 170 systolic and 130 diastolic) and spasm of retinal arterioles, with scattered tiny scars throughout both retinas. The heart size was at the upper limits of normal, and studies of renal function revealed moderate impairment. Her personality structure was that of an immature, hysterical person with severe frustrated dependent longings.

There was intense sibling rivalry and definite underlying hostility to a rejecting mother. Problems related to sexuality and pregnancy were colored with intense unresolved hostility and guilt, which she had had as a child toward her pregnant mother and younger siblings. In adult life she was unable to adjust to the role of housewife or mother. She lived with her parents, and her own babies were cared for by her mother.

The current illness had started when her younger brother returned from the army and she had been forced to move into her own apartment to make room for him at her parents' home. From this situation, which was a repetition of the original traumatic experience, she developed intense underlying feelings of hostility toward her mother and her siblings who were still living at home. These unexpressed feelings appeared to be associated with the severe attacks of headache and abdominal pain for which she was hospitalized.

After formulation of the psychodynamics in the psychosomatic conference, a therapeutic plan was proposed which was directed at meeting her frustrated dependent needs. This included occasional contacts with the psychiatric consultant, offers of material giving when indicated and continued contacts with the medical resident. However, her presenting symptoms in combination with hypertension and severe spasm of the retinal arterioles aroused considerable anxiety in the medical resident who was following the case. The physician's anxiety was manifested by repetitive physical and laboratory examination,

MCV QUARTERLY 5(3): 112-115, 1969

with frequent consultations. This affected the patient in two ways: first, it gave the symptoms attention-getting value, and, second, it augmented the patient's anxiety, with a resulting increase of symptoms.

The psychiatric consultant continually reassured the medical resident that the patient was being handled properly, and, after a few months, the resident became more secure in dealing with her, because he recognized that the symptoms were not evidence of malignant hypertension but that they recurred in direct relation to emotional and environmental problems. As a result of this knowledge, each time the patient suffered an exacerbation of symptoms the physician immediately inquired into her current life situation, with special emphasis on immediate difficulties with her husband, children, siblings or mother which created frustration of her dependent needs with resulting hostility. The patient was allowed to talk freely about such problems, and temporal relationships to the development of symptoms were discussed. This discussion, plus a rapid physical check-up, served to relieve both the patient's and the physician's anxiety. With such therapy there was a remarkable diminution in both the frequency and severity of the "attacks." At the time of writing, although the blood pressure was unchanged, the patient was not only symptom-free but had matured considerably and was functioning adequately as a mother and wife. When there is trouble she and her doctor have little difficulty in quickly discovering the precipitating factors.

We did help the patient considerably, but I find myself wondering whether I would take the same approach today in handling her situation. The key figure in the family constellation was the patient's mother, yet none of us ever saw her. Certainly the husband must have been playing a role in her illness, too, but he was never seen or interviewed. What would I do if faced with a similar situation today? To be as honest as I can, I must confess that, if I had seen her as a *private* patient in 1950, I would probably have done then what I would do today, namely, I would have seen her husband and, perhaps, her mother, too. But, remember, in 1950 D.Z. was not a private patient but a clinic patient —what at that time we used to call a "charity case"—and it was not the custom then for house officers in a teaching general hospital to see members of the family, especially of patients on the medical wards or in the medical clinics. Certainly it was unheard of for the teaching members of the faculty to spend their time so wastefully. I will discuss this particular matter in more detail later.

Now let us review another case from the same paper.

L.M., a 37 year old married white man, seen in the Psychosomatic Clinic because of a chronic recurrent duodenal ulcer of many years' duration. In the past, numerous exacerbations of the ulcer symptoms had responded temporarily to medical treatment. When he was first seen in the Clinic, the current exacerbation of symptoms was of several months' duration.

The patient was seen for one hour each week for six weeks. During this period he was given the usual medical treatment, antacid agents, antispasmodic drugs and a special diet. The interviews were taken up with a discussion of the patient's difficulties on his job, problems with his wife and financial worry. The therapist attempted to give the patient a good deal of emotional support and would offer suggestions which were designed to relieve some of the tension connected with the patient's employment and marital difficulties. The patient developed a slight degree of insight into the fact that certain tensions associated with his job and marriage seemed to cause exacerbations of his symptoms. Symptomatic improvement was noted within three weeks, and at the end of a six week period the patient was asymptomatic. Gastrointestinal roentgenograms revealed that the ulcer had healed. As the patient became aware of the tension surrounding his job, he made the decision to quit and obtain other employment. This was done, and the patient stopped coming to the clinic because he was unable to get time off while working at his new job.

The patient was not seen again until he appeared in the emergency ward with a perforation of the duodenal ulcer. An interval history revealed that the day before the perforation he had been discharged from his job as a truck driver after a slight accident which he felt was not his fault. The next day his wife had left him after an argument, and a few hours later while on his way with a friend to a house of prostitution, he was suddenly seized with the severe pain of the perforation.

Obviously in this case the key family member was the wife, yet she was never seen, let alone brought into the therapeutic program. At the time the case was summarized as follows: "It is our feeling that had this man been able to continue his relationship with his physician, he might have been given enough support and gratification of his dependent needs during the period of acute emotional distress related to his wife's leaving that the perforation might not have taken place." Perhaps this was true, but if I were to handle this patient today, before making the above statement I would certainly see the wife to determine whether anything might be worked out to help her. Instead of just using the physician to meet the patient's dependent needs, I might be able to use a genuine rather than an ersatz source of support.

In addition to the fact that it was not particularly fashionable to use the family approach when dealing with charity cases, such as the two just described, there was another factor that limited us. At the time we were very much influenced by Franz Alexander's concepts in psychosomatic medicine (1950). He stressed the connection between repressed instinctual impulses —especially pregenital ones—and the development of pathophysiological states as well as emphasizing the manipulation of the transference to elicit repressed impulses, especially in the aggressive/dependent areas. This discussion is

not intended as a criticism of Alexander's formulations but is meant rather to point out that we were so fascinated and curious about them that we felt compelled to clarify his formulations as well as meet certain of the patient's needs by acting completely on our own. This is just another example of the frequency with which the narcissistic needs of the doctor take precedence over the needs of his patient.

Let me jump from the past to the present with this case vignette. The patient was an extremely narcissistic and successful businessman in his late 50's who consulted me because he felt depressed. Initially, I thought his depression was related to narcissistic blows resulting from the threat of business failure. But after a few interviews, I realized that this giant of the business and social world became depressed when his covered-up dependency needs were frustrated by his wife, for example, when she paid more attention to her grandchildren than to him. On realizing this, I contacted his wife, explained the situation to her and brought her into the "therapeutic alliance." His improvement was immediate and remarkable. Some six months later he called me—again depressed. As usual, he emphasized the threat of business failure, but, when I focused the interview on the relationship with his wife, the following amazing story emerged.

On Monday his wife had come down with an upper respiratory infection and suggested that he sleep in another room to avoid catching her cold. On Wednesday she was up and around but remained home. On Thursday she resumed her usual routine of charity work for a variety of social agencies. But Thursday night she did not ask him to return to her bed. (Incidentally, their sexual life was practically nil.) On Friday he came to see me and was quite depressed. I immediately called his wife and explained the situation to her. She invited him back to her bed, and he was fine for another long stretch of time.*

Now let us return to a point I brought up earlier regarding the almost universal resistance of house officers to seeing family members, let alone involving them in diagnostic and therapeutic programs. Whenever an inpatient is presented to me by a medical student, an intern, or a resident, I always ask whether they have seen the patient's family. The non-psychiatric house officer responds to the question with either surprise or disdain, as if to say, "Man, what's bugging you? Don't you realize I'm so busy I hardly have time to see my patients?" If, by chance, the family is seen, it is usually for a courtesy call during visiting hours or for permission to carry out special procedures, etc.

The psychiatric trainee on an inpatient service, whether a medical student or resident, usually but not regularly sees a member of the patient's family for the purpose of obtaining information, since he quickly learns that, without such outside information, it is difficult to make a diagnosis. Thus, unfortunately, the family member is placed in the role of an informant rather than drawn into the clinical situation in a meaningful way. But what is far more serious and pernicious, in my opinion, is the good old-fashioned custom in psychiatry of using the social worker to get the so-called family and social history so that, in the classical case conference, the doctor presents the patient's story and the social worker the family's. Now let me make it clear that I am not against the role of the psychiatric social worker in clinical psychiatry, but rather I am against using her to relieve the doctor of his responsibility. I insist that the doctor, at least in the diagnostic work-up, see the family as well as the patient, since to me it is essential to the work-up. Once the doctor assesses the situation, then, of course, he is in a position to call on the social worker for those tasks for which she is equipped, ranging from home visits to a variety of therapeutic interventions with family members and/or the patient directly.

It is always amazing to me how marked the contrast is between the style in which excellent psychiatric teachers function as practicing psychiatrists and the style in which their trainees function in certain areas of clinical work. Actually because of this kind of discrepancy, we at Einstein started our "Walk-In Clinic" when we first opened our clinical facilities. Contrary to what some think, the Walk-In Clinic (Coleman and Rosenbaum, 1963) was started not to do away with the waiting list, so characteristic of psychiatric outpatient departments, or to better meet community needs by offering crisis intervention, even though it did both. Rather, it was established to provide teaching and training experience for second- and third-year residents assigned to the Outpatient Clinic by giving them an opportunity under close supervision to function in their outpatient assignments as they will have to function later when practicing psychiatrists. In other words, we made the training program in the Outpatient Clinic assignment more reality oriented. We simply had them do what most of us do in the real world of psychiatric practice.

When I am asked to see a patient for consultation or evaluation, I usually ask the individual to bring the key family member with him (spouse, parent, etc.) to the consultation. Unlike the practice of

* It may be important to emphasize that I focused on the patient and not his wife. I did not put the wife into the position of a patient by suggesting that she should enter therapy to gain insight or understanding into her obvious hostility towards her husband. The latter course might have been recommended by a family therapist and, thus, have switched the focus from the patient to the seemingly well, but actually sick wife.

some of our university teaching clinics, my practice is not to tell the patient to first see a social worker or a psychologist. Once I see the patient alone and the key family member alone and then both together, I can come to a decision as to how to handle the situation. In some instances I might say, "Let me see you again in a week"; in others I might make a referral to a psychotherapist, a psychoanalyst, a psychiatric hospital, or a social worker. The main point is that the initial responsibility is mine. It is up to me to gather the necessary data from the patient and family or other possible sources. Yet, in many a training program, the resident—usually in his second or third year in his Outpatient Clinic assignment—has his psychotherapy patients referred to him as if he were already a practicing psychoanalyst or psychotherapist.

By now, hopefully, some of you may be saying to yourselves, "What we have heard so far is interesting, but what does it have to do with the topic "Family Tension and Psychophysiological Illness?" Perhaps very little or perhaps a good deal. I could have cited a variety of studies showing that there is a relevant relationship between family tension and psychophysiological illness, but I assume we all know this. What is more important, at least from the point of view of a psychiatric educator, is to develop a method by which the physician and the clinician—the student and the trainee—can be taught to gather information in a systematic way, so that he can formulate family psychopathology and its effect on his patient.

As I have indicated already, I believe data gathered in a family interview is essential in a diagnostic work-up, especially in psychiatry. The challenge for us is to develop a structured outline for gathering the pertinent information from questions and observations which would be similar to the classical mental status examination guide.† But such a guide to the family interview must be tailored to the needs of the average psychiatric clinician rather than to the specialist in family psychiatry. Actually, I have presented this challenge to those members of my department specializing in teaching and training in family diagnosis and treatment. When they come up with a useable and useful form, I will be happy to share it with you.

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† Before such a form can be useable or useful, the administrator (trainee, clinician, student, etc.) must have had meaningful exposure to family interviews conducted by experts and some actual experience in conducting such interviews on his own under proper supervision.

Physical Illness: The Family and the Physician

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The traditional approach of the physician to members of the patient's family has been to send them off to boil water and find clean sheets. Although I am not prepared to summarily dismiss a tried and true method, I would hope that with our new therapeutic skills and hard-won psychological sophistication, we, as physicians, are now able to work with the family in a more meaningful and constructive manner.

As the understanding of disease processes and psychological reactions has enlarged, so has the physician's task. Initially he confined his attention to a symptom and its relief. Later, as he became aware that systemic disorders often presented with local manifestations, he broadened his scope to include the whole body. Under the impact of modern psychology, his next step was to shift from the whole body to the whole person. Now the treatment field for medical practice extends beyond the patient and properly encompasses his family as well.

The title "Physical Illness: The Family and the Physician" covers a very large area ranging from consideration of segregating the family from the patient, which has sometimes been recommended, to involvement of the relatives and the patient in family therapy, which currently is popular. Obviously I must circumscribe the field if I am to stay within my allotted time. I will do so by confining my remarks to the role the physician should usually take in working with families of those patients who have illnesses which are serious and disabling but not necessarily fatal.

Stages of Reaction

According to Garrard and Richmond (1963), the reaction of parents of chronically ill or handicapped children can be divided into three stages: 1) the stage of disorganization; 2) the stage of reintegration; and 3) the stage of mature adaptation. These divisions, which are helpful to the physician in understanding and dealing with parents, are equally applicable to the situation in which the seriously ill patient is an adult, and the family members, instead of being parents, are the spouse and grown children. Let us consider each stage of the family member's reaction in detail.

Disorganization

Disorganization in its extreme form occurs in response to a sudden and overwhelming catastrophe. Less severe forms usually occur in response to events that merely overtax a person's coping mechanisms. I would hasten to point out that it is impossible to predict how one will react to the illness of a close relative on the basis of his reactions to other stresses. Each person has highly specific vulnerabilities, so that, for example, a person may weather military combat well but crumble when confronted by the illness of a close relative. The physician who complains about the miserable or horrible relatives of his patient should try to bear in mind that, under almost any circumstance other than illness, he might find them affable and likeable. The threat posed by illness and the inability to mobilize effective coping mechanisms immediately may elicit the most difficult behavior in the family members.

In the face of disorganization, how does the family handle the situation? The first coping mechanism is usually *denial.* Denial helps avert disruptive disorganization and sustains the relatives until the passage of time allows for the development of an increased capacity to deal with harsh facts. As Garrard and Richmond (1963) pointed out, however, complete denial in the face of obvious disability is a poor prognostic sign, because it suggests that sustained difficulty will be experienced in perceiving and dealing with reality.

Another coping mechanism, *projection,* is especially well-suited for handling guilt and, thereby, limiting the degree of disorganization. It represents an effort to push off feelings of responsibility, feelings that are intolerable. A family member can blame the physician, or he can blame another relative. If the physician's care is held responsible, his capacity for understanding and forbearance may be overtaxed, and, unfortunately, this may cause him to retaliate in kind. If another relative is blamed, a tenuous relationship may be seriously disrupted at the very time it might otherwise serve a mutually supportive function.

Still another coping mechanism, *regression,* may have even more

MCV QUARTERLY 5(3): 116-119, 1969

crippling consequences than the first two. In the following example, regression was the response to a disabling illness, the relative's psychodynamics and the physician's unfortunate approach to the total situation.

Mrs. A., a 70-year-old woman, had been in good health until her 75-year-old husband had a stroke which left him an invalid. After the initial critical period of Mr. A's illness, she developed a severe diarrhea accompanied by marked abdominal distress. She also had many anxiety symptoms. She could eat nothing but baby foods, and she drank large quantities of milk. She dropped all of her activities, constantly talked of her symptoms, and demanded much attention. When the physician told her that her husband would never be any better, that she would have to adjust to him as he was, and that, if necessary, she would have to treat him like a helpless baby, all her complaints became more marked. Not only was she under more tension than before, but her relationship with her husband became so disturbed that she made life extremely difficult for him.

In this instance the husband's stroke and the necessity for treating him like a helpless baby played directly into an unresolved childhood conflict. Mrs. A. had been the oldest of ten children, and, long before her own needs had been met, she had been called on to take care of younger siblings. Her reaction to her husband's situation was to regress to a very dependent state (i.e., to that of a helpless baby). At the same time her marked jealousy and resentment of her husband created considerable guilt. When she was relieved of the pressure to be the strong one and was provided with support by the physician, her emotional balance was reestablished, and with it a more helpful attitude toward her husband (Hollender, 1958).

I have mentioned three coping mechanisms. They are among those most often used, but there are others that also help to soften the blow and limit the extent of disorganization. They include *intellectualization* and *isolation;* both serve to separate the effect from the event. Using these mechanisms, one can deal with the situation so dispassionately that the sick person seems to be as far removed as the newspaper account of a man starving in India. *Avoidance* is still another mechanism. The relative may stay away entirely, or, if present, may avoid major considerations and focus his attention on minutiae —a complaint about a minor detail of hospital care or the patient's failure to have a bowel movement.

Thus far I have spoken of the means used to limit disorganization or to cope with the forces responsible for it. At this point, let me comment about those feelings which promote disorganization—principally, anxiety and guilt.

Anxiety immobilizes some persons but has the reverse effect on others. The latter are propelled into ill-considered and, perhaps, ill-advised activity. The need to do something—action for action's sake —results in activity that serves as little purpose as a boxer's punches when he departs from his fight plan and flails the air. The agitated and desperate relative may exert pressure on the physician for premature treatment, or he may take the patient from physician to physician in quest of a magical remedy. Perhaps the proverbial instruction to "go boil water," which I mentioned at the beginning of this talk, is the physician's intuitive effort to channel anxiety into harmless activity.

Guilt may produce as disruptive an effect as anxiety. In severe form it can be characterized as guilt-seeking. Mark Twain was a guilt-seeker. As Barrett (1955) noted, Mark Twain felt responsible for the welfare of his family and was prone to be self-accusatory. "At the time of his younger brother's death his assumption of guilt became grotesque. Henry died as a result of being severely burned and perhaps internally injured in a steamboat explosion, but the older brother went to great lengths to find reasons . . . for what had happened. He blamed himself for Henry's presence aboard the boat, for not being himself aboard to help and protect him (this required the presumption that he, himself, would not have been injured) and, finally, for what he feared might have been an overdose of morphine which he urged a young doctor to give for the relief of pain shortly before Henry's death."

Let us now consider how the physician can be helpful to the family during the stage of disorganization. First, he should be aware of the feelings the relatives are experiencing and recognize that many reactions are reasonably appropriate—not merely annoyances specifically designed to complicate his task of treating the patient. The appropriate reactions require understanding and support; the inappropriate ones require more definitive measures.

In considering the physician's role as a supplier of information, it should be borne in mind that nothing is more difficult to handle than uncertainty. The family member who has little knowledge of the situation, like the small boy in the dark, can imagine eventualities worse than any known to medical science. Physicians, guided by their own value system of truthfulness or helpfulness, will impart more or less information. I personally favor the guideline of helpfulness. In keeping with this approach, the family should be given pertinent information but need not be acquainted with every possible eventuality. I agree with the well-known surgeon (Mayo, 1968), who said, "I have no great admiration for truthfulness that isn't also kind." Encouragement and helpfulness should be offered whenever reasonably consistent with the facts.

As previously mentioned, some

degree of denial, short of complete denial, should be expected during the early period. It should be respected. Only gradually should an effort be made to reduce it. Usually without combating it, the physician will note that it diminishes in extent as the family member comes to grips with the situation facing him.

The response to projection, especially when the physician's treatment is the object, is a more difficult problem. The more insecure the physician himself feels about his treatment, the more easily he is challenged by the family member's projection. Even under the most favorable circumstances, however, it will tax his tolerance and forbearance. To do battle at this juncture serves no useful purpose. Instead, it usually causes the family member to tighten his hold on his accusations. The physician's best approach is to supply information which lessens guilt and removes the need for projection.

Reintegration

The process of reintegration may begin within a period of minutes, hours, or days, or it may be delayed for weeks. As previously mentioned, the physician can foster it by recognizing that some forms of disorganization are transitory as well as expected. Conversely, he can impede it by not only failing to supply essential information and much needed support, but also by reacting to manifestations of disorganization with impatience, annoyance and anger.

Activity on the part of a family member, especially if it is constructive, promotes reintegration. It interrupts the downward spiral produced by feelings of helplessness and passivity. In instances where the patient is too ill or disabled to participate in decision making, a relative must assume the responsibility. Similarly, the parents of a chronically ill or disabled child should be called on to participate in his care.

During this stage denial, projection, intellectualization and isolation —essentially emergency measures that have been quickly mobilized to limit or contain the extent of the disorganization—tend to recede or disappear. They are replaced by efforts to face the situation as it is and to do whatever is helpful under the circumstances.

Some relatives regain their balance by relying heavily on the support they receive from the physician as an authority until their own strengths can be mobilized or developed. Young parents of a chronically ill or handicapped child may be especially needful of such support (Garrard and Richmond, 1963).

The process of reintegration is illustrated by the following case notes. A 52-year-old married woman, the mother of two young adult daughters, had undergone a left ovarian cystectomy six years earlier for what proved to be a pseudomucinous cystadenoma free of malignancy. Four years later (or two years before the present illness) a total hysterectomy and a right salpingo-oophorectomy were performed for an ovarian cyst. The cyst was diagnosed as benign. One month before the present admission, the patient began to experience mild indigestion and constipation and lost 15 pounds in a period of weeks. Her family physician felt a moveable mass in her left lower quadrant and referred her to a surgeon for treatment. On examination the surgeon confirmed the family physician's finding and also thought he detected fluid in the peritoneal cavity. These clinical findings suggested an intra-abdominal malignancy, but since the diagnosis was uncertain, the surgeon merely told the husband that an operation was indicated and emphasized his concern that he might find something "bad."

At operation, multiple intra-abdominal metastases and two or three quarts of fluid were found. The primary source was believed to be one of the ovarian cysts previously diagnosed as benign. When the findings at operation were described and their implications explained to the husband and two daughters, they reacted as though they were completely unprepared for this eventuality in spite of the warning they had received beforehand. Their next reaction was to try to place blame—on the previous surgeons, the present one and/or themselves. They asked who would discuss the situation with the patient, and they were visibly relieved when the surgeon said that he would. At this meeting, they were informed that Cytoxan would be given for palliation.

Three days later, when the surgeon again spoke to the husband, it was as though the information the husband had received—the diagnosis, the incurability of the illness and the proposed use of palliation—was all brand new. By the time of the next meeting five days later, however, some reintegration had taken place. The husband was beginning to accept the diagnosis of malignancy and was hopeful that Cytoxan would afford effective palliation. He even discussed purchasing a wig to cover the hair loss that the treatment would cause. Reintegration had taken place in a matter of days, and it was evident that an adjustment to the harsh reality would soon follow.

Adjustment

Garrard and Richmond (1963) qualified adjustment with the word "mature." I choose to delete the qualification, because for practical purposes I am speaking of the reestablishment of a state similar to that which existed before the crisis. "Mature" introduces a new dimension and one that is sometimes difficult to define.

To indicate more specifically what is meant by adjustment, I will discuss the case of the parents of a chronically ill or disabled child (Garrard and Richmond,

1963). During the first two stages, guilt feelings may have been evident through conscious thoughts concerning errors of omission or commission. Self-sacrificial devotion and overprotection are also evidence of unresolved guilt. Self-criticism and overindulgent behavior dissipate when the stage of adjustment is reached.

Since the parents of chronically ill or handicapped children frequently are frustrated and angered by their fate, they may hold the sick child responsible for their burden and discomfort. Because of their anger, they struggle with guilt. The result is inconsistency in the handling of their child—vacillation between anger and guilt. Characteristically, they shift from harshness to a compensatory overindulgence. As these parents reestablish their adjustment, the inconsistent behavior diminishes and, finally, largely disappears (Garrard and Richmond, 1963).

Some persons, especially those with well-developed obsessive character traits, prepare in advance for possible eventualities. Since they are not caught by surprise and are ready with what the Army calls "contingency plans," they largely circumvent the stages of disorganization and reintegration and make an immediate adjustment to illness in the family. A 34-year-old woman had the habit of asking herself, "What would I do if . . . if my husband became ill? If my children were lost? If my car went out of control?" She explained that, for other people, thinking of a crisis would have a bad effect, but for her, it had a good effect; it reduced her tension. By thinking ahead she felt ready to meet almost any emergency. She placed great value on being self-reliant, and she traced this attitude back to the childhood fear that her parents would leave her and not return. Her outlook was: You cannot be sure that another person will be there when you need help; you must plan ahead and be ready to handle your own problems. When her husband did become ill, she met the challenge without signs of even transitory disorganization.

Evidence should be sought for failures in adjustment. The general question, "How are you doing?" is poorly designed to obtain this information. Too often it sounds like the social convention of asking at a cocktail party, "How are you?" and brings forth an equally routine or thoughtless answer. It would be more meaningful and productive, for example, to ask the woman who comes to the office some weeks following her hysterectomy about her sexual relations. If such a question brings forth tears and other evidence of unhappiness, it may be essential to talk to her husband. At this juncture the husband usually does not need an intellectual discussion or a sermon. A bit of direct prodding is more to the point. He should be told, "Your wife is as good sexually as she ever was," and he should be enjoined to let her know he finds her attractive. Such statements are icebreakers and foster the husband's adjustment as well as that of his wife (J. R. Wolff, personal communication).

Summary

The modern American family has been described as a precariously balanced, emotionally highly charged system, lacking in ready shock absorbers to handle, within itself, serious illness (Parsons and Fox, 1952).

When confronted by the specific stress of a close relative's illness, the family members' reactions may be schematically divided into three stages: 1) disorganization; 2) reintegration; and 3) adjustment. Either disorganization can be intensified or adjustment can be fostered, depending on the physician's understanding of the feelings the family members experience and his willingness and ability to be helpful. The family members' responses, in turn, will influence the patient's reaction to illness or his recovery and rehabilitation. Accordingly, good medical practice requires that the physician include the family in his total treatment plan whenever possible.

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Social and Community Psychiatry and Its Effect on the Family

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Psychiatry has lagged behind the other medical specialties for some time now, but it is finally emerging from its 19th century concepts both in theory—as represented by social psychiatry—and practice—such as the development of community psychiatry. Its theoretical constructions are beginning to rest more firmly on a broad scientific base, and in its clinical applications it is beginning to find a place in the mainstream of medical practice. Some like to say that psychiatry is currently undergoing its third revolution. Both of these developments will increasingly view the family as the basic unit of biopsychosocial maladaptation. In the explanation and treatment of mental, emotional and behavioral disturbances, greater attention will be given to the interface and interaction between the individual and his environment rather than to the individual alone, as has been the practice in the past. In his book *The Psychodynamics of Family Life,* Dr. Nathan Ackerman (1958) has said,

> The single, most encompassing reason for our conspicuous failure thus far to prevent mental illness derives from our failure to cope with the mental problems of family life. We have somehow kept ourselves so busy, so preoccupied with studying and treating the suffering of individuals, that we have, in effect, blinded ourselves to the significance of the concurrent struggles of the family for mental health and to the way in which the ongoing content of family experience affects the emotional struggles of its adult members. I do not mean to imply that the treatment of the individual patient, the alleviation of the very real sufferings of a single human being, is unimportant or unnecessary. To the contrary. But I do question the effectiveness of any such treatment that does not take into consideration the sum total of this individual, which must of necessity include his environment and his interactions with it.

Simplistic Theoretical Basis

I am fond of announcing to trainees that they already know more about the specialty of psychiatry than they do about any other specialty of medicine, because they have actually been taking a course in human behavior since they were two years of age; yet at the same time they know less about the sciences contributing to psychiatry than they do about the sciences contributing to any other specialty, because this has not been taught in the medical schools. Our medical school pedagogy has focused its attention largely on classification of syndromes and upon the doctor-patient relationship. Curricula rarely include such topics as the emotional and behavioral correlates of physiologic and biochemical factors; heredity, instincts, drive, and maturation; perception and cognition or operant conditioning; family and group dynamics; role theory and communication; ethology or cultural anthropology; or even psychology and sociology. Fortunately, this situation is undergoing rapid change. While many medical schools are making major modifications in their overall curricula, many are inserting the basic sciences of human behavior in place of several hundred hours of anatomy.

Dr. Bond has outlined perspectives in the field of behavioral sciences. Particular notice should be given to the word "field," for the concept of a field of determinants is absolutely essential to our understanding and treatment of behavioral disorders. I recall that, as a resident in Cincinnati, one of my favorite teachers—our host, Dr. Lederer—pointed out to us that much of psychiatric theory was imbedded in the 19th century constructs of linear and singular causality. He contrasted this with later concepts of Maxwell and Lewin and urged us to expand our scope of conceptualization to include the entire field of variables and determinants of human behavior, which range from the molecular to the social levels.

This contrasts to the old "disease model" which, in order to explain a syndrome, often conceives of illness as resulting from some prepotent singular or primordial cause. Although this bears fruit in explaining infectious metabolic and surgical conditions, it is totally inappropriate for psychiatry. Simplistic explanations, such as "early childhood trauma," "the XYY chromosome of psychopathic personality," "imprinting in schizophrenia" and the "biochemical basis of depression," are inadequate and insufficient. Such ideas lead to the belief

MCV QUARTERLY 5(3): 120-124, 1969

that emotionally ill persons have something noxious within them which must be removed—that is, excised or exorcised. Psychiatry has also been haunted by some anachronistic remnants of hydrodynamic and mechanical models. We still speak of such conditions and situations as "dammed-up tension or hostility which needs more outlets," "carrying around a lot of guilt" (as if in a sack), "he had a nervous breakdown," "his nerves are tied in a knot" and "he blew his lid." These depict people like antacid commercials on television. Even modern physicians will tell a patient, "It is just your nerves"; or "You have too much tension."

Such oversimplifications have done much to retard the understanding and alleviation of interpersonal disturbances. Social and community psychiatrists are particularly vociferous in their attack upon the "disease model." Although they do recognize that within individual persons there are constitutional and learned defects which greatly handicap their adapting to the environment, these psychiatrists also center much attention on the transactions occurring at the interface between the individual and his environment. A fuller appreciation of the role of learning in personality development reveals that behavioral patterns are largely shaped by environmental experiences. This, of course, is particularly true for the experiences in the family during early life. Furthermore, there is fuller recognition that, to a great extent, present illnesses are responses or reactions to present external life situations. They recognize that an individual's thoughts, emotions and behavior cannot be fully understood without an appreciation of the past and current fields of socio-ecologic factors which impinge upon him and a realization that mental illness will neither be prevented nor often cured without modification of, or at least awareness of, the patient's relationship to his milieu. Many of these variables are cultural, social, economic and situational, but the most immediate and powerful factors are those found within the family itself—its configuration and the acts and attitudes of its members.

Exclusion from the Community

If the theory of psychiatry has been 50 years behind schedule, it can only be said that the practice has been 100 years behind. Around 1850 such personages as Dorothea Dix indefatigably promoted improvements in hospitals for the insane. Thomas Kirkbride (1847) proposed that such facilities be in the country—not within less than two miles of a large town—and have no less than 50 acres of land. There certainly is no doubt that the intentions of these leaders in the mental health movement were humane. Unfortunately, however, providing these institutions, which involved such enormous cost that they had to be operated by the state, shifted the responsibility for the care of the mentally ill away from the community. Consequently, these institutions evolved into places to hide the banished. It has probably always been true that, if a person should become a bother or a burden (i.e., mentally ill), he could somehow be ostracized from the community. In the old Western towns he could be put on a horse and told to get out. Today we send him out of town on a medical-legal rail called a commitment proceeding, which takes only the signature of several doctors and, perhaps, a fee to an official. In creating such hospitals we have assured the availability of a place to put such troublesome—or troubled—people. As for the family, it is often not very difficult to extrude one of its members who has become too disturbing to it. This member, of course, is not necessarily the sickest; he may simply be the weakest.

By the establishment of these state institutions, not only have families and communities been able to eliminate their bothersome members, but the medical community has been able to abnegate its responsibility to the mentally ill. Physicians and hospital administrators can declare that such patients are the responsibility of the state, and that, therefore, they need not attend to them. In addition, to avoid providing funds for their care in the community, local officials can maintain that the mentally ill are a state responsibility. Hospitals—be they voluntary, university or even public general institutions—and all physicians—be they psychiatrists or family doctors—can and do at times refuse to provide care to the mentally ill. This occurs not only because the patients are too poor, but also often because they are too unattractive, inarticulate, or disturbing. Some reasons given for such rejection are: "Sorry, we have no more beds," "My appointment book is filled," "Our intake is closed—we will put you on the waiting list"; and even "The patient is too sick for treatment"—the last an incredible excuse for a physician. That famous statement "This person needs help" all too often has the unspoken addendum "by someone else."

Who is that someone else? It has been the state hospital. We should remind ourselves that only state hospitals have had a legal obligation to accept all cases; only they have had an inclusive admission policy. As a result, their facilities have always been overburdened and, consequently, the standards of care greatly compromised. Physicians working in the community, who would not think of lowering their own standards, have been complacent or critical about the standards in state institutions. Have you ever wondered what would happen if judicial commitment were removed and state institutions had a legal right to refuse patients? Recently, in Saskatchewan, there was such an experiment in which

the provincial hospital was closed to a certain segment of the population. Local physicians and other community care-givers became involved almost immediately in providing needed services. Speaking facetiously, I venture to say that undoubtedly the best way to immediately establish community psychiatry would be to demolish the state hospitals.

Return of Responsibility

Of course, what I really believe is that we should take the inclusive admission policy and shift it over to the local community where it belongs. Actually we might retain the state institutions to carry on new and sophisticated treatment modalities but disallow their use as collection agencies for the banished. By returning this responsibility to the community, we could undo the well-intentioned error of the 19th century. In my opinion, the cardinal characteristic of the community mental health movement is the community's reassumption of its responsibility to provide the necessary care to its members. Not only the patients, but also the funding and administration should be returned to the community. Furthermore, the "treatment" of these disturbed persons should not be given entirely by local hospitals and physicians but should involve participation of a great many other community care-givers, such as social workers, clergy, associates at work or school, friends, and, above all, the person's own family. We now understand that the disturbed person's rehabilitation is severely handicapped as a result of the dehumanization and desocialization inflicted by removal from society and family.

Several conditions are permitting this revolution or reverse shift to take place. Not the least of these is a change in attitude among people concerning psychiatric illness and emotional problems. A good deal of credit must go to their attainment of psychodynamic insights, many of which have been acculturated through popular communication. In addition, psychiatry has acquired new understandings in such matters as interpersonal relationships, family and group dynamics, communication, social roles and individual and cultural differences. The increase in liberal social attitudes has resulted in public policies which seek the implementation of new humanitarian programs. Community mental health legislation, which has been passed in well over half of the states, is one good example. In the majority of this legislation the states make grants to local communities covering anywhere from 50% to 90% of the costs for broad-based programs of community services. They include not only direct clinical services to care for people at home, but also public information and education programs; consultation to other care-giving professionals, such as general practitioners, public health nurses, social workers, probation officers, clergymen and teachers; information and referral services; and suicide prevention programs, half-way houses and social and vocational rehabilitation programs. Not only are state funds subvented to the local community, but the administration of such programs is also transferred to local mental health boards rather than kept in the hands of absentee state officials. These local boards, which are often non-profit corporations, or the local public health departments are in a much better position to know intimately the needs of the community and to achieve cooperative and coordinated arrangements of services not only in the public sector, but also from private voluntary practitioners and agencies. Furthermore, they provide a source of continued advocacy for the program.

In recent years there has been a tremendous growth in the number of community general hospitals that have accepted psychiatric patients either on their general medical wards or in special psychiatric units. The Federal Community Mental Health Centers Construction Act has been a boon to many hospitals willing to develop such services. Regulations require that basic services be conducted within the framework of a mental health center, meaning that in addition to inpatient services, the hospital must also provide day care, 24-hour emergency care, and outpatient and consultative services. It will probably not be long before all general hospitals of significant size will be required to have psychiatric services in order to gain accreditation, a factor which can be expected to have a major impact in retaining people in the community. Greatly facilitating this step has been the introduction of the new psychotropic medications which, in addition to their direct benefit to the patient, quickly temper his behavior so that he is far less likely to incur rejection by nurses, physicians, family and others.

New Modes of Intervention

Of all the things which have enabled patients to be retained in or returned to the community, perhaps the most important have been the many new therapeutic approaches developed by psychiatry in recent years. Community mental health centers, in particular, are prepared to present a comprehensive array of treatment modalities which can be offered according to the patients' individual needs. In the past, psychiatric practitioners had a penchant for employing only their favorite treatment method, be it electroshock therapy, psychoanalysis, pharmacotherapy or counseling. Now, in addition, we can offer such diverse methods as conjoint family therapy, video confrontation of group therapy, crisis intervention, behavior modification based on learning theories, and resocialization activities. Other methods include special evening pro-

grams for adolescents and their families, augmented outpatient care —where patients come in for portions of a day rather than one hour per week—suicide prevention services and detoxification units.

In a community mental health center the array of treatment methods is compiled into one organizational unit or program. This permits the patient, family or individual members thereof to receive whatever kind of treatment is appropriate for him, it permits experimenting with different approaches, and, most important, it enables patient care to be continuous. Thus, from the inception of his difficulty, throughout the course of his illness, and on to the point of rehabilitation, there exists a continuing interpersonal relationship and a continuing professional responsibility which eliminates any necessity to transfer the patient out of the program.

A community mental health center is also a form of corporate practice. In many respects it is like group practice, with many of the professionals being on salary. With staff members receiving salary, rather than having their income derived from fees, the center is able to assume such functions as emergency room coverage, consultation liaison, conferences and supervision and training. In addition to the psychiatrists, who bear ultimate medical responsibility, there are psychologists, social workers, public health nurses, activities therapists, case aides and others. This expands the base of mental health manpower and allows the center to capitalize on the expertise of the other disciplines. Not only are many paramedical professionals involved in treatment, but even volunteers and other patients are asked to take part in the therapeutic community. Furthermore, family members are often not only asked but required to participate in the therapeutic effort. In the local center it is far more feasible for the family physician to maintain a substantial continuing role and to act as a consultant. The physician's intimate knowledge of his patient and his family and life situation over a period of time can be of enormous value and need not be lost if the patient remains in his home community. After all, such a doctor rarely needs to take a family history.

Family Relationships

A great many psychiatric problems, both acute and chronic, are what we often refer to as "disposition problems." That is to say, the patient has no place to go—he is in the wrong domicile. We are well aware of this in the case of the chronically mentally ill and know that many people, particularly the aged, must be placed in custodial care, either in a nursing home or state institution, because the family can no longer tolerate them. One of the principle problems that a state hospital has in trying to return patients to the community is to find a place where they can live. Often they will seek to return the patient to his family, but many times this is not acceptable; so that, in the absence of nursing or boarding homes, the patient who cannot manage alone must remain in the custodial institution. Simply returning a patient to his family is not always the best solution, because many times that was the very environment which precipitated his mental illness. It is also true of acute psychiatric disturbances that a key question is whether or not the patient will remain in his family. It may be that he cannot stand the family or the family cannot stand him. Many youths have the former problem and attempt to solve it by going to live with their married sister or the father who left the family years ago. Often they have no place to go, and it may require fast footwork on the part of a social worker to find one. It is not unusual for an acute inpatient psychiatric service to perform the function of a sanctuary or hotel for a brief period. If the only hospital willing or able to accept such a person is a state hospital many miles away, there is a complete rupture in the family organization. Members may be somewhat relieved but none the less guilty, and, other than paying infrequent visits, there is little they can do to help.

As previously mentioned, there has been a large increase in the number of local community general hopitals that are prepared to accept mentally ill patients, and most of the community mental health centers have close ties with such units, thanks to Federal regulations. The average length of stay in such facilities is about 10 to 15 days. This means that the separation is only of short duration, and, what is more important, it is only partial. The family can visit regularly and actually be brought into the treatment process. Also, most mental health centers have day hospitals and some night hospitals. These afford some separation from the family, thus giving all members of the family some respite from the turmoil, while at the same time affording an opportunity for them to regroup. Involvement of family members in the therapeutic process is accomplished through home visits, diagnostic sessions with the entire family participating, participation of the families in the activities of the therapeutic community, and, very often, specific individual treatment for one or several other members of the family. Many mental health centers require the involvement of the total family. In Dr. Kiesler's mental health center in northern Minnesota, not only the family, but also the clergyman, social worker and general practitioner are urged to come to the diagnostic sessions. In some ways this is reminiscent of the preindustrial extended family, in which there was little or no opportunity to eliminate family members, and responsibility for aiding

those in trouble expanded to include uncles and aunts, grandparents and in-laws. This doubtless gave a healthy perspective which is not now available to our isolated and mobile small families. It may be that mental health professionals along with other helpers, such as clergymen, social workers and general practitioners, are asked to fulfill some of these roles. In the final analysis, helping people is as much a humanistic as a technical enterprise.

Without further detailing the methodology, I would like to emphasize one point, i.e., a psychiatric crisis need no longer be considered the point of departure for a family member, but rather can be regarded as an entrée for helping the entire family to cope with its interpersonal conflicts. With the kind of help offered in a mental health center, families as total units can often attain a better adjustment than before, and the illness stemming from interpersonal difficulty will not rest entirely on the scapegoat member.

In summary, I should like to emphasize that modern psychiatry is beginning to see the family rather than the individual as the fundamental psycho-social unit for both diagnosis and treatment of disorders. At the same time, community mental health centers are bringing facilities back into the community as a means of repairing rather than rupturing families.

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SECTION III

Psychophysiologic Conditions

The four papers in this section are in contrast to the usual symposia on psychosomatic conditions which primarily focus on the somatic expressions of emotional problems in living or the emotional component of somatic conditions, e.g., peptic ulcer, colitis, hypochondrias, hysterical conversion states, asthma, neurodermatitis, dysmenorrhea. Instead, these papers emphasize the concomitant psychological components of medical problems, which the physician commonly encounters in his daily practice. The first paper points up the emotional factors to be considered in an important obstetrical problem. The second paper discusses a problem which finally is being recognized both medically and educationally as one of great social significance. The third paper emphasizes the emotional factors in any surgical intervention, and the fourth paper discusses the growing importance of geriatric conditions and the emotional sequelae.

—G. K.

Psychiatric Issues in Therapeutic Abortion

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At this moment in the history of American medicine a complex of problems, decisions, and new courses of action faces the medical profession in the matter of therapeutic abortion. In response to the hidden, pandemic occurrence of an estimated one million illegal abortions each year; to the evidence of a population explosion; to the ambiguous interpretations of abortion statutes given by many attorneys, ranging from general to restrictive; and to new, broader concepts of health and illness involving social and economic dimensions, the American Law Institute, the American Medical Association, the American Academy of Obstetrics and Gynecology and the American Psychiatric Association have issued position statements recommending revision and liberalization of the statutes in various states. As a result North Carolina, Colorado and California have modified their codes in the directions recommended, and legislative commissions in other states are studying the issue. Essentially, these new statutes constitute legislative sanction for therapeutic abortions which have been performed in modest numbers for many years by competent physicians in officially accredited hospitals.

For the purpose of this discussion I should like to focus your attention on the psychiatric involvement, questions, dilemmas, and opinions concerning therapeutic abortion. Under most of the existing statutes, therapeutic abortion is only permitted to preserve the life of the mother. Therefore, within the context of strict interpretation, the sole psychiatric indication is a high probability of suicide by the pregnant patient. A few statistical studies have been conducted on the incidence of proven suicide in pregnant women. These data show a significantly low frequency; moreover, an absence of suicides has been reported in several series of women who were refused abortion.

When we couple these statistical studies with the extensive range of psychiatric treatment methods which we can offer depressed, suicidal persons, this major psychiatric indication for therapeutic abortion to preserve maternal life diminishes almost to the vanishing point. However, when making a decision in a singular situation with a particular patient, a psychiatrist might, in good conscience and with competent professional judgment, recommend abortion to reduce the probability of suicide.

I think it highly important that the non-psychiatric physician be aware that: (1) Suicide risk is low in pregnant women; and (2) Suicidal risk can be treated psychiatrically in many ways rather than aborting the pregnancy. Therefore, it seems prudent for the non-psychiatric physician to refer to a competent psychiatrist the woman demanding abortion and backing her demand with suicide threats.

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MCV QUARTERLY 5(3): 126-129, 1969

Such referral should be for consultation rather than for specific recommendations for abortion. Reciprocally, it seems proper for the psychiatrist to clarify that his position is as consultant rather than as the man with the rubber stamp.

Actually there are bigger, unresolved problems which raise the following question: Does therapeutic abortion help preserve maternal mental health, or does it threaten and/or damage maternal mental health? It is of considerable relevance for us to gather information to answer this question. Psychiatrists and other physicians entertain strong convictions and opinions about the mental health sequelae to therapeutic abortion, but they have not conducted systematic studies to check their impressions.

Gladston (Calderone, 1958, p120) expressed the view that therapeutic abortion has serious deleterious effects upon the patient when he said: "Drawing upon my experience I would summate the major psychological effects in three terms: frustration, hostility, and guilt." He also believed that, "Bad as the situation was initially it not infrequently becomes worse after the abortion" (*Ibid.*, p119). Kane and Ewing (1968, p205), in a thoughtful review of the literature, stated, "There seems to be little in the literature indicating that benefit to psychiatric patients from a therapeutic abortion will occur on any but a chance basis." Simon, Senturia and Rothman (1967) proposed the thesis that therapeutic abortion provides an opportunity for neurotically ill women to act out their aggressive and self-punishing fantasies, i.e., abortion would reinforce serious psychological conflict areas in women who request abortion for psychiatric reasons.

Jansson (1965, p110), in a study of post-abortion patients who were admitted to mental hospitals, concluded: "We have thus the paradoxical situation that it is in the cases in which a legal abortion can best be justified from the psychiatric standpoint that the risk of a mental insufficiency during the post-course is greatest." The efficacy of therapeutic abortion as psychiatric treatment was questioned.

In contrast, Höök (1963) reported increased proneness to psychiatric reactions in patients whose applications for abortion were denied. To add to the confusion of findings, Lidz (Calderone, 1958, pp125–128) has treated women who were not granted abortions and who subsequently were not ill but, rather, grateful that the pregnancies went to term. This author stresses that there is a tendency to underrate the ability of most women to accept their babies and that ideas of inadequacy in caring for one's baby can be successfully dealt with in appropriate psychotherapy.

Various reports from Scandinavia and East Germany do not support the impression of deleterious psychological effects from abortion. In the American literature, Kummer's (1963) study of the experiences of 32 psychiatrists in Los Angeles revealed that 75% of this group had never seen a patient with severe or even moderate psychiatric sequelae to abortion, and the remaining 25% had rare contacts with patients suffering post-abortion mental symptoms.

Although the recommendations for more liberal statutes give justification for abortion in order to preserve the mental health of the mother, many psychiatrists consider abortion a necessary factor also for preserving the mental health of certain families and preventing future mental illness in unwanted children. These psychiatrists champion very liberal and permissive abortion laws similar to those of Scandinavia, West Germany, Israel, Great Britain and Switzerland, where socioeconomic difficulties are accepted as determinants of mental health. Schwartz (1968, p104) expressed this point of view as follows: "Although psychiatry may not be able to influence large numbers of parents to do a better job of bringing up their children, there are, nevertheless, indirect ways that society can strengthen family functioning. One of the most important of these is by making it more readily possible for people to control the number and spacing of their children. Because effective contraceptive knowledge and services are not yet universally available to all segments of the population, countless unwanted children are born each year to parents who are not well motivated to provide adequate care." Schwartz cites Karl Menninger's statement "The unwanted child becomes the undesirable citizen, the willing cannon-fodder for wars of hate and prejudice."

The aforementioned group of prevention-minded psychiatrists further favors therapeutic abortion because of the existing inadequate care and provisions for illegitimate children. They point to the serious shortage of adoptive and foster home families, as well as to the demonstrated pathogenic consequences of institutional life for children. Schwartz (1968, p106) summarized: "The psychiatric and social problems associated with unwanted and unplanned pregnancies, and their aftermath, unloved and neglected children, create substantial suffering in our society. Many of these problems could be prevented by adequate contraceptive measures and, where these are inadequate, by judicious use of therapeutic abortion." Bowlby (1951, p157) said, "Deprived children, whether in their own homes or out of them, are a source of social infection as real and serious as are carriers of diphtheria and typhoid. And just as preventive measures have reduced these diseases to negligible proportions, so can determined action greatly reduce the number of deprived children in our midst and the growth of adults liable to produce more of them."

To date, no studies have been undertaken which evaluate the effects of therapeutic abortion or

denial of it upon family functioning and relationships. If it be correct that, following abortion, a mother suffers from frustration, hostility and guilt, how do such emotions reverberate throughout the family system? What happens in the marital relationship? How does the mother treat her living children? Do they become the vehicles through whom she overcomes her guilt, or are they the targets of her hostility? Does the family become more stable and function better, as the advocates of spaced and planned parenthood assume? Through careful attention to these and other questions about the family, we could begin to know in depth the psychotherapeutic or psychonoxious consequences of abortion.

The need for extensive studies is again indicated in those cases of therapeutic abortion performed because of rape or incest. Most persons agree that these two indications for abortion carry tremendous psychological hazards and constitute severe traumas. To date, I know of no follow-up studies of these patients and their families in the post-abortion period, although it would seem obvious that such studies should be made. A similar lack of well-documented and well-constructed follow-up studies exists concerning women aborted because rubella or other causes have raised the possibility of a defective birth. It is quite possible that in the rubella group one might find many patients experiencing post-abortion depression, guilt, frustration and anger.

At present and in the near future, as more states liberalize their abortion laws, there will be opportunities for conducting adequate psychiatric studies on patients and their families, so that we can replace our impressions with solid facts. Hopefully, in such studies particular attention will be paid to the effect upon the marital relationship and upon the husband as well as the patient. In reviewing the existing literature, one finds only rare mention of the husband and prospective father and his attitudes, responses to, and behavior following abortion.

In the face of so many inconclusive findings and such incomplete information, what can be recommended by psychiatrists concerning the issue of therapeutic abortion and the problems of practice associated with abortion? The first matter to consider is the availability of psychiatric examination. The proposed modifications, as well as the existing codes in North Carolina, California and Colorado, are so constructed that only a very select segment of the population can afford a therapeutic abortion. These codes require examinations of the patient by at least two consultants as well as a general physician or obstetrician. In California the costs for such preliminary study have been sizeable and can only be borne by affluent families. Consequently, neither has the goal of reducing illegal abortion been achieved in the few states with liberalized codes, nor has the number of therapeutic abortions been increased. It is clear that psychiatric examinations should be made accessible through clinics and hospitals servicing the less affluent population, and, furthermore, that this population group must be informed of possible services.

A second psychiatric issue is the need to provide adequate treatment following abortion. If an abortion is granted for mental health and the stability of the family, then it is evident that proper arrangements must be made for helping the patient and her family accommodate to the stress of the abortion. It is medically naive to think that an abortion per se constitutes a form of psychiatric treatment and can establish at once a well-functioning, steady state in the patient and her family. It has been my impression that little or no planning for psychiatric attendance in the post-abortion period has been made. In our own hospital, no therapeutic abortion is even considered for psychiatric reasons unless there is an associated plan and arrangement for follow-up psychiatric care. This practice is in response to the type of situation discussed earlier in which those patients for whom therapeutic abortion seems indicated because of high risk to the mental health were found to be the very ones most likely to react with symptoms to the stress of the abortion. In other words, the patient with meager ego resources is most likely to respond pathologically to a full-term pregnancy or to an abortion. Under these circumstances she is very much in need of adequate psychiatric care before, during and after abortion.

A third and related matter is the recommendation that more medical and psychiatric attention be directed to the husband and the family of the abortion candidate. Possibly as a result of the present use of the medical model—of the one-to-one relationship between doctor and patient—most consideration has been directed to the pregnant woman, with only tangential and secondary consideration of her family system. All of the proposals from the legal, medical and psychiatric associations reflect this latter omission. However, present-day psychiatry is rapidly developing a body of concepts and practices concerning family functioning and dysfunctioning in many situations of emotional and mental stress. It is strongly recommended, therefore, that in all cases in which there is a petition or permission for therapeutic abortion, evaluation and—where indicated—therapy should be provided for the family. This recommendation calls for the possible assignment of other mental health professionals, such as psychiatric social workers, to active participation in the total medical responsibility in therapeutic abortion.

A fourth consideration is the recommendation that the psychiatric arm of the medical profession

prepare itself for the eventuality that all abortion laws may be rendered invalid through Supreme Court decisions. Many students of the legal aspects of therapeutic abortion have stated that the abortion laws might be challenged on the basis of the Supreme Court decision regarding the Connecticut laws against contraceptive prescription. As you will recall, the Court based its decision on a new interpretation of basic human rights postulating a human right to privacy. Under such an interpretation, the whole issue of abortion may be considered a private matter between a marital couple and their physician. It is seriously anticipated that a test case may be forthcoming in the near future. In the event of such a change, psychiatric consultation may be neglected because of the ease with which legal abortion might then be obtained. From the studies that have been reported, it is clear that mental health evaluation is needed for the average patient undergoing therapeutic abortion and that decisions must be made for proper treatment where indicated.

It would seem that the medically honest course for all physicians who either participate in or deny therapeutic abortion would be to pursue sophisticated and sufficient re-examinations of these patients and families. These follow-up studies might provide us with information that would help define much more exactly the psychiatric indications for and contraindications to abortion, as well as rational treatment programs when such are needed. In this way, we could contribute toward advancing the situation which Freud (1962) said "would be one of the greatest triumphs of humanity, one of the most tangible liberations from the constraint of nature to which mankind is subject, if we could succeed in raising the responsible act of procreating children to the level of a deliberate and intentional activity and in freeing it from its entanglement with the necessary satisfaction of a natural need."

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Sexual Counseling in Medical Practice

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Sexual problems and marital discord are aspects of emotional difficulty in living that have been relatively neglected by the medical profession. There has been little recognition of the profound role that family life has on the physical and emotional health of the individual. Physicians tend to treat the individual without recognizing that family interactions may play an important part in the efficacy of the therapeutic program prescribed. When confronted directly with a patient's marital or family conflict, most physicians feel overwhelmed, become defensive, and make perfunctory attempts to give advice that is usually banal and inane. ("You ought to spend more time at home. Why not cook his favorite dishes? Stop drinking. When are you going to stop beating your wife?") If the difficulty is sexual incompatibility, the doctor is frequently as embarrassed as the patient. Although the anatomy and physiology of the genital organs are studied in great detail in medical schools, little has been taught on the functional, social, and emotional use of these sexual organs. Therefore, the physician's handling of the subject of sex will depend on his own sexual experiences, on the cultural concepts and taboos learned in his own upbringing, and on his observations regarding sex in his clinical practice. The result is that his advice is limited, his prescription of drugs is ineffectual, and he or the patient beats a hasty retreat. The patient may, or may not, be referred to a psychiatrist or a family agency. Sometimes even the psychiatrist is at a loss and he, too, passes the buck to a family social agency.

Psychosexuality

The following summary of psychosexuality can serve as a frame of reference for the physician in evaluating the sexual complaints of those who consult him. The physician needs to become knowledgeable about the factors that affect sexual behavior, for it is particularly in the area of sexological information that the physician's education has been neglected. (Several excellent texts are available on the latest understandings and techniques; a bibliography is included at the end of this article.)

Sexual relationships in human beings involve two factors: the biological need for lustful gratification and the emotional need for intimacy and physical closeness. The healthy fulfillment of one's lustful needs not only involves the specific behavior leading up to sexual intercourse, but also includes the assertive expansiveness of the individual's masculinity or femininity—his sexual identity.

Sexual Identity

Sexual identity is determined by an admixture of the following biological and social factors:

1. *Biological sex.* This is determined by chromosomes, external genitalia, and hormonal status.

2. *Gender identity.* This is determined by the perception and conceptualization of the roles of maleness and femaleness. Gender identity is social, and studies have shown that parental attitudes toward the infant's gender, attitudes which are unambiguous and clearly delineated from birth until the age of two or three, fix the gender identity for life.

3. *Child-parent relationships.* These are important in developing healthy sexual attitudes. The conditions necessary for normal heterosexual development are:

a. The child's identification with the parent of the same sex. The parent must not be too weak, nor so punishing that the child rejects the parents as a model for adult attitudes and behavior.

b. The child's trust in the parent of the opposite sex. This parent must not be too seductive, punishing, or emotionally inconsistent, or the child will develop a fear of the opposite sex.

c. The child's acceptance of his biological sex. The child must not feel that his biological sex is unacceptable, inferior, or rejected. The parents must manifest acceptance of the child's sex, and they must not attempt to teach or influence the child to adopt the opposite sexual role.

4. *Cultural value systems.* These are most significant in our society, because it promulgates certain models as the social ideals for masculinity and femininity. The tall, broad-shouldered, slim-waisted athletic man with the features of Adonis epitomizes masculinity. The five-foot-five, shapely legged, slen-

MCV QUARTERLY 5(3): 130-134, 1969

der-waisted, ample-bosomed, delicately featured woman represents the American feminine ideal. Unathletic boys or masculine-looking girls sometimes embrace the roles of the opposite gender, in reaction to others and because of their own distortions of their identities, in acceptance of the dominant social values of their environment. Intellectually precocious boys or scientifically oriented girls may be labeled sissies or unfeminine by their peers or the adults in their environment and may assume that they lack appropriate sexual abilities. Acceptance of value orientations may be covert and unspoken, implied by social attitudes of those around them. The segregation of the sexes in schools may affect the person's gender role, particularly at the preadolescent and adolescent levels when sexual curiosity and development are most rapidly occurring.

5. *Sexological knowledge.* This involves learning the appropriate use of the genitalia and the processes involved in lustful fulfillment, which are important determinants of sexual identity. Because lustful desires are biological, it is often assumed that human beings are reflexively knowledgeable in the art of making love. It is an interesting commentary on our culture that we recognize the need to teach our youth proper eating habits and to train them to use their muscular prowess athletically; that we have charm schools, beauty and barber schools, dancing schools, schools for making friends and influencing people; but that nowhere do we teach human beings the elementary techniques for the skillful fulfillment of a basic, biological process. Many men and women have questioned their sexual identity because they lacked knowledge of the mechanics of making love. This involves not only a lack of knowledge on how to satisfy the partner, but also a lack of knowledge on what is involved in gaining full satisfaction for the self.

The second factor in sexual relationships, the need for physical and emotional closeness and intimacy, is equally important in the full gratification of the human being's sexual needs. Sex can be enjoyed on a purely lustful basis, as a sporting activity, but a more intense gratification occurs when it is integrated with our need for mutual emotional closeness. We can enjoy a meal with a relative stranger and generally would prefer the company of someone, rather than dine alone. Our enjoyment is infinitely increased when the meal is partaken with someone whose interests we share and with whom we feel free to express our innermost feelings. Love, a feeling for another person to the degree that his satisfactions in living are as important as one's own, enhances the pleasure of any human activity, whether it be eating, walking, or sex. A subfactor in human sexual behavior is our need for physical contact with others, an aspect frequently overlooked. Human beings have a need to touch other human beings physically. (Try going 24 hours without touching another person. It is possible to do so, but you will find that you have a strong urge to put your hand on someone's arm, to shake hands, or to just rub shoulders.)

Sexual Problems

In general, sexual problems are due to: 1) ignorance of the sexual facts of life, or 2) contamination of the sexual area by other desires, wishes, needs, or fears on a childish level, e.g., considering sexual intercourse to be a criterion of worthwhileness, control of the other person, physical hurt, and so on. Two examples best illustrate these factors.

a. A woman patient confided that she had no interest in sexual intercourse, did not receive any pleasure during the act, and reluctantly had intercourse out of a sense of duty to her husband. Inquiry revealed that she was not sexually frigid, and that she masturbated two to three times a week by clitoral stimulation with orgastic satisfaction. When asked why she could not reach the same satisfaction during intercourse, the patient revealed that, throughout the 20 years of her marriage, she had thought that gratification during intercourse resulted from the penis touching something deep inside her vagina and that clitoral stimulation and excitement were only for masturbation. The final irony is that this college-educated woman is married to a doctor of clinical psychology.

b. A man in his 40's complained of impotence of approximately two years' duration. Prior sexual relationships with his wife had been highly satisfactory. The marital relationship had always been somewhat strained, but two years earlier the conflicts had become more severe. Due to the intensification of the conflicts, he completely lost his erection one night in attempting intercourse. He became concerned as to whether he had lost his manliness, he experienced intense anxiety whenever he attempted intercourse, and he either failed to have an erection or lost the erection at the time of penetration. The lustful activity was contaminated by his concern about his sense of identity as a man, which he equated with the ability to have intercourse. Intercourse became a trial to determine his worthwhileness, rather than a pleasurable gratification of a lustful need. In this marital conflict, the loss of emotional closeness and feelings of mutuality initially diminished the desire for sexual intercourse; and the husband's subsequent questioning of his own virility and worthwhileness completely blocked the sexual relationship. The reestablishment of communication with the wife, the resolution of the marital conflicts, and the resolution of the husband's anxieties regarding his own worthwhileness

and identity restored the mutually satisfying sexual relationship. In most situations there is some overlapping and intertwining of both factors.

Sexual Counseling

A prerequisite to successful sexual counseling is the physician's attitude about sexual matters. He must not only be aware of and accept his own sexual impulses, but also must recognize that his sexual concepts are only one among many patterns of sexual adjustment. If he wittingly or unwittingly assumes that there is only one right pattern of sexual behavior, he will be judgmental rather than understanding of the patient's problem, and he will tend to be condemning, rejecting, or disdainful of the patient's difficulties. On the other hand, he may feel benevolent and, with missionary zeal, decide to rescue the poor soul and show him the right path. He might, because of his own sexual fantasies, encourage or privately admire the patient's sexual adventures or misadventures. There are other overt and covert forms which this judgmental attitude may take, but, regardless of the form, the attitude interferes with the physician's friendly, interested objectivity.

Interested objectivity permits the physician to understand the patient's problem, and understanding is what the patient is primarily seeking. "The patient who is troubled needs understanding and clarification of his difficulties, and the doctor is in a unique position to bring this about. The patient does not need moral persuasion or censure, which he can obtain in abundance from other sources; it is unfortunate if the doctor fails to recognize this opportunity and instead, like others before him, promotes a particular solution or deplores another." (Wahl, 1967, p 242.)

Unfortunately, many physicians have the mistaken idea that understanding psychological problems requires a different type of thinking than understanding physical problems. The same processes and techniques that are involved in obtaining a medical history and in understanding the presenting complaints are applicable in psychological counseling. The difference is that, in the former situation, the physician is attempting to conceptualize physical morphological processess and, in the latter, he is conceptualizing psychological attitudes and emotional patterns.

Specific Procedures

The specific procedure in sexual counseling is, first, to give the patient a chance to state the problem. Patience is required, because this will probably be the first time he has ever discussed his problem with anyone. He may be embarrassed, anxious, and concerned as to how you will react to what he has to say. An interested, matter-of-fact, non-judgmental attitude implying that he cannot tell you anything you have not heard before is immensely helpful. Simply communicating his difficulty to an understanding, nonprejudiced person is a tremendous relief to the patient. The doctor has already helped him. He has exposed himself—laid himself bare—and nothing has happened. If the physician now follows through with the same matter-of-fact understanding manner by asking pertinent questions to elicit further details of the problem, the patient will generally collaborate.

The procedure is the same as that carried out if the patient complained of a pain in his chest. How long has he had the problem? How frequently does it occur? Under what circumstances is it more or less severe, and so on? The physician is not being sadistic or morbidly curious; he simply needs to know the full picture so that he can understand the difficulties the patient is experiencing. The patient may protest or may be embarrassed, but, knowing that the doctor is attempting to understand him, he will cooperate. It is important to obtain the full picture, not only of his present sexual problem, but the history of his sexual experiences. This should include his exposure to sex as a child—the manner in which he discovered the difference between the sexes. Did he see either of his parents nude? What degree of modesty existed in the family? What was the parents' attitude toward sex? Did he learn about sex at home or on the street? How old was he when he first masturbated? When did he begin to date? When did he first have intercourse? What type of girl or boy was involved, and what kind of an experience was this? Did he enjoy the experience? What subsequent sexual experiences have occurred up to the present time? Has he ever had any homosexual experiences? All of these questions and many more permit the physician to make the necessary differential diagnosis as to the particular type of sexual problem that may be involved. Most errors in medicine are caused by lack of a thorough examination and evaluation of the components of the problem. This is equally true on a psychological level. Thorough investigation and evaluation are the keystones of successful sexual counseling. Such a procedure permits the physician to determine what the problem actually is and to ascertain whether the difficulty lies in an ignorance of the sexual facts of life or a contamination of the sexual area by other emotional needs, conflicts, or desires.

Steps in Counseling

The physician is now in a position to assist the patient in handling his problem. Notice that the phrase is "assist the patient in handling his problem." In contrast to the practice of physical medicine, the physician cannot do something to or for the patient, but can only

assist him in doing something for himself.

First, he can clarify the problem for the patient. The aforementioned example of impotence is a situation in which the problem was not impotence but a problem of marital conflict. Patients of both sexes have appeared in my office with the presenting complaint of fear that they were homosexuals. This was based on either an erotic fantasy about, or a feeling of affection toward, a person of the same sex. In some cases, the patient has interpreted his or her inhibited, shy behavior toward the opposite sex as an indication of homosexuality. After all, what more clearly expresses one's doubts about one's own sexual identity than being homosexual. These patients are usually lonely people with little or no sexual contact with either sex, who equate their thoughts, feelings, or fantasies with actual behavior. Clarification of the presenting problem can be of infinite help to the patient, eliminating many pseudo problems and decreasing anxiety.

Second, the physician can supply the correct sexual information when the patient is misinformed. A large proportion of sexual counseling cases can be handled at this level, despite evidence that a deeper personality problem may be present. The degree of ignorance about sexual matters, even among intelligent, well-educated people, is amazing. The lack of appropriate sex education has resulted in a lack of knowledge about elementary sexual physiology and psychology and the perpetuation of old wives' tales and superstitions. Many marital crises have occurred because one or both partners lacked knowledge about foreplay, techniques of arousal, frequency of intercourse, and what constitutes an orgasm. Many persons have questioned their sexual identity because of misconceptions about the size of their sexual organs, secondary sexual characteristics, or the degree of their responsiveness to erotic stimulation. The physician himself should explain these matters to the patient rather than refer him to a sex manual. No sex manual can answer the specific questions that a patient might have and, not infrequently, the patient does not understand what he has read. In addition, reference to a sex manual reinforces the implication that these are matters not to be openly discussed but only to be read about privately. Sometimes, a patient will request reading material. This request should be met, but only after a face-to-face discussion and arrangement of a follow-up interview to ensure a proper understanding of the reading matter. That is particularly important in premarital counseling. The romantic haze of the forthcoming nuptial event may temporarily block out the importance of a satisfactory and successful wedding night. The emotional excitement of being married obscures the realities of marriage.

Third, the physician can assist a number of patients whose problem is primarily a contamination of the sexual area by emotional problems of a more general nature. Many emotional problems of recent origin and mild degree can be helped by an understanding physician. Cases involving premature ejaculation, loss of sexual desire, impotence, and frigidity are often the result of the spilling over of concerns about one's health, acute anxiety regarding economic factors, worry and concern about members of one's family, reaction to marital conflict and strain, and mild agitation or depression. The sexual symptoms frequently disappear when the real problem is pinpointed and dealt with.

Fourth, there will be some cases in which referral to a psychiatrist will be necessary. Some cases of premature ejaculation, impotence, frigidity, promiscuity, and so on are deep-seated problems of long-standing and require the assistance of a skilled and experienced psychotherapist. The physican's role in these situations is to help define the problem, to clarify the need for therapy, to explain what is involved in therapy, and to refer the patient to a psychiatrist. Naturally, the patient himself must feel that he has a problem. If he is satisfied with his particular sexual adjustment, he will lack motivation to seek correction. There is an old adage "You can lead a horse to water, but you cannot make him drink." This aspect frequently occurs with homosexuals, who claim they are "happy" in their sexual adjustment. Although some experts in the field feel it is best not to cast doubts on a pattern of sexual adjustment which the particular patient does not see as a problem, it is, in my opinion, equally a disservice not to confront him with the possible consequences. Frequently, these situations can be handled by suggesting a consultation with a psychiatrist to evaluate the problem and confirm the physician's findings, rather than to initiate therapy.

There are other phases of sexual counseling which cannot be discussed here due to the time limitation. Among others, the problem of premarital contraceptive advice, the unmarried mother, the menopausal state, aging, adolescence, the handling of sexual problems in childhood are specific problems that warrant detailed discussion.

In summary, sexual relationships involve two factors: lustful gratification and emotional and physical closeness. Lustful gratification involves sexual identity which is determined by: 1) biological sex; 2) gender identity; 3) child-parent relationships; 4) cultural value systems; and 5) sexological knowledge. Sexual problems are due to ignorance of the sexual facts of life and/or to contamination of the sexual area by other needs, wishes, or fears. A detailed understanding of the presenting complaints and the sexual history of the patient will enable the physician to make a differential diagnosis. The physician

can then clarify the problem and assist the patient in eliminating pseudo problems. He can supply the necessary information regarding sexual functions about which the patient is misinformed. He can also assist those patients for whom the sexual area is contaminated by other emotional problems of a more general nature. Finally, the physician renders a service to the patient by defining and pointing out the existence of a serious sexual problem which should be referred to a psychiatrist for evaluation and/or therapy.

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Anxiety, Defense and Cognition

A Theoretical Basis for Practical Handling of the Surgical Patient

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Introduction

My aim in this short paper is to review certain dynamics of human behaviour, gleaned from psychological observation and research, that may have direct relevance for the surgeon and his patient. I hope to outline several theoretical formulations and use them as the basis for a guide to practical handling of the surgical patient's emotional reactions to his illness and treatment. Two theoretical models of behaviour have proved of high value in this regard. The first is older, appears enduring, and is probably more familiar to most non-psychiatric physicians. I refer to the "anxiety-defense" model, which postulates that stress produces conflict and arouses anxiety. The anxiety catalyzes the formation of psychological defenses. The second model is of more recent origin. In this, the "cognitive model," the focus is on the effects of stress on cognition—the mental process whereby consciousness is acquired of what is perceived by the senses or conceived by the mind. In other words, stress alters perception and the interpretation of percepts, which, in turn, frequently leads to alterations in behaviour.

Anxiety-Defense Model

I would like to turn, first, to the more familiar model; namely, the stress-anxiety-defense model. Titchener (1967) provides a comprehensive summary of the psychological implications of surgery from this point of view. Stress, he states, is a "stimulus which demands an adaptive response." With particular reference to surgery, the stress is the fear, anxiety, and depression associated with the procedure or the anticipation of it. These painful emotions are vigorously avoided in the mental sphere by a variety of defense mechanisms. Those most frequently encountered in surgical patients are:

1. suppression—a deliberate and willful attempt to avoid thinking about the surgery or some aspect of it;

2. repression—an unconscious and automatic reaction in which a wish, feeling, or thought more or less loses its capacity to enter awareness;

3. denial—an unconscious and automatic reaction which selectively prevents an awareness of some externally perceived event;

4. reaction formation—an unconscious and automatic reaction which attempts to deal with unacceptable wishes, feelings, or thoughts by converting them to their opposites.

Thus, the patient may consciously avoid discussing his anxiety and depression (suppression), or he may be unaware of these reactions (repression). He may show an inordinate degree of passivity and helplessness (regression), or he may refuse any assistance which is offered to him (reaction formation). He may mentally shut his eyes by repressing any internal reaction to his surgery and manifest only irritability and anger; or, in some cases, he may mentally shut his eyes to the reality of the surgery itself. These reactions affect the patient's relationship to the surgeon and hospital personnel, the degree of energy available to him for dealing with other life stresses, and his convalescence generally.

The practical value derived from this theoretical model can be great. First, a knowledge of the defenses helps the staff to understand some aspects of the patient's behaviour which, otherwise, might seem strange, contradictory, or inexplicable. Second, with tact and proper timing, understanding can sometimes be imparted to the patient. Finally, and perhaps of greatest importance, this model forms the basis for a psychologically correct therapeutic attitude. As a result of defenses, hospital staff are often confronted with some of the most difficult aspects of human behaviour (Levine, 1942). If one can keep in mind that this behaviour is defensive—that it is an attempt by the patient to ward off painful feelings of anxiety and depression—then it becomes easier to be noncondemning. It is possible to react kindly without sympathy and firmly without judgment if one understands that the patient is not "just ornery" but is attempting to cope with physical and psychological pain.

Cognitive Model

I turn now to a brief consideration of the cognitive model, which postulates that alterations in perceptual and conceptual awareness occur as a result of stress. As adults, particularly as well-educated adults working in the sciences, physicians are prone to equate cognition with concept formation. We perceive and we think in a word-

oriented fashion, preferring clear, abstract, arithmetic words having concise meanings. Of course, we may accept the more expressive and diffuse word usage of the artist or poet, but generally not in our work. We may fail to recall that cognitive function, like all functions of the human organism, develops. The cognition which I have just described—conceptual cognition—is not the only form of cognition; rather, it represents the highest level in a series of cognitive developmental states (Arieti, 1967). We need only remind ourselves that the 1-year-old lives in a wordless, phantasmic world. The 3-year-old, having a limited vocabulary, communicates predominately by body language; for him, words merely denote, rather than form, the basis of concept. The 5-year-old is just beginning the process of abstraction. In order to appreciate the varieties of wordless, preconceptual cognition, we need only remind ourselves of our mode of trying to communicate with someone who does not speak our language by using signs and charades; of our intuitive and empathic "understanding" of the infant; of the paleological thinking of our dreams; or of the "body English" that we impart when stroking a putt or releasing a bowling ball.

It would appear that stress, particularly the physiological and psychological trauma of surgery, alters cognitive function. The meaning of words and, consequently, concepts becomes less precise—fuzzy and foggy. Their use becomes less abstract and, consequently, more concrete or denotative. Both inductive and deductive reasoning are less dominant; thought becomes more personalized and teleological. We are familiar with many of these phenomena in delirium and other organic brain states, because they appear in exaggerated form. What is fruitful to an understanding of the surgical patient is that regression of cognitive function probably occurs, to some degree, in every patient. I am not implying that every surgical patient suffers from delirium, that is, some physiological alteration in brain function, although further research may prove that this is so. What I am stating is a psychological truism; under stress, more recently acquired modes of function are partly or totally suspended. Earlier, more primitive modes are, thus, released.

What does this mean in terms of the practical management of the patient? It means that a simplified environment is less likely to be misinterpreted by the patient. It means that if actions and speech are slow and deliberate, the patient is more likely to perceive them correctly. It means that if you explain what you are doing in concrete terms and avoid unnecessary conversation, there is less chance of creating an ambiguous situation for the patient. The conclusion to be drawn from the cognitive model is this: for the most effective handling of the surgical patient, be simple, clear, and concrete.

One final point is worth noting. It has been repeatedly observed that the post-cataract patient becomes anxious and disturbed as a result of the prolonged bandaging of the eyes and the enforced blindness. The anxiety is generally explained in terms of feelings of helplessness. Further, it has been observed that patients in traction or large body casts become anxious and disturbed after prolonged confinement. Again, feelings of helplessness are most often invoked to account for the behaviour. The cognitive model suggests another explanation. With cognitive regression, verbal-symbolic communication and conceptualization yield, in part, to non-verbal communication. Motion and gesture become more relevant. Action begins to speak louder than words. However, the patient finds his mobility restricted by bandage, cast, pain, and doctor's orders. He cannot fully utilize action language in his attempts to reach out to others in a way that is meaningful to him. Furthermore, the hospital and the staff compound the communication gap even more. Not only is the staff more likely to attempt communicating in the verbal-conceptual mode, which is more relevant for them, but modern gadgets, such as monitors and two-way intercoms, increase the distance between patient and staff. The manifest anxiety and feelings of helplessness exhibited by these patients is the result, then, of the inability to communicate with those around them. Closing the gap may be something as simple as holding the hand of the patient whose eyes are bandaged so that he can really experience the presence of someone. I am told by the psychiatric consultant of the Syrian Burn Hospital in Cincinnati that the staff attempt to touch some unbandaged spot on each burn patient while giving him nursing care.

Summary

Both the anxiety-defense model and the cognitive model provide a scientific basis for practical handling of the surgical patient. Emerging from both models is a humanistic approach to the patient based on understanding and a nonjudgmental attitude as well as on a knowledge of where the patient is psychologically and a willingness to meet him on his ground. The rewards in terms of a reduction of anxiety, depression, and human suffering can be enormous.

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The Older Population and the Aged Patient

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Modern medical practice requires that the physician and other members of the health team have full appreciation of the impact of disease and disability upon identifiable groups of patients and recognize how nonmedical factors affect treatment and prognosis. It is important for the physician to have some idea of the patient's socioeconomic status and the actual and potential number of patients with not only a common diagnosis, but also similarities in their living conditions. With such knowledge, the physician can be much more realistic and efficient in his therapeutic efforts.

Persons 65 years of age and over are commonly referred to as *the older population.* Brotman (1968) recently identified the special characteristics of those 75 years of age and over, referring to these people as "the aged." This subdividing of the older population is of considerable value, as the important health and socioeconomic facts common to a specific group can be lost in the mass of the older population.

The Older Population

In the United States there are 18,500,000 men and women age 65 and over; hence, one in every 11 persons in the United States is age 65 or over. Since 1900, the percentage of the United States' population age 65 and over has more than doubled (from 4.1% in 1900 to 9.4% in 1965), while the actual number of aged persons has increased sixfold (from 3,000,000 to more than 18,000,000). There has also been a clear reversal in life expectancy for men and women. Women are now outliving men; in fact, there are about 129 older women per 100 older men. Life expectancy for women is still increasing faster than for men. During the next 20 years, although it is unlikely that the percentage of older people will increase, the actual number will go up to 25,000,000. Assuming that the life expectancy trends continue, by the year 2000 the ratio of women to men will be 148 women to 100 men.

Living Arrangements

The majority of elderly people are living in the community. Only one in 25 lives in an institution such as a rest home, nursing home, or medical facility. There are, however, some striking differences between the way the men and the women live. Two-thirds of the men live with their spouses, but only one-third of the women have husbands. Moreover, only one-sixth of the men live alone or with nonrelatives, while one-third of the women live alone or with nonrelatives. Less than three-quarters of a million elderly people require some type of institutional care. Consequently, greater emphasis must be given to making certain that the living arrangements for the elderly within the community are conducive to the maintenance of health.

Surveys of older people indicate that they want to live apart from their children but close to at least one of them (Shanas et al., 1968). Consequently, housing units for the

elderly should be conveniently placed so that the old person can have controlled intimacy in terms of frequency and distance. The units should be located so that it is not only possible but relatively easy for old people to see their families often and call upon them for help if and when needed. Unfortunately, a small percentage of older people, probably around 4%, have no human contact for as long as a week. This small minority of aged individuals is truly isolated, and although such individuals are few, they are so scattered that they are difficult to find. When found, they are difficult to approach, usually rejecting any offer of assistance.

In a national study of older Americans, 59% of those living alone had been visited by an immediate neighbor the previous day, 46% by a friend, and 60% by relatives, including children.

Marital Status and Life Expectancy

As indicated above, most older men are married, whereas most older women are widows. There are almost four times as many widows as widowers. It should be noted that about two-fifths of the older married men have wives under 65 years of age. Furthermore, there are at least 35,000 marriages a year in which the groom, the bride, or both are 65 years of age or over. The number of marriages among elderly people has been steadily increasing.

The difference in married and unmarried status for older patients is of significance to the physician, for it has been noted that the hospital admission rates and stays of the unmarried exceed those of the married (Spiegelman, 1963).

There are about 5,000,000 couples with one partner over the age of 65. In this group 350,000 couples, or 7%, have annual incomes of $10,000 or more. Nine hundred and forty thousand couples, that is, 18%, have incomes between $5,000 and $10,000. The remainder of such couples, that is, 75%, have an annual income of under $5,000; 52% are under $3,000; and 7% are under $1,000.

Unfortunately, the income distribution of persons age 65 and over who are living alone indicates that the majority are living in poverty. Eighty-nine percent have an annual income of less than $3,000, and 62% are under $1,500. It is evident that men 65 years of age or older not only are likely to have more money than surviving women but are much more likely to have a spouse. Although a man is less likely to live as long as a woman, the years he spends as an older citizen appear to be better ones than the many years spent in old age by a woman.

Work and Retirement

The number of men working after age 65 has decreased steadily since 1900. At that time, a man over 65 had two out of three chances of being employed. By 1965, only 25% of males, once they had passed age 65, were in the labor force.

Life Expectancy

Life expectancy is a computed projection rather than an observed or estimated phenomenon. The projection is based upon the assumption that the death rate experienced in a single year or the average of experience in a few years will remain completely unchanged in the future. Obviously, any event that influences future death rates, whether it be natural or man-made, automatically affects the accuracy implied in the prognosis of the computed life expectancy. Since the computed life expectancy cannot foresee negative events, it also cannot include positive changes. No assumed positive changes are included, e.g., changes in medical knowledge and care, sanitation and nutrition; reduced mortality in traffic accidents and wars.

Human longevity is influenced by a complex of interacting factors including genetic makeup, environmental and nutritional factors, and psychologic, social, and economic influences.

Longevity in the United States has changed but little in recent years. The average length of life in 1965 was the same as in 1961. This plateau was the result of an unusually high prevalence of acute respiratory disease which caused a slight setback for two years.

In 1965, the expectation of life at birth for white females was 74.7 years, an increase of only one year since 1956. Among white males the corresponding figures were 67.3 years in 1956 and 67.6 years in 1965, a gain of just .3 of a year. These changes continue to increase the difference in longevity between the sexes. In 1965, the expectation of life at birth among white females exceeded that for white males by 7.1 years as compared with 6.4 years in 1956 and only 2.9 years at the century's turn.

Many more people are reaching old age, but once there, they are not living much longer.

In 1968 there were 7,300,000 men and women age 75 and over in the United States. The aged population is actually growing faster than the older population. Today, at age 75, life expectancy averages about nine years. Brotman estimates that if we eliminated malignant neoplasms as the cause of death from those persons now age 75, life expectancy would go up an average of eight months. If we eliminated deaths from heart disease, we would add three years and ten months. If we eliminated all types of deaths caused basically by cardiovascular-renal disease, we would add eight years and eight months to the life expectancy for the 75-year-olds.

As to the health of these individuals, there are some differences.

Those 75 and over are restricted in their activities because of illness about 12 days more per year than are those age 65 to 74; that is, the aged person is in bed at least eight days more per year, and in general, activity is limited as the result of chronic conditions. Of those 75 and over, 23.7% are unable to carry on major activity as opposed to 9.7% of those between 65 and 74 years of age. Interestingly, the average length of stay of those entering short-stay hospitals is essentially no different for those 75 and over and those between 65 and 74. Of all older persons, 4.4% are living in institutions. The majority of the institutionalized represent the aged persons; 8.1% of those 75 and over are living in institutions as opposed to 2% of those 65 to 74.

The marital status of the aged group reflects the social tradition for men to marry younger women. Twice as many aged men as women are married, and only one-third of them have wives 75 and over. About half have wives between 65 and 74 years of age, and one-fifth have wives under 65 years of age.

Of men 75 years of age or older, 33.9% are living with their wives. In contrast, of women 75 years of age and older, only 17.8% are living with their husbands. Of these women who are 75 years or older, 3% have husbands under 65 years of age; roughly 20% have younger husbands between the ages of 65 and 74, and the remainder have husbands their own ages or older. Each year approximately 2,000 women age 75 or older marry, and 6,000 men 75 years or older go to the altar. Both of these groups are usually moving out of widowhood. Of these 8,000 marriages, over 4,000 involve partners under age 75.

Physical and Mental Health

Fifty-two percent of all Americans over 65 say their health is good. Thirty percent describe their health as fair, and only 18% say their health is poor.

About one-third of all old people over 65 living outside of institutions see a doctor during a four-week period. This means that in any given month some 6,000,000 people over 65 see a doctor, most often in his office or at a clinic; less often in their own homes. In contrast to younger patients, the majority of old people do not seek medical help for acute illnesses; rather, they seek help for chronic conditions. However, the elderly person also experiences acute illness, and although acute serious disease is frightening at any age, it is more threatening to older people. This is not because they fear death but because they dread disability, increased pain, and the possibility of increasing their helplessness and dependence on others.

As of mid-1963, about 292,000 persons 65 years of age and over with mental disorders were residents in long-term health facilities such as nursing homes for the aged, geriatric hospitals, Veterans Administration facilities, and private mental hospitals (Kramer, Taube and Starr, 1968). Fifty-one percent of these patients are in state and county mental hospitals; 43% are in nursing homes and similar types of facilities.

The close relationship between physical and psychological status in old age is particularly relevant, as chronic illnesses are prevalent among the aged and the incidence advances steadily with age. In young adulthood, that is, up to 45 years of age, 45.3% of persons have one or more chronic conditions. Fortunately these conditions produce limitations of activity in only 7.4%. However, according to a report published by the U. S. Public Health Service (1962), between the ages of 45 and 64, chronic conditions are present in 61.3% and limitations of activity in 18.3%. From 65 and over chronic disorders advance to 78.7% and disability to 45.1%. In a recent survey of the elderly in the United States, 2.3% of the aged are bedfast, and 6.1% are confined to their rooms or living quarters. Of the remaining, 86.2% can go outdoors without difficulty, while 5.4% must exert considerable effort in order to venture forth. Obviously such individuals have difficulty maintaining their social activities, lose intellectual stimulation, and lack opportunities for learning. The institutionalized aged persons are particularly afflicted by the coexistence of physical and mental disability. One study indicates that this occurs approximately 80% of the time (Kahn et al., 1960).

Chronic Brain Syndrome

In recent years the proportion of older persons in mental hospitals has increased steadily. On any given day at least one out of every three beds in a public mental hospital is occupied by a person 65 years of age or older. Approximately one-third to one-half of the persons in the 65 or older age group in public mental hospitals were admitted as younger patients. However, the majority were admitted at age 65 or older. Eighty-three percent of first admission older patients are diagnosed as having senile brain disease and/or arteriosclerotic brain damage. The reliability of these clinical diagnoses has been studied for a number of years. The coexistence of senile brain disease and arteriosclerotic brain disease is not mutually exclusive. On the basis of autopsy material, it appears that 45% of elderly patients with organic brain disease are primarily ill because of cerebral arteriosclerosis. Thirty-five percent are suffering primarily from senile brain changes, and 20% show evidence of both pathological processes (Corsellis, 1962).

At the present time no etiology or treatment has been established for senile dementia. The possibility that senile dementia is related

to vascular insufficiency or disturbed blood flow through the brain has repeatedly been considered. Recently, anticoagulant therapy has been used successfully in patients with recurrent stroke and transient ischemic attacks. As a result, the concept has arisen that anticoagulant therapy might prove to be equally effective in the treatment of so-called senile dementia. In one recent report, the value of anticoagulant therapy was seen as encouraging (Walsh, 1968). However, it was recognized that the lowering of prothrombin in the blood can be very dangerous. Patients on this therapy, therefore, require careful monitoring, and in case of hemorrhages the antidote, vitamin K_1, must be readily available. This study used both warfarin sodium and dicumarol. The rationale of this approach is that it breaks up the sludge in the blood. Consequently, it has been speculated that antimalarial drugs may prove to be of similar usefulness.

Numerous attempts have been made to correct the learning and memory defects associated with organic brain disease. Investigations are continuing, and although results to date must be summarized as discouraging, considerable scientific information is accumulating that should result in effective therapeutic measures for at least those individuals in the early stages of disease process. In recent years ribonucleic acid (RNA) has been given orally and intravenously in the hope of restoring intellectual skills. Related substances such as uridine, as well as agents that are believed to stimulate RNA production, have been tried, but results have been negative or doubtful (Solyom, Kral and Enesco, 1968).

Psychoneurotic Reactions

The impression is often conveyed that psychoneurotic reactions in adults are chronic disorders that are sometimes fortuitously alleviated but usually require psychotherapeutic intervention. Longitudinal studies suggest that there are older individuals who, after a period of time, develop psychoneurotic reactions in response to an unfavorable environment. Furthermore, recovery is quite possible if the individual is removed from the stressful life situation or is provided the means of restoring self-esteem. Two psychoneurotic reactions, depression and hypochondriasis, are frequently found in elderly persons. The possibility of a transient psychoneurotic reaction appears to be especially true of hypochondriasis and mild-to-moderate depressions. Careful evaluations conducted over more than ten years strongly support the view that the signs and symptoms of a psychoneurosis are unconsciously selected by the person so that he can maintain his self-esteem in a particular situation. If the sign or symptom is not an adequate defense in that particular situation, he will abandon that defense mechanism for one that is appropriate to the particular circumstances in which he is living. Hence, some psychoneurotic signs and symptoms "come and go" over a period of time. The exacerbations and remissions are largely determined by an identifiable constellation of socioeconomic conditions. Therefore, in some individuals the hypochondriacal pattern dominates, while in others the depressive attitude is the major factor. In general, the hypochondriacal elderly person is more likely to be a female of low socioeconomic status with little change in her work role, relatively younger and less socially active, with patterns of activities suggesting that they are not conducive to a good adjustment (Maddox, 1964). More specifically, the person is forced into a situation hopefully temporary where criticism is the rule and appreciation and work satisfaction are absent. This is compounded by the restricted social activity, so that rewards are few and far between.

It should be mentioned that, in contrast, there are elderly people who utilize a neurotic mechanism of denial; that is, they fail to realistically deal with important physical diseases. This type of person, a persistent optimist, should not automatically be seen as a person with courage, for the courageous person does have a realistic appraisal of the situation. The type of older person who is likely to utilize denial is a male of fairly high economic status who is not burdened with financial responsibility and a demanding work role yet has many and suitable opportunities for social activity (Busse, 1967).

Summary and Conclusions

1. Life expectancy is increasing faster for women than for men. The problem of the increasing number of widows is becoming a very serious one for medicine and society, making it necessary to find avenues of social participation which will be rewarding to elderly widows as well as other elderly people.

2. The vast majority of elderly people are living in the community. Only one in 25 is institutionalized. Consequently, greater emphasis must be given to providing adequate living arrangements that are conducive to the physical and mental health of the elderly.

3. The aged are currently being defined as men and women age 75 and over. Obviously the aged are the most disabled of the older population and require the greatest amount of medical attention. It is possible that these aged will require medical facilities of a transitional type which will permit them to move freely from full hospitalization to the community.

4. The older people in the United States do consume a large amount of medical practice time. In any four-week period one-third of the entire older population are seen by a physician.

5. Chronic brain syndrome remains a serious psychiatric problem among the elderly. Although there are many promising leads at the present time, neither the etiology nor the treatment has been established.

6. Psychoneurotic reactions in the elderly frequently occur in response to a stressful life situation and can be relieved by environmental manipulation rather than strictly by patient-directed psychotherapeutic techniques.

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SECTION IV

Psychosocial Management of Emotional Factors in Medical Practice

Frequently, symposia on the management of emotional factors attempt to teach or demonstrate to the non-psychiatrist physician how to do office psychotherapy or handle a psychotic state. Generally, the physician is not in a position to implement such teaching; either because he is not disposed in this direction or his consciousness of the time factor interferes with his feeling free to devote the degree of time required for carrying out brief psychotherapeutic activity. The emphasis in these three papers is on the broader aspects of psychosocial management. The first paper emphasizes the need to utilize paramedical personnel and touches on future community medical practice probabilities and requirements. The second paper is unusual in its emphasis on normal behavior and the tremendous role physicians can play in this area. The third paper is a comprehensive review of psychopharmacological procedures. A thorough understanding of this area is, of course, of utmost importance in any form of medical practice.

—G. K.

Community Resources—The Role of Other Professionals

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Over a fairly long period of time, many articles have appeared extolling the virtues of multidisciplinary cooperation. If, however, one objectively examines the process of collaboration closely, one does not find an extensive development of this cooperation. Often, the form rather than the substance of collaboration is in evidence. Most of the professionals seem to have heard the music but have not learned the dance. The health professions have more of a city-state configuration than one of a collegial body. Each profession appears to have its boundaries staked out and zealously guarded, and each often seems to be making strenuous efforts to corner the market on prestige and power. Attempts to design and implement programs that could be of immense benefit to patients are frequently hindered by the inability of the various professionals to develop mutual trust. This lack of full commitment to cooperation is often expressed covertly rather than overtly. Since the struggle may be active but unexpressed, it becomes an awkward and troublesome problem. Therapeutic goals can be displaced very easily in team efforts, if intra-organizational conflicts exist.

Societal Forces as Catalysts of Change

The above remarks notwithstanding, there are social changes in the open society that are bringing about forces which may provide a healthy climate for the evolution of more harmonious interprofessional activity. To a considerable extent, the energy and drive of these social forces come from the interaction of rapidly expanding science, technology, mass communication, and our much publicized national affluency. Let us consider the current developments in our society that will assist in propelling the various professions into searching for means to develop greater accord and more fruitful joint undertakings than they have been able to achieve thus far.

The most obvious factor is the large number of persons needing help. The number of persons requiring a special kind of assistance greatly exceeds the number of professional persons qualified to care for them. Thus, the entire number of persons working in the field of mental health is not adequate to cope with the number of persons requiring skilled care. Furthermore, not very many professionals are equipped with the training and personal attributes necessary for working effectively with all social classes and with all forms of emotional problems. To preserve a dog-in-the-manger attitude when this state of affairs exists is tantamount to denying that one is concerned with the well-being of patients. Instead, the situation calls for an intensive and extensive use of all the trained mental health manpower available. To supply the best mixture of professionals for optimal management of each patient's

problems, flexibility of professional roles and mutual support is required. Since population growth is outstripping the production of trained manpower, the best utilization of this scarce resource is very urgent.

A second influence is the closing of the training gap among the various professions. This is taking place at a faster pace than many may recognize, though not nearly as fast as many would have it. A generation ago the psychiatrist's training was vastly different from his colleagues in the other disciplines. Now the availability of federal traineeships and other forms of support has enabled psychologists, social workers, and nurses to secure advanced training. As increasing numbers of these workers are trained at the doctoral level, the difference in competency becomes academic. It seems safe to predict that with the rapid expansion of graduate schools, higher levels of training will become more commonplace in the future.

A third factor is that all the health professions draw from the same large body of basic knowledge about human behavior. It seems pointless to belabor the issue of who has what knowledge. At best, psychiatry and the behavioral sciences are not very precise. No master scientist or group of master scientists has been able to codify these bodies of knowledge in a highly ordered fashion, as has been done in the biophysical sciences. About all that can be said is that Freudian theory is becoming more suspect, and the therapeutic utility of such notions as behavior modification, as adapted from Skinnerian theory and similar theoretical constructs, is beginning to be accepted. The free marketplace of knowledge is equally available to any of the disciplines desiring to draw upon it. Hence, the body of knowledge that is shared by all is constantly increasing in size. The overlapping of abilities in caring for persons in emotional distress is proportionate to the effort each discipline exerts to acquire in depth the knowledge needed for developing expertness.

A fourth consideration is that the high cost of training is emerging as a source of pressure for the full use of professional competence. The cost can be measured in terms of the financial outlay by the individual and by society, as well as by the huge personal investment in prolonged and rigorous training. A costly investment of this size, coupled with the huge demand for patient services, is a catalyst in promoting the full use of the professional talents of all the various disciplines. Professionals grow restless and become alienated from the therapeutic effort if they perceive themselves as undergoing role deprivation. Role deprivation (Bennis et al., 1961) can be defined as either violation of anticipated role expression or failure to meet the expectations of the persons enacting the role. Hence, role deprivation refers to a particular type of conflict resulting from the unmet or violated expectations of the role. When a member of a multidisciplinary team perceives the communicative and decision-making processes as tending to derogate, underuse, or misuse the training and competency he brings to the situation, he is most likely to call attention to this issue by some sort of out-of-field behavior. As he expresses his dissatisfaction in his own particular style, value judgments begin to be placed upon the actions and communicative attempts of others. Energy must be diverted from the clinical ventures to manage the struggles within the group. The irritation of these disruptive events drains off the urge to be innovative and to be supportive of others. It may be the reason why so many stylized, ritualistic, and non-productive interactions become commonplace between the disciplines.

A fifth factor promoting greater collaboration among the health professionals is a better educated public. In one generation, a substantial number of persons in this country have received a college education, and the trend is increasing. When the power of the mass media to keep the public informed is added to this development, the health professionals will find it much harder to justify lack of planning for mutual role facilitation. The assumption of the right of professional prerogative can be taken just so far before the public repudiates this position.

A sixth component that is bringing about new orientations among professionals is the activist theme of the civil rights movement. The civil rights drive is spilling over on all segments of our society. A large portion of the nation's population that has not had adequate health services is now aggressively setting out to insure that it will share in quality service. In addition, there seems to be a spin-off from this social movement that may have a more profound effect on the behavior of professionals. The whole anti-establishment motif is being dramatically demonstrated at many levels of our society apart from the black community. Unless rationality and relevancy are introduced by physicians, nurses, social workers, psychologists, and others in the mental health professions, there is a strong likelihood that establishment-like attitudes will undergo some form of public confrontation. Not only are traditional modes of behavior being questioned outside the professions, but within the professions, the young students are raising burning questions that are not easily answered. Bright, eager students caught up in the excitement of changing value systems will tend to lower the threshold for change by their very presence within each group. The stress of these surging social tides will alter the characteristics of each profession with greater rapidity than at any previous time.

A seventh aspect of professional unification is the necessity for close

collaboration of many types of trained personnel for successful handling of the rehabilitative phase of illness. The fine articulation of the efforts of different health workers may be called for to restore patients to the level of productive living deemed essential for self-maintenance. The interdependency between all the professions involved is of a very high order. Each must be quite sensitive to what the others can do to contribute to the health goals of the patient.

Finally, another emerging reason for a thoughtful reassessment of how various disciplines can participate jointly in this socially desirable undertaking is the growing concern for a program of illness prevention and health maintenance. The abstract quality and the ill-defined dimensions of this endeavor call for every innovative ability that can be mustered from all the professions. Although the concept is not new, it is amorphous and will continue to be until a concrete plan of action can be spelled out by all those who have the competence to be useful in this uncertain enterprise.

Health Manpower as a Scarce Resource

If the above represents a description of the general characteristics of contemporary conditions, what can be done to give society a health service that is possible? Mental health manpower should be viewed as a scarce resource. Its strength differs from one community to another in both quality and quantity. It represents the total capability of respective communities to mount a program of prevention, care, and rehabilitation. Any program that fails to utilize fully this total resource is indicative of professional whim, interdisciplinary power struggles, or poor planning. A careful assessment of each community will assist in designing a way of bringing the total manpower to bear upon a program of community psychiatry.

Shared Power Encourages Cooperation

A major difficulty is assembling models of collaboration that are on target. In constructing forms of action best suited to the professional groups involved, it is easy to become caught up in preplexing issues since so much is of an abstract nature. It is a truism that persons view the world of work through the selective perceptions brought about by the kind of training they have undergone. Since all have been socialized into the role of their own discipline by a process that tends to develop strong professional biases, they have a predisposition to see the problem and their respective roles in it with decided differences. Subtle distinctions in the definition of the situation and the programs of care are almost certain to occur. One study (Chance and Arnold, 1960) found that the length of occupational experience, membership in a clinical discipline, and formal training in a given theory produced major differences in the assessment of patients' problems. When these biases are understood, it becomes easier to work through the communication barriers and to lay the foundation for developing shared meanings.

The primary basis for the construction of models of care should be the demand systems of patients. Models based on one or another of the professions tend to reflect the caprices and vagaries of each professional type. The chief criterion must be what is effective for patients.

Shared-power models appear to offer the best possibility for success. These models tend to generate maximum commitment and professional excitement, because they permit a high degree of self-expression and the innovative use of professional skills. Professionals usually are more stimulated to work at maximal output levels when they experience the rewards of progress and are enabled to contribute effectively to the attainment of program goals.

In conceptualizing the alternate plans of action, it often is easier to plan for the use of knowledge by a discipline than to try to define that discipline. It is far more important to have a discipline translate knowledge into precise action than to have it spell out carefully and methodically the parameters of a profession. Furthermore, each discipline has a different means of entrée to patients and to the community. Since care is so multidimensional, the use of role expression can become an innovative means of helping apply knowledge and competence where it will do the most good. The application of planned role expression reduces the randomness of activity and promotes better articulation of professional competencies.

Essentials of a Participatory Model

There probably is no one model that is a paragon. There probably is a wider range of competencies within each profession than between professions. This being the case, there will have to be variations on the theme of interdependence. Each workable model will have fine differences, but some general principles will be part of all. Shared interpretations of goals and means; a system where mutual expectations can be fulfilled through a process of complementation; facilitation of each other's roles; self-direction without anarchy; and a sense of professional destiny and self-fulfillment are attributes that seem crucial to the successful mobilization of interdisciplinary resources.

Each of the disciplines brings qualities to the situation that, if properly meshed, can have a cumulative effect upon care, rather than the plateauing one which is likely to be produced if these various potentials are linked in a faulty manner.

Errors of omission in the care process are likely to occur in a loosely constructed system. In addition, opportunities for the refinement of care may go unnoticed. Professional energy is rapidly dissipated. If there are less than sincere attempts made to remedy the waste of professional skill, the attitudes toward collaboration will become increasingly apathetic.

To give encouragement and imagery to the process of professional collaboration, a forum for planning and evaluation must be established. Each discipline should be responsible for selecting gifted and insightful representatives to the committees or councils designated for this purpose. These committees should exist at agency, community, district, and state levels, so that the data from the efforts under way could be analyzed and recommendations for improvement could have legitimate channels for expression. In addition, in-service education programs embracing all the disciplines could be planned. When persons learn and study together, their appreciation of each other can be strengthened. When they know they share similar knowledge, they are more prone to use denotative statements with each other instead of the connotative statements employed when there is a lack of shared meanings. When the message system is uncluttered, planning and implementation proceed at an accelerated pace, because ambiguity is kept at a level of tolerance.

In this short paper an attempt has been made to sketch briefly some of the social forces affecting collaboration. A model of shared power has been suggested as a means of most effectively mobilizing the professional mental health manpower and of stimulating the growth of expertness. It is only one alternative among many. The behavioral scientists constantly are studying the best ways to harness human effort for the social good. The application of their findings to the problem of interdisciplinary collaboration may be a valuable means of improving patient care.

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The Physician's Role in the Assessment of Normal Behavior

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I am pleased to have this opportunity to talk to you about the physician's role in the assessment of normal behavior. One source of my appreciation relates to the fact that this topic is rarely discussed explicitly in symposia organized by psychiatrists for non-psychiatrist physicians. A major reason for underemphasis of this subject is that psychiatrists are quite divided in their perspectives and opinions regarding normal behavior. Not surprisingly, we psychiatrists are much more comfortable when talking to non-psychiatrists about the nuances of maladaption or of emotional illness. The history of our profession, our concepts, our style of thinking, and our language reflects this tendency in more ways than we know. For example, when some psychiatrists become involved in assessing non-patient populations, they utilize language derived from psychopathological theory to describe specific persons even when they try to provide plausible explanations for these individuals' superior functioning. To oversimplify the point—a well-organized administrator is described as compulsive; a polished speaker who enjoys contact with large audiences is said to have hysteroid exhibitionistic tendencies; a shy, somewhat taciturn but quite creative research scientist may be seen as schizoid—and so on. These "diagnostic" labels fail to capture the adaptive qualities inherent in being well-organized, having the capacity to communicate, or possessing the ability to be genuinely creative. They are gross descriptive terms which serve to provide a minimal value for communication; furthermore, they lack shading or nuances and, consequently, seem divorced from the life and blood reality that, for example, distinguishes one well-organized administrator from another.

Other psychiatrists demonstrate even less interest, let alone capacity, to describe *positive* features of normal behavior. Here I refer to those members of my field whose concept of mental illness equates psychopathology with severe and gross mental disturbances. This rather classical model defines normal behavior as the absence of the vital signs of emotional turbulence. My colleague who follows this "antonym" model may be very helpful to the non-psychiatrist in providing him with a description of the diagnosis and treatment of major emotional illnesses. Normality, for this psychiatrist, however, is an arid wasteland; he demonstrates little interest in searching for distinctions among the population who are not grossly ill. In this attitude regarding normal behavior he joins forces with his colleague who views psychopathology as ubiquitous.

Hence, on the one hand there are psychiatrists who perceive of normality as an ideal never to be seen in a living person; on the other hand there are those who view normal behavior as the absence of illness, which at any given time pertains to the overwhelming preponderance of people. Implicitly, both groups question the validity of studies of normal behavior. For those who espouse the idealized concept of normality, the language of psychopathology has been sufficient to explain much of human behavior despite some intermittent inroads by those who talk about adaptation or coping. For those who follow the antonym model, there does not appear to be any functional utility to studying individuals who are not grossly disturbed, as compared to the great need to clarify our concepts of schizophrenia, serious depressive disorders, and severely crippling neuroses. Psychiatrists advocating these polar positions clash in many circumstances. Repeatedly we hear them give differing testimony in the witness chair as to whether or not the defendant suffers from a mental illness related to his purported crime. Often a perspective of universal psychopathology will render a psychiatrist more prone to connecting behavioral problems to the alleged criminal act. These polar positions lead to confrontations in many extrajudicial contexts, including training, research, and clinical areas. Nevertheless, both positions converge to serve as subtle resistance against clarifying the meaning of normal behavior.

The aforementioned positions are slowly being opposed by a development which may have considerable significance for the non-psychiatrist physician as well as for the psychiatrist. In a previous publication

(Sabshin, 1967) I have described what I consider to be a neoempiricist trend in American psychiatry. This trend represents the coalescence of several significant forces. First of all, it signifies a retrenchment from our professional penchant for hypergeneralization and our proclivity to "shoot from the hip" with all-purpose deductive armamentaria. Non-psychiatrist physicians have recognized these "symptoms" in us, but by and large they have patiently awaited our "growing out" of them. Secondly, the empiricist trend reflects a slight diminution in our somewhat phobic reactions to epidemiological data, statistical analyses, and quantitation in general. Every day more of us are asking, "How often does X occur?" There are increasingly fine examples utilizing such quantitative data for new hypothesis formation and anterospective predictions. Social and community psychiatry have provided an enormous impetus to the neo-empiricism, although much of this is still in the formative stage. In brief, the newer responsibilities for care of patients and their families in the context of a geographically defined community have, among other consequences, made available a pool of data not heretofore accessible to many psychiatrists. The necessity for empirically derived data becomes paramount in evaluating our efforts in primary, secondary, and tertiary prevention of emotional problems. For example, we must study segments of the population other than patients to judge whether our interventions have reduced the incidence and prevalence of previously expected emotional problems. The relation of this empirical data to the question of normal behavior becomes apparent when one is forced to assess outcome of psychiatric care by techniques more subtle than the decline of hospitalized psychiatric cases, albeit the data on hospitalization rates is useful in its own right.

Another example of increasing psychiatric commitment to empiricism is the growing number of investigations using normative samples to test hypotheses derived from our patient population seen in hospitals or in consultation rooms. Psychiatrists have studied "superior" college students (Silber et al., 1961), groups of modal or typical adolescents (Offer and Sabshin, 1969), astronauts (Ruff and Levy, 1959), Peace Corps volunteers (Fisher, Epstein and Harris, 1967), families of children with fatal illness (Friedman et al., 1963), and many others.

Although my bias toward this neo-empiricism is obvious, I wish to stress my awareness of the continuous need to generate new hypotheses and deductions. Empiricism, in isolated form, has many weaknesses and few examples of brilliance, but in psychiatry it helps provide an undergirding which most non-psychiatrist physicians take for granted. The empirical undergirding of modern medicine has been solid, even though medicine as a whole will undergo complex changes as it approaches increasingly subtle definitions of the early stages of disease.

What significance does the empiricist trend in psychiatry have for the non-psychiatrist physician, and how does it affect his role in the assessment of normal behavior? Above all, the non-psychiatrist medical practitioner is an empirical observer when dealing with human behavior. No other group in our society has greater access to direct information regarding man's attempt to cope with such a range of the exigencies of life and death. In sorting out his observations the medical practitioner is repeatedly called upon to make practical decisions reflecting his own implicit, if not explicit, perspective on normal behavior. For example:

1. Should I let this patient know that he is dying, and how can I titrate his response to my method of communicating the seriousness of his illness? He seems to be reasonably objective about himself and indicates that he prefers the truth, but is he pressing too hard?
2. Is this child retarded cognitively and behaviorally to a degree where I should commence to request special testing? He is quite persistent in learning, even though he has been a slow learner.
3. How common are these fears of sexual inadequacy, and how can I predict their long-term implications? She seems to be able to discuss them frankly and openly without apparent shame or guilt.
4. Does this university student's single experience with marijuana constitute a significant threat to his health? He seems to have been swayed by group pressure to experiment with psychedelic drugs but doesn't appear to have strong feelings one way or the other about repeating the experience.
5. Should I sedate this woman who is so grief stricken about her husband's death? She's crying a good deal, but she's beginning to talk about him in the past tense.
6. Should I give him more details about the dangers of his surgical procedure? He's not visibly anxious about the operation, but he doesn't seem to recognize its seriousness. I wish that there were family members with whom I could discuss this question.
7. Should I recommend that he take a short vacation several times a year or a longer one in the summer? He gets bored easily but, nevertheless, comes back from vacation with much energy and many new ideas.
8. It's hard to judge how uncomfortable this Japanese-American patient is in the postoperative period. He seems impassive—even apathetic—but is that unusual for a member of his group under these conditions?

Indeed, the examples that could be cited appear to be limitless. The relevance of these examples for this presentation relates to several significant points. First, none of these mini-vignettes involves behavior of a grossly abnormal variety. These are not psychiatric emergencies, nor in any of the examples is there a *clear* indication of severe pathology. Second, each of the examples could be interpreted as indicating a modicum of psychopathology. Those who subscribe to the point of view which stresses the ubiquity of pathology might overemphasize this aspect while minimizing the cues indicating coping skills evident in each vignette. The physician's decision to use a particular therapeutic strategy must involve a balancing of the significance of the adaptive forces and potential against such tendencies. Most experienced physicians, whether they are conscious of the process or not, do make such an assessment, and their actions reflect such an evaluation. A latent but functional concept of normal behavior is included in their evaluation. For example: Most young people in this town have sexual concerns, yet they seem to benefit from competent guidance; Japanese-American patients from this type of middle-class family tend to be reticent about asking for medication in the post-surgical period, yet they appreciate being offered analgesics by an interested physician; when people have ordinary grief after the death of a close relative, they seem to do better in the long run. (As long as I see signs that death is being accepted as a reality, albeit slowly, I need not try to intervene at this time.) In each case the clinical generalization may be related significantly to the physician's prior professional experiences. While his experiences may have led to idiosyncratic biases and distortions—each of us has blind spots—the essential process involves *articulation* of the concept of what is common or ordinary, in groups of individuals with the concerns of the particular patient, in order to achieve a pragmatic solution. To this extent the non-psychiatrist physician most often equates normal behavior with typical or average expectable behavior in a particular context.*

There are many problems associated with rigid adherence to this perspective. Obviously, the typical person on a mental hospital ward, in a jail, or in an institution for mentally retarded children would not be normal. Numerous criticisms have been made regarding the weaknesses of a statistical-empirical model of normal behavior by citing such discrepancies as well as other blatant problems which may evolve from equating typicality to normality. Nevertheless, the fact remains that we lack the raw data to know what is typical or ordinary in many circumstances. The neo-empiricist trend in psychiatry, as I have indicated previously, may serve to provide more of this data, and I have lauded its efforts. In my judgment, such information will have special utility for the non-psychiatrist practitioner in his day-to-day decision-making roles, and he should encourage these trends, especially when he perceives their utility for his practice. In addition to supporting such trends and being a consumer of the new data, I should like to suggest a much more active role for the non-psychiatrist physician. This change of role function is predicated on the opinion that most often the non-psychiatrist physician sees a larger sample of behavior than do his psychiatric colleagues. He observes the families who cope with a fatally ill child by normal mourning and, at the same time, provide effective support for the child; the psychiatrist's observations are skewed by those who suffer a depressive reaction in such circumstances. This distinction is a significant paradigm for the complementary skills and experiences of the non-psychiatrist and the psychiatrist.

Mention of this paradigm leads me to the central message of this presentation and what I expect might be a surprising answer to the question implicit in the title of this paper, "The Physician's Role in the Assessment of Normal Behavior"—i.e., *What is it?*" My answer to the question is that the non-psychiatrist physician should become a prime mover in clarifying the concept of normal behavior. In addition to utilizing information obtained by others, he should become increasingly capable of transferring his storehouse of latent information into explicit and manifest statements or even hypotheses. Currently the non-psychiatrist physician tends to derogate his capacity to achieve such a clarifying role as well as ask, "Where would I get the time to do it?"

The first step in developing motivation to accomplish this task involves being aware of its potential and utility. This includes the realization that no other group has more intimate access to fundamental areas of human behavior. The second step might involve recognizing that the psychiatric empiricists might serve as useful colleagues, collaborators, and allies inasmuch as this type of psychiatrist is quite likely to be genuinely interested in the primary behavioral data provided by the physician. He perceives this data as providing a potential contribution to his own concepts of both normality and psychopathology, and this possibility for greater *reciprocality* of information sharing has a good deal of significance for such a psychiatrist. Furthermore, this type of psychiatrist is very likely to be interested in community health and newer methods of health care delivery to be carried out conjointly with his non-psychiatrist colleague. The *opportunity* for sharing of

* In our monograph on normality, Offer and I (1966) have labeled this perspective "Normality as Average," as compared to the "Normality as Health" or "Normality Vs Utopia" perspective.

relevant behavioral information between a psychiatrist and his other medical associates has never been greater than in the context of community health programs. It is not fortuitous that non-psychiatrists interested in community health have a very high degree of interest in mental health and the behavioral sciences. This is the reciprocal of the psychiatrist's willingness to learn from his colleague's experiences. In the process of developing a program to meet the health needs of a specific community, there is high motivation to understand the behavioral norms within the social context of that geographic area. Such motivation bodes well for the non-psychiatrists's interest in clarifying the concept of normal behavior. The community hospital also offers an excellent arena for the delineation of health problems. Paradoxically, the university hospital with its tendency toward ultraspecialization and its lack of a geographically defined, encompassable patient population may inhibit such collaborative efforts unless unusual input is provided to make this feasible.

I look forward to the time when the non-psychiatrist appreciates the significance of his potential contribution to the assessment of normal behavior. Perhaps the day is not far off when psychiatric audiences will attend a symposium where the featured speakers are non-psychiatrists presenting data and opinions on normal behavior.

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Psychopharmacological Procedures

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Of all special fields in medicine, internal medicine and psychiatry probably play the most important roles in general medical practice. This has always been so, but there has also always been a gap between the clinical approach to the medical aspects of the total treatment of a person, and to the psychiatric aspects. This gap, which for many years has alienated psychiatry from the other parts of medicine, has only been bridged in the last two decades. Since the early 1950's psychiatric thinking and practice has moved much closer to general medical procedures, so that treatment of many psychiatric patients has become more rational, more understandable and more practical for the non-specialist.

If psychiatric treatment today is a major concern of general medical practice, psychopharmacology has been one of the most important factors in this development. New and effective pharmacological treatments of various psychiatric disorders have made it possible for any physician to treat patients who previously had to be hospitalized and could be treated only by psychiatrists. In making this claim for the pharmacotherapy of psychiatric disorders, I do not wish to imply that the fine arts of interviewing, listening and psychological understanding are no longer needed by the doctor; they still are and probably always will be among the most important skills of any good physician. I simply want to make the point that psychopharmacology today has grown into a system of empirical and rational procedures which can be studied and acquired by anyone who is motivated to do so. To acquire knowledge and skill of psychopharmacological procedures neither calls for particular assets of temperament or personality nor dedicated immersion into esoteric speculations and polysyllabic terminology.

What is Psychopharmacology?

Psychopharmacology is a new scientific discipline which was born in the first few years of the second half of our century. It is a discipline which deals with psychotropic or psychoactive drugs, i.e., drugs which influence consciousness, mood and behavior. Psychopharmacology, which has played such an important role in bringing psychiatry back into the fold of general medicine, is concerned with four principal aspects of psychotropic drugs: 1) indications for, and dosage of, psychotropic drugs; 2) side effects and complications of these drugs and their management; 3) understanding of the mechanisms of action of psychotropic drugs through the development of operationally defined and measurable research procedures; 4) development and screening of new substances in this field. The first two of these aspects primarily concern the clinician; the latter two lie more within the field of the researcher.

Following the discovery of chlorpromazine, the first of a group of

entirely new drugs for the treatment of mental disorders, it became clear within a few years that the new psychotropic drugs had made a tremendous impact on three areas: 1) the public, for whom—virtually overnight—tranquilizers became a household word and a multimillion-dollar business; 2) research, where the new discipline of psychopharmacology was established in the wake of these discoveries; 3) treatment, where the new drugs made possible an almost revolutionary new approach to the therapy for many psychiatric disorders.

A number of psychotropic drugs have, of course, been known and used by man for a long time. Alcohol, caffeine and certain narcotics are the oldest psychotropic agents known. The discovery of their properties has been lost in the dawn of recorded history. But with the advent of scientific medicine, systematic research during the past century led to the development of anaesthetic drugs and, later, to the introduction of a variety of hypnotic and sedative agents. Thus, after the empirical discovery of intoxicants and stimulants, medical research discovered remedies for some of the universal ills of mankind, i.e., pain, insomnia and anxiety. Effective drugs for more specific uses in the treatment of mental and emotional disorders have been systematically developed since two French psychiatrists, Delay and Deniker (1952), administered chlorpromazine (Thorazine) for the first time to agitated psychotic patients and noted the extraordinary tranquilizing effect of this drug.

Pharmacotherapy in Psychiatric Disorders

Although the title of my paper is "Psychopharmacological Procedures," what I really intend to talk about is pharmacotherapeutics with psychiatric patients. At this point, I would like to remind you that psychiatry is less fortunate than other branches of medicine, because (with very few exceptions) it lacks objective criteria for diagnosis as well as knowledge about the etiology of most of the conditions for which a psychiatrist has to treat his patients. This does not mean that psychiatric diagnosis is entirely subjective, but it does mean that practically all psychiatric diagnosis is based primarily on the observation of behavioral deviations. The causes of the major psychoses are still unknown, although a great deal of promising research is going on in this area. The origin of neurotic disturbances is better understood but is also still subject to controversy between proponents of psychoanalysis, learning theory and genetic or other somatic factors. In spite of all these theoretical uncertainties, we now have a variety of effective pharmacological treatments in psychiatry, and even if their mechanisms of action are not always clearly understood, many of these treatments have empirically proven their worth.

Rather than involve you in the problems of psychiatric diagnosis and classification, I should like to discuss the four major symptomatic conditions which can be effectively treated with psychotropic drugs. These four conditions are: 1) psychomotor excitement; 2) tension and anxiety; 3) depression; 4) perceptual and cognitive disorders (e.g., hallucinations and delusions). Let me briefly define these well-known behavioral deviations or mental symptoms.

Psychomotor excitement is characterized by restless, overactive, agitated, noisy, boisterous and disinhibited behavior; a feeling of being driven—being under pressure—with the mood being either one of aggressive anger or excessive elation. Usually, pronounced psychomotor excitement is associated with insomnia and sometimes with clouded consciousness, i.e., confusion and delirium.

Tension and anxiety are characterized by aimless restlessness and autonomic signs of sympathomimetic (adrenergic) arousal, e.g., tachycardia, sweating, increased blood pressure, mydriasis. At the same time the patient feels uncomfortable, unable to relax and—when not only tension but also anxiety is present—apprehensive and threatened in some undefinable manner. Tense and anxious patients, as a rule, also suffer from insomnia.

Perceptual and cognitive disorders occur mostly in psychotic conditions and indicate impaired contact with reality. Examples of symptoms occurring in this category are: hallucinatory perceptions, in one or several sense modalities, without any corresponding objective stimulation; delusional ideas, i.e., false and persistent beliefs which cannot be corrected by rational proof that they are unfounded; a generalized thinking disorder leading to irrational and bizarre forms of reasoning.

Depression is behaviorally characterized either by agitation or, more typically, by psychomotor retardation, i.e., a general slowing down of all spontaneous and responsive activity, an overall increase of inhibition and reduction of energy output. Most important is the core symptom, a subjective background of an all pervasive feeling of dejection, pessimism and hopelessness which not infrequently leads to attempted or completed suicide.

Classification of Psychotropic Drugs

Having thus classified—though somewhat roughly—the four principal psychiatric conditions which can be effectively treated with psychotropic drugs, let me now give you the brief and simple classification of psychotropic drugs which has been proposed in the report, "Research in Psychopharmacology," published by a World Health Organization scientific group

(1967). The report distinguishes five categories of drugs. The first category is *Neuroleptics*—often referred to as major tranquilizers or antipsychotics—which are represented by the phenothiazines, the butyrophenones and the thioxanthenes, as well as by the reserpine derivatives. The second category is *Anxiolytic Sedatives*—often referred to as minor tranquilizers—which are represented by meprobamate and its derivatives, chlordiazepoxide (Librium) and its derivatives, and barbiturates. The third category is *Antidepressants,* represented by monoamine oxidase (MAO) inhibitors or imipramine and other tricyclic compounds. The fourth category is *Psychostimulants,* represented by the amphetamines, methylphenidate (Ritalin) and pipradrol (Meratran) and by caffeine. The fifth category is *Psychodysleptics* (hallucinogens), which are mainly represented by lysergic acid diethylamide (LSD), mescaline, psilocybin, dimethyltryptamine (DMT) and cannabis (marijuana, hashish or bhang).

Clinical Applications Psychostimulants and Psychodysleptics

Let us first look at the last two categories of psychostimulants and psychodysleptics, because they have few clinical applications and we can rapidly dispose of them. Psychostimulants are specifically indicated for the treatment of narcolepsy. Sometimes they are useful in states of chronic lassitude, such as may be seen following a protracted disease, e.g., a virus infection. The amphetamines may also be helpful in programs of weight reduction because of their anorexogenic effect. In the treatment of depressive conditions, psychostimulants play a very minor role, because a severely depressed patient requires more than a "lift" or "boost." If a depressed patient's state of arousal is increased by a psychostimulant, he is often rendered more tense and sleepless and may well become more depressed. Sometimes, but rarely, an amphetamine or Ritalin may be helpful in the treatment of certain depressive states, but only when the depression is in its very beginning or already fading out. During a full-blown depression, psychostimulants are contraindicated. Because physical tolerance of and psychological dependence on the amphetamine-like psychostimulants develop rapidly, these drugs should only rarely be prescribed. This is the conclusion reached in the report entitled "Control of Amphetamine Preparations" prepared by a special committee* which had been appointed in Britain to study the place of the amphetamines in clinical medicine.

The psychodysleptics, i.e., LSD and similar drugs which produce strange alterations of consciousness —their current popularity notwithstanding—have no clearly established therapeutic indications. Their use is mainly experimental, although considerable literature exists on the use of LSD in neurotic conditions, behavior disorders and alcoholism. Whether or not these drugs are really effective in these disorders and, if so, in what dosage and under which conditions, will be shown by the outcome of a number of controlled studies, the results of which will not be available for another three to five years. There is also the possibility that the recently isolated active principle of marijuana—tetrahydrocannabinol (THC)—might find some clinical applications, perhaps in the treatment of depressions. At the present time, however, the application of the entire category of psychodysleptic drugs, which manifest their action mainly through disorganization of perceptual, cognitive and affective processes, is still in the experimental stage.

* J. Chappell, W. W. Fulton, M. M. Glatt, W. L. Rees and C. W. M. Wilson.

Therapeutic Applications of Neuroleptics and Anxiolytic Sedatives (Tranquilizers)

States of Excitement

Effective agents in the treatment of acute excitement and acute or chronic states of tension and anxiety are the neuroleptics and the anxiolytic sedatives. Both types of drugs are often referred to as tranquilizers. However, if one chooses to do so, he should make a clear distinction between the major tranquilizers (neuroleptics) and the minor tranquilizers (anxiolytic sedatives). There are distinct clinical and pharmacological differences between the two types of tranquilizers. The only drugs which can effectively reduce specific psychotic symptoms—hallucinations, delusions and psychotic thought disorder—are the major tranquilizers. But both the major and the minor tranquilizers will reduce psychomotor excitement, tension and anxiety, although the minor tranquilizers will do it more effectively.

Many of the anxiolytic sedatives are highly *toxic* and, thus, can be used for suicidal purposes. The neuroleptics have a much higher margin of safety. Anxiolytic sedatives *raise* the convulsive threshold and, thus, have an anticonvulsant effect, whereas most of the neuroleptics *lower* the convulsive threshold and, in high doses, may induce convulsions. Most of the anxiolytic sedatives can produce tolerance and psychological dependence, and many drugs in this category will produce *physical dependence* when taken in high doses over long periods of time. The neuroleptics produce neither tolerance nor psychological dependence. Only anxiolytic sedatives will produce *disinhibition* of higher nervous processes and, thus, like alcohol, induce a phase of increased and uncontrolled behavioral

manifestations prior to their inhibitory action. Neuroleptics inhibit only; they do not induce states of transient disinhibition. On the other hand, only neuroleptic drugs can produce *extrapyramidal side effects,* e.g., parkinsonism-like rigidity, tremor or muscular dystonia and dyskinesia.

Since both types of drugs, the minor or the major tranquilizers, can be used for the management of acute excitement or tension and anxiety states, what factors should determine our choice of drugs in these conditions? The physician who is faced with an extremely excited patient is often inclined to choose what he thinks would be the most rapid way of subduing the agitated patient, i.e., by intravenous injection of a sedative drug. It is not advisable to inject neuroleptic drugs intravenously in a patient whose reactions one does not know very well; there may be a sudden marked drop of blood pressure or other undesirable complications. Therefore, the drugs chosen for intravenous administration should be those belonging to the category of anxiolytic sedatives. Barbiturates, e.g., sodium amytal, in doses of 250 to 500 mg; chlordiazepoxide (Librium), in doses of 50 to 100 mg; or diazepam (Valium), in doses of 10 to 30 mg, are often dramatically effective in terminating a state of acute excitement.

However, occasionally the patient does not calm down until very large doses have been administered, thus making the patient toxic and comatose. This difficulty occurs most frequently in states of hysterical excitement. Because of these occasional complications with the intravenous administration of anxiolytic sedatives, and also because this type of drugs in large doses tends to make the patient confused, I feel that it is generally better practice to rely on the intramuscular administration of neuroleptics for the management of acute excitement. Most agitated patients will settle down after an intramuscular injection of 50 to 100 mg of chlorpromazine (Thorazine) or thioridazine (Mellaril). Once calmed by these drugs, the patients also tend to become more rational and cooperative rather than confused or comatose, as with the anxiolytic sedatives.

Not every agitated patient can be controlled with one injection of a neuroleptic. The physician should always consider a state of acute excitement as an acute emergency and should no more abandon a patient before his excitement has been brought under control, than he would abandon a patient before shock or hemorrhage had been brought under control. The effects of an intramuscularly administered neuroleptic manifest themselves after about 15 to 20 minutes. If at that time the patient is still excited, another dose of the neuroleptic, either equal to the first dose or somewhat reduced, should be injected. After another 15 minutes a third injection might be given and, sometimes, still a fourth 15 to 20 minutes later. By that time, however, even the most excited patient should be under control with this cumulative intermittent or staggered sedation.

Tension and Anxiety

The treatment of anxiety and tension states by drugs is only a symptomatic approach to the underlying problem—a symptomatic approach which should be limited to the shortest possible period of time. The treatment of choice in all anxiety states is psychotherapy, unless the tension and anxiety is due to physical causes, for instance, hyperthyroidism or congestive failure. It is obvious that any physical causes of tension and anxiety should receive specific treatment, but in the majority of cases, tension and anxiety are due to psychological causes, e.g., environmental stress, personality disorders or intrapsychic conflicts. For these conditions the treatment of choice is psychotherapy, including the recent modifications of milieu therapy and behavior therapy.

As supportive therapy for a limited period of time, anxiolytic sedatives, or the minor tranquilizers, are very effective in checking symptoms of anxiety and tension. The neuroleptics or major tranquilizers ("major," because they are capable of suppressing psychotic symptoms as well as anxiety symtoms) are less effective in reducing anxiety than the minor tranquilizers. However, the minor tranquilizers tend to produce tolerance and drug dependence and, thus, become dangerous drugs if prescribed in large doses for more than two or three weeks. Tolerance and drug dependence do not develop with the neuroleptics, and for this reason one may sometimes choose to prescribe a neuroleptic drug for a patient suffering from anxiety, even though it is likely to be less effective than an anxiolytic sedative. Such a choice would be indicated if, on the basis of the patient's previous history or his personality structure, one has reason to believe that he might rapidly develop psychological and, also, physical dependence on an anxiolytic sedative. When faced with this hazard it is often wiser to choose the second best drug, e.g., a phenothiazine drug in small doses rather than a minor tranquilizer for sedation.

Of all psychiatric conditions which a physician is called upon to treat, anxiety is undoubtedly the most common. It is difficult to resist the urgent demands of an anxious patient for immediate relief from his symptoms. The doctor must learn to brace himself against these demands and persuade his patient to settle for less than complete relief, particularly if tranquilizing drugs have to be prescribed for periods exceeding two or three weeks. Patients who present anxiety symptoms are often highly sensitive to side effects which may be associated with the use of major tranquilizers, and they will make every

effort to convince the doctor that they *ought* to receive a drug which does not cause them any discomfort. However, patients should learn to accept the comparatively mild inconveniences of side effects, e.g., dry mouth, stuffy nose, even some drowsiness and lack of energy. It is probable that major tranquilizers produce less dependence, precisely because they tend to produce more unpleasant side effects than the minor tranquilizers. When the dangers of drug toxicity, development of tolerance and dependency are threatening, the therapeutic "elegance" of prescribing a drug with no unpleasant side effects should definitely be disregarded.

Although barbiturates are the principal offenders in producing drug dependence and toxic symptoms, it is a fact that almost every minor tranquilizer has these potentials. There is no pharmacological reason for making a distinction between hypnotic drugs and anxiolytic sedatives. Every drug which is used primarily for sleep induction can also be used in smaller doses as a daytime sedative, and every daytime sedative (or minor tranquilizer) in larger doses will produce drowsiness and sleep. The distinction between hypnotics and sedatives is, thus, only a question of dosage. Minor tranquilizers other than barbiturates, e.g., methyprylon, or Noludar (Jensen, 1960; Peters, 1966), and glutethimide, or Doriden (Ossenfort, 1957; Lingl, 1966), are just as likely to produce psychological and physical dependence with dangerous withdrawal symptoms as are the barbiturates. To a lesser degree this is also true for meprobamate (Equanil) and even chlordiazepoxide (Librium) and diazepam (Valium), although physical dependence on the latter two drugs is rarely seen. Librium has the best safety record of all minor tranquilizers; no death has been reported with this drug, although, with large doses, a number of suicidal attempts have been made.

The only minor tranquilizer which seems to be free of the potential hazard of inducing physical drug dependence is tybamate. With this drug it has been impossible to induce physical dependence in animals or humans under experimental conditions, and dependence on the drug has not been reported under clinical conditions. This may be due to the fact that tybamate has an unusually short half-life in the organism; its rapid degradation may prevent the development of dependence through the absence of any cumulative effects (Shelton and Hollister, 1967). Looking for a drug to be less likely to induce psychological dependence, we have noted that one of the new minor tranquilizers, hydroxyzine (Atarax), is less likely than other sedatives to be taken in larger doses or for a longer time than prescribed—possibly because it causes euphoria and disinhibition less frequently than most of the other minor tranquilizers.

In summing up the salient features regarding clinical use of anxiolytic sedatives, we arrive at the following conclusions. Anxiolytic sedatives, which are also called minor tranquilizers, differ from hypnotic drugs only in dosage. Pharmacological and psychological effects of all drugs in this category are very similar, regardless of the chemical nature of the drug. Many of the drugs in this category are highly toxic; therefore, no patient should be given a prescription for more than 15 doses of a barbiturate or meprobamate at one time. With very few exceptions, all anxiolytic sedatives tend to produce tolerance and psychological and physical dependence. There is cross-tolerance between all drugs in this category, e.g., between alcohol and paraldehyde, or alcohol and Librium, or barbiturates and Librium. Once physical dependence on a minor tranquilizer has developed, abrupt withdrawal is potentially dangerous and should always be undertaken in a hospital setting. The safest drug from the toxicity point of view seems to be chlordiazepoxide; from the point of view of physical dependence, tybamate; and from the point of view of psychological dependence, hydroxyzine. Pharmacotherapy of anxiety and tension symptoms is always symptomatic and should only be used as an adjunct to other more specific therapy. One should avoid prescribing the same minor tranquilizer for more than two weeks, unless the patient receives only small doses. It is advisable for a doctor to become familiar with three or four minor tranquilizers at the most and to alternate their use if anxiety-relieving drugs have to be prescribed for more than two weeks or if special indications, e.g., danger of suicide or addiction are present.

Acute Psychotic States

Acute psychotic episodes frequently improve within a few days with the use of neuroleptic (antipsychotic) drugs. In previous years these states usually lasted for months, and even with shock therapy more time was required for a successful resolution of symtoms than is required today with pharmacotherapy.

The prototype of neuroleptic drugs is Thorazine, which still serves as a standard against which newer drugs in the neuroleptic category are evaluated. Thorazine is a phenothiazine derivative, as are most of the other antipsychotic drugs on the market today. In recent years, the butyrophenones and thioxanthenes, derivatives of two other chemical structures, have joined the phenothiazines as powerful neuroleptic agents.

The neuroleptic drugs, which are mainly used in the treatment of psychotic conditions, may be divided into two groups: 1) those with side effects manifesting themselves mainly in *disturbances of autonomic functions* (hypertension, miosis, tachycardia, dry mouth, excessive perspiration and other

symptoms of adrenergic-cholinergic imbalance); and 2) those with side effects expressed mainly in the *extrapyramidal system* (parkinsonism, akathisia, muscular dystonia and dyskinesia). If the drug is a phenothiazine derivative, the nature of its side effects can usually be predicted from the side chain which is attached to the phenothiazine nucleus. Drugs containing a piperazine ring in the side chain are more potent, milligram for milligram and produce extrapyramidal symptoms more frequently than drugs with an aliphatic side chain which, in turn, are more likely to produce changes in autonomic functions and sedation and must be given in larger doses. Despite their designation as major tranquilizers, not all neuroleptic drugs produce sedation. Some of them have distinctly stimulant effects and may even increase tension in the patient if one of their side effects is akathisia, i.e., the inability of the patient to remain still. The hyperkinetic extrapyramidal symptom of akathisia, as well as the hypokinetic symptom of rigidity, may be so disturbing to the patient that antiparkinsonism drugs must be employed to counteract these symptoms. The most frequently used drugs for this purpose are: trihexyphenidyl hydrochloride (Artane), benzotropine methanesulfonate (Cogentin) and procyclidine hydrochloride (Kemadrin). All of these antiparkinsonism drugs have a strong anticholinergic action. We have found that they may produce toxic psychotic symptoms if they are given in daily doses exceeding six or eight mg of Artane or Cogentin, or 15 mg of Kemadrin.

Most neuroleptic drugs have remarkably low toxicity and an extraordinarily wide therapeutic margin, but they also have an unusually broad range of unpleasant side effects, such as somnolence, apathy and restlessness, extrapyramidal symptoms, dryness of the mucous membranes, tachycardia, hypotension, disturbances of accommodation, constipation, obesity, menstrual irregularity and photosensitization. Skin rashes, edema, leucopenia and cholestatic jaundice may occur as symptoms of idiosyncratic hypersensitivity. Rarely, agranulocytosis and venous thrombosis are seen. With very large doses of neuroleptics—over 1000 mg of Thorazine a day or its dose equivalent—convulsions may occur.

Mellaril, the neuroleptic with the lowest incidence of extrapyramidal side effects, should not be prescribed in doses exceeding a daily maximum of 400 to 500 mg for more than two or three weeks, since under those conditions it might produce irreversible retinal changes or dangerous cardiac arrhythmias. Doses of the drug up to 400 mg/day seem to be well tolerated for an indefinite time.

The following is a list of the most frequently used neuroleptics:

1) Phenothiazine derivatives with an aliphatic structure in the side chain: chlorpromazine (Thorazine); triflupromazine (Vesprin); promazine (Sparine).

2) Phenothiazine derivatives with a piperazine ring in the side chain: perphenazine (Trilafon); trifluoperazine (Stelazine); prochlorperazine (Compazine); thiopropazate (Dartal); fluphenazine (Prolixin; Moditen).

3) Phenothiazine derivatives with a piperidyl ring in the side chain: thioridazine (Mellaril).

4) Butyrophenone derivative: haloperidol (Haldol).

5) Thioxanthene derivatives: chlorprothixene (Taractan); thiothixene (Navane).

This list is not complete, but refers only to the more frequently used drugs in the United States. Specific doses for each drug can best be obtained from the information provided by the manufacturer, although dosage information given on the package inserts by the manufacturer invariably tends to be on the conservative side and frequently has to be exceeded in individual cases. Fortunately, this can be done in most cases without particular risk because of the wide safety margin of all neuroleptic drugs.

Which of the many neuroleptics should one choose? Years of careful clinical investigation have made it very clear that for all practical—i.e., clinical—purposes, no specific indications or specific therapeutic properties exist for any of the neuroleptic drugs. Therefore, it is probably best for a physician to become thoroughly familiar with two or three neuroleptic drugs and then restrict himself to their use. What is essential is that adequate doses are given over an adequate period of time. Such specific differences between the actions of various neuroleptic drugs as were found to exist were only of statistical significance and so slight that they probably have no importance for the clinician (Goldberg et al., 1967).

What is an adequate dose? The table on the opposite page shows approximate therapeutic equivalences of doses of various neuroleptic drugs in comparison to Thorazine. If 1 mg of Thorazine is taken as 1 phenothiazine unit, the clinical approximations shown in the Table are obtained. For example, the table indicates that 10 mg of Trilafon are equivalent to 100 mg of Thorazine, and 1 mg of Haldol is equivalent to 70 mg of Thorazine.

The therapeutic daily dose for the treatment of an acute psychotic reaction is between 400 and 1000 phenothiazine units (mg of Thorazine or the dosage equivalent of other neuroleptic drugs). Sometimes higher daily dose levels are required, e.g., 1000 to 2000 phenothiazine units and, occasionally, up to 3000 or 4000 units a day. But 400 to 1000 phenothiazine units a day will be effective in the treatment of most acute psychotic breakdowns. If the dose is adequate, the symptoms of restlessness and insomnia should have subsided after one week of pharmacother-

apy; after two weeks of treatment the patient's anxiety, irritability, depression, suspiciousness and social withdrawal should be significantly reduced. Only after 8 to 12 weeks may one expect the disappearance of hallucinations, delusions and thought disorder. In some patients resolution of all symptoms may, under adequate pharmacotherapy, be telescoped into a few days, particularly if the breakdown has been very sudden in onset. On the other hand, if the above timetable indicates that the patient's symptoms are not subsiding within the expected periods of time, it may be necessary to increase the dose of the neuroleptic (Lehmann, 1965a).

An acute psychotic condition is treated preferably with intramuscular injections, at least for the first few days; then a change to oral administration may be instituted. The risk of giving too much of a neuroleptic drug is small if the general framework of the recommended dosage is followed and one or two test doses are given to observe the patient's initial reaction to the drug.

Maintenance Therapy of Schizophrenics in Remission

Chronic psychotic patients and schizophrenic patients in remission frequently require maintenance therapy with neuroleptic drugs for many months—sometimes for years. The maintenance dose in most cases is from one-sixth to one-fourth of the acute treatment dose. If maintenance therapy is interrupted, the risk of a relapse is between 30% and 50%. This risk can be reduced to 5% or 10%, provided the patient remains on regular follow-up therapy. At times of increased stress, family conflicts, job changes and similar problems, the maintenance dose may have to be increased for a short time; the same applies if the patient shows signs of increasing tension or instability. The clinical situation is similar to that of an epileptic patient on anticonvulsant treatment or of a diabetic on insulin, i.e., the treatment is neither merely symptomatic nor curative, but corrective or compensating in nature.

A long-acting, injectable phenothiazine drug is now available in the form of Fluphenazine Enanthate. The usual dose is 1 cc, containing 25 mg of the drug. For individual patients it is, of course, sometimes necessary to increase or decrease the dose, but the great advantage of this preparation is that the effects of one injection in most cases last for two weeks or longer, thus freeing the patient from the responsibility to take medication himself every day. All he needs to do is return every two or three weeks for his injection. Since Fluphenazine has a piperazine structure in its side chain, the compound is likely to induce extrapyramidal symptoms, and antiparkinsonism drugs might be required to counteract these side effects.

Dose Equivalence of Various Neuroleptic Drugs

Neuroleptic Drugs	Phenothiazine Units
Trifluprомazine (Vesprin)	3
Promazine (Sparine)	½
Perphenazine (Trilafon)	10
Trifluoperazine (Stelazine)	20
Prochlorperazine (Compazine)	6
Fluphenazine (Prolixin; Moditen)	70
Thioridazine (Mellaril)	1
Haloperidol (Haldol)	70
Chlorprothixene (Taractan)	1
Thiothixene (Navane)	20

It is true that probably 50% or 60% of former schizophrenic patients are today receiving neuroleptic drug therapy for months or years without needing it. The trouble is that we cannot tell, by any criterion, which of the patients are the 40% or 50% who will relapse if they do not receive maintenance therapy. If we have seen once that a patient who did not take any maintenance medication had a relapse, we can assume with a high degree of probability that this patient will again relapse unless he receives maintenance therapy. Usually, we do not have this information, because the patient is put on maintenance therapy after the first psychotic breakdown. In these cases one should continue with maintenance therapy for at least six months and then carefully try to withdraw the maintenance medication. Once it is known that an individual patient requires maintenance therapy, this treatment should have considerable priority over all other considerations. The question one would have to ask of oneself is whether it is more advantageous for the patient to stop taking his medication and be hospitalized in a psychotic state or to continue taking his medication and remain a normally functioning member of the community suffering the inconvenience of certain unpleasant side effects.

Serious complications, i.e., agranulocytosis or jaundice, very rarely occur after the first two months of pharmacotherapy. Unfortunately, regular blood counts and biochemical tests have hardly more than legal value, unless they are repeated every two days. Skin pigmentation and lens opacities (usually without effect on visual acuity) have been described after more than six months' medication with high doses of Thorazine, and recently attention has been drawn to extrapyramidal symptoms, usually involving muscles of the tongue and the mouth, which occur after long-term therapy with pipera-

zine derivatives of the phenothiazines. (Unlike the extrapyramidal symptoms occurring under acute treatment conditions, these late involuntary movements are usually irreversible. Fortunately, they occur only in a comparatively small percentage of patients, mostly in the older age group, and only after more than a year of continued drug therapy.)

Therapeutics of Antidepressants

The physician who has diagnosed his patient as being depressed and is considering the choice of treatment must first determine how threatening the patient's condition is. Is the patient acutely suicidal? Does he refuse to take food or medication? Is he psychotic and uncooperative? These features may determine whether the patient can be treated at home or must be hospitalized; they may also indicate whether the patient should receive immediate electro-convulsive therapy or can be treated with an antidepressant drug. In acutely suicidal patients electro-convulsive treatment is often indicated, since most antidepressant drugs take from one to three weeks to produce notable improvement.

A differential diagnosis between endogenous and reactive depression is often helpful, because endogenous depressions mainly require physical treatment, either electroconvulsive treatment or pharmacotherapy, whereas reactive depressions, which may also respond to physical treatments, usually require psychotherapy in addition to other treatments. Today, the extent to which one can really distinguish between purely endogenous and purely reactive depressions is becoming more and more questionable. The concept of "endoreactive" depression, which is used in the German psychiatric literature, reflects the state of affairs which is frequently encountered in depressive states, i.e., one with endogenous as well as reactive components. However, it is still useful to attempt an assessment of the varying degrees to which each of these two components is present in a given depression (Lehmann, 1965b, 1968).

Once the decision to use antidepressant drug therapy has been made, the choice lies between drugs belonging to the class of monoamine oxidase inhibitors and drugs which are often referred to as tricyclic antidepressants, because their chemical structure is characterized by a three-ring nucleus. Examples of the first type are: phenelzine (Nardil); isocarboxazide (Marplan); nialamide (Niamid); tranylcypromine (Parnate). Examples of the second group are: imipramine (Tofranil); amitriptyline (Elavil); desipramine (Pertofrane, Norpramin); nortriptyline (Aventyl); protriptyline (Vivactil, Triptil). The monoamine oxidase inhibitors have approximately the same therapeutic effectiveness as the tricyclic antidepressants, although there is gradually increasing evidence that the tricyclic antidepressants are slightly more effective than the MAO inhibitors. On the average, about 60% to 65% of depressed patients show a satisfactory improvement within two to three weeks when treated with antidepressant drugs.

The physician who prescribes a MAO inhibitor must remember that the effect of this enzyme inhibitor is reaching farther than ordinary drug action, because the inhibition of monoamine oxidase is not easily reversed. Monoamine oxidase is the enzyme that degrades serotonin and noradrenaline, and when this enzyme is inhibited, the biogenic amines are allowed to accumulate. A similar effect is produced by the tricyclic antidepressants, but through a different mechanism; they prevent excessive noradrenaline, which has been freed at the neuronal synapses, from being reabsorbed into the cell body. Both classes of antidepressant drugs, thus, lead to an increase of available serotonin and noradrenaline at neuronal synapses. This has been advanced as an explanation of their antidepressant action, since current neurochemical theories of depression propose that the underlying physical substrate of a depressive state is a reduction of the biogenic amines at the synapses of the central nervous system.

Some MAO inhibitors, e.g., tranylcypromine (Parnate), have an immediate amphetamine-like stimulating and euphorizing effect in addition to their principal antidepressant action, which can be observed only after one to three weeks. Such stimulation is often desirable, but in some cases it might be contraindicated. The side effects of MAO inhibitors are more difficult to manage than those of the tricyclic antidepressants, because MAO inhibitors are incompatible with many other drugs and with certain food substances, e.g., cheese, which may contain the pressor substance tyramine. It is essential that patients receiving a MAO inhibitor abstain from these food items and from most other drugs, particularly adrenaline, amphetamines, thyroid and Demerol which, in combination with a MAO inhibitor, may precipitate very alarming toxic complications. MAO inhibitors and tricyclic antidepressants should not be administered simultaneously, and at least a week should elapse after discontinuation of a MAO inhibitor before treatment with a tricyclic antidepressant is instituted.

Tricyclic antidepressants produce mainly anticholinergic side effects; hence, care should be exercised when ordering these drugs for patients in whom urinary retention or glaucoma may be precipitated. A tricyclic antidepressant should never be administered concurrently with both an antiparkinsonism drug and a neuroleptic, since all three drugs—particularly the first two—have anticholinergic properties and may act synergistically to produce dangerous and even fatal complica-

tions, e.g., adynamic ileus (Warnes, Lehmann and Ban, 1967). Some caution is also indicated in patients with myocardial damage in whom tricyclic antidepressants may produce reversible cardiac arrhythmias.

Some antidepressant drugs, e.g., amitriptyline (Elavil), also have anxiety-reducing effects. Patients suffering from an anxious or agitated type of depression often respond favorably to minor or major tranquilizers, e.g., Equanil, Librium or Mellaril. Anxiety is very frequently associated with depression, and since the manifestations of anxiety are far more conspicuous than the manifestations of depression, there is a danger that the lessening of anxiety in response to a drug is mistaken for an overall improvement in the depressed patient's condition. If this happens, one may relax one's vigilance when treating a patient who, in initial response to therapy, may sleep better, look better and display less anxiety, but may still feel depressed and hopeless and may also still be suicidal. The core symptom of depression is a feeling of sadness, despair, pessimism and hopelessness and the inability to get involved with things or people. Until these core symptoms have subsided, a depressed patient's improvement is far from complete.

After the depressed patient's symptoms have disappeared, drug therapy should be continued for at least two to three months at the same dosage; after this time the dose of the antidepressant might be reduced to about one-half or one-third for another month or two.

For patients with frequently recurrent depressions or patients who have many recurring manic or depressive episodes, lithium has recently been shown to offer valuable prophylactic action. The therapeutic effects of lithium carbonate in states of manic excitement have been known for 20 years. However, the drug seems to have few, if any, therapeutic effects in depressive states. Recently, Baastrup and Schou (1967) have shown that lithium carbonate, in doses of about one-third or one-half of the therapeutic dose in manic conditions, can be given as successful maintenance treatment to prevent the recurrence of both manic or depressive episodes. This is a considerable step forward, because maintenance treatment for affective disorders previous to the introduction of lithium treatment has by no means been as effective as maintenance treatment of schizophrenic patients in remission. However, before treatment with lithium carbonate is instituted, a careful history should be taken and the differential diagnosis should be well established, since this form of therapy does not seem to be effective in schizophrenic conditions and would not be indicated for manic or depressive episodes which occur only at long intervals. Since lithium may cause dangerous toxic complications which may be fatal, it is essential for patients on lithium therapy to have their lithium blood level monitored at regular intervals.

Alcoholism and Antabuse

Drugs are of no value in the treatment of most personality disorders, for instance, antisocial behavior and sexual deviation. Some drugs can play an important role in the rehabilitation of opiate addicts, e.g., methadone, which, in the first few years of a large-scale trial in New York City, has shown remarkable results (Dole, Nyswander and Warner, 1968; Methadone Maintenance Evaluation Committee, 1968). However, the treatment of addicts has not yet progressed to the point where the non-specialist may be advised to undertake it. But there is one kind of addiction, i.e., alcoholism, which is so widespread—there are over two million alcoholics in the United States—that non-specialist physicians must accept a major part of the responsibility for treating this group of patients. Treatment of the alcoholic is a complex problem and involves the application of almost every medical skill, but in the framework of this discussion, I want to draw your attention to one pharmacotherapeutic approach which is specifically applicable to the treatment of alcoholism. I am referring to the use of disulfiram (Antabuse) as a maintenance treatment for alcoholics who are motivated to give up drinking.

Antabuse is an enzyme inhibitor which blocks the breakdown of alcohol in the organism at the acetaldehyde stage. Since acetaldehyde is a highly toxic substance, people who have taken Antabuse and later take alcohol become very ill within a matter of minutes. The alcoholic who takes his Antabuse medication regularly will usually be deterred from taking alcohol by his knowledge of the ordeal he would have to endure. The drug thus serves as a chemical straitjacket, a most valuable aid to those who are seriously motivated to give up drinking, but is not of much value to those who simply stop taking Antabuse when they feel the desire to drink.

Summary

Psychopharmacology has opened the door to many previously blocked parts of psychiatric therapy. It has been a welcome catalyst for a long awaited rapprochement between psychiatry and the rest of medicine. Even if psychopharmacological research is not likely to produce another revolutionary "breakthrough" type of drug in the near future, there is good reason to expect many more useful therapeutic tools to issue from such research in the years to come.

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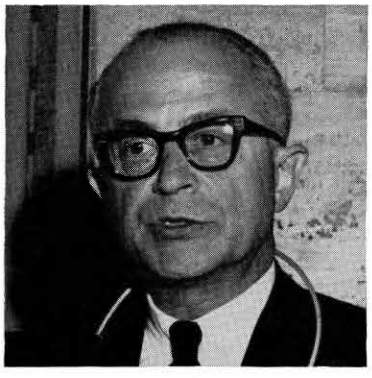
David R. Hawkins (*What Referring Physicians Can Expect from the Psychiatrist*) is professor and chairman of the department of psychiatry at the University of Virginia School of Medicine. A graduate of the University of Rochester School of Medicine, he interned at Strong Memorial Hospital in Rochester. Following his residency at the University of Rochester, he took further postgraduate training at the University of London Institute of Psychiatry and the Washington Psychoanalytic Institute. Dr. Hawkins was formerly professor of psychiatry at the University of North Carolina.



Marc H. Hollender (*Physical Illness, the Family and the Physician*) is professor of psychiatry at the University of Pennsylvania. A graduate of the University of Illinois College of Medicine, he interned at Cook County Hospital, Chicago. Following his residency at the Neuropsychiatric Institute of the University of Illinois, he took further postgraduate training at the Chicago Institute for Psychoanalysis, where he later became a staff member. Dr. Hollender was formerly associate professor of psychiatry at the University of Illinois and professor and chairman of the department of psychiatry at the State University of New York in Syracuse.

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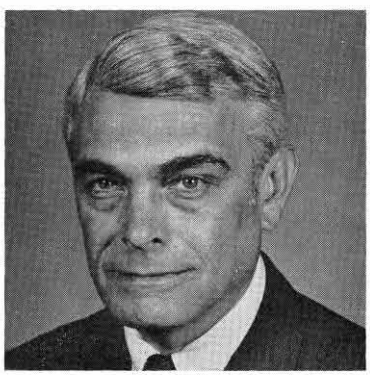
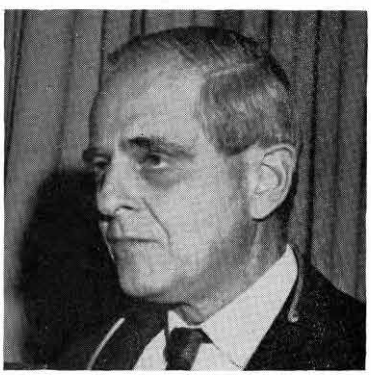
Zigmond M. Lebensohn (*Whom, Why and How to Refer*) is chief of psychiatry at Sibley Memorial Hospital, Washington, D. C., and clinical professor of psychiatry at Georgetown University. A graduate of Northwestern University Medical School, he interned at Cook County Hospital, Chicago. Following his residency at St. Elizabeth's Hospital, Washington, D. C., he took further postgraduate training at the National Hospital, London. Dr. Lebensohn has been consultant to the Veterans Administration, the U. S. Information Agency, the Federal Aviation Agency and, currently, the U. S. Naval Hospital, Bethesda, Md.





Henry D. Lederer (*Psychiatric Issues in Therapeutic Abortion*) is acting director of the Seymour D. Vestermark Division of Intramural Training, St. Elizabeth's Hospital, National Institute of Mental Health. A graduate of the University of Chicago, Rush Medical College, he interned at Cincinnati General Hospital. After his residency at the University of Cincinnati, he taught there and was professor of psychiatry at Georgetown University. Until earlier this year, Dr. Lederer was professor and chairman of the department of psychiatry at the Medical College of Virginia.

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Melvin Sabshin (*The Physician's Role in the Assessment of Normal Behavior*) is professor and chairman of the department of psychiatry at the University of Illinois College of Medicine. A graduate of Tulane University School of Medicine, he interned at Charity Hospital, New Orleans. Following his residency at Tulane University, he was a research fellow there and a research psychiatrist and assistant director at the Institute of Psychosomatics and Psychiatric Research, Michael Reese Hospital, Chicago. Dr. Sabshin took further postgraduate training at the Chicago Institute for Psychoanalysis. He is a former Fellow of the Center for Advanced Study in the Behavioral Sciences, Stanford, Cal.