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THE PRESCRIPTION OF TREATMENT FOR ADULTS

Today, to use the expression "prescription of treatment" in psychiatry is all too apt to sound either quaint or presumptuous. It is both. There was a time, and not too long ago, when we knew so little that there were only a few standard prescriptions for all the emotional ills of man. Now that we know more, we have just begun to think about matching treatments to specific syndromes. We are just beginning to sober up from a thirty-year binge of trying to be all things to all people and remember that ours is a medical specialty.

The psychiatrist—whatever his private interests, aptitudes, aesthetic or socializing ability—is first of all sanctioned as a medically trained practitioner. As a physician, he is expected to fulfill certain responsibilities, including scrutiny of the scientific rationale for his specific therapeutic interventions. A complete scientific rationale does not exist for most drug therapies of even the infectious diseases; but the trained physician is supposed to understand the extent to which such knowledge is available, the research by which such knowledge can possibly be attained, and the risks and gains that pragmatically can be identified for a specific use of therapy in a specific condition, in a specific patient.

Psychiatric training begins in the broad area of human biology and

requires experience in the management of a number of human ills and ailments. The training of the medical student begins with anatomy and cell biology and includes medicine, surgery, neurology, pharmacology, and some exposure to the behavioral sciences, to general psychiatry, and to psychoanalysis. The specialist in psychiatry focuses on the latter three, with emphasis on clinical experience guided by a trained psychiatrist.

What does society expect of such training? The psychiatrist should be able to recognize among the patterns of disordered behavior referred to him those that have some identifiable organic cause, such as toxic psychoses and chronic or acute brain syndromes. He, in fact, will have learned about a number of characteristic problems and their characteristic solutions as they are found in hospitals, clinics, and medical-school environments. In order to identify problems and solutions, lie should have an accurate sense of what disorganized people or people in trouble experience, how their environment characteristically reacts, and how such events influence the behavior in question. If he is very well trained, he should be able to select from among the array of available options the one that is specific to a particular case.

At the least, his preparation entails firsthand experience with the severe psychoses and a range of disordered behavior, from transient anxiety to severe symptomatic neuroses to character problems, with its manifestations in specific situational conflicts. He should be sensitive to vicissitudes

precipitated not only by different social classes and settings but also by the life cycle operating in them—the inherent problems, conflicts, and capacities of age groups such as the adolescent and the aged.

Most of all, he should learn to find, recognize, or elicit the potential for recovery—for organizing and adapting—which to varying degrees is present in all patients. He should appreciate transactional and bio-behavioral factors that impede this process. In so doing, he will employ pharmaceuticals (commonly called drugs), direction, manipulation, persuasion—any *tested* procedure that might aid treatment. This program refers to the realistic responses of an expert, trained to be responsive, responsible, and comfortable in his work. Psychiatric prescription of therapy depends on special training, competence, experience, and the ability to be explicit.

What the psychiatrist really gains in training (apart from specific knowledge about practices, theories, and methods) is a preceptor-guided experience in handling a wide variety of crises. In short, he learns the criteria for self-confidence as he tries to achieve an acceptable level of competence. He also learns something quite general about crisis management and, more importantly, something about himself as a party in it. Thus, it is in some self-mastery in the management of a range of brief or enduring crises affecting personality organization and personal and family life that the psychiatrist has some extensive experience if not expertise. Fully trained, he has acquired

accountability and he has learned how to relate these skills in a social system that requires and trusts in responsible conduct.

The physician is trained to act on carefully garnered half-knowledge—and the mode for accomplishing this training has been called the acquisition of wisdom or clinical judgment. He is also trained to take a high degree of personal responsibility for his task, which can be quite demanding—both of him and of the patient. The patient is an essential collaborator of the physician—while yielding autonomy in technical decisions, the patient expects technical competence to be exercised in his behalf. This orientation around personal responsibility is paramount because as physicians we have inherited the implicit social agreements regulating transactions among the community, patients, and doctors. Like other medical specialties, our discipline is not a science in and of itself, but a collection of sciences, methodologies, and techniques to be used in the service of man, around the central identifiable problem of mental illness. By mental illness we mean, the psychobiological malfunctioning of the person as a whole (Meyer, 1952). This definition put forward by Adolph Meyer is a broad mandate reminiscent of Auguste Comte's ironic statement, "the subject matter of each discipline stretches literally to infinity"(Becker, 1971).

Our dual obligation to be committed to both inquiry and service has kept psychiatry singularly prone to excesses of enthusiasm over new

discoveries. In our eagerness to meet the tremendous and increasing service demands developed in the thirty years since World War II, we have responded with a striking increase in the number and variety of treatment modalities available to psychiatric practitioners. The last fifteen years has seen an exponential rise in their number. Many of them are old treatments in new disguises, a few represent real advances in knowledge (Freedman, 1973). This proliferation of new techniques has been in part the consequence of the application of basic research findings to the area of clinical practice. In other instances, it has been the product of clinical impatience with the long and arduous course of the prevailing mode of treatment along psychoanalytical lines. This impatience was well understood by Sigmund Freud who said that the psychoanalysis should, in fact, not be tried until all simpler methods have been tried and failed (Breland, 1966). It was also Freud who said, "Anyone who wants to make a living from treatment of nervous patients must clearly be able to do something to help them" (1905).

Internal medicine some twenty years ago was faced with a proliferation of new and effective specialized treatment techniques. The response was to develop subspecialty training programs to the detriment of the field from the consumer's point of view. The wise diagnosticians became an aging group without new recruits. Now family-practice training programs are attempting to meet this need, but the shortage will not be rapidly made up.

Psychiatry has similarly been lured into subspecialization by the temptation to know one system of treatment well. In the past we were fortuitously spared severe fragmentation by the dominance of the field by psychoanalytic teaching. Now that several real alternatives exist, we must protect the training of the clinical diagnostician against the temptations of technical narrowness.

When the physician intervenes, his first task is to define the patient's problem. Diagnosis or recognition of the problem for which subsequent treatment may be designed can in itself be a time consuming and extensive technical procedure. Diagnosis of the dysfunction of both person and situation as well as a careful assessment of both personal and situational resources permits the physician to plan. The categorical diagnosis as well as the diagnosis for treatment must both be tested over time. Having defined the problem, the physician assigns and plans the subsequent treatment, makes an ongoing assessment of the process, and watches out for the patient's welfare. The patient may be referred by the physician to special rehabilitation and educational experts or to social or public-health agencies, whose specialists may or may not be required to have medical training. Such generalities obtain for tuberculosis, cerebral palsy, or poliomyelitis as well as for a wide variety of behavioral disorders. As physicians, psychiatrists have particular problems, notably the extent to which the doctor-patient interaction itself may be emphasized as a therapeutic tool and the reluctance with which

patients identify their behavioral as opposed to physiological problems.

The manifest psychoses have historically been the psychiatrist's focus. Yet, paradoxically, during the past thirty years psychiatric talent has been largely deployed to care for a minority of relatively rich people with neurotic and character problems (Freedman, 1973). Currently, the demand is that this care be extended to a wide population of persons with a variety of complaints. If social values were the criteria for extension, arguments could be marshalled for any pattern of service delivery. If proof that therapy works is the criterion, then we have to deal with a number of issues, including the adequacy of research data. Where specific interventions for specific disorders are clearly efficacious—penicillin for syphilis—then the medical imperative clearly is dominant in dictating both social values and the deployment of professional functions. But it is not yet at all clear that specific therapies produce cures of the dramatic variety akin to that produced by penicillin.

Today, the psychiatrist often diagnoses not only the level of organization and capacity for adaptation and response to therapy of a particular patient but also the various systems in which behavior disorder can be enhanced or diminished. He begins to understand families, office organizations, and all the various subcultures—occupational, avocational, and affectional—that bear upon specific instances of misbehavior. He will have seen adolescent children whose acting-up and acting-out behavior somehow

serves to keep marital conflict between the parents contained, while they focus, displace, and agitate through their child. Similarly, the military psychiatrist will have learned that the frequency of behavior problems is often related to the practices and behavior of unit commanders. He will understand that what is deviance in the middle class may be a way of life for the upper or lower classes. Deviance does not necessarily mean disorganization of psychobiological functions any more than conformity means organization (Freedman, 1970).

In dealing with such systems, the psychiatrist should maintain an open and candid relationship with his patient, siding with his patient's capacity to adapt and organize. He is a partisan to growth and development in the patient, but not an advocate of various conflicting positions. He elicits, welcomes, and depends upon the patient's capacity and motives to participate and to direct energy and attention to the tasks of therapy. Therapy is a collaboration in which roles are assigned but personal responsibility—to the degree possible —by the patient is also important, if not crucial (whether he is taking medication or engaging in insight therapy). The psychiatrist attempts not to act out his own moral dilemmas, personal needs, ambitions, and political antagonisms. His job is to help the patient assume some effective control over his own destiny.

Whether the unconscious is deep or extensive—whether it has vertical

or horizontal coordinates—might well be a matter for debate; such metaphors do not lead to the devising of specific responses adequate for a specific problem. Nor do they substitute for evaluations of therapeutic techniques, processes, and outcomes in specific populations. Such sloganeering in psychiatry has diverted attention from realizable accomplishments. The extension of the term "psychoanalysis" to almost any technique that utilizes a fifty- minute time span several times a week (if not a couch) for almost any disorder has further clouded definition and progress in understanding and advancing psychiatric therapies.

The investigative intent of classical psychoanalysis is often forgotten by practicing psychoanalysts, some of whom treat the theoretically desired outcome as a real and proven achievement. The facts are that profound therapeutic consequences often can ensue with brief interventions and that profound experiences occur in many therapeutic settings, from groups to hypnosis. The overwhelmingly challenging fact is that we still lack evaluations that give us scientifically sound bases for classifying different therapies. The real hope for highly differentiated and specific therapies lies in identifying different subgroups of patients, in finding distinctive dimensions differentiating apparently similar kinds of behavior.

This goal has been approached during the past hundred years in such advances as differentiating the psychoses from all toxic conditions and CNS

syphilis or pellegra from all psychoses. New biochemical definitions are beginning to be more clearly articulated, and attempts at dissecting the different modes of intake, modulation, and processing of sensory input show the possibility of distinguishing subpopulations among the schizophrenic psychoses (Klein, 1969). The regulation of sleep through certain brain "centers" is under investigation and distinct "phases" in the course of a psychosis may possibly be delineated. Whether or not drugs are useful or harmful for certain of these subgroups is now being tested. This thrust in research points to the new directions from which genuine progress toward therapeutic control can rapidly advance.

Today, we can recognize a common brand of talking therapy known as "dynamic psychotherapy," or psychoanalytically oriented psychotherapy. The dynamic therapist has cognizance of the characteristics of behavior that the classical psychoanalytic investigations described, but no matter how he comprehends the anatomy of psychological forces, he tends to focus on assets and on explicit and soluble problems. He encourages less regression, less free-floating associations, and a more circumscribed program of focusing upon immediate problems as a paradigm of important personality issues. He has thus learned principles—only some of which he applies—from classical procedures.

The psychiatrist, then, should have had the experience of knowing a

variety of people—both like himself and dissimilar—who present themselves with severe troubles, with mistrust, with hope or despair; he should have seen some quick and some long-term resolutions of these situations into outcomes useful to the patient; and he should have encountered striking failures in his ability to influence behavior. Having dealt with death and disorder in both medical and psychiatric patients, he should have some appreciation of the possible real outcomes of psychiatric (or *any* well-intentioned) interventions undertaken. He may even have found each individual's unique way of organizing experience (and experiencing those modes of being) an education in psychology—but he will not tax the patient unduly for such education.

Whether he orients his activities around notions of self-actualization, the learning of preferred behavior, intervention in social systems influencing the patient, or the dampening of intensity in behavior by pharmacological agents, the psychiatrist develops a keen appreciation of his own limits, the limits the situation offers, the patient's assets and resources, and the pragmatic outcome useful to the patient. He does not expect to "cure" aggression or instincts or any other given fact of life but rather aims for diminished suffering or new learning that can help the patient to develop or to get around previously aggravating and disorganizing obstacles. He will have learned from the experience of the psychoanalyst that one diagnoses or accesses a situation in an ongoing fashion, just as in medicine, and that in

having a sequence of specific goals, an open-ended and expectant view of the unfolding relation is a possible and useful attitude. But he will not prescribe psychoanalysis for every disorder, or mistake it for a really deep therapy striking at true causes (rather than a really broad theory, which it is). After all, the physiology of fever indicates that temperature regulation occurs in the hypothalamus; but physicians do not employ surgery or depth electrodes in treating a fever—mistaking basic anatomy for proximal causes and effects.

Jerome Frank has commented that all therapies must do some good, or they would disappear (1973). In the past decade, there have been serious efforts to establish the appropriate criteria for evaluating therapies (Bergin, 1971). This trend was accentuated with the advent of psycho-pharmacological agents. Studies of their efficacy employ highly sophisticated methodologies comparing various drugs in specified patient populations or a single drug in an appropriate range of dosage in different therapeutic settings. The development of reliable rating scales for a variety of simple or complex kinds of behavior has advanced (Guy, 1970). Criteria for outcomes are intrinsically difficult to establish and global ratings still remain useful, but use of discharge rates from the hospital or clinic as end points appears crude because they may be dependent only on social interactions in these settings and assets in the community. Other dimensions center around the actual kind of psychotherapy undertaken, for the actual behavior and interventions of therapists belonging to the same school might differ vastly. Moreover, the

therapist's level of experience, accurate empathy, and non-possessive warmth and genuineness are characteristics recently indicated to be important (Truax, 1971).

More differentiated criteria have to do with evaluating the status of the patient; these include his self-evaluations and those of others. The patient's comfort, self-awareness, and social effectiveness are important outcome variables. More ambitious research might well provide a description of the neurotic patient, his setting, the phase of his dysfunction, and his specific modes of successful and unsuccessful adaptation and might evaluate, in terms of these, what has happened after the period of therapy.

Psychiatry is thus emerging from the stage of taking either the patient's or the doctor's word for its successes as sufficient data.

For the psychoses, sophisticated studies consistently tend to show pharmacotherapy to be generally more useful than any other approach (May, 1968). Psychotherapy combined with pharmacotherapy has been investigated in such studies; this combination may be useful, but, used alone, psychotherapies do not show superiority for such conditions. The type of psychotherapy shown to be most effective in this combination is work in which old competences are reinstated and new ones developed.

We can look forward to more realistic and sophisticated evaluations,

and the search for predictors (what will be the best drug or therapy for a patient) is in the process of objectifying the field. Yet, it must be recognized that the choice of therapy today is frequently dependent upon what the therapist is comfortable in doing. Thus, most therapists see a wide variety of problems in different phases of development and intensity. If the response is that the patient needs therapy, this statement frequently means that the patient needs what the therapist knows how to do. In situations in which a wide range of talent is scarce, it is difficult to argue with this approach, but one need not be satisfied with it.

The patient, on the other hand, must take what he can get, but he tends to bring to any therapy his intrinsic capacity for recovery of function. Any therapist does well if he can quickly recognize the extent to which his approach and capacity can meet the needs of the patient and, at the very least, can be alert not to put obstacles in the patient's way. Every therapist can—if trained and willing—have a clear conception of his realistic limits and resources. When this potentiality is comprehended by both the patient and the doctor, the patient is able to orient toward the realistic resources that are authentically available to him—an auspicious beginning phase of therapy. Patients establish a relationship and invest their sense of security in even the clinic building or the administrative arrangements of the help-giving resource. This relationship is evident although they may be seen only once a month, primarily for medication (as the ease must be with many chronic

schizophrenics): patients get some orienting anchors and frames of reference in even brief interactions. Thus, the need to be recognized, visible, respected, looked after, or even rescued is basic to bringing doctor and patient together, and some realistic regard *and* limits with respect to these needs are helpful.

Nonrational and rational needs for personal attention and the wish for competence make up the dominating motivational dimensions of the doctor-patient relationship. The patient's willingness to concur with the doctor's regimen or to rebel can be influenced, in both the somatic and the psychosocial therapies, by the physician's attitudes and approach. In successful therapy, many patients have followed the doctor's orders in one sense: they identify their wishes with his wishes to foster some solution to a current or chronic condition or problem. For some patients, the therapy is experienced as a competitive and antagonistic venture, and yet even though full of turmoil, they may well show improvement in spite of—in order to spite —the therapy or therapist.

Just as it is better to be rich than poor, handsome than ugly, so it is better to be a talented healer than one not so gifted if one enters the field of psychiatric practice. This capacity to elicit hope and trust cannot be discounted as an important factor in achieving emotional arousal that leads to favorable change in the patient. Obviously, one of the ways of eliciting this hope and trust is for the therapist to be confident of his potential usefulness,

which usually implies having confidence in his theory of what is wrong with the patient and what he proposes to do about it. One of the hazards is that the therapist usually has only one theory and it may or may not be relevant to what the patient needs. This can, upon occasion, lead to a procrustean application of a theory and a technique to a heterogeneous population of patients that comes to his doorstep.

The population of patients that comes to see a psychiatrist is distributed on a normal curve ranging from high-expectant trust to a very low capacity for this readiness to be helped. Where high-expectant trust is present, particularly in situations of acute stress with only a temporary deficit in functioning, almost any technique will work and often the directive techniques are faster. Where low-expectant trust is present, the opening steps of treatment require a diligent cultivation of the patient's nascent capacity to trust before any specific therapeutic work can be done. This cultivation of the relationship per se works so well to relieve the demoralization of patients that it all too commonly is seen as an end in itself and many therapies focus exclusively upon this one ingredient of treatment. The reason it works so well may lie in the fact that in such a benign and nurturing relationship a great deal of inadvertent learning can take place. Modeling one's self on the therapist can encourage modulation of intolerable affects as well as improved cognitive skills in problem solving. Many of the improvements in technique that have been proposed in recent years have been attempts to deal with this

problem of inadvertence on the assumption that paying attention to what you are doing can be more efficient and goal oriented than not noticing. Our present diagnostic classifications undoubtedly have to undergo revision in order to be relevant to this type of careful assessment of behavioral deficits that call for specific remedies. Steps are being taken in this direction. It is our understanding that DSM-III will be another step closer to using observable validatable data for diagnoses. It would be fair to say that at this time we have much more information than can be taught and made use of by the average psychiatrist treating a housewife in Peoria for headaches. In addition, commonalities of effectiveness are being dissected out of a welter of apparently different techniques (Dyrud, 1968. Goldiamond, 1974; Hunt, 1975). We find that hysterics who improve in any of a variety of treatments have, in fact, received what they need. That is, discrimination training. They simply start with too few conceptual categories for affect and experience in order to modulate their responses. Obsessionals, on the other hand, need to be catapulted into action. Schizophrenics who respond well have received unambiguous cuing that permits them to track better. Ambiguous cuing has been clearly demonstrated to increase schizophrenic confusion (Truax, 1971). Even so, it remains uncommon for a diagnosis to mandate a specific therapy or how possibly it is to be carried out. In this lies the therapeutic art. In our eagerness to transmit all that is new and technically relevant to our residents in training, we must recognize that normative training in the role

remains central and that the selection of trainees for talent will always remain the single most important requirement for advancing the field of psychiatry.

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