Understanding Mental Illness

TYPES OF TREATMENT

Nancy C. Andreasen M.D., Ph.D.

Types of Treatment

Nancy G Andreasen

e-Book 2015 International Psychotherapy Institute

From *Understanding Mental Illness* by Nancy G Andreasen

Table of Contents

Types of Treatment

> *No man is an Isand, intire of it selfe; every man is a peece of the Continent, a part of the maine: if a Clod bee washed away by the Sea, Europe is the lesse, as well as if a Promontorie were, as well as if a Mannor of thy friends, or of thine owne were; Any Man's death diminishes me, because I am involved in Mankinde. . . .*
>
> DEVOTIONS, JOHN DONNE

Fortunately, as Donne has stated so eloquently, no man *is* an island. Facilities and personnel available to help people with emotional or psychiatric problems have increased enormously in both quality and quantity over the past 30 years. The various types of personnel, facilities, and therapy available are described in this chapter.

What Kind of Help?

The first question often asked by a person who recognizes symptoms of illness in himself or a loved one is: Who should I turn to for help? A variety of types of help are available, and the type needed depends to some extent on the problem involved. In general, the more serious psychiatric disorders such as schizophrenia or depression should almost always be handled by someone with a medical background. Supplementary help may often come from others such as social workers and ministers. The full range of people available to help

include the psychiatrist, social worker, clinical psychologist, family doctor, or family minister. Each of these has a different background and different capabilities for helping the person with emotional problems.

A psychiatrist is always a medical doctor or physician who has completed premedical training plus four years of medical school. Thereafter he spends four to five additional years obtaining specialty training in his chosen field of psychiatry by working as a psychiatric resident in an approved training program. This quantity of training is the bare minimum for a person who identifies himself as a psychiatrist. Because the training program in a psychiatric residency also includes some work in neurology, in many areas psychiatrists handle both types of problems, particularly in small towns where no neurologists are available. Likewise, a neurologist may handle psychiatric problems in a small town, for he has received some psychiatric training during his neurology residency. Some psychiatrists choose to take additional specialty training. For example, an additional one to two years are required for specialization in child psychiatry. A person who chooses to emphasize psychoanalysis must spend an additional two to three years working in this area.

The training of the psychiatrist therefore has placed heavy

emphasis on medical illness, and the psychiatrist is most likely to follow the medical model. Among the helping figures available, only the psychiatrist (or another person trained medically such as the family doctor or neurologist) is able to hospitalize patients and prescribe medications for them. The psychiatrist is, therefore, particularly suited for dealing with the types of illness which usually require somatic therapy such as depression or schizophrenia. He is also the person to turn to if there is a question concerning an interaction between physical illness and emotional problems—in the case of the elderly individual with an organic brain syndrome, emotional problems complicating cardiac disease, and other such problems which require an understanding of both psychiatry and medicine. Most psychiatrists provide a wider range of services than simply prescribing drugs, however, and most have been trained in working with the various therapies described later in this chapter—behavior therapy, psychotherapy, and group therapy.

Clinical psychologists are also licensed to provide clinical services, either in private practice or in hospitals in conjunction with a physician. The training for a clinical psychologist consists of undergraduate college education plus a masters and usually a Ph.D. degree. The background of the clinical psychologist tends to be more humanistic than medical, although the Ph.D. clinical psychologist does

receive training in neuroanatomy, neurophysiology, and neurochemistry. Unless supervised by a physician, a clinical psychologist is unable to prescribe drugs or hospitalize patients. Some clinical psychologists work in conjunction with psychiatrists, providing such services as psychotherapy or psychological testing. Others prefer to work alone in private practice, and generally their services include the range of non-somatic therapies such as psychotherapy, behavior therapy, and group therapy.

The social worker has usually completed an undergraduate college degree plus a master's program in social work and sometimes a Ph.D. degree. Like the clinical psychologists, their training has not emphasized medical areas, although many social workers who work in conjunction with physicians or hospitals pick up considerable expertise and knowledge in this area, just as the clinical psychologist may. The social worker, because his training emphasizes social and family problems, is particularly well equipped to handle difficulties in these areas. Like the clinical psychologist, the social worker may work alone in private practice or in conjunction with a physician. He may do individual psychotherapy, and many social workers are often very skilled in handling marital problems or doing family therapy.

A family physician is often a good person to turn to initially for

evaluation and referral to one of the types of clinicians described above. A person in family practice has completed a bare minimum of premedical education, medical school, and a year of internship. Some are now also completing family practice residencies of three years duration. The ideal family doctor knows the entire family whom he serves and is particularly in tune with their overall needs and problems. A family physician or general practitioner may serve either as a referral source or may himself choose to treat a variety of emotional problems. Few are interested in getting deeply involved in psychotherapy or hospitalizing patients for psychiatric problems. On the other hand, many of the complaints for which patients consult a family physician are emotional in nature, and family doctors are particularly adept at handling mild problems of anxiety and depression either by counseling briefly or by prescribing medication. Family physicians sometimes assume total responsibility for handling hyperactive children or schizophrenics on maintenance medication.

In our present social framework, the clergyman is another person in addition to the family doctor who is well equipped to understand the total family and its problems. Usually, like the family doctor, he has come to know all the family members over a substantial period of time. Therefore, he can be particularly helpful in providing advice about whether sudden changes in behavior are significant and

about interpersonal interactions either within the family or the community. Clergymen are primarily trained in theology, but more and more are recognizing their need for specialized training in the counseling role in which they are often placed. Regardless of whether a minister can provide either psychotherapy or medication, he is often well-equipped to provide advice about personal problems or matters of conscience. Further, like the family physician, he may serve as a valuable referral source to a psychiatrist, social worker, clinical psychologist, or family doctor if he recognizes emotional problems of sufficient seriousness that he feels unable to handle them. Often he or the family physician will have more moral authority than anyone else in persuading a family member to seek psychiatric help.

The Various Therapies

DRUG THERAPY. Sedating medications such as phenobarbital, which relax and promote sleep, have been available for many years. These have never been particularly effective in people with significant emotional problems, and they are almost never used today. In 1953 a significant breakthrough in drug therapy for psychiatric illness occurred when chlorpromazine (Thorazine) was placed on the market. This drug, and its later-discovered cousins in the general category known as phenothiazines, is an extremely potent anti-psychotic

medication. This group of drugs is used for a variety of problems, including schizophrenia, mania, and organic brain syndromes. Particularly when first introduced, it seemed to produce miracles, for it often diminished delusions and hallucinations, as well as assaultive and combative behavior. Chemical restraints could replace physical restraint, and psychiatric wards became much more pleasant and humane. Further, many patients who had been chronically hospitalized for a number of years improved sufficiently on phenothiazines so that they could be discharged into the community.

Through advances in pharmacology in the past twenty years, a wide variety of phenothiazines and other related drugs are now available. Some of these are more sedating and particularly suitable for patients when they are hostile or combative. Others seem to be more energizing and are used in apathetic withdrawn patients. Psychiatrists can now tailor their chemotherapy to the particular problems of particular patients.

We realize that these drugs cannot cure all psychotic illnesses. Some patients never get completely well on the antipsychotic drugs, but some schizophrenics do recover fully when treated with phenothiazines during an acute episode. Others are able to lead useful and significant lives while continually maintained on low doses of

phenothiazines. Usually aggressive behavior, delusions, and hallucinations are the symptoms most amenable to treatment with phenothiazines. The emotional flattening in schizophrenia is perhaps the most difficult symptom to eliminate with drug therapy.

All medications have side effects, and these are often a problem in patients treated with phenothiazines. Perhaps the most common is known as the "Parkinsonian syndrome," a symptom cluster consisting of lack of expression in the face, a shuffling gait, a mild tremor of the hands, and a generalized appearance of rigidity. Some patients experience the side effect known as akathisia, an internal feeling of restlessness and the need to keep their legs moving continually. Sometimes the drugs also cause blurring of vision. If these side effects are troublesome, however, most respond to supplementary anti-Parkinsonian medication.

^The antidepressants were discovered in the late 1950s, and to some extent they still seem to be wonder drugs. Like the phenothiazines, a wide battery of antidepressants has been evolved since they were first discovered. Some are more sedating and are particularly useful for patients suffering from anxious or agitated depression. Others are more energizing and tend to be used for apathetic or "retarded" depression. Thus the physician can also tailor

antidepressant medication to suit his particular patients. Ordinarily a person suffering from depression does not respond immediately after antidepressants are instituted, however. Depending on the particular medication and the severity of the depression, the drugs may take from one to three weeks to take effect. Thus a person suffering from depression needs careful supervision during this time. Many patients with depression can be managed as outpatients on antidepressant medication, but those who present a serious suicide risk may need to be hospitalized during the interval required for the antidepressants to act. The mechanism for the slowness of this action is not known, but is probably related to being able to build up adequate blood levels of the antidepressant.

Antidepressants, too, have their side effects. Patients often find these particularly unpleasant during the interval while they are waiting for the therapeutic effect of these drugs, and during this period they may need particular support to continue taking the medication. Common side effects include dryness of mouth, hand tremor, constipation, dizziness upon standing up suddenly, and sometimes slowing of the urinary stream. Side effects should always be mentioned to the supervising physician when they are noted, so that he can evaluate whether supplementary therapy is necessary or whether the medication should be changed or readjusted.

Tranquilizers are a third category of drugs currently used, and they are perhaps the most widely used. These medications are most commonly prescribed for symptoms such as anxiety or mild depression. They have been markedly helpful in patients suffering from neurotic problems, since they tend to decrease the inner feelings of pain and discomfort. They are relatively safe drugs with few side effects or hazards. Perhaps the most serious is drowsiness, particularly if they are combined with alcohol. In general, it is best to avoid alcohol or keep its consumption to a bare minimum when one is taking tranquilizers or any of the drugs mentioned above. A second hazard with tranquilizers is physical or emotional dependency. Many patients find these medications so helpful in easing their anxiety that they are hesitant to give them up after the crisis for which they were prescribed has passed. And indeed some patients do need chronic maintenance on tranquilizers, although this should be avoided whenever possible. We are beginning to realize that when taken in sufficiently large quantities over sufficiently long periods of time, patients may develop a physical dependency on tranquilizers and suffer withdrawal symptoms if they are abruptly discontinued, just as is the case with alcohol. Therefore, a patient who is taking tranquilizers should always notify someone of this if he is placed in a position where they might be abruptly withdrawn.

Several general warnings about drugs should be added. Physicians always need to know a complete list of the types and quantities of drugs that their patients are taking. Drug interactions may be quite complex. For example, a person suffering from high blood pressure who is placed on antidepressants may receive little benefit from his antihypertensive medication because its effect is partially negated by the antidepressants. In other cases, effects may be additive, and the patient taking tranquilizers and drugs for high blood pressure may find himself heavily sedated. Anyone on medication should insist that his physician identify the name and amount to him and should take responsibility himself for keeping a list of the medications and dosages he is taking. These should always be presented when a new doctor is consulted. A second warning concerns the risk of overdose with any of these medications. Antidepressants, phenothiazines, and tranquilizers are all potent drugs. Phenothiazines and especially antidepressants can be quite hazardous in people suffering from cardiac problems, and even small overdoses can be fatal. Further, overdose is even more hazardous in children than adults. One or two pills have been known to be fatal. These drugs should, therefore, be handled very carefully in families with small children, kept high up out of reach, and children should be firmly instructed not to touch them.

ELECTROTHERAPY. The antidepressants and phenothiazines have diminished the need for electrotherapy—variously known as electrotherapy (ET), electroshock therapy (EST), or electroconvulsive therapy (ECT). Nevertheless, some severe depressions and a few patients with schizophrenia (usually acute schizophrenia) do not respond to medication, and it may be necessary for the physician to prescribe electrotherapy. Further, in some cases electrotherapy may be quicker and more efficient than antidepressants. Unfortunately, media such as films have dramatized electrotherapy in a way to make it appear quite terrifying. It is, in fact, a safe and painless procedure which in some cases may be the only effective therapy available.

The technique for electrotherapy is quite simple. Ordinarily, it is given to hospitalized patients, although it may occasionally be used on an outpatient basis. About a half hour prior to the treatment, the patient is given an injection to relax him and dry up secretions in his nasopharynx. Immediately prior to the treatment he is given a series of medications which first put him to sleep for several minutes and then completely relax all his muscles. The actual treatment consists of passing a small current of electricity between electrodes applied to the temples which stimulates a convulsion similar to that which occurs in patients with epilepsy. Because of the medications given previously, the convulsion is “attenuated” and occurs only in the brain without

accompanying body movement. Attenuation of convulsions has markedly decreased the hazards of electrotherapy, which were similar to those of an epileptic seizure—primarily injury to muscles and bones due to the violent movements which occur when an epileptic seizure is not attenuated. The patient wakes up about a minute after the electrotherapy has been applied. Sometimes he suffers from a mild headache, and this ordinarily clears in a few hours.

The primary complaint of patients who receive electrotherapy is the memory loss which occurs. Ordinarily a series of eight treatments is given at intervals of about every other day. The memory loss is cumulative—minimal after the first treatment but relatively troublesome after the last. Memory loss is not permanent, however, and memory usually returns completely within a month to six weeks. No permanent memory loss or intellectual impairment has been found to occur. The number eight is, of course, an average. A physician may choose to give fewer or more depending on the individual patient. Since a course of electrotherapy often can be completed in less than three weeks and a good response is relatively certain, it may be more rapidly effective than drugs, even allowing time for memory loss to clear. Some physicians may, therefore, choose to use it particularly in those people eager to get back to work rapidly.

PSYCHOSURGERY. Psychosurgery is the third of the various types of so-called somatic or physical therapies. Twenty years ago it was widely heralded and publicized as a promising treatment for relieving symptoms in severely disturbed patients. In general, that promise has not been fulfilled and it is now rarely used. Very occasionally, however, it may be helpful. The original procedure, prefrontal lobotomy, was not a particularly delicate or sophisticated surgical technique. Large tracts of white matter in the frontal lobes of the brain were severed, with the result that the individual became much calmer and more manageable but was also even less socially appropriate. Newer techniques involve surgery on very small quantities of white matter, and at present this technique is most commonly used in severe obsessive-compulsive personalities. Very good results have occurred in some cases, but neurosurgeons and psychiatrists both remain extremely cautious about the use of this procedure. Other forms of psychosurgery have also been developed. This includes operations on the thalamus, or pain center of the brain, to relieve severe intractable pain, and on the temporal lobe, to control severe rage attacks or unmanageable seizure disorders.

PSYCHOTHERAPY. Psychotherapy is a general term which refers to a wide range of quite different techniques. They all share the common goal of achieving changes in behavior and attitude through

talking, achieving insight, becoming introspective, understanding interactions with other people, or remembering and reliving traumatic moments from the distant past. Drugs may or may not be used in conjunction with psychotherapy, depending on the therapist's point of view. Some psychiatrists or psychologists adhere to a particular school of psychotherapy such as psychoanalysis. Others use all the various forms of psychotherapy and attempt to tailor the type chosen to the individual patient.

The oldest form of psychotherapy is classical psychoanalysis. This is the "talk therapy" discovered by Freud which became an international movement in the early twentieth century and has been a popular and fashionable mode of psychiatric treatment for many years. It is still widely used, particularly on the East Coast, although its popularity is waning.

Classical psychoanalysis by definition involves hourly appointments for a minimum of three days per week. A few analysts will see patients only two days per week and some will require that the analysis occurs five days per week. The treatment lasts for two or three years. The patient ordinarily lies on a couch with the analyst seated behind him and "free associates," which means saying whatever comes into his mind. Freud discovered that this technique was useful

in helping patients recover memories and relive experiences which they had repressed because they were too painful. The analyst typically says very little but occasionally makes what is known as an "interpretation." This usually consists of pointing out a repetitive pattern in the patient's life or noting an association between a childhood event and the patient's behavior at present. The goal in psychoanalysis is a greater understanding of one's self and freedom from neurotic emotions and behavior. Most analysts feel that this freedom cannot be achieved through insight alone but that the patient must experience emotional catharsis as he deals with traumatic events.

People who provide psychoanalytic treatment are themselves required to undergo a period of psychoanalysis, and training in psychoanalysis requires about five years beyond the ordinary medical training. Most psychoanalysts are physicians, but a few, known as "lay analysts," have had training in psychology or even the humanities and then undergone psychoanalytic training at a psychoanalytic institute in order to become certified by the American Psychoanalytic Association.

Classical psychoanalysis is appropriate only for a small number of people. In the first place, few can afford the time or money required

for the treatment. Secondly, a person who undergoes such intensive self-exploration must be relatively healthy emotionally to begin with, for psychoanalysis itself is painful and traumatic. Because of these limitations in classical psychoanalysis, a variation on it known as psychoanalytic psychotherapy has developed. Ordinarily such therapy is conducted face-to-face rather than with the patient lying on a couch, and more direction or interpretation is given by the therapist. In classical psychoanalysis, the patient is expected to develop a "transference neurosis," which means that he transfers to the therapist emotions which he originally felt for a significant figure in his life such as a parent. If he did not see the therapist face-to-face, the therapist would, therefore, remain a shadowy figure and the "transference would be enhanced." Psychoanalytic psychotherapy places less emphasis on using the development of transference neurosis as a means of treatment, but it does use the valuable and often correct insights of Freud about why people behave and feel as they do. Psychoanalytic psychotherapy also emphasizes remembering and reliving the emotions associated with traumatic past events. Ordinarily psychoanalytic psychotherapy is done for one to two hours a week over the course of a year or two.

In addition, an entire series of briefer psychotherapies has evolved. Most psychiatrists are willing to see patients for only one or

two hours in order to provide assistance and advice concerning a crisis in their lives that they may be facing. This brief psychotherapy tends to be quite direct and to the point, with strong emphasis on looking at the present and the future rather than the past. On the other hand, short term psychotherapy may consist of a series of hourly appointments on a weekly basis over the course of two or three months. Again the therapist will be quite directive, will look at the present primarily, but will use past behavior as a way of understanding how the patient has gotten himself in difficulty and how he may get himself back out of it. In general, the briefer psychotherapies aim primarily at achieving insight and thereby effecting change in behavior. Another variation of briefer psychotherapy is known as "supportive psychotherapy." This is used most frequently for patients suffering from intermittent depressive illnesses or mild neurosis. Such patients are seen for an hour every few weeks, every month, or every few months, and the main goal is to analyze the present and future and to provide practical supportive advice. Supportive psychotherapy is often combined with drug therapy.

Group therapy is one of the more recent developments in psychotherapy. It is popular in the Midwest as well as on the West Coast, where a group of widely publicized institutes has developed and evolved a variety of techniques. The essential ingredient for group

therapy is assembling a number of people together, usually from five to ten, under the leadership of a trained individual. Group members are then encouraged to interact with one another and share their insights and awareness about one another's behavior. Depending on the goal of the group, the leader may assume either an active or a passive role. In a situation known as a "T Group," the leader normally remains relatively inactive. T Groups are in theory composed of normal individuals who wish to meet with others like themselves in order to expand their awareness of their emotions and behavior. The goal is enrichment rather than change. On the other hand, therapy groups are composed of people considered to have some type of psychiatric disorder, ordinarily problems such as neuroses or drug and alcohol dependence, and the aim is to effect changes in their behavior through evaluation, criticism, and analysis by other members of the group. The group leader may become actively involved if he feels this will enhance the therapeutic role. In therapy groups, great emphasis is placed on developing group loyalty and cohesiveness and on using group pressure as a means of effecting change.

Another form of therapy currently available is known as family therapy. This type of therapy is particularly useful for problems which involve the entire family, such as pathological interactions between parents and/or children which may lead to drinking problems,

adolescent rebellion, or marital conflict. The entire family is seen as a group for family therapy, and children and parents are encouraged to comment candidly on one another's behavior in order to identify the nature of their pathological interactions. Once these are identified, the therapist assists the family members in finding new ways to relate to one another. Family therapy is usually conducted by psychiatrists or social workers working either alone or as a team.

BEHAVIOR THERAPY. Behavior therapy grows out of the theoretical constructs concerning the origins of psychiatric illness already described in the third chapter. Like other therapies, at its outset behavior therapy was widely heralded as a rapid and effective means of treating psychiatric problems which had been refractory to other forms of treatment. With time we have come to realize that it may perhaps be no quicker and that it is not as widely effective as was hoped, but nevertheless, it remains a valuable mode of treatment for some disorders.

Negative conditioning is perhaps the most commonly used technique of behavior therapy. It is used most frequently for alcoholism and homosexuality, two problems with which psychiatry has had little success in the past. If negative conditioning is used as a treatment technique for homosexuality, the individual seeking

treatment must make a definite choice that he wishes to change his sexual orientation. Most psychiatrists consider homosexuality a problem only if a particular individual himself identifies it as a problem and wishes to change. Techniques of negative conditioning ordinarily involve putting the patient in the situation which he wishes to learn to dislike. For example, the alcoholic is given liquor to drink or the male homosexual is shown photographs of other men whom he finds particularly attractive. While in this situation, the patient is then given an unpleasant stimulus. For the treatment of alcoholism, this is often a drug which will make him vomit after the ingestion of alcohol. For the homosexual the stimulus is usually a mild but unpleasant electric shock applied to his hand. Depending on the problem and its severity, a series of treatments is used until the patient himself feels that he has learned to dislike alcohol or find other members of his sex physically unappealing.

Another form of behavior therapy is known as reciprocal inhibition. This is often used for phobias or anxiety. The patient is first taught relaxation therapy—how to systematically and consistently relax various muscle groups in his body until he feels a pleasant state of total relaxation. Once he has learned techniques for relaxation, he is then placed near the situation or stimulus which evokes his fear or anxiety. While in the situation he is then requested to assume the

relaxed state of mind and body that he has learned to produce himself. Gradually he learns to gain control over the fear or anxiety through consciously relaxing himself in its presence.

Treatment Facilities

Treatment facilities are basically of two types—outpatient and inpatient. Outpatient treatment facilities include individual physicians' offices, clinics, and a variety of community facilities. Inpatient treatment invariably occurs in hospitals, of which various types are available.

Evaluation on an outpatient basis is the logical place to begin for most people seeking psychiatric help. Some people are lucky enough to have a knowledgeable family physician, minister, or lawyer who can immediately sense the types of problems and recommend the appropriate source from whom to seek help. Most people, however, are not this lucky, and the decision as to where to go can be quite difficult. Facilities vary from one community to another, depending on community size and level of medical sophistication. Thanks to a strong mental health movement established in many areas through the national leadership of a man named Clifford Beers, himself a manic-depressive who wrote an eloquent account describing his experiences

with the illness *(A Mind That Found Itself),* some communities have excellent mental health centers. In others only private facilities will be available.

The typical community mental health center is staffed by a psychiatrist, a psychologist, and a social worker at the bare minimum. Larger community mental health centers will have several workers in each category on a full-time basis, while in smaller ones the psychiatrist may work in the community facility part-time while involved in teaching or private practice activities during the remainder of his time. Community mental health centers are funded by individual states or counties and tend to be community and service-oriented. Ordinarily, treatment at a mental health center is much less expensive than with a private psychiatrist. Community mental health centers can usually be identified simply through telephone book listings, and if you are unable to determine whether or not one is available in your area, you can probably obtain this information through a local social service agency. Because they are service-oriented and try to reach a large number of people, community mental health centers ordinarily do not provide extensive psychotherapy. They are most useful for evaluation, crisis intervention, and brief or supportive psychotherapy, as well as the management of medication. Community mental health centers usually do not have inpatient facilities of their own, and patients

requiring hospitalization are referred from them either to private hospitals or to state hospitals.

Some communities also have family service agencies instead of or in addition to community mental health centers. Family service agencies are typically staffed by psychologists and social workers. Like the mental health centers, they can usually be found by looking under the appropriate heading in a phone book. Some of these are church-oriented, and your minister may know about whether one is available in your area or not. Family service agencies tend to specialize in marital and divorce counseling, family therapy, and youth and drug problems. Like the mental health center, they are service-oriented and provide short-term counseling rather than extensive psychotherapy. They usually do not have a psychiatrist working within the agency, although one may be available to them on a consultant basis. Management of patients on psychoactive drugs is usually outside their scope.

Private treatment facilities tend to be available much more extensively. In a moderate-size mid-western town, an outpatient diagnostic evaluation ordinarily costs approximately fifty dollars and psychotherapy sessions cost approximately thirty-five dollars an hour. These tend to be higher in larger cities and on either coast. More and

more insurance companies, however, are extending their coverage to include outpatient treatment of all types, including psychiatric treatment. The primary advantage of private psychiatric treatment is continuity of care and personal involvement by the physician. Like all physicians, psychiatrists vary in skill and personality. Further, within a particular community psychiatrists also tend to vary in point of view. Some psychiatrists are much more medically oriented and tend to concentrate their practice on drug management and electrotherapy with a minimal emphasis on psychotherapy. Others tend to specialize particularly in psychotherapy and may not wish to take on patients requiring extensive hospitalization. Tactful enquiry of a potentially knowledgeable source, such as a family friend or minister, may be helpful in indicating which private psychiatrist might be most appropriate for a particular problem. If you are unable to obtain the information, it is not inappropriate to phone a psychiatrist's office and obtain from his secretary information concerning fees, types of treatment provided, and whether the psychiatrist has hospital facilities available to him.

Whatever type of outpatient treatment you seek, any good facility will make every effort possible to respect your privacy and to keep your records confidential. All psychiatrists are ethically required to treat anything they are told as privileged communication except

under the special circumstance that their records are subpoenaed on court order. In practice, this means that a psychiatrist will not reveal what a patient has told him without obtaining specific permission from the patient himself. If you ask a psychiatrist about a friend's or relative's condition, he may be rather vague and evasive because of this rule of confidentiality. If the patient has agreed that he can talk freely with a relative or friend, then ordinarily the psychiatrist will do so. In some cases, such as marital discord or adolescent problems, confidentiality is usually an absolute necessity if the psychiatrist is to make any headway at all with the patient. Many private offices are carefully set up to protect the patient's privacy. A series of waiting rooms may be available so that patients do not see one another come and go. If you have a particular concern about privacy, you should communicate this to the psychiatrist you are seeing and usually he will try his best to respect your wishes.

INPATIENT FACILITIES. People who are unfamiliar with psychiatric wards usually accept a stereotyped view. A person may imagine psychiatric wards as snake pits—dark, crowded, dismal places where unkempt people pound the walls or sit in a stupor all day long. At the other extreme, some people envision psychiatric hospitals as full of golden sunlight and cheerful sweet-faced nurses who move through bright modern surroundings tending the needs of patients

who are inspired to get well simply by the beauty of the atmosphere. In fact, psychiatric hospitals or wards are rarely like either of those extremes, but rather tend to fall somewhere between them.

Basically there are three types of hospitals which specialize in the care of psychiatric patients. These are private hospitals, university hospitals, and state hospitals. State hospitals have improved remarkably over the years, and few, if any, meet the "snake pit" stereotype. Some are housed in quite old facilities, however, and making them beautiful and modern would be quite difficult. Further, state hospitals tend to house at least some patients requiring chronic hospitalization who have not responded to any form of treatment and may remain in the hospital the remainder of their lives. Such patients are almost never found in university or private hospitals. Current thinking in most state hospitals now is that even these patients benefit, however, from mingling with patients who have a better prognosis. They are no longer hidden on "back wards," and therefore they are definitely visible to anyone who visits a friend or relative in a state hospital. State hospitals, as the name implies, are financed by state government, and therefore treatment there is usually less expensive.

University hospitals are teaching hospitals. Facilities vary from old fashioned to very modern depending on the wealth and age of the

particular university. Such hospitals are ordinarily staffed by permanent faculty members who may work in the hospital on either a full or part-time basis and by a group of resident physicians in training who care for patients under the supervision of the faculty. Most university hospitals handle both state and private patients. In some cases university facilities exist as completely separate hospitals, and in others they represent a wing or a substantial area of a general hospital. Private hospitals devoted exclusively to psychiatric care are not numerous, but a few very fine ones exist. They tend to be relatively expensive, but insurance coverage increases the availability of such facilities to larger numbers of people. In most cases, however, a psychiatrist seen on a private basis will have hospital privileges on a psychiatric ward within a general hospital.

Routines on psychiatric wards vary from hospital to hospital. In general, physicians, nurses, and aides make a strong effort to keep patients active and busy. Patients usually wear street clothes in most psychiatric facilities, and in many, nurses and attendants also wear street clothing rather than white uniforms. Psychiatric nurses often assume a significant role in counseling patients and providing supportive therapy during their hospital stay. Most hospitals provide some form of recreational activity on a daily basis, such as attending movies, having parties or song fests, or working together on an artistic

project. In many hospitals patients often have private rooms, and they gather for meals or recreational activities in a common living room or dining area. Some hospitals continue to have "locked wards,'' while others do not. In general, these wards occur in those hospitals which care for severely disturbed patients, since they could become a danger to themselves and others if permitted to leave freely without supervision. Even on such "locked wards," however, the majority of patients are permitted to come and go at will simply by asking someone to unlock the door. Facilities which handle acutely disturbed patients often have an area where patients are kept alone in order to quiet them down when they are behaving violently.

Although most people imagine psychiatric hospitals as gloomy or violent, these hospitals in fact tend to be relatively cheerful and pleasant places, even when the buildings themselves are not ultramodern. Both patients and their relatives are often pleasantly surprised when they find out what psychiatric facilities are really like. Patients, in fact, usually show a great sense of relief on being hospitalized, since they know they will be protected from their frightening or harmful impulses. Some patients even grow so fond of the hospital that they must be protected against the condition known as "hospital dependency," which refers to the feeling that they could not maintain a satisfactory life outside the hospital. Psychiatric

patients are sometimes popularly imagined as pitiful people locked away in institutions for life, but in fact the thrust of modern psychiatry is to prevent hospitalizations whenever possible, to make it as brief as possible when it does occur, and to prevent as many patients as possible from remaining chronically hospitalized.