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Editorial

The Humanity of Psychotic Persons and Their Rights

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Stephen Fleck's article in this issue of the *Journal* deals with a moral cornerstone of clinical practice: an appreciation of the humanity of the help-seeker. It reflects his long career as a helper at close quarters of people diagnosed as schizophrenic and their families. It also reflects his experience as a scholarly observer who has participated in the post-World War II transitions of American and European psychiatry. These have taken us from a psychodynamically and socially oriented study of lives to the cross-sectional study of descriptive syndromes understood as disease. The emphasis on disease rather than person, the ignoring of lives coupled with the further truncating pressures of managed care, and the accompanying diminution of psychiatric education have led Fleck to decry what he describes as the dehumanization of contemporary psychiatry.

This is not the first time that the specter of dehumanization has been raised in regard to society's dealings with its mentally ill members. Its recurrent appearance reflects, in part, the inequality that is inevitable in relationships between individuals with disparate power and privilege, such as doctors and psychotic patients. This is so institutionalized that, routine and out of awareness, it has not been fully confronted either by psychiatrists or philosophers. Immanuel Kant believed that membership in the moral community of human beings required status as a "free and rational" or "self-legislating" will.

An element of dehumanization is also inevitable once a person receives a diagnosis. All diagnostic classifications substitute a static, cross-sectional category based on commonalities for the richness of idiosyncratic, individual biography. And, historically, the dehumanizing tendency has reflected the fluctuating tensions between proponents of psychosocial and neurobiological approaches to illness. These have involved many factors, including the classic differences between molar and molecular approaches to behavior; those between a learning theory/psychodynamic, sometimes over-optimistic, perspective on diagnosis and treatment versus a hereditarian, sometimes nihilistic, perspective; and those between contextualized and decontextualized understandings of behavior and mental life. Proponents of the former have given the subjective life and personal relationships of the whole person greater centrality in their thinking than the latter, which is more focused on objective data and the relationships between chemico-physical elements at the neural level. But even advocates of the psychosocial and psychodynamic have had to deal with their sense of alienation from schizophrenic people experienced as so different from them, so interpersonally distant and protected, that empathy or identification is difficult or impossible. The limitations of the preneuroleptic era, though, challenged some talented and compassionate observers to use their own personalities as recording and therapeutic tools. These included such figures as Federn, Sechehaye, and Fromm-Reichmann. In America, the most notable was Harry Stack Sullivan, whose credo remains alive today: "We have found in the most disorganized group of people [schizophrenic] . . . a continuation of very much that is simply human" (1930); "everyone and anyone is much more simply human than otherwise, more like everyone else than different, and the data of interpersonal phenomena which may be derived in participant observation with him are relevant" (1944, in Sullivan, 1962).

Another ubiquitous factor stimulating concern with the dehumanizing of psychotically ill, mainly schizophrenic, persons is the civil power that allows psychiatric physicians to deprive individuals of their freedom on the basis of a clinical appraisal; society sanctions the involuntary, *i.e.*, compulsory, hospitalization and treatment of these individuals on the basis of a medical judgement. But the validity of many such judgments, however reliable when compared with the conclusions

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of other judges of similar background and values, is uncertain. Appraisals of the mental status of another, and extrapolations from them, even by trained observers, are still interpretations based on the perception of one human being by another. They are, thus, vulnerable to influence by the observer's own personal state as well as societal criteria for what is desirable or acceptable behavior. Doubts can be overridden in situations defined as "emergency," which, under the law in most industrial democracies, permit temporary forcible restraints to be applied to anyone judged so psychologically disturbed as to be a danger to himself or others. Under such frightening and exhausting circumstances, relatives, charged with protecting the welfare of family members, may become dependent, rather than critical, and easily persuaded that involuntary treatment is necessary (Brody, 1993). The interpretability of diagnostic criteria has also allowed governments to defend their abuse of psychiatry in order to enforce political conformity.

None of this means that involuntary hospitalization and treatment may not at times be essential to preserving the life, and ultimately the liberty, of mentally ill persons; their disability, after all, precludes their being regarded as truly autonomous in the Kantian sense. Paternalistic medical intervention aimed at transforming an impaired person into one capable of exercising independent choice on the basis of rational considerations may at times be regarded as beneficent (Brody, 1985). But these considerations do suggest a continuing sociocultural challenge to the profession: how to resolve the need to observe principles of justice, autonomy, and beneficence when the clinical encounter itself can threaten a personhood already impaired by illness (Brody, 1985). This has particular significance when psychiatric deficit is difficult to separate from social deficit; social and economic inequality influence professional decisions about what treatment to prescribe and whether compulsion is necessary, and restraint may be lawfully imposed to protect society as well as for presumed personal benefit. The challenge cannot be met by inexperienced, inadequately educated and socialized practitioners of a profession in danger of losing the humane outlook that has characterized its development.

The intertwined issues of compulsion and restraint, of whether psychotic persons are human or less than human, had symbolic significance even at the apparent birth of the profession. Philippe Pinel is often cited for liberating the insane from their chains at Bicetre Hospice in Paris during the French Revolution. But the actual event, commemorated in a widely known painting, apparently never took place. The liberation story, known in France, as "Pinel's gesture" (Weiner, 1994), persists because its social function is unquestioned: to emphasize the humanity of psychotic persons, which means that they have human rights. This fits Pinel's actual accomplishment, which was to promote a psychologically sensitive approach to studying mentally ill persons, raising them from the status of hospital inmates to the more dignified level of medical patients. These considerations assume special significance today, when the patients' rights movement is acquiring new vigor through the formation of organized networks of users and ex-users of mental health services. Their advocacy protects human rights to justice, self-determination, and equality of respect for people diagnosed as mentally ill. It is aimed at their inclusion in the moral community of human beings.

Respect implies dignity, which, with its implication of personal worth, was linked to justice in early Roman thinking. In 1948, dignity was described in the Preamble to the United Nations Universal Declaration of Human Rights (United Nations, 1948) as "inherent" in "all members of the human family." It was linked to "rights," including those to "medical care and necessary social services" (Article 25.1). This was specifically reaffirmed in the Covenant on Economic, Social and Cultural Rights (1966, Article 12.1): "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest obtainable standard of physical and mental health."

In 1989, the World Federation for Mental Health proclaimed its Declaration of Human Rights and Mental Health. These included (Article 4) a "right to coercion-free, dignified, humane and qualified treatment with access to medically, psychologically and socially indicated technology," and (Article 5) a "right to be treated under the same professional and ethical standards as other ill persons."

Fleck's essay can be understood as a call for psychiatrists to respect the humanity of their patients and, thus, to sustain the dignity which will help them regain their integrity.

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Dehumanizing Developments in American Psychiatry in Recent Decades

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The history of modern psychiatry is replete with excesses in both conceptualizations and therapies. But the often punitive and cruel treatments of the insane over hundreds of years were followed in the late 18th century by many efforts to provide humane treatment for the mentally ill. These included the Quaker-inspired asylums (Tuke and Bucknil, 1874) and Dorothea Dix's later success in moving the United States mentally ill from poor houses into hospitals. By the 19th century, scientific sanity seemed to have arrived with the establishment of descriptive diagnostic categories by Kraeplin (1903) and Bleuler (1937), and the careful clinical studies of Charcot (1877) and Janet (1925). However, the discovery of *Treponema pallidum* in the brains of syphilitic patients diverted attention from their work, producing great hope that mental illnesses would be found to be related to infectious agents (Noguchi and Moore, 1913).

Subsequently, with few exceptions, such as fever treatment for neurosyphilis (von Wagner-Jauregg and Breutsch, 1946), hospital treatment was limited to sedation, confinement, and restraints (Myerson, 1939). Clinical concerns focused on making "accurate" diagnoses and a search for the single cause or definitive causes of psychotic illnesses. In the late 1930s and '40s (Greenblatt et al., 1964), sleep therapy and the various shock treatments were tested and overused, and cerebral surgery for psychosis was initiated by Moniz (1936).

The search for single or unitary etiologies for schizophrenia in particular did not recede until midcentury, when, after World War II, psychoanalytic, psychodynamic, and psychosocial considerations began to dominate American psychiatry (Romano, 1994). Psychiatric teaching was mandated in U.S. medical schools with generous support from the newly established National Institute of Mental Health. Emphasis was placed on interviewing skills and understanding patients in terms of their personal development. An essentially biopsychosocial formulation for patients and their illnesses was learned by the evoling psychiatrist, ending in an appropriate diagnosis (*Diagnostic and Statistical Manuals* I and II of the American Psychiatric Association) and treatment plan (Whitehorn, 1944).

After the publication of DSM-III in 1980, these principles were superseded by more mechanical and reductionistic modes of teaching and practice that emphasized the phenomenologically based descriptive rather than etiological considerations of DSM-III (Lipowski, 1989; Reiser, 1988; Romano, 1980). This so-called "remedicalization" of psychiatry implied that "accurate" diagnosis leads to specific treatment. This view, applied to a descriptive diagnosis, is derived from the system of etiology-based diagnoses practiced in internal medicine. It ignores the fact that DSM-III reflects high reliability but unproven validity (Brody, 1994). Apparent progress has induced regression in the field by suggesting that precise descriptive classification is the main purpose of the clinical enterprise (Romano, 1980; Spitzer, 1987; Wilson, 1993).

The arrival of psychoactive drugs, despite the immense therapeutic progress which they permitted, had a major destructive impact upon the broad-gauged view of psychiatry as the discipline and science of persons as developing human beings with biopsychosocial and cultural heritages (Lidz, 1976; Minuchin, 1985; Rutter and Rutter, 1993). On one hand, they contributed to productive research on the biological substrate of psychiatric disorders and the actions of hallucinogenic substances (Aghajanian, 1982; Delay et al., 1953; Freedman, 1963). On the other hand, their ability to suppress symptoms in large numbers of patients abetted the trend toward reductionistic evaluation and treatment, and contributed to the biologization of the field (Brody, 1990; Silove, 1990).

From Hospitals to Community

After the 1948 U.S. Governors' Conference on Mental Health, the states attempted to reduce the number of mentally ill in their hospitals. Deinstituionalization, which began as a political-economic movement (Johnson, 1990), gained additional support from observers of the often-appalling conditions in hospitals for the severely mentally ill, beginning with publication of *The Shame of the States* (Deutsch, 1948). These institutions, an important source of the development of psychiatry as a specialty in the United States, had become overcrowded, understaffed, underfinanced "snake pits" by the turn of the century (Mitchell, 1894). With the arrival of effective psychoactive medication, the movement to discharge patients into the community accelerated. It was supported by civil rights advocates, and facilitated

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by the development of social and community psychiatry, beginning with the establishment of the therapeutic community in England (Fleck, 1990a; Jones, 1976). By then it had been demonstrated that acutely psychotic patients could be treated effectively in general hospital units, partial hospitalization programs, or their own homes (Langsley et al., 1968, Querido, 1956). But these developments, too, abetted the reductionistic approach to patient care, with the focus increasingly on symptom relief and less on the life of the mentally ill in or outside of mental institutions, and still less on the development of their plight. The patient as a sick person was replaced by the patient as a container of symptoms to be subdued (Brenneis, 1994; Fleck, 1990b; Reiser, 1988).

The community mental health centers established by the Mental Health Law of 1963 (Joint Commission on Mental Illness and Health, 1961) were soon overwhelmed by the deinstitutionalized patients as well as by conflicting demands: to treat the underserved, primarily urban sectors; to administer to the identified chronically ill patients released from state hospitals; and to serve acutely ill, impecunious patients. It was made increasingly difficult to send patients from the community to state hospitals even when they clearly needed prolonged full-time care and security (Torrey, 1994), and new commitment laws made it more difficult to hospitalize patients against their will, or even voluntarily. These changes reflected both the civil rights spirit of the '60s and '70s and the court-dictated mandate for "treatment in the least restrictive environment" (Group for the Advancement of Psychiatry [GAP], 1994), but led both to homelessness among the mentally ill (Baum and Burnes, 1993; Johnson, 1990; Lamb and Mills, 1986; Lamb et al., 1992) and to increased numbers of mental patients found in jails, making the Los Angeles county jail the "largest mental hospital" (Torrey, 1994).

Whereas the psychiatric profession embraced these sociolegal developments with enthusiasm, therapeutic work often became more difficult, sometimes dangerously so. Patients were "freed," which allowed them to harm or kill themselves or others so long as they could convince a judge that they would not do so even with clinical judgments to the contrary (Perlin, 1984; Torrey, 1994; Treffert, 1973). Another excess of quasiprofessional opinions attributed psychiatric illness to social deprivation and discrimination. This proposition was supported by the differential prevalence of the severe mentally ill in the lower socioeconomic classes (Hollingshead and Redlich, 1958; Schwab et al., 1979). However, this digression into sociopolitical causation of mental illness faded quickly, unlike the continuing belief that genetic and/or biological factors are the major determinants of the respective major psychiatric illnesses (Judd, 1994).

From Treatment To Management

Community psychiatry has made great strides (Borus et al., 1975; Dorwart and Hoover, 1994; Santos et al., 1994). However, the ever-increasing number of severely disturbed patients, including those suffering from both psychiatric illness and substance abuse, continues to exceed resources (GAP, 1968; Johnson, 1990). This overload has required a policy of "case management" and outreach programs referred to as "assertive community treatment" (Stein and Test, 1980). Each patient is assigned to a case manager who is meant to be the primary care agent, not the therapist, but oversees and manages "traffic," coordinating the many services that a patient may need: drug treatment, rehabilitative services, schooling, workshop placements, possible employment, and procurement of the patient's "security net," *e.g.*, welfare, social security or disability payments, and housing, including placements in supervised lodgings or group homes. In other words, patients' lives are being managed in the community as they would or should have been inside institutions, but treatment as such is usually limited to symptom containment.

A patient's contacts with a therapist occur typically once a week or less and then possibly in groups. However, for many patients, their relationships with mental health workers have become their essential human contacts, whether in the clinic or in the community. Focusing on symptoms and behaviors, these encounters do not encourage exploratory therapy. Psychiatrists in particular have often been reduced to the roles of diagnostician and prescription writer, because they are the most expensive "treaters." Ideally, the case manager/therapist roles would be consolidated in one person with flexible appointment patterns (Alanen et al., 1991; Borus et al., 1975; Fleck and Possick, 1984; Mosher and Menn, 1988).

Another reductionistic influence has been managed care. Insurance carriers or their managed care agents have increasingly balked at payments for "prolonged" psychiatric treatments, interfering with lengthy and intensive psychotherapies or full-time hospitalization. Utilization reviewers and similar managed care agents now monitor most hospital admissions, dictate the length of stay, and may force psychiatrists to hospitalize patients in an institution designated by the insurer. There has been significant regression in psychiatric care as the push for a "least restrictive environment" has been translated into the notion that full-time institutionalization is not only restrictive and discriminative, but undesirable or inherently bad as compared with part-time hospitalization or community-based treatment (GAP, 1994).

This extreme interpretation of originally humane principles is prevalent in both public and private sectors. Insurance companies often have definite rules as to how long somebody should be hospitalized for a particular diagnosis, ignoring the fact that "diagnosis" usually means an axis I label of the DSM, which indicates nothing about the patient's psychosocial circumstances or the availability of appropriate help and treatment in the community. Also disregarded are axis II problems (personality disorders), which may be the patient's major problem and a factor in the "revolving door" phenomenon (Swigar et al., 1991); the acute development of the axis I condition may be of minor concern compared with the enduring personality pathology for which treatment is often severely limited (Lazar et al., 1993). Here the basically sound multiaxial scheme has led to serious treatment limitations, despite ample evidence that effective treatment is available, including psychotherapy for most psychiatric (and other) illnesses, psychoses included, and that the long-term prognosis need not be deterioration (Bellack et al., 1990; Blatt and Ford, 1994; Ciompi, 1988; Frank and Frank, 1991; Frank et al., 1991; Harding, 1993; Heinicke and Ramsey-Klu, 1986; Henisz, 1984; Klerman and Weissman, 1993; Lazar et al., 1993; Lidz and Lidz, 1982; Robbins, 1993; Spiegel, 1989; Strauss, 1994).[2]

The length-of-stay issue is not unique for psychiatry. Such interference for the sake of the dollar besets all of medicine and surgery (Lazarus, 1994; Lazarus and Scharfstein, 1994; Relman, 1992). Herbert Pardes, former Director of the NIMH, recently wrote of "the assault" of managed care and government policies on the revenue resources of academic medical centers (Pardes, 1994). Questions of conflict of interest in prepaid care agencies have also been raised because physicians' incomes are often tied to the "cost effectiveness" of their treatment, procedures, and referrals. Prepaid services appear to do less well in recognizing major depression in "medical" patients than do fee-for-service physicians (Dorwart and Epstein, 1992; Hansson et al., 1994; Hillman, 1987; Wells et al., 1989). Unfortunately, however, abuse of patients' insurance resources by psychiatric hospitals and colleagues is not uncommon; in one example, up to one third of disputed claims reviewed by independent psychiatrists were observed to be excessive or unfounded.[3]

Another area of regression is family therapy, now practiced mainly by non-physician mental health professionals. It is eschewed in the mainstream of current psychiatric care partly in deference to the Alliance for the Mentally Ill, because it is often perceived as an accusatory process. Psychoeducation often replaces therapy and can abet this reaction by presenting psychotic illnesses as chronic brain diseases, exonerating the family of any contribution (other than heredity) to the illness and its course (Anderson et al., 1986; Newmark and Beels, 1994). But there is family involvement in any illness and families need help whether it is called therapy or education (Bahnson, 1983; Blustein, 1993; Brown and Harris, 1978; Brown et al., 1972; Fleck, 1994; Goldstein, 1985; Linderman, 1950; Malla et al., 1990; Minuchin et al., 1978; Parker, 1983; Sturgeon et al., 1984; Weissman et al., 1987; Wolf and Bruhn, 1993).

Expressed emotions studies have demonstrated clearly that the emotional climate in the family, or the patient's significant group, influences the course of psychiatric illness, just as it does the course of hemodialysis patients (Malla et al., 1990; Leff and Vaughn, 1955; Rolland, 1994; Streltzer, 1983). But here, too, a simplistic application of the expressed emotions findings is often used instead of a broader focus on the affective climate and other disturbances in the group (Doane and Diamond, 1994; Doane et al., 1986; Docherty, 1994).

Family therapy has been shown to be necessary and effective with certain patients and their families (Alanen et al., 1991; Ciompi et al., 1993; Doane and Diamond, 1994). Although one does not blame patients or relatives, detrimental interactions in any system (including therapeutic agencies) need correction if possible. A person with liver disease may feel blamed or guilty if advised that alcohol consumption plays a role in the condition and needs help to translate such feelings into constructive behavior. To accomplish this without alienating the patient or the group is the earmark of the skilled healer (Mohl et al., 1990; Tumulty, 1970).

Family therapy is often not covered by insurance plans or, if covered, is subject to managerial scrutiny like other treatments. Without therapeutic family contacts, family health can be impaired, recidivism is higher, and professional awarness of familial and sociocultural parameters is lost (Brody, 1994; Jahoda, 1993; Lidz, 1992; Minuchin et al., 1978).

The Impact of Neurobiological Research

The "Decade of the brain" has witnessed a decline of psychiatry as the specialty concerned with understanding people—sick or well. Often ignored are Adolf Meyer's (1933) lessons that, in addition to detailed knowledge of the brain, a person's life history is essential to understanding what has gone right or wrong in rendering a person mentally ill. Or as Hippocrates and Osler are reputed to have said, "when it comes to treatment, it is more important to know what kind of patient has the disease than what disease the patient has."

The recent advances in understanding and conceptualizing brain mechanisms summarized by Michels and

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[2] The *Wall Street Journal* (August 10, 1994, pp. 3) recently published an article titled Cutting Psychotherapy: Cuts May Trim Productivity.

[3] B. Astrachan, Department of Psychiatry, University of Illinois, Chicago, personal communication, 1994.

Marzuk (1993) as Progress in Psychiatry are important, but so far provide neither a reliable marker for psychotic illnesses (Buchsbaum, 1990; Gorman and Papp, 1994; Mesulam, 1990; Szymanski et al., 1991) nor a clear biological chain or systemic constellation for the development of major psychotic illnesses (Ciompi et al., 1993; Fleck, 1992). This includes heredity markers or lesions, despite ample evidence of familial clustering of the major psychiatric illnesses and of several neurotic conditions. The search for genetic markers continues, although much evidence has been gathered that in addition to one or more genetic factors, the nature of the intrauterine and postnatal environments is important in bringing about phenotypical expressions (Mann, 1994; Reiss et al., 1991; Sullivan, 1962; Tienari et al., 1987; Torrey, 1992).

Posttraumatic stress disorder, a much-studied condition over the last 20 years, is a classic example of extracorporeal insults producing lasting changes in neurochemical and endocrine systems, as first pointed out by Kardiner (1941) 50 years ago and observed even earlier in animals (Cotman and Nadler, 1978; Gantt, 1944; Kraemer, 1985; Pavlov, 1941). W.B. Cannon's (1934) studies on pain, hunger, fear, and rage also seem forgotten, and the likely relevance of such data observed many times in posttraumatic stress disorder patients to the development of other psychiatric disorders is generally ignored (Antelman, 1988; Coon, 1994; Day, 1989; Engdahl et al., 1991; Fleck, 1992; Giller, 1990; Halbreich et al., 1988; Kandel et al., 1983; Kolb and Multipassi, 1982; Krystal et al., 1989; van der Kolk et al., 1985).

The abundant and well-financed research of the Decade of the Brain has, so far, not produced specific and consistent data regarding the etiology of psychiatric illness. Many suggestive findings are presented with a causative implication that is explicitly denied on questioning. This reflects the way in which hope or belief in the specific etiological agent finds its way into many publications, even those scrutinized by careful investigators (Carlson and Carlson, 1990; Judd, 1994; Walker, 1994). Such statements can lead not only to false hopes, but also to disregarding the importance and revelance of personal psychosocial histories and sociocultural contexts (Brody, 1994; Day et al., 1987; Fleck, 1990b; Lipowski, 1989). The significance of results to date remains unclear, let alone whether or not reported aberations represent cause or effect (Kirkpatrick and Buchanan, 1990). Thus, research, no matter how important, can inadvertently produce constriction of clinical exploration and treatments.

In this regard, the impact of Feighner's diagnostic research criteria on the development of the last three DSMs should be mentioned (Feighner et al., 1972). The establishment of as accurate diagnostic criteria as possible, even though descriptive, was an essential element for exploration of the biological substrate of mental illnesses, and the specific effectiveness of drugs. This necessarily reductionistic scheme has contributed to the frequently narrow definition in DSM-III and beyond, *e.g.*, the stipulation that schizophrenic symptoms must be of 6 months' duration to justify this diagnosis. This makes sense for selecting patients for research, but otherwise does not fit with clinical experience.

Education

The most marked regression leading to the dehumanization of psychiatry has been in the field of professional education. Mastery of the new fields of psychopharmacology and neurotransmitter biochemistry is expected without any lengthening of the official training period (Sabshin, 1994; Verhulst and Tucker, 1990). This contributes to a reduction in residents' general clinical experience. In addition, moonlighting by residents has become an accepted practice because of financial need. The outlook in this regard is dim, as there has been no clear proposal concerning monies for undergraduate and postgraduate medical education in the current medical care reform proposals. Income is now largely derived from patient payments in nongovernmental hospitals, which are prone to curtailment under health care reform (Meyer, 1993; Pardes, 1994).

The major retrenchment in psychiatric education stems from the changes in clinical practices (Brenneis, 1994). Most patients on inpatient units now spend days rather than weeks or months, and thus are not usually available for thorough study, let alone significant therapeutic involvement with psychiatric residents or other staff. Yet 1 year or more of the 3-year residency is typically spent on inpatient services. From psychiatric inpatient services, patients usually move after chemical symptom suppression to other agencies, such as partial hospitalization programs, day care, or outpatient services. Such moves often mean that patients change to a completely different treatment team. The next change, *e.g.*, from a day hospital to outpatient care, may again occur after some weeks, with a shift once more to different staff persons, whether in the public or private sector.

Such disrupted care exposes patients to recurrent separations in brief succession, and usually disrupts treatment processes, which is especially deleterious to trainees' meaningful involvement with patients over time (Brenneis, 1994; Lewis, 1978). Care continuity is a costly proposition because it often involves crossing administrative boundaries, but it must be accomplished if patients are to be spared repetitive separations and readjustments and if trainees are to be afforded continuing involvement with patients. A psychotic patient whose symptoms are subdued chemically within a matter of days can neither be studied properly, nor engaged meaningfully with a therapist whom he or she is apt to lose in a matter of days or weeks. Psychiatric residents are deprived of the opportunity to pursue the underlying meaning of symptoms and significant relationships bearing on the patient's dilemma.

On outpatient services, with few exceptions, contacts may be weekly or less. This is hardly conducive to intensive involvement of patient and therapist (Dorwart and Hoover, 1994). A Brazilian colleague who returned after 13 years to his training site confirmed and deplored these adverse changes in education (Vascon-Ellos, 1989).

A most serious problem for psychiatry is the decline in the number of medical graduates seeking psychiatric residencies. The percentage of U.S.-educated medical graduates seeking psychiatric training has shrunk by more than one third since 1988 (Weissman, 1993). The reasons for this change are as unclear as is its impact on our specialty's future, but certainly students' experiences in clerkships are an important element in career choices (Association of American Medical Collegues, 1993). If this trend continues, it may lead to further shrinkage of psychiatrists' roles in institutional settings, whether public or private, and continuation of the trend toward office practice by nonphysician mental health professionals.

Prevention

Although there has been noteworthy progress in psychiatric epidemiology (Freedman, 1984; Robins and Regier, 1991), regressive developments in preventive health care, not unique to psychiatry, require attention. Whereas health maintenance organizations (HMOs) were conceived in the early '70s to do just that, maintain health, *i.e.*, provide preventive services, most now will perform a routine physical examination only for an extra fee. Until the last 2 years, the percentages of immunized preschoolers had declined (Children's Defense Fund, 1994). Two decades ago at a local county medical meeting discussing the establishment of an HMO-type organization, I was laughed out of court for suggesting the inclusion of a free premarital examination including a discussion of sexual hygiene (Fleck, 1975; GAP, 1973, 1980).

Preventive measures have been eliminated by prepaid care providers as not cost effective, a concept dubbed a "red herring" by McGlashan (1994). Despite good evidence that prevention works, that programs for maternal and child health are effective (Bowlby, 1950; Buckner et al., 1985; Caplan, 1964; Rae-Grant et al., 1989), they have been reduced over the last two decades. The report of the Carter Commission on Mental Health emphasizing early attention to families and child care is collecting dust in various government and other offices (Bachrach, 1994; President's Commission on Mental Health, 1978). The annual reports by David Hamburg (1991, 1992) of the Carnegie Corporation of New York, as well as other studies (Burgess et al., 1987; Carnegie Corp., 1994; David, 1992; Simons et al., 1991; Zeanah, 1993), which have addressed preventive measures against childhood neglect and maladjustments, seem equally fated for deaf ears and blind eyes. The value of psychiatric input in well-baby clinics and other primary care services has been well established over five decades, but is as rare now (if not rarer) as it was then (GAP, 1988; Greenspan, 1992; Levy, 1943; Strayhorn, 1983). There has been indifference and decline in support for such programs, and only since 1993 has there been a modest increase in funds for Head Start programs, the best-validated project for promoting good school and home adjustments (Children's Defense Fund, 1994; Zigler and Lang, 1991).

The increase in youth violence, including suicide, bespeaks our failure to provide proper guidance and treatment, if indicated, for our young, whether they live with one or with two parents (Burgess et al., 1987; Green, 1978). The risk factors are well known (Bowlby, 1984; Comer, 1985; Lewis, 1989; Patterson et al., 1992). Public health may be unpopular because it costs money without obvious results. To quote former Surgeon General C. Everett Koop (1994), "We used to be our brother's keeper and there used to be a concept that each of us had to do something for all of us." Equally ignored is the Bill of Children's Rights of 1928 promulgated by Herbert Hoover for the White House Conference on children in 1930 (see GAP, 1988).

Conclusions

The list of negatives in the preceding pages is not intended to ignore progress over recent decades, even though some of the progress has also led to regression in the scope of our field. Improvement has occurred in outreach and emergency services and other community facilities, but these advances are peripheral compared with the core of psychiatric work, which is therapeutic engagement with patients over as long a time as needed. As a well-known internist put it, communication is the main tool of the physician: "What the scalpel is to the surgeon, words are to the clinician" (Tumulty, 1970), and as Engel (1977) pointed out, communication can be "scientific." Appropriate communication with patients takes time at best (Jackson, 1992), and psychiatric patients are not at best in communicating, so it takes more time and that costs more money. Referring to the computer-oriented data collection schemes in medicine, such as laboratory findings (or the DSMs), Lewis Thomas (1983) observed: "I would be apprehensive [now] that my real job, caring for sick people, might soon be taken away, leaving me with the quite different occupation of looking after machines" (p. 60).

We need to emphasize treating patients as people rather than as containers of neurochemical aberrations, and to advocate vigorously for equal care for mental disorders. No illness is purely "organic," as implied by some, but mental illnesses unfortunately are often prolonged, requiring intensive treatment, no matter what better chemical or pharmacological relief may come next. Dichotomizing labels such as "biological psychiatry" or DSM-IV's consistent headings (psychosis, etc.) "due to" medical conditions promote regression to Descartes' notion of mind-body duality. Our profession needs to get used to thinking and conceptualizing in systemic terms; the human condition is one of systemic interdependence from cells to celestial levels. The most crucial system interphases, however, are the individual and his or her immediate context: family, community, and culture.

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