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American Psychopharmacology: Second Class Status?

By WILLIAM S. APPLETON and CHING-PIAO CHIEN

In the July 1964 issue of *The Atlantic*, William Sargant (6), made some controversial comments on American psychiatry. "Freudian converts", he said, fear "allowing any other methods of psychiatric treatment to gain any real recognition and acceptance in . . . teaching centers" where physical and biochemical treatments are "dismissed" as "symptomatic" and "second-rate". He argued, furthermore, that psychoanalysts' views are unrealistic because these practitioners are experienced merely with the "very mildest forms of mental illness". "Only psychoanalysis holds out any real hope in treatment" is the credo which Dr. Sargant attributes to U.S. psychoanalysts. If these opinions were solely those of one author, they might be overlooked, but they are held by many European and American psychiatrists (1).

The angry debate stimulated by this article has diminished, but it has had at least one beneficial effect, namely to force some of us to ask ourselves the very questions Dr. Sargant posed. (Being analysed, we can make use of his charges rather than trying to defend ourselves against them!) We studied the attitudes of the residents and staff of the Massachusetts Mental Health Center, a Harvard University teaching hospital, to discover answers to the following questions:

(1) Have the physical and biochemical treatments been sufficiently recognized and accepted in medical schools and university teaching centers?

(2) Are these treatments dismissed by leading Freudian academic and medical teachers as "symptomatic" and "second-rate"?

(3) How do psychoanalysts behave when confronted with major mental illness rather than the "mildest forms"?

(4) Has the increased use of drugs over the past six years been an enthusiastic or a reluctant one?

The Setting

The Massachusetts Mental Health Center is a state institution staffed by Harvard, servicing 150 adult in-patients and 50 day patients. There is a large out-patient department, a children's service and a 10-bed research ward. The adult admission rate is about 900 per year, one quarter of whom are referred by the courts. The medical staff includes 70 residents and 70 staff psychiatrists. Most patients are between the ages of 14 and 45, but children and older patients are accepted. While all diagnostic groups are represented, the hospital specializes in the care of acute psychiatric illness as well as in training and research.

The Center is divided into four separate services each with its own senior psychiatric staff adviser, third-year chief resident, six or seven first-year residents, nurses, attendants, occupational therapists, psychologists, social workers, medical students, rehabilitation counsellors and ministerial students. All wards are open and patients are admitted randomly among them.

Patients are given intensive, individual care by the psychiatric resident, under the supervision of the senior staff, many of whom are psychoanalysts. Analytically-oriented psychotherapy has been and is the most highly valued treatment method. But the eclectic orientation of the hospital is evidenced by the fact that 40–60 per cent. of patients admitted in the past 20 years have received somatic therapy. Insulin and to some extent electroshock have been replaced by drugs. At present 60 per cent. of those admitted receive medication.

Procedure

The Mason-Sachs (4, 5) "Attitude Toward the Effectiveness of Chemotherapy in the Treatment of Mental Illness" Scale (CAS) was administered to all 16 first-year residents at

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the Massachusetts Mental Health Center in 1960 and to all 24 first-year residents at the same institution (the first-year resident group had been enlarged in the six-year interim) in 1966. The aim was to compare the overall attitude of first-year residents after more than six months training at this university teaching hospital toward psychotropic agents in 1960 and in 1966. While it is easy to show an increase in drug use over this period, it is unknown whether there has been a corresponding change in the psychiatrists' attitude.

The CAS was selected for this study because it elicits such attitudes of the psychiatrist as: (1) whether or not he considers chemotherapy a magical, easy way, which avoids the patient's real problems and destroys his motivation for self-help; (2) whether or not he believes drugs produce at least symptomatic relief; (3) whether he sees the use of medication as severely hampered by dangerous or undesirable side-effects; and (4) whether he considers psychotherapy as aimed at underlying causes and resulting in genuine, long-lasting improvement, while drug relief is temporary.

Then, we studied the "Freudian" teachers themselves, by administering the CAS to all supervisors of first-year residents in 1966. Although we do not have similar information for supervisors in 1960, we nevertheless wished to compare their present attitudes towards chemotherapy with those of the residents. Common sense suggests that those trained in a pre-tranquillizer era, which prided itself in developing psychoanalytically-oriented psychotherapy, would be less favourably inclined toward pharmacotherapy. We wished to see if this is in fact so.

Finally, we analysed the last item of the CAS scale separately. Here the psychiatrist classifies his own opinion toward tranquillizers on a 5-point scale ranging from high degree of confidence to marked lack of confidence. We wondered whether self-rating would coincide with overall CAS score. Would the doctor tend to deny the importance of drugs when directly *asked*, in this psychoanalytically-oriented setting, while "revealing" a more positive medication attitude when approached somewhat more indirectly via the complete CAS?

Results

A. Overall CAS score 1960 and 1966 (*after having completed six months of the first year residency*)

The average attitude score in 1960 was 72 and in 1966 was 78. The estimated standard deviation of the test scores, obtained by pooling the CAS scores, is 8·6. The difference in average attitude between the 1960 and the 1966 group is significant by t-test at the 5 per cent. level.

Table I

Analysis of CAS Scores: First-Year Residents (1960 and 1966) and Supervisors (1966)

Analysis of Variance			
Source	Degrees of Freedom (df)	Mean square	F
Between	2	228	3·26*
Within	77	74·2	
Total	79		

(1) 1960 vs. 1966 residents
Mean difference: 6 points. t=2·08*
(2) 1966 residents vs. supervisors
Mean difference: 4 points. t=1·37
*significant at 5 per cent. level.

Therefore, the psychiatric residents' attitude toward psychotropic agents has become significantly more positive over the period studied.

The sample has also been divided into three groups according to the range of CAS scores: a most positive drug group scoring over 80 on the CAS, a middle group scoring 70–79 and a least positive drug group scoring less than 69. A chi-square test at the 5 per cent. level shows a significant change in attitude between the 1960 and 1966 groups. By 1966, for example, 45 per cent. of the resident group scored over 80 on the CAS, whereas in 1960 only 18 per cent. did. In 1960 37 per cent. scored below 70, now only 8·3 per cent. do.

B. The CAS scores of the Residents' Supervisors

The CAS was distributed to all 51 supervisors of first-year residents in 1966, a group composed of junior and senior staff psychiatrists plus four head nurses. Forty-three (78 per cent.) returned the form.

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TABLE II

Overall CAS Score

CAS Score	1960 No. of Residents	1960 % of Group	1966 No. of Residents	1966 % of Group
Above 80	3	18·7	11	45·8
70–79	7	43·7	11	45·8
Below 69	6	37·5	2	8·3

The difference in CAS distribution between 1960 and 1966 residents is significant at the 5 per cent. level. ($\chi^2 = 7 \cdot 41$ df=2 $p < \cdot 05$)

The difference in attitude between 1966 residents and their supervisors is not significant at the 5 per cent. level both by t-test (see Table I) and chi-square test (see Table III).

C. The 1966 Self-rating vs. CAS Score

When classifying his own opinion toward psychotropic drugs the doctor was found to be much more confident in their effectiveness than he seemed to be when viewed on the overall CAS scale. This conclusion was reached by dividing the overall CAS scores into five equal parts and comparing the resident's rank to his self-rating (see Table IV).

DISCUSSION

(1) *Freudians do not fear drugs*

General impressions of American analytically-oriented psychiatry by foreign visitors and by non-dynamically oriented American psychiatrists themselves has been and continues to be that Freudians are reluctant to accept tranquillizing drugs as making a significant and in some cases major contribution to the treatment of the mentally ill. Our data show that such impressions by foreigners may have had some validity in the 1950's, but are now very much out of date. When somatically-oriented American psychiatrists describe analytic psychiatrists' attitudes toward psychoactive agents they too are often unaware of the 1966 situation.

It is clear from our findings that this teaching hospital *has* allowed drugs to gain "recognition" and "acceptance" and has not dismissed them as merely "symptomatic" and "second-rate". The percentage of patients receiving psychoactive drugs has markedly increased, from 35 per cent. in 1960 to 60 per cent. in 1966 at this hospital. This increased drug utilization is not a reluctant one, but has been accompanied by an increasingly positive attitude toward these agents, as measured on the CAS. This scale carefully evaluates such attitudes as whether drugs are considered second-best, magical, temporary expedients which avoid the patient's real problems and prevent long-lasting cures or whether they are an important, first-class, essential, treatment modality. The 1966 first year resident's average CAS score shows his attitude toward drugs to be significantly more positive than his 1960 counterpart. He now sees medication as aiding rather than sabotaging psychotherapy. It is important to remember that employing a drug as an adjunct to psychotherapy is not the same as regarding it as "second-rate". The analytically-oriented psychiatric resident in this teaching hospital has read the psychopharmacological literature, has listened to his teachers, has utilized his own clinical experience and has not kept his head in the sand as some of his critics imply.

TABLE III

CAS Score

	Supervisors 1966	Residents July 1965	Residents Jan. 1966
Most positive group (more than 80)	15 (35%)	4 (17%)	11 (46%)
Middle group (70–79)	13 (30%)	14 (58%)	11 (46%)
Least positive group (less than 69) . .	15* (35%)	6 (25%)	2 (8%)

* 3 included who returned a blank form with the comment, "I don't use drugs".

Supervisors vs. resident (July 1965): $\chi^2 = 5 \cdot 44$ df=2 $p > 0 \cdot 05$
Supervisors vs. resident (Jan. 1966): $\chi^2 = 5 \cdot 62$ df=2 $p > 0 \cdot 05$

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TABLE IV

Confidence in the Effectiveness of Psychotropic Drugs

	1966 Residents	
	Self-rating	C.A.S. range*
	No. of Residents	No. of Residents
A. High degree of confidence	2	0
B. Moderate confidence	19	9
C. Suspended judgment	3	14
D. Sceptical	0	1
E. Marked lack of confidence	0	0

* The CAS score range has been divided into 5 equal parts for comparison with the distribution of self-rating.

One reason for the continuing mistaken impression of American psychiatry may derive from the psychoanalyst in private practice who deals largely with what is referred to as "mild mental illness". Incidentally, no one knows how many of these "pure analysts" exist, since, at least in Boston, many analysts do psychotherapy with schizophrenics and use phenothiazines. It is perhaps true that "pure analysts" do not accept drugs, but they do not have to do so. This group's view may have given others a mistaken impression of American psychiatry. Our study shows that when reality in the form of hospitalized psychotics confronts the psychoanalytically-oriented psychiatrist, he responds not only by using drugs, but with a positive attitude toward them.

(2) *Freudian supervisors*

We were interested in two things about supervisors: first, how do they regard drugs, and secondly, how much do their opinions influence residents. Supervisors are almost equally divided among the three CAS scoring groups (see Table III): 35 per cent. most positive, 30 per cent. middle, and 35 per cent. least positive, while over half of the residents entering in July 1965 fall in the middle group. Instructors seem to have made up their minds on drugs vs. psychotherapy, while residents are undecided. Nevertheless, beginning residents in July 1965 showed no overall statistically significant difference in their attitude toward tranquillizers from their instructors. Tested six months later (January 1966) there is still no difference in attitude between the two groups. However, their trend after six months is away rather than toward the direction of their teachers. For example, only 8 per cent. of residents after six months are in the least positive group, compared to 35 per cent. of supervisors. Freudian supervisors, therefore, had not brain-washed their students.

Although supervisors are somewhat less in favour of drugs than residents after six months (see Table III), it is not necessarily due to Freud. Kaplan and Lefkowits (2) have called attention to the fact that those less intimately involved in the care of psychotic patients, such as social workers, psychologists, and to some extent psychiatrists themselves, tend to be less favourably inclined toward drug use than those, such as nurses and attendants, who must deal with them directly on the ward. We postulated that the age of the supervisor might be related to his attitude toward drugs, those having been brought up in the pre-tranquillizer era being less comfortable in the use of medication and more inclined to rely on interpersonal techniques in the management of patients. We found to our surprise that when we divided supervisors into those 22 under age 40 and 17 over age 40 no significant difference in CAS attitude was evident.

(3) *The doctor views himself*

Klerman (3) has asserted that residents in American university Centers regard medication as involving them in the "traditional role model of physician", which they believe "inappropriate to psychiatry" and to represent "failure . . . of their personal therapeutic effectiveness". If drug therapy is in fact initiated only after failure of psychotherapy, analytically-oriented residents could be expected to begin medication later in a patient's hospital course than eclectic ones. We found no statistically significant difference between the time elapsed from admission to initiation of pharmacotherapy for patients of high and low CAS-scoring doctors. The fact that medication is begun with equal promptness by residents of differing orientation means that tranquillizers are regarded as aids

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or adjuncts to psychotherapy, rather than as evidence of its failure.

We wondered whether psychoanalytically-oriented residents would deny the importance of drugs when directly questioned, although they might prescribe them when necessity dictated. We found that 88 per cent. of our sample rated themselves either moderately or highly confident in the effectiveness of psychoactive drugs, while no resident rated himself as sceptical or lacking confidence in them. The fact that self-rating is even more positive toward chemotherapeutic agents than overall CAS scores (see Table IV) indicates conscious, open and enthusiastic acceptance of drugs. In the American university Center we studied, psychopharmacology does not suffer "second-class status".

Conclusion

We decided to inspect this American psychiatric teaching hospital to see if it clung stubbornly to psychoanalytically-oriented techniques with eyes shut to advances in psychopharmacology. The answer is an emphatic no. Not only are drugs widely used, but they are accepted as a first-class treatment modality by the majority of the psychiatric staff. This acceptance has grown over the years as the evidence has increased.

Bibliography

1. Freyhan, F. (1965). "On the psychopathology of psychiatric education." *Comprehensive Psychiat.*, **6**(4), 221–226.
2. Kaplan, A., and Lefkowitz, H. (1961). "Influence of staff attitudes and environmental factors on treatment selection." *J. Hillside Hosp.*, **10**, 2, 84–96.
3. Klerman, G. L. (1965). "The teaching of psychopharmacology in the psychiatric residency." *Comprehensive Psychiat.*, **6**(4), 255–264.
4. Klett, C. J., and Lasky, J. J. (1962). "Attitudes of hospital staff members towards mental illness and chemotherapy." *Dis. nerv. Syst.*, **23**, 101–105.
5. Mason, A. S., and Sachs, J. M. (1958). "Measurement of attitudes toward the tranquillizing drugs." In: VA Dept. Med. and Surg. *Transactions of the Second Research Conference on Chemotherapy in Psychiatry.* Washington, 25, D.C., **2**, 118–122.
6. Sargant, W. (1964). "Psychiatric treatment: here and in England." *The Atlantic*, 88–95.

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