

Letter from . . . Chicago

Spaz attacks

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A recent book published by the American Psychiatric Association claims that at any one time some 25% of Americans are "demoralised," meaning that they suffer from psychological distress, with or without actual psychiatric disease.¹ This estimate, though lower than Henry Thoreau's—"The mass of men lead lives of quiet desperation"²—speaks well for the future of psychiatry. That is if only the methods of treatment were a little more standardised and amenable to objective evaluation, especially when it comes to psychotherapy—an issue so well summarised in a recent editorial.³ As an alternative, however, it may be worth looking at a popular little book on a different approach, behavioural therapy, by two psychologists who also question the value of getting at the roots, of going back to the traumas of childhood, and of delving into the unconscious and the id. These authors believe that deliberately changing behaviour and attitudes does improve the quality of life; and they describe techniques such as role playing, simulating events, changing habits, learning to speak up and respond to "put downs," negotiating compromises, and even formalising the time, place, and manner of fights and how disagreements are to be handled.⁴ Promising to help people break away from self limiting ways of life, they tell about individuals who do not know who they are, what they feel, what they want. They explain how individuals can learn how to be normal, not neurotic, but free to communicate, achieve a social network, form close relationships, get thin and stay so, enjoy sex, and assert themselves at work and play.

All this may be achieved through assertion training and behavioural therapy,⁴ designated in the book as AT and BT, important first in a lineage of established abbreviations such as CT (scans), DTs (from alcohol), and ET (from outer space). For those (of us) prone to having temper tantrums, which teenagers nowadays call *spaz attacks*, the book helps by emphasising the difference between assertive and aggressive behaviour. So AT and BT may come in handy in the queue at the supermarket when the clerk yells "who's next?" and a woman pushes in from behind and says "I am." At this point an unassertive lady would say nothing but later decide she will never go back to that store again. The aggressive approach is to berate both the pushy woman and the clerk. But the controlled assertive person simply says "Sorry, I was next," and then tells the clerk she wants "the black bikini hose, size small," or whatever the object of the shopping expedition was.⁴

For those who prefer but cannot afford conventional psychoanalysis, a New York cabinet maker has made a tape that saves time and provides treatment for a mere \$6. The tape starts off by asking "what are you thinking?" and continues every minute with comments such as "go on," "why do you think that is?" or just "uh, huh."⁵ Some psychiatrists were amused by the tape and considered lending it to their patients; but others viewed it

as "a very negative comment on the therapeutic community as a whole." Others, still, have turned to the computer, using it not to replace the therapist but to act as a consultant on call 24 hours a day, to "enhance diagnosis and patient care while reducing costs."⁶ With terminals, printers, and software the computer costs \$20 000 to \$60 000, and it administers a variety of tests for one third the cost of a traditional psychological assessment. The computer can assess levels of depression or responses to treatment. It may ask embarrassing questions and yet be well accepted by patients who prefer the impersonal nature of the interview, enjoy interacting with the computer, and find the approach interesting.⁶

In some instances, we are told, the computer has actually "outperformed" the psychiatrist and made a better diagnosis. It could also turn out to be effective in preventing the recurrence of spaz attacks on stressful occasions—for example, when the hospital telephone operator disconnects you four times in a row and then accuses you of being too impatient; when yet another confused patient sets his mattress on fire, but the hospital administration continues to allow patients to smoke in bed; when your resident drones on with his history for half an hour and still has not told you why the patient came to the hospital in the first place; when the septuagenarian doctor from "utilisation review" thinks your patient with staphylococcal septicaemia could have been treated just as well as an outpatient; when the nurse telephones in the middle of the night to ask if "bed two" can have milk of magnesia; or when your great liberal friend, who has probably not been asked about milk of magnesia for a decade, philosophises how doctors are élitist and how their work could be carried out by "physician extenders." Then there is the doctor from a prepaid medical plan, with his group of nurses and science graduates, who carried out a "prospective, randomised, controlled trial of self care educational interventions." With counselling and written materials, reference books and clinical algorithms for over 100 common problems of adults and children, and a telephone information system (that was offered but not used), they reduced visits by 17-35%, with "important effects on medical care costs, physician satisfaction, and patient confidence."⁷ The authors quote studies indicating that unnecessary visits constitute the most important cause of frustration among British doctors, and that general practitioners' satisfaction correlates inversely with the number of visits estimated to be for trivial complaints. But in America, where the medical schools will soon be turning out more doctors than General Motors do new cars, physician satisfaction may decrease substantially when doctors are reduced to driving taxis while patients are being treated for everything but life saving emergencies by nurse practitioners, algorithms and telephone hotlines.

Difficulty in communicating

Still on the subject of two countries divided by a common language, I note some concern about difficulties in communication between scientists. In a recent article two doctors from

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Nashville pointed out that, as English has become an accepted universal language of the scientific community, as many impediments as possible should be eliminated to allow it to retain its position against "such formidable challengers as Arabic, French, Japanese, Russian, and Spanish"—politely arranged in alphabetical order, rather like AT, BT, and CT. Having no desire to rush in where angels fear to tread, they merely allude to the spelling and pronunciation vagaries that have already given rise to so many imaginative but unsuccessful solutions. Instead, they merely question the necessity of having adrenaline, orciprenaline, pethidine, and ergometrine also referred to as epinephrine, isoproterenol, meperidine, and ergonovine; or why indeed the American billion should be so much smaller than the British one. They go on to suggest adopting the British nomenclature as general standard, not only out of deference to the place where the language came from in the first place but also because British English is spoken by millions in the Commonwealth countries and by most other people, who use it as a secondary language, other than the Japanese. It might also help to depoliticise the use of English as a possible issue between the superpowers.⁸ An even less radical solution, suggested in an accompanying editorial, would be to make a start by putting the other name in brackets, such as pethidine (meperidine).

Also of potential transatlantic interest, I note that in January Mr Rupert Murdoch made his entry into Chicago after purchasing the *Sun-Times*, one of the last two surviving newspapers, for \$90 million. On the first day of the new régime the chief editor and his main assistants resigned or were fired. Nobody seemed excited about the *Sun-Times* joining a large family of which London's *The Times* is the most venerable member, but Mr Mike Royko, the popular columnist, promptly resigned with the comment that not even a self respecting fish would want to be wrapped in one of Mr Murdoch's papers. A suit charging breach of contract having been dismissed in a local court, Mr Royko then resumed his column in the *Chicago Tribune* with the comment that now that the alien had been repulsed there were better things to write about. So far the *Sun-Times* has not undergone any changes, and local scandalmongers are still waiting to have their appetites titillated. But there was medical interest in the story that the editor of the *Journal of the American Medical Association* had ordered an article on nifedipine to be published in its science section to make up for an earlier "unbalanced" story on calcium blockers. This allegedly happened after the drug manufacturers had cancelled \$250 000 worth of advertisements and further threatened to remove another \$2 million because the article was biased against nifedipine. While the editor denied the charge, others commented adversely about advertiser interference with the scientific contents of the journal.

Then there were some ruffled feathers about an American Medical Association recruiting letter extolling the virtues of private medicine as a voluntary exchange between two parties. "How hard would you work in England, Sweden, or other socialist countries when the exchange between the two parties is not voluntary? Would you travel a half hour to the office on Sunday or get up at night to tend a health service patient?" asked the letter, concluding that, whereas "most American patients get their problems treated promptly and professionally without waiting long hours in an emergency room," we find that "mediocrity grips the once fine health care systems of Sweden and Great Britain." This letter, with its offer of six months' membership for only \$157, probably went largely unnoticed in the daily pile of unsolicited mail of the average American doctor. But in England it gave offence, leading to such comments as "it seems bad taste to have to knock your overseas colleagues to raise the membership of your association." Yet clearly it was merely an innocent recruiting letter, intended not to downgrade hard working British or Swedish practitioners but merely to contrast the dead hand of state monopoly with the total patient satisfaction brought about by private enterprise.

For it is patient satisfaction that counts, as I learnt in a bus in the Arizona desert, talking to a lady while we looked out at cactuses and rattlesnakes. The lady, a great believer in homoeo-

pathy, insisted on showing me pamphlets extolling the virtues of this 170 year old science based on the principle that like cures like. The homoeopathic physician, said the pamphlet, graduates from an arduous school, considers the whole person and not just a single organ (how often have we heard that before), and uses some 1000 medicines that are effective in minute but poisonous in large doses. Even the Queen of England, we learn, carries a little box that contains 11 different homoeopathic preparations: belladonna for headache, poison ivy for rheumatism and lumbago, strychnine for digestive disorders, arsenic for food poisoning and diarrhoea, arnica for bruises, aconite for cold and chills, and bee venom for swelling. Then the lady in the desert told me how she had gone to Las Vegas, where she had put her hands in the diagnostic machine and obtained a score of only two on the dial. Yet with vitamins, exercises, and pamphlets she soon improved, and on the next visit the machine recorded an easy 10. "What was the matter with you in the first place?" I asked. "I don't know," she answered, "I just wasn't feeling well, that is until I took the test and the treatment." Which suggests a need for further studies comparing the effectiveness of poison ivy, AT and BT, the computer and the tape, 50 minutes on the psychiatrist's couch and five in the homoeopathic machine, and an algorithm for the most common 100 conditions of children and adults—all this for a variety of conditions including utter demoralisation and spaz attacks.

References

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- 2 Thoreau HD. *Walden*. New York: Signet Classic, 10.
- 3 Anonymous. Psychotherapy: effective treatment or expensive placebo? *Lancet* 1984;i:83-4.
- 4 Fensterheim H, Baer J. *Don't say yes when you want to say no*. New York: Dell Book, 1975.
- 5 Stevens CW. Need counselling? A lifetime fee for this psychiatrist is only \$6. *Wall Street Journal* 1984 January 6:35.
- 6 Sullivan T. Computer joins couch in clinical psychiatry. *American Medical News* 1984 January 27:2, 7-8.
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Is cholestyramine of any value in preventing coronary thrombosis?

The usefulness of cholestyramine in the secondary prevention of coronary heart disease has not been established so unequivocally as has its value in primary prevention, as shown recently by the lipid research clinics trial. Nevertheless, there have been at least two trials of colestipol, which has a similar mode of action to cholestyramine, in patients with severe hypercholesterolaemia (type II) and pre-existing coronary heart disease. One of these trials, which had several defects in its design, showed a decrease in deaths from coronary heart disease in men but not in women treated with colestipol¹; the other trial showed non-progression of coronary lesions on angiography in patients whose serum cholesterol concentration was appreciably reduced by treatment.² A recent study at the National Institute of Health of cholestyramine in the secondary prevention of coronary heart disease in type II patients, which has been reported only as an abstract so far,³ showed a similar arrest of progression of disease in those patients whose cholesterol concentrations responded well to the drug. Thus the answer to the question is a qualified yes, depending on the type of hyperlipidaemia and its response to treatment.—G THOMPSON, consultant physician, London.

¹ Dorr AE, Gundersen K, Schneider JC, Spencer TW, Martin WB. Colestipol hydrochloride in hypercholesterolemic patients—effect on serum cholesterol and mortality. *J Chronic Dis* 1978;31:5-14.

² Kuo FT, Hayase K, Kostis JB, Moreyra AE. Use of combined diet and colestipol in long-term (7-7½ years) treatment of patients with type II hyperlipoproteinemia. *Circulation* 1979;59:199-211.

³ Levy RI. The influence of cholestyramine-induced lipid changes on coronary artery disease progression: the NHLBI type II coronary intervention study. *Circulation* 1983;68:111-88.