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WARREN T. VAUGHAN, JR., M.D.
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Planning for early treatment psychiatric services

The concept of "psychiatric first aid" or early treatment psychiatry is not new. Such services have existed, in some measure, in various medical settings: general hospitals, private psychiatric practice, and psychiatric receiving hospitals. What is relatively new, however, is the idea of developing a service program with early treatment or immediate care as its central focus; in other words, to develop a crisis-oriented psychiatric program for a large community.

Both the Committee on Public Health of the American Psychiatric Association and the Joint Commission on Mental Illness and Health have been concerned with the problem of developing psychiatric and mental health services which will be able to provide clinical psychiatric services of a general nature to communities as a whole, as well as services which will be able to provide early diagnosis and prompt treatment, a basic aim of public health and medical care programming. At the 1958 Annual Meeting of the APA, the Roundtable on Emergency Psychiatric Services brought together people interested in these matters.

Dr. Warren Vaughan planned and moderated the Roundtable. Drs. Coleman and Zwerling reported on the Emergency Psychiatric Clinic of the Bronx, N. Y., Municipal Hospital, which has been in operation for several years. This was followed by a discussion of a new, immediate treatment program being developed presently by Dr. Tobias Friedman at the Boston, Mass., State Hospital, and known as the Psychiatric Home Treatment Service.

Dr. Joseph Weinreb dealt with the Worcester, Mass., Youth Guidance Center and its role at the time of the Worcester

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This paper is based on the Roundtable on Emergency Psychiatric Services sponsored by the Joint Commission on Mental Illness and Health and the Committee on Public Health of the American Psychiatric Association at the 114th Annual Meeting of the APA held in San Francisco in May, 1958.

Dr. Vaughan, moderator of the Roundtable, is director of the Mental Health Training and Research Project for the Western Interstate Commission for Higher Education, Boulder, Colo.

Dr. Downing, the editor of these proceedings, is program chief, Mental Health Services Division, County of San Mateo, Calif.

tornado disaster. Chief John Holstrom of the Berkeley, Calif., Police Department reported on the role of the psychiatrist in liaison and consultation work with the police department.

Discussants included Dr. Marvin E. Perkins, Department of Public Health, Washington, D. C.; Dr. Arnold Schwartz, California State Department of Public Health; Dr. Paul V. Lemkau, Johns Hopkins School of Hygiene and Public Health. Dr. Grete Bibring of the Beth Israel Hospital in Boston closed the Roundtable with a discussion of the implications of emergency psychiatric services for the training of physicians and other prefessionals.

INTRODUCTION

Moderator, Warren T. Vaughan, Jr., M.D., Members, Committee of Public Health, American Psychiatric Association, and Associate Director, Task Force on Patterns of Patient Care, Joint Commission on Mental Illness and Health

We must assume that in psychiatry, as in most other branches of medicine, care is often indicated following the dictum, "The sooner the professional intervention, the better the prognosis for the patient." If certain processes are allowed to proceed unchecked, prognosis may be worse, and the work of the psychiatric personnel may become more difficult and more complicated. Delay may place additional stresses on the family and the community, on clinical personnel, facilities and financial resources.

Dr. Arie Querido of Amsterdam, The Netherlands, has considerable experience with an emergency psychiatric program in which the psychiatrist goes to the scene of the crisis, interviews the patient and others and makes a clinical assessment of the total situation.

He has found that many and varied types of psychiatric disorders can be handled at the crisis point, in this fashion, by study and disposition of the problems within a few hours or days following initial professional contact. He said, at a meeting with the New York City Community Mental Health Board, that "one psychiatrist on this service is more effective than [all] the personnel in a 60-bed ward." He further stated:

> The service is ready at any time to meet any personal emergency, with minimum delay or bureaucratic machinery, between the moment the problem comes into the open and the time the first psychiatric contact is made. By going to the place where the crisis has occurred, the psychiatrist may view the patient as a whole. He is better able to visualize the patient's relationships with his family and his work situation, and to see *their* influence on the patient's illness.
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> The possibility of examining the psychiatric problem *in situ,* in order to understand its genesis and the mechanism of psychopathological dynamics cannot be overestimated. A "site visit" also permits a psychiatrist to determine whether adaptation of the patient in his own surroundings is feasible. This may permit hospitalization to be avoided in a certain number of cases, with all the resulting advantages in view of the oft-noted impoverishment in the relational life of the hospitalized patient.
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> Furthermore, such an emergency program has two other distinct advantages:
>
> (1) It serves as an excellent training ground for psychiatrists and psychiatric personnel. It pries them loose from the hospital and the office, from the traditional one-to-one clinical aspects of psychiatry and introduces them to the community and the sociological aspects of mental illness and emotional disorders;
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> (2) Such a service educates society and its representatives to accept the patient. Every time the service swings into action, it teaches by precept how to deal with the mental patient.
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> The psychiatrist teaches by his own behavior that situations can be changed by certain attitudes; that by treating the patient with understanding and honesty—particularly honesty—without showing fear and without using force, it is possible to reduce existing tensions in such

a way that they can be dealt with in the community setting.

Such occurrences deeply impress laymen and are apt to change their concepts of mental illness more than any preaching, teaching, or printing.

There are various types of "barriers" between psychiatric facilities and the individual in need of psychiatric care. These barriers seem to be an integral part of psychiatric treatment systems. As such, they deserve more critical examination than received hitherto. It is, of course, in emergency situations that these barriers become most visible, conspicuous, and potentially traumatic.

What are the various cultural, administrative, financial and geographical and other barriers to psychiatric service? How necessary are they? How permeable are they? We hope to gain some insight into this problem of barriers that represent such a fundamental issue in the development of good programs of psychiatric care.

AN EMERGENCY CLINIC IN A METROPOLITAN HOSPITAL

M. Donald Coleman, M.D., Emergency Psychiatric Clinic, Bronx Municipal Hospital, New York, N. Y.

At the Bronx Municipal Hospital, the initial aim was to develop a service to handle pressing psychiatric emergencies on a 24-hour-a-day basis, seven days a week. Experience showed that the sooner patients were seen the less the need for hospitalization, long-term psychotherapy, and other prolonged forms of psychiatric treatment. A plan was set up to handle all new psychiatric patients, when they presented themselves, within an hour. This includes patients referred from other outpatient clinics in the hospital.

The screening barrier common in many clinics is eliminated. Anybody who comes will be seen by a psychiatrist. The only person who interviews the patient prior to his psychiatric interview is the receptionist who asks the name and asks the patient to be seated. This enables the psychiatrist to deal directly, at first-hand, with the patient and his crisis situation.

In the Emergency Admitting Room of the general outpatient department, about 200 patients a month are screened by the psychiatric service. The Emergency Psychiatric Clinic also handles about 200 cases each month.

First and second-year residents are assigned to the emergency admitting room of the general outpatient clinic, where they are on call for psychiatric interviews. They also cover emergencies on week-ends and evenings.

The resident makes an assessment and disposition of the case in the emergency admitting room. He may refer the patient from the emergency room to the Emergency Psychiatric Clinic for more prolonged diagnosis and treatment. He can also admit patients for emergency overnight hospitalization, to be seen the next morning in the Emergency Psychiatric Clinic.

Important to the successful operation of the emergency clinic is the variety of therapeutic dispositions available to the psychiatrist who first sees the patient. These include admission to either a closed or open ward in the hospital, admission to a day care or night care program, or referral to the long-term psychotherapy clinic. The patient may also continue at the emergency clinic, be referred to many community health and social agencies, or finally, may be discharged home.

Third-year residents and fourth-year fellows all devote one entire day a week to the emergency clinic service, seeing seven to eight patients a day. They may arrange up to five regularly scheduled therapeutic

meetings on an "emergency" basis during the crisis period. These interviews may occur daily, or up to a week or more apart. Interviews may take several hours with the patient and with family members as well. Each resident sets aside one hour a day for follow-up interviews, in addition to his regular day in the emergency clinic.

Of all patients seen in the emergency clinic, only 10 per cent go on to prolonged therapy in the regular psychiatric clinic, which provides a program of analytically-oriented psychotherapy. The emergency clinic handles 90 per cent of patients through some treatment modality other than traditional long-term psychotherapy. This enables them to choose more carefully patients for whom long-term psychotherapy represents the optimum form of treatment.

Five types of cases in which there have been striking benefits from emergency psychotherapy are as follows:

(1) The patient with anxiety and a hysterical character structure and symptomatology who is given an authoritative explanation of anxiety symptoms as fear equivalents.

(2) The guilt-ridden patient given an opportunity for catharsis and forgiveness.

(3) The angry patient who needs an opportunity to ventilate.

(4) The very dependent patient who derives support from the quasi-magical authority figure.

(5) The obsessive compulsive patient whose defenses begin to break down and who is attempting to reinforce old obsessional patterns.

Another interesting group has been the chronic ambulatory schizophrenic patients. The immediate availability of psychiatric attention provides a kind of flexible, long-term supportive treatment for these patients. A conventionally rigid clinic structure cannot economically provide such supportive treatment, because these patients come in to the clinic at highly irregular intervals. For long periods they do not appear, then they are likely to need a patient-doctor contact at the time of crisis, with perhaps more than the usual once-a-week appointment. The emergency clinic easily adapts to these needs.

The following are illustrative cases:

Case 1:

A 48-year-old, married, childless woman came with chief complaint of depression after a half-hearted suicidal attempt with a few sleeping pills. This was some few months after her mother had died which, in turn, had followed her father's death by a few months.

When she came in, she reported a dream the night prior to presenting at the hospital: "My father was in the emergency room; my mother and sister and myself were there also . . . all of a sudden, he drew a gun and I cried, 'Mother, he wants to kill us,' and I woke up."

The session was spent in exploring her anxiety symptoms as resulting from fears which had developed following the death of both parents. She was told by the doctor that he did not find it surprising that powerful fears about death and violence should have been stirred up by these deaths, beneath her level of awareness.

She returned for a second and last interview, six days later, well-dressed, looking much better, and having returned to work for the first time in some months. She reported another dream prior to this visit; "I was in the waiting room in this hospital, my sister and mother were with me, my chair was rocking gently back and forth while I was falling asleep; my husband woke me."

Case 2:

A 26-year-old Puerto Rican woman had a serious social environmental problem and was a very dependent, helpless person. She responded positively to the powerful authoritarian doctor figure. She had vague aches and pains, but proceeded to tell a story of extreme reality difficulties.

The therapist was very active in calling on social agencies, housing authorities and others for action. He helped her to work out reality problems that she could not work out by herself.

She borrowed strength from the magical, powerful figure of the doctor. Her symptoms disappeared and her life situation improved.

Case 3:

This case illustrates a rather unpredictable kind of help which patients may receive. A young schizophrenic male developed acute paranoid symptomatology on the occasion of his wife's pregnancy. This patient had had a previous acute breakdown with six months of hospitalization.

The psychiatrist related himself immediately and emphatically with the distress of the patient on the occasion of the pregnancy by telling him that he himself was in the same position—i.e., his own wife was pregnant—and that this did create problems for the prospective father. He actively aligned himself with the negative feelings of the patient, his anxiety and distress.

The patient began to relate positively to the psychiatrist right away. The focus was not on the paranoid system at all. The patient continued to see the physician through the nine months of the pregnancy, and for several follow-up interviews thereafter.

A remarkable relationship has been established with various social and health agencies in the community. It was feared that the clinic would be flooded and immobilized by the sheer numbers of referrals from agencies. Actually there was an initial "testing out" by agency personnel to see whether the clinic really would see any case within a matter of minutes or hours.

Finding by experience that this indeed was the situation provided a great deal of reassurance, enabling personnel to work with patients longer, and often successfully, through crisis situations. Workers in the agencies, when faced with patients who, for instance, threatened suicide, were not panicked by the threat because they knew that psychiatric help was available at a moment's notice. The clinic now receives fewer referrals from agencies than before, those being patients really in need of a total change in the nature of care.

The Albert Einstein Medical School Department of Psychiatry in New York is now establishing an emergency clinic arrangement for the adolescent and children's services. Cases are being started on an experimental basis, with hopes that it will prove to be as successful as the adult emergency clinic.

PRE-ADMISSION HOME VISITS FROM A STATE HOSPITAL

Tobias Friedman, M.D., Director, Psychiatric Home Treatment Service, Boston State Hospital, Boston, Mass.

This experimental service makes a psychiatric team available to a patient and his family at the time of an extreme crisis: namely, referral for admission to a state hospital. The simple mechanics of admission to the hospital are confusing to patient and family, full of delays, and complicated by problems of communication and transportation. This confusion is often compounded by family and social problems involving alcoholism, economic distress, and marital strife.

The aim is to integrate mental health services at the state hospital, at the community level and within the family as is the case in the public health care of tuberculosis and venereal disease. Generally, state hospitals have treatment of a "yes or no" type only; either the patient is admitted to the hospital or little else is available to him. Responsibility for treatment is not at the community level but at the state level, with patients sent to state hospitals and left there without warning or planning.

There seems to be the expectation that the patient will be "factory rebuilt," altogether in isolation from his previous environment. This type of treatment is archaic, and is inconsistent without an understanding of the origin, the dynamics and the natural history of psychiatric illness. Inte-

gration between hospital and community should take place at all stages: casefinding, referral, diagnosis, treatment and continued care.

The Psychiatric Home Treatment Service has as its aim to develop alternatives to hospitalization in the patient's own family and community setting, to use the hospital only as a phase in a total treatment plan. The service fills the gap between the home and the hospital. The service can operate (a) in emergency situations, (b) in continued long-range treatment programming for patients, and (c) to maintain contact and work with poorly motivated psychiatric patients who do not or cannot attend the usual clinical resources.

On its staff are a psychiatrist, a psychiatric social worker, a public health nurse and a social science researcher. It has interpreted its aims to physicians, clergy, social agencies, housing authorities and police and others in the community, and has indicated its interest in coming into the homes of seriously mentally ill individuals—those for whom one would consider hospitalization.

The psychiatric team first goes to the home where a group family, team and patient interview is held. The psychiatrist next interviews the patient while the social worker interviews and works with the family members. The patient is not treated as a "naughty child" but is required to participate actively in all discussion and decision-making concerning himself and the family situation.

With a clearer picture of the total situation, the staff formulates a "total prescription" which considers the psychiatric and social needs both of the patient and his family. One of the aims of the prescription is to co-ordinate and encourage efforts already made in the community to help a family.

There seemed to be a direct relationship between degree of motivation and treatment offered. The more intellectual, more verbal younger, middle-class individual brings motivation with him, and because of the response of the professionals to the motivated patient, he gets priority in treatment.

The acutely disorganized individual will deny illness and need for treatment. These patients, who may be seen first in outpatient clinics and then break off psychiatric treatment, are then more inaccessible to treatment than ever before. A home service can seek out such patients in their own homes. Motivation then becomes less crucial.

Case Example:

A 30-year-old mother of two children attempted suicide following an unwanted third pregnancy. One private psychiatrist recommended termination of pregnancy; another disagreed.

Home visiting by the team revealed the intimate relationships between the patient's illness and the passivity of her husband. Both husband and wife were unwilling to seek any psychiatric care and insisted on termination of the pregnancy.

The team continued to visit and during the course of treatment, the husband's passivity and desire to see the pregnancy terminated were discussed and dealt with. At one stage, the patient entered Boston State Hospital briefly, then returned home. Regular visits were made in the home by the public health nurse.

The pregnancy continued to a successful completion, and the depressive reaction was relieved. Both husband and wife decided to continue their interviews at a Family Service Agency where they had received help in an earlier marital crisis.

COMMUNITY PSYCHIATRIC SERVICES IN A DISASTER SITUATION

Joseph Weinreb, M.D., Director, Worcester Youth Guidance Center, Worcester, Mass.

Psychiatric services at the community level in a community crisis situation were put to the test during the Worcester tornado. This disaster, of course, caught the community completely by surprise and the

Youth Guidance Center was swept into the mobilization effort of the medical and social agencies.

There was a general lack of planning by community agencies for major disasters. The reaction of the community leaders, agency executives and others was to move precipitously into action.

For instance, fast action schemes were proposed, such as evacuating all children to summer camp settings which were, in June, ready and waiting for the influx of summer campers. It was important to state that camp life with fresh air and good food was not enough for these children if the parents were not with them during the crisis. It was much more important to have the children stay with the parents while reorganizing and rebuilding their shattered homes. Insofar as the individual psychiatric emergencies go, there was no influx of individual cases to the guidance Center. Thus, psychiatric skills were most importantly directed at preventing the drive for community action, resulting in doing things that should not be done.

Psychiatric services of a consultant type were most needed at the top of the community organization pyramid. The confusion between the many agencies concerned took weeks to clear up. Planning should be done with the participation of psychiatrists as well as other social science consultants. In addition to the problem of major decisions being made precipitously in response to the immediate shock of the disaster, problems such as interagency hostility, rivalry, delineation of duties and responsibilities of the various agencies were dealt with by the psychiatric consultant.

Among the various immediate action programs suggested but discarded was that the Youth Guidance Center set up emergency psychiatric services and make radio announcements that such services were available. Again, this action might have done more harm than good. There were certainly not enough professional personnel to handle a large influx of anxious individuals responding to such a mass media announcement.

Furthermore, any parents who indeed had a seriously upset child knew through normal channels where to go and what to do. Those emergencies which did occur in individuals and families attendant to death and serious injury of loved ones were handled in the main by family physicians and the clergy. In fact, only a trickle of patients came to private psychiatrists or to clinics as a result of experiences during the tornado.

The Youth Guidance Center did feel that a most vital function was to disseminate authoritative information concerning emotional reactions to disaster, giving parents and others a reasonable understanding of the emotional impact of the disaster on children.

Therefore, the center prepared a pamphlet, "Your Children and the Tornado," for distribution by the Community Chest. Focusing on the acute disruption of the secure environment of the average child and the powers of repair and readjustment inherent in family solidarity and security, useful suggestions were made concerning anxiety symptoms, night fears, nightmares. It recommended further that any persistent emotional or other reactions resulting from death or injury should be carefully reviewed by the family with the help of trained professionals.

PSYCHIATRIC SERVICES IN A POLICE DEPARTMENT

Chief John D. Holstrom, Chief of Police, Berkeley Police Department, Berkeley, Calif.

The Berkeley, Calif., Police Department has worked with psychiatrists since 1951,

when members of the police first received elementary training in recognizing gross symptoms of emotional and mental disorders.

Psychiatrists have been used in the recruitment of police officers since 1921. Since 1949, the police department has had 10 hours per week of psychiatric time available either in the psychiatrist's office or at police headquarters. During these years it was found important that the police not only get to know the psychiatrist as a person and thus gain an estimate of his personality, abilities and reactions, but also that the psychiatrist gets to know the police, their special abilities, shortcomings and attitudes.

The psychiatrist provides a valuable consultation service to the police in many types of emergencies. The police receive many reports concerning people who are disturbing the peace. Policemen who investigate often wonder what course of action would be best. Should the individual have protective custody, or can the matter be dealt with in the home or neighborhood. Is the individual dangerous to himself or to others? Consultation with the police psychiatrist, even by telephone, often helps in working out the most expeditious disposition of such cases. Not infrequently in routine investigatory work, the policeman may interview and interrogate an individual who appears to be quite unstable. At this point, the policeman would like to have a very informal type of psychiatric screening which is usually impossible or inappropriate to obtain through usual clinic or hospital channels. Here, the policeman can refer the individual directly to the police psychiatrist, in an informal fashion, for a psychiatric interview, appraisal and consultation, with no red tape.

The police psychiatrist is used in situations where individuals are under arrest. This is a typical use of medical psychiatric services, where examination by the psychiatrist may determine whether the person will "go the route of prosecution" or go to a mental hospital. Sometimes individuals who are in temporary police custody make a major disturbance in jail or elsewhere. In this immediate situation, the police want some idea of how basically disturbed this individual is and what should be done about it immediately or prior to the patient having a major breakdown.

Not infrequently, juveniles come to the police for consultation and advice in a state of confusion and emotional disturbance. Immediate referral to a psychiatrist in an informal fashion is extremely helpful to the youngsters. The psychiatrist can advise the parents, the police, the youngster himself, thus getting at the problem at its very earliest stages.

Special problems in which the police psychiatrist is particularly useful are in evaluation and disposition of sex offenders, who may be simply community nuisances or, on the other hand, may be dangerous aggressive sex deviates.

A second special group seen by the police psychiatrist includes individuals who threaten or attempt suicide. A unique function for the psychiatrist is the occasional instance when the police are investigating complaints of various sorts against physicians. Often, it is helpful to use the police psychiatrist instead of, or in addition to, formal referral of problems to the medical society. The latter course of action is a slow process whereas the use of the psychiatrist on an informal basis provides a mechanism for working with the problem immediately for an emergency situation.

Few people, including psychiatrists, understand the police or understand the police process. Also, few people seem to understand psychiatrists or the psychiatric process. Both police and psychiatrists can

work together through a psychiatrist who can work as a middleman and develop this important liaison (4) This service has been found not too expensive for the police department, and to serve the best interests of the community.

DISCUSSION

Marvin E. Perkins, M.D., M.P.H., Chief, Psychiatric Services Division, Department of Public Health, District of Columbia.[1]

In the District of Columbia, there are many potential psychiatric patients living at home who, though disruptive, are not sufficiently disturbed to warrant the police action needed for obtaining mental observation. These persons are ones not motivated to seek psychiatric care; furthermore, their families are often not wealthy enough to afford private medical care.

Many of the families turn to various agencies at times of crisis to seek relief from a difficult situation through the local cumbersome commitment channels.

The municipal health department is trying to develop a psychiatric consultation service which will approach recurring situational problems on a public health basis, trying to help these various families find acceptable and reasonable solutions to their problems: assisting in prompt hospitalization, if needed; avoiding unnecessary hospitalization; helping to find untapped family strengths and community resources to improve the patient's and the family's lot. Thus our projected consultation service will be more like Dr. Querido's program than either that of the Bronx Emergency Clinic or the Boston Home Treatment Service.

These two experiences are heartening, however, and may provide some answers to the question of whether or not a high proportion of the cases responding to emergency measures and home psychotherapy will "hold up."

Our question is related: Will home emergency consultation in the District of Columbia result in as highly gratifying and worthwhile an experience as that had in the Bronx Emergency Clinic? We feel the need for development of techniques to evaluate new services such as these.

In order to adequately staff the home consultation program, the health department has consulted with psychiatrists responsible for training in our area. We feel confident that this will be a valuable experience for all: trainee, teacher, and practitioner in psychiatry. Most importantly, the interests of improved training opportunities and the need for a community service are bringing professional people together in an active participation in program planning.

Arnold D. Schwartz, M.D., Chief, Mental Health Service, Department of Public Health, State of California

Emergency services have their focus of interest in crisis situations involving the patient and his environment, crises which, as one study has shown, cannot continue for more than four to six weeks without successful or unsuccessful resolution.

The concern is with the epiphenomena, the precipitating situations superimposed on the mentally ill person; for example, why is the patient who has been sick for 10 years needing hospitalization now? This is in contrast to the usual psychiatric focus on individual character structure, the dynamics of the illness and individual treatment.

How can we move one step further into the realm of prevention, so familiar to

[1] Dr. Perkins is now commissioner of mental health and director of the Community Mental Health Board, New York City.

public health? Can we get to the person before the intense stress has built up to the point of breakdown? Can we identify populations which have special risks of such breakdowns? Can we, then, with a minimum of time and personnel do a maximum job, perhaps working with parents, spouses, responsible children, ministers and others? Can we focus on environmental manipulations, external problems of an interpersonal nature rather than focus on intrapersonal psychopathology, with the idea of affecting some change in individuals, reducing stress, promoting return to "pre-crisis levels of homeostasis? (5)"

The clergy in one California county have recently asked if professionals in mental health can make telephone consultation time available to help them. They need to understand better particular cases which have come to them, to help them make appropriate referrals, or to help them "listen therapeutically" during the process of working out solutions with their parishioners. What can we use of our clinical knowledge in trying to orient the many "nonprofessional mental healthists" who are dealing with crises all the time in our communities, in the middle of the night as well as in the daytime?

Paul V. Lemkau, M.D., School of Hygiene and Public Health, Johns Hopkins University, Baltimore, Md.

These presentations bring up several interesting matters. First, with respect to the handling of the obsessive compulsive patient, I have been impressed with the fact that many people with obsessive compulsive character structures seem to gain considerable help with their personal problems through the use of books and through contacts with such nonmedical professional people as ministers.

In psychiatric practice, we see patients who are "locked in" their obsessive-compulsive defense patterns, who have been under states of anxiety and tension for so long that these patterns have become an absolute requirement in their psychological economy.

Perhaps in the emergency clinic set-up, patients with obsessive compulsive defenses are seen who are early in this reaction pattern, in stages of reversibility, and can be prevented from falling into the fixed severe chronic stages with which we are familiar in the usual clinic setting.

As more emergency clinic services are established, perhaps we can begin to do epidemiologic studies which will show us if there are these real differences in stages of obsessive compulsive reactions and whether we can actually prevent long-term illness by early and energetic treatment.

A second extremely important point which I want to emphasize is the usefulness of these services in the maintenance of psychiatrically "maimed" persons in the community, people who, for instance, are withdrawn, chronically hallucinating, but who are not disturbing to the community.

Dr. Querido has pointed out that it takes a remarkably small amount of professional time to maintain these patients and their families in situations in which the patient can even be socially productive. Care of mentally retarded and senile patients in the family settings becomes possible when the families know that they do not have to make an absolute choice between caring for the patient either in an institution or in the family.

It has been shown that admission of senile patients rises in the spring, and this seems related to families preparing to go on vacations. The ordinary mental hospital, however, admits such a patient "for good," rather than taking them only while

the family is on vacation. The implications of the one-way street to the mental hospital, with hospitalization being final, represents a community habit which can be altered through the flexible programming made possible by such emergency services.

A final question is, of course, how large will these services have to become to meet the needs? In our Baltimore survey, we found a minimum of 10 per cent of the population seriously psychiatrically ill. Rennie and Leighton in their studies talk of 30 per cent who need psychiatric care. Only about 14 per cent of any population is reported "symptom free."

How do we interpret these findings? There certainly are many "uncomfortable" people. Is this the same as being "ill?" We cannot tell until we have many more programs which deal with emergency situations. We can then begin to find out how much "discomfort" is interpreted as illness and brings some people to seek medical psychiatric care.

Ilse V. Colett, M.D., Acting Director, Mental Hygiene Clinic, Fresno, Calif.

We have found over the past several years that the public nurse not only knows many families with acute psychiatric difficulties, but can be the main person to make contact with the families and to help them work out solutions to their problems.

Our public health nurses have been very enthusiastic in their psychological approach to the families and have learned to develop strong, positive, helpful relationships with these people. We have given them consultation and inservice training on both a group and individual basis, with regard to how to make adequate referrals and how to build relationships. These nurses are working with people who are not well-motivated to utilize the usual clinics.

The idea of working with psychiatric cases on an emergency basis not only involves casefinding and early utilization of psychiatric resources, but implies the need for education on a large scale to allied professional workers and the public at large. We are going to have a problem of selling this emergency idea to traditional clinic people. I am sure it is partly a problem of training our own people and overcoming administrative resistances.

Mark G. Field, Ph.D., Research Sociologist, Joint Commission on Mental Illness and Health, Cambridge, Mass.

From the point of view of the system of medical care implicit in emergency service, I am most impressed with the fact that the emergency clinics raise no barriers for the patient. They have ready access to professional help, which apparently has the important by-product of reassuring the community. Perhaps communities will be better able to handle psychiatric cases locally rather than use the hospital.

It seems extremely important that it may be more economical of personnel time and institutional money to see the patient as soon as the psychiatric emergency is defined. By immediate attention, we may avoid not only the wait and increased resistance to treatment for many illnesses, but also the many negative aspects of hospitalization, the separation from family, resistance on the part of family and community to reintegrate patient, the regression of the patient in the hospital setting, the resulting long and ultimately expensive state of chronic hospitalization.

Grete L. Bibring, M.D., Director, Psychiatric Service, Beth Israel Hospital, Boston, Mass., and Clinical Professor of Psychiatry, Harvard Medical School

These are very promising projects which we have heard discussed this evening, and

one feels encouraged by the concerted effort to find adequate solutions.

A most important factor, which cannot be emphasized enough, is how can we train professional people better to succeed in their work with disturbed people? Whom should we train, and how should we train them? First of all we should consider people who are on the spot in the emergency situations. They include police, clergy, lawyers, social workers, teachers, physicians, psychiatrists, nurses and counselors. All of these have a claim on us to be trained, and trained to the point where they can then be teachers themselves.

We know that there are many ways to do emergency therapy. The psychotherapist vis-à-vis the distressed person stands for security. He stands for strength. By his kindness, he can alleviate the self-depreciation of the patient. Through his understanding the patient may regain security and contact with the world of reality. There are many ways to work with people in distress and we as therapists should master these ways, be in command of them —not drift and flounder or rigidly adhere to a limited therapeutic principle.

In our program at the Beth Israel Hospital, we train psychiatric residents in psychotherapy. We also teach other physicians not only so that they understand the possibilities of psychiatric psychotherapy for their medical and surgical cases, but mainly so that they can learn to apply the principles and procedures of medical psychotherapy (2).

What we refer to as medical psychotherapy consists mainly of two principles. First, the purposeful utilization of suggestion based on a transference relationship; i.e., on the patients' readiness to rely on our knowledge, ability and integrity and be guided by us.

Secondly, adjustive intervention or, as it was called originally, psychotherapeutic manipulation (1). In adjustive intervention, we try to find ways, with the help of the patient, within the existing framework of his conflicts and needs and within the framework of his system of defenses, for a more suitable adjustment to the immediate crisis situation brought about by the realities of his illness and the concomitant interpersonal and emotional factors.

We must offer teaching that provides a good understanding of psychodynamics and psychopathology in order that the therapist may be free and flexible in his approach to patients. We must train them in using the techniques of their specialty.

Finally, they have to learn to gauge how far they might expect, and be expected, to go in their psychological work with patients, and have to acquire a clear notion concerning the types of cases in which they must not become deeply involved and the types of problems for which they should use psychiatric consultation and referral (3).

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