Discussion

Session II - Future of Psychological Social and Educational Approaches.

Let me first point out that predicting even six months ahead is not an easy task. The program committee had asked Dr. Gruenberg to discuss Social Psychiatry hoping that he would deal with the eventual disposition of the following burning issues of the day: (1) the relation of social class to mental illness; and (2) the role of social cultural factors in the actiology and rehabilitation of the mentally ill. But I missed even this short term prediction. Dr. Gruenberg has limited himself to the future of social organization of psychiatric services -- an important area, indeed, but we shall miss his comments on the other issues. He has made the prediction that the future of psychiatry will be determined by (a) the state of society as a whole with regards to trends in place of residence (urban, suburban or rural), standard of living, prevalence of poverty, spread of social service, etc., (b) the advances in research with regard to possible break throughs in schizophrenia, arteriosclerosis, senile deterioration, mental retardation, and (c) possible changes in the professional organization of psychiatry itself.
As a result of the interaction of these three factors, psychiatry, he predicts, will become more and more socialized in so far as its focus will become the patient within the family or the family itself in the community, rather than the isolated patients in the state hospitals. The psychiatrist of the future will be less of a specialist and more a general practitioner of psychiatry and will devote himself to a segment of the population rather than to a segment of the specialty of psychiatry. Even the hospital buildings themselves, such as will survive, will not be segregated into admission, continuous treatment and back-wards. Instead each building, perhaps even each ward will be a self-contained unit caring for the patient from beginning to end and even in after care. To do this, the hospital will have to become an integral part of the community even as community recreation centers are today. So much for the predictions. Now, for their evaluation.

It is difficult enough to make predictions. To predict whether these predictions will come true — the job of the discussant — is even more difficult. I, however, do not feel bound by the self-imposed limitations of the speakers and will, in the spirit of this symposium rush in where angels fear to tread. In order to prevent controversy I am going to predict not for 1980 but for 2080, i.e. resort to science fiction. Please remember, however, that the truth of today is only the fiction of tomorrow and the fiction of today perhaps the truth of tomorrow.
I heartily agree that the face of psychiatry will change radically, but I believe that certain forces now beginning to emerge have been given insufficient recognition. As a result of these new forces, the psychiatrist of the future will be quite unlike his contemporary prototype and willy nilly will have to share his work with the newcomers invading his claim stakes. This will not happen in our lifetime nor perhaps during this century, but it is bound to come sooner or later.

Social psychiatry as a profession may materialize in the near future, but eventually it will disappear, as will child psychiatry, geriatric psychiatry, psychosomatic and somatopsychic psychiatry and all the other specialties of psychiatry. Thus far I am in agreement with the first speaker. The scientific models provided by the social cultural point of view, the developmental, genetic, learning theory, internal environment, brain function and similar points of view will remain largely in the hands of research workers, but the findings in these fields will become so highly technical that the application of techniques derived from these fields to the patient for diagnosis, prognosis, and evaluation, will have to be done by specialists.

But why will the dismemberment of psychiatry into its components occur? First, the amount of knowledge about psychopathology will increase in the next half century geometrically, while our channel capacities for receiving and integrating this ocean of information will at best develop arithmetically. As a result, to
paraphrase Daniel, "many shall run to and fro and confusion (rather than knowledge) will be increased." Our insufficient channel capacity has already been demonstrated in several studies. Thus, in the selection of clinicians for the VA, too much knowledge proved a dangerous thing. The team that received the lesser amount of information about the candidates had the better success in selection. No single person will be able to diagnose, treat and maintain the rehabilitated patient alone any longer. The anthropologist, sociologist, psychologist, neurophysiologist, biochemist, and social worker will have to share the burden. Integrated cooperative but interdependent services will become a must. What now goes under the name of psychiatry will have to be reconstituted into its social, biological and physical components on an equal basis.

Of course, the sciences with high level of articulation like physics have the channel capacity to absorb a great deal of new knowledge because the new information can be encoded into previously discovered scientific laws. Thus, there is no need today to catalogue the characteristic behavior of all objects falling from a certain height. We know that they will all descend with the same acceleration, and even feathers and objects less dense than air can be included in this generalization provided we take friction and density of air into consideration. That is why computers can now be of help in physics. In psychopathology articulation is of a much lower order and there are no generalizations yet of the type comparable to physics. That is why
computers can not yet be of practical help and human integrators are still required.

Whether the psychiatrist will remain the center of treatment and will act as the integrator of the information provided by his colleagues on a given patient is debatable. Perhaps, eventually this integrative work will be taken over by rapid computers. But even when computers take over, someone still have to carry out the recommendations.

For accomplishing this integrative task, which no rapid computer is apparently capable of now, he will indeed need to have a wide acquaintance with the entire spectrum of sciences, which impinge on mental illness. Without such acquaintance the proper selection of therapy would be impossible in the day when the number of types of therapies will be very large.

Perhaps this change will come gradually. At first, when the data become available, the psychiatrist of that day will serve more in the capacity of a judge in court sifting the evidence and drawing as Samuel Butler said, "sufficient conclusions from insufficient premises." Because we will then have suitable evaluation methods and follow-up techniques, the errors committed by these judges will soon lead to better and better judgments, increasing our knowledge as need for it arises. Finally, the judgments will become so precise that lesser equipped men, in the form of general psychiatric practitioners will be able with the help of the scientific evidence, to minister to the
individual patient. The diagnosis of certain types of heart disease has already proven to be possible by means of information fed to a computer. That mental disease will eventually also yield to this trend is a great possibility.

Let me lead you on an imaginary tour of the clinic of the future. I can foresee the day when the mere getting of an anamnesis will be placed in the hand of a specialist. We already know of some 150 important traits in the development of the premorbid personality that are predictive of outcome of schizophrenia alone. Without a knowledge of these important facts, no systematic therapy could be initiated. There are already methods available for eliciting such information about early development, adolescence, about current feelings and emotions, and about expectations for the future on the part of the patient. At the present time these require endless sessions with a therapist and cost far more than the average individual can afford. Applying the advances already achieved by investigations of verbal behavior we can look forward to patients sitting in cubicles explaining their past history, present difficulties, and future expectations to a tape recorder while the direction of their verbal output is guided by an unseen interviewer through subtle reinforcement techniques. The data are immediately fed into computers and the results made available before the patient has finished his first day in the hospital or clinic.

The results of physiological, biochemical, anatomical and
biopsy assays already become available in such fashion. To these will be added results evaluating the sensory, perceptual, psychomotor and conceptual capacities—all fed into the computer and evaluated for diagnosis, prognosis and choice of therapy.

The recording of the course of the illness will also become more automatic through behavior rating scales filled in by the therapist, nurse, ward attendant, work-supervisor and social worker. These will be collected at short intervals and processed by automatic method to yield indexes of progress along various dimensions.

The follow-up of the patient will similarly become much more developed through the use of rating scales and other methods of recording data.

But all of these innovations will become possible only if the research progress in these various areas, now merely a trickle, will develop into the mighty stream it must become before these achievements can be attained.

In the area of preventive work, specialists in genic counseling, maternal care, infant development, education, vocational guidance, will become more and more recognized as potent agents in the prevention area, so that the load of the psychiatrist will decrease as time goes on.

In order to hasten these developments, closer cooperation between psychiatrists, social scientists, physical scientists and biological scientists, biometricians, criminologists and statisticians.
will become a must and provision for the training of such specialists in the mental health and disease areas must be arranged now if we are ever to harvest the future.

One element in this prediction is so surrounded with doubt that I hesitate to tackle it. Will we have the same diseases in the next century? How many diseases will either have disappeared or be on the way out once their etiology is discovered as was the case with general paresis or syphilis? How many iatrogenic diseases such as Charcot's clinician-produced hysterias will appear? How many new diseases will result from the current therapies following the pattern set by the production of hepatitis from blood-transfusions? The role of increased infant survival in producing subsequent increase in mental disorders is another still unknown quantity and the role of released mental patients in the community as a factor in increasing the dysgenic elements in our population is another problem which will be clarified only with time. These factors, unless checked by scientific progress may result in even a greater burden of mental disorder in the next century. What role radiation, natural as well as man-made, and space travel will play in future mental health and disease is still problematical. Hopefully, science will rise equal to the challenge.

Even if all the present diseases will have disappeared by the year 2080, the work of the therapist will still be with us. Just as the conquest of the acute diseases in the physical area forced attention on the chronic ailments, so will the conquest of the major
mental illnesses bring the so-called minor ones into focus. Perhaps the psychopathologist of the future will deal with the psychopathologist of every day life.

Unlike Dr. Gruenberg, Dr. Meehl has set himself a less formidably appearing task — that of surveying the present goals and purposes of therapy.

It is quite clear that the goals of the therapist determine to a large extent the success he attains, low levels of aspiration yielding high proportions of success and vice versa. Dr. Meehl's insistence that to free the patient from his symptoms is not enough, will certainly strike a respondent chord in many therapists. Not only must therapy be directed at uncovering, but it must also tide over the patient's initially unsuccessful attempts at reconstructing his behavior along normal lines. Even a normal penny, as Meehl points out, will come up heads rather than tails consistently for long sequences.

Looking into the future, it becomes quite clear that goals of therapy will perforce become more modest. Short of prevention, complete "cure" of chronic disorders is well-nigh an impossibility and "cure" of genetically based disorders is not even a probability short of retroactive birth-control measures, though methods of containing genetic diseases are, of course, possible. The purpose of therapy in these chronic or genetic conditions will be to prevent the disease by counselling or chemical intervention, to stop the disease once it is started, from progressing, alter the disease into a defect and teach
the patient to live with his defect. Similarly, if the disease is
genetically based, treatments such as insulin for diabetes ought to
be found sooner or later.

Dr. Meehl's distinction between respondent and operant
conditioning can be translated into more clinically recognizable
language by indicating that once the noxious conditioning has been
extinguished, normal behavior of the operant variety should be en-
couraged. It is, however, difficult for me to believe that respondent
behavior is entirely fortuitous. There must be some reason why the
person chooses to expose himself repeatedly to situations resulting
in noxious respondent conditioning such as ulcer producing situations.

Dr. Greenblatt's reference to behavior therapy reminds me
that in the future, methods based on learning theory will become more
popular. Such methods as reciprocal inhibition, used by Wolpe, ex-
tinction as used by Dunlap in his Beta hypothesis for elimination of
bad habits, and later used by Mowrer for enuresis and by Gwynn Jones
and Yates, or retroactive inhibition as suggested by Bunch are now
developing rapidly in the treatment of phobias, tics, stuttering,
enuresis, and other minor ailments. In this way learning theory has
already made a contribution to therapy not only by direct application,
but also by uncovering for the therapist the psychological principles
on which he operates knowingly or unknowingly. Whether these
derivatives of learning theory are going to develop further and make
inroads into more severe conditions, remains to be seen. The analysis
of verbal behavior into its components and the influence of reinforcement on elicited verbal behavior may also prove to be a boon for therapy, as it already has started to do for diagnosis. If verbal catharsis is important, directed reinforcement should hasten it, if not improve it.

One transcending aspect of patient behavior that will appear more clearly in the future is its predictability and lawfulness. Abnormal psychology has the unhappy facility of losing the ground it gains in hard-won battle by ceding the newly won territory to normal psychology once the battle is over. In this way depersonalization phenomena have led to the self-concept; phantom limb to body image; registration to consolidation of memory traces, etc., etc. Psychiatry too suffers this fate. Such diseases as epilepsy, general paresis, pellagra with psychosis, phenylpyruvic oligophrenia became part of non-psychiatric medicine as soon as the etiology of these diseases became known. Only diseases of unknown etiology remain permanently in the psychiatric fold, as Dr. Werts has pointed out. Thus, the abnormal gets incorporated into normal psychology. This will be the fate of psychotherapy. It will gradually be absorbed into learning theory and developmental theory. In this manner, all the abnormal phenomena which are attributable primarily to learning and development will cease being regarded as abnormal and will fall into the bailiwick of the educator or remedial therapist. Only the recalcitrant cases and individuals suffering from genetically based conditions or physiologically
based conditions will remain in the hands of the psychopathologist. The battle for the possession of psychotherapy will persist only as long as ignorance about the nature of therapy and its efficacy remain. Once these are unravelled, the competition for possession will change into a cooperative effort for finding the best way of administering therapy in accordance with, not law or authority, but in accordance with the patient's best interests.

In summary, while the practice of psychiatry may alter, the science of psychopathology will be even more altered. The new knowledge will break down the constraining fences of disciplines and will force the psychiatrist to depend more heavily on the adjacent fields of knowledge for diagnosis, prognosis, and choice of therapy. In the last analysis, however, the actual application of this knowledge to a given patient will have to remain the prerogative of the individual therapist as long as our scientific knowledge remains insufficient. Should we ever reach the day of sufficient knowledge, general practitioners of psychiatry, educators, counsellors, and even computers may be able to take over and share the burden.


V. Papers at Conventions

April 23, 1960 - Joseph Zubin - "Biometric Approach to Mental Deficiency" - Conference on Social Disorders in Mental Subnormality - New York Medical Hospital (Flower Fifth Ave. Hospital), New York, N.Y.

May 5-6, 1960 - Joseph Zubin - "Translation of Psychological Research into Clinical Practice" - Annual Psychology Conference, Department of Mental Hygiene, New York, N.Y.


May 26, 1960 - Joseph Zubin - "An appraisal of a research proposal differentiating organic brain pathology from functional psychotic conditions" - Reiss Mental Health Pavilion, St. Vincent's Hospital, New York, N.Y.


July 1, 1960 - Joseph Zubin - "Current Biometric Research in the U.S.A." - at the staff meeting of the Pruzska Mental Hospital and the Psychoneurological Institute of the Polish Academy of Science.


IV. Publications
