EAST-WEST PSYCHIATRY: A HAPPENING

Psychiatrists from Socialist and Western traditions are shaken by efforts to close a 20-year gap.

Psychiatrists from the United States and Eastern Europe came away last week from a Chicago conference that left both groups a little shaken.

Neither was prepared to contend with the profound gap the Iron Curtain has created over the past 20 years between Western and Eastern psychiatry.

The five Easterners—from Poland, Hungary, Bulgaria, Czechoslovakia and East Germany—had to take a strong dose of American psychiatry; the Americans were appalled by what they considered Eastern naivete in psychotherapy. Adding to the difficulty were cultural differences between Europe and the United States.

International scientific meetings, plagued by language differences, are difficult enough. But when scientists, supposedly dealing in the same discipline, find they are not speaking the same scientific language, the result can be frustrating. And the psychiatrists were frustrated.

"There is no question in my mind," said a U.S. pioneer in family therapy, Dr. Nathan Ackerman of New York, when it was all over, "that the people who planned this meeting intended a happening. No one has responded with neutrality," he said. "I'm plumb worn out with anger."

The meeting was set up as an East-West Seminar in Family and Group Psychotherapy by the Forest Hospital Foundation in Des Plaines. Besides the Eastern Europeans, the Foundation also brought representatives from France, Greece, Turkey, Scotland and Israel to continue a dialogue that began last September in Madrid, at an international psychiatric meeting.

If the Chicago conference had stuck to prepared papers and case histories, there would have been no happening. Instead it staged live interviews with disturbed families before an audience of 150 psychiatrists and 10 foreign guests. Moreover, the interviews were conducted jointly each time by an American and a European psychiatrist, for the purpose of revealing the different techniques of family therapy.

What it did was set the U.S. brand of no-holds-barred, emotion-based therapy against the kind of supportive counseling that has been practiced in Eastern Europe for the past 20 years.

Dr. Ackerman, who is with the Family Institute in New York, for instance, drew on years of Western development in personality dynamics to strip through the emotional defenses of a couple facing divorce. In a matter of minutes, he laid bare a long-standing emotional dishonesty in the 30-year marriage.

His co-therapist, Dr. Karoline Jus of Poland, did nothing of the sort. She asked biographical questions, sympathized with the couple and accepted the husband's decision that he wanted a divorce. Her aim, she said later, would be to separate the couple "as delicately as possible," since she did not believe the marriage could be saved.

If the patients were estranged, they were matched in conflict by the two therapists facing them—each representing a different medical tradition: one Freudian, one Marxist and highly anti-Freudian.

Dr. Jus, who started off the interview, was interrupted rather abruptly by an increasingly angry Dr. Ackerman. The two switched chairs, and the American took up the interview. Displeasure with each other's techniques was plainly visible.

Response from the audience to the entire procedure was electric.

When the couple was gone, Dr. Carl Whitaker, professor of psychiatry at the University of Wisconsin, spoke out plainly. "The question," he said, "is whether psychiatry is surgery or a medical palliative. I don't know the answer, but it's clear by now what side I'm on." Endorsing Dr. Ackerman's approach, he said, "the cost of recovery is the pain of the operation." The aim of U.S. psychiatry, in other words, would be to salvage what was left of the couple's married life by breaking down and restructuring their emotional habits.

Responding to the attack, Dr. Jus replied she was sure the marriage was lost. Her answer, she added with a touch of sarcasm, would be to treat each married partner separately, "put them on the couch and invite some of your eminent psychoanalysts to carry on."

Dr. Zolton Boszormenyi of Hungary set the East-West conflict in perspective. "I liked Dr. Ackerman's approach," he said. " Maybe this sounds a little psychoanalytic, but I'm infected, or I should say, reinfected."

Dr. Boszormenyi's comments reflected both Eastern isolation and the recent return of Eastern Europe to the study of psychodynamics.

Twenty years ago, the Soviet Union drove out the theories of Sigmund Freud, labeling them false dogma. In so doing, it blocked all further study of personality dynamics.

Under Soviet domination, Eastern psychiatry developed on an entirely different plane from that of the West. Instead of sex, family and emotions, the East focused on physiology, neurology and brain damage. Rather than treating individuals with the kind of emotional working out of problems that is common to Americans, the East treated with drugs and community services.

If a boy, for example, could not get along in society, he would be examined for brain damage, given drugs and then handled through the sophisticated network of social services common to a Socialist country.

Most likely he would be placed in a special school and given work and

physical therapy. But there would be no systematic investigation of the boy's emotions or family life. Socialist psychotherapy was, and for the most part still is, a counseling affair with the therapist offering his patient moral support and telling him what to do.

That pattern is now changing and Eastern psychiatrists are reaching for modern Western techniques. Dr. Jus, herself, for example, recently translated into Polish a French book on psychodynamics, written by Dr. Leon Chertok who started the whole process of the East-West exchange. Freud is still taboo, but the tradition he began is being rapidly accepted.

Conversely, the United States is reaching for community services of the kind that have been highly developed in Eastern Europe. The two blocs, psychiatrically speaking, are moving toward each other.

And there are many to mediate the move. The Chicago conference ended on an upbeat—with a continental embrace between Drs. Ackerman and Jus. It was an appropriate gesture, since the representatives from Western Europe, Turkey, Greece and Israel had been softening the East-West confrontation all along.

"I think Dr. Jus' approach inhibited free expression in the patients," commented Dr. Orhan M. Osturk of Turkey, "but the way Dr. Ackerman told the husband he was blushing also inhibited the man's expression."

Dr. Osturk is familiar with U.S. psychiatry and aware as well that it cannot be transplanted whole to another society. His own answer has been a blend of Freudian emotional stripping and the supportive, authoritative techniques that are necessary for the more traditional Turkish culture.

"We are people from different countries and we don't agree," said Greece's Dr. George Vassiliou. But, he said, the conference will not be a one-shot affair. "All of us have plans for meeting again; we have started a process."

The comments of Scotland's Dr. J. K. W. Morrice, however, deliberately chosen to close the conference, sealed an East-West reconciliation:

"Britain used to be a world power," he said. "Now it is a small island, set in a cold sea between two Goliaths," with the task of mediating differences. There are stereotypes on both sides, said Dr. Morrice.

Europeans, on one hand, consider Americans "psychoanalytically oriented beyond words." Americans, on the other, view European psychiatrists as "kind of effete and rather tired, more rigid and lacking in vigor." The truth is, he said, "We are brave people wherever we are because we stick our noses into other people's lives."

Drug Prices Under Scrutiny

In New York City, 500 tablets of a common tranquilizer costs $9.45. In Atlanta, the same 500 tablets costs $31.20.

A potent antibiotic costs New Yorkers $25.95, but Chicagoans can't buy it for less than $50.00.

The price of drugs varies as much as a staggering 4,000 percent from city to city.

The high cost of drugs—one witness blamed price-fixing—is under Senate investigation in what could be a repetition of the 1962 assault on the powerful pharmaceutical industry by the late Senator Estes Kefauver.

The lengthy probe of drug houses and drug regulations opened in Washington last week when the Senate Select Small Business Monopoly Subcommittee heard testimony that the poor pay more for medicine than the rich and that brand name products are generally twice as expensive as their generic counterparts.

Subcommittee chairman Gaylord Nelson (D-Wis.) does not expect to settle the long-standing brand-versus-generic controversy. His investigative subcommittee is seeking public exposure and information that may be the basis of recommended legislation for a pricing scheme for drugs. The panel does not itself originate legislation.

But the record Nelson is building will have its impact when the Senate Finance Committee takes up the Administration's Social Security bill—possibly by mid-June. Its hearings are also expected to cover legislation introduced by Senator Joseph M. Montoya (D-N.M.) to bring drugs under Medicare benefits (SN: 4/22). Senator Montoya's bill calls for generic prescribing and purchasing of drugs for Medicare patients when those drugs are of proven quality.

Similar legislation introduced by Finance Committee chairman Russell Long (D-La.) requires low-cost generic prescribing of all drugs bought under Social Security programs.

Both the Montoya and Long bills provide for a Formulary Committee, headed by the commissioner of the Food and Drug Administration, to determine which specific drugs are of a reasonable quality and which are not, and whether a drug sold under its generic name is as good as its branded cousin. And that's the rub.

FDA cannot now guarantee that all drugs are of equally high quality, regardless of how they are named or prescribed. Commissioner James L. Goddard concedes that FDA cannot prove that drugs licensed for the same purpose are necessarily therapeutically equivalent. Virtually imperceptible differences in a drug's formulation can determine how it is absorbed or metabolized by a patient. Without a formulary committee backed by clinical tests, the question of equivalency of one drug to another remains unanswered.

But supporters of inexpensive generic rather than high-price brand name buying assume equivalency, and that drugs made by different manufacturers can be identical.

At least, this is the premise from which many economy-minded Federal and state officials charged with drug-

THORAZINE AND COMPAZINE
INTERNATIONAL PRICE COMPARISONS
PRICE TO DRUGGIST

	Paris	London	Bonn	Mexico City	Rio de Janeiro	United States
THORAZINE						
10 mg. 100's		$ .70				$ 4.26
10 mg. 500's		2.85				20.24
25 mg. 100's	$1.08	1.08	$2.40	$4.80	$2.53	6.06
25 mg. 500's		4.75	9.45		9.98	28.79
50 mg. 100's		2.06				7.26
50 mg. 500's		9.05				34.20
100 mg. 100's	3.16	3.96				9.66
100 mg. 500's		16.94			19.97	46.32
COMPAZINE						
10 mg. 100's	$1.75		$1.95			$ 7.86
10 mg. 500's			6.68			37.34
5 mg. 100's		$ 1.88		$4.00	$2.00	6.06
5 mg. 500's		8.64				28.79
5 mg. 5000's		84.00				243.00
25 mg. 50's	1.35	2.33			1.90	5.13
25 mg. 500's		21.00				48.73