BEHAVIOR

Joel Greenberg reports from the annual meeting of the American Psychiatric Association in Toronto

Phobics respond to drug treatments

Of all the claims made for behavior modification over the years, perhaps the most consistent therapeutic (and commercial) successes have been recorded in the treatment of phobics. Today, almost invariably, a traditional psychotherapist will refer a phobic patient to a behaviorist. The treatment basically consists of desensitizing a person's irrational fear of heights, closed spaces or almost anything else by forcing the phobic progressively to associate good thoughts with the feared object until the fear has disappeared or diminished.

Though reports have been favorable, the technique does not help everybody, and certain severe cases seem impervious to behavior modification. Now, a group of psychiatrists from the National Institute of Mental Health and Harvard Medical School report that treating severe agoraphobia—fear of open spaces and crowds—with antidepressant drugs as well as therapy "results in a clear if not striking increase in therapeutic efficacy."

In a three-month study of 57 agoraphobics at the Massachusetts General Hospital, the researchers found that up to 94 percent of those treated with the antidepressants phenelzine and imipramine improved, with up to 81 percent rated markedly improved. This compared to about a 50 percent improvement among those treated only with behavior therapy. The group plans further follow-up studies to assess the long-term effects of such treatment.

Sex changes and the real world

Sex-change operations—while they may do wonders for a certain tennis player's career—produce a lifestyle far from the nirvana envisioned by many applicants for the operation, according to a follow-up study of such candidates by psychiatrist John Meyer of the Johns Hopkins Hospital. Meyer followed 32 persons (including 24 biological males) who received the operation and compared them to 66 (52 males) who did not get a sex change.

While he found little difference between the two groups in levels of socioeconomic advancement and emotional stability, Meyer did detect a postoperative pattern common to most who went through with the change: during an initial phase of elation extending for two to five years, such patients are often exhibitionistic, seeking situations or jobs calling for considerable bodily exposure. After that period, however, most are "overtaken by the painful realization that nothing had really changed except certain elements of body configuration."

Preexisting emotional and personality problems reemerge and the patient begins to realize that he or she is only a "facsimile" of what was hoped for. "It is highly questionable," Meyer says, "whether sex reassignment per se could be considered personally (and) socioeconomically rehabilitative."

Money problems cause ghetto stress

Psychiatric journals are filled with complex explanations about why individuals in ghettos and poverty areas have a high incidence of psychiatric disorders. Lack of self-esteem, hope and social membership have been identified as possible causes of the phenomenon.

Now, a study of 2,299 Chicago area residents—ranging from people who earn less than $4,000 to those who make more than $30,000 annually—concludes that while certain psychosocial factors may influence emotional problems among the poor, there is just one primary, overriding cause: lack of money. Frederick W. Ilfeld of the University of California at Davis surveyed the families with social stress and coping tests.

Among all the variables on these tests, only those dealing with financial stress were significant in connecting low income with high symptoms, Ilfeld reports. "The implications for low income then are clear: relieving current financial stressors should be the most direct route to decreasing symptomatology," he says. "Of secondary import would be such strategies as solidifying social membership, increasing hope or increasing feelings of self-esteem."

Battered wives: A list of symptoms

One of the main problems over the years in treating battered wives has been the reluctance of many such women to report that their husbands beat them. While a number of these women wind up in psychiatric clinics for resulting problems, psychiatrists complain that even at that point, the wives are reluctant to mention the beatings, and, hence, therapy is unsuccessful.

In a study conducted by Elaine Hilberman of the University of North Carolina Medical School, all women entering a rural health center in that state were screened for signs of marital violence. Over a 12-month period, 60 women were identified as beaten wives. Only two of them had volunteered the information during their primary evaluation—the rest admitted it only after being asked about it.

After treating the women and studying their backgrounds, the researchers have come up with a checklist of symptoms that appear to be common with the families of battered wives: (1) violence, child abuse and/or incest; (2) children with somatic, behavioral or sleep problems; (3) husbands that are aggressive, alcoholic or pathologically jealous; (4) the woman herself has multiple physical complaints and clinic visits; (5) the wife is agitated, anxious, suffers from insomnia or has violent nightmares; (6) the wife directs aggression against herself, and exhibits impaired self-concept, chronic depression, passive or active suicidal behavior or self-mutilation. Hilberman suggests that such symtoms may serve as warning signs to therapists that they may be dealing with a battered wife.

Over-labeling emotionally ill children

Schizophrenia, manic depression and other common labels are too often attached to emotionally ill persons for convenience, critics of over-labeling have charged. And with growing regularity in recent years, some of the same diagnoses are being ascribed to children, says a study team from Washington University at St. Louis and Pahlavi University at Shiraz, Iran.

Asserting that relationships between adult and childhood illnesses have yet to be established, the researchers performed a five-year, follow-up study on 20 youngsters released from a general pediatric hospital between 1967 and 1973. All had been diagnosed as depressives. Three had been admitted for suicide attempts, 13 for physical symptoms and 4 for behavior problems.

When reached for followup, 10 of the youngsters had no psychiatric disorder. One girl had a depressive illness and one boy was schizoaffective. Six were undiagnosed, although three in that group had multiple symptoms.

The researchers reject the original rationale that most of the children were depressed because they appeared to have symptoms similar to adult depression, along with a family history of depression. They suggest "the use of adult diagnostic labels for children with a few depressive symptoms is premature and unwarranted."

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