South African Snake Pits: For Blacks Only

"The situation," says Boston psychiatrist Charles Pinderhughes, resembles "what would have been the case if the South had won the Civil War." In quoting "a friend" of his on the quality of life in South Africa, Pinderhughes's tongue was only partially in cheek. Having completed a 17-day survey of South African psychiatric hospitals, Pinderhughes and three other U.S. psychiatrists report that the treatment of black patients there could be worse, but not by much.

Invited by a public relations-minded South African government, the psychiatrists have returned with a tale of medical neglect to the point of death, filthy, often inhuman living conditions and an overall attitude toward black patients by the psychiatric establishment that reflects the apartheid mentality with chilling precision.

"The most shocking finding of our investigation was the high number of needless deaths among black patients," says American Psychiatric Association President Alan Stone, who headed the four-member team. "There was evidence of patients being allowed to die who had treatable illnesses," Stone said last week at a press conference in Chicago at the annual meeting of the American Psychiatric Association.

Since the tour was carefully limited in time and scope by South African officials, Stone could not estimate the total number of neglect-related deaths among black psychiatric patients. But the evidence reflected in the case records the group did study indicates that such deaths are far from isolated occurrences and that "thousands of black patients' lives were at stake," according to Stone.

The U.S. team primarily visited private institutions run by Smith, Mitchell and Co. Those facilities — segregated by skin color — are funded by the government, however, which is solely responsible for any medical care that might be necessary, according to the U.S. team. The records indicate that no such care was even contemplated for blacks suffering during the treatable stages of pneumonia, cardiac problems, gastrointestinal difficulties, epilepsy and other ailments that eventually proved fatal to some.

"Our random survey did not find a single black patient whose medical record demonstrated adequate medical care during the final illness," the psychiatrists report. "Even when patients were in fact diagnosed by a physician as having a treatable illness, e.g. bacterial pneumonia, there was no evidence that the patients received antibiotics, and the course of these treatable illnesses indicated that no proper treatment was given." Subsequent interviews with staff members substantiated this picture of neglect, they report.

Though these were the most dramatic cases, they were far from the only indications of the "incredible discrepancy" between black and white psychiatric institutions in South Africa. Overall medical care is almost nonexistent for blacks, with some patients going for decades without even a physical exam; psychiatric care, similarly inadequate, is provided by part-time psychiatrists who speak none of the black native languages and demonstrate questionable knowledge about various areas of psychiatry — deficiencies also encountered among many of the staff. And the sanitary conditions of the toilet, bath and sleeping areas are so bad that Stone suggests they have contributed to some of the illnesses that led to premature deaths of black patients.

Contrary to some suspicions, the U.S. group found no evidence that anti-apartheid blacks are being hospitalized because of their political beliefs, as political dissidents are alleged to be in the Soviet Union. The average ages of black psychiatric patients, however, are much lower (in the 30s, 40s and 50s) than those of their white counterparts, most of whom are elderly.

The U.S. team, which also includes psychiatrists Jack Weinberg and Jeanne Spurlock, observed no evidence of electric shock use in the surveyed institutions. But in general, the findings condemn South African treatment of black psychiatric patients far more harshly than host government officials appear to have expected. The South African Department of Health has officially disagreed with the group's findings and "impugned our objectivity, honesty and opinion," says Stone. "But world pressure has had an effect [on such problems] and we feel it will continue to do so. South African psychiatrists argue that apartheid is not involved in the care of black patients," he says. "But it *is* involved — apartheid does not stop at the door of a hospital." □

Flying in the face of phobias

In an era when phobics are coming out of, or rather stepping into, closets, elevators, airplanes and other dens of unspeakable fears, agoraphobia remains the Mt. Everest of the field: It can be conquered, but only with much effort and some luck. Agoraphobia can be defined simply as "fear of open spaces" but is often far more complex. Many of its victims are afraid to venture anywhere where they cannot get help if needed; some are literally housebound.

What fires agoraphobia is a fear different and more pervasive than that of the "simple" phobic who may be afraid of specific objects or situations, such as heights, elevators, cats, and so on. The agoraphobic is petrified of a sudden panic attack that can strike anywhere, at any time; the phobia may become associated with a specific place if the attack occurs there.

"All [phobias] have anticipatory anxiety, but agoraphobia is very hard to treat because it has the spontaneous panic attacks," says Donald F. Klein, director of research at the New York State Psychiatric Institute and professor of psychiatry at Columbia University.

Now, as the result of "a fluke" that occurred 20 years ago, Klein reports a rather unlikely, but effective, way to reduce hard-core agoraphobias to simple-type phobias. "In 1959, we had [agoraphobic] patients wracked with anxiety, who did not respond to intensive psychotherapy and got nowhere on thorazine — they were at the end of their ropes." Although the patients — at Long Island Jewish-Hillside Medical Center — were not clinically depressed, Klein gave them Tofranil, a brand of the antidepressant imipramine.

In what Klein describes as "a very striking series of events," the patients' panic attacks disappeared within a few weeks, leaving just the anxiety common to most other phobias. "With Tofranil, we got them to almost simple phobias, which we then could treat," he says.

Klein has continued to use antidepressants for agoraphobia since then, but now he reports on the first systematic, comparative study of the treatment's effectiveness. During the past four and a half years, Klein and co-therapist Charlotte Zitrin have studied more than 200 phobics at Hillside. Their data, presented at the annual meeting of the American Psychiatric Association, show that imipramine is indeed more effective than a placebo in curtailing spontaneous panic attacks among agoraphobics.

Perhaps more surprising, the researchers found that once panic attacks are eliminated, conventional, "supportive" therapy works equally as well as the highly touted behavioral approach of step-by-step "desensitization" in lessening phobic anxiety. "The main finding is that anything works as long as the person is persuaded to confront the fear," says Klein, who adds that the alleged superiority of desensitization, which unlike other methods involves no inquiry into psychological causes of the phobia, now appears to be "a crock." □