Letter from . . . Chicago

Compulsion

GEORGE DUNEA

About a quarter of a century ago I failed psychiatry because of my imperfect understanding of the obsessive-compulsive disorders. I had not grasped the difference between compulsions and obsessions, the professor pointed out from behind his big desk; and I had written that these disorders were rare when in fact they were exceedingly common. So I spent the summer clarifying these points in my mind, which is the last time I ever thought about them. Nor have I ever seen a case since, which shows how much the professor knew, unless one were to include my proclivity to walk half a block back to the car to make sure that the headlights are switched off. But now it turns out that my own case represents merely the tip of the iceberg, and that millions are compelled, or perhaps obsessed, to take drugs, drink, gamble, or work.

Of these various compulsions, working probably represents the least harmful disorder. As we shall see later, its victims often feel remarkably well and, remaining undiagnosed, do not inflate the professor's statistics. Furthermore, even the philosophers have said that we should work in our garden without arguing or speculating, and that work is better than introspection. For "blessed is he who has found his work; let him ask no other blessedness"—and it is easier to know our job than to know ourselves, poor tormented unknowable creatures.[1]

Yet working in one's garden presents its own difficulties in this worst of possible climates. Increasingly, we hear of people leaving the snow belt for the sun belt; and earlier this year a presidential committee recommended that the Federal Government should no longer squander valuable resources trying to reverse the decline of our older North-eastern cities, "which are no longer the most desirable settings for living, working, or producing."

Drinking may also be an unsatisfactory experience in a cold climate. Perhaps this is best illustrated by the sad tale of the young man who drank just enough at a Christmas party to want to step out to clear his head. He went out of the house into the cold—and was found frozen on Boxing Day.

Another young man this year tried to establish a new world record by drinking a quart of vodka within ten minutes. He was successful—but never woke up to collect his prize. Meanwhile, the National Institute on Alcohol Abuse and Alcoholism reports that the consumption of beer, wine, and spirits continues to rise; and alcohol is a factor in 10% of deaths in America. One in ten social drinkers end up being alcoholics; and there is a tremendous toll in terms of suicide, teenage drinking, chronic illnesses, falls, fires, and drowning. Furthermore, between 35 and 65% of all car accidents are caused by drivers who have been drinking; and in Illinois the number of accidents is increasing, but arrests and convictions for drunken driving have declined by 70%. This is because loopholes in a too liberal law allow drivers to delay or even to refuse to take the mandated second breath-analysis test. It now takes a policeman more than three hours to arrest a drunken driver, and the procedure has become so cumbersome that generally the police will bother only with the most blatantly inebriated drivers, suggesting an urgent need to amend the law and close the loopholes.

Even more devastating is that other common compulsion, drug abuse, especially among teenagers. Some 500 000 Americans are believed to be addicted to heroin, over one million take cocaine, and perhaps 15 million smoke marijuana. Add to this the myriads of people who abuse Quaaludes, "purple hearts," and angel dust, and it all amounts to a $64 billion a year industry with international ramifications that have been impossible to eradicate. The newest drug on the market, a synthetic narcotic known as fentanyl, is 80 times more powerful than heroin and is being passed on the street as "china white," which is a South-east Asian high grade heroin. Because the drug is difficult to dilute (or "cut") it often leads to respiratory paralysis and has already caused several deaths, especially in California. But ordinary heroin also continues to cause its share of deaths or near-deaths—which brings us to the 20-year-old girl who last Christmas had a heroin house-warming party at her new apartment. As everybody started skin popping, the hostess received too large a dose and passed out, so her friends filled up the bathtub with ice and beer cans, put her in, and then forgot about her. Two or three hours later, as the guests emerged from their stupour, somebody remembered the hostess, who by now was cold and apnoeic. They rushed her to hospital, but on the way the car broke down and had to be fixed. At last they reached the casualty department, where after trying to resuscitate her for two hours the doctors pronounced her dead. Yet eventually everybody was greatly relieved, and only the undertaker was rather perplexed, when, presumably emerging from her hypothermia, she began to exhibit unexpected signs of life at the funeral parlour.

Lady Luck

Meanwhile, there are reports from Atlantic City that over a hundred nurses, technicians, and clerks have left the hospital to take up more lucrative jobs at the local casino. Perhaps this underscores America's inclination to consort with lady luck in what has been termed an attempt to provoke fate and ask the mysterious forces of the universe to decide for or against us.[2] At the present time, Americans are believed to spend some $20 billion betting legally on horses, dogs, bingo, pools, and lotteries, and perhaps twice as much on illegal gambling.[3] Forty States

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have legalised gambling; Atlantic City has become a flourishing multimillion dollar business; and at least ten more States are considering opening casinos, looking to raise funds for public hospitals, schools, or universities. Nor does gambling represent a new interest of mankind, for dice have been found in the tombs of prehistoric Indians, in the pyramids, and in the ruins of Pompeii. Gambling has received more than its share of attention in literature, some of the greatest writers of all times, such as Dostoyevsky, being not only inveterate gamblers but also writing extensively about it. Famous gamblers include the colourful Casanova, the elegant gamblers of the Mississippi riverboats, and the many notorious gamblers of modern casinos.[2]

Yet in recent years the local governments, while enjoying the extra income from gambling, have also become aware of the social problems it creates and have encouraged the development of a variety of treatment programmes. Already Gamblers Anonymous has over 6000 members; and the American Psychiatric Association has also become interested and has declared compulsive gambling a mental disorder. Some psychiatrists now view gambling as one of the purest forms of psychological addiction known, one in which all ability to control the gambling impulse is lost, leaving the individual helpless and dependent on gambling to the exclusion of everything else in life.[3]

Compulsive gamblers are four times as likely to be men than women. Many are highly intelligent, competitive people who developed a false sense of optimism but eventually end up in financial trouble, leading a life dominated by constant debt, sometimes to the point where they consider suicide. Some gamblers appear to have had problems during childhood; and Sigmund Freud has viewed compulsive gambling as a need for self-punishment because of deep-seated guilt. Other psychologists have stressed masochistic tendencies, megalomania, aggressive feelings, and needs for instant gratification, leading to an eventual loss of control, true dependence, severe withdrawal symptoms on stopping, and a progressive course from which nobody has ever been cured without treatment.[3] Even with intensive counselling, possibly a stay in hospital, and intensive rehabilitation, only about half of the patients are cured; and there has been much emphasis on restoring the patient's self-esteem and gratifying his need for challenge. One approach, sometime effective, is to substitute one compulsion for another by converting the compulsive gambler into a compulsive worker, or workaholic.[3]

Workaholics

According to a recent estimate some 5% of the population are full-blown workaholics, people who work out of compulsion and are unable to stop without developing severe withdrawal symptoms. They are found in all walks of life, not only among professionals and executives, but also among janitors and filing clerks. Most of them are characterised by having an unbounded amount of energy, so that they need little sleep and rise early even if they go to bed late. Possessed by an overwhelming compulsion to work long hours, they prefer labour to leisure and tend to blur the distinction between the two; spend much time away from home and little with their families; have few or no outside interests, hate vacations, and dread the thought of retiring; make the most of their time and are able to work any time and anywhere; are energetic, competitive, and efficient people who make daily lists of what to do; and may be seen working at weekends or reading while eating alone.[4]

Unable to stop working and restless when forced to be idle, some workaholics may have strong self-doubts, though seemingly assured to the point of arrogance. They fear failure, fear boredom, fear laziness. Completely absorbed in their work, they may be extremely efficient but sometimes are counter-productive by delegating too little, being too demanding, having difficulty in dealing with co-workers, losing perspective, and not seeing the wood for the trees. Driven by an enormous will to succeed, they often pay little more than lip service to their families; their marriage may become a failure on the altar of workaholism; and if persuaded to take up a hobby may pursue it with the same relentless determination as their work. Though they are difficult to live with, certain adjustments are possible ("making workaholism work for you"); and students of the syndrome[4] have found that, far from being unhappy or emotionally unbalanced, most workaholics were in fact remarkably content and satisfied with their lives, their success, and the excitement of their job. Not that some did not express regret about their problematical family lives; but many had adjusted adequately and were thriving on stress, without signs of ill health. In fact, it is the lack of stress that may be harmful for the workaholic, who may be "literally bored to death" and value work more than life itself—thus confirming Nietzsche's aphorism that discharging one's energy rather than self-preservation is the main instinct of the human race.

Burnout

Yet although workaholics are generally a healthy, happy, and energetic lot, people working long hours without vacations and outside interests may develop psychological or somatic symptoms, especially when obliged to work in conflict or under unsatisfactory conditions and unable to express anger. So that whereas, "it is almost axiomatic that if a patient complains of being overworked he is not," some workaholics, in their overwhelming drive to succeed, are believed to lack an inner governor and truly work themselves into a state of exhaustion.[5] Such people may develop severe symptoms from overwork and may require enforced rest or vacations.[5] A less acute syndrome, however, which in recent years has received increasing attention, is burnout, a debilitating psychological syndrome brought about by work-related chronic stress and by the failure to realise one's expectations. Some have described burnout as, "a confrontation with reality in which the human spirit is pitted against circumstances intractable to change,"[6] or where you feel like hitting your head against a stone wall.

Burnout often afflicts professional people,[7] idealistic but disappointed, who have become resigned to their lack of power to change things, no matter how hard they try. First described in mental hospitals by Freudenberg,[8] it is especially common among health professionals,[9] such as doctors, social workers, and nurses in oncology, intensive care, dialysis, or terminal care units; but it is also seen in divorce and criminal lawyers, policemen, teachers, administrators,[10] and business executives. Such individuals may be variously described as stagnant, ineffective, visionless, resigned, disinterested, or at times over-involved. Nurses may show a blunting of affect, care little for their patients, joke about them or demean them, or become overconcerned in the technical aspects of the job. A business executive may work long hours but inefficiently, producing little and blaming others for his failures. A social worker may begin to despise her patients; a doctor immerses himself in administrative trivialities and avoids patient contact; a lawyer comes to believe that it is all his clients' fault anyway. Some workers cope by using various techniques of physical or psychological withdrawal; others exhibit high absenteeism rates and complain of constant lack of energy and fatigue, or develop somatic symptoms. Some become suspicious, bordering on paranoia; others display cynicism, irritability, negative attitudes towards their job and their co-workers, or a feeling of helplessness. Effective treatment includes changing work schedules, reallocation of work or authority, group planning, therapeutic workshops, and, at a personal level, reassessing one's priorities and developing outside interest. Even small modifications in daily routine help. Prevention, of course, is better than treatment, and may require not creating unduly high expectations in the first place. But above all comes diagnosis, for there are many guises

under which this important syndrome may appear in an industrialised society.

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Musings of a Dean

Teaching and service

As education cuts threaten to bite deeply, the deans of medical schools are contemplating a plea for special treatment. This would not be as unreasonable as it may sound because medicine is the only faculty which is obliged to admit as many students as last year (and substantially more than a few years ago) to honour a national commitment. Medicine is also under unique constraints from the General Medical Council to maintain the depth and breadth of its course. It was partly because of these external requirements to diversify the curriculum that new academic departments were set up, with a consequent strain on resources.

In short, the nation may have to spare an extra penny for medicine if it is to ensure doctors sufficient in number and satisfactory in quality for its needs. Need is a very controversial matter and may in any case conflict with preparedness to pay for more working doctors. There is also the problem, in hospital at least, that the career structure may be too inflexible a pyramid to allow for the legitimate career aspirations of the number of doctors now on the stocks.

Types of education

The notion of quality in relation to need is not so much a technical requirement as an attitude of mind. Doctors have not proved outstandingly adaptable to changing medical and social needs, or, if they have, it has been in spite of rather than because of their medical education. Their educational experience has been cushioned from the world, whether in multifaculty intellectual abstraction at Oxbridge or elsewhere, or in a proud teaching hospital medical school, standing a little aloof from the everyday needs of the people around it.

Times are changing. The most outstanding intellects (and many lesser lights) still receive an excellent scientific education in abstraction, a foundation sufficient to set feet on a Nobel-prizewinning path. But whatever the pattern of their training most doctors have a rather pedestrian assignment ahead. They might better bend their minds and hearts to everyday medicine by spending all the five years of their training nearer the sharp end of their subject, especially as teaching hospital awareness begins to spread outside the narrow confines of its own parish.

Denigration of applied knowledge, whether in science, maths, or medicine, is a peculiarly British arrogance. Small wonder that in therapeutics, for example, most major advances have stemmed from the unashamed practicality of the pharmaceutical industry and not from the universities. Surely it does not degrade to emphasise the practical relevance of learning? It may positively inspire students if teachers are competent in basic and clinical science besides being actively concerned in patient care, whether in psychology or surgery.

Reports from London suggest that smaller integrated schools may be the first casualties of financial constraint on grounds better intelligible as a reflection of educational power politics, the "big is beautiful" school, rather than proved economic reason. This shift in the balance of education perpetrated in the name of economics threatens to halt in its tracks the movement towards a more adaptable approach to medicine. It favours again the comparatively sterile split between science and medicine, which makes it more difficult to bridge the gap between the narrow physical technology and the wider behavioural art of medicine.

A close partnership between the many strands of basic science and clinical science has made great strides in the past 15 years, not least in forging an educational harmony "welcomed by students, who, from the outset, appreciate the importance of studying basic medical sciences in their own right but also of learning how to apply them to the problems of sick people."[1] The partnership is no less productive in research because it "ensures that advances in medical science have the maximal impact on patient management, on research, and in the prevention of disease.[1]

The symbiotic relationship between basic science and clinical practice can be developed even further. The reflective intercalated BSc year offered at many universities during the medical course is rightly cherished. In Australia this option has been developed as, in effect, a BSc in clinical science,[2] a concept which could with advantage be developed in Britain too. Finally, a continuing strand of basic science in the clinical years helps to mould the course into a coherent whole. But for this to be achieved economically departments must be next to one another and the five-year course must be jointly planned.

Teaching versus service?

The time-hallowed conflict between teaching and service is another aspect of the same problem. The conflict is one of time not of content; service is first the training ground of medicine (at which students are eager to arrive at the earliest opportunity) and then its lifelong battlefield. For teachers to find time for both scientific and clinical teaching, for research and for service these activities need to be as compact in geography as in spirit. As clinical responsibilities cannot be adequately undertaken at a distance it is not difficult to see the inherent advantage of a teaching hospital and complete medical school on one site. At the