psychotherapy, where intensive individual supervision—rightfully—considered of primary importance for teaching psychotherapy. But for lack of training, drugs may, and actually are, prescribed for the wrong reason, administered with faulty techniques, and evaluated without sufficient knowledge of action and complications.

Seen in historical perspective, this situation reflects an unresolved conflict in the relationship of psychiatry to medicine. When modern pharmacotherapy arrived on the therapeutic scene, psychiatric theory and practice were farthest removed from the mainstream of medicine. Lacking viable biological theories of mental disorders, professional interest focused primarily on psychodynamic theory and intensive psychotherapeutic methods. The rapid expansion of psychopharmacology into a new science with not only therapeutic but major theoretical significance for clinical psychiatry created serious controversies regarding changes in the conceptual frame of reference for treatment and training.

At present, pharmacopsychiatry appears to be in the paradoxical state of rapidly advancing theoretical knowledge, on one hand, and only hesitating progress in the quality of clinical treatment, on the other. There are, of course, many reasons for this disparity. The role of clinical pharmacology in medicine is today generally a matter of critical concern for professional and governmental authorities. Neither undergraduate teaching of pharmacology nor postgraduate education prepares physicians for their therapeutic responsibilities in the use of drugs. Furthermore, the rapidly growing number of new drugs overtaxes medical practitioners in all specialties.

But so far as psychiatry is concerned, the situation is still more complicated by the fact that drug treatment is regarded very ambivalently. Psychiatric theory has not been brought sufficiently up to date to bridge the gap between psychodynamic and psychobiological aspects of etiology and treatment. Psychotherapy is still widely taught to be the treatment of choice. Yet drugs have proved their value and are prescribed on an enormous scale by psychiatrists of all orientations. In the absence of valid differential evaluations of therapeutic methods, drug treatment is popularly rationalized as either a substitute for or adjunct to psychotherapy. While it is true that drug treatment can make patients accessible for psychotherapy, it is equally important to acknowledge that there are specific indications for only one, or only the other. A recent study evaluated the attitude of psychiatric residents on drug treatment of patients hospitalized in a prominent training center. Medication, it was found, was begun with equal promptness by physicians with psychoanalytic and eclectic orientation. This seemed to confirm the nonexistence of bias regarding drug treatment. Special tests were developed to evaluate these physicians' competence in the area of drug treatment. It turned out that both groups knew most about psychosocial, least about medical, aspects of drug treatment. But the psychotherapeutically oriented physicians scored worst on questions pertaining to adverse effects and pharmacological typology of drugs. The fact that physicians use drugs in spite of their biases, but without adequate knowledge in clinical pharmacology, may, therefore, seem more disturbing than if bias were to keep them from treating with drugs at all.

What amounts to a disturbing schism between psychiatric pharmacotherapy and medicine can not be viewed with complacency. A recent congress of ophthalmologists was reported to have brought to light an increasing incidence of glaucoma and other serious eye disorders due to antidepressants with anticholinergic effects. The opthalmologists were critical of the seemingly injudicious use of antidepressants by general practitioners, internists, and psychiatrists, since many patients had repeated episodes of glaucoma prior to the prescription of these drugs and because, in some instances, there had been repeated prescriptions despite the recurrence of serious ocular symptoms. An editor's comment on this report was to the effect that any physician who prescribes an antidepressant should be aware of the potential hazards to which he exposes a patient. But while nobody would disagree with this editorial opinion, it nevertheless fails to come to grips with the issue. As a matter of cold fact, neither evaluations of medical histories nor systematic physicial examinations are taught to be preliminary procedures for the prescription of antidepressants or, for that matter, other psychoactive drugs. Nor have standards for monitoring drug effects been developed, let alone implemented, to guard effectively against multitudes of adverse reactions.