We may now ask whether the availability of physical techniques as adjuncts or alternatives to purely psychotherapeutic methods constitutes a significant advantage for the psychiatrist in contrast to other therapists. There are, as noted above, three such techniques to be considered, one diagnostic and two therapeutic. The diagnostic techniques is, of course, the physical examination. The most obvious fact relevant to this technique is that the psyche—the object of study of *psychi*atry and *psycho*logy—is not a physical object and hence cannot be examined physically; its disorders cannot be diagnosed by physical methods. It is hardly surprising, therefore, that most psychiatrists do not perform physical examinations except on hospitalized patients, and then frequently only as a matter of routine compliance with hospital rules. I am sure that I am by no means atypical in reporting that I have not done a single physical examination in 8 years of private office practice and 4 years of clinic practice. I am sure also that I am not typical in stating that I would not trust my own ability as a physical diagnositican in any but the most obvious situations. In the kinds of cases in which the interpretation of physical findings is diagnostically important—cases involving cardiac symptoms, suspected hyperthyroidism, questionable neurological manifestations, and the like—sound practice demands the sort of reliable and expert opinion which can be provided by the internist or the neurologist, not the opinion of one whose expertise lies in quite a different field. For really serious purposes, then, the physical examination is not a functioning part of the average psychiatrist's armamentarium. To maintain sufficient expertise in physical diagnostic observation to offer definitive judgments in cases such as those mentioned above, the psychiatrist would have to continue to perform numerous physical examinations; such use of psychiatric time would appear manifestly unwarranted in view of the availability of specialists in the appropriate medical fields.

It is a fascinating irony that many psychiatrists who hold the view that physical medicine is an appropriate basis for mental health practice and who would object strenuously to any questioning of the relevance of physical examination techniques to that practice make no secret of their ignorance of the only *psycho*diagnostic tools we have other than the interview (or pure observation)—i.e., psychological tests. Whatever may be their usefulness, they constitute the only method we have which even roughly approaches the diagnostic tests of physical medicine; it would seem only reasonable, therefore, for all workers in the field to be at least somewhat conversant with them.

The prescribing of drugs has become a far more important part of psychiatric practice since the advent of the "psychotropic" drugs; and while there are some psychiatrists who avoid all use of drugs, there can be no doubt that for many, the ataractics, antidrepressants, sedatives, and stimulants constitute a useful set of pharmacological tools (Bahn, Conwell, & Hurley, 1965). Even those psychiatrists who use these drugs infrequently would presumably agree that they do contribute significantly in the task of helping certain emotionally disturbed people, particularly the psychotic and the severely depressed.

The actual administering of drugs by psychiatrists is usually limited to hospital situations. There are a few psychiatrists who occasionally use intravenous pentothal for office interviews, but this practice is apparently extremely rare, and most psychiatrists' offices are not equipped for this sort of medical procedure—a fact which in itself indicates that most psychiatrists do not regard it as a significantly helpful technique. It is safe to say that the overwhelming majority of drugs employed by psychiatrists are prescribed, not directly administered by the psychiatrist himself.

The use of electroshock has, of course, decreased markedly since the beginning of the "drug era." There remains, however, a group of patients for whom it is unquestionably extremely useful, if not irreplaceable; these are the patients with severe endogenous depressions who do not respond to antidepressant drugs and with whom psychotherapy is a practical impossibility. It is of crucial importance to note, however, that many, if not most, psychiatrists do not actually give electroshock therapy themselves. It is, for this large group a specialized procedure for which they refer patients to practitioners who employ it frequently and who are thoroughly familiar with its use and with the complications which may ensue. These practitioners are equipped, either in hospitals or—less often—in their offices, with the apparatus and additional staff needed to administer the treatment; they are also covered with the substantially larger amounts of insurance required. Since the number of patients for whom electroshock is definitely "indicated" has shrunk so drastically with the advent of the psychotropic