Important Advances in Clinical Medicine

Epitomes of Progress—Psychiatry

The Scientific Board of the California Medical Association presents the following inventory of items of progress in psychiatry. Each item, in the judgment of a panel of knowledgeable physicians, has recently become reasonably firmly established, both as to scientific fact and important clinical significance. The items are presented in simple epitome and an authoritative reference, both to the item itself and to the subject as a whole, is generally given for those who may be unfamiliar with a particular item. The purpose is to assist the busy practitioner, student, research worker or scholar to stay abreast of these items of progress in psychiatry which have recently achieved a substantial degree of authoritative acceptance, whether in his own field of special interest or another.

The items of progress listed below were selected by the Advisory Panel to the Section on Psychiatry of the California Medical Association and the summaries were prepared under its direction.

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Meditation: Clinical and Health-Related Applications

REPORTS OF ALTERED STATES of consciousness and extraordinary feats of bodily control by Zen and Yoga masters have been filtering into the West for several decades. However, it is only within the last 15 years that Western scientists and health care professionals have begun to look seriously at Eastern techniques, such as meditation, to determine their possible efficacy in mental and physical health-related concerns.

Meditation refers to a family of techniques that involve a conscious attempt to focus attention in a nonanalytical manner and an effort not to dwell on discursive, ruminating thought. Based on brain neurophysiology, these techniques may be divided into three groups: concentrative meditation, in which the person attempts to focus attention on one particular object (such as a sound, mantra, candle or "third eye"); mindfulness (opening-up) meditation, in which the person attempts to be receptive to whatever internal and external stimuli come into awareness, and a combination of the two, in which the person has an object of focus, but when other stimuli arise, he or she notices the other stimuli and then returns to the original object of focus.

Western research has looked almost exclusively at dependent variables related to meditation as a self-regulation strategy and has been carried out in laboratories and field settings with persons who have been meditating for only a relatively short time. Physiologically, research findings seem convincing that meditation can produce a hypometabolic state in which there is decreased oxygen consumption, reduced heart rate, increased regularity and amplitude of electroencephalographic alpha activity, increased skin resistance and decreased blood pressure.

Because of these physiological changes, it was suggested that meditation would be a useful self-regulation technique for relaxation training. The clinical literature has borne this out. In a recent review of the psychotherapeutic and health-related effects of meditation, it was shown to be a promising clinical intervention in reducing stress and tension, decreasing addictive behaviors and helping to manage hypertension. These clinical changes appear to occur equally well with a variety of different meditation techniques.

Recent research on meditation has attempted to determine more accurately when meditation is an appropriate intervention, and for which persons and for what types of clinical problems it is useful.

It appears that as a self-regulation strategy, meditation is equal to, but no more effective than, other self-control strategies such as biofeedback, hypnosis and progressive relaxation.

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The Diagnosis of Schizophrenia

THE ADOPTION BY THE American Psychiatric Association of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, effective 1980) entails many changes in the diagnostic practices of American psychiatrists and other mental health professionals. An important inclusion in DSM-III is a particular set of diagnostic criteria for schizophrenia. These criteria render a clear verdict regarding a critical dispute that has lasted almost a century over opposing concepts of this most distressing and disabling of mental disorders.

Eugen Bleuler, who formulated the term schizophrenia, based his concept of the disorder on certain essential symptoms that could be identified in many persons who had never been psychotically ill. He believed that in mild grades and in its simple form, schizophrenia was extremely widespread in nonclinical populations:

> . . . the simple schizophrenics vegetate as day laborers, peddlers, even as servants. They are also vagabonds and hoboes. . . . On the higher levels of society, the most common type is the wife. . . , who is unbearable, constantly scolding, nagging, always making demands, but never recognizing duties.

Bleuler's broad concept of schizophrenia became rooted in American psychiatric diagnostic practice as exemplified by the very general diagnostic criteria established for schizophrenia in DSM-I (1952) and which persisted in DSM-II (1968). Many clinicians came to share the dismay of sociologically oriented observers that the label of schizophrenia, admittedly a sticky one, was being applied too often in a haphazard and potentially damaging way to patients (and nonpatients) with extraordinarily varied presentations in diverse settings and under diverse conditions of evaluation.

DSM-III stipulates that for a diagnosis of schizophrenia to be made, a patient must have had signs of the illness continuously for at least six months and that the six-month period must include an active phase with clearly psychotic symptoms (from an explicit list). Although DSM-III includes a list of potential prodromal or residual symptoms of schizophrenia, which encompasses Bleuler's essential symptoms, these are neither necessary nor sufficient for a diagnosis of schizophrenia.

The definitional requirement that schizophrenia be an illness characterized by psychotic symptoms and a continuous course of at least six months duration may help reduce the still existing skepticism that there is such a group of mental disorders and may improve treatment and research efforts for those who suffer from them. American psychiatry has taken a large step toward the Scandinavian practice of waiting five years from the onset of initial symptoms before confirming a diagnosis of schizophrenia.

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Tardive Dyskinesia

TARDIVE DYSKINESIA IS the most serious long-term side effect of all antipsychotic drugs. These drugs, in use for some 25 years, are the cornerstone of therapy in schizophrenia. Aftercare studies show substantial drug-placebo differences in relapse rates (favoring antipsychotic drugs) and, accordingly, it is accepted practice to prescribe maintenance antipsychotic drugs to most schizophrenic patients after their discharge.

Tardive dyskinesia consists of repetitive, involuntary movements that primarily involve, at least initially, the muscles of the face, lips and tongue. Involuntary mouthing, chewing, sucking, licking movements and tongue movements inside the mouth are frequent early manifestations. Later, the syndrome may include grotesque facial grimaces. choreoathetoid-type movements of the fingers, hands, arms and feet, abnormal trunk movements, peculiar gaits and abnormal diaphragmatic movements that result in grunting, difficult respiration and voice abnormalities.

Tardive dyskinesia occurs after several years (occasionally months) of antipsychotic drug therapy, with an estimated prevalence of between 15 percent and 50 percent after long-term therapy.

Patients are usually unaware of any abnormal