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MENTAL HEALTH

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THE SHORT-DOYLE ACT



STATE OF CALIFORNIA
DEPARTMENT OF MENTAL HYGIENE
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A CRITICISM OF THE TERMS "PSYCHOSIS," "PSYCHONEUROSIS,"
AND "NEUROSIS" ¹

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Two of the most fundamental and widely used terms in psychiatry are "psychosis and "psychoneurosis" or "neurosis." We venture to say that there is not a psychiatrist in this audience who does not frequently ask himself or his associates "Is this a case of psychosis or of neurosis?" The meanings of these terms may at first seem obvious and hardly in need of clarification at this late date in their usage. A quick perusal of psychiatric literature, however, offers ample evidence that there is a great deal of confusion both practically and theoretically in defining and applying these terms. We feel, therefore, that with the radical revision of psychiatric nomenclature which is to appear in the next issue of the Standard Nomenclature of Diseases a review of the use of the terms "psychosis" "psychoneurosis," and neurosis" and an analysis of the reasons for confusion in current usage is timely and in the interest of clear thinking in psychiatry.

There is so much variation in meaning in the common usage of these terms that it is next to impossible to make common usage the basis for defining "psychosis and neurosis" for purposes of classification. We hear the two distinguished on the basis of different etiologies, of different descriptive clinical pictures, of different prognosis, of quantitative differences in symptomatology, and of qualitative differences in symptomatology. Sometimes the distinction is made by dividing psychiatric disorders into "major reactions" involving the whole personality and "minor reactions" involving only a part of the personality. The terms are frequently used to refer to legal and social differences - the psychoses are considered to be hospital cases ordinarily committable, in contradistinction to the neuroses, which are considered to be mostly ambulatory, treatable in private practice or on an outpatient basis, and not legally committable. "Psychosis" is very often used as synonymous with the term "schizophrenia."

The reasons for variation in the use of the basic terms in psychiatric classification are to be found partly in the origin and historical development of the use of the terms and partly in the fundamental problems of scientific method and psychiatric classification. The purpose of this paper is to try to clarify some of the problems involved in the development of past and present psychiatric nomenclature, with special reference to the use of "psychosis" and "psychoneurosis" or "neurosis" as diagnostic classifications. Our procedure will be, first, to summarize briefly the origin and historical development of the terms and, second, to examine the relationship between the present status of psychiatric understanding of mental illness and the recent revision of the official system of nomenclature.

Those disorders that we know as "mental illnesses" were brought into the domain of medicine during the eighteenth century. Physicians for the most part believed that "mental" illnesses were really physical illnesses, that is, neurological disorders. Late in the eighteenth century, William Cullen introduced the term "neuroses" to designate the functional diseases of the nervous system as they were being studied by neuropathology, at that time in the infant stage as a branch of medicine (1). During the nineteenth century, the major work in psychiatric nosology was done by German psychiatrists, whose study of mental disorders we might call psychobiological in the sense that mental illnesses were believed to be specific disease entities involving both the physiological

¹ Read at the 107th annual meeting of The American Psychiatric Association, Cincinnati, Ohio, May 7-11, 1951.

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A CRITICISM OF CURRENT USAGE OF THE TERM
"SEXUAL PSYCHOPATH"

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In attempting to deal in an enlightened way with persons accused or convicted of sexual offenses, many state legislatures in recent years have passed special laws that are generally referred to as "sexual psychopath" laws. These usually require a sorting of offenders into 2 groups: (1) those who are to be labeled "sexual psychopaths" (or some equivalent term) and who are to be committed as mentally ill, and (2) those who are not to be so designated and who are to be tried under regular criminal statutes. (We are not here considering sexual offenders who are known to be insane or mentally deficient persons, since these are dealt with in all states under time-honored laws governing commitment to state hospitals.)

The administration of this new kind of sex legislation entails the establishment of criteria, presumably clinical, whereby the courts can readily sort out the mentally-ill offenders from the nonsick offenders. That the establishment of such criteria of discernment has been exceptionally difficult if not impossible is attested to by the many demands for help in clarifying the term "sexual psychopath" that have come from judges, legislators, district attorneys, and others who are engaged in making, administering, and studying the law. The crucial factor in the success or failure of legal proceedings under these statutes is the definition of the mental condition that makes an offender subject to psychiatric commitment rather than penal sentencing.

The practical and theoretical problems raised by use of the term "sexual psychopath" and its equivalents are fundamental in both psychiatry and the law. Analysis of these problems requires consideration of the main issues involved in understanding and controlling not only deviant sexual behavior, but all forms of antisocial behavior. This paper will deal with the nature of the difficulties that have been encountered in legal and medical attempts to solve the problem of defining the term sexual psychopath and suggested alternatives. Our hope is that this discussion will be useful in bringing about revision of present sex legislation so that it is neither behind nor ahead of psychiatric knowledge, thus making its application to the public health and welfare smoother and surer than is presently the case.

EVALUATION OF CRIMINAL SEX LEGISLATION

Traditional sex legislation has been ineffective in controlling sex crimes, especially those violent crimes against which public pressure for legal control is especially strong. The criminal sex laws are concerned with 3 groups of offenders: (1) those whose sexual behavior is morally condemned even though it is not potentially dangerous to others and is not a public nuisance; (2) those whose sexual behavior constitutes a serious nuisance, is shocking and offensive to any member of the community who is subjected to it; and (3) those whose sexual behavior is dangerous to the life and health of others or is a threat to the emotional or physical welfare of children. If the laws were enforced as written, they would provide the necessary protection for the public

PRESIDENTIAL ADDRESS¹

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Two years ago at our last annual meeting we celebrated the passing of one hundred years since the founding of The American Psychiatric Association. We looked back and reviewed past achievements. We were all justly proud of our Association, the oldest national medical society in the United States. Today at the first annual meeting in our second century of existence, let us look forward and consider what should be the future development of psychiatry.

There are certain things which I believe we should agree upon as the basis for future development. The first of these is the establishment of a simple credo to which we can all subscribe, and which we can present as a simple statement of the fundamentals of psychiatry. We recognize that there are many differences of opinion in psychiatry. A certain amount of disagreement is a sign of healthy growth. Although we have some fairly fundamental differences among ourselves, I believe that we can agree upon a simple statement of the fundamentals of psychiatry. This should be presented to the medical profession and to the general public as a basis upon which we ask for outside support.

Psychiatry is a specialty of medicine; as such it is concerned primarily with the problem of mental health and mental disease. Like other branches of medicine it has started by recognizing serious disorders; has attempted to find their causes; has developed more or less successful methods of treatment; has then turned to disease prevention, and has finally advanced to the concept of robust health as a goal for which all medicine must work.

The mere absence of clear-cut mental disorder in people is not enough. We want the optimum of mental health for everyone. As psychiatry has progressed it has not only infiltrated every other field in medicine, but

has entered upon the study of the fundamental bases of man's behavior. It has recognized that man is a social being, and has therefore spread into such fields as cultural anthropology, sociology, political science, law and religion. Psychiatry has much to learn from all of these fields, and in turn can contribute to them much that will be helpful.

Many schools of religious education have courses in psychiatric work. Our most progressive courts make use of psychiatrists both to examine those charged with crime prior to trial to determine their mental responsibility, and to study those convicted to develop constructive methods of dealing with them. The latest works in cultural anthropology are replete with psychiatric material. We find, therefore, considerable acceptance of our fundamental psychiatric concepts by these many other fields of study.

At the moment we have popular acceptance of psychiatry and keen interest in it; in fact, one might almost say that psychiatry is oversold, and is in the embarrassing position of being called upon to perform miracles which unfortunately can occur only in some of the absurd formulations in popular moving pictures and novels. It is perhaps well to call public attention to the fact that we have not yet solved the problem of mental disease; that we have made only a very modest beginning, but that within certain limits we can accomplish a great deal. There is danger that by expecting too much of us the public may react and decide that because psychiatry cannot prevent and cure all mental disorders, it therefore has no value and should be discarded.

Remember that following World War I there was a similar flood of popular interest in psychiatry, and a rather general assumption that psychiatry could now solve all human problems. When, as was to be expected, psychiatry failed to measure up to this impossible standard, much antagonism arose, and many claimed that psychiatry had little or nothing to offer. Let us, therefore,

¹ Delivered at the one hundred and second annual meeting of The American Psychiatric Association, Chicago, Ill., May 27-30, 1946.

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Some current trends in problems of the aged

KARL M. BOWMAN, M.D.,
and BERNICE ENGLE

SAN FRANCISCO

◆ The United States has a population of 175 million persons, of whom about 15 million, or 8½ per cent, are aged at least 65 years. The people in this age group make up the highest proportion of a country's population in history, and they are now increasing at about twice the rate of the over-all population.¹

LONGEVITY

The average length of life for white people in the United States reached in 1956 a new high of 70.2 years, a gain of ten years in the past 2 decades and double the average life of 34 years at the end of the century. The increases in average longevity, however, may now be nearing their limit, according to Woodhall and Jablon,² unless the mortality rates in later adult life fall, as they would with the conquest of cardiovascular-renal diseases or of cancer.

The proportion of aged persons, however, is expected to continue to increase, though at a less rapid rate. According to a U. S. Bureau of Census forecast, by 1960 there will be nearly 16 million aged 65 and over, and by 1975 almost 21 million, or about 9.5 per cent of the population.³

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After 65, women increasingly outlive and outnumber men. In general, the majority of biologic, genetic, cultural, and psychologic factors favor female longevity but the explanation of the causes is often obscure. Problems of posture, personality changes, sexual life, intellectual capacities, work performance, and retirement have especial importance to the aged. Here again sex differences appear. Scientists do not yet know what old age is.

MALE VERSUS FEMALE LONGEVITY

So far the gains in average longevity have favored women above men. The life expectancy at birth is now about 73 years for white females and 67 years for white males, a difference of six years in favor of women. In the age group of 65 and over, women have long outnumbered men.⁴ The disparity is expected to increase, with nearly 3 million more women than men forecasted by 1970. Some demographers are said to point "to the prospect of 'a nation of old ladies.'"⁵

THE VULNERABLE MALE

Bond's recent article in *Geriatrics* on the "fragile male" contains many interesting facts.⁶ Female death rates in the U. S. white population since 1900 have declined 65 per cent, men's, only 50 per

THE COMMUNITY
MENTAL HEALTH
CENTERS ACT

(1963)



A COMMENTARY

DO OUR MEDICAL COLLEAGUES KNOW WHAT TO EXPECT
FROM PSYCHOTHERAPY?

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A title in the form of a leading question is commonly used to provoke thought and to dispel complacency. We frankly confess to this purpose, our intention being to present a factual report and personal commentary on psychotherapy - a form of healing which in our times has changed the face of medicine. This change has taken the shape of a spectacular boom in psychiatry - a phenomenon which is primarily a reflection of the public acceptance of the effectiveness of psychotherapy. Our shock and other physiological therapies and our progressively more efficient and humanitarian hospital practices have spread our influence, to be sure, but no one who observes even casually the public temper would deny that everyday usage of the term "psychiatry" is almost synonymous with "psychotherapy." We ourselves as specialists are inclined to soft pedal our physiological therapies, and even to become apologetic about them. Indeed, most of us feel that psychiatry's main claim to distinction as a specialty rests on a system of psychotherapy based on a sound theoretical framework customarily called psychodynamics.

To get back to our title, which raised the question as to whether our fellow physicians are clear about psychotherapy, this audience has doubtless already surmised our answer. It is, in general, "no." That we are frequently misunderstood and even maligned by our medical colleagues, sometimes fairly and sometimes unfairly, is a truism which the experience of the members of this audience will surely corroborate. Our own experience - we have not made a formal poll of medical opinion - indicates that a great many physicians are muddled in important respects about the methods, goals, and effectiveness of psychotherapy. We will go further and suggest that this muddle is in considerable part a reflection of our own muddled state. Evidence for this is plentiful in the voluminous professional literature which is pouring from our busy brains.

That all of us in medicine, psychiatrist and nonpsychiatrist alike, should be confused in our views and expectations of psychotherapy appears to us to be inevitable, because of the nature of the times and of ourselves as physicians (with respect to our training) and the nature of the human mind which is the object of our study and practice. Happily, this situation is not without remedy. There appears to be an inherent self-correctiveness in major movements, whether they be scientific, artistic, or social - a sort of natural "feed-back" propensity. The signs of the times indicate that this tendency toward self-correctiveness has already begun to appear in psychiatry. This paper is itself a reflection of such a trend, and other examples are not hard to find.

In the first place, there is an increasing interest in quantification, always a sign of a developing critical, or, you might say, scientific attitude. Science, broadly speaking, requires the invention, testing, and confirmation or rejection of hypotheses to fit the data, and the possibility of making

¹Read in the Section on Private Practice at the 110th annual meeting of the American Psychiatric Association St. Louis, Mo., May 3-7, 1954 ²The Langley Porter Clinic, Department of Mental Hygiene, State of California, and the Univer

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Samuel W. Hamilton Award

SOME PROBLEMS OF ADDICTION

By KARL M. BOWMAN, M.D.*

MANKIND has developed habits of eating, drinking, and smoking and taking drugs by injection subcutaneously, intramuscularly, or intravenously. Man may even take some drugs by sniffing them up his nose, as snuff or cocaine. Some of the substances used are unhealthy and undesirable. Some, used in moderation, are healthy, so that it becomes a quantitative matter.

I should like to consider first the actual eating of food and the drinking of fluids, even water, which may involve fairly common and sometimes very serious problems and which are akin to drug addictions. Next is the use of tobacco. Alcoholism is one of the most serious drug addictions that we have.

Undereating and overeating may be harmful, as may be the drinking of too much or too little water. A good deal has been written recently about overeating; in some cases it represents a form of oral satisfaction to the individual who feels insecure and deprived of affection. The overeating may be a constant procedure, with the individual growing fat. It may be only an occasional eating bout, somewhat akin to the drinking bout of the alcoholic; in some cases it may alternate with periods of undereating. In the extreme cases of undereating, we have the well-known syndrome of anorexia nervosa. Here again the undereating seems related to an emotional situation in the patient's life. Likewise some persons have special dietary fads that may or may not be harmful. In general, addiction to vitamins will not harm the patient unless he takes greatly excessive amounts of vitamins A or D. We find, therefore, that both overeating and undereating may represent conditions comparable to the addictions which we are discussing.

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Past, Present and Future in the Treatment of Drug Addiction

By KARL M. BOWMAN

IF ONE STUDIES the use of narcotics in the United States a hundred years ago, he finds that comparatively little attention was given to the problem, that opium, particularly in the form of paragonic or laudanum could be purchased freely, and there seems to be no linking of the use of opium with criminal behavior. It is probable that the greatest amount of opium per capita was consumed from about 1860 to 1875 and that there was a slow and steady decrease of its use from then on. In 1914, the Harrison Act was passed by the Congress of the United States. It was primarily a revenue law, and as such, it set up a control of the sale and use of opium. Other drugs were included and at a later date still further drugs were added. A few years later the Volstead Act made the sale of alcohol for beverage purposes illegal. Some of the same attitudes that applied to national prohibition soon developed in the attitude toward the use of narcotic drugs, and when national prohibition was finally repealed there was an increase in the intensity of the enforcement of the Harrison Act. In addition, various states set up state legislation against the use and the sale of narcotic drugs except by physician's prescription.

The medical profession participated in this extreme viewpoint and the various out-patient clinics for the treatment of narcotic addicts were closed. This led to a very repressive and punitive attitude towards all drug addicts, and the setting up of constantly increasing penalties for the illegal sale, possession or use of these drugs. Gradually there developed considerable protest at what was felt to be the extremely punitive attitude under which the anti-narcotic laws were administered and the interference with physicians in their attempts to treat narcotic addicts. There was a failure to discriminate between simple drug addiction and the illegal sale of narcotics. The prevalent idea was that both were the same and that there was never any difference between the peddler and the addict. The general attitude developed that all drug addicts were hopelessly degenerate persons, liars, thieves, habitual criminals, etc.

It was held that no form of treatment was of any value and that practically all cases of narcotic addiction were hopeless. Then followed the claim that only more strict laws with further increases of penalties both for addicts and for peddlers would solve the problem. The opinion prevailed that drug addiction was primarily a police problem and not a medical one. Attempts to suggest liberalization for the treatment of addicts was fought bitterly by the Federal Bureau of Narcotics. Finally Congress was persuaded to set up the death penalty for certain cases of the sale or gift of narcotics to minors.

The claim was advanced by Commissioner Anslinger that the facts of drug addiction should not be taught in the schools since this would start more children experimenting with drugs. Although a number of psychiatrists and

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Culture and Mental Disease, with Special Reference to Thailand

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The following ideas have been expressed regarding the occurrence of mental disease in different cultures: 1. Mental disease does or does not occur with the same incidence everywhere. 2. There are or are not variations in the incidence of specific types of mental disease in different cultures. 3. There are or are not variations in the symptomatology of some or all mental disorders in different cultures. A review of the literature shows that most writers limit themselves to one part of this problem and do not discuss all the possibilities mentioned above. A few authors, showing various studies and conclusions, are cited.

Lin,⁹ who did a thorough psychiatric and sociological survey of three Chinese cultures in Formosa for the period 1946-1948, inclusive, found that the incidence of major psychoses and epilepsy did not differ appreciably from that of other countries. On the basis of the criteria for diagnosis in the department of psychiatry at National Taiwan University Hospital, 214 persons, or 10.8 per 1,000 population, were diagnosed as mentally ill.

Some writers claim there is a low incidence of mental disease in primitive societies, and most of them feel that this incidence increases with contamination by other cultures. In his study of the Papuans of New Guinea, Seligman stated¹⁴:

There is no evidence of the occurrence of mental derangement . . . among natives who have not been associated with White Civilization. . . . Apart from brief maniacal attacks . . . the psychoses do not

occur except as the result of stresses set up by white influence.

Carothers,³ in his study of 558 Kenyan Africans, the first admissions to a Kenyan hospital for a five-year period, found the incidence of all disorders except "frenzied anxiety" to be consistently lower than that of American Negroes. The Kenyan admission rate from 1939 through 1943 was 3.4 per 100,000 of the population per annum, as compared with 57 in 1939 in England and Wales, a variation of between 72 and 86 from 1917 to 1933 in Massachusetts, and 161 for Negroes alone in Massachusetts during the same period. After allowing for factors such as the mentally sick or defective being deliberately killed, their being housed in other institutions, their being unnoticed, their being deliberately thrown out of their homes or allowed to wander off, or their being looked after at home, Carothers concluded that these factors could not possibly account for such a small incidence, and hence that mental disease occurs much less frequently among the Kenyan Africans than among American Negroes.

A few observers find variations in the incidence of specific types of mental disease. For example, after Kraepelin observed the Javanese, he said: "The manic-depressive psychoses are definitely less frequent among the natives than among the Europeans, but they are not totally absent."⁷ He further observed that "conditions which we may more or less reliably diagnose as mental epilepsy are relatively frequent. . . . Dementia precox as we define it today was particularly frequent." Upon visiting a mental hospital in Singapore, Kraepelin found almost 80% of the

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Read at the Annual Meeting of the California Medical Association, San Francisco, February, 1959.

RECOMMENDATIONS OF THE GOVERNOR'S COMMITTEE ON MENTAL HEALTH PLANNING

From the Second Year Grant Proposal:

"A planning committee of sixteen private citizen members...was carefully selected by the Governor on the basis of geographic representation and considerations of interest and involvement. The planning committee has been charged with the actual development of the mental health plan. It will review the reports that are developed by special task force groups and by local communities, consistent with the shared intent in the original proposal. This will be a working committee and members have accepted appointment with this understanding."¹

The recommendations of the Governor's Committee follow from the charge in the Second Year Grant Proposal:

"Each of the committee will be responsible for making recommendations to the entire committee on matters relating to the specific problem area assigned to the task force. The committee will then recommend to and advise the Mental Health Division on the types of plans and the means of implementation that will be included in the comprehensive mental health plan."²

The recommendations of the Governor's Committee will be grouped according to the original task forces.

I TASK FORCE ON PROGRAM INTEGRATION

"To study the relative responsibility for providing mental health services, including the respective roles of various State agencies, local organizations, and private practitioners. This committee will have the important responsibility of developing recommendations on the optimal integration of existing services."³

The Governor's Committee adopted the recommendations developed at a meeting in Juneau, April 19-20, of the task force on Program Integration.

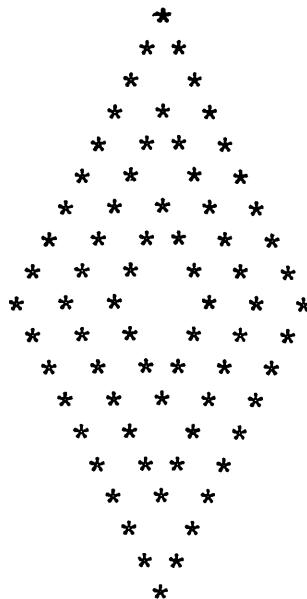
Chairman - William Rader, M.D. - Chairman, Governor's Committee		Anchorage
Levi Browning, M.D.	Commissioner, Health and Welfare	Juneau
Karl Bowman, M.D.	Director, Div. Mental Health	Anchorage
George Spartz	Director, Div. Public Welfare	Juneau
Dove Kull	Supervisor, Child Welfare	Juneau
Thomas McGowan, M.D.	Director, Div. of Public Health	Juneau
Gordon Cavnar	Area Social Worker, BIA	Juneau
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Martin Underwood	Commissioner, Public Safety for Alaska	Juneau
Royce Morgan, M.D.	President, Alaska Medical Association	Anchorage
Fred Bowersox	Youth and Adult Authority	Juneau

¹ Comprehensive Community Mental Health Planning Proposal, May 28, 1964

² *ibid.*

³ *ibid.*

STATE PLANNING AND COORDINATION OF RESOURCES
FOR EXCEPTIONAL CHILDREN



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**STATE LAWS
AND
REGULATIONS
AFFECTING THE**

Mentally Retarded

A CHECK-LIST



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