Present-Day Psychiatry*

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Introduction

As part of the excitement and challenge of our times, psychiatry shares with the rest of human activity a soul-searching, candid questioning of principles and practices and a responsibility for developing new perspectives and patterns of action. During these times when there seems to be a strong swing toward conformity and stereotypy in our society, there is also an intense counteraction—especially in those under 30—of questioning all tradition, respecting no sacred cows. These phenomena lead to heated debates, voices raised in anger, and hot letters to editors; but, through all of the dust raised, I believe we can see encouraging prospects and clearing of the atmosphere—possibly because there has been open disagreement. The late John Courtney Murray is credited with having said, "One of the great difficulties of our time is to ensure disagreement." In present-day psychiatry, we have assured ourselves not only of many unresolved disagreements, but also of ferment from which we can expect a burst of further growth.

Not many years ago it would have been easy to define psychiatry as the medical discipline concerned with diagnosis and treatment of the mentally ill. In the past decade almost every part of this definition has been challenged and, by some, largely rejected. There is the extreme position taken by Dr. Thomas Szasz, who rejects the very notion of mental illness. Less unusual objections either question our systems of diagnosis or look coldly upon our treatment procedures.

At present we find ourselves having to accept an operational definition of psychiatry as the work activity engaged in by a wide range of physicians who are concerned with problems of human existence that present any of the following conditions or any combinations thereof:

1) personal discomfort;
2) behavioral deviation leading to social rebuff and isolation;
3) failure to realize personal and group potentiality for creativity, productiveness, and perceptiveness.

I should be the first to express dissatisfaction and uneasiness about this definition, but I believe that it describes broadly what is meant today by psychiatry.

Another approach to what constitutes psychiatry might use operational definitions describing the locales in which the psychiatric physician practices: for example, state hospitals; private sanitoria; out-patient clinics offering psychosomatic liaison and child guidance in addition to contributing to forensic, industrial and student health, etc. Such designations, however, only tell us *where* psychiatry is, not *what* it is.

An urgent dialogue has developed among psychiatrists as well as between psychiatrists and other professionals over the question of whether or not a medical background is necessary for accomplishing all of the activities, particularly psychotherapeutic, now attempted by psychiatrists. We recognize the problems of deciding whether or not nonmedical psychotherapists should be certified and licensed, thereby being severely limited by state laws. A related question is whether or not nonmedical therapists should be legally required to be supervised by board certified psychiatrists. Some state legislatures already have licensed clinical psychologists as psychotherapists. Moreover, many federal and state mental hygiene clinics are staffed by clinical psychologists who regularly conduct various psychotherapies. Despite these legislative and practical sanctions granted nonmedical psychotherapists, it may be of some profit to reexamine the rationale for a general medical training for psychiatrists. What, if any, are the benefits to the psychiatrist derived from his medical background? After considering this question, I should like to discuss some of the peculiarities of psychiatric medicine as distinguished from the other branches of medicine.

The Value of Medical Education for Psychiatrists

One can identify three types of advantages to the psychiatrist accruing from his medical education. These are: (1) substantive knowledge; (2) technical skills; and (3)

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ethical and attitudinal orientation. In terms of some of his substantive knowledge, the psychiatrist is in a position to evaluate and advise in psychosomatic disorders. His general medical training provides a base for appreciating and understanding the intricacies of psychophysiological reactions. Moreover, he knows through direct observation the impact and effects of various medical and surgical procedures on patients and their families. In addition, a general medical background is a necessity for prescribing and administering drugs and evaluating new psychoactive agents.

Recent advances in neurophysiology and neurosurgery point toward future treatment possibilities that may involve electrode placements or other interventions in discrete brain regions. The psychiatrist's medical background will be much needed in the event of these treatment procedures.

As far as technical skills are concerned, the methods of medical problem solving are important in the practice of psychiatry. I am referring to the repeated experiences of exploring the presenting complaint; assembling the history of the present illness as well as the development and past history of the patient; combining these data with direct observation and examination of the patient's immediate functional status; supplementing this information with special tests; logically correlating all such information into a formulation which summarizes stress, response to stress, special strengths and vulnerabilities; and then predicting the immediate future course of events. Obviously, medical problem solving is a special application of general logical thinking and is not the sole property of physicians. However, the experience gained in repeated exercise of this approach to problem situations is of tremendous value to the psychiatrist. He obtains this skill through his training as a physician.

Other technical skills are those related to the conduct and evaluation of scientific research, both in laboratories and in clinics. Again, these technical skills are not limited to, or even best presented in, general medical education. However, the prolonged exposure to methodology in medical school equips the future psychiatrist with a general scientific orientation which in some ways may extend his effectiveness both as a practitioner and as an independent investigator.

In regard to ethical and attitudinal matters: medical school, internship and medical practice, when honestly pursued, indoctrinate anyone with a sense of responsible commitment to sufferers requesting his assistance; with the realization that such commitments take priority over all other relationships; and with the recognition that life truly presents serious problems that demand the full use of one's intelligence, self-control, and steadfastness. Furthermore, the ancient responsibility of all physicians not only to minister to human suffering, but also to observe it, record it, and share unreservedly any new insights with colleagues, is an ethical charge that psychiatrists assume as physicians. As members of the medical profession, they have voluntarily accepted roles and status which involve accounting to their colleagues and being judged, if necessary, by these colleagues as to the proper or improper discharge of their responsibilities. It is in this latter area that nonmedical therapists cannot provide a truly professional attitude, since there is to date no mechanism for their policing their own activities.

Divergencies of Psychiatry from General Medicine

Let us now consider some difficulties in our medical affiliation. After almost a century of struggling to establish psychiatry as a medical discipline and having achieved a modest degree of acceptance as "card carrying" members of the medical fraternity, we are faced with the disturbing prospect of challenging the accepted medical model.

In the latter half of the 19th century, psychiatry based its claim for medical legitimacy on a family connection with neurology. The very term neuropsychiatry indicated and stressed the medical nature of psychiatry. The advantages of this emphasis were obvious. Inmates of asylums were accorded the status of patients, which, at least hypothetically, entitled them to such privileges as compassionate acceptance, non-judgmental diagnosis, and tolerance of deviant behavior as being evidence of sickness rather than lax morality.

On the other hand, this emphasis on the medical nature of psychiatry resulted in attempts to apply to the study of psychiatric conditions the methods that had been productive in the rest of medicine. For example, the success of cellular pathology in general medicine led to elaborate searches for brain lesions as underlying factors in the mentally ill. The most positive results were those gained through the study of neural changes in general paresis. However, this same approach failed to yield any reliable findings in patients exhibiting schizophrenic, depressed or neurotic behavior. Another mixed blessing stemming from the use of the 19th century medical model was the concentrated attention on the individual patient. The positive result of this was the development of refinements in interviewing and, even more important, in the clarification of transference processes. The negative result of the one-to-one doctor-patient approach was the failure to recognize the weight of family and group dynamic influences as determinants of behavior.

In recent years there has been serious questioning of treatment methods directed toward the pa-

tient abstracted from his milieu. The original concept of mental illness, constructed on the classical medical model, focussed on disturbances in the inner economy, either in terms of defense mechanisms or regression to early levels of personality integration. This point of view reasonably calls for a therapeutic approach directed toward reestablishing healthier emotional equilibria and more mature levels of integration. It assumes that the major impact of therapy must be on the patient himself. Therefore, the treatment maneuvers of hospitalization, individual psychotherapy, drug therapy and shock therapy are viewed as the core of essential and sufficient treatment.

Probably the first breakaway from this approach began in the 1920's in the child guidance clinics. Just as pediatricians found it impossible to treat child patients in isolation from their families, so child psychiatrists learned the futility of an exclusive one-to-one doctor-patient relationship as sufficient therapy for their patients. Successful therapy seemed to depend upon much attention to the actions, strengths, biases, etc., of the parents and other persons in close contact with the child patient. Often the child designated as the patient became symptom-free when the major intervention was directed toward the parents, even when directed by a nonmedical person such as a psychiatric social worker. This radical departure from the medical model did not penetrate the medical profession, possibly because of the isolation of child guidance clinics from other medical centers.

It is interesting that, in the field of non-psychiatric medicine during the first quarter of the 20th century, there was a parallel movement away from the classical medical model in the therapeutic practices offered in tuberculosis sanatoria. In some ways the TB sanatorium represented one of the first therapeutic communities in which the total activity of the hospital was geared to treatment purposes; all persons—physicians and non-physicians alike—were engaged in assisting the patient to overcome his illness. Isolation, often in high mountains and rural areas, kept this approach from influencing the rest of medicine.

Freud's Position vis-à-vis Medicine

In basing psychoanalysis on a theory of instinct, Freud remained well within the 19th century medical model; however, when he extended this theory to include the vicissitudes of instinctual expression, he directed attention to social and psychological dimensions outside traditional medical purview. Moreover, in stressing early family experience as the breeding ground of neurosis, Freud was introducing a new schema for conceptualizing disease. Now, almost 70 years later, psychiatry is more fully accepting the implications of this idea by seriously attempting family psychotherapy.

Another early break with the classical medical model which marked the psychiatrist as a different sort of physician from all others was the view of certain symptoms as symbols, i.e., as having communicative and emotionally expressive meanings. The psychiatrist became a new breed of physician when Freud proposed in his monograph, *Studies on Hysteria,* that the symptoms of hysteria were not the end result of nerve dysfunction but, instead, were the symbolic statement of a conflict between the patient's wishes and his conscience, and, still further, that this conflict was obscured by a meaningful amnesia. Any physician who accepted this thesis was committing himself to a new path in theory and in therapy that has led far from traditional medical practices.

In his own professional life Freud seems to have tried to retain as much of the medical model as possible, especially in such matters as intense stressing of the one-to-one doctor-patient relationship, the ultimate in strict confidentiality, and the attempt to maintain high objectivity. He departed considerably from general medical practice by assuming a very passive role—eschewing the laying on of hands, avoiding giving medications or advice, restraining the impulse to reassure, and insisting that the patient take a responsible role in his own treatment. In the area of theory Freud tried valiantly to remain true to the medical science of his day and devised the libido theory as a psychological extension of the mechanistic approach of the Helmholtz School of Physiology. Moreover, by his dogma of strict determinism he also kept psychoanalysis and dynamic psychiatry within the same philosophy as that underlying the rest of medicine. However, Freud's eventual stress on the primacy of the resolution of the transference neurosis as the necessary therapeutic maneuver transposed psychiatry into a dimension different from any other in medicine; that is, in stressing the doctor-patient relationship as the chief element in therapy, Freud departed from the older medical model, which saw the doctor-patient relationship as the art through which scientific methods could be applied.

To some degree all dynamic psychiatrists who engage in individual psychotherapy differ, as did the pioneer Freud, in the aforementioned ways. One either must extend the concept of the physician's work to include these psychotherapeutic innovations or must recognize that psychiatrists, although similar to other physicians, are also significantly dissimilar.

The Existential Analysts

In very recent years the group of psychiatrists who variously call themselves existentialists or onto-

analysts have openly rejected the suggestion of compromise with classical medicine made not only by their colleagues, but also by Freud. To stress in their psychotherapy the matters of decision making and choice places them quite counter to the thesis of strict determinism. They object to the dehumanizing effects of the medical model on both the patient and the doctor. They strive for a therapy in which the issue of authenticity of character is seen as the central goal rather than the resolution of a transference neurosis. They claim a concentration of attention on the unique existence of each patient and are not concerned with such medical matters as diagnostic classification and cataloging of symptoms. Moreover, their insistence upon the singularity of each patient leads logically to a studied ignoring of statistics. Some representatives of this group do not hesitate to express indifference to charges of being unscientific, because they claim that medical and scientific analyses impede their understanding the person as *being* and *becoming*.

It is quite interesting that their insistence on an unbiased view of the raw material of human existence, that is, their attention to subjective phenomena, has actually cleared up certain diagnostic problems such as differentiating varieties of depression.

Behavior Therapy

At another pole from the existentialist, one finds a group of psychiatrists who approximate the medical model far more than most. These are the behavior therapists who concentrate their attention on symptoms, who are satisfied with modest treatment ambitions such as the relief of phobias, and who base their work on a modified Pavlovian neurophysiology. They seem little concerned with symbolism and accept symptoms at face value. Their approach and theoretical stand are almost as simplistic as those of their medical colleagues' common sense psychology. This group remains more faithful to strict scientific methods, for example, in their statistical conservatism, than most other psychiatrists.

To return to our tentative definition, we can see a wide range of physicians who engage in psychiatric work. But, at the same time, it becomes clear that most psychiatrists do stray from the usual paths followed by other doctors.

An Extended View of Suffering

In the definition offered, I mentioned personal discomfort as one of the problems of human existence about which psychiatrists are concerned. Now, to some extent this discomfort is very similar to that which engages the efforts of other physicians. Unusual and painful sensations, as well as physical dysfunction, may represent the end products of certain existential problems. Clinically, there is an overlap in diagnostic work associated with many of the symptom complexes of conditions such as hypochondriasis and depression. However, psychiatrists have pushed far beyond usual medical concern into areas of human discomfort experienced as lack of self-confidence, self-disgust, masochism, despair, disillusionment, apathy, etc. These matters are distressing and uncomfortable as ongoing features in any human life experience, and psychiatric concern about them parallels that of the clergy, educators, moralists, artists, and humanists, rather than that of medical men. In other words, those physicians whom we call psychiatrists frequently share their concern in an intellectual and social community with nonmedical professionals. It is over these issues that Dr. Szasz seems exercised. His claim that it is logically incorrect to equate mental illness with physical discomfort stems from his recognizing fundamental differences in kind in the varieties of human suffering.

In fully accepting as factual these differences—that is, fundamental qualitative differences between mental and nonmental illness—we must honestly reflect on our own attempts to establish a professional monopoly on the treatment of mental suffering.

The Social Aspects of Emotional Illness

In reflecting on the nature of psychiatry, it seems to me that one must repress his awareness of many aspects of mental and emotional illness if he is to adhere to a strict biological and medical point of view. In sharp contrast to other forms of illness, mental illness is always a social matter; that is, it always involves other persons in addition to the designated patient. As the members of the interpersonal school of psychiatry have demonstrated, some of the most troublesome aspects of psychiatric illnesses are communicative disturbances. The patient's deviance is in one way or another expressed as difficulty in transmitting, receiving, and decoding messages to and from others. Psychiatrists, perforce, must depart from a medical base and associate themselves with social scientists and communication theorists until the time when nonpsychiatric physicians adopt a general systems theory in their thinking and action.

Because of the social facet of psychiatric disturbances, psychiatrists treat many patients through a process of social and legal intervention rather than voluntary contract. Our medical and surgical colleagues rarely, if ever, undertake the treatment of a patient on legal injunction. In fact, aside from a few laws requiring immunizations, society does not prescribe medical procedure except in our field. This matter has again been considered by Dr. Szasz, who misinterprets it as a conspiracy joined

by psychiatry and the law to penalize the social deviant and strip him of his civil liberty. Although this interpretation seems extreme and false, nonetheless, it has pointed up a very fundamental difference between much of psychiatric practice and that of other physicians.

On a far less dramatic level than that concerned with commitment policies, there has been increasing psychiatric concentration on the dynamics and derivative therapies of various social groups: the hospital ward population, the family, and even neighborhood networks. The tremendous thrusts toward community mental health approaches as well as the growth of milieu, group and family therapies seem to have exploded forever the exclusive one-to-one doctor-patient relationship as the *sine qua non* of treatment. With these changes, psychiatry finds itself either far ahead of or far away from the rest of medicine. There is very little in the general medical curriculum that involves medical teachers and students in community networks such as those into which we are moving. Consequently, for the average physician, psychiatry may become even more strange and difficult to comprehend than it was only a decade ago.

Who Should and Could Do Psychiatric Work

I should like to digress at this point for a few moments to consider the inherent difficulties in teaching psychiatry under present-day circumstances and the associated problems of recruiting present-day graduates into our field. Despite the pious pronouncements in the catalogs of most medical schools which claim to present a comprehensive approach to patients, in actual practice this is not the case. In fact, with the tremendous accumulation of substantive information in most fields of medicine, there is much anxiety about finding curriculum time to teach these new facts to each student. This attempt leaves little time or program for a comprehensive approach. In addition to this difficulty we find that, with the development of full-time medical school faculties, much of the teaching devolves upon highly sophisticated clinical researchers whose work divorces them from the view of the patient as a total human being in his environment. With few exceptions, faculty psychiatrists seem to be the only medical school teachers presenting a comprehensive approach. In other words, we are struggling against the main current and, consequently, appear as nonconformists on medical faculties. When we add to this the facts which Dr. Harold Lief has described—that the majority of medical students are intellectually and emotionally conservative persons—we should not be surprised that the comprehensive point of view recommended by psychiatric faculties is ignored in favor of an overwhelming disregard by other teachers.

After 20 years of earnest attempts to have psychiatry incorporated as a major part of the undergraduate curriculum, we continue to meet disheartening resistance and rejection by most students. This fact has been detailed in a recent survey in which it was found that only 3% of recent graduates thought that psychiatry was a relevant subject in their studies.

Consequently, one can see the serious problems of recruiting new blood into our ranks. These sobering facts impel me to share some thoughts with you about who can and should do psychiatric work. This question becomes almost painful to those of us responsible for residency training programs. On the one hand, we are faced with the necessity of offering training experience to as many young physicians as we can gather from a population of medical graduates who lack motivation for, interest in, curiosity about, or the capacity to assimilate a psychiatric point of view. On the other hand, we must assume the responsibility for not accepting candidates who cannot actually learn to function as psychiatrists must.

Fundamentally, any physician in the last third of the 20th century who elects to be a psychiatrist should possess or acquire most of the following characteristics. Along with an ability to maintain an objective point of view toward the accumulating data in our field, he must be flexible enough not to be afraid to use empathic, imaginative, and subjective hunches about his work.

Because of psychiatry's immaturity as a discipline and its high state of ignorance about human behavior, one aspiring to practice psychiatry must be mature enough to live and work with considerable uncertainty. No one who requires the high degree of certainty which one obtains from standardized laboratory tests should enter psychiatric work, for we have not arrived at a point of closure in our knowledge. On the other hand, the young physician who can work comfortably while uncertain will find great opportunity for original creative work in the open-ended field of psychiatry. To put it in our own clinical jargon, psychiatry is no place for a compulsive character, since he will be threatened repeatedly by doubt and indecision arising from the lack of firm guidelines.

Anyone aspiring to be a psychiatrist has an advantage if he can move intellectually with fair ease in humanistic studies and the social sciences as well as in basic biology. Now, this broad span of intellectual interest is not commonly found among the majority of medical graduates. A fine example of the universal, intellectual man was Freud, who combined humanistic interests in language, the Greek classics, and mythology with a good working knowledge of the British social philosophers from Hobbes

through Mill, and yet managed to become a master in his researches in microscopic neuroanatomy. Since psychiatry must take as its objective the study of man as man, then psychiatrists must be acquainted with man's works in the humanities, his various methods of social affiliation, as well as the physiological apparatus by which he lives. This is a vast and at times almost overwhelming task, particularly in a world in which the accumulation of knowledge is accelerating in an exponential manner. A recent brief note by a psychiatric resident in *Psychiatric Opinion* expressed rather plaintively the shock experienced by many young physicians upon entering psychiatric studies. He asked that his teachers try to confine themselves to biologic and medical approaches and to present other matters in as gentle a fashion as possible. In reading his complaints I thought the author lacked the intellectual stamina called for in psychiatry, since he was asking for a watered-down version of necessary training.

Because it is not centrally located in the medical "establishment," psychiatry is a field in which one can continue to be curious and skeptical about man, entertaining all kinds of notions about human behavior. Emotionally, if not physically, one can experience the satisfactions of the life of an explorer rather than of a comfortably settled inhabitant. Something of the qualities of a pioneer are valuable assets in any candidate aspiring to psychiatry. Those who, figuratively, want to sleep soundly in well-made beds of theory and practice should avoid the wide open spaces in which psychiatrists must roam.

It seems to me that anyone who is electing psychiatry must have the courage to be a minority member of the medical fraternity. He must face the displeasure of his medical colleagues when his ideas and practices jar their composure. That is, he must be man enough to stand up for his convictions even though this costs him considerable popularity. (I always warn applicants for psychiatric residency that they will enter a field in which they will not gain great popularity, but in which it is quite real and possible to obtain respect and self-respect.)

Ideally, the candidate for training in psychiatry should be able to accept the social and professional responsibilities of being a physician while renouncing, as far as humanly possible, the special privileges associated with membership in a guild. Specifically, I am referring to the responsibilities of caring for distressed persons regardless of their position in society; maintaining a non-censuring and non-judgmental attitude toward patients and their families; evaluating social change in terms of its benefits for the preservation and improvement of health; and conducting oneself in a way that may serve as an example of mature and healthy action; at the same time not exploiting the misfortunes of another for one's personal gain in terms of prestige, power, and/or possessions.

The ideal psychiatrist should be one who does not feel alarmed by the knowledge, ideas, or criticisms offered by professionals outside his own group. He should be able to recognize the value of information gathered by neurophysiologists, psychologists, social scientists, poets, and all persons concerned with the vagaries of human behavior. To cite an example: the open-minded psychiatrist will find delight in the work of the ethnologists, particularly those who are making fresh observations on the behavior of our close primate relatives. The ethnologist Konrad Lorenz has joined us in concern over the issue of aggressive behavior. His monograph on aggression has been informative and interesting to most psychiatrists who study human violence. I cite this as an example of the rewards that come to those psychiatrists who can respect and examine the thoughts and opinions of knowledgeable persons in fields other than psychiatry.

With the movement toward community mental health services, it will be especially helpful to train in our own field those men who can work productively with other professionals and still maintain their own identity. To accomplish a team approach, future psychiatrists will have to occupy leadership positions without becoming dictatorial. Only a combination of humility and true respect for the integrity of other team members will accomplish community mental health goals.

To continue, in thinking about who should do psychiatric work, it seems to me highly important that a psychiatrist be a person capable of independent study which he can organize and sustain throughout his entire career. In any intellectual pursuit as incomplete and unfinished as psychiatry, one must remain a student forever. If we consider the history of psychiatry over the past 20 years, we can see how necessary it is for a psychiatrist to pursue unrelentingly his studies of behavior. During these 20 years, we have been deluged with information about many new concepts: group dynamics; group psychotherapy; psychopharmacology; a new neurophysiology which has introduced us to the reticular activating system, motivational physiology, sensory deprivation and physiology of sleep; family process and family psychotherapy; behavior therapy; communication theory, etc. I doubt that in a comparable time practitioners in any other medical field have had to master so many new concepts and so much substantive information. It is a most valuable asset to any psychiatrist to conduct independent study in a critical and benevolently skeptical fashion. Again, the experience in medical school until very recently has not been one to encourage such scholarship, since most medical teaching is of a lockstep variety.

Still another important capability

of anyone doing psychiatric work is the ability to study oneself as an object. Almost 2400 years ago Socrates stated, "The unexamined life is not worth living." Few persons systematically undertake a continuing examination and evaluation of their own lives. There may be some grounds for contesting Socrates' statement, although I believe no man can be considered truly mature who has not devoted great effort to self-understanding. In a psychiatrist, continuing self-scrutiny is imperative. Many of the reasons for this necessary introspection have been detailed for years in the psychiatric literature. It is still debatable whether or not all psychiatrists should personally undergo some form of psychotherapy. Certainly most psychiatrists who have undertaken personal psychoanalysis have found this experience of extreme value in their individual and professional development.

To be introspective is not typical or characteristic of most physicians; they are usually oriented outwardly, and their training, aside from a touch of psychiatry, has in no way encouraged introspection. So, again, we find a significant difference between the psychiatrist and the non-psychiatric physician.

Closely related to the introspective study of oneself is the understanding of symbolism. There is a need to comprehend the symbolic qualities of human life. Most psychiatrists agree that Freud's greatest contribution was his classic on symbolism, *The Meaning of Dreams*. Each of us in psychiatry has known some physician whose attempts to master our field foundered on the rocks of symbolic communication. The successful psychiatric resident is the one who, in some way or other, has managed to maintain responsiveness to symbolism despite the great emphasis of his medical education on literal-mindedness.

In addition to possessing the ability to understand symbolism, the psychiatrist must continue to cultivate it throughout his career. He must increase the acuity of his third ear. To do so involves him in exposure to such nonmedical influences as poetry, novels, the graphic arts, and other symbolic expressions of human existence. Again, he must have the courage to follow these stars, although they may at times estrange him from his medical colleagues.

Finally, those who would do psychiatric work should be those who recognize both the tragic and comic aspects of life and can focus on these rather than on the banality of pathos. Again, we can reflect on the history of Freud, who clearly distinguished between what was tragic and what was pathetic but did not lose his capacity for laughing with the comic. Perhaps the greatest reward of introspection is the discovery that one can laugh with oneself about one's own absurdities. No patient is more unfortunate than he who has to trust himself to a humorless psychiatrist, and none more fortunate than he who finds a therapist who can join him in a tolerant and delighted chuckle over our human comedy.