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Study of the integration of psychiatry and general medicine in Nebraska

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A STUDY OF THE INTEGRATION OF PSYCHIATRY AND GENERAL MEDICINE IN NEBRASKA

By

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

A STUDY OF THE INTEGRATION OF PSYCHIATRY AND GENERAL MEDICINE IN NEBRASKA

Introduction and Purposes

Recent trends in psychiatric treatment include a general increase in the demand upon all psychiatric facilities and a corresponding increase in the reliance upon the family physician for treatment of a psychiatric nature. Several explanations are offered. Financially, it is now more feasible to obtain these services because the standard of living has increased more rapidly than the cost of psychiatric treatment, and greater insurance coverage is available for psychiatric disabilities. Demands for psychiatric treatment have also increased because of greater emphasis on the emotional involvement in all illness and on the relationship between early treatment and improved prognosis. In addition, the general public is more prepared to admit to their emotional problems due to the promotion of a better image of the psychiatrist and psychiatric treatment. The public expect treatment for their emotional problems and in many cases turn to their general physician for care of the psychiatric type.

There are several reasons why frequently the general physician is the first, and perhaps the only, medical person who will confront the patient with an emotional problem.

Obviously, the greater number of general physicians allows the patient readier access to his care. But there are more subtle reasons. A greater stigma is attached to seeing a psychiatrist than any other specialist; most patients would still prefer to have a major physical illness than to admit to having a minor mental disability. Similarly, visiting a general physician may be an attempt to avoid undesirable complications which are anticipated because of the prejudices of other persons. The separation of physical and emotional complaints is frequently not discrete, and psychological stresses and strains of daily interaction often manifest themselves as physiologic complaints, leading to a visit to the family practitioner, with whom the patient has already established a comfortable relationship.

Several studies have been done which show that the family physician is capable of treating the majority of emotional disorders. He is in an ideal position to detect the early signs of mental illness at a time when the treatment and prognosis are most favorable. He also plays an essential role in the post-hospitalization follow-up treatment of the psychiatric patient when he returns to his home community. Consequently, the isolation of psychiatry from the general practice of medicine can only act to the detriment of the patient.[1]

This has resulted in a major effort for the integration of psychiatry into the comprehensive medical management of all patients. A greater cohesion between the psychiatrically and the non-psychiatrically oriented physician would not only allow the non-psychiatrist the opportunity to utilize his talents and training more completly, but would also help to avoid the progression of illness to a point of fixation, unyielding to psychotherapeutic efforts.

It bears re-emphasis that there must not be a separation of the psyche and soma because these two entities are highly integrated components of each individual. A large number of patients have minor emotional disturbances which do not require the services of a psychiatrist. On the other end of the spectrum are those patients whose illness is of such a degree that treatment is possible only in the hospital setting; these patients are almost entirely within the realm of the psychiatrist. Between these extremes there are those patients whose mental illness is more acute, more subtle, or less threatening to society. To this group, the integration of medical and psychiatric care is most essential.

The Executive Committee for Comprehensive Long Range Mental Health Planning in "Nebraska Long Range Mental Health Plan" has made the following statement:

> The integrated management of the mentally ill should extend from the family physician to the most complicated forms of treatment as is possible in the private and state psychiatric hospitals. This entails systematic instruction, training and involvement of family physicians in the local management of their patients through the clinics and hospitals....
>
> We are all agreed that there are not enough psychiatrists at the present time nor will there be in the foreseeable future, to enable them to be the sole medical practitioners dealing with psychiatric illness. Thus if the treatment of the medical aspects of the illnesses are not to fall, by default, into the hands of those outside the medical profession, the non-psychiatric physician must deal with many of the psychiatric problems of his patients.
>
> ....This brings into focus more clearly the need for family physicians and medicine in general to be in closer juxtaposition with psychiatry, enabling the family physician to share responsibility in mental health work.[7]

Obviously, the practice of a generalist cannot entirely be directed toward the area of psychiatry. As Dr. R. H. Kampmeier, an internist, has stated,

> Even though in theory the family physician should encounter the major burden of psychiatric problems in practice, this quite obviously is not true, since this facet of his practice is also diluted by the other items he gathers to himself in practice -- acute infections, 'minor' surgery, normal obstetrics, preventive medicine (immunizations) and, in fact, the whole spectrum of human ills.[8]

The above ideas were the impetus for this study. We were motivated by the desire to ascertain the present degree of integration of psychiatry and general medicine in Nebraska, by discovering what role the family physician

is now playing in psychiatric care as a part of total comprehensive medical care of the citizenry of this state.

Methods

In this study, we felt that the best way to determine how active a part the generalist is playing in the practice of psychiatry was to contact him personally and enquire of him. To assure a random sample of physicians, the American Medical Directory was utilized.[2] Using the listing of Nebraska physicians who specified general practice as their emphasis, every third name was selected and that physician was mailed a questionnaire.

The first question requested the physician to estimate what percentage of his patients had major psychiatric difficulties; "major" was emphasized in an attempt to eliminate persons who are primarily unhappy and need someone to whom they can talk. Questions two and three concerned age and sex of these patients for demographic information. Question four concerned treatment without referral and was designed for a description of the severity of illnesses in relation to the capabilities of the physicians. The fifth and sixth question were included to determine the approximate amount and type of treatment the general practitioner offers. Questions seven and eight were designed to determine whether or not availability of psychiatric facilities influenced referrals. The ninth question was utilized in dividing the questionnaires on the basis of whether or not the physician had participated in post-

graduate psychiatric training. The final question dealt with an evaluation by the general practitioners of available psychiatric facilities in Nebraska.

After the completed questionnaires were received, the results were tabulated. These figures provided the totals for all of the physicians from whom a questionnaire was received. Then the questionnaires were subdivided. The subdivision was based first on location and secondly on whether or not a post-graduate course in psychiatry had been taken. The separation by location depended on whether or not the location of the practice of the physician fell within a twenty-five mile radius of an established psychiatric treatment center. The centers used were based on the report of the Executive Committee for Comprehensive Long Range Mental Health Planning.[7] Those chosen were Omaha, Lincoln, Norfolk, Hastings, North Platte, and Scottsbluff. The first four have state hospitals and out patient clinics as well as privately practicing psychiatrists. The last two have state clinics. Thirteen general hospitals in Nebraska offer hospitalization facilities to psychiatric patients; these are all located in the previously mentioned cities.

Limitations

Any study done must be interpreted in the light of its limitations. Physicians within a twenty-five mile radius of the treatment centers previously mentioned were considered to be within adequate proximity of these facilities to allow easy referral and to prevent distance from being a major factor in the choice of treatment. Twenty-five miles is admittedly arbitrary. The separation between those physicians with post-graduate training and those without is also somewhat artificial because of the varying lengths and depths of these courses. Another limitation is the probability that physicians who sense a greater need in the area of psychiatry are perhaps more likely to have answered the questionnaire; this would tend to skew the results for greater emphasis on psychiatric problems and treatment.

The results of the study are presented with these limitations and reservations in mind.

Results

Two hundred one questionnaires were mailed to physicians throughout the state of Nebraska. A total of one hundred twenty-nine or 64.2% of those sent were returned. Ten of those returned were not useable because they were incomplete. Of the original two hundred one, one hundred nineteen or 59.2% were useable questionnaires.

Of the one hundred nineteen answers to the questionnaire, forty-eight or 40.6% indicated that they had taken part in a post-graduate course in psychiatry, seventy or 59.4% indicated they had not, and one was unanswered. Fifty-two questionnaires or 43.6% were returned from cities having major psychiatric facilities, sixty-five or 54.6% were returned from outside the defined area, and two or 1.7% could not be located. Occasionally it will be noted that total questions answered is less than 119; this is because of omitted answers. It should also be noted that in some cases multiple answers were received.

The results of the study are as follows:

Table 1. Answers to question no. 1: What is the approximate percentage of your patients whose major problem is a psychiatric one?

Answers	All useable questionnaires		With post-graduate course		Without post-graduate course	
	No.	Percent	No.	Percent	No.	Percent
a. 0- 5%	39	33%	6	13%	33	47%
b. 5-10	26	22	15	31	11	16
c. 10-15	15	13	8	17	7	10
d. 15-20	14	12	5	10	9	13
e. 20-25	9	8	3	6	6	9
f. 25-30	0	0	0	0	0	0
g. 30-35	5	4	3	6	2	3
h. 35-40	5	4	4	8	1	1
i. 40-45	3	3	3	6	0	0
j. 45-50	1	1	1	2	0	0
k. >50	1	1	0	0	1	1
Total	118		48		70	

Table 2. Answers to question no. 2: Which sex predominates?

Answer	No.	Percent
Male predominating	4	3.4%
Female predominating	107	90.0
Neither sex predominating	8	6.7

Table 3. Answers to question no. 3: Which age group predominates?

Answer	No.*	Percent*
a. 0-10 years	0	0%
b. 10-20	4	3
c. 20-30	13	11
d. 30-40	40	34
e. 40-50	63	53
f. 50-60	13	11
g. 60-70	10	8
h. >70	4	3

* multiple answers

Table 4. Answers to question no. 4: Of all the patients referred to above, what is the approximate percentage which can be treated without referral?

Answer	All		<25 mi.		>25 mi.	
	No.	Percent	No.	Percent	No.	Percent
a. 0- 20%	22	18%	10	20%	11	17%
b. 20- 40	8	7	5	10	3	5
c. 40- 60	21	18	12	24	9	14
d. 60- 80	40	34	16	31	23	35
e. 80-100	26	22	8	16	18	27

Table 5. Answers to question no. 5: What is the approximate number of hours per week which you spend in treating those patients?

Answer	All		Course		No Course		<25 mi.		>25 mi.	
(hr/wk)	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.
a. 0- 5	47	40%	12	23%	35	49%	24	47%	22	34%
b. 5-10	36	30	15	32	21	30	16	31	20	31
c. 10-15	26	22	15	32	11	16	7	14	19	30
d. 15-20	6	5	4	9	2	3	2	4	3	5
e. >20	3	3	2	4	1	2	3	6	0	0

Table 6. Answers to question no. 6: What is your principal method of treatment of all these patients?

Answer	All*		Course*		No Course*		<25 mi.*		>25 mi.*	
	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.
a. Drugs	91	77%	32	68%	59	84%	39	76%	50	76%
b. Conferences p.r.n.	72	61	30	62	42	60	30	59	42	64
c. Scheduled conferences	9	8	7	15	2	3	3	6	5	8
d. General hospital	5	4	2	4	3	4	1	2	4	6
e. Referral	18	15	7	15	11	16	12	23	6	9

* multiple answers

Table 7. Answers to question no. 7: In the last 12 month period, about how many patients have you referred for psychiatric treatment?

Answer	All		<25 mi.		>25 mi.	
	No.	Percent	No.	Percent	No.	Percent
a. 0- 5	30	25%	9	17%	21	33%
b. 5-10	51	43	23	44	27	42
c. 10-15	18	15	8	15	9	14
d. 15-20	10	9	5	10	5	8
e. >20	9	8	7	13	2	3

Table 8. Answers to question no. 8: To whom were the majority referred?

Answer	All		<25 mi.		>25 mi.	
	No.	Percent	No.	Percent	No.	Percent
a. Private psychiatrist	84	71%	38	78%	44	67%
b. Private clinic	0	0	0	0	0	0
c. State clinic	25	21	11	22	20	30
d. State hospital	19	16	5	10	14	29
e. Other	1	1	1	2	0	0

* multiple answers

Table 9. Answers to question no. 9: Have you participated in a post-graduate course in psychiatry since you entered practice?

Answer	All		<25 mi.		>25 mi.	
	No.	Percent	No.	Percent	No.	Percent
Yes	47	40%	17	35%	30	46%
No	70	60	35	65	33	54

Discussion

In our consideration of the data which has been presented, it must be re-emphasized that these figures are based upon estimates and statistical analysis is not applicable; hence, our discussion can only draw inferences and speculations rather than conclusions.

The first question in the questionnaire asked the local physician to consider what percentage of his patients had a psychiatric problem as their major problem. The results of this question have been tabulated previously in Table 1. This table shows that thirty-nine of the answering physicians or 33% indicated they felt that from zero to five percent of their patients had problems primarily of a psychiatric nature; in considering all the questionnaires, this is the largest single group. This percentage gradually falls with each succeeding 5% interval until no physicians estimated that 25 - 30% of their patients had primarily psychiatric problems. Thus, the total population of physicians is divided into two groups: The approximately 88% who felt that less than 25% of their patients had primarily a psychiatric problem, and the approximately 13% who felt that greater than 30% of their patients had a major psychiatric problem. We will consider some possible explanations for the biphasic nature of this distribution.

1. Variation in patient population. The type of patients which are treated by one physician are likely to be quite different from those seen by another for a variety of reasons, but primarily because the patients with a psychiatric problem would tend to migrate to those physicians demonstrating facility in this area.

2. Variation in interest and training of physicians. The inclinations, style, and personal qualities of a physician are intangible factors, impossible to evaluate, which would influence the nature of his practice. We have attempted to make some comparison, however, using as a basis post-graduate psychiatric training. Figure 1, below, demonstrates a correlation between number of psychiatric patients seen and the degree of psychiatric training. After having had a post-graduate course in psychiatry, relatively few physicians (13%) indicated that only 0-5% of their patients had primarily psychiatric difficulties, while without the training, 47% stated that only 0-5% of their patients had an emotional basis for their visits. After this large initial difference, the curves become more coincidental. However, the curve representing those physicians with post-graduate training is more definitely biphasic, perhaps due to limitation of practice. These figures demonstrate a tendency for the physicians with post-graduate training to recognize psychiatric problems in a larger percentage of their patients.

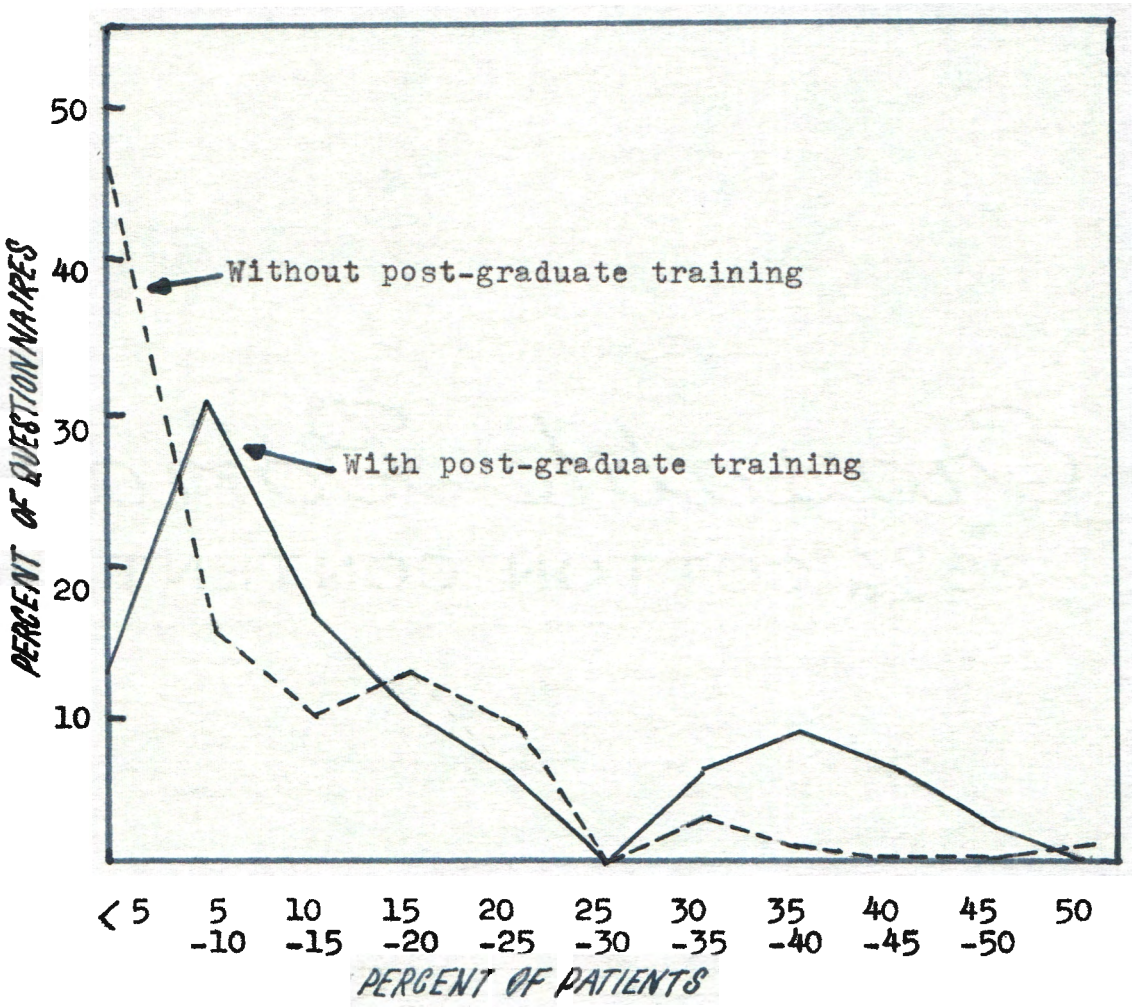

Figure 1. A comparison of the effect of post-graduate training in psychiatry on the estimated percentage of patients whose major problem is psychiatric.

3. Variation in interpretation. The interrelationship of organic and psychologic disease is so complex that the word "major", as mentioned in the question, is open to considerable variation of interpretation.

Our study, as shown in Table 2, indicated that a large majority of the physicians who were polled felt that women predominate in those patients contacting them for problems with an emotional etiology. An earlier study entitled, "A Census of Nebraska Residents Treated by Psychiatrists for Psychiatric Disorders during 1963" is contrasted with our data.[3] The 1963 study showed that of all patients treated in 1963 by psychiatrists (17,877), 9,153 or 51% were male and 8,724 or 49% were female. Although our evidence is insufficient and bias has not been eliminated, it would be reassuring to assume from our data that the more frequent consultation of the family physician by the women serves as a factor in preventing their illness from reaching a degree of severity requiring more specialized treatment.

The same study previously referred to found that the largest percentage of patients in psychiatric treatment was in the 30-39 year age group, followed closely by the 40-49 year group. Our data, listed in Table 3, also reflects this finding, although we found the 40-50 year group predominating, followed by the 30-40 year group. Using the same reasoning which we applied to sex predominance,

one might expect a contrast rather than a parallel between predominating ages of the patients treated by a psychiatrist and those treated by the non-psychiatrist.

From our study, it would appear that the majority of physicians felt competent to handle most of the patients who presented to them with primarily psychiatric problems. Sixty-six physicians or 56% felt that they could handle more than 60% of these patients, as shown in Table 4. Although there was not a considerable amount of difference, Figure 2 demonstrates that more physicians who lived 25 miles or more away from a major psychiatric center indicated that they felt they could handle a larger percentage of these patients than those who lived nearer facilities. Perhaps the physicians without ready access to treatment centers are compelled to treat without referral whereas those closer to a psychiatrist find referral more satisfactory than attempting their own treatment. Table 7 lends some support to this hypothesis by demonstrating that those physicians within 25 miles of psychiatric treatment centers also indicated that they made a greater number of referrals, 38% making more than ten referrals as compared to 25% for those in more out-lying areas.

The data in Table 5, which represent the approximate number of hours per week spent in psychiatric treatment are diagramatically represented in Figure 3. An interesting

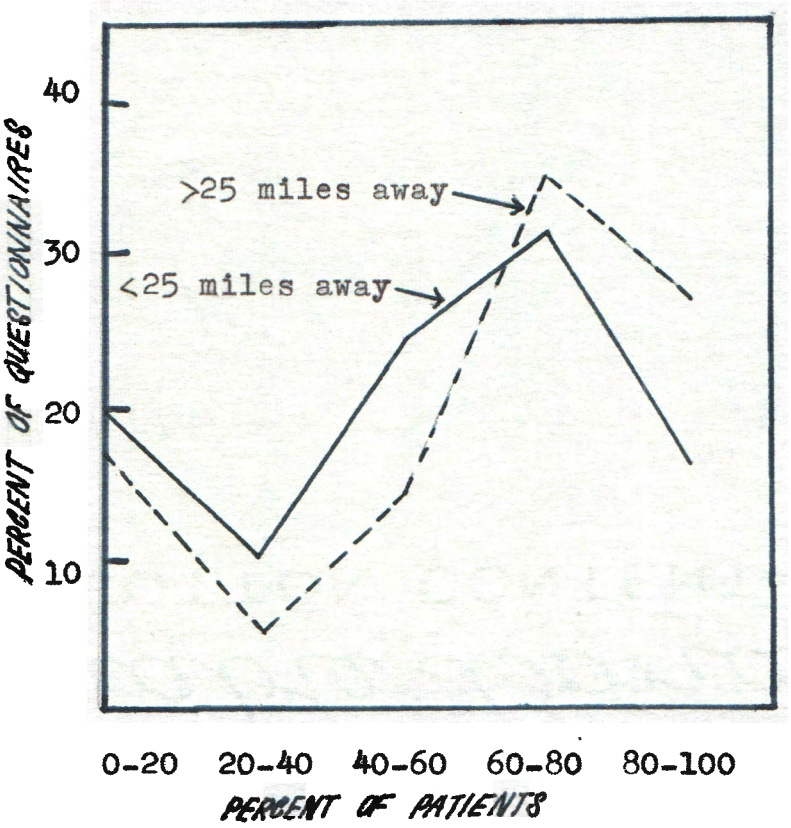

Figure 2. A comparison of the effect of distance away from major psychiatric facilities on the estimated number of patients with psychiatric problems who can be treated without referral.

comparison can be made from this figure. Those physicians having taken a post-graduate course in psychiatry and those living greater than 25 miles away from psychiatric facilities indicated that they spend about the same amount of time in treating emotional problems, a relatively greater amount than those without the additional training and those with easy access to referral. Although Table 9 domonstrates that 46% of the physicians outside the predefined area had further training as compared to 35% inside the 25 mile radius, the similarity of these curves is greater than might be expected on this basis alone.

The principal methods of treatment are summarized in Table 6. It was found that 91 physicians or 77% used drugs as their principal method of treatment and this figure was not influenced by regional distribution. However, in those who had had a post-graduate course in psychiatry, 68% indicated that they used primarily drugs, while a total of 84% of those without post-graduate training indicated that they relied chiefly on drugs. The physicians with post-graduate training are perhaps more aware of what Dr. Kampmeier has said:

> It has been established that many disappointments in treatment of psychiatric illness have resulted from the incorrect choice of drug, inadequate dose levels, too short treatment periods, and the failure to understand drug treatment as but one phase of the comprehensive

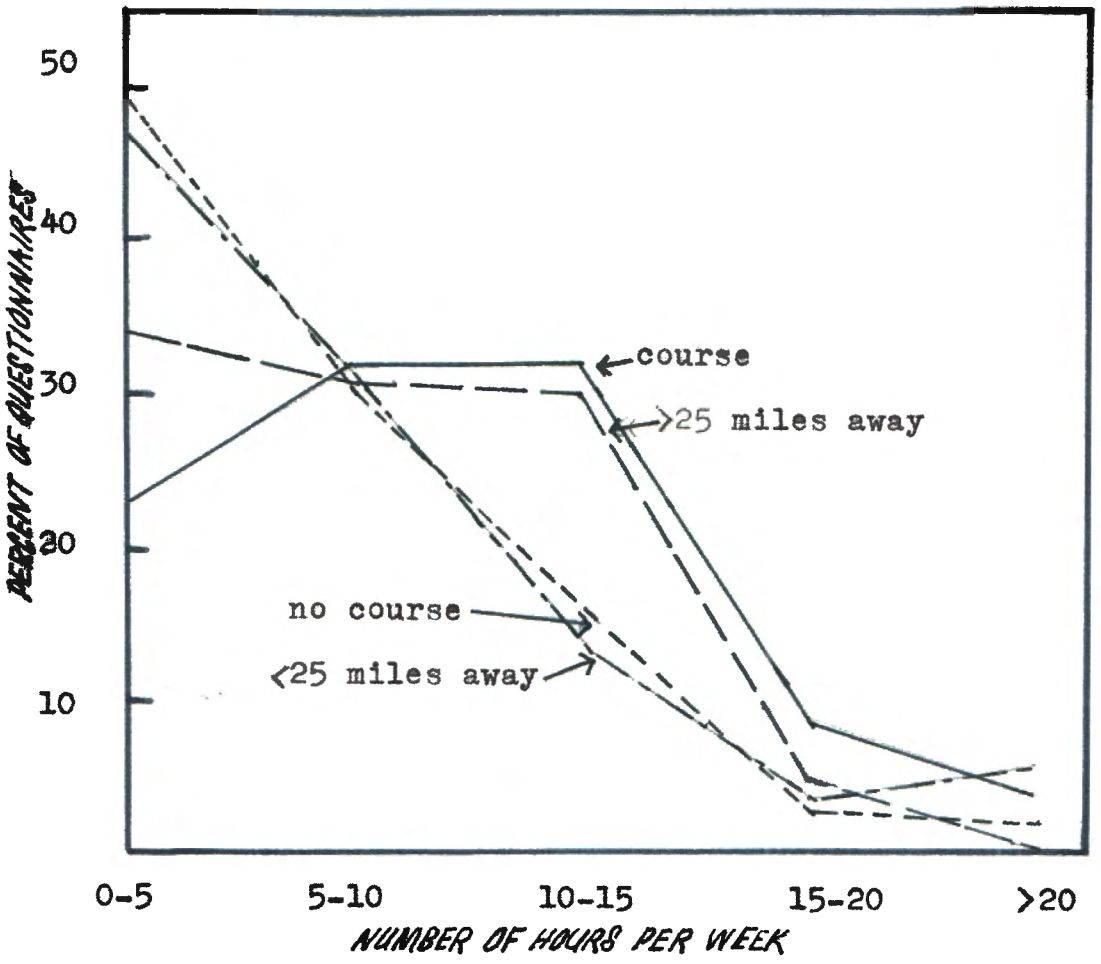

Figure 3. A comparison of the effect of distance away from major psychiatric facilities and of post-graduate training on the estimated number of hours per week spent in treatment of psychiatric patients.

> care of the patient in which the doctor-patient relationship is an integral part....
>
> Psychotherapeutic drugs are best used symptomatically as a part of the total treatment of the patient. They are never a substitute for an understanding and meaningful interpersonal relationship between patient and physician, for it is often in the context of the breakdown of a personal relationship that the acute illness has appeared.[5]

However, we cannot be too critical. Seventy-two physicians or 61% indicated they used personal conferences when needed; there was little variation in this figure in regard to region or training. Other types of treatment were less significant in numbers, but it should be mentioned that 23% of those near psychiatrists used referral as their primary treatment while in out-lying areas, only 9% offered this as their choice.

Table 8 points out that the physicians nearer the psychiatric treatment centers relied more heavily on private psychiatrists for treatment of their referred patients. This stands to reason since the majority of the privately practicing psychiatrists are located in these cities. The out-state physicians relied more heavily on the state hospitals and clinics, as might be expected, since in many cases this is the only alternative available to them.

The final question on the questionnaire requested comments concerning the greatest need in the area of

psychiatric care in the state of Nebraska. A total of 80 physicians remarked that they felt there is an inadequate amount of psychiatric treatment available from psychiatrists on a referral basis. Several stated that this was specifically in the area of facilities available for those who could not manage to privately finance psychiatric care. Of those answering from Western Nebraska, several described a need for more psychiatrists in that part of the state, especially those in private practice.

Others commented that there is a need for greater emphasis on psychiatric care by the generalist and likewise a greater amount of under-graduate as well as post-graduate training for these physicians. A significant number indicated that there is inadequate liaison between the physician making a referral and the person to whom they are referred; one specifically mentioned that this could be, if improved, an invaluable means of educating those physicians seeing the patient initially. Several referred to an inordinately long delay between the time the initial consultation is requested and the time it is made; probably as a result of the queuing up of referrals at the level of the psychiatrist. Facilities for treatment of the acute psychiatric emergency are also felt to be inadequate. Of all the physicians answering the questionnaire, only four indicated that they were satisfied with available facilities.

Conclusions and Summary

In the preceding study, we have shown that 88% of all the answering physicians felt that less than 25% of their patients had problems primarily of a psychiatric nature, while 13% felt that greater than 30% had significant emotional problems. These figures were influenced by whether or not the answering physician had taken post-graduate training in psychiatry; a near majority of those without this training felt that less than 5% had problems with an emotional etiology, while only 13% with further training indicated that such a small percent had difficulties of this type.

Of those answering, 90% indicated that the women predominate among the psychiatric patients seen in their general practice. The predominant age group was found to be 40-50 years with 87% indicating between the ages of 30 and 50 years.

The study showed that 56% indicated they could handle at least 60% of these patients. These figures were influenced by the availability of major psychiatric facilities: less than 50% of those within 25 miles of such facilities felt competent in handling these patients while over 60% of those at a greater distance indicated that they could care for them. Distance and training were apparently a factor in the amount of time which the physicians spent in treating psychiatric problems; the

physicians with post-graduate training and those outside the 25 mile radius indicated that they spend more time than those without the training and with ready access to psychiatric referral.

Psychotherapeutic drugs were the primary method of treatment for 77% of all the answering physicians. This percentage was not affected by a distance factor, but after having a post-graduate course, drugs were relied on to a lesser degree than without this training. Distance did become a factor when referral was the method of choice; the physicians closer to a psychiatric resource used referral as their primary method of treatment to a greater extent and referred a greater number of patients to psychiatrists than the remainder of the physicians. The majority of these referrals were made to privately practicing psychiatrists, but those in more out-lying areas referred to a greater extent to the state supported clinics and hospitals.

The majority of the questionnaires indicated that the answering physicians felt that psychiatric facilities are available to an inadequate degree. Large numbers indicated that the general practitioners need more training in the area of psychiatry, and that there is inadequate liaison between the psychiatrist and the non-psychiatrist.

Although our study would indicate that where psychiatric facilities are available, the physicians in the

area make use of them, and that where they are not available, the physicians tend to be more independent, it was not the purpose of this study to determine deficiencies.

We would like to suggest possibilities for more efficient use of available facilities which might help overcome a hiatus in comprehensive medical treatment.

1. The primary role of the family physician should be in the area of early and accurate diagnosis and treatment or referral as indicated by the diagnosis. Definitive treatment should begin at this level, but it should also end at this level as the patient is returned to the care of the family physician after more specific treatment by the psychiatrist. There are certain goals for which each physician should strive in his training so that he might be more effective in the treatment of the psychiatric patient. These have been ennumerated at a meeting of the Association of American Medical Colleges:

a. Ability to interview

b. Ability to diagnose the condition of patients who are emotionally disturbed and express their problems in physical, psychologic or social disturbances.

c. An understanding of how the physician can manage and treat the emotionally sick. (Since our study found that physicians relied quite heavily on the use of psychotherapeutic medications,

we must specify an emphasis on the values and limitations of this type of treatment.)

d. Some training in the emergency management of disturbed persons.

e. An understanding of what the physician cannot and should not do in treating the mentally sick patient.

f. An understanding of methods of referral to specialists, hospitals and clinics.

g. Knowledge of the interrelationship between psychiatrist, social worker, psychologist, nurse and others caring for the mentally sick patient.[4]

2. An increased utilization of facilities, usually interpreted as being non-psychiatric, in meeting the psychiatric emergency bears emphasis. Distance should not be a consideration in the type of treatment on an acute basis, and greater use of the general hospitals in these situations might help alleviate existing deficiencies.

3. Post-graduate training in psychiatric treatment centers should be increased in amount and promoted to a greater extent to improve diagnosis of the various psychiatric syndromes and facilitate early treatment. Additional personnel should be trained in the human sciences to relieve the psychiatrist of duties which are actually

outside the realm of his specialty and would free his time for more specific forms of psychiatric treatment.

4. Continued progress in the area of integration of psychiatry and general medicine is essential. By better liaison between the psychiatrist and the referring physician, the patient can be benefited because of better and more rapid treatment. The referring physician should become a part of the ongoing treatment of the psychiatric patient and make available to the psychiatrist information of which he is more likely to be aware. Consultations at the bedside or over the coffee cup could improve the relationship between these physicians and benefit the patient.

All physicians are compelled to practice psychotherapy to some degree because of the inherent nature of the physician-patient relationship. In this particular area the type of practice a physician has will be affected by the interest and education of the physician, but even perhaps more as a result of attitudes about psychiatry which have developed out of past experiences with this specialty. The psychiatrist can draw upon the family physician to broaden his background in a particular case and also to gain experience with the more physiologic side of medicine. Our study was designed to show to what degree that this has been accomplished in Nebraska. The interdependence of general medicine and psychiatry is essential to the comprehensive medical case of each patient.

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