

# Letters to the Editor



The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

## Family Emotional Health

To the Editor:

Studies of behavioral medicine and psychiatry are fraught with difficulties of definition and sampling. The paper by Goldstein, Snope, and McGreehan, "Family Emotional Health: A Survey of Family Practice Patients," in the January issue of *The Journal* (10:85, 1980), aptly demonstrates some of these problems. Family emotional health has been extensively and intensively studied in recent years and the authors' conclusions are mainly a repetition of the work of many sociologists and psychiatrists interested in this subject. I was surprised to see only four references quoted from the massive literature on the subject.

I have concerns about the study design. Did the sample of patients surveyed reflect the practice population served by the three family practice programs? If not, one cannot make general statements about the conclusions drawn by the authors. What was the time frame of the study? It is known that winter exacerbates psychiatric and psychosocial problems, and the seasonal timing of the study could therefore bias the results.

Although no patients refused the questionnaire and 82 percent completed it, were all the patients approached who attended and were in the waiting room of the centers? If

not, this would again add bias to the results. It would be important to have this information in order to understand what kind of sample was being selected.

There is nothing in the paper that indicates the definitions used for "psychosocial problems." After all, the areas of concern which the authors use as headings in their tables cannot necessarily be equated with problems, or to put it another way, when is a problem really a problem? and to whom?

The authors also studied patient charts in order to identify psychological symptoms. Again, these are undefined in the paper but could include such symptoms as nervousness, headache, fatigue, trembling, and hyperventilation which could just as easily be organic symptoms. Another problem is that the results are displayed in absolute numbers. They do not indicate which patients and families had multiple areas of concern or multiple psychosocial problems or multiple psychological symptoms. If such multi-problem situations occurred, and I would venture that they did, then the percentages of the family practice center's population with emotional health problems would have to be adjusted.

It is self-evident and established in the literature that most families

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## RONDEC Tablet

chlorpheniramine maleate, 4 mg; pseudoephedrine HCl.  $\mathcal{R}$

Before prescribing, please consult complete product information, a summary of which follows:

### INDICATIONS AND USAGE

Rondec Tablet is indicated for the relief of seasonal and perennial allergic rhinitis and vasomotor rhinitis symptoms. This drug may be given concomitantly with analgesics and antacids, when indicated.

### CONTRAINDICATIONS

**Antihistamines:** Sympathomimetic amines and antihistamines are contraindicated in nursing mothers.

**Antihistamines:** Contraindicated in patients with hypersensitivity or idiosyncrasy to any ingredients, in patients taking monoamine oxidase (MAO) inhibitors, in patients with narrow-angle glaucoma, urinary retention, peptic ulcer, or in patients undergoing a sympathetic attack.

**Sympathomimetic amines:** are contraindicated in patients with severe hypertension or severe coronary artery disease.

### WARNINGS

**Pregnancy:** Safety for use during pregnancy has not been established.

**Sympathomimetic amines:** should be used with caution in patients with hypertension or ischemic heart disease.

**Elderly persons:** (approximately 60 years and older) are more likely to have adverse reactions to sympathomimetic amines and antihistamines.

### PRECAUTIONS

**Antihistamines:** should be used with caution in patients with hypertension, heart disease, asthma, hyperthyroidism, and increased intraocular pressure. Patients particularly sensitive to antihistamines may experience moderate to severe drowsiness. Patients should be cautioned while taking the drug to exercise care in driving or operating appliances, machinery, etc.

**Sympathomimetic amines:** should be used with caution in patients with a history of asthma, diabetes mellitus, hyperthyroidism, increased intraocular pressure, and prostatic hypertrophy. In the presence of enlarged prostate, administration of sympathomimetic amines may cause urinary retention. Those patients particularly sensitive to sympathomimetic amines may note mild central nervous system stimulation.

Patients should be advised to avoid alcohol and other CNS depressants while taking the drug.

**Drug Interactions:** Antihistamines have been shown to enhance the effects of tricyclic antidepressants, barbiturates, alcohol, and other CNS depressants. MAO inhibitors prolong and intensify the pharmacologic effects of antihistamines. Sympathomimetic amines may reduce the antihypertensive effects of reserpine, veratrum alkaloids, methyl dopa and mecamylamine. The effects of sympathomimetics are increased with MAO inhibitors and alpha-adrenergic blockers.

**Pregnancy Category C:** Animal reproduction studies have not been conducted with Rondec Tablet. It is also not known whether this drug can cause fetal harm or affect reproduction capacity when administered to a pregnant woman. This drug should be given to pregnant women only if clearly needed.

### ADVERSE REACTIONS

Adverse reactions to antihistamines in decreasing order of severity are: sedation, dizziness, diplopia, vomiting, dryness of mouth, headache, nervousness, nausea, anorexia, heartburn, weakness, drowsiness and dysuria. Antihistamines may cause excitability in children.

Adverse reactions to sympathomimetic amines in decreasing order of severity are: convulsions, CNS depression, cardiac arrhythmias, respiratory difficulty, increased heart rate, pressor effects, hallucinations, tremors, nervousness, insomnia, weakness, drowsiness and dysuria.

### DOSAGE AND ADMINISTRATION

AGE	DOSE	FREQUENCY
Infants and children		
1 to 2 years and over	1 tablet	q.i.d.*

\*In mild cases or in particularly sensitive patients, less frequent or reduced doses may be adequate.

### HOW SUPPLIED

Rondec Tablet Filmstab<sup>®</sup> tablets are available in bottles of 100, NDC 0074-5726-13; and bottles of 500, NDC 0074-5726-53. Each tablet marked with Ross  $\mathcal{R}$  and the number 5726 for professional identification. Dispense in USP tight container.

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B159/0880

# VALIUM<sup>®</sup> diazepam<sup>IV</sup> Roche

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other anti-depressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension; changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium<sup>®</sup> (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose<sup>®</sup> packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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are dysfunctional, at some time or other. Do these dysfunctions need to be uncovered at all times by the physician, and does the intervention (which is the logical sequence), in fact, alter the outcome, except in cases selected by their request for help?

I am not sure that we should be in the business of routinely picking over family dynamics; rather, using skillful interviewing and experience, one can identify the patients who may wish to be helped. My bias comes from a two-year experience (in private practice) of screening women in the 30- to 60-year age group for emotional and organic health problems using a questionnaire and outreach method. I was overwhelmed by the number of problems that came out of the woodwork and could have only continued by giving up a significant proportion of the "organic" element of my practice.

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*The preceding letter was referred to Drs. Goldstein and Snope, and Ms. McGreehan who respond as follows:*

There are several issues raised by Dr. Curtis' letter regarding our article (Goldstein HS, Snope FC, McGreehan DM: *Family Emotional Health: A Survey of Family Practice Patients*. *J Fam Pract* 10:85, 1980). First is the question of the results being self-evident and a duplication of already published data. We, of course, surveyed the extensive literature; data on family emotional health in family practices were not found. We would wel-

come specific citations if such studies have been done.

Secondly, the questions about survey design are valid. The data were collected in the fall and early winter and all patients were approached who were in the waiting rooms.

Thirdly, the question of what constitutes a problem is perhaps the most basic issue. The point being made is that a patient perceived problem is a symptom that requires evaluation. The patients by being surveyed were given the opportunity to say they had a symptom, just as symptom checklists do for organic symptoms. Of course in practice, if a physician communicates (by *not* asking) that emotional health is outside his/her specialty or expertise, then patients will only infrequently present such symptoms.

The core problem for family medicine as a specialty is made abundantly clear in the author's last paragraph. Is the family physician going to treat the whole family or is he/she going to ignore the family emotional health because to treat the whole family is "overwhelming." And why is it overwhelming? Is it lack of training that makes it so? Or are we too much imbued with technological medicine as an ideal? Family medicine (in spite of its stated goals and early investment in psychosocial training) has yet to declare conclusively that part of the definition of a family physician is one who is expert in the area of family emotional health.

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