

- 742 Motivation Problems Related to Secondary Prevention in Industrial Mental Health. W.E. Pow W.W. Winslow, E.P. Rubin, and W.D. Ross. *Am. J. Psychiat.* 123, 297-302 (1966).

Efforts at secondary prevention (early case finding and treatment) made during an industrial mental health project were less successful in securing follow-through of treatment recommendations than the more traditional consultation by a psychiatrist. These were conclusions resulting from a study of 38 industrial employees seen in previous psychiatric consultation as compared with a group of 325 employees with whom an attempt was made at application of secondary prevention methods by an industrial mental health research team. Cases selected for study in secondary prevention were: (1) individuals who were problem-free and functioning optimally, and (2) individuals manifesting job-disrupting behavior. Direct intervention by mental health specialists with employees not under pressure of symptoms or other duress appeared little benefit. Occupational physicians or other professionals within an industry are better able to bring about the follow-through of recommendations of a psychiatrist to employees. A mental health program in an industrial setting could be pursued by a combination of the principles of screening for secondary prevention and those of consultation and referral after an employee is aware of a threatening problem.

-- J. Occ. Med. Absts.

- 733 Mental Health in Industry: Whose Responsibility? D. Coffee and A.A. McLean. *J. Occ. Med.* 9, 213-214 (May, 1967).

The author suggests five criteria for evaluating mental health in industry, namely: (1) Treat people as individuals, not stereotypes. (2) Be flexible under stress, rather than rigid and routinized. (3) Provide for gratification from a number of sources: people, tasks, ideas, etc. (4) Accept the capacities and limitations inherent in the program; try to provide the resources needed but not to strain those presently available. (5) Be active and productive; avoid the temptation to do more than is needed, but rather maintain a primary concern for fulfilling the professional responsibilities of both the medical and nonmedical practitioners in the work organization. If programs which meet these standards can be developed and staffed with adequately trained managers, supervisors, and medical personnel, more persons may be found in work organizations who can withstand the growing pressures of an increasingly complex and demanding society.

- 734 Effects of Alcohol on Performance in Continuous Attention Tasks. G.A. Talland. *Psychosom. Med.* 28 (4, Pt. 2), 596-604 (1966).

Alcohol addicts and control subjects were tested by experimental tasks to determine the effect of moderate doses of whisky on performance demanding continuous attention over relatively long periods. The control subjects were men without any history of alcohol addiction, but who were incarcerated in the same correctional institution as the addicts. When working in isolation the two groups of subjects did not differ significantly in accuracy; nor did alcohol significantly affect their performance. Working under competitive instructions in a group setting, the addicts made more errors than the control subjects, and alcohol impaired accuracy in both types of subject. An experiment in visual and combined audiovisual signal detection requiring rapid search showed a sizable drop in performance as a result of alcohol, and gradual improvement as the toxic effects wore off.

-- J. Occ. Med. Absts.

- 735 Cardiomyopathia Alcoholic. B.B. Aslaksen. *Tidsskr. Norske Laegeforen* 87, 618-621 (April 1, 1967).

Two cases, both with the probable diagnosis of alcoholic cardiomyopathy are described. One patient died and an autopsy was performed. The other showed regression of symptoms during abstinence from alcohol.

-- J. Am. Med. Assn. References & Reviews

- 736 Automation of Electrocardiographic Diagnostic Criteria. J.R. Whiteman, et al. *J. Am. Med. Assn.* 200, 932-938 (June 12, 1967).

A complete system with capabilities to provide automatic clinical evaluations of standard 12-lead electrocardiograms has been developed. The basic equipment includes a magnetic tape ECG machine and a medium-sized digital computer. The computer accepts data directly by telephone or by tape playback. Each of the 12 leads is converted to digital samples, measured, and stored. A three-step program then recalls the measurements to be condensed, combined, and refined to one or several diagnostic statements. These are immediately available for use at the processing center or may be transmitted by teletype to the clinical site. At an experimental automated heart station, now operational for more than two years, more than 50,000

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