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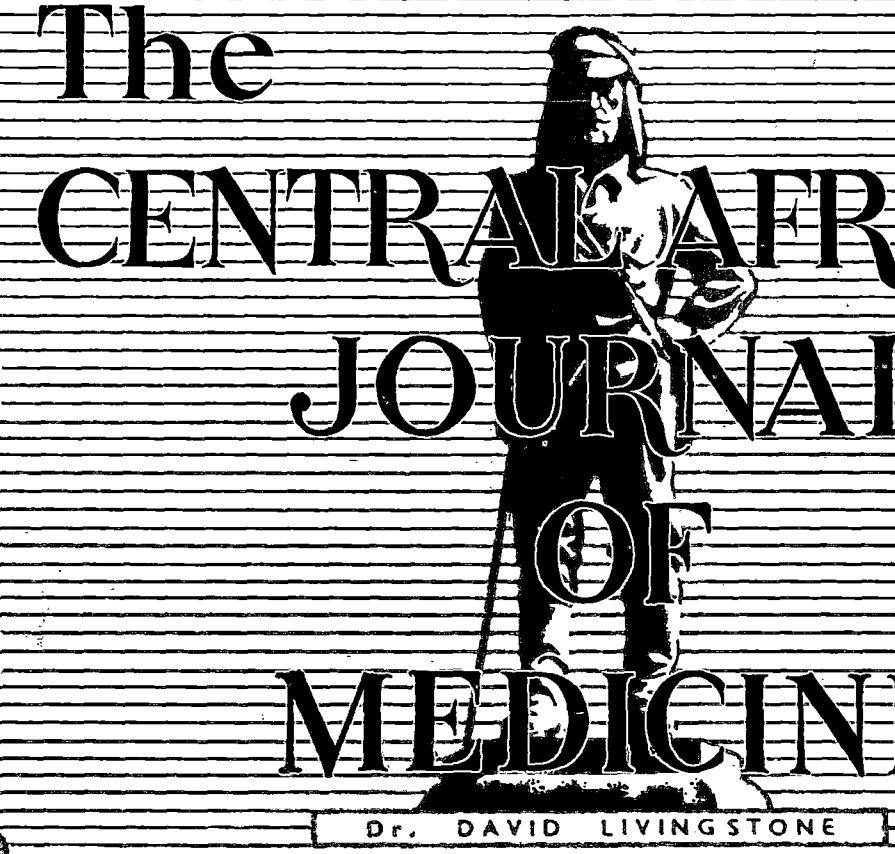

Dr. DAVID LIVINGSTONE

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SUPPLEMENT TO VOLUME 17, NUMBER 1, JANUARY, 1971

FACTORS AFFECTING THE OUTCOME OF TREATMENT OF PULMONARY TUBERCULOSIS IN SUB-OPTIMAL CONDITIONS:

An 18-month Follow-up of 224 Patients

By

D. H. SHENNAN and M. LOUISE WESTWATER.

Psychiatric Services

(Based on a lecture given to the Malawi Medical Association on 21st May, 1970.)

BY

MYRE SIM, M.D.(EDIN.), F.R.C.P.(ED.), D.P.M.

Consultant Psychiatrist, United Birmingham Hospitals, Lecturer in Psychiatry, University of Birmingham, Visiting Lecturer in Psychiatry, University College of Rhodesia.

The provision of psychiatric services on a national scale poses many formidable problems for homogenous communities which are traditionally accustomed to adequate and sophisticated medical services. In countries like Rhodesia and Malawi these problems are even greater and more diverse. A simple example which is common to all countries is the impact on these services of variations in population density. In large cities it should be possible to cope with most patients on an outpatient basis or in a day hospital, but in more isolated areas there is a greater demand for inpatient accommodation because of the difficulty in organising intensive supervision and treatment outside. Furthermore, duration of stay in hospital tends to be more prolonged in rural areas because of delays in obtaining information from relatives and others, and the reluctance to discharge early because of the uncertainty of adequate follow-up. The effectiveness of social workers is also diminished because of the large distances involved.

Even in well-developed countries with a relatively homogeneous population differences in cultural patterns occur, and these make for uneven and excessive demands on psychiatric services. The following examples will explain:—

(a) *Retirement habits* in Britain have led to a concentration of the aged in the south coast, with consequent over-loading of the psychogeratric services in that area.

(b) *Social problems* like alcoholism and drug addiction can saturate a limited service both regionally and nationally, while in some countries where food is scarce or dietary habits are faulty, pellagra can greatly increase the incidence of mental disorder.

(c) *Migration* to the cities of unemployed, unemployable, vagrants and others contribute to the unstable population, and as they are generally of no fixed abode and with no family support, their rehabilitation is formidable.

(d) *Mobility of population* affects all classes. People forsake the villages for the towns in their search for work and sacrifice the emotional security they derived from their village culture. The re-organisation of business into larger complexes increases the movement of personnel at all levels, and enforced changes in housing, schools and social contacts can be traumatic for all members of the family. A rapid increase in the student population with a simultaneous tendency to study away from home has contributed to the psychiatric hazards of this population and to an increase in suicide. Immigration too contributes, though this is reflected more in the first generation than in the original settlers, for the former are not entirely accepted by the indigent culture and lack the support of the old which they may have renounced.

(e) *Social mobility*, which is closely linked to economic factors, is a common cause of instability. In affluent and emergent societies the movement is generally upwards and it is the lower ranks who are most vulnerable, for they have lost the support of the proletariat and have entered the wide-ranging and subtle stratification of the middle classes. Even when roles have been defined, the scene is a rapidly changing one and newly-formed relationships may have to be abandoned with intervening isolation. Re-adjustment can involve schools, clubs, housing areas, clothes, cars, holidays, hobbies and even churches. Even within the family, tensions may be increased and children become progressively aliena-

ted from their parents as they identify more and more with their peer groups.

(f) *Pathoplastic Effects of Culture.*—This may not in itself affect the true incidence of mental illness, but it can affect the numbers who seek help for cultural by-products such as spells and witchcraft or an excessive preoccupation with sexual potency. Some cultures have a greater tendency to "act out" problems and in doing so disturb the environment with increased demands, not only on medical and nursing staff, but on police and magistrates. Though the condition may, in itself, be trivial, by its presentation it becomes an emergency and brings in its train the legal formalities such as certification with a need for escorts and transport and special observation in hospital. In addition, the initial disturbance lowers the community tolerance to mental illness and to that patient in particular.

(g) The introduction of contraceptive pills to unmarried teenagers launches both sexes into behaviour for which they are emotionally unprepared, with resulting heightened guilt feelings and a serious handicap in forming a mature and permanent relationship.

CULT AND FASHION IN PSYCHIATRY

It must not be assumed that all psychiatric services, even those of long-standing, are necessarily effective. Cultism is prevalent in all societies, but in those which provide comprehensive welfare services there are pressures to include all manner of healing cults. In organic medicine the appeal court of the laboratory has helped to remove these pressures, though not entirely. In psychiatry, where frequently the definition of successful treatment is that which the patient declares makes him feel better, or what a vocal section of the community regards as appropriate, the situation is very different. In the past the latter has led to the creation of larger complexes of mental hospitals which, even when they were built, were entirely unsuitable for the task and are now a monumental embarrassment. It has also led to the abandonment of a perfectly good arrangement for one which was less effective or harmful. This point was made by Greenland (1961) in his comments on the rejection in 1889 by the Japanese of an enlightened thousand-year-old system of looking after the mentally ill in favour of what was then considered to be the new asylum system in Europe and America.

Even in a democracy, availability or effectiveness of services is not necessarily equated with need. An articulate middle class can monopolise the mass media and create a "lobby" which will syphon off resources for their own problems, regardless of the competing and more established claims of others. An example is in the field of infantile autism which is probably caused by a variety of agencies, mostly undefined, which render the child from birth or from an early age severely handicapped in acquiring speech and with marked perceptual defects. The diagnosis achieved some respectability in that it was claimed by Kanner (1943), who originally described it, that the parents tended to be intelligent and of the professional classes. As he was working on the Johns Hopkins campus and many of his patients were faculty members, his conclusion may have been influenced by sampling, but surveys in England (Wing *et al*, 1967) have shown that 60 per cent. of the parents belonged to social classes 1 and 2, while only 18 per cent. of the parents of mental defectives belonged to these classes. It is possible that in indistinguishable clinical problems the upper-class parent would secure a diagnosis of infantile autism, while the lower-class parent would not object to the child being labelled mentally defective. There is now tremendous pressure on government to provide more facilities for this small and select group, though this can only be done by depriving mental defectives of their already meagre allocation, even though most of the evidence indicates that infantile autism is generally not amenable to intensive and prolonged treatment.

Another example is in the field of drug-taking. Here, too, pressure from the mothers of drug takers who are generally middle class has persuaded the government in Britain to set up "treatment centres". They are not expected to treat, but are really off-licence premises where drugs are distributed but not consumed at the time. As drug-taking frequently results from oral pacifying in infancy or childhood, one can see the propaganda for "treatment centres" as another attempt to ensure that "Johnny gets his sweets"!

The mushrooming of the so-called therapeutic communities in psychiatric units and the vogue for group therapy are developments whose efficacy in the treatment of the mentally ill has still to be validated. The large field of child guidance with its concentration of professional skills is yet another example which even after 40 years has provided no satisfactory evidence that the results have justified the investment. Similarly, the proliferation of clinical psychologists, psychiatric social workers and psychiatrists, too, has still to pass the scrutiny of an Auditor General. Even

if it be shown that all or most of what they do is of value, their geographical distribution is so disparate that some areas are virtually deprived of psychotherapists and psychiatric social workers, while the London area which accounts for only 20 per cent. of the population is relatively saturated.

The Problems of an Underdeveloped Country

At the outset it can be said that manifestations of psychiatric illness are not racial but cultural, and as such are liable to change. There will be considerable differences in the needs of those who are organised in primitive tribal associations, those who are beginning to acquire the outlook of Western civilisation and those whose training and employment have committed them to the now international standards of the modern world. It is not profitable at this stage to compare these cultures and express value judgments. It is probably true that the more primitive are happier and the more advanced are more anxious, but anxiety is the stimulus of modern society and it is through its mastery that man progresses, certainly materially.

Psychiatric illness is heavily dependant on cultural influences apart from the pathoplastic effects described above. It varies in nature from culture to culture, and even within the same culture where it is possible to study the differing social classes and levels of responsibility, the range can be striking (Sim, 1946). In more primitive societies the incidence of anxiety states and depressive psychoses is very low, while hysterical and what one might label schizophrenic states are proportionately high. As cultures approximate to those of the modern world there is a greater number of anxiety states and depressive psychoses. Even in a relatively homogeneous community like Britain in the 1940s the nature of mental illness in British Army personnel varied as widely between officers and non-commissioned officers and other ranks as between British personnel as a whole and East Africans.

All societies, even the most primitive, have their own brand of medical practice, and though in organic medicine the less developed countries do not match the more developed, in the treatment of the functional disorders of their members they would appear to be at least as successful. A developing country has therefore need for its traditional psychiatric services in the form of the witch doctor, an intermediate service for those who are beginning to meet with anxiety and depression and a more modern service for those of all races who have reacted similarly to the more advanced cultural conserve. The African, whether of the professional or business class, is beginning to reflect the problems of his adopted culture and is presenting the same psychiatric problems as the European. Nobody can predict how long it will be before the vast majority of the African population will be in a similar position, though if history is a guide it will be sooner than later. Pathoplastic influences will probably persist for many years, but these will be like medallions on a black cloth and will not unduly influence the true nature of the reaction in its essential clinical features or in its response to treatment.

The scene, though rapidly changing, will in the initial phase rely heavily on what one must call African psychiatry, and it will require a major re-adjustment of traditional medical attitudes in recognising that in this respect Western medicine has less to offer. The mistakes of previous generations of Western psychiatry must not be repeated and the asylum system should, if possible, be eliminated by more effective psychiatric "first-aid" at the site of origin and the provision of the essential agents to control the acute episodes of the alcoholic, the pellagric or the "acting-out" of the unstable. In-patient accommodation and out-patient services should be reserved for those who can be helped by modern psychiatric treatment, and as these problems are generally readily recoverable there would be every advantage in siting these units within the general hospital. Furthermore, a progressive unit with a high discharge rate would overcome the resistance of those who need its help but have not yet accepted the fact that their problems are within the competence of modern psychiatry.

Personnel and Their Training

At the medical level this involves post-graduate training and there is considerable advantage in locating these in or near the country to be served. In psychiatry, training is a matter of suitable patients, of which there is an abundance, and experienced teachers. The traditional method of sending young doctors overseas has disadvantages in that their community is deprived of their services while they are away, some never to return. The training overseas cannot entirely suit the local scene and they are likely to import inappropriate schemes or express dissatisfaction with the shortages which are inevitable in a developing situation. This does not preclude foreign travel at a later date.

Similarly, nursing personnel should be locally trained and at the village level somebody should be competent to administer psychiatric first-aid,

even if it be the local policeman. It is not often that the opportunity presents to initiate psychiatric services, almost from scratch. These opportunities must not be wasted.

REFERENCES

GREENLAND, C. (1961). *Lancet*, II, 605.
KANNER, L. (1943). *Nerv. Child.*, **2**, 217.
SIM, M. (1946). *J. Ment. Sci.*, **92**, 118.
WING, J. K., O'CONNOR, N. & LOTTER, V. (1967). *Brit. Med. J.*, **3**, 389.