WORLD HEALTH ORGANIZATION
REGIONAL OFFICE
FOR THE EASTERN MEDITERRANEAN

ORGANISATION MONDIALE DE LA SANTE
BUREAU REGIONAL
POUR LA MEDITERRANEE ORIENTALE

SEMINAR ON THE PLACE OF PSYCHIATRY IN MEDICAL EDUCATION

EM/SEM.MENT/11
EMRO 0112

Alexandria, 8 - 15 July 1970

ENGLISH ONLY

APPLICATION OF PSYCHIATRIC KNOWLEDGE TO MEDICAL PRACTICE IN THE COMMUNITY - THE SICK INDIVIDUALS, THE FAMILY WITH THE SICK AND SOCIAL PROBLEMS RELATED TO MENTAL HEALTH

by

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Mr. Chairman, Ladies and Gentlemen,

This is the fourth day of our Seminar on the Place of Psychiatry in Medical Education. We have already listened to several distinguished speakers on the subject. I am afraid there is very little to add to what we have already heard. However, I am going to attempt to discuss briefly the topic of application of psychiatric knowledge to medical practice in the community under three main headings as indicated in the programme:

a) How to deal with sick individuals, whatever the diseases they suffer from.

b) The inter-relation of the family with the sick person as well as the mental health aspects of family life.

c) The social problems which may emerge in a given society in relation to mental health.

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Address by Dr. Wagdi on Plenary Session of 10 July 1970

I. The Sick Individuals

a) Patient as a person

The organic approach of the broad field of medicine to the study of patients which was brought about by expanding scientific knowledge and resultant specialization, had made necessary a specific attempt in medical education to introduce the concept of the patient as an integrated unit, i.e. a whole person reacting with his illness or health, his body and his mind as one unit. Any patient is a person with a set of values, dreams, ideals, wants and needs. No one of us can treat an appendix, a pneumonia, or any other disease; whether we are aware of it or not, any doctor is treating a person. In other words, only when we have a working concept of a patient as a person can we give complete medical care. This acceptance of a patient as a person when deeply instilled becomes an automatic response which is an essential tool in working with people. It must be clear to the practitioners that such an attitude is certainly built upon knowledge, is perfected through practice and finally becomes the disciplined understanding of the skilled practitioner.

b) Medical care through understanding

How any one person will behave towards another will depend upon his interpretation of the second person's behaviour. Interpersonal relationships are definite therapeutic tools and have a real effect on the course of a patient's illness. Our (medical profession) own behaviour towards patients must be directed by an intelligent understanding of why they behave as they do and of what purpose or purposes their behaviour may accomplish. We must therefore develop skills in objectively identifying the why of patients' behaviour, whether he is suffering from a clear-cut psychiatric disorder or from a psychiatric disease or symptom on top of an organic lesion. Man is a social creature and his social needs are often deep-seated and powerful motivating factors in behaviour. Interpersonal relationships, the give-and-take between patient and his doctor, are tools of medical care used to promote the patient's health. As we all know, the role of the doctor in society has changed rapidly over the past twenty years consequent upon the great developments in the biological sciences and equally great changes in the society in which we live. In the R.M.P.A.'s Memorandum to the Royal Commission on Medical Education, 1966-1968, the following factors were stated which would influence the medical curriculum:

"1. Medicine is increasingly recognised as a branch of social sciences.

2. Patterns of disease are changing and one example of this is the increase in the so-called stress disorders. This has resulted into a growing awareness of psychological and social factors in both physical and mental disease.

3. The psychological aspects of the doctor/patient relationship needs re-emphasis. Its importance is widely accepted, but its effective handling demands skills which can be imparted by systematic training. The basis for the understanding of the complex psychological factors involved in the doctor/patient relationship must be laid before the student comes into regular personal contact with patients and before he falls into the habit of adopting a purely authoritarian attitude towards them.

4. The practice of medicine relies more and more on collaboration between specialists and on contributions from workers in the basic sciences and social welfare agencies."

c) Interviewing a patient in general practice

The distinction between case-taking in psychiatry and in other aspects of medicine lies not in principle, but in the qualities, attributes and aspects of the patient that are the subject of detailed scrutiny, and in the nature of the events and experiences in his history that are especially relevant to his illness. There is a greater influence, in psychiatric cases, of the attitude of the doctor to the patient; and for this reason correct psychiatric case-taking is not only the first step in diagnosis, it is concurrently the first step in treatment.

The patient's attitude to the interview: Many patients feel that they are misunderstood, that no one will listen to them, or even that every man's hand is against them. For a long time, perhaps, they have been told to pull themselves together, or to "snap out of it" or have been given a superficial advice that is as impracticable as telling a man with a broken

leg to get up and walk. In others, just the reverse may have occurred; the patient may have been surrounded by over-anxious, over-protective relatives, told not to do this or that, and he may be convinced that he is gravely disabled by a mysterious disease needing special arrangements for transport, nutrition and medication. Some patients are elated or excited and tend to make little of the need for being examined at all, though they do not actively oppose it. In this group are some, indeed, who welcome examination because they are sure it will prove them to be in perfect bodily and mental health. Others, labouring under the onset of a paranoid illness, are hostile and suspicious, believing that the doctor is in some kind of conspiracy with their relatives or employers to "put them away." One of the commonest attitudes of the patient and his family is that of fear, though they may not show it. The patient or his family may harbour secret fears about his physical or mental health, they may be afraid that he has some lethal disease or is going mad and they are prone to show these secret fears by a rather continuous reference to his nerves.

The doctor's attitude: The doctor who can think himself into the patient's attitude for a moment will soon see the importance of his own attitude. It is not only what he says to the patient that is important, it is his manner of saying it, his general demeanour and his facial expression. If any of these show that the doctor regards the patient as being not wanted or a neurotic nuisance, or arouses no interest in him, the interview is likely to fail in its purpose. The doctor's attitude to the patient should be that of a sympathetic listener. He should give the impression to his patient that he will hear the whole story, that he is not there to judge or criticize or take sides but simply to give such medical help as may be necessary in the management of his illness. He should take great care not to become involved in his patient's emotional situations, while making it clear that he understands their nature and the points of view that are put to him about them. Nothing, however, is more important than conveying the notion of help to the patient. Most patients need this and know that they need it.

The advantages which general practitioners have in dealing with psychiatric cases: The general practitioner has a first-hand knowledge of the family and its social background. He has ready access to all members of the family and has existing relationships with them which makes it easier to obtain additional information and makes them willing to co-operate. Because of the continuing relationship with the patient, the general practitioner need not disturb the interview by writing labourious notes. The brief interview should not be hurried and an impression of leisure can be created. The best way for the psychiatric interview in general practice, in my view, is the general technique of free discussion with timely interjections. The general practitioner must have three objectives in his mind during his interview:

i) Interpretation of the complaint.
ii) Planning of management.
iii) Explanation of treatment.

i) Interpretation of the complaint: The patients always try to formulate their problems in somatic terms. Sometimes patients whose defensive denial of mood disturbance takes place at a deeper level, they manage to conceal their feelings even from themselves and only the passage of time with the gradual accumulation of negative investigations and opinions arouses suspicion. Therefore, the first objective in the mind of the general practitioner must be to give the correct interpretation of the symptoms to his patient.

ii) Planning management: In planning the management of a case, the general practitioner must

- Know from the beginning when to refer his case to the specialist.
- Know how to assess the suicidal risk in a given case
- He must also obtain a comprehensive background information about marital and interpersonal relationships, occupational activities, leisure interests, etc...

- He must also have a good idea about the social agencies to which he may resort.
- If the general practitioner thinks that there is clearly more than can be discussed in the available time, if there are puzzling aspects to the case or if the patient is not well known to him, a special interview with ample time has to be arranged.
- Finally, the general practitioner must plan for the continuing care of his case. He will always ask his patient to come back for future aims at the back of his mind. The opportunity to talk about and ventilate symptoms, combined with a display of concern by the doctor, may be therapeutic and not only the pills prescribed or the investigations asked for.

iii) Explaining the treatment: At least one third of the time of the first interview has to be spent in explaining the treatment to the patient. Patients must be reassured and the probable length of treatment and the way to stop it must be discussed with them.

d) Emotional components of physical illness

As we all know, organic physical diseases may be provocative of emotion that may greatly complicate the somatic disability. Many persons who already have a well-defined disease experience exacerbation or complication of it in relation to severe life stress. Also a patient suffering from a serious and progressive physical disorder is very prone to develop some psychological response to it, e.g. repression, denial or exaggeration. Some patients may consciously desire cure but unconsciously wish that the symptom may continue. The motive may be self-punishment, appeal for gain, revenge or protest. Also we must never forget factors arising from the patient's social environment or from interaction between patient and the social setting.

In short, I may say that practically, every speciality of Medical Care is accompanied by procedures or situations heavily weighed with elements potentially disturbing to emotional life or personality.

e.g. in ophthalmology : bandage of eyes
in the genital system : contraception, illegitimate pregnancy ... etc.
in surgery : ideas of loss of organs, ... etc.

Also convalescence from a serious physical disease may constitute a psychiatric problem. The longer the patient defers his return to his responsibility, the harder it is for him to come back and any unwholesome personality reactions that have been established becomes more fixed. (e.g. the problem of compensation neurosis).

II The Family with the Sick

As well known, one of the simple insights about the mental health implications of family life which we have developed in recent years is that we should not just focus on the patient alone. The approach now is

much wider and better include almost every member of the family. We must realize that everyone in the family has psychological needs that have to be satisfied. The family group is an interdependent system. What affects any one member affects others in the family. As we know, a family has a life history of its own as a unit. It has a beginning, a middle and an end. Some authors prefer to divide the whole family system into sub-systems which are the marital system, the parent-child system and the sibling system. These authors trace the separate development over time of each of these sub-systems and their influence upon each other. At the beginning of the formation of a family, the marital system, the relation of the man and the woman who became the husband and the wife, is a close system. The wife emerges from her family or origin as well as the husband and they are enabled to do this because of the close link they make with each other.

In the second phase of the history of a family the marital system becomes distant. As the parent-child system appears in the family, the marital system changes and this facilitates a close relationship between each of the parents and the children. This is the middle phase of family life.

Eventually the children leave the family through marriage or through growing up and leaving home and then the marital system shifts to its original status again and this is the third phase in which parents must find each other again and refocus their affectional ties on each other.

As in most aspects of development, previous phases influence subsequent ones, e.g. the man and the woman may bring with them problems which were unresolved in their previous families. Also if parents, in the third phase of family life do not find each other again, they are apt to extend beyond the boundaries of their system and interfere with the new systems that are forming as a result of their children leaving home.

Therefore, I may summarize this point by saying that there are recurring patterns in the natural histories of families.

Every member in the family has psychological as well as physical needs. The pscyhological needs, as we all know, include love, support, impulse control, the need to feel part of a group and personal achievement and recognition ... etc. The satisfaction of such needs in the appropriate proportion is necessary for mental health. The family is to be regarded from this point of view as a small social group of people bound together by meaningful emotional bonds, so that they focus their needs upon each other and satisfy each other's needs. If this process works satisfactorily it is conducive to the mental health of all the family members. If there are disorders in the relationships of people, in their ability to perceive each other's needs, in their respect for each other's needs and in their ability to satisfy each other's needs, they are apt to get into difficulty. If the family gets disrupted by the removal or disease of one or other member in its life cycle, then they are also apt to run into trouble. This is then one important aspect in the functioning of the family in regard to the mental health of its members. Certainly the nature of the family's reaction during a crisis situation created by one of its members falling ill is an important factor. An individual facing such a situation is more likely to emerge in a mentally healthy way if during such a situation the family adds its strength to his, supports him and does this in a way that is conducive to effective problem-solving than if his family either does not add its strength to his, or if it presses him to move in an unhealthy direction.

The Community approach to preventive psychiatry.

This is certainly the ideal approach to preventive psychiatry. Any treating physician must have the additional goal of dealing on a community-wide basis with factors that are thought to be pathogenic, in the hope that this will lead to a reduction in the incidence of illness in the population i.e we must widen our scope by looking into the whole community and not confining ourselves to study of patients or families.

As we all know, a community programme for primary prevention of psychiatric disorders must aim at:

a) the reduction of the occurrence of psychological stress in a community and the increased provision for satisfying the psychological needs of individuals.

b) provide the help with problem-solving for individuals facing crisis situations so that they may emerge from the crisis period with improved potential for mental health. According to Gerald Caplan these services may be provided by modifying the behaviour of large sections of the population through governmental action and also by preventive intervention which is focused upon individuals through methods based upon face-to-face contact. The latter category includes:

   a) Direct intervention focused on the individual and his emotionally meaningful milieu during crisis.

   b) Indirect intervention through amelioration of disturbed interpersonal relationships focusing upon the individual which could have the effect of interfering with the long-term satisfaction of his psychological need. Also indirect intervention by the provision of mental health consultation to the community caretaking agents whose role brings them into contact with the individual during his period of crisis.

III Social Problems Related to Mental Health

We are all aware of the intensive list of social problems which are related to mental health and which certainly fosters the inter-relation between mental health and public health. I do not intend to discuss all these social problems in such a short time. I shall only mention some of them which I believe are pressing upon the psychiatric profession now-a-days and I shall wait to hear views in the discussion groups.

1. Problems of family planning
2. Problems of abuse of drugs in general and psychotropic drugs in particular
3. The problem of geriatrics
4. The problem of addiction
5. The problem of adolescence
6. The impact of chronic diseases on various members of the society
7. The problem of the handicapped, physical or mental

Finally, I hope that I have given here a simplified illustration of how to help the G.P. to apply the psychiatric knowledge which he gains (during his undergraduate or post-graduate studies) in his medical practice in the community. This will definitely help in raising the standard of medical care in general and in alleviating the sufferings of humanity which is ever increasing.