POSTGRADUATE TRAINING IN PSYCHIATRY: OPTIONS FOR INTERNATIONAL COLLABORATION

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Since its foundation, the World Health Organization has convened meetings of experts and produced reports on a variety of topics related to the training of personnel to work in the mental health field, with particular attention being paid to psychiatry. More recently, WHO within its mental health programme, has strongly advocated that the concept of mental health be broadened from only including issues related to the treatment of mental disorders to one that includes the prevention as well as the promotion of psychological well-being and development, not just as it applies at an individual level but also at community level. Nevertheless, key workers within such broadened mental health services are often psychiatrists and psychiatric nurses who have been trained primarily to help those with mental disorders.

Several major WHO reports on the teaching of psychiatry appeared in the early 1960s (e.g. WHO 1961). Since then the Organization has mainly dealt with the issue at the Regional level. Much of WHO's work since the 1960s has focused on the training of general health workers and paramedics in an effort to extend mental health care as broadly as possible. Given the implications of this for the way services are delivered, and the new role that this gives to psychiatrists, it is now opportune to take another global look at the training of psychiatrists and to look particularly at how countries can help each other in providing a better psychiatric education.

This document presents the deliberations from a WHO meeting on the subject of International Collaboration in Postgraduate Psychiatric Education held at the Institute of Psychiatry, London, UK, 21-24 April 1986.

In previous decades collaboration referred to the sending of psychiatric trainees from developing countries for training in developed ones. Although this is still a significant aspect, it is now realised that collaboration is much more of a two way process, and that increasingly collaboration is taking place between the developing countries. The documents presented here still concentrate strongly on the treatment of mental disorders, since that is still an important aspect of a psychiatrist's work. Nevertheless, especially in the developing countries, a broader concern for mental health is required of psychiatrists and some of the papers reflect this. Certainly, throughout the presentations made at the meeting, a recurrent theme centred on the fact that a psychiatrist's role in the developing countries was often very different from that role in the developed world. WHO has frequently emphasized that psychiatrists in developing countries need to delegate their functions to a much greater extent and spend most of their time in supervision, training and administration (WHO 1975).

The WHO Fellowship programme has supported a large number of psychiatric trainees from developing countries to study in centres in the developed world. In more recent years WHO has also facilitated the way for trainees to get paid employment to support them while receiving conventional psychiatric training in developed countries. The Organization has however ensured that such training includes attention to issues that are especially important to the developing world (Tantam and Goldberg 1988).

It is intended that this document will focus attention on what is required from psychiatric training in our changing world so that existing or proposed programmes can be examined to see whether they do indeed answer the defined requirements.
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Chapter One
A CALL FOR ACTION
Griffith Edwards and Neil Holden

"... if we mean now to make good training our chief immediate aim, we shall be forced to traverse some awkward country, throwing away goods that we have prized, and learning to distrust and redraw some of our time-worn maps".

Aubrey Lewis (1947)

This volume focuses on essential issues which would have to be addressed practically and in detail by the many individuals and institutions who at country, regional and international level are responsible for postgraduate psychiatric education. The purpose of the meeting was not however simply to produce committee output for the files. Its aim is to identify a practical approach to strengthening a highly important and complex aspect of international health collaboration, and on that basis to issue a call for action. What is required is a partnership between nations which will ensure that young psychiatrists are at best possibly equipped to serve the needs of the people of their home countries.

In the larger part the world mental health services are inadequate, and in some places even non-existent. It is toward the amelioration of that entirely unacceptable situation that collaborative training efforts must now be directed. If efficient use is to be made of the scarce resources which are available to support such training and manpower development these efforts will have to be planned, monitored and reviewed. Those involved however, in postgraduate psychiatric training in developed countries are also examining their own work carefully and a realization exists that steps could be taken to make such training more appropriate to changing service needs. More frequent exchanges of students and teachers between countries can profit all concerned in broadening their experience.

Rather than having a "Summary and Conclusion" at the end of this document, the decision was made to put "A Call for Action" at the very beginning. By stressing the need for action the document is reflecting the very strong consensus view of the meeting out of which it was developed. This first chapter seeks to identify a range of new directions which collaboration must now explore.

Part II sets out some of the general and underlying challenges which need to be met. It examines the realities of mental health service provision and psychiatric training in the developing world and outlines the revisions which these realities will require in patterns of collaborative effort. The importance of rethinking the basic science curriculum is stressed and the need to ensure appropriate arrangements for examinations and certification.

Part III has the title "Primary Care as Bedrock for Psychiatric Training". Its four chapters not only discuss the general principles which must determine an effective connection between the primary health care perspective and psychiatric training, but provide case examples. Part IV goes on to discuss various issues relating to training for service development, and makes recommendations on such matters as the teaching of administrative skills, training for advocacy and innovation, research training, and the training of teachers. The Workshop thus gave prominence to a requirement that young psychiatrists from developing countries should in future be prepared appropriately for careers which will demand much more than just the traditional clinical skills.

Part V analyses questions relating to training in the sub-specialties. It was concluded that a worthwhile and evolving place for collaboration in these sectors will continue to exist provided that what is attempted is as ever tempered by an appraisal of the real service needs.

A call for action on a twelve-point programme

1. Psychiatric training should be "service-led"

An untoward consequence of training in advanced centres is that sometimes students trained in such centres will practice in places very different from these and may find themselves unequipped to deal with the mental health problems by which they are confronted. The expectation should be that the
future service needs should determine the type of psychiatric training offered by postgraduate training centres.

2. The pattern of postgraduate training should not be restricted to any one type of arrangement and encouragement should be given to innovation
Training should not be constrained within the dictates of any stereotype. Psychiatry is at different stages of evolution in different parts of the world, and training needs must be seen as continuously evolving rather than static. A high degree of flexibility will therefore remain necessary together with the ability to rethink and recast training in the light of changing requirements.

3. Postgraduate training in psychiatry should wherever possible be given in the trainee’s own country
The Workshop realised that this ideal is still not fully attainable but believed that it is the goal toward which all countries should strive. Only through training in the indigenous setting is the young professional likely to learn fully and sympathetically to appreciate the realities of the cultural, social and economic conditions in which he is going to work. To spend these postgraduate training years in an alien environment may still on occasions be the only means of obtaining the necessary education, but it is unsatisfactory that a psychiatrist should qualify without ever having seen or treated a psychiatric patient in his own country.

4. For the foreseeable future a need will continue for sub-specialty training which can be offered to psychiatrists in centres in countries foreign to the trainee
Such training should be in accord with the principles outlined in paragraph (1). In some sub-specialties there may be a call for a 12-month specialist course while other trainees may benefit from shorter courses or specially arranged visits. More than one centre, operating perhaps in more than one country, should be willing to “network” a training experience specially designed for the individual academic need. Such an arrangement may be a specially appropriate formula for the senior psychiatrist who is attempting to plan in his own country some new aspect of training or service development.

5. Research training
Psychiatrists from developing countries require research training which will teach skills applicable in their own countries. Epidemiological research and methods bearing on service evaluation are likely to be particularly appropriate. It may be useful to arrange for some preliminary research training in an advanced centre while the actual data gathering which forms the core of the research experience is conducted in the trainee’s own country with further help then being given in the analysis. What should be avoided is engaging students from developing countries in high technology research which will have no feasible utility in the home setting.

6. Support for developing countries in the acquisition and design of teaching material.
In many developing countries there is an evident lack of textbooks, journals, and other teaching material for psychiatric training. A support scheme is badly needed which will remedy this state of affairs and low cost schemes should be set up for provision of journals and textbooks. It should however be noted that many existing texts by themselves do not fill the total need and efforts may be needed to assist in the low-cost production of more culturally relevant materials, specially for primary health care training.

7. Visits by psychiatrists between teaching centres in developed countries and developing centres can be of great value.
Many such visits already take place and with considerable mutual benefit. Support for these arrangements could be strengthened and their cost effectiveness might often be high. Further thought should however be given as to the type of task in which academic visitors can most usefully engage, with an emphasis perhaps on curriculum development, research planning and coordination, as well as giving lectures or leading seminars.

8. Advanced centres of training must be more informed on service needs and better equipped to mount training courses to meet these needs
What has been said under previous headings carries the implication of a very considerable commitment being required by host centres if, in changing circumstances, their training programmes are to be re-gearred toward increasingly appropriate models of training. It is vitally important that at every stage of a student’s stay he is invited to examine the relevance of what for his own ultimate service setting is being learnt. The chapters which follow will point to many aspects of detail but it should in
Particular be emphasised that collaborating centres must be equipped to offer a primary care and public health perspective: teach administration, service development, advocacy and basic research methods; develop the trainee's own capacity as a teacher especially in relation to other professions and primary health care workers. Such centres must possess adequate bibliographic and video resources. They should have visiting teachers and members of their own faculty staff who are themselves familiar with mental health service needs in a broad range of settings.

9. All parties to international collaboration in postgraduate psychiatric education should be encouraged to develop and adhere to mutually acceptable "guidelines for good practice" relating to their shared responsibilities towards trainees
Such a suggestion is analogous to the useful practice which now exists in many universities regarding responsibilities toward Ph.D. students. Without here attempting to approach the detailed level of drafting which would clearly lie with the parties concerned, issues which might generally be made usefully explicit were identified as follows:

- The trainee's sponsoring authority should inform the host country explicitly and in detail as to what type of training experience is expected of the visit and what special training needs are to be met.
- The host country should make an explicit statement on the content of the training course which it is offering.
- The country of origin should ensure adequate language training.
- There should be evidence that arrangements have been made for the trainee's professional employment on returning home thus obviating needless anxiety.
- Personal supervision and support should be available in the host country not only as regards professional issues and feedback on training performance, but also in relation to living arrangements and any problems in adjustment.
- Where it is still relevant for examinations to be taken in the host country, issues relating to certification should be discussed with the trainee at an early stage and examinations should be so constructed as to test skills and knowledge which truly bear on what will be expected of the candidate in his own country.

10. Examinations and certification should so far as possible be determined by authorities in the trainee's own country
Certification for basic psychiatric qualification should wherever possible be determined locally or regionally even if training is given abroad and this was a goal to which the Workshop attached considerable importance. Many undesirable consequences result from developing countries having to rely on "international" qualifications in basic postgraduate psychiatry. For sub-specialty training it may still often be appropriate for certification to be given by the host country but in such instances what is being expected of the candidate must be culturally appropriate.

11. Regional Centres for psychiatric training should be formed
Useful experience has already been gained in international collaboration in psychiatric training. The formation of advanced Regional Centres could now be further encouraged. The faculties of Regional Centres should be drawn from countries of the region concerned although some assistance might at times be sought from academic visitors from other regions. There should be the capacity to offer shorter as well as longer periods of training. The training base should include a community psychiatric service which can demonstrate the practical workings of a primary health approach, rather than the training only offering hospital-based experience.

12. The role of the World Health Organization
WHO has provided considerable input into international collaboration in postgraduate psychiatric education over many years. This has been through the provision of guidance by synthesising the views of experts from many countries, and also by providing fellowships to enable exchanges to take place between countries. WHO has a continuing role to play in ensuring that information is available which encourages the development of appropriate learning opportunities for students from other countries, for identifying appropriate centres of learning and for putting potential students into contact with them. WHO should continue to use its own funding wisely to facilitate international exchanges and should where possible search for extrabudgetary support for such activities.
Old Goods

These twelve calls for action developed out of the proceedings of the meeting point the way to exciting future directions. Sir Aubrey Lewis however, warned that any effort to improve training may lead to the sad conclusion that the time has come for some throwing away of goods that we have previously prized. The conclusion of this report is, in sum, that a new basis for collaboration in psychiatric training should now be planned and implemented. In the process some of the old structure will certainly have to be dismantled. There is however much good quality experience on which to build and these efforts to appraise directions for the future owe a very great deal to those who over previous decades had courageously built the collaborative foundations.
Part II
THE CHALLENGES
Chapter Two

PSYCHIATRY IN THE
DEVELOPING WORLD:
DIFFICULTIES BUT NO
GRONDS FOR
DESPAIR

R. Gonzalez and R. de Alarcon

The Background of Need

Human beings are distinguished from all other life forms that populate this planet by capacities of mind. Paradoxically, it is equally the case that concern for the good health of this unique characteristic of mankind generally remains in the estimation of the public and governments of low importance. Mental health issues are never accorded the same priority as seemingly more dramatic matters relating to physical health. The often quoted WHO estimate of at least 40 million people across the world suffering from gross mental health problems with an immeasurably greater number experiencing the adverse emotional consequences of increasingly difficult social and economic circumstances, appears to attract little serious attention from government policymakers. This situation is present both in the developed and the developing world. This is exemplified by the fact that in many countries of the developing world there is one or less psychiatrist per million people (WHO, 1975).

In more affluent regions, already blessed with an abundance of primary health care workers in the shape of general practitioners, and with armies of psychologists, social workers and nurses, the desirable level for psychiatrists is believed to lie at about 1 per 10,000 or 20,000 of the population. Although such figures may not be applicable worldwide one of the major challenges for collaboration in psychiatric training is the need to train sufficient manpower in the developing world. Minor changes are not enough. Altering the curricula, introducing new topics, or extending the period of training are not by themselves sufficient answers. Much wider conceptual and organizational changes are required if the needs of the developing countries are ever to be met.

Realities of Psychiatric Practice in the Developing World

The fact that psychiatrists in developing countries may often see 50 or more patients in a morning is well known. The same situation may continue throughout every working session of the week. However, the patients that doctors deal with represent only a fraction of the patients existing in the community. In some regions, population growth (and hence psychiatric patient population growth), is accelerating faster than the production of new psychiatrists. In such circumstances the psychiatrist trained in a developed country reacts by comparing his state with what he enjoyed as a trainee and by grieving for the solutions that were enjoyed in the training environment. Time is then spent lobbying administrators for more hospitals, more psychiatrists, more laboratories, more of the technical apparatus which had been experienced during such a training. The pattern is pervasive and not easily changed.

Potentially, the situation is not altogether bleak. Outside the psychiatric clinic traditional healers often exist in large numbers. An even more fundamental resource is found in the extensive and supportive family and clan groups. It is within these networks that the majority of people with mental health problems receive attention and emotional satisfactions. Unfortunately, models for tapping into such resources have not been fully developed.

Beyond the exploitation of those rich cultural strengths it is widely accepted that the solution in developing countries lies in the adoption of primary health care systems, with decentralisation of psychiatric facilities and the delegation of traditional psychiatric and medical skills to community
health personnel (German, 1987). WHO has adopted this as a working aim and seeks to promote such systems through international collaboration.

If it is accepted that psychiatric needs amongst the majority of the world's population can only begin to be met adequately at the primary health care level, then it becomes apparent that the major role for any psychiatrist in a developing country is educational, supervisory, and consultative. Apart from the need to see patients to maintain his or her own clinical skills and to provide a service for exceedingly complex and difficult diagnostic and management problems, any direct clinical activity undertaken by a qualified psychiatrist over and above that required to meet the needs just stated is, logically, a waste of expensive professional time and a squandering of the money which has been invested in training.

The variable nature of training worldwide: a pointer to deficiencies

Postgraduate training in psychiatry has only in recent decades reached a formal structure in developing countries and thus far no more than sporadically. The history of such education in developed countries, on the other hand, is longer. Any comparisons must therefore make allowance for the relatively limited time base of developing country experience. Furthermore it is essential that the purpose of comparison is not conceived mistakenly as simply that of determining where less developed countries have to catch up, with the richer countries for ever taken as the ideal. With those provisos borne in mind an exercise in comparison may offer some useful leads as to possible ways forward.

It should not be thought that the pattern of teaching in the developed world is everywhere ideal. There are indeed good centres and there are poor ones. Similarly, within the developing countries, there are those centres which offer a high level of training and those that offer little. An outline of some of the deficiencies that can exist, include situations that occur more frequently in developing countries, but nevertheless may also be found in the developed.

Programme structure

Postgraduate training centres in developed countries may be better defined both at the curricular and personnel level. The facilities on offer for trainees however may be very variable between the various countries of the world and indeed within countries. Situations may exist in which there are few formal seminars or courses, even though they may be described on paper. The lack of bibliographic support can make activities such as journal clubs and clinical reviews and presentations, inconsistent and weak. There may be no co-ordination between the different components in the programme. The psychiatric trainee may have to face such difficulties as lack of adequate training in psycho-pharmacology and psycho-therapy, inaccessibility of laboratory tests and other technical advances, and inconsistent support from other members of the mental health team.

In the more advanced centres in developed countries the training programme lasts at least three years with rotations between different clinical services in the North American model. In other centres, the old European pattern of informal ward attendance for several years with the approval of the head of service will suffice to qualify as a specialist. Finally, in some areas training is exclusively a self-education effort.

Clinical settings for the training programmes

Although not universally the case, some countries lack adequate university-based or teaching hospitals. The state hospitals, contemporary equivalents of the old asylums, stand out as often the primary training centres (Thompson et al, 1983). The distortions that this kind of training creates are self-evident. The poverty of physical resources for adequate lectures, case presentations, patient interviews and so on, is further complicated by the overcrowding of the wards themselves. Paradoxically, the overall number of treatment options is pathetically scarce. Other facilities used for training may include community-based hospitals, charity hospitals, social security hospitals, or even private clinics. Although well equipped the latter may be the least appropriate training settings for developing skills by which the majority of those in need will be served.

The larger number of psychiatrists in developed countries assure ready availability of teachers in academic centres. In developing countries fewer staff are going to be available for teaching (Griffith and Ruiz, 1977). Those who can teach are not necessarily full-time and such work is likely to take them away from private practice. Together with the "professional distortion" that such private practice generates, another issue may be the unavailability of personnel after the morning hours.
Evaluation
Training is more often evaluated in developed countries. The periodic assessment of the trainee’s performance, the provision of adequate and individual supervision, the availability of bibliographic resources, and other factors, make it only natural that at the end of the training process examinations aimed at determining proficiency are taken by a majority of trainees. This not only enhances their public image but certifies their skills and makes them look respectable in the eyes of their non-psychiatric colleagues. Trends towards more evaluation are being seen in developing countries.

Financial aspects
Training centres in developed countries are supported either by university funds, private hospitals or the State mental health system. The trainees usually receive an adequate salary which they are often able to supplement. The picture is radically different in some developing countries where the trainee receives a meager salary, and is therefore not expected to have a full-time commitment to the training programme and has to hold different jobs in order financially to survive (Howard, 1983). This diminishes the academic benefit that can be derived from the training programme. Between the two extremes is a spectrum of provision varying from country to country and area to area.

Number of trainees
At the last count there were close to 300 psychiatric trainees in Latin America and perhaps half that number in training centres of Asia and Africa. It is estimated that by 1995 there will be about 300,000 medical students in Latin America which implies that approximately 40,000 will graduate annually. If about 1.5% of each graduating class go into psychiatry then about 600 young men and women will try to obtain psychiatric training each year. It is likely that roughly 20% of this number will attempt to get into training programmes outside their country of origin, particularly in North America and Europe; thus, almost 500 psychiatrists-to-be will start their training in centres within Latin America (Beaubrun, 1971). The projections for the developing world as a whole for the year 2000 suggests a very approximate total of 1,500 potential psychiatric trainees per year looking for training in their country of origin, plus another 450 travelling abroad in search of training. These developments are largely haphazard rather than influenced by the kind of “manpower training” exercises which have become familiar in Europe or North America.

The job market
This is one of the most critical considerations. There is a market bottleneck for the graduates of some training programmes, especially in Latin America. Job opportunities are saturated in the urban centres of many developing countries, with the rate of psychiatrists per 100,000 inhabitants much higher in urban than rural areas. Yet at the last count there were only about 9,000 psychiatrists in Latin America and about half that number in the whole of Asia and Africa. In many countries institutional employers are very scarce. When this is the case the psychiatrist has to enter private practice and as a result becomes primarily interested in providing services to the small middle and upper-class segments that can afford his services. Academic activity becomes a hobby and continuing professional education comes to a halt. And expansions of the job market with more widespread opportunities to work for the real needs of the community would demand and support advances in appropriate training. Increased manpower allocation for semi-urban or rural areas is badly needed (Tucker et al, 1981).

Criteria for selection of trainees
There is great variability in terms of criteria for acceptance of postgraduate students among different countries in the world. Some require no preconditions at all while others stipulate a loosely defined prior assignment to existing services. In still other countries, the applicant has to take an examination in order to be admitted into a training programme. The brightest students are not going to be attracted to psychiatry if they have received only a poor undergraduate grounding in this subject. A minority get into psychiatry as a result of not finding places in their first or second choices for postgraduate training and a question of motivation may arise. These are problems which may affect selection at times even in the richer parts of the world.

Non-psychiatric influences on psychiatry
International efforts towards an articulated postgraduate training in psychiatry will have to take into account factors which go beyond the expertise of the medical and psychiatric educators. The cultural, socio-political and economic factors which shape the ultimate realities in any country or region, must be taken into reckoning. Cultural factors become important in several different ways.
It would not be easy for instance to transplant a set of training postulates from a developed country to an under-developed one where clinical practice is enmeshed in folklore and primitive beliefs.

Perhaps more important than the cultural factors are the socio-political features of the different countries and their influence on health care structures. These issues have played a substantial role in the ups and downs of international collaboration. The flow of technicians and equipment as well as undergraduate students and postgraduate trainees has been, in most cases, dictated by the nature of the political relationship between developed and developing countries. It seems clear that for a number of decades prior to the 70's and 80's Western European and North American countries received the bulk of postgraduate trainees emanating from developing countries. In later years a change seems to have been taking place, with more trainees either choosing to remain in their countries of origin, or looking to Eastern Europe for training. The nature of this shift is still not completely understood, but it has to do with the international climate of political liberation and autonomous decision-making which marks the de-colonisation period, as well as the polarisation of the two superpowers and their political systems. The concept of "spheres of influence" has been maintained in some areas even so far as postgraduate training is concerned, but these patterns are breaking down.

The economic factors are also important. The crucial question in postgraduate training from a financial point of view is the cost-effectiveness of trainees from developing countries continuing to come to developed countries such as has been the practice for many decades. The developing countries invest a great deal of money in training people who, as soon as they finish their undergraduate studies, may decide to travel in search of a better postgraduate training. As a result, so the popular conception goes, the trainee becomes part of a working medical force in the host country, and deprives his own people of his talents and of the investment they have made in him. If a large number of these trainees decide never to return to their countries of origin then the damage is consummated. An example of this trend is shown by the fact that whilst there are fewer than 100 trained psychiatrists working in Pakistan, the number of Pakistani psychiatrists in the UK and USA exceeds 700 (Beulburen, 1971 and Brown, S. personal communication).

Conclusion

Lack of structure, difficulties in providing adequate supervision or periodic assessments and the poverty of resources may mean that despite the high quality of the teachers, the training which is offered in poor countries cannot be of the highest standard. An ambivalent dependency on imported sophisticated technology, and the personal survival mentality which goes with the economic conditions of developing countries can be further ingredients in this difficult mix. Those problems need to be openly and fearlessly admitted but they do not constitute grounds for despair. In the face of such obstacles a great deal has already been achieved and there is much diverse experience on which to build. If the difficulties are more fully analysed and cooperation between countries strengthened, there are realistic expectations that by the year 2000 psychiatrists will be properly trained to make their contribution to Health for All.
In many parts of the world psychiatry has been until very recently a matter of mystery and faith. In a number of developing countries, faith healers, the fore-runners of psychiatric practitioners, still out-number the professional psychiatrists and dominate the therapeutic field, particularly among rural populations. However, in the wake of the growing socio-economic developments and scientific medical advances, the psychiatric scene has been slowly but progressively changing. Emphasis on training and the development of qualified psychiatric personnel has been the moving force behind this progress.

Learning psychiatry is, of course, a life-long undertaking. To master the art of this medical discipline, the candidate has to go through the well known six phases of education and learning, namely the pre-medical, the pre-clinical, the medical, the graduate, the postgraduate and finally continuing education with possibilities for differential training leading to sub-specialisation. This continuum of phases provides a convenient line for understanding models of psychiatric training.

Although the systems of general education in developing countries vary widely, there is strong competition to enter medical school. Motivations are essentially determined by a common wish for a recognisable status, social prestige and a good income. No studies have however been conducted in developing countries to explore the factors which make the student opt for psychiatry but experience shows that a lot of effort has to be made to attract the promising medical novice to specialisation in psychiatry.

Psychiatry in Medical Education

Over the last three decades a series of efforts have been made at international level to help the general health worker to be more knowledgeable and skilled in dealing with mental health problems. In reviewing trends in mental health over the years 1949-1960, for instance, the WHO Expert Committee on Mental Health (1961), noted with approval the recommendations made by previous committees on the training of general health workers. However, a study which was conducted in the WHO Eastern Mediterranean Region (Ghia, 1970), clearly revealed the serious deficiencies which existed in the teaching of psychiatry in medical schools. In this study a questionnaire was sent to 39 medical schools. The findings pointed to wide variations in the allocation of teaching time, the methodology and the content of psychiatric training, and the phasing of psychiatric training within the current curriculum. The hours of instruction given to medical undergraduates in psychiatry, mental health or medical psychology, varied from 16 to 232 hours. Eight of the medical schools did not include the behavioural sciences in their curricula.

The 1970 WHO Study "noted with regret that the minimum requirements recommended by the WHO Expert Committee 1961 have not yet been implemented in most of the Medical Schools of the Region." It strongly recommended that the following requirements be implemented as a first step:

- behavioural sciences—sixty hours of instruction,
- clinical psychiatry—twenty-five hours,
- full-time clerkship under supervision— one month.

To make such recommendations is one thing but to implement them can be quite a different matter. Such recommendations imply a clear appreciation of the important place of psychiatric training, and its role in the promotion of health and in prevention of mental illness. However, two questions will immediately be raised. Who will implement these recommendations and how? Until the early seventies psychiatric training was in many developed countries coming last in any list of priorities. Over
the last decade, however, political and social changes as well as bi-lateral, regional and international co-operation, have facilitated the development of a fresh and more critical look at medical curricula. This has led to more insightful planning and a better balance in medical training. The need for psychiatric training has been increasingly recognized. Such trends can be seen particularly in the newly established medical schools such as those in Kuwait, Saudi Arabia, Somalia and Zambia.

Psychiatric training in Canada and in the UK have recently been reviewed (Lemenda & Burke, 1983; Goldberg et al, 1983; Blackwood & Alexander, 1983). For developing countries such models have to be modified in critical respects and adapted to local conditions. The following might be seen as some of the most essential elements which would contribute to any initiative which aims to develop an adequate national capacity for psychiatric training:

1. Establishment of professional units or departments of psychiatry in undergraduate medical schools.

2. The development of an integrative approach with general medical training and paediatric, public health and social medicine.

3. Psychology should be taught at the pre-clinical level in close linkage with the biological sciences.

4. Special attention should be given to clinical psychiatry and case demonstrations in outpatient settings, in-patient units in general hospitals, and suitable psychiatric hospitals. Old custodial and isolated psychiatric hospitals can be counter-productive in training. Efforts have to be made to show the students new or acute presentations and demonstrate the outcome of treatment. Such practical demonstrations form a good basis for learning problem-solving methods.

5. Medical students should be attached to a teaching psychiatric unit for clinical clerkship. This has to be arranged within the framework of the general teaching programme and according to the number of students and available facilities.

6. The teaching programme has to be systematically evaluated. This must entail the inclusion of psychiatry in medical examinations and feedback from students into the teaching programme. Such measures will induce the student to take psychiatry more seriously.

**Psychiatric Training for the Medical Graduate who is not going to become a Psychiatrist**

Until comparatively recently, there was a conspicuous lack of organized psychiatric training for the medical graduate in many developing countries. Exceptionally, the medical graduate might find the opportunity to gain psychiatric experience if he has been attached to a psychiatric unit or department as an intern or later to a psychiatric institution as a medical officer.

The very serious deficiencies in postgraduate psychiatric training only came to attention when it was realized that approximately 15 per cent of patients attending general health services were suffering from psychological problems. The lack of knowledge and inadequate skills of the general medical practitioner inevitably meant that this important sector of the patient population were failing to receive proper care.

Towards the end of 1975, a WHO collaborative Study on Strategies for Extending Mental Health Care was initiated (Baasheer, 1976), and eventually covered seven countries in the developing world. The main objective was to develop and evaluate the effectiveness of alternative and low-cost methods of mental health care. A central component in this study was the development and evaluation of methods for task-oriented training in mental health for general health workers. Each country developed a treatment plan and implemented a practical training programme for the general health worker, including the medical practitioner. The study was satisfactorily completed and critically appraised (WHO, 1984a). The impact of this activity has been far reaching. An interesting example is the Indian experience with mental health training programmes for general physicians working at primary health care level (Wig & Parhee, 1984). A study in Fayoum (Egypt) also proved highly successful in the training of general medical practitioners and the extension of psychiatric care to rural areas (Baasheer et al, 1979). A plan is now underway to extend this approach to the other twenty-five governates with psychiatric training as the main focus of an evolving national strategy.

Short elective courses can also be of great value in strengthening general medical competence to deal with psychiatric problems. During the last two years a number of countries in the Eastern Mediterranean Region, e.g. Pakistan, Iraq, Democratic
training courses for medical officers working in PHC. Elective courses in psychiatry for school medical officers and public health officers have been initiated in a few countries (e.g. Kuwait). However, these courses are still at a very early stage of development.

The idea of organizing an international mental health course for public health officers in centres in industrialised countries is interesting and attractive. The psychiatric education for public health officers organized by the London School of Hygiene and Tropical Medicine in collaboration with WHO provided some useful general orientation for overseas students. However, questions regarding the relevance of the teaching have, of course, to be kept under review and will enhance future development.

**Postgraduate Training**

Until the mid-seventies, postgraduate diploma courses in psychological medicine had in the developing world been limited to a relatively few developing countries such as Egypt, India, Indonesia, Iran and Nigeria, where psychiatric teachers were available to organize comprehensive training programmes. Of the 12,000 psychiatrists in the developing world, it has been estimated by Lenz (1984) that 90 per cent from Africa, 50 per cent of those from the Middle East, 40 per cent from Asian countries, and 25 per cent from Latin America, had received their training in industrialised countries.

While students from the developing world, for example, go to the United Kingdom to obtain professional qualifications in psychiatry such as the MRCPsych., M.Phil., or Diploma in Psychiatry, some countries in the developing world have established local psychiatric training and specialist examinations. Genuine attempts have been made to match and adapt the training objectives, methodology and contents of the local course to the academic standards required in industrialised countries. There are appreciable differences due to the historical gap, to the quality and number of the training staff and the availability of technological resources, but these problems are gradually being surmounted. Bilateral, regional and international cooperation has proved of great help in this respect. In the development of the psychiatric diploma course in Saudi Arabia, for example, cooperation was satisfactorily developed between the Ministry of Health, the psychiatric hospital at Taif, the University teaching staff in Jeddah and Riyadh, and leading psychiatric teachers from Egypt, Holland, Lebanon, Pakistan, Sudan, Britain and the USA. Co-operation with WHO was established from the beginning. It is to be noted, however, that an essential criterion for the success of such cooperation is the attainment in due time of a state of self-reliance and independence.

There are several issues to be considered when discussing training for higher psychiatric qualifications. The basic shortage of competent and experienced teachers in the developing world constitutes a major constraint in organizing and meeting the growing needs for postgraduate training in psychiatry. On the other hand, as already outlined in Chapter Two, training in developed countries is for many reasons not ideal.

Some developing countries have been endeavouring to strike a balance between organizing local training and sending students abroad. The overall aim has been to train and develop a core of consultants with good professional knowledge in psychiatry who are competent to diagnose, treat and manage general aspects of mental illness. Such a broad training has been the first priority in the developing world. However, as psychiatry becomes an increasingly advanced sector of medicine, the importance of special training in specific areas has begun to be recognised in some developing countries.

Ndetei (1984) outlined what he felt to be the necessary training for the psychiatrist in Africa. He stated that they should be clinicians with an excellent grasp of the Mental State examination and neuropsychiatry. They have to be researchers and epidemiologists, administrators and efficient organizers of services, teachers and leaders. They require specific experience in transcultural psychiatry and knowledge of the history of psychiatry. They should have completed at least six months practical experience in the relevant sub-specialties.

Most of Ndetei’s suggestions are also applicable to other parts of the developing world. It seems likely that psychiatrists in these settings will have to be involved in at least the following responsibilities. They will have to be competent in setting up, supervising and administrating treatment services and related teaching programmes at many levels. They will also need to develop skills in organizing financial support for these services and in improving cost-effectiveness. Part of the job is also likely
to be advising government agencies regarding services and public health measures with an awareness of socio-political change in their countries.

A large part of the role of psychiatrists in the developing countries lies, of course, in working with or within the primary health care system. This demands the development of some very special skills which are not commonly taught in the "centres of excellence" in developed countries. These skills include the ability to motivate, teach, lead, supervise, and encourage the primary health worker and generalist. It is important to learn the ability to delegate diagnosis and treatment while taking an overall responsibility for service provision. Learning the necessary administrative skills to operate in this type of setting is of fundamental importance.
Chapter Four

PATTERNS OF COLLABORATION: LOOKING FOR A NEW DEAL

G. Allen German

It has been traditional for aspiring psychiatrists from the developing world to trek towards the developed countries for training. This reflects the ties of language and colonial history, and the belief for some that the developed world is the source of all knowledge and power. This pattern of postgraduate training has provided the developing world with small numbers of psychiatrists, well trained in clinical psychiatry, and potentially capable of functioning as leaders for further development in their own regions. Unfortunately, such training has failed to produce enough psychiatrists who are creative within their own cultures, who are resourceful about methods of meeting the extraordinarily different needs of their own cultures, and who are willing to think in ways other than those suitable for centres of distinction in the developed world.

What is said here about the difficulties in these international training relationships should not be interpreted as negative in tone or intent. There is a long history of often very successful and sensitive provision of postgraduate psychiatric training experience for young professionals who have come from developing countries to centres in the developed world. It cannot be too strongly emphasised that the purpose of this report is to build on what has already been achieved rather than engage in demolition. But benefitting from past experience must involve a constructive willingness to learn from what has gone wrong as well as from what has gone well.

Problems of Cultural Adaptation

Trainees from the developing world travel for training to the international centres armed with high expectations. Immediately they are faced with language barriers (even if only colloquial) and with the painful process of cultural acclimatisation. Along with prejudices and sometimes financial hardship, this initial “culture shock” can account for an early sense of bitterness or failure. The trainee is aware of being an alien in a foreign educational system where he feels discriminated against, and where, as a fee-paying student, he is frequently super-numerary to the local training establishment and has less clinical involvement and responsibility. Local trainees in these centres provide strong academic competition without themselves being culturally disadvantaged.

The cost of these training courses is often unduly expensive (Leff, 1980). If the trainees join the health services of the developed countries to avoid paying fees, they then frequently find themselves in posts with heavy clinical commitments and little time for, or access to, academic training. In such situations, there is a high failure rate in postgraduate examinations and trainees return home without any real gain. Increasingly, paid training posts are being restricted by legislation to “protect the market” for locally qualified graduates. The effect of registration examinations (such as ECFMG or PLAB), is to curtail and restrict fee-paying postgraduate students as well.

Although adaptation to these cultural and “political” problems occurs with time (usually within a year), the postgraduate trainee overseas is faced with further problems later. As the end of the course approaches after three or four years, he or she often feels ambivalent about the return. Sometimes students have no definite posts waiting for them at home or there have been unwelcome political changes in their absence. What invariably occurs is a period of reverse cultural-acclimatisation, occasionally just as painful as the first. Colleagues who have not themselves travelled
may regard these sojourners with jealousy and suspicion.

However, the worst cultural aspect of their training is the fact that some will have managed to qualify as a psychiatrist deemed fit to practice in their country of origin without ever having treated an indigenous psychiatric patient. They will have been instilled with ideas about developed, technological psychiatry, and will return to find these perspectives worthless. Worse still, it is human nature to seek to protect these inappropriate views against reality, leading to the new psychiatrist's involvement in the development of entirely misconceived psychiatric care for the population.

The Content of Training in Developed Countries

The most important skills for a psychiatrist to master are the clinical skills of interview and examination. Although this is taught extremely well in most developed centres, there is no certainty that these skills can easily be transferred across cultural barriers, without a process of major re-learning. Even where awareness is drawn to these cultural differences by the involvement of the trainees with patients from minority cultures, this is no substitute for practice with the indigenous population of the trainee's own culture. Similarly, the back-bone of psychiatric services of developing countries is increasingly becoming primary health care, and training in this type of practice needs to be given. Exposure to primary care in the United Kingdom or United States is inadequate because the fundamental principles of the health systems of the developed and developing worlds are different.

Generally, there is a lack of training in prevention and public health in the courses of the developed countries. There is little training for students or junior colleagues on how to administrate a health service. What training is offered in this regard is probably irrelevant. The similarities, for instance, between lecturing to nurses in a developed country and teaching primary care workers or traditional healers in a developing one are remote.

The psychiatry of some developed countries has been described as based on psychiatrists giving the service which they want to give, rather than that which is most efficient for the population concerned. There are often different tiers of care for rich and poor. Psychiatry and its training schemes have become orientated towards high technology. In some centres primary prevention and social psychiatry are relatively ignored.

There is no doubt as to the wealth of resources for psychiatric training that exist in the international centres, and it would be a tragedy if students from developing countries were unable to study there. However, collaboration in psychiatric training has to come up with a new deal for overseas trainees which acknowledges that basic training in such settings may well become increasingly inappropriate for psychiatrists from the developing world.
Chapter Five
IMPLICATIONS OF A TRANSCULTURAL PERSPECTIVE
H.B.M. Murphy and Xu Taoyuan

Meaning of Terms

Any discussion of "Transcultural Psychiatry" must be preceded by a consideration of what is meant by that phrase. Like many commonly used labels, its use has sadly descended to the level of jargon with many meanings and little precision. Three of its more popular usages are as follows:

1. Transcultural psychiatry is seen as the study of psychiatric illnesses in different cultures, with special regard to the differences that socio-cultural and genetic influences create in the presentation, natural history and response to treatment of mental disorder.

2. The opposite view also exists, that Transcultural psychiatry is the study of the psychiatry which transcends cultural differences, and which is not affected by local variation.

3. Another view gives the term a more restricted meaning than either of the above, and sees it as implying the promotion of cultural public health or cultural prevention of illnesses.

In addition there are other elements which can be included under this "umbrella" term, such as the study of ethnic minorities within a larger culture ("sub-cultural" psychiatry), and the awareness of the psychiatrists own cultural restrictions in understanding the phenomenology of his patients.

The Essential Issues

Ultimately, labelling is not of primary importance. Transcultural psychiatry's main aim is to elucidate the effects which the socio-cultural background has on the risk, symptomatology, course and treatment of mental illness. For its basic material it draws on two main sources, namely comparative studies, usually of an epidemiological but sometimes a clinical nature, and ethnographic studies of illness patterns and interpretations in small, single societies. The first of these sources permits us to offer some measure of just how much cross-cultural variation in morbidity patterns needs to be allowed for; the second enables us to demonstrate how far medical concepts can be the products not so much of logical deduction as of the cultural preferences of the societies from which they are derived.

In the primary training of psychiatrists, transcultural psychiatry's main contribution must lie in making both trainees and teachers aware that cultural influences exist, rather than in showing just what these effects are. This is because the acquisition of social behaviour is extremely complex, defying all attempts at simple codification, and because the world has thousands of cultures, each with its own behavioural norms. Hence, although it is easy to demonstrate the difference between the symptoms or communication styles most used in two contrasting cultures, it is very difficult to teach what differences to expect when patients from still other cultures are to be examined. Fortunately, as already mentioned, most psychiatric trainees can afford to ignore such differences, since they are going to be working to a very great extent only with patients sharing the same cultural backgrounds as themselves and the patients on whom they are taught. But when it comes to training students in one society for practice in a different society, then an awareness of the influence of socio-cultural factors on mental illness should be an essential part of the course.

In the following recommendations, the importance of including elements into training which will give trainees a proper perspective on the variations caused in psychiatry by cultural differences, is taken to be the priority.
The Relevance of Transcultural Elements in Training

To increase his understanding of mental illness, a good psychiatrist should be interested in the culture of his patients. However, involvement at the level of curiosity or care is insufficient. It is important that he is given a conceptual framework for understanding his observations. As with all psychiatric training, his initial steps into transcultural experience should be supervised.

Transcultural elements, in their broadest sense, are found everywhere, between countries, regions, and even within cities. Even working in his own country, a psychiatrist will be exposed to individuals of different cultures and different social classes.

Training therefore should be extended to all trainees and should aim to produce psychiatrists who are culturally sensitive, who are able to communicate sympathetically across a cultural and class divide, and who have knowledge of the differing concepts of disease in different populations.

Finally, transcultural training should attempt to avoid the de-culturalisation which affects trainees travelling to international centres to study psychiatry. It should help them to remain proud of their own cultural backgrounds and understand the importance of translating their training into a culturally relevant form for their own use.

The Teaching of Transcultural Psychiatry

In the past, many medical schools and training centres for psychiatry preached the universality of medical science. The obvious attraction of this approach is the simplicity that it offers to student and teacher, reducing the amount of training necessary. However, for the reasons outlined above, it is important for a balance to be achieved between universality and cultural sensitivity.

The most important time for transcultural training appears to be during the first six months of training. Trainees are initially very interested in transcultural aspects of training, but this interest declines progressively through the training programme as their de-culturalisation occurs.

The following suggestions for training are recommended:

1. That trainees, whether training locally, regionally or internationally, should be exposed to participation in specific transcultural groups at an early stage of training. These groups, ideally with five to ten members, should discuss, over a number of sessions, their cultural differences within the group, their differences from the external population, and the way in which these differences affect their clinical practice and theoretical concepts. Through these groups, it is hoped that they will preserve their own cultural identity whilst at the same time arriving at a more tolerant attitude to others. The trainee will be aided in taking a phenomeno-logical approach to the assessment of his patients, and will be given insight into his lack of cultural understanding. Just as psychoanalytical groups might enable a potential therapist to understand his or her own transference and counter-transference problems, so that the group will hopefully enable the trainee to understand what might, as an analogy, be called "cultural transference".

2. Later in the psychiatrist's training, didactic teaching on transcultural topics should be introduced, covering formalised knowledge such as international comparative studies of illness and treatment, studies of variation in ethnic minorities, and special interest topics.

3. At late stages in training, when reasonable knowledge of general principles have been learned, exposure to the clinical problem of available ethnic (sub-cultural) populations should be introduced. Under supervision the trainee will learn to rise above cultural differences in dealing with real patients and real problems.

The Development of Expertise and International Collaboration

International, regional and local centres of training will suffer from a relative lack of expertise in the area of transcultural psychiatry, and this forms a real barrier to the development of effective training. The creation of specific departments of transcultural or international psychiatry needs to be stimulated by the efforts of the WHO and other organisations. This can only be a gradual process, going hand-in-hand with research and the development of elements of transcultural training.
The scientific basis of psychiatry rests on three areas of knowledge: clinical science, biological science and socio-behavioural science. The teaching of basic science to the trainee concerns the last two of these headings and raises a number of issues. Those organizing basic science teaching for the trainee must ask themselves which subjects should be taught, in what proportion, at what stage of the training, by what method and by whom?

The Content and Balance of Basic Science Training

A new balance between the biological and socio-behavioural sciences is needed. For years, the socio-behavioural sciences have been ignored, whilst the biological sciences are taught over and over, at the same standard, but at different levels of training.

Biological sciences should be taught adequately at medical school, and all the graduate, entering into psychiatric training, should need a brief revision course on the neurological aspects of these sciences. However, perhaps because of availability (or non-availability) of the various teachers of basic science, biological sciences are taught at the expense of the socio-behavioural sciences, of which the trainee is almost completely ignorant.

Clearly, the balance has to be changed in favour of the socio-behavioural sciences. Teachers have to be trained (or borrowed from other facilities) to teach these subjects, and this must be done as a matter of urgency.

A WHO seminar (WHO, 1970) noted that the minimum requirements of basic science teaching for undergraduates were often not met, and strongly recommended that undergraduates should receive a minimum of sixty hours of induction in behavioural sciences. As well as attempting to maintain standards of undergraduate teaching, it seems vital that postgraduate training should ensure adequate knowledge.

The socio-behavioural sciences consist of clinical and social psychology, medical sociology, medical and social anthropology, and the socio-economics of health care. Included in these subjects should be adequate coverage of epidemiology and demography and a sensitivity to social and cultural issues needs to be inculcated.

The Timing for Training

For some time it was fashionable to hold the view that, since basic sciences formed the foundations for clinical knowledge, they should be taught as a "block" at the beginning of training. In recent years, however, there has been considerable effort to integrate basic science teaching with that of clinical science. This has been difficult, but some success has been forthcoming. Now, for instance, a Membership Examination for the Royal College of Psychiatrists of the United Kingdom, has been instituted which examines basic sciences in their integrated form.

A model for training might be in the following system at the different levels of basic science teaching:

Level One An introductory course at an orientation level. This should repair the gaps in the undergraduate training.

Level Two Dealing with the clinical application of basic sciences - the bulk of the postgraduate training.

Level Three The carrying out of small research projects involving the application of basic science to clinical problems - either at the postgraduate or post-postgraduate level.
The Teachers for Basic Science

The argument as to whether teaching should be carried out by basic scientists, psychiatrists or both, is often overshadowed by the lack of availability of any suitable teacher. There is a shortage of basic science teachers in the developing world.

Often psychiatrists lack the knowledge (and inclination) to teach basic sciences, and scientists the ability to apply the relevant knowledge clinically. When possible, collaboration between psychiatrist and scientist to cover these elements is the ideal solution, with both teachers benefitting from the experience. However, another solution is to get clinicians with areas of wider interest to give the teaching.

Ultimately, whoever the teacher is, the importance is that principles should be communicated thoroughly rather than many matters of detail, otherwise the basic science teaching can become burdensome and counter-productive. Teachers must be given adequate guidance by the course organizer as to what subject and at what level he is expected to teach.

Methods of Teaching

There are three main forms of teaching, didactic lectures, seminars and experimental learning. All can be relevant to basic science teaching, but a correct balance needs to be formulated. Seminars should form the mainstay of postgraduate science teaching. The content should be organized around specific problems for discussion, so as to retain relevance to psychiatry. Valid and interesting themes should be chosen, such as illness behaviour, models of care and specific illnesses. Cultural elements need to be addressed, and the seminar format allows the development of strategies to cushion the cultural shock faced by trainees from diverse cultures.

In situations where the need arises to teach large numbers of trainees or students, then it is necessary to resort to the lecture format. However, provided that lectures are delivered with enthusiasm and sensitivity towards the audience, it can be a very effective form of teaching. Experimental learning can either be in the seminar situation where groups work out solutions to real or hypothetical problems, or can be in the form of small projects which involve the trainee in learning as his work progresses. Undoubtedly, the latter is the best way of learning such subjects as experimental design and methodology and statistics. Finally, trainees need to be provided with a reading list, and adequate library facilities.

A Model: The Teaching of Anthropology for Psychiatrists

It is useful to look at a model of how a basic science subject can be taught, assessing its contribution to psychiatric training. The teaching of anthropology is just such a useful model, as anthropology is taught at a minority of training centres (including developed ones), and when it is taught, is often taught inadequately.

The contribution of anthropology can be reviewed at a number of levels:

1. Making use of the anthropological data base

Ethnographies can provide psychiatric trainees with detailed information about the social and cultural context within which their patients live and they themselves practice. These ethnographies provide basic data on social organization, including kinship and family systems, work and school settings, political-economic practices, local/community structures. In recent decades, ethnographies have often canvassed concepts of the person, coping styles, and ideas about and reactions to illness generally and mental illness in particular. Medical anthropologists have described local health care systems, especially their lay and folk sectors (Janzen, 1978; Kleinman, 1980; Lewis, 1974; Ohnuki-Tierney, 1984). Psychological anthropologists have increasingly provided detailed findings on cognitive, affective and behavioural processes (LeVine, 1975; Levy, 1973; Rosaldo, 1980; Schieffelin, 1978). A recent surge of interest in what has come to be called psychiatric anthropology has extended the scope of such studies to include cultural beliefs about depression, bereavement, anxiety, schizophrenia, and cultural influences on the ways emotions and mental disorders are experienced, including responses to psychiatric treatment (Estroff, 1981; Sheper-Hughes, 1981; Kleinman and Good, 1985). For example, ethnographers have described the different idioms of distress that laymen use to express dysphoric bodily complaints, images of natural phenomena like clouds and rain for depression, cosmological and kinship metaphors of distress. These idioms can confuse diagnosis, delay help seeking and present problems in clinical communication and treatment (Nichter,
1981; Parsons, 1985; Rhodes, 1984; Marsella and White, 1982).

Drawing on these and other studies, psychiatric trainees can begin to assemble for themselves an appreciation of how basic psychological and psychopathological processes are shaped by culture and social institutions. This information is central to diagnosis, establishment of effective clinical communication, and organizing appropriate therapeutic interventions. Where large numbers of the patients seen by psychiatrists come from different cultural groups or ethnic background, it is essential that psychiatrists master this background information (Harwood, 1981; Helman, 1984).

2. Applying anthropological methods in the clinical setting

Another contribution to psychiatric training is the use of anthropological methods to elicit ethno-psychiatric and ethno-psychological beliefs of patients and families, to evaluate the influence of cultural rules and values on abnormal behaviour, and to improve cross-cultural and cross-ethnic communication in the clinical interaction.

Techniques from ethnography and from cross-cultural comparison aid the psychiatrist in the interviewing process, his central clinical skill. Crucial to this skill is the work of interpretation of normal from abnormal, of delusion from illusion, of the meaning of symptoms, the degree of severity and the quality of life.

3. The place of anthropological concepts and perspectives in psychiatric training

Clinicians routinely use anthropological and other social science concepts without realizing it: Culture, social reality, social support, social network, family, labelling, communication, negotiation, to name examples, are more than merely terms; each has a history of theoretical usage in social science. Though they are part of the clinician's conventional wisdom, these terms benefit from interpretation. By more precisely defining these categories the clinician begins to gain insight (of a countertransference sort) into influence of his professional culture and his own cultural background on his thinking about behaviour, distress and disorder. For example, stress is a Western folk model that has been scientifically, and much of the tacit knowledge about stress is folk wisdom that subtly biases the clinician.

Anthropological methods hold the potential of teaching us how to become systematically aware of our own biases and prejudices: a role as therapeutically important to the psychiatrist as it is to the psycho-analyst. We might think of this as involving evaluation of cultural counter-transference.

But it is the anthropological perspective that is the most fundamental contribution that anthropology can make to psychiatric education and training. The essence of this perspective or vision can be summarized thus: The anthropologist seeks to understand the way his indigenous informants think about their world and their problems. He or she is respectful in the face of this alternative knowledge, treating it as comparable to, though different from, his or her own knowledge. Moving back and forth between lay and scientific perspective, anthropological inquiry creates a dialectic between lived experience and its scientific observation. Out of this oscillation of meaning emerges an interpretation of how individual experience is shaped by local social contexts of norms and relationships of power. This anthropological vision of the human condition is of importance to psychiatry as a model of empathic understanding of patients' predicaments, tolerance in valuing and responding to patient and family interpretations of these problems, and insight into the way local contextual processes contribute to illness.

Outline of a Programme for Teaching Anthropology at Different Levels and in Different Contexts of Psychiatric Training

1. Introductory level

Seminars should be introduced into the didactic course for first year residents introducing them to the relevant anthropological literature. Where a training programme has a large ethnic patient population or its students are having to relate to different ethnic patient groups, or where such a programme is in a developing society where substantial anthropological research has been conducted, seminars should focus on key cultural values, behaviour norms and practices, and on family and other social institutions that can significantly influence behaviour. Life course questions from child rearing to adolescence, and from marital patterns to old age may both enrich psychiatric contacts with particular patients and be of practical clinical relevance to patient care. Even in Western settings with no or limited ethnic populations, seminars can focus on studies of the core cultural orientation of the mainstream population. Besides
the specific content being of value, it is important that trainees feel comfortable in reading anthropological materials and handling social science concepts and language.

2. Intermediary level

For trainees in the middle of their psychiatric training, anthropology is most effectively taught in clinical settings, in the context of patient care. For example, ethnic influence on the experience and expression of chronic pain is best learned while evaluating or treating ethnic patients with pain. This knowledge is useful in evaluating to what degree cultural patterns of responding to pain influence symptom amplification (for instance, dramatic expression of distress, anxiety over meaning of symptoms, low threshold to pain). It will also assist in understanding help-seeking and acceptability of, and response to, particular treatments such as psychotherapy, surgery, or acupuncture. Psychiatric ethnographies of the illness beliefs and behaviours of particular groups facing particular problems are best used to answer these questions. The same is true of anthropological studies of patient and family values and expectations that create problems in clinical relationships and communications: for instance, breaking rules of etiquette, introducing misunderstandings, failing to appreciate the extent to which the family is responsible for making decisions, among a long list of others. Ethnic and cross-cultural patterns of help-seeking, utilization of alternative therapies, and treatment by folk healers also are best understood in the on-the-ground setting of caring for out-patients or in-patients. These practices may be effective, but they also may delay appropriate treatment, produce non-compliance and dissatisfaction, and defeat effective care. The pertinent anthropological knowledge can help the practitioner avoid these problems which are often worsened rather than improved when working through interpreters.

Clinical case rounds, clinical consultation from an anthropologist or cross-cultural psychiatrist, special clinic or ward conferences on difficult diagnostic and management problems are a better forum to present and discuss the pertinent anthropological literature and its application to cases than didactic conferences. The latter may be useful, however, to deal with large cultural issues, such as somatization of mental disorders, hysterical (or brief reactive) psychoses, normal trance and possession states, culture-bound syndromes, routine culturally based conflicts in clinical care that pose significant local problems.

One very effective pedagogic technique is to require psychiatric trainees to make supervised home visits to their patients' communities so that they can have the experience of participant-observation in the local cultural context. After such visits, debriefing by an anthropologist can help in generalizing from the experience. Similarly, visits to local alternative practitioners or folk healers routinely used by patients can be a useful way not only to teach about the powerful influence (positive and negative) of the greater health care system, but also to help neophyte psychiatrists to come to terms with ingrained biases which reflect differences in class, ethnic, religious and educational backgrounds.

Supervised clinical interviews should include attention to anthropological skills in eliciting patient and family explanatory models of illness (Kleinman, 1980), in describing and conceptualising culturally based problems affecting the illness and its treatment (Kleinman, Risenberg and Good, 1978; Katon and Kleinman, 1981; Johnson and Kleinman, 1984), and in working through translators across different languages. Patients explanatory models of illness usually respond to these questions, "Why me?", "Why now?", "What is wrong?", "How long will it last and how serious is it?", "What problems does it create for me?", "How do I get rid of this problem?", "That is, what will make me better?". Cultural models may implicate sacred or secular causes and treatments, but they tend to relate personal distress to social circumstances. Patients may believe they are victims of sorcery or witchcraft, have broken a taboo, or that for religious or other reasons they cannot accept medical advice and treatment. Blumnhagen (1981) showed that North American hypertensives often believe their disorder is too much tension not high blood pressure and thus they take their medicine only when they feel tense. Rhodes (1984) shows that medicine for chronic schizophrenic patients may not be taken because of the metaphors the patients use to understand what medicines do: control the mind, turn off creativity, sap strength, provide "artificial" rather than "natural" support. The elicitation of patient explanatory models should be a routine part of psychiatric care and can help obviate these problems. Similarly, working through interpreters always carries with it the possibility of introducing serious distortion. Ask-
ing interpreters to describe precisely patients' explanatory models, no matter how traditional or different they sound, can aid in protecting against such distortion. To elicit explanatory models, the psychiatrist asks the patient what his or her view is of the etiology, reason for onset at a particular time, patho-physiology, course and expected and desired treatment. He can then systematically compare patient (and family) modes with his own to detect major sources of conflict. Negotiating with patient explanatory models can prevent tacit conflicts from interfering with patient care.

Community rotations should always have anthropological or other social science input. For these are opportunities to learn ethnographic skills and obtain local cultural insights crucial to the practice of psychiatry. This is the very best setting in which to foster negotiation skills between community and health care or public health agencies that enable psychiatrists to bridge the gap between the culture of patients and the professional culture of the mental health field. Here one learns that barriers to effective care arise as often from the latter as from the former.

This community experience is also the right background against which to teach trainees about ecological and social sources of distress, cultural and institutional shaping of illness behaviour and help-seeking, and preventive interventions. In order to teach in such settings either the anthropologists must possess clinical experience or they must teach conjointly with clinicians who have a social science background. In North America there is already a cadre of psychiatric teachers with social science training who are able effectively to bridge psychiatry's clinical and social science bases. Our experience is that they are often more effective in conveying cultural influences on the shaping of illness and the response to treatment than they are in clarifying the social origins of alienation, demoralisation and distress in local contexts of power that differentially transmit the effects of macrosocial forces on individuals. This is a subject that can be best taught by immersion in local community contexts in which lack of support and inadequate caring resources magnify stresses.

3. Advanced level

Whereas all psychiatric trainees should have instruction at levels (1) and (2), only those with a special interest in cultural issues will want more advanced instruction. Here the possibilities are very large. Reading courses can be set up with psychiatric or psychological anthropologists on topics of the trainees' choosing; for instance, child development cross-culturally; child abuse in particular cultural and ethnic contexts; suicide, alcohol and drug abuse, adolescent problems, anorexia nervosa across the cultures; depression, anxiety disorders, schizophrenia cross-culturally; cultural aspects of psychotherapy or psychopharmacology; or comparative analysis of healing systems.

Reading courses that support trainees' efforts to do small (archival or field) research projects that can be critically evaluated and written up for publication as research papers, are particularly useful. These are especially important in non-Western societies where trainees' research can help make psychiatric diagnostic and treatment approaches culturally valid. Hence critiques of DSM-III and ICD-9 that point out the problems in their use with particular cultural and ethnic groups, as well as critiques of the psychometric instruments based on these nosologies, can aid local programmes to develop more culturally appropriate and anthropologically sophisticated nosologies.

Advanced training can take the form of postdoctoral fellowships, M.A. and even Ph.D. programmes. But for most trainees with this interest, simply doing focused reading and conducting a literature review and small pilot studies should be sufficient.

4. Special situations

Cultural and anthropological training are especially valuable for trainees working with refugees and migrants (who are under heightened risk for illness and for culturally relevant problems), and for trainees who themselves are engaged in cross-cultural care or the acculturation process. Courses, clinical supervision, and collaborative cross-cultural research projects can be devised to provide basic information on such high risk groups useful for preventive and therapeutic programmes, and to help trainees assess their own cultural countertransference. Again the purpose of training is to focus on the practical issues requiring anthropological assessment as a means of teaching relevant anthropology as much as for solving applied problems. As in the earlier instances, anthropology should help liberate trainees from biases and the tendency to de-humanise inherent in socialisation in professional and bureaucratic rational-technical paradigms.
Chapter Seven
EXAMINATION AND ACCREDITATION
A. Binlle

At the end of a course of training the trainee should be evaluated by examination of his skills and knowledge, and should be assessed for accreditation as a psychiatrist. However, there is wide variation in the methods employed and in the meaning of such endeavours. Accreditation can be either of the individual or of a course of training. It can be tied to the passing of examinations or can be based on the trainee's competence over a number of years. Examinations can be carried out at various levels in psychiatry and can be a basic qualification or a specialist one. Qualifications can be "local" or "international". Moreover, the candidates purpose in sitting the examination can vary enormously. Some aim simply at a qualification which will enable them to become a specialist in psychiatry in their own country, whilst others want a qualification which will, when required, act as a passport for emigration in the face of political or financial adversity.

Examinations and accreditation also have the problems of elitism and post-colonial effects. Many countries still insist on qualifications from a developed centre (often the old colonial power), even though such qualifications themselves make no pretence at being anything other than local qualifications, and are certainly not appropriate internationally. Such tendencies are perpetuated by the fact that senior colleagues in the developing countries will have these "old" qualifications, and do not necessarily accept alternatives. The role of the WHO and other international agencies in this area is clearly to promote collaboration. However, they must stop short of recommending or setting examinations, as there is no precedent for such action. Accreditation and evaluation are very much the domain of the local governments and national medical associations and international agencies can only give advice and guidance.

If the developments are to take place so that local or regional training centres are responsible for the bulk of general training, then it would make no sense to impose an "International Examination" in general psychiatry. Clearly, such an examination would be divorced from the local courses, and also from the needs of psychiatry in local settings. Examinations such as the Membership of the Royal College of Psychiatrists or State Boards in Psychiatry make no apology for not covering areas of international psychiatry, and cannot be expected to make allowances for language and cultural barriers amongst candidates from the developing world. Hence, it is important that collaboration should take place towards the development of appropriate examinations locally or regionally. These examinations will be able to evaluate the candidates' grasp of cultural psychiatry, and can be in the candidates native language (and that of his patients). Similarly, accreditation should be the responsibility of the local authorities, as they know the needs of their populations, know the restrictions on training, and ultimately are involved in the financing of services.

The use of the general psychiatry qualifications of developed countries can only increase the emigration of trained psychiatrists to those countries. Local examinations can be held even if there is no local training. Lenz (1984), surveyed the state of development of such local examinations under the auspices of the WPA and found it to be patchy but to constitute a reasonable beginning.

One problem which pervades the developing world is that of a lack of confidence in national identity and national institutions. This is a root cause of the present dearth of local examinations, but this situation directly worsens the lack of confidence. Hence, there are positive benefits to be gained by development of certification procedures which support independence and self-sufficiency. The exceptions to this need for local accreditation and examination is in the area of specialty training. It seems likely that training for such specialties as addictions and child psychiatry will frequently be a matter for international centres of excellence. In this case, certification following evaluation should occur at that level. In this clear objectives should be planned for the course, and real evaluation should be carried out to show that these objectives have been achieved.

It is very easy to become over-concerned and pre-occupied by international standards for examination and accreditation. It is unrealistic to try and impose uniform standards on proposed local and regional examinations. The local requirement for training levels are probably the best guide to what is appropriate. In setting standards it is right for local boards to decide what form the examination should take, whether it is to be a test of knowledge or skill, and whether it is to be determined by continual assessment or single examination. One way of improving standards is by having external examiners. They can be instrumental in improving the quality and prestige of the examination. They are not however essential, and it should be a local decision as to whether external examiners are required or not. International agencies might be responsible for organizing their participation, but it is important that arrangements should be two-way, with return visits by examiners to the other country.
Part III
PRIMARY CARE AS BEDROCK FOR PSYCHIATRIC TRAINING
Chapter Eight
THE PRINCIPLES OF PRIMARY HEALTH CARE
Allen German

The WHO and its member countries are committed to the principle of the Alma Ata declaration (1978). The aim is for health for all by the year 2000 and the main tool for change will be the implementation of primary health care systems. Some of the problems which the developing countries will have to overcome if they are to provide professional training and the training infrastructure which will be required to support and enable provision of adequate mental health care have been outlined in the previous section. Training must be in harmony with patterns of service need, and such is the emphasis that must be put on the primary level of care that it seems useful to explore what is to be meant by that phrase in the psychiatric context.

The favoured system for primary health care is that of a tiered structure with primary health workers and technicians with medical responsibility delegated to them under close supervision and support, forming the wide base of the system. These workers will have close contact with the local population. The second tier then consists of personnel (generalists, psychiatrists or psychiatric nurses) capable of supervising the primary health workers in the treatment and prevention of mental illness. Higher tiers consist of more specialised psychiatrists with responsibility for development and administration of the system, and seeing difficult referrals. It is an important principle that the first tier should be generic and trained in all aspects of health care (especially preventive and public health measures), and not just mental health. However measures must be taken to avoid adverse attitudes to mental illness occurring in these workers, and to prevent mental health being ignored or cases of mental illness inadequately referred. The structure of health services must not be allowed to foster the belief that mental health interventions can only be carried out by psychiatrists.

The development of adequate strategies to satisfy the demand of psychiatric services, both in industrialised and developing countries, has attracted much interest and research during the last decade (WHO, 1984a; Sartorius and Harding, 1983; Harding et al, 1983a and 1983b; Srinivasa Murthy and Wig, 1983; Wig et al, 1981). The emphasis of most investigations has been on primary health care. It has been shown (Giel & Harding, 1976) that in order to satisfy the unfulfilled needs, it is necessary in the first instance to identify a few key priorities. These would represent the most common psychiatric illnesses, clearly recognised as important by the community, and susceptible to effective treatment within the given resources. Examples might be major anxiety, depression, epilepsy, psychiatric emergencies and psychosis.

The primary health workers should acquire technical knowledge through training courses and field work, but they should also possess certain personal characteristics which result in the effective and concerned care of patients. Most of these characteristics are not learned, but require reinforcement during the initial training and follow-up exercises. These features include the ability to communicate effectively with others, to function as a member of a multi-disciplinary team and the ability to feel empathy for human suffering. Training has to bring out the flexibility and tolerance to function under conditions of uncertainty and this is helped by an understanding of the value of the work. Trainees may need help in clarifying their own values in life and the personal meaning of their participation in primary health care.

Essential in the provision of primary health care is the availability of simple manuals and flow charts to guide the worker in the field (WHO, 1987). The production of such material is not a difficult task, and there are many examples already in use that
can be followed. However, they may need translation and adaptation. Other basic elements in the organizational development in primary health care are the formulation of an appropriate referral system and the selection of an essential list of drugs. An emphasis on preventive psychiatry should also be firmly maintained. It is thus important to devote adequate training time to teaching the primary health worker about water purification, sanitation, anti-malarial programmes and so on. They must then in turn learn how to educate the population in which they work on these health measures. Through adherence to these principles, a high standard of primary care and skills necessary to referral should become available to the poorest of countries and communities in the most isolated rural areas.
To imagine that developing countries are areas devoid of all psychiatric resources is quite wrong, and would lead to the erroneous conclusions that an ideal system of care could be suddenly imposed on these countries overnight. Clearly, care of a variable nature and degree is currently available, and in many countries has been on offer in this form for centuries. In setting up a programme of health care, these existing systems should not be destroyed or alienated, but should be incorporated and enhanced so that they become a useful component of the health care system. Such existing resources include the traditional healers, the urban psychiatrists, the colonial institutions (asylums and prisons), and parallel government agencies and systems.

**Working with Traditional Healers**

One risk in introducing psychiatry is the destruction of established cultural systems of care (Higginbotham, 1979). New moves should be sensitive to the existing cultural structure. As Higginbotham states “The agent of traditional medicine, the folk healer is a paragon of cultural continuity. His manner, rituals, problem explanation, even non-verbal messages and action, are all appropriate to the expectations of patient and audience”. We should learn from traditional systems of care, adopt them where appropriate as an integral part of the new service, and use sympathetic liaison and teaching to improve the existing systems where possible.

Clearly, traditional healers, with their enormous advantages of cultural appropriateness and local acceptance, make better colleagues than enemies. Some traditional practices will inevitably be so unscientific and potentially dangerous as to make them undesirable, and if changes and reforms cannot be introduced, then it may be that liaison will be impossible. However, in the majority of cases, it will be possible to harness the skills of the traditional healers in a powerful partnership. Traditional healers are able to assess their patients from within the local cultural context. They meet the expectations of the patients, and can prescribe remedies which are almost always available (such as herbal preparations or religious rituals). This contrasts with the psychiatrist, who assesses his patients from a scientific, but therefore “foreign” view point, sometimes fails to meet their cultural expectations, and finally prescribes expensive and sometimes unavailable drugs. Clearly the psychiatrist, or his trained deputies such as the primary health worker, have much of value to learn from these established healers.

The ideal symbiosis would be a system where either the primary health workers are trained to liaise closely with traditional healers, or alternatively where traditional healers are encompassed in an educational training scheme and effectively become the primary health workers themselves. This will depend on the culture and nature (and political system) of the countries concerned, and each country will have to develop matters in its own way so as to make health care relevant and efficient. A problem which should not be under-estimated however, is the difficulty some psychiatrists encounter in their personal resistance to liaison with untrained and often superstitious traditional healers. They each threaten each other’s system of care, and it is important that tolerance and common-ground are found. An example of the way in which traditional and modern medicine can co-exist side by side is found in China where acupuncture and highly technological treatments can be used in conjunction, often in the same patient and deployed by the same practitioner.
The Utilisation of Private Practitioners

The majority of developing countries have a number of well-trained psychiatrists working in urban centres in private practice, and catering for the more wealthy sector of the population as we have already described in Chapter Two. In some cases these psychiatrists are working part-time in universities or government hospitals. Some psychiatrists adopt this style of working as a result of personal financial considerations, others simply because there is no state system of care to employ them.

There are two ways in which this national resource can be brought back into the national system of psychiatric health care. The first is the adoption of posts in state psychiatry. Obviously, remuneration has to be realistic, and this financial consideration, and other political considerations may make such a suggestion completely impracticable. However, if no state posts exist, then it is inevitable that psychiatrists will have to take up private practice or emigrate. The second method is to persuade psychiatrists in private practice to give sessions without charge. These sessions can be for teaching, administration or clinical service. One way of achieving this move is by making the donation of such sessions prestigious, either through University titles or social recognition. Ultimately, if University and State hospitals are made attractive enough then the process of "internal brain-drain" into private practice can be partly stemmed or reversed.

The Use of Other Governmental Agencies and Systems

Health services do not exist in isolation. Other services will be developing in parallel. The best and most relevant example is that of education, which is often well developed at a primary school level even if sometimes fragmented in its organization, with sections run by religious communities, the government and other agencies. Primary school teachers, and through them their pupils, are a valuable resource in the promotion of preventive health. Directly, or through psychiatric nurses or primary health workers, psychiatrists have to promote good mental health measures through education. Similar processes must also occur at other levels of education.

Other institutions which can be employed in this way are religious organizations, the armed forces, and the civil service. All can at times be brought into partnership to foster measures in preventive psychiatry. Radio and television can also be used, and more traditional forces of entertainment such as puppetry, acting and popular singing.

Relevance to Psychiatric Training

Collaboration with the communities existing and traditional resources can offer exciting and innovative possibilities both for service development and preventive strategies. Those who teach psychiatry must try to motivate and train their students to be able to take advantage of these possibilities in the setting of their own countries.
Practical examples of health care can be extremely powerful in shaping future developments. The influence from training in a foreign setting is similarly of great potency but whilst there is much good in it (Leff, 1980), there is also much that is destructive and which effectively serves to entrench irrelevance. Under the auspices of WHO, schemes for primary health care have been set up in the developing countries to pioneer new methods and to act as examples for larger projects on a national basis. These models have been the subject of a WHO collaborative study (Srinivas Murthy and Wig, 1983), which has highlighted their local success. It is therefore worth looking at such schemes both to highlight in general what can be achieved, and to examine in particular the approaches to training of primary health workers in these settings.

In Cali, psychiatric services at the public health level are directly provided by primary workers and generalist doctors under the supervision of a psychiatrist. The model functions with some variations in several different health centres, both urban and rural (Climent et al, 1978, 1980, 1983).

**The basic model in Cali, Colombia**

Primary health workers have on average a background of two years of high school and a formal 18-month course of general health training. They are socially and culturally closer than professionals to the patients and their sufferings, and they are available in every health centre in the country. They live nearby and have been selected by their community and have responsibility for the entire health needs of the local population. They identify the existing health problems and keep a register of each contacted case. Such workers know the people well, their past and present social history, their psychosocial stresses, their weaknesses and their strengths. They are therefore, key informants and the natural community therapists.

The generalists work one session a week at a given health centre. They are government employees during these sessions and are in charge of the entire clinical practice of the health centre. They supervise the primary health worker's clinical work, interview each case presented by them, review the information gathered, formulate a diagnosis, propose a treatment plan and decide the follow-up procedure. A psychiatrist provides continuous training for the primary team through weekly visits. Case interviews are not carried out by the psychiatrist unless they are needed for training purposes or for resolution of specially difficult clinical problems. The main responsibility for the psychiatrist is to supervise the proper operation of the model of care.

The course for primary health workers consists of 12 sessions of theory and 8 sessions of practice on selected priorities. The supervision of the practical part is carried out with patients from the out-patient clinic. This training is given locally by a psychiatric nurse or psychiatrist. Each trainee is given a manual which is an essential prerequisite for the successful implementation of primary health care. It is written for the primary health worker, but also defines the roles and functions of the doctors. It serves as a teaching tool as well as a basis for the identification and management of some selected psychiatric priorities.

**Training programmes for generalists and other professionals**

The manual for generalists (Climent and Burns, 1984) provides the essentials for the diagnosis and
clinical management of the most common psychiatric problems among the adults and children seen by health professionals. Due to the realities of their work, generalists face the largest proportion of ambulatory psychiatric cases in any given community, and thus constitute a most valuable, although largely under-utilised, resource for the treatment of the mentally ill. One of the reasons for this under-utilisation is the absence of appropriate guidelines for effective diagnosis, treatment and referral. Thus, clinicians avoid working in a field in which the diagnosis is perceived as ambiguous and the treatment process as unclear, complex and full of hypothetical alternatives. The training manual attempts to tackle these issues by presenting a training tool and a practical guide for daily work through simple but reliable mechanisms for diagnosis, together with a systematic approach to the management of the most common mental disorders seen in general medical practice.

An attempt has been made to design a manual in which sufficient diagnostic instructions are included without being unnecessarily complicated, with practical but not over simplified guidelines covering important priorities in clinical practice. Material is presented in a sequence that follows the thinking that the clinician would pursue when confronted with a person who suffers from a mental disorder. This allows a diagnostic conclusion after excluding other important diagnostic considerations, and should then be followed by a clear management plan. With straightforward guidelines for diagnosis and treatment, it is hoped that the resistance traditionally found in medicine toward psychiatry can be reduced. The principles guiding the development of these concepts are that psychiatric disorders can be diagnosed in objective, valid, and replicable ways, and that the therapeutic process can progress through a series of logical steps.

One of the innovations is the use of standard diagnostic and management questionnaires adapted for clinical use from several sources. One obvious advantage offered by standard diagnostic questionnaires is the possibility of making a diagnosis on the basis of a simple, standardised approach. Diagnostic questionnaires and flow-charts have been designed as a supplement to training programmes for physicians and nurses offered by the Department of Psychiatry, Universidad del Valle, Cali (Clement et al, 1978, 1980, 1983). The clinical approach, which utilises questionnaires and diagnostic and management flow-charts, provides the potential for close and efficient supervision at each step in the clinical process.

Training programmes for psychiatrists
The relevant training activities for psychiatrists are part of the residency training programme in social psychiatry. The goal is to teach about the supervision of the model in which the primary health worker is in charge of the direct patient contact. The psychiatrist’s weekly visits are aimed only at selected cases and at providing continued education for the health team. The major difficulty for these specialists has been intolerance of this redefinition of their roles and resistance to accepting that therapy can be given by non-psychiatrists.

During their first year of psychiatric training residents spend 4 hours each week supervising the course for the primary health workers. In addition they periodically meet with the Social Psychiatry staff to discuss any difficulties. Once the training programme has ended, they are assigned to supervise the actual work of the health teams they have trained. During the second and third year of their residency, trainees rotate for periods of six months as supervisors in urban as well as rural programmes. Meetings with the staff and visits to the field assure the continuity of the work as well as ensuring that strategies are modified according to specific needs.

Problems in the development of the primary care model
One of the most difficult problems is the inability of the medical profession to consider psychiatry as an integral part of medicine. Many generalists fear emotional and mental disorders, fail to make a proper diagnosis and ignore treatment needs. In comparison with these resistances which have to be overcome at the personal level, the technical difficulties in creating training programmes and manuals for primary health workers are relatively slight. Much material is already available, and only needs local adaptation to cope with different conditions. The reward has been the satisfaction which comes from seeing the model’s success in providing care for many patients who would otherwise have been unhelped and the firm establishment of the model for more than a decade in the real life of the rural and the deprived urban communities.
Chapter Eleven

POSSIBILITIES FOR RELATING MENTAL HEALTH PROGRAMMES TO "MOTHER AND CHILD HEALTH": EXPERIENCE IN TANZANIA

G.J. Ebrahim

The Importance of Preventive Services

Pediatric and obstetric training in the developing world has too often been modelled on that provided in the Western world. It has therefore tended to remain too largely clinical and technological, creating marked lack of congruence between the training of the specialist and the true needs of the society (Swift, 1972; Dale and Ben-Tovim, 1984). A high proportion of the diseases in the Third World are those of poverty and the technologies evolved in the more affluent parts of the world may not be appropriate. The emphasis should be on preventive care and health promotion, and yet even today there are few medical schools and universities in the developing world which offer training in preventive aspects of mother and child health. The lessons here are important for postgraduate psychiatric education. Promotion of mental health must receive priority over curative care in all training programmes (Giel and Van Luijk, 1969; Kapur, 1979; Harding et al, 1980; Giel et al, 1981; Essex and Gosling, 1983).

The maternal and child health (MCH) services in Tanzania are largely supportive services providing counselling, surveillance, prevention and a certain amount of first contact curative care as the individual passes through the various phases of development from conception to maturity and can be seen as providing a useful framework for the promotion of mental health. As the individual moves from one phase of life into another, his or her status, responsibilities and expectations change. Relationships within and outside the family also change and herein lie many possible causes of tension, anxiety, discord and emotional upset. With a better understanding of the psychological processes involved, MCH workers can identify the need for mental health counselling or intervention in the same way as they deal with physical problems.

By their very nature the MCH services are in close contact with families, and are sensitive to family dysfunctioning or discord which may lie the origins of a large proportion of emotional problems. Basic psychiatric training of all MCH workers should prepare them to appreciate the significance of certain important areas of family functioning for child rearing. As families pass through the ups and downs of life, crises invariably occur. Many such crises are due to excessive reactions to inevitable life events. The manner in which families respond to crises often determines whether physical or emotional problems arise.

Strategies for the promotion of mental health and the training needs

Because of the characteristic demographic pattern of developing countries women of child-bearing age and children under the age of 15 years constitute up to two-thirds of the total population. Thus the MCH services have the potential for providing surveillance, counselling and care for a large proportion of families in developing countries. By applying carefully selected criteria for identifying high-risk, the MCH services can begin to concentrate their resources on vulnerable families. At present MCH care reaches out to not more than a third of families in an average developing country. The national health plans of many countries have singled out MCH care as a priority, and appropriate training programmes are being evolved for raising the national output of MCH personnel. It should be relatively easy to find room in the curricula at this planning stage for the inclusion of the main principles of developmental psychology and mental health in the relevant training courses.
Mental health: strategies and the training requirements for the immediate future

The benefits and outcomes of the above strategies can be expected to accrue only after a decade or so. In the meantime provision must be made for dealing with the current load of mental health problems. A three pronged programme for mental health is required as follows:

1. A popular awakening with regard to mental disorders, so that superstitious beliefs can give way to a more informed understanding of mental disorders. This requires national campaigns of health education at repeated intervals in the same way as is at present happening with breast feeding campaigns. This will require the production of appropriate health education material and leaflets.

2. A national policy for the promotion of mental health with financial provision to meet specified targets for the evolution of a national mental health plan.

3. Training programmes for the inclusion of basic mental health care in the routine work of the national health system at all levels so as to deal with the backlog resulting from past neglect. Such training programmes should be supported by the creation of a network of facilities, decentralisation of services and the establishment of national resource centres for data collection, research, and for the preparation of training materials.

The national health services have to contend with four problem areas in mental health: acute psychiatric emergencies, chronic psychiatric disorders, mental health problems in patients who present with physical complaints, and the psychiatric problems of high risk groups. Appropriate strategies for dealing with patients at the first point of contact and for selecting those who require referral for more skilled care need to be worked out. Strategies will vary from country to country depending upon need, the level of health service development, and the availability of resources. A number of steps for dealing with mental health problems in the immediate future can be identified. These include establishment of priorities with regard to the overall mental health needs of the population, with preventive needs accorded salience, definition of the tasks involved in meeting these needs, identification of the knowledge and skills needed for performing these tasks, establishment of the kind of health worker needed to carry out these tasks through the creation of a wide network of informed community agents such as teachers, religious and community leaders, social workers and so on.

Such an approach suggests a hierarchy of services and functions as follows:

**Level A**

The local community, within 1.5 km. from the home. Served by the Community Health Worker.
1) Surveillance and counselling as part of MCH care.
2) Educational services including family life education.
3) Early diagnosis and referral.
4) Care within the family and the community of patients assessed by the specialist services.

**Level B**

The Health Centre, within 8 km. from the home. Staffed largely by auxiliaries and some professionals.
1) - 4) as above for the local residents.
5) Supervision and support of workers at level A.
6) Training for level A workers.

**Level C**

The District Hospital, within 40 km. from the home. Staffed mainly by professionals.
1) - 4) as above for the local residents.
5) Supervision and support for workers at levels A and B.
6) Training for levels A and B.
7) Dealing with referrals from levels A and B.

**Level D**

The Regional Hospital.
1) - 4) as above for the local residents.
5) Supervision for levels A,B & C.
6) Training for levels A, B & C.
7) Dealing with referrals from A,B and C.

**Level E**

The National Resource Centres and Ministries.
1) Epidemiologic surveillance and ensuring that evaluation of services take place at all levels.
2) Identifying training needs.
3) Preparing and procuring training materials.
4) Evaluation of training.
5) Liaison with social services, community development, education and other services and departments.
6) Policy decisions.
Training needs for mental health services
The hierarchical system of care outlined above proposes a similarly multi-level approach to training:

Level A
Community health workers
- Illustrated manuals.
- Simple technologies.
- Well defined tasks for care of patients within the community after assessment by specialist services.

Level B
Health auxiliary
- Manuals for training institutions.
- Knowledge of the indications and contra-indications regarding a few psychotropic drugs.
- Teaching methodology.

Level C
Physicians and nurses
- Books.
- Knowledge of the pharmacology of commonly used psychotropic drugs.
- Other intervention methods.
- Skills in teaching level A and B workers.
- Manuals for the supervision and support of level A and B workers.

Levels D and E
Administrators and policy makers.
- Specialist training.
- Epidemiologic skills.
- Teaching skills.
- Management skills.

The manuals and texts for workers at levels A, B and C may eventually be produced nationally by levels D and E, but a start can be made through workshops and collections of readings.
Chapter twelve

ADVOCACY AND INNOVATION
Timothy Harding

Defining the Terms

Advocacy and innovation, in the context of this report, need defining and explaining. Advocacy refers to the ability of a psychiatrist and his colleagues to advocate, plead for, or put the case for better mental health services. Innovation refers to the need for new ideas and methods to be incorporated in mental health systems. Together, they imply the need for a psychiatrist to improve the health services in which he works, either directly or through delegation (perhaps through the setting up of pressure groups to further the cause).

The skills of advocacy and innovation are closely linked. Innovations need advocating, and advocacy needs the enthusiasm of the innovator. Both are essential in the promotion of better mental health care systems. In developed countries it is seldom necessary for psychiatrists to innovate completely new services, and, with the exception of services such as alcohol and addiction and old age psychiatry, most psychiatrists will work in long established posts with relatively clear job descriptions and static work roles. In contrast, psychiatrists in the developing countries, whether trained locally or overseas, are likely to be faced with the task of innovating many different schemes to improve the state of mental health services. Their psychiatric training therefore needs to give adequate preparation for innovation.

In less developed countries where rational planning and resource allocation is of vital importance, the necessary infrastructure to allow the idealised "planning cycle" simply does not exist. The myth takes on a destructive quality which erodes the confidence of health workers who would wish to change the existing pattern of health services. In fact in most developing countries, the existing patterns, imposed during the colonial era (Collomb, 1972), are patently inadequate and inappropriate (Harding, 1978). The need for de-centralisation and closer links with general health services are so obvious that a careful epidemiological evaluation is not necessary. Mental health workers are, however, constantly aware of resistance and inertia from health care providers and planners with general health services. There is always a temptation to fall back on the traditional model of a psychiatric hospital with out-patient care on a specialist basis.

In some countries, however, promising developments have taken place. In the 1960’s, Aro village provided a striking example of innovation and imagination (Lambo, 1966), although, even now, the model has not been extended to a national level. By the 1970’s, the need for radical changes in mental health care delivery were widely recognised (WHO/AFRO, 1974; WHO, 1975; Giel and Harding, 1976). The mental health tasks which could be assigned to primary health workers were defined with some precision (WHO, 1979b, 1986c), as well as the necessary infrastructure, including the supply and distribution of psychotropic drugs (Harding and Chrusciel, 1975).

Attempts to introduce and evaluate mental health care according to these ideas were facilitated by a growing awareness and support for the primary health care concept in general terms (Newell, 1975), leading to the Alma Ata conference and its
recommendations. In some countries, mostly of limited size and population, attempts to meet these expectations were made at national level (Botswana, Lesotho, Jamaica), while elsewhere more limited scale innovations were carried out. A WHO Study Group has made a critical appraisal of evaluative research findings (WHO, 1984a) examining various national examples. The Study Group also examined the results from a WHO co-ordinated research study carried out in seven developing countries (Harding et al., 1983); this study demonstrated the feasibility and the effectiveness of providing limited forms of mental health care through primary health services.

Development of services is rarely a rational process, however. As Morris Carstairs has pointed out, schizophrenics throwing stones are a much more powerful argument for change than the soundest epidemiological data. The WHO collaborative study referred to above was conceived and carried out within a framework of "scientistic" thinking for data collection and intervention planning. The results have also been reported in such a framework. Nevertheless, experience within the study shows that what really mattered in developing services was the individual personalities of key mental health workers and their relationships with professional colleagues. Underlying all the work there was a personal value system about "reaching the unreach" (Murphy, 1978) and about a just response to human suffering. Perhaps this is the essence of enthusiastic advocacy and innovation.

The Problems to be Overcome by Advocacy and Innovation

There is an intrinsic anomaly in the idea that psychiatrists can and should be taught how to develop services. This anomaly is rooted in an assumption about medical politics and power: that doctors should control and manage health programmes. This assumption is being challenged in the industrialised countries where political decisions and administration are being influenced and controlled to a greater and greater extent by economists and specialists in management. This trend is resisted by doctors, who react defensively against "bureaucratic decisions" about resource allocation, management structure, and staffing patterns. The correspondence columns of the major medical journals bear witness to the visceral opposition of doctors to the idea of non-medical "interference" in health service management.

The overall track record of doctors as managers is not impressive. "Service development" for most doctors means increasing the prestige, the influence and the power of their department/institute/faculty/hospital by acquiring additional resources for staff, building and equipment. During postgraduate medical training of any kind, the trainee will therefore gain the impression that the most successful and admired teachers are those who fight effectively to gain funds, staff or research grants and who manage to channel as many resources as possible into prestige-raising activities like research, seminars, travel, publications and the like. This neo-Darwinian "survival of the fittest" has for many years been the basis for the evolution of medical services in most developed countries. The postgraduate student sees therefore service dinosaurs struggling to survive in an environment which is rapidly changing. He sees also health services in virtually every industrialised country, characterised by:

1. Geographical inequalities of resource allocation, with socially under-privileged areas receiving less than their share of services;
2. A strong bias towards curative and hospital-based care, with relative neglect of preventive care;
3. Lack of resources for certain groups of patients for example the elderly, and the mentally retarded;
4. Duplication of certain costly, high-technology services;
5. Lack of adequate concern for the social and emotional needs of patients and their families.

The "service development" as seen by the overseas postgraduate student will then be impregnated by a sense of competition, rivalry, resentment and self-interest, leading to inappropriate, unbalanced, inefficient and costly services.

In the field of psychiatry, the scene is complicated by an overall sense of inferiority in the medical pecking order and a need to re-inforce the "scientistic" and "medical" aspects of psychiatric practice in order to gain prestige. Once again resources are often distributed unevenly, with striking differences in levels of care. Tensions are endemic between academic and non-academic units, between general psychiatry and sub-specialties and between various schools of psychotherapy. There is in addition the institutional aspect of psychiatry, which
though less pronounced than twenty years ago, still places the doctor in the position of a hospital manager ("superintendent" or "director"). This tends to create or exacerbate inter-professional rivalries between doctors, nurses, occupational therapists, psychologists and social workers.

There are, of course, examples of academic departments and of mental health services, in which planning and management are carried out in an enlightened manner with an authentic attempt to assess and respond to community needs by gearing services to clearly identified and quantifiable objectives and by carrying out regular evaluations. Such examples are however exceptional and re-iterate the sense of disorganization and detachment which prevails in most mental health services.

Training experience in industrialised countries for psychiatrists from the developing world is therefore poor so far as appropriate skills and attitudes for service development are concerned. The environment is mainly counter-productive. The trainee may acquire highly developed and complex skills in diagnosis and treatment: simultaneously, he or she learns that such skills require specialised centres and a team approach to be effective. Without a bevy of psychiatric nurses, a school of social workers, a pride of psychologists and a pack of occupational therapists the psychiatrist with his ten year training is paralysed. His professional life is likely to be devoted to combating the realities of the developing world, in order to create, albeit on a small scale, a "centre of excellence" corresponding to the model of psychiatry in developed countries. In such centres, patients can be interviewed by several professionals, brains scanned, lithium levels monitored, plasma levels of tricyclic drugs measured, individual/group/family therapy carried out and interminable staff meetings held. Appropriate services will not just fail to be developed - they will be positively resisted.

**Proposals for Training in Innovations and Service Development**

Despite the problematic themes outlined above, definite suggestions can be made for further training in the skills of advocacy, innovation and service development.

The psychiatrist who is going to break new ground and develop new forms of services must command the respect of his psychiatric colleagues, other specialists and the community in general. He must also have a sense of self-confidence and feel at ease in all major aspects of psychiatric practice. If he is to propose training for primary health workers in recognising mental disorders and providing simple forms of treatment, he must have authoritative knowledge of psycho-pharmacology, of diagnostic methods, of counselling etc. His "paper" qualifications must be at the highest possible level. For these reasons, psychiatrists from developing countries should be trained to at least the same level of scientific and practical competence as trainees from industrialised countries. Shortcuts, lesser qualifications or accelerated training will inevitably create the impression of a second-class psychiatrist. This would be fatal for the professional standing of the developing country psychiatrist and hence his effectiveness in service development.

Epidemiology is an essential part of the training for innovation and service development. In organizing a training course for a postgraduate from the developing world, the availability of competent teachers of epidemiology should take a high priority. Epidemiology, together with social psychiatry should take up at least 10% of the teaching time of the formal course.

In order to gain specific skills related to developing services in developing countries, several complementary approaches can be employed:

1. Preparation of reading lists of recent and "classical" articles on developing country psychiatry. A tutor, who has experience of Third World psychiatry, should be available to discuss and direct the student of this literature. It should include (a) "historical" articles from the colonial era; (b) articles describing innovative work in the immediate post-colonial era (e.g. Lambo, Collomb, Tigani el Mahi); (c) articles describing country programmes of community psychiatry; (d) articles on sociological and epidemiological findings relating to mental disorders in developing countries; (e) articles on the evaluation of new forms of mental health care.

The specific objectives of this directed reading would be:

- to promote specific skills in applying methods of psychiatric epidemiology to developing countries;
- to instil a critical sense of evaluating different approaches to service development;
• to create an historical sense of the origins and evolution of mental health services in the developing countries.

2. An attachment or regular teaching sessions with developing country trainees in other specialties. This element should be directed by teams with experience and expertise in overall health development programmes, as found for instance in the United Kingdom in the Ross Institute of Tropical Public Health, the Liverpool School of Tropical Medicine, or the Institute of Child Health in London. The teaching should embrace (a) overall problems of development and economic constraints (Third World debts; neo-colonial influences; rural vs. urban and small vs. large scale development strategies; corruption); (b) resource allocation in the health sector; (c) the primary health care concept; (d) preventive approaches (immunisation, nutrition, sanitation); (e) examples of service development in specific fields: maternal and child health care; tuberculosis and leprosy control; (f) skills necessary in preparing written programme proposals: aims, objectives, approaches, evaluative criteria and budgeting; (g) the role of the WHO, other international agencies and aid programmes.

The specific objectives of this component of the training would be:
• to allow the trained psychiatrist to participate in overall planning of health care;
• to provide concrete examples of health programme areas in which a mental health component is needed;
• to provide models of community-based health programmes to stimulate parallel developments in psychiatric services;
• to enable the trained psychiatrist to prepare programme statements, budgets and reports, and to elaborate requests for various forms of technical co-operation.

3. Visits to existing mental health services in developing countries. Such visits should not only include pilot or experimental programmes. Selected centres (e.g. WHO Collaborating Centres) should organize a sequence of contacts with custodial services, prisons, general hospitals, academic departments, community services and primary health care services.

Resources for such visits should be included in the overall financing of the postgraduate training. As well as providing direct contact with the realities of developing countries, visits would also encourage contacts with colleagues in such countries. The relative isolation of developing country psychiatrists can be countered by building up a network of direct links between developing country centres rather than encouraging further dependence on the industrialised countries.

The most formative process in instilling critical attitudes and innovative ideas, may be in the working experience of the trainee. Exposure to areas in which contacts with non-psychiatric services are prominent is likely to dissipate the impression of psychiatric isolation, omnipotence and inbreeding. Working in the fields of mental retardation and psychiatric rehabilitation bring the trainee into contact with social and employment services as well as various forms of community care; in forensic psychiatry there are regular contacts with lawyers, probation officers, courts and prisons.

General hospital liaison psychiatry is another field which could be introduced preferentially into the training attachments. Here, regular contacts with non-psychiatrists can only broaden attitudes and encourage a collaborative approach. Such work also builds up the self-image of the young psychiatrist in relation to general medicine. Finally, by attachments to units such as renal dialysis, cardiac surgery and neurosurgery, the trainee will experience directly the problem of resource allocation as a burning issue in industrialised countries. Such experience shows that the allocation of scarce resources is a problem in all health systems.

Training in Advocacy

Many of the best advocates are born with the skills of advocacy rather than learning them. However, the general level of good advocacy can be improved by the teaching of some of the methods. Psychiatrists often lack the politician's skill and rhetoric, and frequently are at a disadvantage in their dealings with politicians, administrators and co-professionals. The following proposals may be of benefit.
The psychiatrist should remember that he is the expert in his own field. He should therefore have a firm knowledge of the subject which he is advocating, and have all the relevant information at his fingertips. His proposals for the change which he is advocating should be thoroughly worked out and costed as far as possible, and solutions for potential problems should be to hand. The psychiatrist should be prepared to exploit the sensitivities of the politicians and administrators. He should be aware of their statutory duties and the power of publicity. Areas such as crime, alcohol and drug abuse, divorce and youth problems, which are politically sensitive, should be introduced into the scheme in prominent positions. He also should exploit political or topical scandals to promote services. The advocacy of international agencies should be harnessed to back the demands of the psychiatrist. He should be familiar with international recommendations and standards and use the comparison with his own country's services to promote their growth. He should use the example of models of prevention and primary health care, as discussed above, to promote similar services in his own country where appropriate, and if necessary arrange visits of prominent politicians and administrators to see these "ideals" in action.

**Conclusions**

The psychiatrist who is to develop appropriate services in developing countries needs self-confidence, a sense of social justice, an awareness of the origins of social injustice and an enquiring, critical and innovative spirit. Only then will specific skills in epidemiology, planning, evaluation and training come into play.

Therefore, a complete postgraduate training corresponding to industrialised country norms should be complemented by:

1. A directed reading programme in relevant literature;
2. Contacts with specialised teams concerned with developing general health care in developing countries;
3. Visits to developing countries organised by WHO Collaborating Centres;
4. Clinical attachments favouring contacts with non-psychiatric services (mental retardation, rehabilitation, forensic psychiatry and general hospital liaison psychiatry).

Through these measures, innovation and advocacy by psychiatrists will improve, and the enthusiasm that they create will fuel further enthusiasm for change.
Although the majority of psychiatrists would regard themselves as clinicians, it is a fact of life that they become increasingly involved in administration as their careers progress. However, whilst psychiatrists in the developed countries are "protected" from some of this burden by various levels of professional administrators who have been trained to deal with the financial and administrative aspects of health, the psychiatrist in a developing country is likely to carry the whole burden.

In developing countries there is an increasing need for better planning, programming and organization of services, and a growing demand for good team work. With these changes goes the requirement for better training in relevant areas of administration, especially:

- managerial processes in the planning and development of psychiatric care, including leadership of the primary health care team.
- setting of priorities.
- monitoring and evaluating planned activities.
- skills of communication.
- promotion of knowledge and skills in understanding the structure and function of complex organizations.
- understanding and making effective use of group dynamics.
- the production of public information and encouragement of community participation and mobilisation of resources.
- organization of teaching.
- mobilisation of international support and contact with international organizations.

In many of the models for psychiatric care, outlined previously, the importance of the psychiatrist's role in administration is highlighted by his executive role at the top of a wide pyramid of health care workers.

**Administration Training**

The problem of providing adequate training in administration for psychiatry trainees from the developing world is complicated by their training in international centres where their role is essentially supernumerary. They have little exposure to real administration and hence the importance of providing appropriate teaching of administration as part of the course in psychiatry.

The trainee psychiatrist will need at least the following skills:

1. Administration of health services
   - man-power recruitment, allocation and support.
   - services and facilities.
   - finance.
   - training of staff at all levels.

2. Dealing with government departments and politicians (e.g. canvassing for an increased share of a small budget).

3. Learning how to pull together the fragmented resources of health services with many part-time staff located in different clinical facilities with the ultimate aim of systematic re-organisation of services along planned lines. Old concepts of colonial mental health care must be replaced by systems with a national identity.

Some aspects of administration can be taught in didactic form, or in seminars. Knowledge of the basic facts of administration and administrative systems is an important background. The functioning of committees and the preparation of agendas
and minutes provide examples. Methods of accounting and financial control of resources and manpower might be other areas of knowledge which can be taught in seminars.

However, it is important that practical experience, supervision and the experience of responsibility are incorporated into the training. Practical experience could be obtained by attending committees as guests or observers to see how things are done, or it could involve the trainee participating in a committee which has a real role in deciding the form of their own training. The trainees in this latter system would take turns at being the elected officer, and so gain experience in acting as chairman or secretary. In this system, real responsibility is experienced.

In another system of teaching, much used in industry and government administrative supervision of a trainer, small committees with specific objectives are formed. The trainees take turns at acting as secretary or chairing the meeting. Roles as advocates of change or opponents of proposals can also be given to the trainees forming such role-play committees. This useful experience has the real advantage of being supervised practical experience. The sessions can be interrupted for constructive criticism, or feedback can be given at the end. Examples of skills that need to be learned from such training would be those of the secretary in taking accurate minutes, and that of the chairman in guiding the committee efficiently. The trainee needs to learn the protocol of being a chairman, and also the familiar working strategies such as how to summarise the discussion or establish consensus.

In short, it is obvious that all trainees need to have some training in methods of administration. It is a topic which has long been neglected in the majority of training schemes for psychiatry. However, it is no longer acceptable for training in administration to be ignored, and efficient and appropriate methods of teaching these skills need to be evolved and learned from other professions.
Chapter Fourteen
THE RELEVANCE OF RESEARCH TRAINING
N. N. Wig

Introduction

The importance of research is by no means a universally held ideal, either amongst individuals or training centres. The number of psychiatrists who continue research after qualifying is small, even in the developed countries (10% in the USA and 5% in the United Kingdom). This is partly due to the demands of their clinical workload and other considerations, but is also due to the variable attitudes instilled in the trainees from different centres. This variation is reflected in the different requirements for research and research training in the syllabuses of various postgraduate examinations in psychiatry. Some require no knowledge of research methodology, others require theoretical knowledge, whilst others again require proof of some research in the form of a thesis. The wide variations in teaching of research skills in the postgraduate psychiatric education of different countries and at different centres within the same country, is an indication that there is no general agreement on the need for the teaching of research. Those who are opposed to compulsory teaching of research have usually argued in the following way:

1. Most of the trainees are not going to be research workers or academic teachers in later life; hence why waste time learning research skills. The same time can be utilized for learning other subjects or sharpening clinical skills which are more relevant for future psychiatric specialists, most of whom are going to be clinicians. By avoiding a research component such as the obligatory writing of a thesis, we can reduce the duration of training programmes.

2. Compulsory research training in the postgraduate curriculum helps the teachers more than students. Teachers use students as cheap labour to finish their own pet research projects and publish more papers.

3. Good research cannot be completed by students in the limited time available and under the stress of studies and examinations. Hence this effort is wasted. In fact students end up by learning more about how to fake results rather than how to do good research.

4. Research is a kind of luxury for a developing country. The psychiatrists in these countries need not waste time on learning research. Enough knowledge is already available. A psychiatrist in a developing country should concentrate on the application of existing knowledge.

On the other hand those who believe in the need for the teaching of research have argued that it is an essential component of education. The contribution of research may not appear to be so significant in providing a student with knowledge or skills for his future role as a clinician, but it is vital in fostering in him an attitude of scientific curiosity and critical observation which is so essential for a medical specialist. For this reason it is important that the learning of research is not undertaken in isolation as a thesis-writing project. It should be fully integrated with all aspects of training.

To argue that developing countries need less research is invalid. If anything, more scientific research is required to solve the complicated health problems of developing countries. It is easy for medical professionals to accept the role of nothing more than a provider of clinical services. His role then becomes rather like that of a salesman of goods which are manufactured abroad. To be truly useful to his community, the medical specialist should be able to modify and adapt technologies to
local needs. It is not enough for a doctor to know what is given in a textbook but it is crucial for him to understand how statements get into textbooks and what is their validity. Only by developing these critical faculties will he build the confidence to question the teachings of these authors and think of alternative solutions to the problems which he sees in his daily practice.

The arguments in favour of including research training in postgraduate psychiatric education can be summed up as follows:

1. It is true that most of the psychiatrists in developing countries will not pursue a full-time career as research workers though some will be encouraged to do so by teaching of research methodology. The purpose of research training, however, is not to make students researchers at this stage, but to equip them with elementary principles so that they develop a healthy scientific attitude towards the subject. Without training in research, psychiatric education is incomplete and the trainee is likely to end up as a technician rather than a scientist.

2. As is well known, a psychiatrist has often to deal with highly subjective clinical material. The current treatment procedures in psychiatry are also often empirical. Against such a background it becomes very important that a student learns objectively to balance his subjective observations and "insights". Training in research is an essential component in teaching scientific objectivity.

3. Due to the shortage of quality manpower, a considerable number of psychiatrists in developing countries are going to take up teaching roles to train more psychiatrists in their countries, as well as to train various other categories of health personnel in mental health. To become good teachers a background in research is useful and, therefore, desirable.

4. The problems of developing countries are very complex and varied. Often the solutions evolved in industrialised countries are not applicable or relevant. By developing a scientific attitude, health professionals will be more able to modify existing technology for local needs.

**The Teaching of Research**

The objectives of teaching research are two-fold. Firstly, it can be taught as a necessary skill for those who are going to be involved in research as a part of their future career as a scientist or as academic teachers in medical institutions. Secondly, research training is a means of fostering a scientific approach amongst students for their future professional activities. The two roles are, of course, not clearly separate but it is desirable to keep the distinction in mind when planning the teaching programme.

1. **Teaching methodology**

   This can be taught at two levels, a general level suitable for the trainee who wishes to be able to understand enough to reach a critical appreciation of the research of others, and at a more intensive level, suitable for the trainee who intends to devote time to carrying out an original research project.

   Knowledge of methodology includes consideration of experimental design and statistics at one level, but in a wider context involves the skills of data collection, broad planning of research projects and grantsmanship. All trainees should have an understanding of terminology, and should be familiar with concepts such as a treatment trial with double-blind control design. They should have knowledge of systems of classification and structured interviewing techniques.

2. **Experimental learning**

   The learning of research techniques by "hands-on" experience is by far the best method. Divorced from practical research, research methodology and statistics can appear pointless and boring to the trainee, but learned directly for the purpose of carrying out a small piece of research, it becomes interesting and can develop into a passion. This type of experience can be gained by undertaking a modest research project in an informal manner, or can be formalised into the requirement of preparing a practical or theoretical thesis.

   Preparing a dissertation or thesis is a traditional approach in which a student has to go through the various steps of an actual research project. He develops a proposal and writes a protocol, reviews literature, outlines objectives and methods and states his plan of work. Subsequently, under supervision he collects data, makes observations, learns the use of various research instruments, reads more journals and original articles, analyses his own findings using various statistical techniques. He ultimately writes his dissertation which in some centres he has to defend before his peers, and he will later publish his results in a scientific journal. Unfortunately, the exercise often does not happen this way. Many
students who join postgraduate training courses in psychiatry do not possess either the calibre or the background training which will allow them to conduct sophisticated research by themselves. The help which is required from teachers in terms of time and guidance is often lacking. A student without a previous background in research as is common in developing countries, is suddenly confronted with a bewildering variety of tasks and decisions. He desperately looks for technical and emotional support which is often not to hand. The result is a kind of research output which does little credit to the student or the institution. In many places in India and other countries, the students have protested against compulsory writing of a thesis as a part of postgraduate degree programmes. Conducting independent research under supervision is no doubt the best method of learning research but to carry it out successfully, it must have the necessary input of time and support by of the student and the support of the expertise of the supervisor. Some institutions have tried to introduce alternative lesser research requirements like publication of a paper in a recognised journal or simple analysis of a retrospective series of cases, instead of insisting on a thesis based on original research.

To create a research attitude among the trainees, it is important that research should not appear as an activity in isolation but should be integrated in the day-to-day work. Wherever possible, learning should be made into a problem solving exercise. Students should be made to see how information in a given situation can be made to bear on the solution of the problem. Students should be encouraged to take on small projects and collect data which is discussed in peer groups with a teacher so as to encourage critical scientific thinking. Many examples can be found from day-to-day work where a student can be encouraged to look at a problem from the research point of view.

The Choice of Research Topics

1. Research by trainees

The purpose of the research conducted by students is not so much to produce outstanding results but to learn research methods and develop research attitudes for their future careers. The choice of subject will depend greatly on the inclinations of the student as to what he feels is worth doing, but he must be guided at the beginning about the need to link research with the health problems which he sees around him. It is desirable that he takes a line of enquiry which he can follow through in his later years. One need not enter into a controversy at this stage about the relative importance of basic research versus applied research. Obviously, both are important but the research should not only serve to fill the pages of a scientific journal but must deal with real life problems and a possible way of solving them. The priority for the developing countries is a decision-oriented or action-oriented research. Hence a student should be made familiar with this approach. For example, while selecting a topic for research a student should be encouraged to visit primary health centres in the community, meet health personnel, and discuss with them what they feel are important mental health problems in the community and the current difficulties in management. In the teaching departments also, there must be seminars and group discussions on research priorities and the need for goal-oriented research in developing countries.

It is important that realism is retained in research. Since sophisticated laboratory facilities are unlikely to be available in most of the developing countries for some time, it is impractical for a trainee from the developing world to devote his efforts in this direction. Experience of areas such as epidemiology, clinical and social psychiatry and delivery of mental health services is more relevant and realistic.

2. Research in developing countries

One of the major problems facing a researcher in developing countries is the lack of proper research instruments suitable for his country. For example, even if he wants to mount a simple prevalence or attitude survey, he finds the psycho-social questionnaire which he used abroad not suitable for his population. It would be helpful if during the period of his training such problems were discussed. Training centres in developed countries, which undertake the training of students from developing countries, should not confine themselves to the reviews of research done in the host country but must pay particular attention to the good research conducted in developing countries by periodically reviewing published material in local or foreign journals.

The psychiatrist in developing countries needs to be trained for “action-oriented research”. Emphasis should therefore be given to the development of a psychiatric data-base for that country, the furtherance of epidemiological studies, the
evaluation of psychiatric programmes, the evaluation of training activities, locally and elsewhere, and problem-orientated research in that locality. To this end, translations of structured interviews or assessments may need to be prepared.

**Collaboration in Research and Research Training**

Psychiatrists in the developing countries need the tools for research. These tools include both skills and facilities, such as libraries, journals and computers for statistical analysis. Collaboration between psychiatrists in the developed and developing countries needs to take place to provide these skills and facilities, and to tackle the task of indigenisation of the technologies. Visits to the developing world of guest lecturers from research centres can serve to stimulate research and give an impetus to training methodology through lectures and seminars. These same psychiatrists can provide supervision, albeit from a distance, to guide and stimulate potential research. Access to international journals should be made easier. "Leads" or articles from the developing countries could be commissioned by the major journals.

This flow of help is not one way. The developing countries, their patients and psychiatric services can provide a wealth of research material for developed centres. The possibilities for comparative psychiatry and epidemiology are enormous, with psychiatric knowledge receiving the main benefit.

The WHO and other non-governmental organisations have a role in this collaboration. They are in a good position to make these recommendations happen. They can help fund and guarantee the future of collaborative research projects. Through their publications they can stimulate all types of research. They can act by collecting and publishing relevant reviews and annotated bibliographies related to significant research done in the developing world.

**The Way Ahead**

Training in research should form an integral part of postgraduate psychiatric education. It is required not only for imparting basic research skills but it is also an important means of fostering scientific attitudes among future psychiatric specialists. Training in research is particularly relevant for developing countries because appropriate technology must be evolved effectively to deal with the prevailing health problems. Medical students in their undergraduate years often have good exposure to biomedical sciences but have generally very little contact with the psycho-social sciences (Chapter six). Hence, research in psycho-social and epidemiological aspects of mental health should receive particular attention during postgraduate training. Similarly, special emphasis must be laid on action-oriented research to enable the student to learn to apply research findings to his daily work.

Training in research is best learnt by actually taking up a research assignment under guidance but there are many difficulties in implementing such training due to the shortage of trained staff and the time available. Even if specific research projects can not be undertaken, training must be imparted in general research methods. To prepare the student for future work in the developing countries there should be adequate exposure to research instruments appropriate for use in those countries. It is also desirable that there should be regular exchange of information on research and training between centres in developing and developed countries.
Training in teaching skills for psychiatrists has long been ignored. In the developed countries, this leads to avoidance of teaching by some psychiatrists, and inefficiency in teaching by others.

In contrast, the psychiatrist in a developing country is morally obliged to devote a substantial proportion of his time to teaching. However, other demands on his time mean that he has to be efficient in his teaching methods, and trainees have less time in which to learn. Hence, skills in teaching, important to all doctors, are essential to the psychiatrist in the developing world.

The question “How to teach?” can be applied to both individuals and institutions involved in training, and there are many subsidiary questions such as “What to teach?”, “How much?”, “Whom?” and “Where?”

The Teaching-Learning Process

The process of teaching is inseparable from the process of learning. Its aim is to change the performance of one or both participants. It is composed of the acceptance, conscious and unconscious, of information and influence, reasoning with this input, and attaining a re-organisation of old attitudes and skills. There should be no boundaries between theory and practice in teaching. Theory is practice explained, and practice is theory applied. It is not the role of teachers to be transformers of personalities. Students have the right to privacy and personal and cultural identity. Selection of candidates is of outstanding importance, and it is vital for motivation that they themselves have chosen the particular area in which they are training.

Both trainers and trainees must be aware of the objectives of the course. In this regard teaching systems differ, as can be shown by the following examples. The system often favoured in the United Kingdom tends to accept that the objective of the course is to teach the trainee whatever they are able personally to learn, from a course. Implicit in this is the fact that some will learn more than others, depending on their ability. In contrast, the system most frequently used in the United States centres on specific objectives for all participants to learn. The course is a success when all candidates reach their objectives. Clearly, there are benefits in each system but the differences must be acknowledged and understood.

Supervision is essential in most forms of teaching but supervision does not necessarily imply hierarchy. Respect of the trainee for the trainer must be reflected by respect of the trainer for the trainee. In a similar vein, it is clear that the trainer cannot be responsible for the ethics, politics or social-conscience of the trainee. These aspects are the responsibility of the individual. One of the main objects of improving teaching skills is to produce more learning for less teaching. It is a question of efficiency. Necessary for efficiency is a realisation of what knowledge it is necessary to impart in which course and the competence to produce the right syllabus.

The Teaching Syllabus

Before psychiatry can be taught, it must be familiar to the teacher. However, it is clear that the knowledge must be imparted at an appropriate level. Giving either too little or too much knowledge can lead to failure. The psychiatrist in the developing country may find himself teaching medical stu-
Skills Involved in Teaching

Confidence and the ability to communicate form the back-bone of teaching skills. There is no doubt that the ability to lecture or lead seminars is acquired through practical experience. Sadly, few trainees have adequate opportunity to obtain experience in teaching, especially when training abroad. Therefore, an attempt should be made to rectify this fault, perhaps by the “Show one, do one, teach one” technique, where the trainee watches a procedure, then does it himself, then teaches it to another, all whilst under close supervision.

Some aspects of the skills of teaching can be taught. The theory of good lecturing is an example; a lecturer should punctuate his lecture by lighter interludes so as to revive the concentration of a flagging audience. He can be taught the basic principles of voice production and presentation. He should take the centre of the stage and should without reading (except as a necessary aid), capture and hold the attention of his audience. He should avoid talking on the move, and avoid mumbling anecdotes. Instruction should be given in the use of the microphone.

Visual aids can be used to great effect in lectures and seminars, but the techniques of using them correctly are not picked up instinctively. For instance, slides in a lecture should not be used as an extended series of notes but should be appropriate and understandable to the audience within a few seconds. If the audience has to spend time comprehending the slide, then they are distracted from what the teacher is saying. Similar considerations apply to the use of an overhead projector, where special techniques such as the marking of the acetate sheet, or the use of further sheets as overlays, can be extremely useful.

The production of such visual aids is within the capabilities of most teachers. However, there are again certain rules which can be taught. When preparing slides, the material should be planned to fit the 35 x 22 mm. slide proportions, punctuation should be used sparingly, and full-stops avoided. Labelling should be horizontal on all graphs and diagrams. With overhead projector slides, 8 words per line, and 8 lines per slide are the maximum amount of information that can be included. It might at first seem inappropriate to mention here such small matters of detail, but they provide examples of exactly the kind of practical teaching skills which need to be taught, whatever the country setting.

When visual aids are not readily available from departmental sources, the teacher can be taught the skills of producing his own. Instruction can be given in photography, the use of the typewriter (for preparing handouts, slides and booklets), and the use of duplicating machines. These and other skills can be used in the adaptation of material from international sources for local use. Translation, involving the use of local languages, or English at a simple level, is a useful skill. Knowledge of how to produce simple pictorial systems can also be helpful. It must be remembered that even illustrations may need “translation” for local use, for example the re-drawing of faces or environments for local relevance.

Other skills which need to be learned for teaching are those involved in the administration of teaching. Again, some of this information can be learned by didactic methods, but much needs practical experience under supervision. Administrative skills will be essential for the psychiatrist to arrange clerkships for medical students, rotations and in-service training for psychiatry trainees, the teachers within a course, the financial aspects and the syllabus. Practical experience may be made available by the involvement of trainees in the organization of, and feedback from, their own courses. Finally, the skills of motivating students must be acquired. Some of this will stem from the teachers own enthusiasm, but thought can be given to the problems of making subjects interesting and entertaining as well as instructive.

Methods and Models

The teacher of psychiatry can learn from a number of models which have been developed as efficient methods of teaching. The Institute of Child Health, London, in teaching paediatric medicine to post-
graduate students from developing countries uses a scheme which focuses the attention of their students on a series of 10 or 20 major problems of health. In concentrating on these topics they learn the principles of dealing with other problems, as well as knowing these major and relevant areas in depth. As described earlier, the model of teaching described as "Show one, do one, teach one", is used in many centres in the United States. It allows the benefits of theoretical teaching and practical experience to be combined in a supervised learning experience with a clear objective and easy evaluation. When the lay-population is to be educated, then much can be learned from the practices of traditional healers in teaching within local cultures. They have the advantage of being able to fulfill the expectations of their own culture in their practice and teaching. These skills are important for the psychiatrist who is to teach and work with primary health care workers, and who is to educate the population in primary prevention.

The Role of International Collaboration

Whilst there is a high level of awareness in the international community of the problems of famine, poverty, and lack of medical supplies in the developing countries, there has often been a failure to focus on, and correct, the famine which exists for information and knowledge. The damming back of the flow of teaching materials and other resources from the developed to developing countries is a scandal which needs urgent action, and one which can be helped by international collaboration. International efforts need to be directed towards the teaching of teachers, the provision of audio-visual aids, books and other teaching materials, and the classification and publicising of information on available resources.

Little attention is paid to the development of teaching skills in psychiatric trainees and this situation must be changed. Psychiatrists should be offered short courses to train in teaching methods and models. These courses could fit in with basic training in local or regional centres. Methods of distance teaching for teaching skills could be produced and evaluated by international centres. Examples of this would be manuals, flow-charts and videotape demonstrations on how to teach in a step-by-step fashion.

International agencies such as the WHO and WPA have a role to play in the promotion of teaching skills and the training of teachers. They can help to promote the political climate in which potential teachers now practicing in the private sector in developing countries can be persuaded to return to spending more time in teaching colleagues. They can also sponsor visits by teachers from centres which have spare teaching capacity to teach psychiatry trainees in centres where resources and personnel are scarce. Such travelling lecturerships would have to be efficiently organized, partly to maximise the efforts of the lecturer, but also in respect to the limited time available for in-service training in the developing countries.

The key factor in the provision of learning materials is that the cost of such material is kept to a minimum. Developing countries have barely the foreign exchange to buy books for their main libraries, and certainly cannot afford to equip trainees with manuals and text-books at international prices. A second factor in the production of such aids is an awareness of who will be reading the books. Some will need to be produced for specialist psychiatrists, but others need to be geared at different levels such as medical students and primary care workers.

The example of the Institute of Child Health in producing a range of teaching aids at lost cost (TALC) is worth noting. They have written and commissioned a range of test-books and slides for all levels of primary health workers and professionals, which are then distributed by mail-order to the developing countries. Although the range is largely restricted to mother and child health services, it is slowly being expanded to cover a wider area of medicine. The experience that has been gained in setting up this venture should not be lost to the field of international psychiatry. As it takes two years to produce a book for such a system, much hard work and patience is required, but the goal is very worthwhile. Such a system can also produce teaching materials such as slides and flow charts.

Pairing of centres in the developed and developing world can be one way of enhancing international collaboration. By this system some centres in developed countries have supplied spare journals, books and teaching materials to their "sister-centres" in the developing world. Similarly, connections between centres can be built up through
the postgraduate students who return home. Centres wishing to improve collaboration could ensure that such returning students would be provided with personal libraries of teaching and reading material, photocopied or otherwise.

Again there is a role for the WHO or other agencies. A directory of available teaching and reading materials needs to be compiled in which these materials would be evaluated and classified (see WHO 1987 as an example of such a directory). They would include the many useful WHO booklets. The agencies might be able to finance the distribution of such materials. Centres in the developing world also need to be provided with modest equipment for producing their own teaching aids. Examples would be the provision of typewriters, acetate sheets and over-head projectors, and possibly micro-computers. Sadly, under-development of a country is usually global, with gaps in technology, but also a lack of availability of electricity and telephone lines.

The availability of journals needs to be improved. Some of the major journals will provide a few free copies to Universities of the developing world on request. However, psychiatric associations in developed countries for instance could ensure that journals are available to developing countries perhaps by having regional journals which negotiate the reprinting of relevant abstracts and articles from the major international journals. Centres of training in developing countries or for trainees from those countries should ensure that they have in their libraries an adequate range of trans-cultural journals, and journals of local importance to the developing countries.

Finally, international collaboration should ensure that not only are centres that train psychiatrists developed, but that knowledge of their existence should be available (e.g. WHO 1988). International agencies should disseminate information about local, regional and international courses, so that prospective students who wish to be teachers of psychiatry know the type of training they will receive, and know whether or not they will be taught “How to teach”. By this simple method, market forces should improve the availability of courses in the teaching of psychiatry.
Part V
TRAINING IN THE SUB-SPECIALTIES
Chapter Sixteen

ORGANIC PSYCHIATRY
Alwyn Lishman

Delineation of the Field of Organic Psychiatry

"Organic Psychiatry" refers to a segment of the field of mental disorder encountered clinically, i.e. to a definable territory within the corpus of mental illness generally. It deals with those disorders which can be demonstrated to owe their origins to brain malfunction of a clearly identifiable nature, whether this be the consequence of brain damage or disease per se, or of brain dysfunction secondary to systemic physical disorder. It encompasses, for example, the effects of brain degenerations, trauma, infection, tumour and epilepsy, but also the effects of malnutrition, hypoxia, metabolic and toxic processes which only implicate the brain indirectly. "Organic psychiatry" is therefore broader in scope than "neuro-psychiatry", though the two are broadly congruous with regard to teaching implications. The chief difference in practical terms is that organic psychiatric teaching must aim to equip the student for a broad range of psychiatric disorders likely to be encountered in general medical and surgical practice, not merely for those seen in relation to neurology. This has immediate implications for the growing tendency to site psychiatric units in general hospitals and for the increasing involvement of practitioners in "liaison psychiatry".

Organic psychiatry differs from "biological psychiatry" in that the latter concerns itself with mechanisms and pathophysiology of a biological nature which can be sought out and studied in relation to virtually all forms of psychiatric disorders. Organic conditions certainly, but also the major psychoses, the personality disorders, the addictions and the neuroses. Biological psychiatry represents an orientation and approach to elucidating mental disorder, not specialisation in a particular clinical field. This said, there are obvious overlaps in the material to be covered in the teaching of organic psychiatry and biological psychiatry, particularly when it comes to consideration of underlying mechanisms.

Maintaining Balance in the Approach to Organic Psychiatric Problems

The core discipline in relation to organic psychiatry remains general psychiatry and it is essential that the subject be taught by psychiatrists. This may seem self-evident, but there is risk when resources are scarce that aspects may come to be taught by other medical specialists. The development of "behavioural neurology" in the USA, for example, has derived from under-involvement of psychiatrists in the teaching of borderland areas. There has also been a tendency in certain specialised units for physicians to become "expert" on psychological consequences of particular diseases. When nothing better is available such initiatives are to be welcomed, but direct psychiatric involvement brings far broader perspectives.

It is essential, for example, that the trainee should see that organic psychiatry must capitalise on all that psychiatry has to offer, and appreciate that organic factors are often operative in conjunction with others in leading to the final clinical picture. Concentration on organic aspects of the subject must not result in a narrowing of approach; the medical model of disease will be central but must be supplemented by other avenues of understanding. For example:

1. The individual's response to brain damage is profoundly shaped by his personality and pre-morbid modes of functioning. Proper assessment of such issues can be crucially important in understanding the clinical picture and in formulating management plans appropriately.
2. Family and inter-personal relationships often need detailed consideration when dealing with disability; attention to such matters can be important, particularly in maintaining patients in the community.

3. Psychodynamic (and environmental) factors can influence the content of delusional experiences in acute organic reactions. Psychodynamic understanding is important in the care of the chronically disabled, especially in the handling of dependency responses.

4. The role of social factors, for example in the declaration of dementia, must be understood, likewise their influence on rehabilitation and capacity to cope. Health care planning issues must frequently be addressed.

5. Cultural influences will sometimes be powerfully operative, e.g. in relation to patterns of care, or in contributing to disability as with "compensation neurosis".

6. In differential diagnosis problems will regularly be confronted which tax general psychiatric understanding and require a broad approach. Exploration of conflict must sometimes go hand in hand with organic investigations, and the mental phenomenology displayed will always need detailed appraisal. Examples include the pseudo-dementias due to depressive illness, the pleomorphic symptomatology accompanying anxiety states, and the classical problems of catatonia and the hysterical conversion response.

7. In treatment, supportive psychotherapy and assessment of relatives' attitudes can be as central as pharmacotherapy and other "organic" approaches. The management of epilepsy illustrates this well. Team work must often be coordinated, with proper appreciation of the roles of nurses, social workers, clinical psychologists, occupational therapists and physiotherapists.

In all these respects it is necessary to emphasise the role of skills and techniques derived from general psychiatry, of which organic psychiatry is an integral part. The correct balance can only be communicated by teaching firmly centred on clinical problems as they arise in practice. Hence the importance of an adequate clinical service upon which such teaching can be based. A knowledge of primary prevention and public health measures designed to reduce the causes of organic psychiatric conditions is essential. Skills in advocacy and teaching of such measures is also important for the psychiatrist working in the developing country.

**Relevance of Neurology and Other Medical Disciplines**

Where organic psychiatry is concerned there is substantial advantage if trainees have had additional experience of general medicine before embarking on their psychiatric training. Experience in neurology is particularly valuable. When such has not been obtained attendance at medical and neurological clinics during the course of psychiatric training can be greatly beneficial. The areas of medicine which have most relevance will vary according to the situation in which organic psychiatry is practiced. In the developed countries it is helpful to be conversant with metabolic, endocrine and geriatric disorders; in other countries knowledge of tropical diseases and the effects of malnutrition could be especially important. Hence it would seem relevant for these aspects of training to be carried out in the country of origin of the trainee.

In all settings neurology has special relevance for reasons set out in "The Training of Psychiatrists" (1970). They may be summarised as follows:

1. The distinction between psychiatry and neurology is partly a matter of history and is still not practised universally. Where resources are scarce both disciplines may need to be encompassed, at least to a certain level.

2. The two disciplines share borderland clinical territories, e.g. with epilepsy, dementia and certain movement disorders.

3. Experience in neurology brings a close working knowledge of investigatory techniques such as electroencephalography and neuropathology which must come within the psychiatrist's purview when available.

4. Cerebral disease may lead to admission to a psychiatric hospital and be overlooked initially. The prime responsibility for suspecting the situation often rests with the psychiatrist.

5. Where psychiatrists work in relative isolation from other clinical colleagues they must to some extent be self-sufficient in the provisional
differential diagnosis of diseases of the central nervous system.

Several of these considerations are likely to be especially important in developing countries.

**The Necessary Skills for Organic Psychiatry**

The important point should perhaps be highlighted, nonetheless, that clinical knowledge is the first essential in organic psychiatric training. Any course must be tailored towards this end. The most fundamental need is to teach how and when to suspect that an organic cause may be operative in patients presenting with mental disorder, and how to investigate such patients appropriately. The need to use clinical psychiatric skills in such a manner that one can be discriminating in the use of investigatory procedures will always deserve emphasis, and particularly so in developing countries where advanced facilities are scarce.

The following is a list of necessary skills which are the minimum requirement for an organic psychiatrist:

- Principles of nosology and terminology in organic psychiatric disorders.
- Assessment of the organic mental state.
- Principles of differential diagnosis - stressing overlaps between organic and non-organic psychiatric disorder.
- Revision of key aspects of the medical and neurological enquiry and examination.
- The use of investigatory procedures (especially EEG and neuro-radiology), including the importance of liaison with medical and neurological specialists when necessary.
- Principles of management of organic psychiatric patients.
- The dementias - primary, secondary and pseudodementias.
- Head injury - including medico-legal aspects.
- Psychiatric aspects of epilepsy - including the fundamentals of management of epileptic patients and the differential diagnosis of sudden aggressive behaviour.
- Amnesic syndromes and their differential diagnosis and management (including drug-induced movement disorders).
- Psychiatric aspects of space-occupying lesions, cerebrovascular disorders and intracranial infections.
- Psychiatric aspects of other neurological disorders (multiple sclerosis, migraine, etc.)
- Psychiatric aspects of endocrine, metabolic (anoxia, uraemia, hepatic disorder, etc.) and nutritional disorders (especially vitamin deficiencies)
- Organic aspects of alcohol and drug abuse, toxic effects of drugs, heavy metals and chemicals.
- Organic and psychogenic pain.
- Conversion hysteria.

In many countries there will be a need for two levels of training in organic psychiatry. A few will need training to the level of specialists, working in tertiary referral centres, and with investigative facilities at their disposal. However, with the high organic case load in developing countries, general psychiatrists and primary health workers will need adequate training in the diagnosis of and primary treatment in organic psychiatry.
Chapter Seventeen

DRUGS AND ALCOHOL
Joseph Westermeyer

With so many other pressing concerns confronting psychiatry and psychiatric training programmes in developing countries a strong case has to be made out for paying attention to any sub-specialty. This statement must apply as much to training on drug and alcohol problems as to any of the other topics discussed in this section of the report.

The justification for giving some special attention to these issues is in fact persuasive. Misuse of drugs and alcohol constitute a threat not only to urbanised countries but also in many instances to the health, social welfare, and indeed national development of less developed countries. There has been a strong call from around the world for more forceful health action on these matters coupled with a more adequate provision of training. Training needs were, for instance, given prominence at a recent conference of Ministers of Health on narcotic and psychotropic drug misuse (WHO, 1986a):

"Whether in relation to prevention or treatment a paramount need was recognised for training which can develop manpower resources at primary health care level and enhance the skills of the non-specialist. Training is needed for early detection as well as for treatment and rehabilitation".

Substance abuse will undoubtedly be a major problem for our societies into the indefinite future. A cause for concern are the potential high lifetime prevalence rates. With most psychiatric disorders, the maximum lifetime prevalence rates are relatively low (for instance, around 1% for schizophrenia, perhaps 10% for major depression). There are several examples of prevalence rates for substance use problems among males which range up to 20 to 25%, with the likelihood that 50% of all adult males who reach adulthood develop substance abuse before their death. Rates of this magnitude have been observed for alcohol abuse among certain American Indian groups (Whittaker, 1982) and for opium addiction among Asian poppy farmers (Westermeyer, 1983).

Medical facilities are increasingly concerned with education and training in substance abuse. Without special education and training, physicians neglect the assessment and care of substance abuse, and indeed sometimes contribute to its development and maintenance. If the problem is not currently widespread in a society, it is likely to become so during the future careers of today’s psychiatric trainees. Substance abuse however, is too diverse a field to be taught only in psychiatry. In the basic science years as well as in the clinical and postgraduate years, various facets of substance abuse are appropriately taught under many other headings, and by specialists in many branches of basic and clinical science other than just psychiatry. Psychiatrists have therefore, a particular contribution to make not only to the training of psychiatrists in this field but also to the training of medical students, other branches of the medical profession, and other professions. Co-operation between countries in this aspect of psychiatry must therefore take special note of the need to prepare psychiatrists for a very broad teaching role particularly in relation to primary health care.

The argument has been made that psychiatrists should initiate and guide curricular changes in substance abuse. No one department should of course “own” the substance abuse curriculum. In order to cover essential features of substance abuse, and not needlessly to repeat contact, a task force or
curriculum committee sub-group should assess, direct and monitor the substance abuse curriculum over the years of medical education (Coggan et al., 1984) and psychiatry should be represented. So far as developing countries are concerned, the prime purpose of any specialist training must be to produce leaders and educators to strengthen the primary care response. The social and public health perspective is very important.

**Psychiatric Contributions to Information on Substance Abuse**

**Definition**

Like other psychiatric diagnoses, there is no one set of widely accepted diagnostic criteria for substance abuse although ICD 10 and DSM III-R offer considerable advances. The lack of agreement over definition complicates the work of psychiatrists, but does not make it impossible. It is a problem which is also faced with affective disorder, schizophrenia and other disorders. It is the psychiatrist’s job to bring as much clarity as possible to bear on these issues and at the same time admit the difficulties. An awareness of the nature of what is being talked about in this area, a closer appreciation of the social as well as the clinical dimensions of what is to be defined as “the problem”, must be an essential aspect of teaching.

**Pathological courses and pathways to recovery**

The natural course of substance abuse varies with the drug, the age at onset, genetic loading, and access to treatment (Arif & Westermeyer, 1986). Even when these variables are held constant, there is still considerable variability in the natural history. Some individuals recover and make outstanding contributions to their communities, some have recurrences over many years, some maintain abstinence but never resume their former level of social competence, and some die of drug-related problems despite intensive treatment. The psychiatrist must learn (and teach) that substance abuse pathways are widely variable and, at our present state of knowledge, are difficult to predict. Recovery can follow a highly erratic path over several years.

**Epidemiology**

From an epidemiological perspective, substance abuse shares certain common attributes with other psychiatric disorders. As a chronic and sometimes recurrent problem, it tends to show a high prevalence but low incidence. Epidemiological studies of substance abuse often involve methods similar to those of other psychiatric epidemiology (i.e. establishing rapport, skilled interviewing, confidentiality) rather than to the methods more appropriate to disorders such as infectious disease or cancer. Those who study teaching the epidemiology of substance abuse should be aware of certain differences from the epidemiological study of other psychiatric disorders. Special methods exist for investigating the distribution of substance abuse in populations. These include, but are not limited to the study of body fluids in selected groups (e.g. arrestees, accident victims in morgues, the military, emergency room patients) and the study of certain tissue abnormalities highly correlated with substance abuse (e.g. hepatic cirrhosis). Familiarity with the nuances of these methods facilitates the task of the academic psychiatrist charged with education in this field. There is a demand in many developing countries for better data on alcohol and drug problems as a basis for prevention and treatment policies.

**Pharmacology**

Familiarity with neurotransmitter theories of psychiatric disorder, with the neurotransmitter effects of the medications, and with the growing literature on CNS neurotransmitter substances are needed by the medical school teacher.

**Diagnosis**

Many medical and surgical conditions can be defined in terms of abnormal tissue, pathological laboratory findings, or physical examination. Whilst this is true of some psychiatric conditions, this is not generally true of most conditions which the psychiatrist treats. In substance abuse, there is no one physical finding, laboratory test, or tissue abnormality which is pathognomonic. There are additional data which the psychiatrist must acquire for the diagnosis of substance abuse. For example, studies on the reliability and validity of self report among substance abusers should be appreciated, as well as the factors which augment or undermine these. The educator in substance abuse must know the markedly different excretion rates of different drugs. Most importantly the trainee should be equipped to teach methods of recognition to the primary health care worker.

**Treatment**

Psychiatrists who will work in the field of substance abuse must learn much new information regarding
the care and management of patients. This includes interventions for overdose, management of withdrawal and other acute drug-related emergencies, and concomitant treatment of substance abuse in the presence of medical, surgical, or other psychiatric conditions. The risks of concurrent administration of certain psychotropic medications in the presence of drug or alcohol abuse should be appreciated. Treatment approaches often not familiar to psychiatrists should be studied. These include special medications (e.g. disulfiram, clonidine, naltrexone, methadone) and special procedures (e.g. withdrawal regimens, over-dose regimens). Psychiatrists should be taught the goals and methods of family therapy, group therapy, and self-help groups as these relate to substance abuse. The trainee must also be in a position to teach the primary level worker the skills relating to very simple types of intervention.

Prevention
Psychiatrists should appreciate their role in prevention of substance abuse and be capable of advising on preventive strategies at every level. The substance misuse field is an area of psychiatry offering quite unusual opportunities for multiple strategies aimed at prevention. The psychiatrist’s training should equip him to know what strategies are likely to be effective in any setting and thus put him in a position to advise professions, communities and governments.

Attitude Towards Substance Abusers
Attitudes towards patients affect the quality of care which is rendered. This fact has particular relevance for substance abuse care, since medical students come with a range of attitudes toward drug abusers which reflect the general attitudes of their society. These attitudes are often negative and deteriorate further during medical school. Nurses and other health professionals also share these anti-therapeutic attitudes. Fundamental attitudinal change cannot be mandated, or tested for on an examination - although instruments are available to monitor attitudinal change (Chappel et al, 1985). It can be facilitated and assessed however. This can be accomplished in various ways. One effective means consists of having students examine and reconsider their own attitudes towards substance abuse before and after a learning experience. This process may also be helped along by having psychiatrists in training consider and re-assess their attitudes towards their own psychoactive use (including caffeine, tobacco, alcohol), as well as that of their peers, friends, and family. Positive attitude changes can also develop solely from positive clinical experiences with substance abusing patients during training. These considerations are clearly of great importance to the training of primary health care workers.

Goals and Phasing of Training in Substance Abuse
Objectives and the priorities must be determined by the health needs of the population and the health care system. One of the first needs of the psychiatrist is to be able to recognize substance abuse in his clinical work setting, ideally at an early phase. A further stage of training must involve pre-treatment assessment, which goes beyond mere diagnosis. What are the patient’s current resources, therapeutic needs, and past successes or failures in treatment? It is also necessary to educate the postgraduate student about the processes of and approaches to treatment, so that the trainee can then select particular treatment approaches for the patient.

Sub-specialty training in substance abuse usually requires about one year. Those completing such a course should be able to assess all substance abuse patients including forensic, complex, and treatment-failure cases. They should be able to apply or supervise a wide variety of treatment modalities. Graduates at this level should be able to establish, develop, direct, administrate and evaluate services for substance abuse. Given adequate supervision, trainees at this level can learn to conduct clinical supervision of trainees who are at more elementary levels. One approach to this training has been published (Westermeyer, 1985). Training in research prevention methods, and policy development should also be undertaken. Conferences for practicing psychiatrists or other doctors can be valuable in upgrading information and skills. These can ordinarily be conducted for only a few hours to a few weeks, so they must be carefully planned and highly organized. From 1979 to 1985, the World Health Organization conducted annual three week training courses in drug misuse for doctors in Asia. Approximately 200 medical practitioners from twenty countries participated in these sessions. In turn, many of these doctors have conducted similar conferences in their clinics, hospitals, medical centers, schools and professional organizations.
International Collaboration in Substance Abuse Training and Transferability of Knowledge

In the drug field as in any other areas of psychiatry there can be difficulties in transferring knowledge gained in specialised Western centres to the setting to which postgraduate students from a developing country will return. This is also an issue for senior, experienced visitors who are accomplished in matters of academic and technological transfer. These risks can be ameliorated to an extent by the following:

- exposure to a variety of approaches, including especially those with broad applicability and low cost;
- assigned reading and literature review which is relevant to the candidate's country of origin;
- conferences, seminars and/or individual sessions focussed on issues of applicability to the country of origin, historical and cross-national examples of both successful and unsuccessful approaches;
- public health approaches to substance abuse, including prevention;
- education and training of primary health care workers and others in the country of origin;
- ability to think in terms of systems organization, and to plan an integrated system of care;
- sufficient clinical skill and experience to understand substance abuse and to develop clinical curricula for students, residents and practitioners upon returning home;
- exposure to a multidisciplinary training facility;
- principles of management and administration, so that the candidate works collaboratively with other team members;
- skills in educational methodology.

The World Health Organization has been developing training materials in substance abuse. One recent publication on this is a manual of this subject for community health workers with guidelines for trainers (WHO, 1986b). Another includes guidelines for the teaching of this subject in medical and health institutions (Arif and Westermeyer, 1988).
Chapter eighteen

CHILD AND ADOLESCENT PSYCHIATRY

A.D. Cox

Introduction

It could be asked why it is necessary and indeed appropriate to train doctors in developing countries in child and adolescent psychiatry when there appear to be massive and much more pressing problems such as poverty, malnutrition, infectious diseases and the impact of rapid socio-economic changes and wars. Firstly, a concern for child mental health can significantly influence child-rearing practices, governmental and institutional policies, and the manner in which families and organizations respond in dealing with the effects of these stresses on children. For example it is clear that the extent of childhood malnutrition is not just related to the availability of food but also child-rearing practice (Cravioto and DeLicardie, 1976; Kempe and Goldblum, 1987). Secondly, there is an intimate relationship between physical and mental health so that not only do physical disorders have emotional concomitants or consequences, (Graham, 1985), but mental health and emotional factors may have a significant influence on the course of physical illnesses affecting for example adaptation of life style and response to and compliance with treatment in ways that influence prognosis (Marteau et al, 1987). Thirdly, mental disorders frequently present with physical symptoms (Hersov, 1985; Nikapota et al, 1988). If this is not recognised it can lead to inappropriate and ineffective treatments which are a major waste and misallocation of resources. Fourthly, personal suffering from mental illness may be no less intense than that resulting from physical illness and there is a strong need therefore to develop services to promote emotional health or alleviate mental suffering. This is particularly true for children and adolescents who may have less control over their environment and whose suffering may arise in part from the behaviours of those around them. In many developing countries children form 40-50% of the population and there is no reason to believe that mental disorders amongst children are less common than in developed countries (Graham, 1980). Finally, there are economic arguments. Developing countries are spending an increasing amount of resources on providing education for children as a means of ensuring progress within the country. Services for child mental health would facilitate maximal utilisation of these opportunities. Mental ill health in children is frequently the precursor of limited capacity to function effectively as adults (Zicotlin, 1986). Developing countries cannot afford to neglect those who will be the work force of the next generation.

It may be concluded that there are strong general arguments for promoting child psychiatric services in developing countries but that the major effort should be in training health and other professionals in child mental health skills within primary care services (WHO, 1977). An appropriate model could be that some general psychiatrists and paediatricians be trained in child and adolescent psychiatry and mental handicap in order that they develop services and implement training within primary care, training also other psychiatrists and paediatricians so that there is a core group of resource persons to provide clinical support and extend further training and services within the field (Bardlett, 1987; Cox, 1984).

International collaboration has contributed to thinking about appropriate ways of making available to developing countries the knowledge and skills that have evolved in developed countries. The basis for thinking that such collaboration may be relevant has been the accumulating knowledge about the cross cultural similarities that exist in the field of child and adolescent psychiatry. There are
now a number of epidemiological studies which indicate that the prevalence of psychiatric disorders in children are remarkably similar from one country to another, including an urban-rural difference in prevalence which has been observed in both developed and developing countries. However, in some countries the rates of mental handicap and other organically determined disorders may be higher (Graham, 1980). Secondly the types of disorder found are also similar although distribution of the different diagnoses and the presentation of various disorders may vary. For example in some developing countries emotional disorders frequently present with physical symptoms or education difficulty (Cox, 1984). There may be some sub-cultural flavouring seen in content or style of behaviour, but nevertheless there are few disorders or presentations which are peculiar to particular locations. Thirdly general categories of aetiological factors and the mechanisms by which they bring about emotional and behavioural disorders are common to all countries although there may be quite big differences in child rearing practices, patterns of family life and the types of stress encountered. (Sartorius and Graham, 1984). This means that the general body of knowledge about child development and child psychiatric disorders is highly pertinent but needs to be intelligently applied. An understanding of local practices and customs is clearly relevant in appreciating what may be significant in aetiology and in thinking about modes of intervention. Knowledge arising from research in one population can have some direct applications in others, but often it is principles rather than particular detail which can be brought to bear on local practice. There is a need for further research amongst different groups across the world to provide more specifically applicable knowledge. There are also implications for the mode and content of training of professionals from one part of the world by specialists from another.

In the case of assessment and treatment skills certain principles are of general application. These include the value of systematic observation and obtaining data from a variety of sources, the need for setting goals for treatment and for evaluation of change. Modes of assessment and interventions used in any setting require adjustment so that they take into account the nature of the problem, how it presents, characteristics of the child and its family including any strengths and weaknesses and the cultural context within which the child lives. Understanding the importance of a flexible approach which permits adaptation and selection of methods is a crucial part of training for all professionals wherever they are working. At a more detailed level selection and modification of clinical skills is required where cultures differ and resources are scarce. The range of assessment skills commonly used in countries with developed services need alteration in terms of what is both acceptable and possible if they are to be used in such situations. For example where resources are plentiful the multi-faceted nature of child psychiatric disorder is used to argue for a collaborative assessment involving a variety of professional disciplines. Although this can be seen as ideally desirable it is not feasible in many parts of the world.

The requirement to have a variety of techniques available is a common feature of treatment whatever the setting or cultural context, and the use of a particular therapy in a routine way in all cases would not be appropriate even where resources are sparse. However it is apparent that in these circumstances certain approaches such as intensive individual child psychotherapy cannot be applied, while others such as behaviour therapy may be more viable. This can argue on the one hand for the development of interventions for use within primary health care, and on the other for modification in the way in which hospital-based treatment facilities are used. (WHO, 1977).

The high prevalence of child and adolescent psychiatric disorder means that even where there are well-developed professional services, specialist child and adolescent psychiatry and psychology cannot deal directly with all problems. Thus any design for satisfactory child mental health services should include a primary care component, and a significant part of resources should be employed in the development of this component by the training of other professionals working with children, whether in the field of primary health care, education or social services. There is a strong association between child psychiatric disorders, and chronic physical disorders, and mental handicap (Graham, 1983; Corbett, 1985). In addition there are associations with mental disorder and chronic physical disorder in parents (Rutter and Cox, 1985). Where there is much sub-specialisation, service design must ensure close collaboration. On the other hand, where facilities are scarce, functions may have to be integrated by, for example, combining adult and child psychiatry services, or linking mental handicap provision with paediatrics or child and
adolescent psychiatry. The requirement to evaluate the effectiveness of assessment intervention and monitor service implementation is present whatever the location of the service. Monitoring may be particularly relevant where services are evolving and there is a need to determine the most useful mode of development.

It can be concluded that the body of knowledge about child development and child psychiatric disorders and the associated clinical skills which are currently available in developed countries have much relevance for training of those professionals from developing countries who have a responsibility for developing child mental health services. Basic principles deriving from scientific methods have direct applications but detailed aspects of knowledge and clinical skills need to be applied intelligently and flexibly. An open-minded critical approach should be a characteristic of any good service in child and adolescent psychiatry. What is crucial is that any training emphasises and exemplifies such an approach. The training needs to be based, so far as is possible, on knowledge of the pattern of child psychiatric disorder and of resources for child mental health services that are available in those countries from which the trainees come. The body of knowledge the trainees may need to acquire includes areas which in developed countries are specialties in themselves such as mental handicap. Research is an important part of any training curriculum because of the need to study and understand local patterns of disorder and foster the intelligent development of services.

The Form of Training

A major issue is whether developed countries should run courses attended by groups of professionals from developed countries or whether specialists from developed countries should visit developing countries and provide consultation and training on site. The advantage of a specialist visiting a developing country is that they are able to apply themselves to problems as they exist, taking into account local conditions. However, visiting specialists will take time to acclimatise to, and become familiar with local culture and conditions and may also have problems with the local languages. Therefore, it can be argued that visiting specialists are appropriately used for short term courses designed to increase skills among groups of professionals who already have some training experience in child psychiatry, and who can therefore facilitate the adaptation of specialist experience to local conditions during a short visit.

The visiting specialist's approach will not meet the need for training general psychiatrists and paediatricians in child psychiatry to enable them to initiate child mental health services in their countries of origin. The objective of courses which seek to respond to this need is to develop in the trainee sufficient knowledge and skills that they can be a leader and trainer in the organization and development of child mental health services. These trainees will often be professionals who have just begun moving into the field of child psychiatry. Therefore they need to spend a significant period of time in training in order to acquire a good level of competence and confidence. As a sine qua non, the course must instil a satisfactory level of clinical skills, acquired against the background of academic study of child development and child and adolescent psychiatry, with opportunities for demonstrating the connection between academic study and clinical work. Such a clinical apprenticeship needs a period of at least six months and ideally not less than a year. Clinical services, their range, organization and administration form another important area. Related to this are the study of research methods particularly in the fields of epidemiology and service evaluation. Finally, since it should form a particularly important part in their future practice, trainees should be exposed to and have experience in teaching methods appropriate to professionals of different levels of skills and sophistication.

The advantages of providing a course with these objectives at a large academic and clinical centre for child psychiatry are several, even where the centre is located in another country or very different part of the world. The disadvantages relate to differences in culture and service resources. Trainees may also have problems with the language of instruction in the host country. These disadvantages can be minimised by careful planning of the content and mode of training. What then are the advantages? Firstly, far greater resources can be brought to bear on the training programmes. Secondly, it is usually possible for the trainees to be seconded for much longer periods of time than the specialists can spend on visiting any particular developing country. This means that trainees have more space to acquire knowledge and to develop reflective thinking in a way which is necessary to review material whether for planning services or
for research. There is also a greater opportunity to acquire clinical skills because there is the possibility to provide high levels of detailed instruction and supervision. A further advantage is the presence of a peer group deriving from different cultural backgrounds, thus ensuring a cross cultural perspective, helping free individuals from parochial considerations that reduce flexibility. The group can also provide mutual support, reducing isolation and providing a potential reference group when participants return to their countries. This approach can also be more cost effective and efficient since it may be possible to gather a larger group for long term training than would be available in any one developing country. Basic criteria for admission to such a course is a good level of competence in a relevant professional field such as paediatrics or psychiatry and fluency in the language of the host country.

As developing countries acquire staff trained in child and adolescent psychiatry other training formats become possible. For example, specialists based in developing countries may be in a better position to run courses for professionals from other developing countries than are specialists in developed countries, provided they have the academic and administrative support to do so. A further mode of collaboration is to provide support for such training or invite the participation of trainers from developing countries for courses based at academic centres in developed countries. The content and mode of training discussed below relates particularly to courses designed for the acquisition of child psychiatric skills for clinical work and service developments for professionals new or relatively new to the field of child mental health.

The Content of Training

The broad form of training has already been indicated. It would be useful however to reiterate some of the basic principles relating to content. Trainees should become familiar with the full range of clinical skills and intervention techniques potentially available in a developed country for child and adolescent psychiatry and associated problems such as mental handicap. There should however be a major emphasis on the acquisition of basic skills in interviewing and observation with children, parents and families together with the facilities to apply readily administered standardised psychometric assessments of development, behaviour and educational attainment. It is important also for trainees to know how to devise measures for particular purposes whether questionnaires, interviews or observational scales. Again with regard to intervention techniques emphasis should be placed on the acquisition of skill in economical methods such as environmental manipulation, brief counselling, behavioural techniques and the administration of drugs. Some principles of group training may also be helpful (WHO, 1977).

Research from a cross cultural perspective should be introduced into the academic programme in child development and child and adolescent psychiatry. Areas that require particular attention include child rearing practices in relation to the development of maladaptive behaviours, optimal and risk factors in development including institutional care and the effects of malnutrition, neuropsychiatry, the physical presentation of mental disorders, research into drug treatments, adolescent disorders and the assessment of the need for services for mental handicap, or emotional and behavioural disturbance. Research methods that can be used in situations with limited resources should be discussed in some detail. For example, manuals have been devised to aid assessment by staff at primary care level (WHO, 1982b).

The requirement to write up a clinical case in detail in the context of current academic literature and to write a dissertation addressed either to a major clinical topic or research proposal can form a useful part of the curriculum. Research proposals can focus on the conduct of an epidemiological investigation or the monitoring or evaluation of services. The dissertation may take the form of a national "case study" (Graham et al, 1985). Such exercises give practice in preparing outlines for service development and its evaluation. Finally there should be opportunities to learn and practice teaching techniques with the emphasis on adjusting material and method to fit the group of trainees concerned. Trainees should also be familiarised with teaching materials available which may be of particular use within primary health care (WHO 1982b, WHO 1984c).

The Training Method

The aim of the training is the acquisition of knowledge and skills in a fashion which will lead to autonomy in practice and flexibility in their application. Course attenders should be able to go away prepared to adopt a scientific problem solving
approach to assessment, treatment and service development and have sufficient confidence in their knowledge and skills to enable them to do so. They should also be familiar with the academic literature and with the leading academic and service centres so that they will be able to sustain communication with other child and adolescent psychiatrists directly or through journals once they return to their countries of origin.

To achieve these aims a programme has to be carefully planned to adjust to the needs of particular trainees. This means allowing adequate room for discussion throughout on cross-cultural adaptation of materials and methods, and continuous monitoring of the appropriateness of clinical placements, the review of experience and knowledge acquired and the injection of additional training to meet particular needs that may arise. The programme should insist on the active involvement of trainees at all points in order to increase their autonomy and self-confidence, and to ensure that skills and knowledge which may have been acquired are more likely to be retained in the future when the environment may be less supportive. Active participation has the added advantage of giving the trainee opportunities to develop increased fluency in the language of the host country which will be necessary for work with families and preparation of written materials such as the dissertations mentioned earlier. Methods of developing active participation from the outset of the course include role play, use of a seminar form for academic work and the prescription of an active role during observation tasks and visits to various facilities, when trainees are asked to note or obtain certain information to be used later as a basis for discussion. It is of course vital that trainees have direct experience of treating children and families involving a variety of techniques, and they should therefore take on cases at the point when they are ready to do so. They should be encouraged to use interventions which would be appropriate where resources are scarce.

By encouraging exchange of ideas and experiences tutors can give trainees the sense that their active participation is of value to the course as a whole since it facilitates the adaptation of training to the needs of the countries from which the trainees come. The fostering of peer group interaction can give course members valuable support in a strange country and as the course proceeds promote shared thinking about service development. It is also important to have a good level of supervision and leadership by experienced child and adolescent psychiatrists from the start. This is one of the advantages of the course being held in a well resourced centre and is vital from the point of view of morale and the fostering of group cohesion. Appropriate leadership is also required to ensure the sharpening of critical qualities and to encourage trainees to bring in perspectives from their different cultures, thus emphasising the need to relate skills and knowledge to circumstances. Ideally there should be continuity in terms of tutor or tutors in order to more effectively monitor the acquisition of skills and knowledge, foster flexible thinking, and enable trainees to discuss more readily particular problems or difficulties that may arise. Tutors should meet regularly to ensure active planning and modification of the course throughout the training programme.

The use of observational exercises is a useful method for maintaining the active role of trainees and the emphasis on the importance of seeking the relevance of experience for application to the situation in another country. It is particularly valuable during the induction phase before direct involvement in clinical work. For example, trainees can be requested to observe child behaviour in a variety of situations such as in a school, or in a hospital. This familiarises the trainee to a new cultural environment, provides a basis for discussion of culture-bound differences in behaviour and prepares for systematic interviewing and data gathering.

To conclude, training courses for professionals from developing countries have to lead to the development of knowledge, skills and confidence allied to a flexibility of approach. They place perhaps greater demands on trainers in developing countries than courses for local professionals would do, since it is necessary also to evolve modes of training which overcome deficiencies that research literature and clinical skills may have in cross cultural applicability, although these deficiencies are present at least to some extent even where training is conducted in developing countries. It is certainly possible to make a much needed and valuable contribution to child psychiatric training if resources in centres in developed countries are used intelligently to provide knowledge and skills that are useful and relevant for child mental health services in very different situations.
Chapter nineteen

MENTAL HEALTH OF THE ELDERLY

Neil Holden and Klaus Bergman

The Old Age Explosion

The burdens of old age psychiatry have until now largely been borne by the developed countries where the demography has conspired through decreased birth and increased longevity through better health care, to increase the proportion of elderly persons in the population. Urbanisation and the weakening of the nuclear family have worsened the problem.

A similar situation is however now being increasingly encountered in the developing countries, but whereas the crisis of the old age explosion is now well under-way in Europe for instance, it is due to hit the developing world with full force only in the 21st Century. Current figures for the percentage of people over 65 in different populations are: Great Britain 14%; USA 10%; Canada 9%; Japan 7%; India 2-3%.

The projected increase in the world’s elderly populations between 1980 and 2000 are 100 million in the developing areas and 38 million in the developed areas (WHO, 1984b). By the year 2,000, twice as many people in the world will be aged over 80 as in 1970.

Whilst health agencies embrace the prospect of “Health for all by the year 2,000”, this geriatric explosion in the early part of the next century will be a disaster for these aspirations, if plans and remedies are not now devised which will be able to cope with these added service demands. It is easy to make the mistake when resources are scarce, of giving priority to younger groups in the population at the expense of the elderly. However, apart from the obvious factor that most of us will be old in the future, it is fool-hardy to regard the elderly as economically unimportant, especially in the developing world. The figures below show the percentage of the population aged over 65 that is economically active (WHO, 1984b).

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<td>Now</td>
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<td>More developed regions</td>
<td>21.1</td>
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<td>Less developed regions</td>
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It is easily seen that the elderly play an important active role in the economy of developing countries. In addition, the cost to an economy when younger adults have to give up work to look after an elderly family member has to be considered.

Models of Caring in Developing Countries

It is clear that the adoption of the “Poor Law” system, as used by the developed countries for so long, is inappropriate. As populations grow older, the ratio of tax consumers to tax givers shifts so as to place an ever growing burden on the economy; hospital and custodial forms of treatment for the elderly mentally ill could not be afforded by developing countries, even if they were desirable. If this inappropriate model is not to evolve by default, then effort must be directed towards supporting the families so that they can contain their elderly. This should be carried out by the primary health workers who should receive proper training and supervision. Diagnosis is of paramount importance, followed up by early and adequate training and support of the family, together with close team work in terms of the supervision and training of primary level workers.
This supervision of the primary health personnel and referrals of difficult cases would be carried out by doctors and psychiatrists at secondary centres, and tertiary centres in turn would deal with national organization, training and research. It is likely that old age psychiatrists will have to be trained specifically to organize the care of the elderly mentally ill, as the experience of developing countries has shown that general psychiatrists, even with the best intentions, tend not to devote a sufficient proportion of their time to their elderly workload. As an alternative to training specialist old age psychiatrists, some countries might prefer the solution of specialist geriatricians who would deal with both the medical and the psychiatric problems of the elderly through a primary health care scheme.

Training for Old Age Psychiatry

Trainees will need extensive experience in the diagnosis and treatment of dementia, sub-acute and acute organic states, and functional psychotic and neurotic conditions in the elderly. In addition they will have to be able to organize services and be able to train and supervise primary health workers. Those workers will in turn need to be trained both in basic medical and psychiatric care (especially the assessment of cognitive function) and in the skills of other disciplines, such as social work, occupational therapy, and nursing. Organizers could devise flow sheets to guide primary personnel in the diagnosis and management of the elderly.

Public health measures designed to prevent mental illness in the elderly have been outlined (WHO, 1982a). These are:

- Adopt a positive attitude towards the elderly.
- Make careful diagnostic evaluations (e.g. hidden depression), thereby reducing excess service usage.
- Let people age in good health.
- Treat delirium properly.
- Use drugs judiciously.
- Detect reversible dementia.
- Learn about genetic risks.

- Be critical of "wonder agents" - e.g. lecithin.
- Help answer "why survive?"
- Treat sensory impairments (glasses and hearing aids).
- Emphasize a reality orientation.

Research in Old Age Psychiatry

Many of the current research strategies of the developed world are in the direction of "high-tech" solutions e.g. CAT scanning, brain tissue implants and acetylcholine supplementation. Although these techniques are promising, they have little immediate relevance to developing countries. The real need is for an epidemiological approach (WHO, 1979a). Figures and facts are needed in different cultures for:

- The projected numbers of elderly in given populations.
- The proportions of elderly affected by different illnesses.
- The differences in illness between cultures.
- The attitudes of different populations towards their elderly.
- The effectiveness of the applied treatment strategies.
- The incidence of old age disorders in populations with varied cultural factors giving information on the role of varied aetiological factors.

Planning for the Future

Whilst many of the other problems for psychiatrists in the developing countries have already reached crisis proportions, psychiatry in the elderly is unusual in that the bulk of the problem is yet to arrive. However, this should not be a reason for complacency; now is the time for old age psychiatrists to be trained and appointed, so that the opportunity to develop rational and expanding services is not missed. Methods of caring for the elderly mentally ill should be developed according to the countries national requirements and identities along the lines suggested above.
Chapter Twenty

OTHER SUB-SPECIALITIES
J.S. Neki and N. Holden

Psychotherapy (J.S.N.)

In the face of the mushrooming of different psychotherapies in the West, all with different and sometimes opposing methods and theories, the trainees from a developing country could be forgiven for asking the question "Is psychotherapy relevant to the psychiatry of my country?". However, as Kennedy (1960) reflected: "There is no psychiatrist, whatever his main theoretical orientation, who does not spend part of his working time doing psychotherapy of some kind". In the light of this truism, it is important to consider how exportable training in psychotherapy can be, and how it will fare in competition with the indigenous traditional healing cults of the recipient country. Many professional workers have learnt much from the abilities of some traditional healers, and they have held that blending Western medicine with the world views of non-Western cultures would allow psychiatrists and traditional healers to work as a team (Lambo, 1978). Sadly, however, this has proved often to be no more than a pious wish with only small and occasional local success. It appears that both traditional healers and psychiatrists find it hard to transcend the conceptual barrier that separates them.

Efforts have been made by workers such as Frank (1967) to extract and foster those principles on which internationally valid psychotherapy could be founded. Neki (1977) and Neki et al. (1984) have looked at the problems and have attempted to produce a culturally appropriate model for psychotherapy. However, much more research is needed in this difficult area. Psychotherapy has been criticised as being little better than a placebo. However, even accepting this nihilistic view, it remains to be shown what it is that constitutes the placebo effect in different cultures.

The best hope for psychotherapy in the developing countries lies in the training of culturally sensitive psychiatrists in the most pragmatic and eclectic of the psychotherapy systems. This training might be expected to allow them to produce useful psychotherapeutic models for their own cultures. In this training, the trainees must be aware that values will differ amongst the patients, as will the ultimate aims of psychotherapy. What might be regarded as the promotion of normal behaviour in the West might be regarded as highly abnormal in another cultural setting. In developing countries, where trained psychotherapists are scarce, there is need for the development of simple problem-orientated therapeutic modules to cope with common psychological problems at the primary care level. Such problems will inevitably include issues such as hysterical dissociation- conversion syndromes, which are increasingly rare in the developed world, but which cannot be ignored by the psychiatric services in the developing world.

By attention to such details, and the training of psychiatrists in certain minimum skills including the art of listening, establishing a relationship, providing psychological support and counselling, it should be possible to foster good practice in psychotherapy throughout the world. Psychotherapy training is obviously an important part of the psychiatrists skills. However, it seems most appropriate that training be carried out at a local level. International training in psychiatry is bound to be handicapped by the usage of culturally inappropriate models. Local models which are acceptable to the local population have to be devised, and psychiatrists trained to use these models with appropriate aims and skills.
Forensic Psychiatry (N.H.)

This section is brief in that it deals with a subject which is in its infancy in a world-wide context. There are many reasons why this is so. However, the brevity of this report does not imply any lack of importance of the needs in this area. Indeed, forensic psychiatry is a vital part of the training of the psychiatric trainee. A knowledge of the laws relating to the mental health of the country in which the trainee is to practice is essential. Because of the differing nature of these laws, it follows that training should be local, perhaps with later attendance at international courses or conferences to study elements of forensic psychiatry which are internationally applicable, or "comparative".

Issues which are of relevance to all countries include aspects of aetiology and the treatment of psychiatric conditions which result in forensic presentation. Methods of containment of dangerous patients are also relevant. Aspects of human rights and professional ethics may require consideration. The role of the psychiatrist in the advocacy of reforms is crucial and in this, psychiatrists may need the moral support of their international colleagues.

Psychiatrists in the developing countries will need to be aware that the prisons and courts will be major sources of patients with psychiatric morbidity. An effort has to be made to give assessment and treatment to these unfortunate patients, which may have to be carried out in the context of the prison hospital, or custodial hospital placement. To deal with these cases, a specialist or part-specialist forensic psychiatrist may have to be trained. This is thus a subject which exemplifies the very general question of the role of sub-specialism in psychiatric services in the developing world, and the consequent implications for training. This brief note on forensic psychiatry thus seeks only to make the point that any country which is today giving thought to the planning of treatment, prevention and training in the mental health area should have forensic issues on the check list.
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