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PSYCHOTHERAPY IN DEVELOPING COUNTRIES : A PUBLIC HEALTH PERSPECTIVE

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SUMMARY

Psychotherapy is being increasingly recognised as an important treatment modality for various mental health problems. However, minimal efforts have been made to examine the utility of psychotherapy from the public health perspective, especially for developing countries. This paper outlines the present situation in developing countries with respect to the magnitude of mental health and related problems requiring psychotherapeutic help, the existing health and mental health facilities, the current training in psychiatry and psychotherapy in different training programmes, and the current state of mental health knowledge and skills of primary care personnel. A number of strategies for public health action are delineated to enhance the availability of this form of treatment to the large number of people requiring psychotherapeutic help. The needs for systematic research in this area are highlighted.

There is an increasing recognition of psychotherapy as an important aspect of management of many psychiatric and medical conditions. Currently there is an accelerating growth of literature in this area. A recent issue of Index Medicus cites more than 400 articles under the head psychotherapy (Index Medicus, 1986). Much of the current research is focussed on systematically evaluating the efficacy of psychotherapeutic interventions in different clinical populations. From India, the literature on psychotherapy has been principally descriptive. A number of authors have discussed therapeutic modalities suitable to Indian patients (Neki, 1973, 1975; Hoch, 1977; Shamasundar, 1979; Varma 1986, 1988).

Despite the increasing growth of psychotherapy literature, examination of this area from the public health perspective has not recieved adequate attention. In a recent article, Sartorious (1986) has noted with concern the dehumanized approach of current medical care, and has voiced the need for training health workers in psychotherapeutic skills. From India, Agarwal (1989) in his editorial, has deplored the current biological-reductionistic approach to mental disorders and has called for a greater application of psychotherapeutic methods in the care of patients.

The focus of this paper is to highlight the importance of psychotherapeutic aspects of management from a public health perspective, in the light of empirical findings. The pertinent issues are discussed under the following heads (1) Magnitude of mental health and related problems requiring psychotherapeutic help (2) Existing health and mental health infrastructure in developing countries (3) Curriculum in psychiatry and psychotherapy in various courses (4) The current state of knowledge of primary care personnel with respect to mental health (5) Strategies for public health action.

1. Magnitude of mental health and related problems requiring psychotherapeutic help

It is difficult to make a precise estimate of the number of people requiring psychotherapeutic help at any cross section, since mental health professionals often differ in their opinion regarding the choice of the therapeutic modality in different clinical conditions. But it can be safely presumed that patients

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with neurotic disorders, adjustment reactions, certain personality disorders and psychosomatic conditions would require psychotherapy as the principle or as an important component of the therapy, while the psychotic conditions would chiefly be treated with physical methods. Several epidemoilogical investigations conducted in developing countries indicate that a sizeable proportion of patients in the community suffer from neurotic disorders. The prevalence of minor psychiatric conditions (chiefly anxiety and depression) is noted to range from 5-20% in community surveys (Verghese et al., 1973; Carstairs and Kapur, 1976; Bhide, 1982). Between 10-50% of patients who consult primary care physicians in rural settings and the general practitioners in urban settings have a recognisable psychiatric disorder, principally of a neurotic nature (Giel & Van Luijk, 1969; German, 1972; Harding et al., 1980; Mari & Williams, 1984; Shamsundar et al., 1986; WHO-SEARO (1984-85), Sen, 1987; Sriram et al., 1987). A high percentage of morbidity has also been reported in the medical outpatients (Sriram et al., 1986), orthopaedic outpatients (Yijay et al., 1988) and gynaecological outpatients (Mohan Chandran, 1982). These figures underscore the importance of psychotherapeutic components of care, especially in general medical setting. Recent research has also documented the role of psychosocial factors like stressfull life events in the onset of physical illnesses (Creed, 1985).

2. Existing health and mental health resources in developing countries

Most of the developing countries are faced with the problem of accelerating population growth but with meagre resources to manage the health problems. The following statistics from India (WHO-SEARO, 1984-85) as of 1983-84, are adequate to highlight the gravity of the problem. For a population of over 700 million, there are just 500,000 hospital beds (6 beds per 10,000 population), around 2,72,000 doctors (3.8 doctors per 10,000 population) and about 400,000 professional and auxiliary nurses (5.7 nurses per 10,000 population). Three fourths of the national population lives in rural areas. The annual expenditure for health is just two percent of the total annual budget. In the urban areas, the health care is provided by government and private hospitals, supplemented by general practitioners. In the rural areas the health care delivery occurs principally through the network of primary health centres (PHCs). There are about 80,000 PHCs in India which are manned by qualified medical officers (one to three for each centre) supplemented by a team of paramedical workers. The PHC medical officers, in addition to providing curative services to the relatively large number of people attending the health clinics (often above 100 per day), are also involved in preventive and promotive services.

With respect to mental health manpower and resources, in most of the developing countries there is a gross shortage of trained professionals and psychiatric facilities (WHO, 1975). In India, as of 1982 (National Mental Health Programme for India 1982), the mental health manpower was as follows: Psychiatrists-900; Clinical Psychologists-400 to 500; Psychiatric social workers-200 to 300; psychiatric nurses-600. Most of the psychiatric beds (20,000) are in 42 mental hospitals situated in different parts of the country. There are less than 3000 psychiatric beds in general hospitals. Evidently the psychiatric manpower and facilities to deal with mental health problems is far below western standards.

3. Curriculum in Psychiatry and Psychotherapy in various courses

The present medical education in most developing countries has paid scant attention to training in psychiatry in general and psy-

chotherapy in particular. Medical graduates have about two weeks of teaching in psychiatry during their course and about two weeks to one month duration of exposure during their compulsory rotatory internship. There is no separate paper in examinations during any of the clinical years. Also there is no separate course on behavioural sciences in the undergraduate medical curriculum. Similarly no separate examinations are conducted in psychiatry for either the post graduates of internal medicine or neurology, the two specialities where psychiatry is perhaps most relevent. As a consequence non-psychiatric specialists have limited expertise to manage psychiatric problems. Even when psychiatric problems are recognised, management is restricted to the mere prescription of drugs even in situations that warrant psychotherapeutic intervention. This issue is further discussed below.

4. Current state of knowledge and skills of primary care personnel with respect to mental health.

In view of the inadequate exposure to mental health problems and the psychological aspects of management, health personnel are currently in a state of relative ignorance to deal with these problems effectively. Many authors have noted that mental health problems are poorly recognised in non psychiatric settings, leading to unnecessary and often costly investigations and patient recidivism (Harding et al., 1980 Giel & Workneh, 1980; Srinivasan & Srinivasa Murthy, 1986). At the National Institute of Mental Health & Neuro Sciences (NIMHANS), Bangalore, India, considerable experience has been gained regarding the background knowledge and skills of primary care personnel regarding mental health. A regular training programme in mental health of two weeks duration is being held for the PHC medical officers of the Karnataka State since 1982 at NIMHANS. Similar training programme of one week duration goes on for health workers. The training is assessed by multiple-choice questionnaire and case vignettes administered before and after the training. Pre-training evaluation of the doctors reveals that their baseline knowledge of mental health and psychosocial aspects of emotional disorders is far from satisfactory. Additionally the medical officers frequently express the need for training in these aspects.

The above discussion highlights the need to work out a number of strategies at different levels to enhance the application of psychotherapeutic knowledge and skills in patient management.

5. Strategies for public health action

A. *Training in Psychotherapy and counselling for different cadres of personnel*

(a) *PHC doctors:* Considering the organisational structure of health care in developing countries and the nature of mental health problems presenting at Primary care, attention needs to be focussed on training health personnel working in these settings in psychotherapeutic skills. There are several advantages of training this group of personnel (a) PHC doctors are more acceptable to patients than mental health professionals in so far as no stigma is percieved in consulting a PHC doctor (b) Primary care physicians can better understand the dynamics of patient's problems because of their greater knowledge of patients' socio cultural milieu. (c) Follow up care is likely to be better because of the proximity of health centres.

(b) *General Practitioners (GPs):* Gps, in contrast to primary care physicians, work in the private sector and collect fees from the patients for their services. Their area of practice is predominantly confined to the urban regions. In contrast to primary care physicians who are subject to transfers, Gps generally continue their practice in the same locality once they have established practice. Unlike the PHC physicians, they are only

involved in curative services, and are devoid of any administrative responsibilities. The reputation of GPs depends on their clinical competence and hence they are a well motivated group to undergo training in mental health. Training GPs has advantages similar to those described for training PHC physicians. Since 1977, training in mental health is being organised for GPs (Shamasundar et al., 1980, 1983). Recently Shamasundar (1987) also made an attempt to expose GPs to psychotherapeutic skills by a group process similar to that described by Balint (1964). His experience were encouraging.

(c) *Health Workers* : Health workers, also called multipurpose workers (MPWs) have a minimum qualification of 10th grade, and principally visit households in villages to identify various health problems, and refer them for treatment to health centres. They are also responsible for educating patients and relatives regarding promotion of health. They undergo a period of training consisting of theoretical and clinical aspects prior to their regular appointment. Skills in interviewing patients, identification of the psychosocial stress factors, and techniques of counselling for psychosocial problems can be taught for health workers in a simple language.

(d) *Nurses* : Nursing professionals have a greater scope for interaction with patients and their relatives. This makes them particularly suitable for training in psychotherapeutic skills. Additionally, nurses holding teaching positions can further diffuse these skills to trainee nurses.

(e) *Non-psychiatric specialists* : In view of the high prevalence of psychiatric morbidity in non-psychiatric speciality settings, there is a need to sensitize the non-psychiatric specialists in the early recognition and management of these problems. This would avoid unnecessary investigations, delays in treatment and unwarranted referrals. The format of training should, however, be different from what is used to train medical officers and GPs, as discussed below.

Content and method of training

An important consideration needs to be given to the issue of what needs to be taught to the different groups of professionals. There are so many schools of psychotherapy with different (often complex) theoretical foundations, that neither is it relevent nor practical to provide an exposure to all these therapies. As Sartorius (1986) has pointed out, psychotherapists must translate complex and highly theoretical notions into a series of skills and techniques which can be taught quickly and well. Further, these techniques must be easy enough to apply in the setting under consideration and efficacious enough to be promoted on a large scale. An eclectic approach should be preferred instead of promoting any specific form of therapy. The common factors in the different therapies which are therapeutic, like the quality of doctor-patient relationship, the factor of emotional catharsis and suggestion (Wolberg, 1977) must be emphasized. Additionally it is necessary to include culture appropriate precepts in the therapeutic package to enhance the acceptability of the therapy (Agarwal, 1989). A number of authors (Neki, 1973; 1975; Vahia et al., 1973; Hoch, 1977; Shamasundar, 1979; Giel & Worknch, 1980; Varma, 1986; 1988) have discussed the different modifications in therapy suitable for patients from the developing countries. Greater use of directive and supportive methods, involvement of the family members in the therapy, explanations of psychopathology in culture appropriate terms, use of proverbs and excerpts from mythologies, and employment of techniques like yoga and meditation are some of the important components in therapy that would be culture appropriate. Further the possibility of utilizing group psychotherapeutic methods could be explored, considering the time constraints

of primary care personnel. Such training programme could be ideally incorporated into the general mental health training programme.

As to the method of training, it would be useful to spplement didactic teaching with audio-visual demonstrations of interview techniques. Trainees' interviewing techniques could be observed and feed-back given of their performance. It would also be useful to provide a manual to facilitate training. Prior experience has shown that provision of a manual on mental health (Isaac et al., 1986) acts as a useful supplement to the training programme. Considering this, a manual on psychotherapeutic and counselling skills in its preliminary form has been developed at NIMHANS (Sriram 1989). This manual includes the following topics: the relationship between emotional processes and bodily illness; origin of emotional problems including intrapsychic conflicts, environmental stress factors and faulty learning; techniques of interviewing, with special reference to exploration of conflicts and stress factors; desirable qualities for a therapist; some commonly applied psychotherapeutic techniques; and treatment techniques in certain specific clinical situations. The manual is being currently evaluated systematically to assess its utility for primary care personnel.

While the above methods of assessment are useful for PHC medical officers, GPs and Paramedical personnel, the method of training needs to be different for non-psychiatric specialists. Refresher courses, seminars and case conferences are more appropriate to non-psychiatric specialists. The content could also include greater discussion of the different schools of psychotherapy and the focus of current research in this area.

B. *Strengthening undergraduate and post grauduate curriculum*

Along with efforts to train in-service professionals in psychotherapeutic skills, efforts should also be made to strengthen the undergraduate and postgraduate curriculum. Even in the post-graduate psychiatric curriculum, formal training in psychotherapy is restricted to very few centres (Agarwal, 1989). At NIMHANS, Psychotherapy training occurs principally through group supervision. Similar group supervision could be initiated at other training centres. Further, seminars and workshops conducted at the national level should address to the larger administrative and technical issues. One such workshop was conducted at NIMHANS a decade ago (Kapur et al., 1979).

C. Research

There has unfortunately been a paucity of empirical research on psychotherapeutic aspects from the developing countries. Vahia et al (1973) in a study of patients with psychoneurotic and psychosomatic disorders, demonstrated the efficacy of psychophysiological therapy based on the concepts of Patanjali. Varma and Ghosh (1976) conducted a questionnaire survey to understand the nature of psychotherapy as practiced by Indian psychiatrists. Less than one fifth of psychiatrists responded to the enquiry. The respondents felt that psychotherapy was useful, but expressed the need for modification of techniques suitable for Indian situation. Shamasundar (1987) described a study in which 10 general practitioners underwent training in psychotherapeutic skills and the efficacy of the training evaluated. Though the GPs responded to the programme with initial skepticim, there was an overall favourable response at the end of the training programme. Recently a case report was presented, highlighting the utility of psychotherapeutic aspects of management even in psychotic conditions like chronic schizophrenia (Sriram et al., 1989). These few reports apart, research literature on psychotherapy in India are scanty. There is much scope for systematic research in this area. For

example research could focus on identifying therapeutic models suitable for Indian subjects (Agarwal, 1989). With respect to the training of non-psychiatric health care personnel it would be important to find out what kind of changes occur in knowledge and attitude following training in psychotherapeutic skills, and whether gain in knowledge and skills is actually put into practice. Further as Sartorius (1986) has highlighted, attempts should be made to identify techniques which are most efficacious and least time consuming.

CONCLUSIONS

Psychotherapeutic and counselling techniques form an important aspect of management of many medical and psychiatric problems seen at primary care settings. Yet, lack of knowledge and skills of health care personnel regarding these techniques has lead to their inadequate application in patient management. There is a strong need for training primary health care personnel in psychotherapeutic skills. Efforts are required to strengthen the undergraduate and postgraduate curriculum in this area. Mental health professionals should also identify areas for systematic research with respect to the appropriate application of psychotherapeutic techniques in patient management.

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