PSYCHIATRY FOR THE UNDERDEVELOPED OR UNDERDEVELOPED PSYCHIATRY?¹

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Mental health services in developing countries tend to suffer from many problems, including underuse by those in need and a dearth of professional personnel. Nevertheless, much of the difficulty could be surmounted by paying closer attention to each particular country's sociocultural conditions and by making greater use of auxiliaries, volunteers, and other support personnel.

Introduction

When conventional psychiatry, which originated in the industrialized countries of Europe (5), was introduced into the Third World, it not only failed to meet the care needs of developing nations but dissipated their meager resources. It therefore proved an ineffective tool for raising mental health levels in those countries.

Although the status of mental health has only recently become a matter of concern in the developing countries, the medico-social reality created by existing mental health problems in the communities involved is very different from that which the psychiatric services are equipped to confront (2). In general, these services are devoted primarily to secondary prevention (treatment of the sick)—to the neglect of both primary prevention (health education and specific disease prophylaxis) and tertiary prevention (rehabilitation). Furthermore, since there is no liaison between these services and no continuity of treatment, patients tend to feel neglected. And while public services usually seek to be self-supporting, the private services, ruled as they are by the profit motive, do not generally take the trouble to investigate the environmental conditions of their patients (2).

The Population Served

Since the natural interactions within human groups are ignored in this manner, coordination is lacking between the preventive, curative, and rehabilitative services, just as mental health services are disassociated from those concerned with physical and social problems. For this reason, the mental health services tend to be considered extraneous by the population that needs them—a fact demonstrated by their low level of utilization.

In the final analysis, the attention available is absorbed by a small segment of the population for the recurrent treatment of minor problems. The focus is on passive therapy and the traditional type of medical consultation in which one practitioner treats one patient with no provision for house calls, coordination with other services and hospitals, or the planning and implementation of preventive primary care activities. This is a far cry from the ideal of full health care coverage available to all.

The consequence of all this is what might be termed an “irrelevance” syndrome which results in alienation of the mental health services from the communities they are meant to serve. The communities, in turn, cease to influence the services and bring no pressure to

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bear upon them, thereby creating a vicious circle of mutual indifference. The mental health services, then, become cloistered and establish internally-oriented goals—setting care priorities and planning teaching and research in accordance with the interests of their professional staffs. High-level professionals do tasks properly assigned to auxiliaries and volunteers. They also become inflexible in their attitudes, and the services they represent take on the same rigidity. The groups that form within these services become independent of each other and do not communicate. Under such conditions the professional staff and the services involved take the easy way out—they specialize, and in so doing become even further removed from the needs of the population.

Current Goals and Needs

To make matters worse, the mental health services suffer from following the traditional pattern for providing psychiatric services—trying to attain the ideal goal of personality change through methods of little use in treating groups or populations because they are oriented to the individual’s psyche.

Despite this, mental health difficulties constitute one of the world’s gravest health problems, and investigation has shown that at least one-quarter of the world’s population (including the population of the developing countries) stands in need of mental health care. For example, the prevalence of alcoholism, mental retardation, psychoses, and neuroses among the people of Latin America is estimated at 25 per cent. and studies on violent death (homicides, suicides, and accidents) in Latin America clearly show that the area’s general level of unhappiness is such as to forever explode the myth that we Latin Americans are “poor but happy” people (3, 4, 6).

Not only must we cope with these past shortcomings that have created a disturbing gap between psychiatry as a discipline and the psychiatric needs of the population, but we have neither plans nor prospects for the future. The most sacred psychiatric institutions are being challenged. Psychiatric hospitals, and even psychiatry itself as a discipline, have been accused of inventing mental illness to relieve families in industrial societies of the burden of caring for those said to be mentally ill.

Psychiatry and the Developing World

Modern psychiatry happens to be an urban phenomenon. It grew up in, adapted itself to, and is applied in prosperous industrialized countries. The mental health programs of these countries have been reasonably successful—whether implemented through general practitioners dealing with relatively minor problems or through psychiatric hospitals (5). They have been successful because of factors such as the following: concentration of the population in urban areas; good means of communication that provide access to large hospitals’ services; an adequate supply of well-qualified personnel; money to pay for these services; and the fact that public confidence in outpatient psychiatry has grown, so that such confidence is no longer restricted to the area of institutional psychiatry (5).

Nevertheless, three-quarters of the world’s population live in rural areas. And in Latin America, where rapid urbanization is underway, shantytown regions on the outskirts of large cities that lack water supplies, basic sanitation, and roads may rightly be considered rural areas. For in such places the peasant or agricultural worker who abandons the countryside ends his journey and finds disillusionment. There he must cope with other disadvantages in addition to those of the rural areas, while being unable to enjoy most urban advantages. His struggle must then deal not only with poverty but also with environmental pressures.

The mental health care provided for such migrants tends to be wasteful and inadequate, largely because its efforts are focused upon organizing psychiatric hospitals that are
actually no more than patient "dumps." In addition, the existing psychiatric services have no significance for a person experiencing acute psychosis in a community, a depressed mother, or a retarded child. The psychotic wandering about the streets who becomes a public nuisance (5) has a better chance of obtaining treatment from those services. Persons really in need do not enjoy the benefits of modern psychopharmacology or other innovative means of treatment and preventive care. The few psychiatrists available work in the large urban centers, and most patients do not receive the care they might provide.

Personnel Problems

One of the reasons for this situation is that mental health training follows developed country models ill-adapted to local conditions. Psychiatrists have no concept of public health work and no training in administration, supervision, or teaching—all things they need to work effectively in countries so lacking in basic health care personnel.

The acute shortage of mental health workers could be alleviated, at least partially, if specialists were only willing to avail themselves of the supervised help of auxiliary, volunteer, and other psychiatric service support personnel. To appreciate the extent of the existing personnel deficit, it should be noted that for every million inhabitants in the United States there are 120 psychiatrists; in the Soviet Union there are 50, and in Brazil there are about 19.5.

Furthermore, official psychiatry disdains indigenous mental health practices. Trance states, religious or magical rituals, dances, tranquilizing native medications, nonscientific forms of support and rehabilitation, and the effective application of placebos—all methods that may be valuable in treating the population—are ignored by the profession.

Moulding Care to Local Conditions

Ineffective as conventional psychiatric care may be, however, any attempts to eliminate it before having alternatives is unjustified. Certain disorders—such as acute psychosis, deep depression, and epilepsy—that cannot be treated by autochthonous methods are helped by modern psychopharmacology. It would be more logical, therefore, to use both the official and the traditional systems. Members of the community—once accepted in their own environment—could thus be trained in modern methods of mental health treatment. This would overcome one of the major problems of psychiatry in developing countries—namely, its estrangement from the bulk of the population.

A major obstacle here is that mental health professionals, although identified with the cultures to which they belong, are steeped in knowledge and treatment methods developed in other contexts. These methods may be applicable to members of the upper middle class in the developing countries, but they are utterly inadequate for treating most of the population (7).

By thus copying foreign models and applying them indiscriminately, mental health workers in the developing countries betray a lack of sensitivity and a loss of the creative and innovative capacity needed to plan and develop services able to provide coverage for all of their people. The special types of treatment reserved for the mentally ill of the privileged classes underscore the lack of sensitivity shown in dealing with different population groups.

Operating in accord with existing directives, state and public welfare mental health services directly or indirectly serve to perpetuate the exploitation of mental patients and their families by those who have the training and legal mandate to treat them. As a consequence, the emphasis given to sophisticated hospital care and the development of ever-more-complex therapeutic technologies applied within a structure completely alien to that of the patient’s family or community context tends to create a dialogue of the deaf between mental health professionals and the mentally ill.
The psychiatry of underdeveloped countries, then, is an underdeveloped psychiatry, not because it has been unable to imitate or adopt the advances of the developed countries, but rather because it has accepted a condition of subservience and has not evolved technology of its own appropriate to the human and material resources available and the kinds of populations to be treated. By so doing, it has lost an opportunity to contribute with scientific discoveries of its own—not only to areas of psychiatry strictly within its own purview, but also to the psychiatry of the developed countries, which are facing difficulties in extending mental health service coverage to their whole populations.

**WHO Activities**

In an effort to confront these problems, the World Health Organization has been conducting a large-scale study directed at adapting psychiatry to Third-World poverty (5) through peripheral health units manned by personnel who receive short-term training in understanding mental disorders and administration of appropriate drugs, and who become skilled in handling mental health problems. In this vein, it has been found that individual communities are in fact capable of dealing with mental health problems. The WHO investigators involved have concluded that it is feasible to define treatment priorities on the basis of a problem's prevalence and gravity, the community's level of concern, and the availability of suitable treatment methods. That being the case, acute psychotic pictures, epilepsy, and many neurotic symptoms commonly seen at peripheral health services can be treated by unspecialized professionals; and routine procedures can be established for identification and simplified good-quality management of each of these priority problems by primary health care workers.

Also, the skills required for controlling the mental health problem can be acquired by members of the community who wish to help improve the population's mental health, as well as by professional personnel. Another alternative, which should not be scorned, is that of providing these skills to indigenous health workers—folk healers and the like—to whom the families of patients usually turn in time of need.

The success of a program like that envisaged here depends on appropriate training, the availability of needed drugs, an effective system of supervision, and community participation. There are experimental projects conducted along these lines that have proved successful.

**Conclusions**

All this suggests that if the psychiatry of the developing nations is to mature, it must stop copying foreign models and must adjust to a conceptual framework that takes account of existing sociocultural realities (1)—without adopting dogmatisms separating us from the mainstream of psychiatry. If this were done, if our psychiatry went its own way and ceased being an "underdeveloped" psychiatry, it might then evolve to the extent that it would gain an identity of its own consonant with the destiny of Latin America (1). It is also possible that, by adopting approaches suited to prevailing economic and social conditions, such a psychiatry could give rise to new methods and technologies that the developed countries might one day adopt for themselves.

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SUMMARY

The mental health services of Third-World countries suffer from many shortcomings—including the clustering of professionals in large urban centers and low levels of utilization by the population needing treatment. Because of these and related problems, it is recommended that health auxiliaries, volunteers, and support personnel be used to partially relieve the existing personnel shortages in this field. It is also suggested that official psychiatric services be supplemented with the indigenous mental health services provided by native health workers—folk healers and others—who should be trained to use modern methods of treatment in their communities.

REFERENCES


