Australian and New Zealand Journal of Psychiatry (1981) 15:343-347

TRAINING OF PSYCHIATRISTS FOR DEVELOPING COUNTRIES

M. PARAMESHVARA DEVA

There are significant differences in approaches to the training of psychiatrists in developed and developing countries. In the latter, with acute shortages of manpower in psychiatry and gross deficiencies in psychiatric services, there is a need for training programs to emphasise the practical needs of the country. The aim should be to produce a well-rounded generalist who is capable of coping with most psychiatric problems with little access to a clinical psychologist or social worker, both of whom are usually not readily available in developing countries. The trainee should have a good grounding in the briefer psychotherapies and behaviour modification. There is a need to pool resources in developing countries to initiate local training programs. Cooperation between developed and developing countries can also play a useful role in the starting of regional training programs to benefit several countries.

The training of psychiatrists has over the past decade received considerable attention in training centres throughout the world. The Royal Medico-Psychological Association published in 1970 a comprehensive document of the Conference on Postgraduate Psychiatric Education held in London in 1969. Another was the Royal College of Psychiatrists' document, **Psychiatrists in Training** (Brook, 1973). Workers in the U.S. have also been active in this field (American Psychiatric Association, 1976) especially as new entrants into postgraduate training have tended to fall off rather sharply over the past decade.

That there is a continuing and in fact increasing demand for psychiatrists all over the world is undeniable, perhaps more so in the developing world where levels of psychiatric manpower are critically low when compared to the more developed areas. There are today over 40 million men, women and children in developing countries suffering from serious and untreated mental disorders. In many of these countries, there is less than one psychiatrist and one psychiatric nurse per one million of the population (WHO, 1975) and even these numbers are optimistic as the numbers are further diluted by many psychiatrists concentrated in urban areas or involved in administration or other non-clinical duties.

While these figures may seem hopeless to psychiatrists from the developed world, they must be tempered with knowledge of these countries and their social structure. Whereas the emotionally ill in the urban jungle of a large city in a developed country may have only the neighbourhood psychiatrist to turn to, most people in developing countries still have a surprising network of social and family support systems. Family ties are basically strong. Religious and cultural modes of help and traditional healers account for the management of a considerable proportion of the more manageable forms of psychological distress. In a study done in Malaysia (Teoh *et al.*, 1972), it was seen that 31% of patients attending a psychiatric clinic had sought help from traditional healers alone. The authors felt that traditional healers not only supplement but complement the treatment of psychiatric patients. Kapur (1975) found that the majority of patients in rural India consulted both the doctor and the traditional healers for psychological problems though females generally preferred the doctor to the traditional healer. Kapur felt that what mattered more to the

psychiatric consultees in relation to the treatment agency they chose was the individual healer's merits rather than his conceptual framework. Certainly, this seems to be the case in many countries. However, what has not been resolved successfully is the system of working together by the modern psychiatrist and his traditional counterpart. For the most part, in developing countries the need for psychiatrists seems to be felt more in the management of the more severe psychoses, while the traditional healer is able to manage well a wide range of situational reactions (Kinzie *et al.*, 1972).

From the above, it may be said that the psychiatrist-patient ratio in the developing country need not follow that in the more affluent West where such a support system of traditional agencies may not be available. Having said that, one is still faced with the fact that there is little way in which one psychiatrist can cater for all the psychosis that exists among a million people in a developing country.

Despite the severe shortage of psychiatrists, and indeed perhaps because of this privation, there has been the phenomenon of migration of trained psychiatrists as well as trainee psychiatrists to the developed countries. This has been recognized for some time and Carstairs (1973) reported that in 1969, a total of 71% of all trainee psychiatrists at senior house officer level and 60% at the registrar level in England and Wales were from overseas. In the United States and Canada, the picture was no less disturbing. Few of these trainees return to their home countries on completion of training.

This state of affairs calls for a reappraisal, not only of policy (and as Carstairs has suggested, political action) to change or reverse the 'brain drain' but a rethinking in training plans for developing countries. For as Carstairs (1973) and Wig (1973) have pointed out there are strong reasons for the setting up of local training programs. These include problems centred around such areas as culture (Persad, 1970) as well as greater emphasis on local psychiatric problems and management.

Place of Training

Most experts in the field agree that the training of psychiatrists must be wholly or at least substantially done in the trainee's own cultural setting. Psychiatry more than most medical disciplines has strong cultural roots. Unfortunately, in the developing countries where the training should be done, there is usually a shortage of training facilities. This takes the form of inadequately-staffed training programs, and poor availability of local research and other material that make local emphasis difficult. Even in developing countries, the availability of manpower and materials varies from place to place. One of the antagonisms seen in many countries is that which exists between the new university departments of psychiatry and the larger, established, but less academic psychiatric hospitals. This has been a factor in the success (or failure) of many training programs. In developing countries with limited psychiatric manpower, such difficulties can be costly and wasteful. There is therefore a need for a healthy integration of psychiatrists working in all fields to contribute to training programs in developing countries.

Contents of Training Programs

While training programs should ideally have emphasis on all important aspects, theoretical and practical, of psychiatry, the actual content is often decided by practical and logistic problems of the place where the training is conducted. In developing countries, these logistic needs take on a different meaning – something that may not seem satisfactory to psychiatrists in more developed areas. While there is little doubt that basic sciences and principles of psychiatric diagnosis or treatment must be part of any reasonable postgraduate curriculum, the need for emphasis on a particular aspect is less clear. That this depends on the needs of the psychiatric patients of the country to an extent cannot be ignored. Some of these relate to the shortages of specialists in other medical disciplines.

A trend has started in more developed countries to separate neurology and even internal medicine from psychiatry in training programs. In these countries, the move may be justified on the grounds that neurology or internal medicine should be the province of neurologists and internists who have their own specialised training programs. In developing countries with acute shortages of trained psychiatrists and neurologists, a psychiatrist often has the responsibility of not only diagnosing but continuing to treat physical problems in psychiatric patients. Because of this, a strong emphasis on physical illnesses related to psychiatry is necessary in the training program. Another aspect of treatment is the almost universal use of electroconvulsive therapy (E.C.T.) for some psychiatric conditions such as primary affective disorders. With an acute shortage of anaesthetists, psychiatrists in developing countries must have the basic skills to anaesthetise patients who are undergoing E.C.T.

In the field of psychotherapy, emphasis on individual psychotherapy has to be tempered with the prospect that the vast majority of patients in developing countries cannot ever have the benefit of such therapy. While the experience of individual psychotherapy for the trainee is of great importance, that of group, family and marital therapies seem of greater practical value for a majority of patients who have limited access to the psychiatrist who may see from 30 to 100 patients on an average clinic day. In developed countries where psychiatrist-patient ratio is close to 1:10,000 or 15,000 and where the psychiatrist may see at most a dozen patients a day, the emphasis may rightly be on the finer aspects of long-term individual psychotherapy. Therapy with one patient on an individual basis for three, four or five years in a developing country is only possible at considerable expense to the thousands of others who are in need of urgent help.

Emphasis on Local Psychiatry

A truly local psychiatric training program must have considerable emphasis on local problems. Just as alcoholism and now divorce therapies are being emphasized in some developed countries, the role of indigenous concepts of mental illness has to be emphasized in the developing countries. Trans-cultural psychiatry has investigated peculiar syndromes in exotic places but the psychiatrist in many of the developing countries has to use these concepts in his daily work. Trainees in developing countries must be familiar with local beliefs and value systems and indigenous therapies not only to be able to understand his patients but to empathise with them and utilise those concepts in the management of his patient.

While the siting of the training program in teaching or academic centres may promote modernization of medicine and psychiatry, the trainee must be given the opportunity to understand less developed practices that exist in the mental institutions of his country. This should be done with a view to bringing about changes in these institutions where appropriate. The psychiatrist in many developing countries is not only a clinician but an agent of change. The psychiatrist in a developing country has to be at the forefront of bringing about changes in the system of psychiatry in the country. Suffering from years of neglect by authorities and the community, mental patients in many developing countries are managed in rambling, overcrowded and poorly-staffed institutions. Modern methods of care such as therapeutic community techniques, rehabilitation and patient independence are seldom practised in these institutions. Locked wards, high fences and absence of personal property and identity are the hallmark of such systems. Bringing about change to such systems is a long and arduous task that many a psychiatrist has to take on himself in a developing country. The psychiatrist must also spearhead efforts at mental health reform in the country through measures ranging from the establishment of greater public awareness of mental illness to changes in mental health laws. While the psychiatrist's involvement in such changes may be optional in a developed country, the few psychiatrists in a developing country have to do the task themselves or continue in the archaic system. This change must be an area of major emphasis in the training program. Failure to emphasise this responsibility can give rise to two systems of psychiatry in countries that can ill afford antagonisms among their limited trained manpower resources.

Teaching and Research

Inherent in any training program should be opportunities to learn research methods and to teach others. Developing countries have not only shortages in psychiatric but also para-psychiatric manpower. Trainees should be given chances to participate in training of nurses, social workers and psychiatric assistants. Often, on qualifying, the trainees are called upon to give talks to various organizations both professional and non-professional. Another void in developing countries is the dearth of local research. A trainee who is content to rest on his laurels within his clinical work can contribute little to the understanding and improvement of psychiatry in his country. It is essential that basic research methods be an integral part of any training program. The inclusion of a dissertation or research project within the training program has great merits in a developing country.

Length of Training Program

The two year diploma course in psychiatry has in the past decade gradually given way to the three year and lately, four and five year program. In developing countries, there are understandable difficulties in taking on five year training programs. Aside from the fact that few young doctors seem keen on psychiatry, an inflexible five year requirement may further reduce entrants into the discipline. There is a feeling that a two year program does not provide time to cover the essentials of post-graduate training requirements. A possible

compromise is a two tier training program. This could mean a three year program leading to a Masters Degree in Psychological Medicine followed by a two year period of work experience and research during which the candidate could work towards a doctorate if he so wishes.

With the recent interest in 'barefoot medicine', a similar trend has been noticeable in the field of psychiatry. Many eminent psychiatrists in developing countries have argued that what psychiatry needs in developing countries is a larger number of para-psychiatric 'primary care workers' instead of more psychiatrists. Though superficially attractive, this argument has numerous flaws only noticed by those who work in the developing countries. These include the already low priority that psychiatry has in the health care system. This poor emphasis has given rise to and maintained a state of apathy about psychiatry and psychiatric patients in the medical care system and the medical profession. An official move to establish a para-professional psychiatric care system at the expense of a system based on trained psychiatrists at psychiatric treatment facilities will only further weaken psychiatry in most developing countries. It is likely to further alienate psychiatry and psychiatrists from the main stream of medical care. In the very large developing countries which have little hope of ever improving their psychiatric care by the training of psychiatrists in large numbers because of expense or policy, such 'bare-foot' psychiatrists may certainly be an answer but only a temporary one. The desire of most developing countries to attain greater excellence in medical care must be recognised as an inevitable one that is unlikely to be satisfied by temporary two or three tier systems of care. In many developing countries (as perhaps in developed ones too) the development of a health service is basically dependent on the ability of its professionals and administrators to strive for a larger budget with which to train and hire more staff and improve or build better facilities. A para-professional system of mental health care is less able in developing countries to fight for improvements when other health care agencies staffed by professionals join the battle for financial allocations. The developing of a system of psychiatric care based on para-professionals at the expense of training more psychiatrists is akin to training more midwives at the expense of obstetricians for developing countries. More often than not, the arguments for a 'bare-foot' program are motivated by frustration resulting from the psychiatric community's difficulty in organising support for development of psychiatric training programs. Purely budgetary and lobbying considerations may make the para-professional system attractive while conveniently ignoring the long-term objectives of mental health care.

How Can Training Be Improved?

The level of development of training programs in developing countries varies widely. Some have token programs serving a few trainees. Yet others do not have any training programs and depend entirely on those trained in the developed countries. In some countries, there is a rather wasteful trend to start many poorly staffed centres for training that compete both for staff as well as for trainees. If the limited resources are to be used to best effect, there is clearly a need to centre training programs on a regional basis (Wig, 1973). Each of these centres could serve one or several countries according to the needs. Once regional training programs are set up, there can be pooling of staff and trainees.

Despite the pooling of resources, several of these training centres will probably still lack both material as well as manpower to make such programs viable and meaningful. This can probably only be remedied by aid from the developed countries either individually or through world organizations. Regional training centres are a reality in many other fields of technology and can be a reality provided the need for training of psychiatrists is realized as an urgent problem in the developing world. It would not only help the needy countries as a source of urgently required psychiatrists but provide valuable opportunities for studies and research into common psychiatric problems across cultures.

Conclusion

The training of psychiatrists for developing countries is worthy of the attention of educationists in both the developing and the developed world. It has unique features that call for innovations in and modifications of existing training concepts. There are available resources which need to be moulded to suit the requirements of developing countries. The proposal for regional training centres for the training of psychiatrists for developing countries is one that should be given some consideration despite the complex organizational problem. The task is indeed enormous but can be overcome with a pragmatic approach that combines the efforts of psychiatrists in both developing and developed countries to bring better care to the mentally ill who need it most.

References

American Psychiatric Association (1976) Working Papers of the 1975 Conference on Education of Psychiatrists. Hennage Crative Printers, Washington D.C.

BROOK, P. (1973) Psychiatrists in training. *British Journal of Psychiatry*, Special Publication No. 7. Headley Brothers, U.K.

CARSTAIRS (1973) *Psychiatric Training for Foreign Medical Graduates in Comparison to Psychiatric Studies.* (Ed. A Forrest) Churchill and Livingstone Press, Edinburgh.

KAPUR, R. (1975) Mental health care in rural India: a study of existing patterns and their implications for future policy. *British Journal of Psychiatry*, **127**, 86-93.

KINZIE, TEOH and TAN (1972), *Native Healers in Malaysia.* Paper presented at Conference on Culture and Mental Health in Asia and the Pacific Social Science Research Institute and East-West Centre, Hawaii, U.S.A., 20-24 March, 1972.

PERSAD, R. (1970) Some cultural factors in psychiatric training – a personal view. In *Report of a Seminar on Mental Health in Developing Countries,* Toronto, Canadian Mental Health Association, 1970.

TEOH J. I., KINZIE J. D. and TAN, E. (1972) Referrals to a psychiatric clinic in West Malaysia. *International Journal of Social Psychiatry*, **18**, 301-307.

World Health Organization (1975) Organization of mental health services in developing countries. *Technical Report Series No. 564*, W.H.O., Geneva.

WIG, N. (1973) Training of psychiatrists. In *Report of Seminar on Mental Health Services in Developing Countries, Adis Ababa, 1973*, W.H.O. Geneva, 111-117.

M. PARAMESHVARA DEVA,
M.B., B.S., F.R.A.N.Z.C.P., M.R.C., Psych., D.P.M., A.M.
Associate Professor,
Department of Psychological Medicine,
Faculty of Medicine,
University of Malaya,
Kuala Lumpur, 22-11, Malaysia.