PSYCHIATRIC SERVICE IN RELATION TO PUBLIC-HEALTH ACTIVITIES[1]

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IN allying itself with public health, psychiatry has the unique opportunity of extending its insights and concepts into a field that has to do with the preservation of the health of a major segment of the population. From its early beginnings as an institution for the control of the disastrous effects of epidemics, public health has evolved to a broadly based philosophy of preventive medicine, with a deep concern for the person in all of his biological, cultural, sociological, and environmental involvements. The interests of public health parallel the interests of community psychiatry and the participation by psychiatrists in public-health activities offers much toward the mutual enrichment of the two fields for more effective service to patients.

The full development of the contribution each field can make to the other encounters many internal difficulties in both, but for the present discussion I shall confine myself to a consideration of the problem from the point of view of the psychiatrist. A good many orientations that have been found valuable and rewarding in clinical psychiatry need to be reëxamined and reformulated when applied to public-health activities. I shall discuss some of these orientations as background to an exploration of the creative possibilities for psychiatric participation in public health.

The Clinical Bias. The central concern of the psychiatrist is the care and treatment of the patient with a decompensated psychiatric problem. This is in the tradition of medical practice and education, with their emphasis on descriptive and etiological pathology. The psychiatrist as physician is oriented

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toward the individual patient, whose problems he isolates for purposes of study and treatment. The social pattern that is the basic reality in the living experience of the patient is reproduced for treatment purposes in the doctor-patient relationship, although subject to the distortions of the authoritative, magical, and dependency implications in this relationship.

The major forms of psychiatric illness—the psychoneuroses, the functional psychoses, and the psychosomatic conditions—occupy a special position in the catalogue of human disease. They are ubiquitous and pervasive; they exhibit a marked tendency to chronicity; they are intimately related to cultural and social conditions; and they commonly show phases of remission, exacerbation, and compensation in relation to the life experiences of the individual, and the fluctuations, often accidental, in the character of his interpersonal relationships. They demonstrate in the mass an unbroken line from the very mild to the very severe, and they may stabilize or show social compensation at any level of severity.

Because of the particular nature of these affections, any approach in medical management that is based upon individual psychotherapy as an end in itself is likely to be peripheral from the point of view of the totality of the problem. The psychiatric case-study approach is of course a basic medical responsibility, and an invaluable research source in the understanding of psychopathology and psychodynamics, but *alone,* without an alliance with a broader epidemiological approach, it remains unrealistic and unavailing. If there were ten or a hundred times as many psychiatrists as we have to-day, and if they were all skilled psychotherapists, their contribution to our problem would still be of relatively little importance. Nevertheless, the value of direct psychotherapy for the individual patient may be so great that it becomes essential to avoid treatment waste, not only through careful attention to treatment indication and goals, but also through the study of those institutionalized community activities which have a bearing on the extent of psychiatric decompensation.

Actually, in spite of the shortage of psychiatrists and of psychiatric treatment resources in communities, the psychiatric problems of people who live in the community do not go untreated; for if they did, our society would be disrupted and chaotic. Institutional patternings are constantly being created in efforts at adaptation to the changing needs of people in a changing world. In effect, direct psychiatric treatment is a relatively minor social method of reducing individual anxiety, reconciling inner conflicts, and satisfying personal emotional needs. However, because patternings in society evolve slowly, we find, in a transitional society such as ours, a mounting incidence of decompensated psychiatric disturbance, particularly of psychoneurotic and psychosomatic conditions.

The most important institutional forms in which attempts are being made at this time to develop the skills and professional resources to meet these increased demands of human need and distress are: social work; nursery, primary, and secondary education; and public health. In each of these fields the problem is identified as belonging to mental hygiene, and explorations of one kind or another have been under way to discover how psychiatric personnel may be included, administratively and functionally, within existing organizations. A basic difficulty has been the tendency to separate psychiatric problems from their original context in the service programs of the agencies, and since psychiatrists have offered encouragement and support to this tendency, it might be worth while to consider more carefully this matter of psychiatric insularity.

The Isolative Tendency. If the psychiatrist is to participate in collaborative programs with professional workers in other service fields, it must be on the basis of a preliminary two-way learning experience in which goals and objective are carefully discussed in relation to the staff needs that the psychiatrist is expected to meet. The rôle of the psychiatrist may be characterized as that of a participant rather than of a consultant, in order to emphasize this two-way learning process. While the psychiatrist has a great deal to offer other professional workers

from his knowledge of behavior and personality, his contribution usually cannot be assimilated directly—*i.e.*, in its original psychiatric or psychoanalytic conceptual framework—but must be reformulated, translated, and adapted to the frame of reference, the terminology, and the procedural modes of the particular professional group with whom he is working.

It would seem that persons whose field of concentration is that of dynamic psychology tend to develop a psychological gun-barrel vision, and find it difficult to give up their biases of terminology and conceptual habit frameworks. Although this may be no different from the attitude of other specialists, the psychiatrist is being called upon more and more to contribute to fields other than his own, and this makes the problem of cross-disciplinary communication of particular interest and importance in psychiatry.

Actually, the problem is not merely one of semantics. There is the fundamental assumption prevalent in psychiatry that anybody can benefit from psychiatric knowledge, particularly the knowledge of psychodynamics, and that, having such knowledge, anybody can apply it directly to his personal or professional problems. At first glance, such an assumption does not seem to be isolative in tendency, since it would certainly appear that psychiatry is extremely generous in sharing its insights and concepts not only with other professional workers, but with the lay public as well. However, when it does so, it is almost always on its own terms, in its own ways, by its own methods, with little questioning of the value, the applicability, or the effects of what is done. The psychiatrist remains isolated when he does not avail himself of the opportunity to acquire a knowledge of the field in which he is teaching, or when he tries to reorient the field in the direction of psychoanalytic method. The worker in the field runs the risk of becoming isolated from the original sources of his professional training and experience, by substituting dynamic concepts for those from his own profession.

Now how do these considerations apply to the field of public

health? In what way can psychiatry make a contribution that would reinforce existing achievements of value, without attempting to change the patterns of public-health activities or the direction of its growth? How can the concepts and methods of psychiatry be adapted to fit the needs of the thousands of public-health personnel who have an expressed interest in obtaining mental-hygiene assistance with their professional problems? And how can public-health administrators be of help in working out the problem?

If I offer here some principles for consideration, I do so with caution and restraint, and with the awareness that there is little in this particular area of collaboration that is not untried and untested.

The mental-hygiene approach, based on a broad consideration of the welfare of the individual, is an integral and inseparable part of the philosophy of public-health practice. It is concerned with the individual's problem-solving capacities and potentials in relation to his emotional needs, his personal difficulties, and the stresses in his social situation.

Clinical personnel in health departments have three generalized functions, in addition to the particular service they are carrying out; these three are mental hygiene, health education, and nutrition. The first is of basic importance since it pertains to the doctor-patient and nurse-patient relationship, by virtue of which the cultural rôle of medicine as the guardian of health attains reality in the confidence and faith of the patient. Health education is the medium through which this relationship is established, fostered, and translated into concrete health services. Nutrition is more limited in scope, but of importance because of the high incidence of primitive attitudes and disturbed emotional patterns in relation to eating. In all three areas, the clinician and the public-health nurse should have basic competence in relation to the recognition and to some extent the identification of problems, with an awareness of the limitations inherent in generalized as contrasted with special training.

The patients who receive health-department services present a wide range of emotional problems. With some, anxiety is a reaction to the presence of the illness or its acceptance, as in the case of the patient who has learned as a result of the mass-survey X-ray that he has pulmonary tuberculosis, or the adolescent who has contracted an initial venereal infection. The anticipatory anxiety of the woman in the prenatal clinic is often well covered up by stereotype cultural attitudes, and hence is not always readily accessible. In child-health stations, mothers are particularly worried about problems of child care in the first year of life, and particularly about problems of feeding, sleeping, and elimination. In school health services, the physician meets the gamut of child psychiatric syndromes, and it is the estimate of one observer in this field that 65 per cent of all problems found in routine physical examinations of school children are psychogenic in origin, or have important psychological components.

The most reasonable orientation for public health, then, is to regard mental hygiene as an intrinsic part of its own job, related to its every-day work, and applicable to the problems of all its patients rather than a selected few. At the present time, most health-department personnel recognize that they have some measure of responsibility for the emotional problems that are found in patients in relation to the health services they receive, but a lack of professional preparation in this area and of available psychiatric consultation usually leads to their failing to recognize, or ignoring, or dealing mechanically with many of these problems.

The contribution of psychiatry to public health is contingent upon an acceptance and approval of the philosophy and aims of public health, a willingness to work within its administrative and functional organization, and a recognition of the mental-hygiene objectives that public health has already achieved.

One may distinguish between *indirect* and *direct* treatment services. In the former, the objective is not psychiatric

treatment, but a different kind of service. In a children's institution, for example, the primary service is to provide a satisfactory setting for the total life experience of the child, and psychotherapeutic benefits will come out of it to the extent that the setting is satisfactory from the standpoint of this primary function. Indirect or *supporting* treatment services represent organizational modes of meeting human need, and they are successful in direct ratio to the flexibility of their organizational structure in allowing the expression and gratification of individual strivings.

A public-health unit is likewise a method of patterning interpersonal relationships, in this instance for the purpose of rendering health service. As an institutional response to an important area of need in the community, it plays a significant supporting rôle in relation to psychiatric problems. Even though its personnel may be for the most part almost entirely unsophisticated in psychiatric thinking, yet the mode of organization of the child-health station, for example, is such that it is able to accomplish its mass objective of substantially reducing the reservoir of anxiety in the large group of parents who receive its services. Its supporting function can be improved, true, but it is already a vital force in the family life of many communities to-day, particularly in the large urban centers.

In any of the supporting services in a community, whether it be a children's institution, a welfare agency, or a public-health unit, the psychotherapeutic potential is inherent in the form of organization that patterns the interpersonal relations of the staff and the persons receiving service. When psychiatric service is added, it must be related to the basic organizational pattern through administrative channels, if its contribution is not to remain inconsequential. The psychiatrist must extend his conceptual awareness from the relatively narrow range of the individual doctor-patient relationship to the complex network of interpersonal relationships in the large organizations.

In order that they may be accomplished, the administrative

staff of the public-health unit has a responsibility for entering with its psychiatric personnel into a continuing process of clarification of function, demarcation of responsibility, and establishment of administrative channels for the proper integration of mental-hygiene services with others in the health department. The responsibility cannot be left to the psychiatrist alone, since he cannot be expected to understand the particular administrative framework in which he is expected to work. On the other hand, the psychiatrist's participation is obviously needed in planning a psychiatric service in order to protect the technical demands of the job.

With regard to their method of teaching, psychiatric personnel must consider the factors of readiness and interest in the public-health staff, their level of psychiatric sophistication or lack of it, and their flair for dealing with problems of individual patients.

The aim of a psychiatric service in a health department is not to teach psychiatry, but to help public-health workers with the emotional problems that they find in their patients. It is to help them to be better public-health workers, not mental-hygiene aides or minor psychiatrists.

Interviewing is a basic method in public health. For the administrator or the clinician or the nurse, interviewing is an essential skill. The public-health worker pays little attention to process or technique in the interview, but centers his interest on its purpose, which is very often educational, and on his own activity of obtaining and giving information. It is easy for the patient as a person to become lost in the process. One observes that nurses and clinicians often seem not to hear what patients are saying, or if they hear, to pay no attention, so intent are they on moving through their established routine of interviewing, as if it were a ritualistic ceremonial. My impression is that behavior of this kind is based on tension and that it is most apparent when an observer is present; but it is common in public-health practice.

It has seemed to me that the tension is a product of adminis-

trative defects, arising out of a lack of clarification of job status and of responsibilities and limitations of function; administrative confusions in relation to the goals and purposes of public health itself and anxieties as to its standing in the world of medical opinion; lack of coördination and lack of attitudes of coöperation among services, particularly in a large health department; rigid and punitive attitudes of supervisory personnel; and certain difficulties in the nurse-doctor relationship due to the traditional attitudes of each as well as their rôle differences in existing health-department structures. These are all factors that impair the spontaneity of the health worker's response to patients, and tend to substitute mechanical routine for a free use of the professional personality in response to the needs of patients.

The psychiatrist can do very little about such problems except to point out their effects to the administrator to whom the responsibility does belong. Yet in his teaching he must take their results into consideration, and deal with tensions and resistances as the first step in teaching—and often as a major objective—until his own relations with the staff are such that they can accept and make use of his contributions. The psychiatrist may participate in public-health clinics, workshops, conferences, and training programs, and in each area he must be alert and responsive to the anxious and hostile attitudes of the people he is working with, whether those attitudes are derived from the unfamiliar contact with psychiatry, from administrative lack of clarity, or from the personal problems of some of the staff members themselves.

The teaching of techniques of interviewing is a temptation that should be resisted. It seems to me that emphasis should, instead, be placed on helping the staff to discover their own potential objective interest in and curiosity about people, and to free them to be helpful in terms of the patients' needs rather than their own. Since public-health workers are in any case not doing a direct psychiatric job with patients, any stimulation of interest in techniques of interviewing can only lead them down

byways away from their primary goal of rendering health services.

To summarize, my main thesis has been that public health carries a large and important responsibility for mental health in terms of its own practice and its own functions. It deals with masses of people who have the usual run of psychiatric problems. These people, however, are for the most part applying for health services, and many may be helped with their emotional problems by a better practice of public health if consideration is given to the principles of comprehensive medicine. By participating as consultants and educators in a staff-oriented program, psychiatrists may make a significant contribution in this new epidemiological approach to the mental-hygiene problem in public health.