PHYSICAL MEDICINE IN PSYCHIATRY

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IN physical disorders both diagnosis and treatment are usually carried out by the doctor alone along conventional lines. Psychological problems, however, require a less stereotyped approach.

The psychiatric patient's symptoms are either the direct or indirect result of mental trauma which may have occurred at any time during his life, and are of such a diversified nature that the routines and formulae which we associate with physical disease cannot be applied. A true psychiatric assessment is difficult, for it depends on a number of obscure factors. The doctor has to rely upon the evidence of a patient who is unreliable and on the defensive, and of relatives who are incapable of impartial testimony. Moreover, he sees the patient during consultations for only about 4 hours a week. What happens to the patient during the remaining 164 hours of the week is of utmost importance, for a patient's history and family history are not enough to determine his condition. His everyday actions and reactions must be known if the cause is to be treated. The removal of the cause is the essence of all treatment.

The patient should, therefore, be under observation for 24 hours a day. This requires a team of workers and the team grows as our knowledge increases.

Diagnostic and Therapeutic Team. The personnel of the team should comprise:

(*a*) *Medical:* Psychiatrist, neurologist, physician, neurosurgeon, paediatrician, clinical encephalographer, opthalmologist, ENT specialist, radiologist, physical medicine specialist, etc.

(*b*) *Psycho-Social:* Clinical psychologist; social worker.

(*c*) *Nursing Staff.*

(*d*) *Auxiliaries:* Occupational therapist, craft instructor, physical educationalist, sports instructor, physiotherapist and dietician.

Close co-operation between the various departments is ensured by:

(*a*) Weekly staff conferences.

(*b*) Administration meetings (Fig. 1).

(*c*) Reports from nursing staff; occupational therapy, physical education and physiotherapy departments; and from the social workers.

(*d*) Immediate reports to the doctors on any unusual feature.

The administration of Tara is to be congratulated on the efficiency and adaptability of this system of co-operation and co-ordination.

Patients. Alcoholics, certifiable cases, the conspicuous and the unassimilable, and infants are excluded from Tara; but otherwise the patients form a cross-section of the European population and have the advantage of mixing with people of all types and from all walks of life; 835 in-patients were admitted during the past year. They live at the hospital but are allowed 48 hours' leave at the discretion of the doctor. The attendances of day-patients during the year were 2,457; these stayed from 10 a.m. to 3 p.m. Their number is increasing because certain patients do better in their home environment, while incidental advantages result from the larger turnover of patients and the relief afforded the short-handed nursing staff. In addition there were 1,464 attendances of out-patients ,who came for special treatment only.

As soon as a patient enters Tara (Fig. 2) he is under observation. He becomes an individual nucleus in the group structure of Tara's microcosm. A specially qualified clerk is responsible for reception as tact and careful questioning are essential to make the patient feel at ease. The registrar on duty is informed of the patient's arrival and the first interview is with the patient himself and those who accompany him. The doctor takes a full history, carries out a complete physical examination and makes a psychiatric assessment. He prescribes occupational and recreational therapy on a special card drawn up 5 years ago.

Occupational therapy is started within 48 hours. This is chosen by the occupational therapist in charge after an interview with the patient. Meanwhile the patient is shown the ropes (Fig. 3) by selected fellow patients and is given a week in which to settle down to the hospital routine.

Time-Table. The average stay of the psychiatric patient at Tara is 8 weeks; the week (168 hours) is divided up more or less according to the following programme:

1. Seventy hours are spent in the wards by 70% of the psychiatric patients.

2. At occupational therapy 25 hours are taken up by 98%.

3. Ninety-five per cent. participate in sports (Fig. 4), consuming 15 hours.

4. Physical training involves 60% of the cases, using 4 hours.

5. Six hours are spent on physiotherapy by 10%.

6. Twelve hours are passed at evening recreation and entertainment such as cinema, social club, ward entertainments, concerts, plays (Fig. 5), dances and indoor games, at which 98% attend.

7. Relaxation (either group, private or inaction) involves 65% of the patients for 1 hour.

8. All have consultations with specialists for half an hour.

9. Twenty per cent. require special investigations, e.g. electroencephalography, air encephalography, arteriography, etc. which take half an hour.

10. All have special treatments (including psychotherapy, E.C.T., insulin) which occupy a further 2 hours.

11. Ninety-eight per cent of psychiatric patients attend the following meetings, which allow for 3 hours: (*a*) With medical superintendent (Fig. 6); (*b*) Recreation committee; (*c*) Sports committee; (*d*) Library committee; (*e*) Ward representatives (Fig. 7).

Physiotherapy. This is applied as though the symptoms resulted from physical disease. Thus for pain, diathermy is usually applied and for impaired muscle power, faradic stimulation. The *tense* patient is given heat, sedative massage and hydrotherapy, and is taught to relax. The *lethargic* patient has contrast baths, electrical stimulation, high frequency, stimulative massage and tonic ultra-violet light therapy.

Above all, however, the physiotherapist must radiate reassurance.

Occupational and Recreational Therapy. Occupational and recreational therapy is an integral part of the field covered by physical medicine and rehabilitation. I should define occupational therapy as 'any activity, mental or physical, prescribed by a physician for its remedial, diagnostic, or prognostic value.' It seeks to arouse interest, courage and confidence, all of which are necessary for overcoming disability and for the patient's return as a normal member of society.

Its history dates back to the early Egyptians. It has at various times been called diversional, moral, cure or work therapy. Its application depends, not on a prior classification of patients, but on the results it achieves with each individual patient. Until recently occupational therapy was controlled mainly by lay personnel as arts and crafts teachers; however, it is gradually falling under medical guidance. Its aims and *modus operandi* can be summed up as follows:

Objects and Operation: (1) *Observing Behaviour.* This is fundamental to treatment, for in the atmosphere of the consulting room it is not possible to envisage the patient in social situations. The set-up at Tara makes observation of spontaneous behaviour possible, thus providing a background for a living diagnosis and prognosis. The patient is constantly watched at work and play. He cannot keep up a pretence all the time and data can be obtained on, e.g. inter-personal relationship, work tolerance, teaching tolerance, application, memory, judgement, aptitudes, personal habits, reliability and endurance. At weekly staff meetings (Fig. 8) these findings are discussed with the doctor who interprets them and directs further treatment and observation.

2. *Assessing Ability.* The way a patient tackles a task, the methods used, his power of co-operation and his ability to mix with his fellows are carefully noted, special regard being paid to his concentration, natural dexterity, endurance and intelligence.

3. *Providing Creative Outlets.* Man's inherent desire to create is often blunted by mental, monetary and social setbacks or by unresolved emotional difficulties. It can, however, be restored by careful selection of interesting occupations, the use of colours and designs (Fig. 9) and by encouragement with timely advice and help. Samples of the work turned out by patients are on exhibition for all to see.

4. *Providing Opportunities for Emotional Expression.* Generally speaking, people are unable to express emotions with the same intensity as they are felt. Socially unacceptable and, therefore, usually unexpended energy is directed into constructive channels. The patient is thus relieved of his often unconscious burden. Those with frustrated aggressions hammer away at metalwork (Fig. 10), saw away at carpentry (Fig. 11) and pummel the clay at pottery (Fig 12). Repetitive mechanical work (e.g. rug making, sewing, weaving (Fig 13) and basketry (Fig 14) is found useful in the treatment of anxious and agitated patients. During and after sessions of relaxation (Fig. 15) there are often bursts of tears and much talking, after which the patient feels better.

Art therapy (Fig 16) and music therapy are other forms of emotional expression with which we are experimenting. A music room (Fig. 17) with a piano, radiogram and record library is available for the patient.

5. *Physical Reconditioning.* Mental illness usually comes on gradually after long periods of suffering. The patient neglects himself, loses interest, eats badly, smokes heavily and drinks excessively. He becomes unfit, losing weight and suffering from hypovitaminosis. The dietician has to make the food tempting and appetising and this is served in a pleasant environment (Fig 18). By careful selection of occupation with possible adaptations and adjustments, as well as by graduated physical training (Fig. 19) and sport, the patient is put on the road towards a more active and normal life.

6. *Improving Concentration.* The power of concentration is usually impaired by illness and is gradually restored by providing interesting and varied occupations, by constant encouragement and by insisting on the highest standard of work of which the patient is capable. Metal work, leather work (Fig. 14) and carpentry are particularly useful in promoting the power of concentration.

7. *Developing Confidence.* When new patients are shown samples of work that others have done, they usually say that they are unable to do such work. But when, under guidance they, too, turn out a good article, their confidence, usually impaired through illness, is re-established.

8. *Restoring Independence.* Patients lack initiative and require support and encouragement. It is the aim of the therapeutic team to make them aware of their capabilities and limitations and to make them less dependent on others. To this end the patients are allowed to elect their own committees.

9. *Developing a Sense of Responsibility.* Through the microcosm of the staff-patient community the patient is made aware that everybody plays a part in society. The patients have their own recreation committee, its chairman, secretary and the dining-room representative being recommended by the doctor. The patients also elect their own ward representatives. Some take on library (Fig. 20), snooker (Fig. 21), wheelchair, telephone (Fig. 22) and sports equipment (Fig. 23) duties; others take on sport field duties e.g. cricket (Fig. 24), hockey (Fig. 25), soccer, soft ball, (Fig. 26), basket ball, archery (Fig. 27), croquet (Fig. 28), tennis (Fig. 29), tenniquoits (Fig. 30), golf, bowls (Fig. 31) and swimming (Fig. 32). Other responsibilities include arranging of evening entertainments and week-end recreations.

10. *Restoring Self-Esteem.* The unremitting efforts of the therapeutic team in a controlled environment restore the patient's confidence and self-esteem. In this respect the status enjoyed by members of the recreation committee (Fig. 33), particularly by the chairman, the secretary and the dining-room representative (Fig. 34), has had a most valuable effect.

11. *Recognition of the Patient as an Individual.* By treating the patient as an individual who happens to be ill, instead of as a mere vehicle for an illness, the therapeutic team does much to inculcate self-respect.

12. *Integration into Society.* This can be achieved by encouraging the patient to find his place in the patient community through group activities, of which most important are sport and recreation. Group therapy for patients with similar problems also helps to strengthen fellow-feeling.

Moreover, Tara has its social club, which is open to all ex-Tara patients and there are regular evening meetings in town to which selected patients from Tara are taken to mingle with the members. Membership of this club entitles

one to use the amenities of Tara during week-ends and holidays.

At our Y.M.C.A. canteen (Fig 35) the patients may purchase requisites at approximately cost and can entertain their visitors.

To further the work of social integration the social worker keeps the doctor informed about the patient's work and his domestic and social life.

13. *Rehabilitation.* I define this as 'the optimum restoration to the patient's normal physical, mental, social and economic standards.' This is the ultimate goal (Fig. 36) of all our work. The psychologist and the social worker with the help of the Department of Labour can, if necessary, find suitable employment.

In recent times sex determination has become an important factor in the process of rehabilitation. It has received much publicity in the press and it is no longer enough to decide whether one is man or mouse. Tara seems to be the ideal place for the treatment of problems arising from sex diversities.

Fig 1. Administration confers with representatives of the therapeutic team.
Fig. 2. Tara Hospital is in Hurlingham, a quiet, select northern suburb on the outskirts of Johannesburg. It covers an area of 61 acres, 34 of which have been developed.
Fig. 3. A patient guide shows a new patient the mobile post office.
Fig. 4. Scene on 9-hole golf course.
Fig. 5. Patients watch a play produced and acted by fellow patients.
Fig. 6. The Medical Superintendent and certain members of the team listen to propositions from patients to improve their welfare at Tara.
Fig. 7. The ward representatives meeting, a doctor and nursing staff being present.
Fig. 8. The doctor meets all members of the team.
Fig. 9. Soft crafts showing felt work and embroidery. Females fill this section, which is most socializing. Note the finished articles.
Fig. 10. Hammering away aggressions at metal work promotes concentration. A number of females have worked here. Note the specimens.
Fig. 11. Sawing at carpentry requires concentration. Exhibits are shown.
Fig. 12. Pummelling clay, one of the best outlets for suppressed emotions.
Fig. 13. Weaving, usually sedative. The colours and patterns stimulate interest. Mixed groups. Product are shown.
Fig. 14. Basketry, mainly used for relaxation, is very sociable. Leather work aids concentration. Embossing and painting induce interest. Mixed groups. Note the samples.
Fig. 15. A female class at relaxation.
Fig. 16. Art therapy must be done in a quiet atmosphere. The doctor listens to patients' interpretations of drawings, which assist in diagnosis.
Fig. 17. Music room. A patient plays the piano.
Fig. 18. Part of dining room. Note the light, clean conditions. Waiters are correctly attired.
Fig. 19. A female group square dancing while a part-time pianist plays.
Fig. 20. A portion of the library. Patients' duties are to assist the librarian.
Fig. 21. The snooker room is very socializing. Mainly males. Concentration is essential.
Fig. 22. Telephone duties are taken on by females. Messages are written on the board. This restores confidence.
Fig. 23. Part of equipment room. Note the completeness; also the cups and trophies.
Fig. 24. Cricket (for the younger males) assists concentration.
Fig. 25. Hockey. Our patients are divided into 2 main sides—yellow (*The Tigers*) and red (*The Lions*)—to stimulate the competitive spirit. Note the mixed group.
Fig. 26. Softball is a good outlet for suppressions, socializing for team and spectators. Mixed group, with a wide range of ages.
Fig. 27. Concentration is essential in archery. Mixed group. Less active, e.g. wheel-chair patients.
Fig. 28. Croquet is socializing for the less active (mainly females).
Fig. 29. Tennis on one of the 4 courts for a physically fit mixed group.
Fig. 30. Tenniquoits (mixed group) maintains concentration.

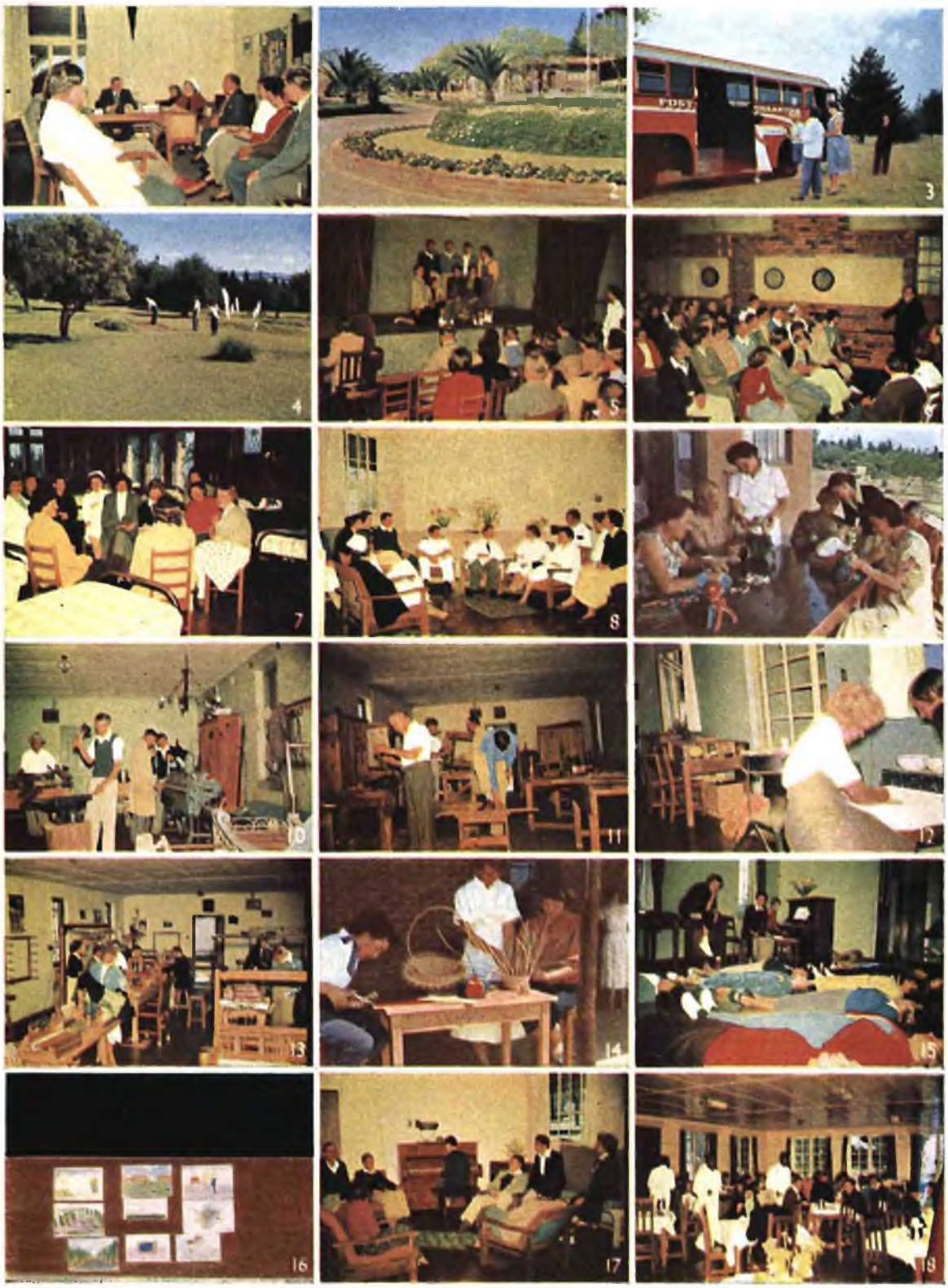

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Fig. 31. Bowls. This shows one of our two regulation size greens. It is most socializing and relaxing. Mixed groups.
Fig. 32. Swimming bath (17 ft. × 37 ft.), mixed groups. Socializing and stimulative.
Fig. 33. A recreation committee meeting. All the representatives of the patient community are present with member of team.
Fig. 34. The dining room representative hands serviettes to new patients, conducts them to their tables and introduces them.
Fig. 35. The Y.M.C.A. canteen where patients entertain visitors.
Fig. 36. A rehabilitated patient escorts a new patient to town and is responsible for him until he returns.

The Occupational Therapist. The occupational therapist is a properly trained and fully qualified person. It is by no means essential for her to be an expert on crafts. It is far more important that she has an awareness of people, knows how to handle them and how to foster good inter-personal relationships. She should be a good teacher and observer, able to adapt the selected craft to the patient's requirements and be ready and able to draw up adequate reports.

The patient is persuaded and not coerced into taking part in some activity at Tara. Thus the greater the scope the easier it is to cope; and amongst the amenities Tara has to offer, some activity that appeals to the patient can always be found. We do not want to know what occupational therapy the patient is doing, but what occupational therapy is doing for the patient. (The Society representing the occupational therapist is a new body which is growing rapidly and will no doubt play a great part in the future).

The much proclaimed benefits of modern civilization are to a considerable extent offset by a more intensified competitive spirit and by the increased strain of everyday life. The rise in the cost of living, war, the threat of war and its aftermath, the insecurity often attendant on longevity and the entrance of women into nearly all walks of life are some of the factors which help to fill the wards of such institutions as Tara.

It was Galen who said: 'Occupation is Nature's best physician.' A modern sequel of this dictum could well read: 'Occupational therapy is Nature's best medicine.'

SUMMARY.

1. The psychiatric patient requires 24 hours' daily observation for diagnosis and therapy.
2. The doctor's time is limited and he therefore requires assistance from the diagnostic and therapeutic team.
3. The type of patient admitted to Tara and his introduction to the hospital routine is outlined.
4. The physiotherapeutic angle is described.
5. Occupational therapy is defined, as is our concept that it consists not merely of crafts but the wider field embracing group activity and group participation of all kinds necessary to resocialize the patient to face his daily problems in the outside world.
6. The role of the occupational therapist is indicated.

OPSOMMING.

1. Vir diagnose en terapie is dit noodsaaklik om die psigiatriese pasiënt 24 uur per dag waar te neem.
2. Die geneesheer se tyd is beperk, en hy het derhalwe die hulp van die diagnostiese en terapeutiese span nodig.
3. 'n Beskrywing word verstrek van die tipe pasiënt wat tot Tara toegelaat word, en sy voorstelling aan die hospitaalroetine word kortliks beskryf.
4. Die fisioterapeutiese sy van die saak word bespreek.
5. Arbeidsterapie word omskryf. So ook ons opvatting dat dit nie bloot uit hulpkunste bestaan nie, maar ook uit die breër aspekte, insluitende groepbedrywigheid en al die verskillende soorte groepbedrywigheid en al die verskillende

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BRANCH NEWS

Miss Lovely, of the staff of Addington Hospital, Durban, is at present on leave in England. Meanwhile, Mrs. P. Pilkington and Mrs. Greenway have taken up posts at Addington.

The members of the Natal and Zululand Branch offer their condolences to Miss Cherrington (Addington Hospital), on the occasion of the death of her father, who died on August 28th after a long illness.

Miss Coreen Knox-Perkins (Addington Hospital) is on a trip to visit friends in the U.S.A.

Mr. A. D. Moig has taken up a post at Edendale Hospital, Pietermaritzburg.

Miss J. Thomas-Davies, from the United Kingdom, and Miss J. Roberts, from New Zealand, have joined the staff of the King Edward VIII Hospital, Durban.

NORTHERN CAPE BRANCH NOTES

Members are delighted to hear that Miss D. Tredrea returns to S.A. in September after successful eye operations in London.

News of Mr. E. J. Nicholson is that he has been appointed to the Rehabilitation Orthopaedic Hospital, Stanmore, England.

The Helen Bishop Orthopaedic After-Care Home is at present without a permanent Physiotherapist. Miss Setzer and Mrs. Yeowart are doing part time work there to help bridge the gap a little.

WESTERN PROVINCE BRANCH

We wish Mr. MacMurray well in his new office as Examiner to the Royal College of Surgeons. He has always been a good friend to Physiotherapists.

Mr. Hodges has left a well functioning workshop in Cape Town and has gone to Rhodesia to bring to that community his able help in the shape of Taylor's Braces, Gorman Springs and Camp Corsets, etc. He was a tonic to know and he made it his business to be *au fait* with the latest trends from overseas.

Mr. Bill Woodgate. We wish happiness in his new post at the Lady Michael's Orthopaedic Home, Plumstead.

Mrs. Sweet. We wish her joy in her new home at Tokai.

Miss J. Goldman. We trust her semi-retirement is happy and with the better weather we hope to see more of her.

Mr. K. Nicol. Ii is no longer necessary to read Prof. Spock, as he has gained a wealth of experience looking after Junior whilst Mrs. Nicol was overseas.

Our General Meeting on July 22nd with Miss J. Blair as guest speaker was a pleasure. We were able to learn at first hand what C.E.C. were doing for us. It is a pity there cannot be more migration and interchange of Physiotherapists.

Change of address:

Mrs. E. Myer, 7 Oakley Court, Protea Rd., Claremont.

SOUTHERN TRANSVAAL BRANCH NEWS

On July 12th, Dr. Jack Gear gave the branch a very stimulating and interesting talk on "Some Pitfalls in the Evaluation and Medical Treatment". The talk was thoroughly enjoyed by all members present.

A Film evening was held on August 21st. A disappointingly small audience saw three very good films. Two of which were of general interest and one of "Short-wave Technique."

MARRIAGES

Miss S. Levitt to Mr. J. Halpern, August 5th, 1956.

Miss Eileen Booth — Medway. Mrs. Medway is still at Wynberg Hospital.

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It was only possible to attend about a quarter of the lectures. The complete proceedings are to be published in January so that you will be able to read them then. One of the most helpful and stimulating lectures discussed the method of using "tonic neck reflex" in the treatment of hemiplegia.

Amongst the tips that I picked up was glosso-pharygeal breathing or frog breathing. Patients with respiratory paralysis are taught to "gulp" air into the lungs, so that they become filled after 10 "gulps" and therefore can build up their vital capacity.

In conclusion I must say how much I enjoyed the conference and how grateful I am that I had the opportunity to attend it as the representative of the South African Society of Physiotherapy. Let us do everything in our power to see that South Africa is fully represented at the next World Confederation in Paris.

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soorte groepdeelneming wat nodig is om die pasiënt opnuut te sosialiseer sodat hy sy daaglikse probleme in die buitewêreld weereens die hoof kan bied.

6. Die rol van die arbeidsterapeut word aangedui.

The colour photographs (Figs. 1—36) were taken by the author and they show the various activities of the Physical Medicine Department.

I wish to thank Dr. H. Moross, Medical Superintendent of Tara, for his very kind advice and co-operation in making this presentation possible.