

## Shock Doc

DAVID S. GOLDBLOOM

Monday morning, 0745h. I arrive at the electroconvulsive therapy (ECT; “shock”) suite of my hospital to prepare for my regular shift on Canada’s busiest ECT service where, five days per week, 10-20 patients each morning receive treatment. The anesthetist is drawing up syringes of methohexital and succinylcholine, three nurses are readying the recovery room and preparing electrodes and monitoring equipment, and a small group of patients sits in the waiting room, chatting and reading.

It is 2010. Over the last thirty years, various “decade of the brain” announcements have been made to herald neuroscience advances and several generations of new antidepressants and antipsychotics have been launched. Clinical practice guidelines have been promulgated, and for the treatment of severe mood disorders any number of combination drug therapies is recommended prior to ECT, although sometimes ECT is recommended “when the rapid relief of symptoms is required”. This has always struck me as odd; why would the slow relief of symptoms be preferred?

ECT was first introduced to the world in Rome in 1938. It heralded the beginning of the enduring biological treatments in psychiatry, preceding lithium by a decade, the antipsychotics by 15 years, and the antidepressants by almost 20 years. Despite the advances in therapeutics, ECT remains a mainstay of help for severe psychiatric illness.

My first exposure to ECT as a junior resident in psychiatry in 1981 was memorable – as it is for many medical students and residents. I saw a woman restored from a catatonic depression to a warm, pleasant, interactive adult in the wake of 6 ECTs, or about 3 minutes’ worth of induced seizure activity and its sequelae. While ECT disturbs and even erodes memory in its recipients, it ingrains and intensifies memory in its observers. Over the last 25 years, when I ask medical students which patients they remember best during their inpatient rotations, they often cite those who received ECT because the changes were so dramatic.

Like many others in our profession, I eagerly awaited the release of new antidepressants and the manualization of new forms of brief psychotherapy that offered new hope for our patients. And I have seen the benefits. But almost 30 years after I first observed ECT, I find myself among the small group of physicians at our hospital who form the ECT service, providing consultation and treatment. And when my Monday shift ends at 11 a.m., having treated 18 patients in three hours, I find myself in a utilitarian calculus wondering whether this is the most good per minute that I will do clinically all week.

Friends, and even professional colleagues, are “shocked” that the treatment is still given and that I would choose to be giving it. The Ontario Coalition to Stop Electroshock had a list of bad doctors who administer ECT. In Ontario in 2010, a New Democratic Party member of the provincial parliament recently introduced a private member’s bill to have ECT de-listed from public health insurance, likening it to cosmetic surgery that people could choose to have but should pay for.

What’s the problem with ECT? First there is the perception problem. For better or

*ECT is recommended “when the rapid relief of symptoms is required”. This has always struck me as odd; why would the slow relief of symptoms be preferred?*

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# Welcome to the autumn 2010 edition of Synergy.

**S**ynergy has been redesigned both in layout and in content. The visual design has been updated to make the content readable – more white space, clean fonts – and to reflect the kind of content we plan to publish – good prose, current topics in psychiatry, and ideas presented with vigour.

Our essays will remain scholarly in outlook but not in number of footnotes. We plan to continue to publish authors from Kingston and Eastern Ontario but will also reach farther in order to draw the best writing.

Good writing will be our priority. Carl Elliott, physician and bioethicist, has written about the practice of ghostwriting within academic medicine – when an anonymous writer actually composes the scientific paper to which multiple authors then assign their names for publication. He writes: “In the culture of academic medicine, accepting credit for a ghosted journal article is not seen as a serious ethical failing, simply because the skill of writing is not seen as a valuable intellectual talent.”<sup>1</sup> The authors who attach their names to the articles we publish will actually be the prose stylists themselves. We take writing seriously.

Our lead article examines electroconvulsive therapy in both its current and historical contexts. It reflects the type of articles we plan to publish. The essay is current (and even controversial, although this is not required), it has a point-of-view, and it is scholarly in its thoughtfulness but not its format.

Our other articles include a reflection on the use of titles in medicine as well as the first of a proposed regular column: a brief explanation of a psychiatric symptom – “phenomenology” is the technical term for this field – meant to be useful to the non-psychiatrist. Finally, the back pages of the current issue go to “African Journal”; these will be occasional pieces, likely personal, which examine transcultural psychiatry.

We remain a print journal, we never were a peer-reviewed journal (but, hopefully, a well-edited one), and we strive to be one worth reading front-to-back.

<sup>1</sup> Elliott, Carl. *White Coat, Black Hat: Adventures on the Dark Side of Medicine*. (Boston, 2010), p. 33.

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## SYNERGY SUBMISSION GUIDELINES

*Synergy* invites submissions from members of the mental health community in Southeastern Ontario and beyond. We encourage articles on current topics in psychiatry. Our essays are scholarly in outlook but not number of footnotes. We strive to publish good prose and ideas presented with vigour. Articles range from 500 – 1000 words. Longer articles may be accepted.

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Articles may be submitted in the form of a Microsoft Word document as an email attachment.

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worse, throughout medicine the *lingua franca* of therapeutic exchange between doctor and patient relies heavily on the prescription pad and its patina of science. In precise milligrams, medications are given with scientific explanations of how they might work. Of course, until that anticipated moment when we understand the etiology of any disease, we cannot say how their treatments work; at best we can say what they do, without knowing whether that observed action accounts for the therapeutic effect. We are on more firm footing when we quote science that says treatments do work, even when we don't know how. Therapeutics in medicine has always leapfrogged ahead of etiological understanding.

So the first problem with ECT is that it is not a pill. People would gladly swallow any number of unvalidated, unregulated concoctions before contemplating ECT. The second problem is an increasingly historical cultural context: the depiction of ECT in the 1975 film *One Flew Over The Cuckoo's Nest*. This memorable movie, increasingly unknown to young people today, shaped perception of ECT for a generation.

Whenever I discuss ECT with patients, I ask if they've seen the movie. If they have, I remind them of several essential differences between it and real life with regard to ECT:

1. Jack Nicholson's character, Randle McMurphy, does not have a mental illness; rather, he is purposely hiding out in an asylum.
2. When ECT is ordered for him, it is not as treatment but ostensibly as punishment for bad behaviour.
3. When ECT is administered to him, there is no general anesthetic or muscle relaxant; instead, several burly men in white hold him down as he has an unmodified grand mal seizure.
4. Following treatment (and subsequent psychosurgery), he is a dazed and empty shell, with all humour, invention and charm depleted.

None of these pertain to the administration of ECT in the 21<sup>st</sup> century – except for the anti-psychiatry movement's belief that

psychiatry's biological treatments in general and ECT in particular represent social control and assault.

Many of our patients receiving ECT do so as outpatients, coming to the hospital three times per week for an acute course or as little as once per month for maintenance treatment. For some of them, this minor intrusion on their schedules and functioning is preferable to the daily side-effects of medications.

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But like all treatments throughout medicine, the side-effects are both present and variable. There is no single set of experiences for ECT. Like all treatments, it doesn't work for everybody and the disappointment of treatment failure is shared by patients and their doctors. Many patients dread general anesthesia for its sense of loss of control, and the few patients who experience the temporary diaphragmatic paralysis of succinylcholine prior to full barbiturate sedation describe it as a terrifying experience. The headaches and temporomandibular muscular pain, particularly in the first few treatments, can be difficult.

The big problem, however, is the memory disruption. For most people, the disturbances are in the access/retrieval aspects of memory, but it is also not uncommon – and socially embarrassing – to lose completely select recent and remote memories (as opposed to the "I can't recall anything of my life before age 27" claims). As defensive practitioners, we have often minimized the occurrence of this or attributed it entirely to the erosive effects of depression itself on memory. This is wrong. Interestingly, when people have radiation and chemotherapy for malignancy, the enduring side-effects can be legion – but they are accepted because **it's cancer; it could**

**be fatal.** Severe depression can be a fatal illness as well, but its lack of legitimacy in public perception extends to the treatments that are proven to relieve it. The medical error literature has taught us that the more candid and direct we are about mistakes, the more patients are willing to accept them. We need to be equally candid in advance about side-effects, helping patients assess the risk/benefit ratio for any proposed treatment.

That being said, when patients ask me what the chances are a treatment such as ECT will help them, I can offer them the persuasive efficacy data as well as the reality that no drug in the last 50 years has been demonstrated to be superior to it. However, I remind them as well of a more personal calculus – that if the treatment works for them, it's a 100% response and if it doesn't, it's a 0% response; the fact that it helps 70-80% of other people will feel like cold comfort.

In the ECT suite, as the patient lies on the table awaiting the sharp prick of the anesthetist's needle, there are a few moments to talk about how the treatment is going, to rest a hand on the patient's shoulder as simple physical comfort while the vein is pierced. From the moment the anesthetic and then the muscle relaxant are administered, at most a minute follows before the electrical stimulus is applied. Within a second, a tonic-clonic grand mal seizure follows, typically lasting 20-40 seconds, and most often manifested by the flapping movements of the toes. It ends spontaneously, and about one minute after that, the patient resumes breathing and starts to wake up. For observing students from the health professions (as long as they don't faint from watching their first anesthesia induction, a distracting thunk as they slide to the floor), their typical response is, "that's it?" Their anticipation mirrors societal perception. Similarly, as I visit patients in the recovery room post-ECT, they often ask if they've had the treatment, a reflection of both the anesthesia and the amnesia that ECT induces.

Our ECT service is now housed within our Brain Stimulation Program. Newer

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techniques such as rapid transcranial magnetic stimulation (rTMS) offer hope for symptom relief without anesthesia or seizure induction. More invasively, other centres offer deep brain stimulation via electrodes implanted neurosurgically in patients with severe, treatment-resistant depression. But for now, the value of ECT has not been supplanted by any other brain stimulation techniques or by any pills.

Two final ironies:

1. There is an entire literature on treatment-resistant (meaning generally drug-resistant) depression and therapeutic approaches to it. ECT has a high response rate within psychiatry and within medicine in general. Is it legitimate to call depression treatment-resistant prior to a trial of ECT?
2. Psychiatry residents are often scarce on ECT services and two national surveys in which I have been involved (1, 2) illustrate the high variability of training in ECT across our residency programs in Canada. Can we imagine a cardiology

training program where residents viewed as optional the need to be comfortable with the theory, technique, and skills of cardioversion, saying they planned to treat only people with mild congestive failure and hypertension?

When people who have had ECT come forward to talk about their experiences (3-6)

positively, it provides tremendous hope for others contemplating the treatment – and is often of more value than wads of scientific data on its efficacy. But it takes courage to do so, because the treatment – as well as the people who have it and the people who give it – is still shunned despite the help it provides.

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# Doctors without Orders

JONATHAN GRAY

"Jonathan Gray here."

This is the friendly way I introduced myself to staff and patients as a resident, and even later as a staff psychiatrist. My rationale was that I was going to be different from the stereotype of the aloof physician who becomes angry when not referred to as "doctor". Psychiatrists, I sensed, were paranoid that their colleagues in other fields did not respect their area as "real" medicine, so they were all the more insistent on their well-earned titles. I, on the other hand, was going to follow the trend to narrow the distance between physicians and other members of the multidisciplinary "team", and between physicians and their "clients".

I didn't want to lord over the nursing staff or the patients, to flaunt my academic credentials at every turn. Just as a new wife has a hard time being the namesake of her mother-in-law, so I couldn't quite feel comfortable in the stiff, starched lab coat-ish name "Dr. Gray". I stuck to plain old "Jonathan Gray" – a name as cozy and comfy as an old sweatshirt from high school. As an added bonus to the warm familiarity of the name, it also lent me an air of profound humility of which I was justly proud. I didn't have to make out that just because I had a medical degree and years of specialist training in my field I was somehow *better* than anyone else. Why, most of the nurses had far more experience with dealing with the patients than I did. I was happy to share my concerns with them and invite their suggestions, input, and advice.

In the end, the approach I adopted did little to make relations between different disciplines better. I thought the nurses and other allied professionals would prefer to see barriers eradicated. Instead, they felt uncomfortable with a physician seemingly trying to evade his role. Why should they be made to feel responsible for making decisions they weren't being paid to make? Making those decisions was my job. Why was I so reluctant to take it on?

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In retrospect, I wonder if I was not thereby trying to evade my own obligations as a doctor. Perhaps as a newly qualified doctor I was not yet ready to shoulder the enormous responsibility of making major decisions that affected the lives of real people. Maybe it was not so much the humility that drove my casualness, rather simply the fear of facing up to what was expected of me. It's harder to blame a "Jonathan" or a "Jennifer" if things go wrong. People sue doctors; they don't sue Sues.

Those people who are truly modest do not debase themselves and try to project an image of incompetence. Rather, they are acutely aware of where their talents lie and work to use them to help others. The humble physician knows the limits of his knowledge and is willing to seek outside help when he is forced to go beyond them. Insofar as there is a hierarchy in medicine – a certain respect that is accorded to doctors – it is there to help the patients feel able to put their trust in us as we make important decisions about their health and treatment. There is no place for ego here, whether it is the ego that wants to prove itself great or the ego that wants to prove itself humble. The authority a doctor assumes when he takes on the appellation "doctor" is the respect in our profession as a whole. Therefore it is incumbent on every young doctor to take on this formal role, however stiff and uncomfortable it may seem at first, and to the best of his abilities to live up to the title.

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## THE LANGUAGE OF PSYCHIATRY

### Delusions

If I am forever describing the porterhouse with truffles at a certain restaurant in Tribeca, I am just a snob. A steak supper in New York City is all that really happened. However, precision in language is not always a result of pretention. I tell my friends I broke my arm playing hockey, but I tell other physicians that I broke my distal radius, not because I want to insult my friends' intelligence or because I want to traffic in technical jargon with other doctors, but simply because I want to be precise when appropriate.

Medical language is rich in Latinate phrases (*status epilepticus*), food allusions (blueberry muffin baby, chocolate cyst), and eponyms (Smith fracture, Capgras Syndrome). Some terms are of little but historical use, but many serve to describe symptoms and diseases with precision: *Status Epilepticus* denotes diagnosis, urgency, and prognosis all in one splendid fusion of Greek and Latin.

The language of psychiatry should not be foreign to other physicians. It is not different in quality from the accurate and useful language all doctors use to describe signs, symptoms, and disorders. Its vocabulary may be larger and the symptoms described sometimes bizarre; nevertheless, the meanings of common psychiatric terms must be familiar to all physicians so that, at the very least, we can communicate in consultation letters. It is as basic and necessary as pointing to the clavical or finding the carotid pulse.

All delusions are paranoid delusions. Therefore, they are also all grandiose delusions.

The late American historian Richard Hofstadter in a seminal essay in 1964 entitled "The Paranoid Style in American Politics" defined *paranoid* as "heated exaggeration, suspiciousness, and conspiratorial fantasy".<sup>1</sup> At least he conceded that he was "borrowing a clinical term for other purposes", because this is not the definition psychiatrists use. His use of the word does illustrate, though, how often psychiatric terms are used by the layperson for other purposes. "I am depressed" in no way means the speaker suffers from Major Depressive Disorder. "I felt schizophrenic" has come to mean something like "I was of two minds". "He was delirious" usually means he was noticeably happy. We must continue to reclaim the clinical meanings of these terms in order to say what we mean and to avoid stigmatizing our patients by imprecision and layers of connotation.

*Paranoid* in psychiatry means "self-referent".<sup>2</sup> "The man who is paranoid may think that events on his way to work are not coincidences but are overly self-referent: the beige car that cuts him off has significance

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beyond its common colour and the fact that bad drivers are everywhere at rush-hour. Its swerving means something about *him*.

Persecutory delusions are certainly paranoid delusions. Grandiose delusions are also paranoid delusions according to this definition. The manic woman who believes she has special knowledge about the universe has delusions that are strikingly self-referential. And the reverse is true as well: paranoid delusions are grandiose. It is surely a little grandiose to believe that the CIA is deeply interested in me specifically, despite my humble lifestyle and lack of espionage work.

But the CIA actually is after some people. What then is a delusion?

It is usually defined as a fixed, false belief out of keeping with one's cultural or religious context. First, it is false. As a psychiatrist, I must ensure that I am satisfied that the CIA is not after my patient, or at least to the extent he believes, before I label delusions. It is fixed, unshakable. Despite all evidence to the contrary, he still believes the CIA has infiltrated his home. It is out of keeping with his cultural background. While worries that undue power is in the hands of government agencies are common, beliefs that one's neighbours are all spies are not.

Delusions may seem very different from other beliefs but they are quite subjectively similar. I can believe that I am both a doctor and that the CIA is controlling me by means of a chip in my brain. I can hold both beliefs with unshakable conviction – and at the same time – but one is true and one false. In the next moment, I can imagine myself a Formula One driver with no problem realizing this is pure fantasy. "A delusion is much closer to a true belief than imagination."<sup>iii</sup>

How can the man who truly believes that all the resources of Central Intelligence are pursuing him calmly sip coffee in the hospital cafeteria day after day? Perhaps his delusions are partially treated. Perhaps the meaning he attaches to his delusions allows for this behaviour. After all, many non-delusional religious persons believe in the imminent enactment of cosmic events or that eternal punishment is meted-out based on present behaviour, and yet live lives of seemingly cosmic obliviousness. Hofstadter, when describing the American paranoid political style, did get it right when he wrote that "the paranoid seems to have little expectation of actually convincing a hostile world, but he can accumulate evidence in order to protect his cherished convictions from it". Sometimes the psychiatrically paranoid seem to have this mixture of conviction and nonchalance, too.

It is important, however, for clinicians to take delusions seriously. Delusional patients describe their ideas as true not as fantasy. Further beliefs or actions following logically from the firmly-held delusions must be explored. If my patient thinks his neighbour is a double-agent, my patient

may be able to sit calmly on his porch day after day waving pleasantly to the mole, or he might call the police, or he might be too scared to call 911 and try to silence the traitor himself, or he might kill himself in an attempt to remove the chip from his brain. I can't simply assume any of these will follow from his delusion.

Persecutory, grandiose, religious, nihilistic – delusions come prefaced with many adjectives. They can be present in Schizophrenia, Major Depressive Episodes, Mania, Dementia, Substance Intoxication and Withdrawal, and Delusional Disorder itself. They are sometimes bizarre, sometimes banal. They are not necessarily present in one's political opponents or enemies. And they certainly aren't necessarily present in the mentally ill. They are specific symptoms, part of a patient's thought content awaiting description and heralding diagnosis, urgency, prognosis, and treatment.

A broken collarbone is descriptive, but a compound fracture of the distal clavicle means a great deal more.

*For a fictional treatment of this topic read Ian McEwan's great 1997 novel, Enduring Love.*

<sup>i</sup> Hofstadter, Richard. "The Paranoid Style in American Politics." *Harper's Magazine*, November 1964.

<sup>ii</sup> Sims, Andrew. *Symptoms in the Mind*. 3<sup>rd</sup> ed. (Philadelphia, 2003), 144.

<sup>iii</sup> Sims, 117.

DEPARTMENT OF PSYCHIATRY

QUEEN'S UNIVERSITY AND AFFILIATED PARTNERS

COLLABORATIVE MENTAL HEALTH CARE

# "In *The LOOP*"

## "Learning Opportunities on Partnership"

Mental health care is best provided with the patient as full partner in their care and with the acknowledgement that no one discipline can facilitate care and healing.  
*Collaborative Care Model Working Group, 2010.*

The Collaborative Care Sub-Working Group E-learning webinar series on Collaborative Care was attended by many members in the Department of Psychiatry, and clinicians from Community and Primary Care settings.

Teaching and learning by webinars has sparked interest and ignited requests for a new **Fall 2010 – Spring 2011 Webinar Education Series**. The series will include topics on child/adolescent psychiatry, psychopharmacology, and others. For more information, please go to the Department of Psychiatry website:

**<http://psychiatry.queensu.ca/page.asp?id=76&tab=about>**

An **Interprofessional Collaborative Mental Health Care Education Curriculum** is in development and the goal is to pilot it in late fall 2010. Drs. Ken Le Clair and Joe Burley are co-leading the education initiative with Psychiatry Resident, V. J. Parmar.

A virtual advisory working group has been formed with representation from various disciplines and healthcare sectors. Lara Hazelton and Raylene MacDonald from Dalhousie University, and Nick Kates, McMaster University, are all working in partnership.

If you wish to learn more about this initiative, please contact Linda Robb Blenderman, Project Coordinator ([blenderman@cogeco.ca](mailto:blenderman@cogeco.ca)) or Mary Andrews, Project Administrative Assistant ([andrewm1@providencecare.ca](mailto:andrewm1@providencecare.ca)).

*Archiving* the presentations has begun, but there is still much work to be done. In the meantime, the **Spring 2010 Webinar Education Series** is available on the Department of Psychiatry website: **<http://psychiatry.queensu.ca/page.asp?id=76&tab=about>**

Bringing Research to Interprofessional Collaborative Mental Health Practice (June 2010)

Changing Culture with Interprofessional Education (April 2010)

Interprofessional Collaborative Mental Health Care in the Clinical Setting (March 2010)

If you want further information, or if you wish to submit a brief article on collaborative care, please contact Mary Andrews, Project Administrative Assistant ([andrewm1@providencecare.ca](mailto:andrewm1@providencecare.ca)).

DEPARTMENT OF PSYCHIATRY  
INTERPROFESSIONAL COLLABORATIVE MENTAL HEALTH CARE  
RESOURCES

## Frameworks:

National Interprofessional Competency Framework:

**[www.cihc.ca/resources/publications](http://www.cihc.ca/resources/publications)**

B.C. Competency Framework for Interprofessional Collaboration:

**[www.chd.ubc.ca/resources-publications?q=teaching-learning/competency/bc-framework-interprofessional](http://www.chd.ubc.ca/resources-publications?q=teaching-learning/competency/bc-framework-interprofessional)**

Ontario's Chronic Disease Prevention Model Framework:

**[www.health.gov.on.ca/english/providers/program/cdpm/index.html#1](http://www.health.gov.on.ca/english/providers/program/cdpm/index.html#1)**

## Mentoring Toolkits:

The Interprofessional Mentoring, Preceptorship, Leadership, and Coaching Super Toolkit:

**[www.ipe.utoronto.ca/initiatives/ipc/implc/supertoolkit.html](http://www.ipe.utoronto.ca/initiatives/ipc/implc/supertoolkit.html)**

## Implementation Tools and Toolkits:

Canadian Collaborative Mental Health Care Initiative Toolkits:

**[www.ccmhi.ca/en/products/index.html](http://www.ccmhi.ca/en/products/index.html)**

On this site there are a variety of tools for implementing collaborative mental health care in primary care settings, and toolkits for consumers, families, caregivers, providers, policy makers, and educators.

## Integrating Family Medicine and Pharmacy to Advance Primary Care Therapeutics:

**[www.impactteam.info/impactHome.php](http://www.impactteam.info/impactHome.php)**

Provincial Mental Health and Addictions Strategy:

**[www.ofcmhap.on.ca/node/459](http://www.ofcmhap.on.ca/node/459)**

Shared Care, Collaborative Mental Health Care:

**[www.shared-care.ca](http://www.shared-care.ca)**



## A Tale of Two Women ERIC PROST

The psychiatrist's craft is well-suited to the 21<sup>st</sup>-century. This is not because more and more of the citizenry of the West are living longer and will thus need expert medical care for their dementing brains; nor is it because life is getting more and more complicated and stressful and thus the overworked and under-recognized will increasingly flee to professionals to shore up their mental health. It is not even because neuroscience is advancing rapidly, or because the mentally ill, along with the worried, the bereaved, and the criminal are now directed to psychiatrists rather than to priests, family members, and magistrates. Psychiatry is prepared for the early 21<sup>st</sup>-century because it prepared well for the early 20<sup>th</sup>: without new technology, its practitioners observe intently, listen empathically, and are, by necessity, able to synthesize enormous quantities of information to discern what is valuable for diagnosis and treatment.

The world's total noise is undoubtedly growing. Even while I sit writing at a bar in Uganda's capital, Kampala, three television screens broadcasting three different channels flash in my peripheral vision. The second one shows CNN which, apart from a split screen

with two commentators, is busied with two corporate logos, a title and sub-title, and a news update along the bottom irrelevant to the main story, as well as a reminder to visit cnn.com. And all this "noise" assaults me despite all three TVs being muted. If I were to attempt to sign on to the website, apart from the connection problems I always encounter in Africa, I would face the problem of deciding where to look, what to click on, and what cyber path to follow, likely never to return to the original site to pursue any of the topics that first piqued my interest and were ultimately more wholesome

*No needle was hidden in the total noise of a life-story;  
instead, there was a pitchfork stuck in the ground in front  
of the haystack, her feminine innocence impaled on it.*

than why a minor celebrity violated her probation.

All of my patients here in Uganda are African and many of them female, but two young women stood out this week. The first was 21 and, coming into the clinic, promptly kneeled to formally and deferentially request my help, the child on her back asleep and immobile during the genuflection, his two-year-old head pressed tightly at right angles to her body, the soles of his feet protruding into the interview just above each hip as she seated herself to face me. She wore a turban of venous red and, despite bowing to her doctor, kept direct eye contact during the visit and spoke English. She had come to Mulago Hospital from the far side of Kampala that morning the same way she had come from Congo one year before – on foot with her only child swaddled and bound to her. The boy who was silent and invisible save for the feet presenting themselves to me as I listened had not always been an only-child. Nor had he always been fatherless or his mother a widow.

"After they killed the others, they raped me," she said, and paused. Then she added, rather loudly I thought, "Front and back."

Why speak quietly? Why shut the door on such an interview? Was anything left for her to lose? Husband, daughter, home, country, dignity, innocence. That was enough. I handed her a tissue, which was, as it always is at Mulago, a length of toilet paper torn from a roll which sits upright and unashamed beside the calendar and blood pressure cuff on my desk.

Treatment for posttraumatic stress disorder over the previous two months had helped little and she still feared that soldiers were attempting to kill her even in the relative safety of Kampala. She needed more intensive treatment and a safe environment, let alone suf-

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ficient sleep, food for her and her toddler, and new shoes. I found 2000 shillings in the pocket of my lab coat for bus fare to the psychiatric hospital and wrote a referral letter to its inpatient ward.

The facts of her story would have punched their way through all the damp cardboard and tangled wrappings that the typical tangential and circumstantial mind uses to encase the truth. Her experiences in Eastern Congo would have been as obvious and as abhorrent even if packaged in the usual misleading boxes and tied tightly with string, for any psychiatrist would have seen movement within and known just what to ask to be allowed a peek, and then a gape, inside. But she exhibited her truth, her symptoms, while clear-eyed, and delivered her plea, expressing her very appropriate needs, in direct and limpid English while her only son slept on her back. She needed the psychiatrist's empathy and advocacy, but his skill in distinguishing the important from the unimportant in her presentation was never used: no needle was hidden in the total noise of a life-story; instead, there was a pitchfork stuck in the ground in front of the haystack, her feminine innocence impaled on it.

Most Canadian patients are talkative during the psychiatric interview. Some are depressed and have a paucity of both thought and speech, but most just talk. The clinician needs to direct and redirect, ask questions multiple times, rephrase, and outright interrupt. Ugandan patients, unless exhibiting symptoms of mania, are more reticent, give shorter answers, and even speak in quiet tones. But they still begin – or their accompanying family member begins – with a story, one which may be, more often than not, long, mostly irrelevant, and, as an African twist, contain no reference to chronology. Even with interruptions and enunciated questions about what happened when and what happened before the other thing, the timeline is still usually more of a dotted line than a sequential narrative. Simple questions like,

"Did the shaking start *after* you began your tablets?" are taken as cues to explain more about tremors or medication than they are as direct inquiries about cause and effect and thus about the timing of events.

The second woman was in her early thirties and three months pregnant. She attended with her uncle, who provided the initial (and subsequent) narrative stream, albeit one which did not flow from the continental divide to the sea, but rather meandered, serpentine, through the hillocks of his niece's distress, sometimes flowing east, sometimes west, but never drying up. Her complaints were vague: headaches, neck pain, memory problems, "loss of power". I have learned that the Ugandan English phrase, "... then I lost power," has connotations less about low energy or even weakness (and certainly none about any human equivalents to quite sudden and discouraging sputtering noises an engine might make on a cold Canadian morning) than about drowsiness and sedation. I had particular difficulty eliciting clarity concerning her memory: was it a deficit of immediate recall, did she ever get lost in her village, could she cook over a charcoal stove safely and follow sequences in preparing local stewed bananas?

What this young Ugandan mother and her uncle presented was what most psychiatric patients offer when they sit down and answer my question, "What brings you in today?": the total noise of a whole life or, in her case with the added difficulties of translation and cultural differences, the total noise of a whole continent. How to attend to this din? And how to discern what is important to truly understand this patient and to accurately diagnose and form a treatment plan?

The psychiatrist's key for over a century now has been a combination of pattern recognition and creative thought. The psychiatric interview is a balance of these variations on the science and the art of medicine in general. I listen to the patient as he runs on in order to understand what

is important to *him*, to understand who he is and just what type of din he thinks it important that I hear. If he is simply banging the lids of trash cans together, this in itself is important. I will then interrupt him though, get him to put down the makeshift cymbals, and pull him this way and that towards various patterns I know often exist in patients like him that I have seen before, or my colleagues the world over have seen before and written about, or the fathers of psychiatry have with pain and pain-staking diligence documented over decades in Heidelberg, London, New York, or Topeka.

I decided that, based on poor information and poor translation, I would treat with anti-depressants as she did have some symptoms of depression, was pregnant and, therefore, currently at increased risk of developing a mood disorder, and because depression-induced memory problems are, at least, treatable ones. She readied herself to leave with her uncle, a script for an old and cheap anti-depressant, and a date to return to see me again during her second trimester.

With my first patient, the Congolese woman, I broke a rule. When a psychiatrist finds himself saying to a patient, "Well, I don't usually do this, but. . ." he should step back, perhaps talk to a colleague, and evaluate why he is making an exception. Perhaps a psychopath has just charmed him into crossing a professional boundary or has been persuasive enough to be given privileges off the ward or outside his prison range that are actually neither warranted nor wise. I have made it a practice here in Uganda not to give any money to patients. So when I found myself fumbling amongst the lint and scraps of oily paper in my lab-coat pocket for bus fare for the Congolese woman, at least I paused to ask why I was breaking my own law before giving her four 500 shilling coins (total equivalent of US\$1.00).

Giving a dollar to a refugee and victim of torture who had walked all morning to reach my clinic so that she could now trans-

port herself to the national psychiatric hospital for admission hardly seems like an act deserving further analysis. In fact, perhaps only a psychiatrist would attempt to wrest anything further from it. But a psychiatrist, indeed a doctor, is nothing if he cannot palpate his responses to his own patients and observe his reactions to them and the possible motives for his behaviour and treatment choices. Why did I treat her differently? Why did I advocate for her admission and give her the money?

Her interview had been easy, her diagnosis straight forward. In the glow of a patient who could filter her own thoughts

*I was angry at the perpetrators who defiled her and left a stump of a family to roam about East Africa seeking healing. It was not purely righteous anger though; it couldn't be.*

and give me coherent answers that each yielded much relevant and useful information, a patient who fell neatly into a recognizable diagnostic pattern and required little creative thought, I failed to use my full complement of skills. I quickly concluded that pattern recognition was all that was needed for her management because that was all that was needed to reach her diagnosis. But where pattern recognition ended, creative introspective thought should have begun. It had crossed my mind that her horrid tale was packaged too well and that she came to the clinic kneeling and bowing with a child for the purpose of asking for money, and that she did so at other clinics and to other *muzungu* doctors. But she did look Congolese, and her story if anything was less graphic than those of other refugees I had treated. And she couldn't have known that a western psychiatrist was in the clinic that day. No, the introspection should have dwelt on my wish to save a young African rape victim and the impotence I felt in being able to diagnose

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her with ease, but heal her not at all. I was impotent knowing that recovery from her wounds would be long and surely incomplete; knowing that her lack of housing, money, and food would likely keep her from long-term treatment; and knowing that the bureaucracy, inefficiency, and corruption at all levels of possible aid would thwart even the mentally healthy.

I was angry at the perpetrators who defiled her and left a stump of a family to roam about East Africa seeking healing. It was not purely righteous anger though; it couldn't be. The acts were inexcusable but I am capable of them. The dictators of Africa, the roving armies, the ancient tribal hatreds (and the new ones) – these are not unique to Africa throughout history or at present. Armies of young idle men left Claremont for the first crusade in the 11<sup>th</sup>-century; armies of young men and women “guarded” Abu Ghraib in the 21<sup>st</sup>. I am capable of the acts perpetrated.

And so with anger emanating outward and inward, and with guilt knowing that I could commit such acts but am impotent to reverse or even really treat their effects, I fingered the coins in my pocket – and then gave them to her. Once again I became the kind and selfless *muzungu* doctor accepting her gratitude.

I failed to use creativity in assessing the Congolese woman because patterns fit her presentation and she did not challenge me

as an example of total noise awaiting the extraction of anything of psychiatric utility. The pregnant Ugandan with vague complaints and an unending tale was different. I did extract some useful details from the vast history and forced them into a pattern – intra-partum depression – because nothing else fit. At the end of the interview, after I had written my prescription, discussed side-effects, and given a follow-up appointment, the patient's uncle began one last story. I was not inclined to listen (empathically or otherwise) and the narrative gave no hint of being succinct.

“Once a long time ago. . .” it began, as I continued writing my summary in her chart, “. . . she was struck by lightning and was unconscious for a very long time.”

I paused and listened. The woman with the long history of memory problems, stable ones, not getting worse, had been struck by lightning and unconscious years before, likely suffering respiratory failure and a brain injury from prolonged lack of oxygen. There was my explanation.

I don't know which comparison is more worn, a difficult search being like looking for a needle in a haystack, or an improbable event being as likely as a lightning strike. But I do know that searching for the lightning in the haystack is nigh impossible. Sometimes the psychiatrist's craft must simply await revelations.

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*This essay is based on actual patients seen at Mulago Hospital, Kampala, Uganda. Efforts to contact the two women for consent to publish were unsuccessful. Identifying details have been omitted to preserve confidentiality. The main barrier to identifying these women from the essay is, unfortunately, the commonness of even the details of their stories: even the most shocking specifics could be documented about hundreds of women seen at the clinic (especially the refugees). Being literally lost in a mass of the similarly dispossessed is, in the end, their story.*