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EMOTIONAL PROBLEMS IN A UNIVERSITY COMMUNITY

The student population is a predominantly healthy one physically, and the major part of the student health service doctor's time will be occupied with the treatment of acute illness, both medical and surgical. On the other hand, there are many psychological problems that beset this community and ones which, owing to pressure of work on the doctor, coupled with the reluctance of students to seek aid when they find they are in emotional trouble form a void that should be filled, to the benefit of both the universities (in terms of student wastage) and, more important, the unfortunate students themselves who, with the help of group and/or individual psychotherapy, may overcome the stress hurdles they encounter during their college days.

It must be remembered that the end of schooldays and the beginnings of an academic life are conditioned by the ability of the student to obtain a university pass and the pocket of his parents who can finance his career. Little cognizance is taken of the student's potential aptitude, suitability and emotional stability to *make the grade* in a competitive academic society with the mistaken 'rose-coloured vista' of freedom from authority in its strictest sense.

Emotional problems may on the one hand hinder a child's function and ability so that he will never enter university, but the converse may be true, where these problems may be ostensibly promotive—where defects in the personalities may be compensated for by excessive concentration on studies and an almost psychopathological desire to succeed. This striving, manifesting itself during their lives at school, have produced isolated children with an inability to make friends easily, and they are beset by feelings of rejection and possibly depressive or anxiety-provoking episodes.

The freedom from fixed work schedules and the *laissez faire* attitude they feel, have replaced the teachers upon whom they could previously lean and depend, and this is 'promotive' of stress and alarm. Many a potentially bright student may become entangled in examination hurdles, working with his anxiety and despondency and not with his subjects, thus failing his course. This type of student desperately needs the counsel of a physician, and the health service should be geared to meet these felt needs. Early detection of such cases may be made at the initial medical examination, if they are skilfully directed to enquire about psychological difficulties in the school period, and bring 'at risk' students to treatment.

In some cases supportive care in a stress situation by the health service physician, in consultation if necessary with an academic staff member who knows the student, may suffice. More serious forms of illness can be directed towards the appropriate specialist facilities available at teaching hospitals.

Students with severe emotional problems are more likely to present themselves in the initial phases of their career. Study difficulties emerge sooner or later, but are related to primary difficulties, neuroses, reactions to difficulties with the opposite sex, financial anxieties or home troubles. Unhappiness preoccupies the student and he does not function at an adequate level in his studies; this can precipitate fur her anxiety and his progress is further impeded.

A further subdivision of emotional difficulties may be seen in Malleson's handbook,[1] and those who wish to go deeper into the problems may do well to consult it.

University teaching staff are aware of the pre-examination 'jitters', but the strain on certain types of students can be intolerable. There is an important mental health aspect to academic difficulties—it is not only the 'won't-works' who fail their courses, but many who have put in long and arduous hours and who, if they were emotionally at peace, would have had no difficulty with their examinations.

The point is that university students are possibly subject to a great deal of emotional strain, which they may or may not be able to bear during their studies. Awareness of the problem by teaching staff, the student health service and the student himself, and the structuring of facilities to meet the problems of those in need, are important aspects of university administration and could assist in overcoming the problem of student wastage if our resources are mustered to meet it.

1. Malleson, N. (1965): *A Handbook on British Student Health Services*, p. 56. London: Pitman Medical Publishers.

OSTEOPOROSE EN LEWERSIRROSE

Verdunning van die skelet is alreeds volledig beskryf in pasiënte wat aan langdurige obstruktiewe geelsug ly. Atkinson en sy medewerkers[1] het osteomalasie en osteoporose, of elemente van altwee letsels, in volwassenes gevind wat onderhewig was aan lewersiekte en cholestatiese geelsug oor 'n lang tydperk. Hulle het aangeneem dat die gebrek aan gal in die spysverteringskanaal gelei het tot wanabsorpsie met oormatige verlies aan kalsium en stikstof in die stoelgang, en dat dit die neerlê van beenmatriks en beenmateriaal verminder het.

Summerskill en Kelly[2] het tekens van erge osteoporose gevind in middeljarige mans wat gely het aan alkoholiese lewersirrose sonder enige geelsug. Hulle het oor drie sulke pasiënte tussen die ouderdomme van 50 en 63 jaar verslag gedoen, wat gekla het van erge beenpyn met patologiese frakture maar sonder bewyse van belemmerde absorpsie in die spysverteringskanaal.

Die diagnose van osteoporose is gemaak op grond van die kliniese geskiedenis van beenpyn en fraktuur, radiologiese studies en beenbiopsie. Laasgenoemde het mikroradiografie vir die meet van beenvorming en beenresorpsie ingesluit. Daar was egter ook belangrike negatiewe bewyse —die afwesigheid van ander oorsake van beenresorpsie. Daar was byvoorbeeld nie radiologiese tekens van osteo-

2

malasie of osteïtis fibrosa nie; die serumwaardes vir kalsium, fosfaat en kortikosteroïed was normaal, en intestinale absorpsie en die beenmurg was ook normaal. Geen ander oorsaak van osteoporose, anders as lewersiekte, kon gevind word nie.

Die graad van lewerbelemmering het verskil in die drie gevalle; net een het hipoalbuminemie gehad. Net twee van die drie het 'n goeie eetlus behou en genoeg geëet, ten spyte van hul alkoholisme. Mikroradiografie het bewys gelewer van verminderde beenvorming-oppervlak en vermeerderde beenresorpsie-oppervlak in vergelyking met vyf manlike kontrolegevalle in dieselfde ouderdomsgroep.

Summerskill en Kelly[2] gee verskillende moontlike meganismes aan die hand om hul bevindings te verklaar. Slegs een persoon het erken dat sy diëet ongenoegsaam was, maar wanvoeding kan nogtans een faktor wees. Wanabsorpsie was nie klaarblyklik teenwoordig nie. Die verlies van proteïen en kalsium deur parasentese mag van belang gewees het in een geval, terwyl eksudatiewe enteropatie verantwoordelik kon wees vir verdere verliese, alhoewel toetse hiervoor nie uitgevoer is nie. As gevolg van die wanfunksie van die lewer kon daar verminderde proteïensintese, vermeerderde teen-liggaamvorming en weefselvernietiging as gevolg van chroniese inflammasie gewees het. Endokrienversteurings as gevolg van lewersiekte word ook genoem, maar die skrywers dui nie aan *hoe* hierdie faktore verwag kan word om op te tree nie.

Wat presies die meganisme wat optree ook al mag wees, wil dit voorkom of osteoporose as gevolg van alkoholiese sirrose van die lewer kan ontstaan en dat sirrotiese pasiënte met beenpyn ondersoek moet word met hierdie moontlikheid in die gedagte. In een van hul drie gevalle kon Summerskill en Kelly[2] effense verbetering van die mikroradiografiese beeld bespeur na behandeling oor 'n tydperk van dertien maande. Die behandeling het bestaan uit standaardmaatreëls vir sirrose plus metieltestosteroon, kalsiumglukonaat en strontiumlaktaat spesifiek vir die osteoporose.

1. Atkinson, M., Nordin, B. E. C. en Sherlock, S. (1956): Quart. J. Med., **25**, 299.
2. Summerskill, W. H. J. en Kelly, P. J. (1963): Proc. Mayo Clin., **38**, 162.

NON-MOTIVATION IN HEALTH CARE—A SOLUBLE PROBLEM

Throughout the world, health authorities are faced with the frustrating problem of preventing disease and promoting health in families in the community that need it the most. The numbers are without doubt the greatest among the poor and uneducated. Socio-economic studies have shown that important factors are social class, income, education, culture and family disorganization, to mention but some of the correlates that affect the non-utilization of health services even where these are adequately provided.

These 'hard-to-reach' groups are families with reality problems which take priority, such as simply maintaining their existence on their meagre earnings. These needs for food, shelter, clothing, and medical care of an emergency curative kind must be resolved before any interest is likely to be shown in preventive or promotive services.

We should be fully aware that we cannot impose our values on theirs without recourse to education in health matters—our pleas then fall on 'closed ears and doors'. Hochbaum[1] states that these kind of people are difficult to reach 'primarily because we . . . appeal to values which are ours, but not theirs, and because we would like them to strive for things which are simply not important, or perhaps . . . not . . . understandable to them'.

The attitude of public health workers to the unresponsive must be objective. It is easy to 'pigeon-hole' and categorize them with stereotyped labels—'ignorant', 'hostile', 'uncooperative', 'stupid' or to imply that uneducated people can neither understand nor benefit from organized health programmes. Let us look again at these people and try and understand their problems in their psycho-social environment. We must not prejudge, because prejudgement can cause prejudice, instead of developing a positive climate in which professional help can be both supplied and accepted.

Channels of communication must be opened between the health agencies and the people they serve; priorities can be assessed and health education techniques honed down to the culture to which they are applied; this should then be a positive and rewarding line of action. Are we sufficiently aware of the beliefs of our communities where these are prejudicial to their health promotion? Do we know what our communities want and expect from our programmes? Do they look upon our efforts as help, or inculcation of doctrines and patterns of behaviour foreign to them? An objective look at our goals and means of fulfilling them must serve two purposes; on the one hand we must be sufficiently flexible to change our attitudes and behaviour in order to meet the demands and needs of those we serve, and accept that our own cultural barriers may be hindering us in reaching out to those with *different* sets of mores and values, whether we think them primitive or not.

There is a good deal of variation in the range of health knowledge, habits, attitudes and the utilization of services among people, particularly those in the lower echelons of education and income. If a health agency is to function effectively it must carry its messages and its services *into* the community. Attention must be given to special in-service training for its staff. This applies to the whole health team whose doctor as the leader may guide his paramedical staff, and himself in turn be kept informed of the priority problems that beset not only 'problem families' but the 'problem community'.

Health education still lags too far behind, but every effort is being made to rectify this deficiency. It is almost like quoting 'there are no problem children only problem parents', but, modified, the adage would read 'there are no problem families but health service problems'. What is required is a reassessment and possibly a more flexible approach—needs will then be met and the health authorities may find that their efficient services are being attended more frequently, and with a greater comprehension of their meaning and purpose.

1. Hochbaum, G. M. (1960): *Research Relating to Health Education*, p. 10. Health Education Monograph No. 8. New York: Society of Public Health Educators.