

## THE RATIONALE OF TREATMENT OF MALADAPTATION SYNDROME

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Under the present socio-economic and political structure, a man cannot be divorced from the society. In fact, it is difficult to conceive of a man in the modern age as an independent existing unit. He has to conform to certain rules and regulations, which dictate his behaviour pattern, and demand certain contributions, and he has no choice other than to face dire penalties.

However, man, contrary to a popular saying, is not born gregarious. The newborn baby accepts no company. Gregariousness is induced culturally, and in the process of cultural induction, a man has to make constant adaptations. Failure in adaptation makes itself manifest in many ways, and passively, it takes the form of "ill-health" of a protean nature, which may be broadly grouped as maladaptation syndrome.

Theoretically, adaptation is a result of the interaction of two parties—the environment and the organism. A hostile environment, or an unadaptable organism or both in combination are necessary to cause maladaptation.

Hitherto, it is assumed that the treatment of maladaptation is a combination of drug therapy, psychotherapy, and social readjustment, but the fact that the disease manifestation is protean, and the incidence generally accepted to be rising must mean that as yet we are not treating the "disease" effectively.

In general, treatment of a disease is dependent on the accurate knowledge of the epidemiology, and the therapeutic skill. In maladaptation, however, although much has been said, little is known in a systematised manner. In order to arrive at some rationale of treatment, an analysis is made of 400 consecutive cases seen in a private consulting practice of an internist. This results in a pick up of 104 cases, which fit the label of maladaptation. The following report is based on an analysis of some of the relevant aspects of these cases.

These cases are divided into two broad groups—one that continues to receive medical super-

vision, 'repeaters', and one that very quickly wanders off and ceases to come up, 'non-repeaters'. We may oversimplify the case by assuming that the first group represents people who accept medical guidance readily, have trust and faith in their doctors, and are willing to keep up with the supervision, presumably because they are getting some benefit. In contrast, the other represents the treatment failures, and the sceptics who are ready to change their mode of medical care, presumably because they do not get satisfaction. It can be seen that the numbers are about equal—51 : 53. (A previous unpublished study of mine showed that the success rate of non-psychiatric consultant in the treatment of maladaptation cases was 50%, a figure similar to the present study, whereas that of the private practitioner in general practice and that of the psychiatrist was 70% and 25% respectively).

These cases are analysed with regards to age and sex, the nature of the complaints, and the duration and quality of medical care received.

Table I shows that these cases are predominantly Chinese showing more a selection due to sociological reasons rather than a reflection of differential racial incidence. For example, Malays tend to seek much less of western medical care. Indian prefers cheaper institutional facilities, and those classified as others include a large number of foreigners, whose stay in Singapore was brief such as tourists etc..

TABLE I  
RACE

	Repeaters 51 (49%)	Non-repeaters 53 (51%)
Chinese	46 (90%)	45 (85%)
Indian	3 (6%)	1 (2%)
Malay	2 (4%)	1 (2%)
Others	0 (0%)	6 (11%)

Table II shows that whereas the sex distribution is about 1 : 1 in non-repeaters, the repeaters show a strong female bias. The peaks in females of both groups are in the fifth decade, whereas in the male, one has no peak, and in the others, this occurs in the fourth decade. This permits many interesting speculations, such as

TABLE II  
AGE AND SEX

	Repeaters		Non-repeaters	
	Males	Females	Males	Females
< 15 Years	0	0	1 ( 4%)	0
16—20	2 (13%)	2 ( 6%)	1 ( 4%)	1 ( 4%)
21—30	2 (13%)	6 (17%)	7 (25%)	4 (16%)
31—40	2 (13%)	6 (17%)	9 (32%)	11 (44%)
41—50	3 (22%)	10 (28%)	5 (18%)	6 (24%)
51—60	4 (26%)	9 (24%)	2 ( 7%)	2 ( 8%)
> 60	2 (13%)	3 ( 8%)	3 (11%)	2 ( 8%)
TOTAL	15 (29%)	36 (71%)	28 (53%)	25 (47%)

that the male is more difficult to satisfy, and has no peak periods for the onset of maladaptation, whereas the menopause may be a significant factor, as in fact has been the belief among doctors for a good long time (Menopausal syndrome).

Table III shows that a significant number of these patients (32%—51%) has physical anomaly, and of these anomalies, only about half of them are trivial. The incidence of physical disease is more in the group which continues with medical care. It is of interest to note that cardiac diseases form the majority, more than can be accounted for by the relative incidence of diseases. This may mean that the campaigns on prevention of cardiac diseases have contributed to the increased awareness and fear resulting in a rise of maladapted cases among cardiac cases.

TABLE III  
PHYSICAL SIGNS

	Repeaters	Non-repeaters
No physical sign	25 (49%)	36 (68%)
Physical Sign:		
Significant	13 (25%)	9 (16%)
Insignificant	13 (25%)	9 (16%)
Cardiac	15 (45%)	4 (22%)
Respiratory	3 (10%)	2 (11%)
C. N. S.	5 (15%)	4 (22%)
G. I.	5 (15%)	3 (17%)
Other	5 (15%)	5 (28%)

Note:— Some cases belonged to more than one system.

Table IV shows that mental subnormality has an insignificant role to play in maladaptation diseases.

TABLE IV  
I. Q.

	Repeaters	Non-repeaters
Normal	48 (94%)	53 (100%)
Subnormal	3 ( 6%)	0 —

TABLE V  
MALADAPTATION TYPES

	Repeaters	Non-repeaters
Psychiatric cases:		
Schizophrenic	2	1
Affective	1	1
Others	1	0
TOTAL	4 ( 8%)	2 ( 4%)
Psychosomatic:		
Anxiety	24 (56%)	30 (57%)
Depression	17 (39%)	10 (19%)
Hysteria	1	8 (15%)
Malingering	1	1
Others	0	4 ( 7%)
	43	53

Note:— Some cases belonged to more than one category.

Expectedly, psychiatric illnesses are few (4%—8%), and the majority of the manifestations are anxiety, depression or both in combination (Table V). Also as expected is the high proportion of cases with multiple complaints (Table VI).

TABLE VI  
NUMBER OF COMPLAINTS

	Repeaters	Non-repeaters
One complaint	8 (15%)	15 (28%)
2 complaints	17 (73%)	16 (30%)
>2 complaints	6 (12%)	22 (42%)

TABLE VII  
DURATION OF COMPLAINTS

	Repeaters	Non-repeaters
<1 month	3 (6%)	4 (8%)
1 month—1 year	11 (21%)	18 (34%)
1 yr—5 yrs	21 (41%)	14 (26%)
>5 Yrs	16 (32%)	17 (32%)

TABLE VIII  
NUMBER OF DOCTORS SEEN

	Repeaters	Non-repeaters
1 doctor	5 (10%)	4 (8%)
2 doctors	15 (29%)	23 (43%)
> 2 doctors	31 (60%)	26 (49%)

TABLE IX  
USE OF SPECIAL SERVICES

	Repeaters	Non-repeaters
Specialist	28 (49%)	22 (42%)
Hospital	23 (45%)	15 (28%)
Psychiatrist	3 (6%)	4 (8%)

The next three tables are of particular interest in showing the economic significance of maladaptation diseases. They cause prolonged morbidity, and make the patients seek medical aid much more. Specialist services and hospital facilities are likewise much utilised without much evidence of benefit. The use of psychiatry appears to be confined to only those cases who are frankly psychotic. This could be due to a number of factors at work, included among them may be mentioned the following:—

1. The general reluctance of the medical profession, and the maladapted patients (at least in this series) to avail themselves of psychiatric service. Perhaps psychiatry has yet to convince the medical profession that it is able to make significant contribution towards the treatment of non-psychiatric maladaptations.
2. Some cases may have been sent to psychiatrists earlier, and being improved, would not show up in this series. In other words, these cases could represent failed psychiatric cases in part. Comparison with series by general practitioners, psychiatrists, and specialists in other disciplines would yield interesting information.
3. The small number of psychiatrists available would militate the psychiatrists towards psychotics, who would occupy their time almost in toto, with little to spare for other conditions.

If we assume that the principle of treatment is the early restoration to normal health, then this series has told us that treatment has been on the whole unsatisfactory. Perhaps, our present technique of drug therapy with little psychotherapy, amateurish or professional, is inadequate, and the real solution lies elsewhere.