

Focus on psychiatry in India

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India is a country with a population of over 1 billion, and immense diversity in the languages spoken, levels of literacy, and social and cultural practices. Organising mental health services for this predominantly rural population is indeed a daunting task. Compounding this problem are low budgetary resources, the presence of competing and conflicting healing systems, scarcity of mental health personnel, 'brain drain', and the stigma of seeking help for problems related to the mind. This paper looks at the mental health scene in India with respect to services and research. It deals with conditions such as schizophrenia, acute psychoses, minor mental morbidity and drug misuse, highlighting aspects unique to the Indian scene. Indian families exhibit great tenacity in caring for relatives who are ill, and are a great resource in treatment and rehabilitation.

THE CLASSICAL TRADITION

The medical compendia of ancient India are replete with references to mental health covering a spectrum of diagnoses, classification and treatment methods. A description of insanity – *unmada* (oon-ma-tha) – dating back to 1500 BC exists in the *Atharva Veda*, the most ancient authentic Indian medical scripture. Descriptions of conditions similar to schizophrenia and bipolar disorder appear in the Vedic texts; these texts differentiated doctors practising magical medicine from scientific physicians and surgeons, who lived and practised in cottages surrounded by medicinal plants. An ancient textbook of Ayurvedic medicine, *Therapeutics and Surgical Practice* by Charaka and Susruta, has a vivid description of schizophrenia. It states clearly that only an expert in the field of mental health should treat people with this illness. Other traditional medical systems, such as Siddha, which recognises various types of mental disorder, flourished in

southern India. The great epics such as the *Ramayana* and the *Mahabharata* made several references to disordered states of mind and means of coping with them. The *Bhagavad Gita* is a classical example of crisis intervention psychotherapy (Trivedi, 2000).

This article aims to provide an overview of the state of psychiatry and mental health research in the country. While it is well nigh impossible to cover all areas of psychiatry in India, we have made an attempt to provide some highlights of the recent developments.

HEALTH CARE SERVICES

The Indian government provides several levels of medical services at nominal or no cost; these are essential in a country where much of the population is impoverished and there is no viable health insurance system. Despite this, medical services in the costly private sector flourish. The relationship between the public and private sectors has seldom been addressed by research or policy planners. Understanding how patients and families use each is critical. The work of Chisholm *et al* (2000) is a valuable demonstration of how important it is to consider the work of the private sector when attempting to evaluate mental health services in primary care in India.

Mental hospitals

Ernst (1987) described the growth of mental asylums in British India as a 'less conspicuous form of social control'. The city of Calcutta had the first mental hospital in India in the year 1787, followed by Bombay (Mumbai) and Madras (Chennai). There are now 37 mental hospitals in the country with a total bed strength of 18 024 (National Human Rights Commission, 1999). A study of the status of the mental hospitals commissioned by the National Human Rights Commission revealed gross inadequacies in all aspects of care, clinical

services and rehabilitation. The subhuman living conditions in some of them were a stark violation of human rights and a painful eye-opener to many. Steps are afoot to allocate more resources to improving these hospitals (National Human Rights Commission, 1999).

General hospital psychiatric units

The establishment of general hospital psychiatric units began in the 1930s and intensified in the 1960s, leading to a change in the quality of care. These units are attached to the medical colleges throughout the country and offer a total bed strength of about 3000 (Sharma & Kala, 1999). However, admission is voluntary and families have to remain with the patients. It became evident that a number of people with minor mental morbidity or psychosomatic disorders preferred to use these facilities because they were less stigmatising. Establishment of these units also paved the way for a more active liaison psychiatry.

Voluntary agencies and non-governmental organisations

The past two decades have witnessed a surge in the voluntary mental health movement in India. There are several non-governmental organisations (NGOs), many of them in the southern part of the country, for example those offering specialised care to people with chronic mental illness (the Schizophrenia Research Foundation, Chennai, and the Richmond Fellowship Society, Bangalore and Delhi), those with suicidal ideation (Sneha, in Chennai), elderly people (the Alzheimer's and Related Disorders Society of India (ARDSI) in Kerala, with chapters in several other states), children, (Sangath, Goa) and substance misusers (T. T. Ranganathan Research Foundation, Chennai). Self-help and support groups consisting largely of the families of people with mental illness are also making their presence felt on the national mental health scene (Patel & Thara, 2003).

Traditional healers

Traditional healers in India make up a large proportion of the private health sector. The use of traditional healers is driven by cultural factors, such as explanatory models of illness and treatments that patients and families understand (Patel *et al*, 1997). It is not the case that traditional healers in India always harbour an 'irrational',

unscientific model of explanation – both patients and healers readily accept psychosocial and biomedical models of mental illness. Even in urban areas, there are many who seek help from both traditional and modern Western medicine simultaneously. ‘Traditional’ healers often employ an amalgam of traditional (e.g. dietary and herbal) and biomedical interventions, some bordering on quackery. However, the easier accessibility of such healers for rural populations and the empathetic nature of their relationship with their clients often determine the effectiveness of the intervention, especially in cases of minor mental morbidity.

Religious treatments

Places of worship – Hindu, Muslim and Christian – are still important centres for the treatment of mental illness (Thara *et al*, 1998). Here the locus of control is placed outside the sufferer and problems may be attributed to black magic, a curse, divine wrath, or *karma* (determinism) of a previous life. The explanatory model therefore largely influences the type of help sought. Treatments at religious centres range from performing a series of rituals such as bathing in the temple tank and circumambulating the temple, to prayers at specified times. Physical restraint by chaining patients to a pole or a tree is not uncommon. Belief in the efficacy of religious treatment has led to the growth of unauthorised shelters housing mentally ill patients around such centres of worship. In August 2001 a gruesome event occurred when fire broke out at one such shelter, in Yerwadi, in which 26 mentally ill people burnt to death because they had been chained to prevent them from escaping. This disaster led to a rethink of the mental health scene and some governmental action followed.

Indigenous medicine

Three distinct indigenous (non-Western) systems of medicine are practised in India: Ayurveda, Siddha and Unani, all of which pre-date Western medicine. Evidence for their efficacy according to Western scientific requirements is not yet forthcoming, but the growing interest of scientists in these disciplines is encouraging formal research into traditional psychiatric therapies. The treatments investigated include varying combinations of drugs, herbal

extracts, dietary regulations, physical exercises and lifestyle modifications.

Health service utilisation

In comparison with rural communities, urban areas are usually replete with psychiatric health care facilities in the private and public sector, and it is presumed that these communities will have better rates of use of health services. However, a survey of an urban community in southern India, served by four state-run general hospitals with psychiatric services and a large psychiatric institution, found that a third of people with schizophrenia had never accessed any treatment (Padmavati *et al*, 1998). Even after these individuals and their families were offered treatment, a third of them continued in their untreated state (Srinivasan *et al*, 2001). People with schizophrenia who were living as part of an extended family accessed treatment less often, even when it was considered essential to do so. The families, when interviewed on the issue, replied that they were used to their relative’s illness and that other family members compensated for the person’s non-productivity. Once they had reached this equilibrium they did not want to disturb it by seeking treatment. This underscores the importance of cultural, social and family factors in service utilisation. In a country like India it is not easy or appropriate for a health care service to bypass the family to reach the potential patient; the family may have to be persuaded first of the need for treatment. More positively, however, this situation reflects the intrinsic coping style of the community and the family in dealing with disability, which may contribute to the better outcome of treated schizophrenia in India.

National Mental Health Programme

The National Mental Health Programme (NMHP) was developed with the objective of ensuring availability and accessibility of basic mental health care for all sections of the population. Based on the philosophy of decentralisation and demystification, the NMHP sought to integrate mental health care with primary care, by training personnel at primary health centres, making policy planners and bureaucrats more sensitive to mental health issues and providing basic medicines at the primary health centres. This programme has been operating since 1984 in a few states, but many other states have yet to adopt it in even a rudimentary fashion,

despite the expectation that the Yerwadi disaster would give rise to a more concerted effort at its implementation. The good news is that the Government’s current 5-year plan has allocated a substantial amount to the implementation of the NMHP in all Indian states.

Community mental health programmes

James Mills, describing the history of modern psychiatry in India (Mills, 2001), stated that it was only in the 1990s that an increasing emphasis on out-patient care and more modern facilities was seen. It should be pointed out that in fact community-based programmes were first initiated in the 1980s, the impetus being provided by the NMHP. Some NGOs also embarked on community-based programmes, which although efficacious and cost-effective were always restricted by their dependency on time-limited funding (Thara *et al*, 1998; Chatterjee *et al*, 2003). Some programmes have demonstrated the feasibility and cost-effectiveness of such initiatives, but the hurdles they faced have discouraged the process (Srinivasa Murthy, 1999). Poor allocation of resources, insensitivity to the needs of people with mental illness on the part of both professionals and policy planners, and indifference to mental health in general have all acted as deterrents.

SCHIZOPHRENIA

Epidemiology

Prevalence studies of schizophrenia in India report rates of between 1.5 per 1000 (Surya *et al*, 1964) and 2.5 per 1000 (Sethi *et al*, 1974). After correcting for age at risk, the rates range between 2.6 and 3.4 per 1000. Sample sizes ranged from 674 (Nandi *et al*, 1980) to 101 229 (Padmavati *et al*, 1987). There appears to be no consistent difference between rural and urban areas in the frequency of the illness, and no clear pockets of high or low prevalence. Incidence studies are few, with estimates of an annual incidence of 0.35–0.38 per 1000 in urban populations and 0.44 per 1000 in the rural population (Rajkumar *et al*, 1993).

Course and outcome

The International Pilot Study of Schizophrenia (IPSS; World Health Organization, 1979) and the Determinants of Outcome of Severe Mental Disorders (DOSMED) study

(Sartorius *et al*, 1986) have provided convincing evidence for a better outcome in India (along with other less industrialised countries) than in the West. This finding of a good outcome of treatment also emerged in the Chandigarh studies (Kulhara & Wig, 1978; Kulhara, 1994). Kulhara *et al* (1989) showed that regardless of diagnostic definition, the outcome in Indian patients was favourable. One spin-off of the IPSS in India was the multi-site Study of Factors Affecting the Course and Outcome of Schizophrenia (SOFACOS), sponsored by the Indian Council of Medical Research. This was a 5-year follow-up of 386 patients in three centres, aimed at identifying social and clinical factors affecting course and outcome. The 2-year follow-up revealed that among the 423 patients followed up, 64% were in remission, and only 11% continued to be ill (Verghese *et al*, 1989). Data from the Madras centre also revealed a better outcome for women at the end of 5 years of follow-up (Thara & Rajkumar, 1992).

The Madras cohort was followed up for another 10 years and was found to have a better outcome in marital and work functioning than has been reported for similar populations in the West (Thara & Eaton, 1996; Thara & Srinivasan, 1997). Another interesting aspect of the Madras study has been the quality of social support enjoyed by the cohort. All the patients continued to live at home and were cared for by either their spouse or their parents. This can be generalised to other parts of the country, where the concept of patients living alone because of their illness still meets with considerable social disapproval. However, the increase in nuclear families and the reduction in the number of joint families, increasing urbanisation and the changing role of women may all, unfortunately, alter this picture in the years to come.

The occupational functioning of men is still crucial in the Indian setting, where the man is largely the main breadwinner. Unemployment and underachievement act as threats to his social status. Compounding this situation, the social security system in India does not consider patients with schizophrenia as its beneficiaries and people with chronic mental illness are not yet eligible for any welfare measures.

In India, relapse is difficult to ascertain. Rehospitalisation is one of the chief criteria of relapses in the West, but is not so here (Rajkumar & Thara, 1989). This is due to a combination of factors such as lack of

beds and personnel, the costs involved and the reluctance of the family in some cases to have the patient repeatedly admitted. Costs also determine the type of medication, and many patients are still given conventional antipsychotic drugs.

Abnormal movements in never-treated schizophrenia

The presence of a substantial number of untreated people with schizophrenia in the community presents a unique opportunity to study the illness in its natural state. A series of studies conducted at the Schizophrenia Research Foundation (SCARF) in Chennai looked into the nature and prevalence of abnormal involuntary movements in never-treated schizophrenia (McCreadie *et al*, 1996, 2002a,b). The studies showed convincingly that involuntary movements similar in nature and degree to drug-induced tardive dyskinesia occurred in these patients. This indicates that such movements are an integral part of the disease process and not always induced by medication. The relationship with memory dysfunction, changes in volume of the basal ganglia, increased prevalence of involuntary movements in unaffected first-degree relatives and spontaneous remission and appearance of dyskinesia in previously symptom-free patients during follow-up have all been reported (McCreadie *et al*, 1996, 2002a,b).

Phenomenology

Indian psychiatrists still do come across catatonic states, especially in patients living in hospital. In the SOFACOS study, nearly 40% of the 386 patients at inclusion had a catatonic syndrome; this figure fell to 4% after 5 years' follow-up. The Agra sample of the IPSS was the only cohort with more than 15 patients diagnosed as catatonic. It is, however, likely that the numbers of persons presenting with such a picture are on the decline; this is yet another fertile area of research.

Families in schizophrenia

The role of the family in the Indian scene is all-pervasive, influencing as it does the decision to seek help (when, where and how), the nature of help (medical or non-medical), the need to continue treatment, and other issues such as employment and marriage. A report by Srinivasan & Thara

(2002) describes the role of the family in dealing with acutely ill patients with schizophrenia who are unwilling to take medication.

The fact that over 90% of those who are mentally ill live with their families and are dependent on them has led to research into family burden, family interventions and expressed emotion, and more recently into support groups. The finding in Chandigarh that Indian families show less expressed emotion than their Western counterparts has not been extensively replicated. The recognition of the importance of families has led to the creation of facilities for families to stay with patients in some centres, such as the National Institute of Mental Health and Neurosciences in Bangalore, and the Christian Medical College in Vellore. This facilitates the extensive participation of families in therapeutic programmes. The burden on families of people with mental illness is emotional, physical, financial and medical. Two instruments have been developed specifically to study this burden (Pai & Kapur, 1981; Sell *et al*, 1998). Coping by families has also received some attention, with particular reference to religious coping methods (Rammohan *et al*, 2002). In the past 10 years India has witnessed a degree of growth in the consumer and family movement, resulting in the formation of support groups in major cities. A National Federation of Care Givers has also been formed, and it is expected that families will begin openly to articulate their needs and viewpoints.

ACUTE PSYCHOSIS

Several kinds of acute psychotic states have been described, ranging from the so-called culture-bound syndromes presenting with acute psychotic symptoms, to those seen as a sequel to infective and toxic processes. As part of the DOSMED study, an association between fever and acute brief psychosis (Collins *et al*, 1999) was noted. The same study compared the long-term outcome of brief psychoses with remitting psychoses, and concluded by supporting the ICD-10 concept (World Health Organization, 1992) of a separable group of acute and transient psychotic disorders (Susser *et al*, 1998). Short-term follow-up also showed the delineation of acute psychosis as distinct from schizophrenia and affective disorders (Susser *et al*, 1995).

The issue of acute psychosis contributing to better outcome in developing countries has been the subject of debate (Stevens, 1987).

POST-PARTUM PSYCHOSIS

Among women's mental health issues, post-partum disorders have received attention, largely because they pose a distressing clinical problem (Agarwal *et al*, 1997). Female foeticide is a major problem, especially in rural India. Indian researchers have often referred to infanticidal ideas that were known to occur frequently in the post-partum state. Infanticidal ideas were associated with depression in the mother, adverse maternal reaction to separation from the infant, having a female baby, and psychotic ideas toward the infant (Chandra *et al*, 2002). Low income, birth of a daughter when a son was desired, relationship difficulties with the mother-in-law and parents, adverse life events during pregnancy, and lack of physical help were risk factors for the onset of post-partum depression (Chandran *et al*, 2002). A study from Goa showed conclusively that postnatal depression in women correlated not only with low weight and height, but also with adverse mental development quotient scores (Patel, 2002). There is enough research evidence to underscore the importance of post-partum disorders in women, and it is imperative that they figure prominently in programmes aimed at improving the reproductive health of women.

MINOR MENTAL MORBIDITY

People with minor mental morbidity form the bulk of patients attending not only psychiatric services but all primary care services. Such morbidity causes significant dysfunction in the sufferer and needs active intervention. The prevalence of these disorders has been found to be comparable in developed and developing countries. People with minor mental health problems commonly present with somatisation phenomena: Srinivasan & Suresh (1991) found that patients with minor mental disorders could be detected at the primary care level through somatic symptoms alone with a fair degree of validity. The busy primary care physician could use such symptoms to screen probable psychiatric morbidity and deal with it appropriately, avoiding the wasteful use of scant medical resources. The phenomenon is more common where

literacy rates are low and in poorer countries, which has been attributed to low 'psychologisation' of symptoms and the lack of vocabulary to express distress in emotional terms. However, reviewing the literature – most of which derives from research in developed countries – does stress that this phenomenon is universal. Indian patients do experience emotional symptoms as well as somatic symptoms, but prefer to present the latter as the predominant complaint in primary care. The suggestion that patients prefer to present with somatic rather than psychological symptoms because Indian languages lack the vocabulary to express emotional distress comes from workers who may not have had the benefit of living experience with regional languages and dialects, and has little foundation.

One somatisation syndrome claimed to be an Indian phenomenon is *dhat*, commonly diagnosed in men. The patient presents with vague symptoms of fatigue, multiple somatic complaints, anxiety and depression, all attributed to the loss of semen through masturbation or nocturnal emissions. This is accompanied by fear about sexual performance in marital life and fertility. In the Indian system of medicine, semen is considered one of the important *dhat* (vital body fluids) essential for well-being; its wasteful loss thus becomes symbolic of a deterioration in health. The argument could be that the clinical syndrome is a mixed anxiety-depressive disorder with the explanatory model of its aetiology implicating a loss of semen as the primary factor. Evidence of its cultural exclusivity to the Indian male needs to be established. There have also been a series of studies on common mental disorders in primary care and in special groups (mothers, adolescents) in Goa. Patel & Oommen (1999) have demonstrated compelling evidence of an association between depression and poverty, especially in women, and argue that the entire gamut of better economic policies, enhancement of the social network, increased availability of antidepressant drugs and counselling services with the involvement of primary care physicians and health workers is needed to combat this public health problem.

Research into common mental disorders includes qualitative studies, descriptive epidemiology, controlled treatment trials and studies on the relationship between reproductive health and mental health. A

major contribution has been the demonstration of the efficacy and cost-effectiveness of antidepressant treatment for common mental disorders in general health care settings (Patel *et al*, 2003).

SUICIDE

Although a staggering number of people – nearly a hundred thousand – die by suicide in India every year, there has been little research into this problem. Depression and suicide are probably the mental disorders most related to environmental, family, social and religious factors. Suicide is viewed differently by the various religions. Although Islam condemns it, a section of Hindu women are known to practise *sati* (suttee), a process in which the widow voluntarily burns to death on her husband's funeral pyre. This has social sanction and temples exist solely devoted to women who kill themselves in this way. For others, self-immolation is not an uncommon mode of suicide (Singh *et al*, 1998). However, in contrast to the West, firearms are rarely used, being seldom accessible. Self-immolation, hanging, overdose with medication and ingestion of pesticides are the most common means of suicide. The last is especially common in rural areas.

Studies of suicide by women have pointed to the high stress levels in women with poor support systems (Venkoba Rao, 1987; Banerjee, 1997). Although female gender, poverty, a large number of children and debts have all been associated with suicide, a case-control study employing the technique of psychological autopsy revealed that a psychiatric diagnosis, alcoholism, family history of psychopathological disorder and recent life events were significant risk factors (Vijayakumar & Rajkumar, 1999). The association of alcoholism and suicide has important public health implications in India. Most suicides are by people under 31 years old. There are pockets of high prevalence of suicide, for example in Kerala, West Bengal and Tamil Nadu.

The average medical practitioner is oblivious to early indicators of suicidal behaviour. Even mental health services are not sufficiently geared towards crisis intervention in such cases. A few NGOs run suicide prevention programmes, but there is a desperate need for more in order to handle a problem of this magnitude.

SUBSTANCE MISUSE

Substance misuse and dependence are increasing problems all over the world. India's geographical location has made it a part of the international trade in illicit drugs, but substance misuse as a clinical problem has gained recognition only in recent years. No study in India has attempted to identify in the general population a 'dependent drug user' based on clinically used diagnostic criteria. A study in the Delhi metropolis reported prevalences of tobacco, alcohol, cannabis and opioid use among men of 27.6%, 12.6%, 0.3% and 0.4%, respectively; rates were highest in resettlement clusters, followed by urban villages, and were unchanged in a follow-up survey 1 year later (Mohan *et al*, 2001). A high prevalence of drug use – even injecting use – among street children in the cities and working children is a matter of concern. Although initiation to drug use usually occurs during adolescence, few adolescent drug users seek help (Patel & Greydanus, 1999). The use of *pan masala* (a powdery mixture of betel nut, lime and arecanut) and home-brewed products containing marijuana and alcohol is widespread, posing a management problem on account of the easy availability of these substances.

One of the most heated arguments over cannabis use has been the existence of a distinct nosological entity identified as 'cannabis psychosis'. Although alluded to in the Indian Hemp Drugs Commission Report of 1893–4, the first scientific communication regarding 'Indian hemp insanity' came from Ewens in 1904. In fact, this condition was earlier thought to be 'peculiar to the country' (i.e. India). Although later reported from other parts of the world such as Africa, Scandinavia, the West Indies, the UK and the USA, the clinical validity and nosological status of 'cannabis psychosis' remains unclear.

Dual diagnosis appears to be less of a problem in India than in Western countries. Basu & Gupta (2000) noted that the prevalence of drug use among people with mental illness was twice that found in the general population. The prevalence was 16% in bipolar disorder, 14% in schizophrenia, 5% in organic psychosis and 2% in non-psychotic disorders. In India there is a need to develop and integrate the management of patients with dual diagnosis.

CHILD PSYCHIATRY

Children constitute nearly 40% of the country's population. Although the infant mortality rate has decreased, many children still live in impoverished socio-economic conditions. These take the form of malnutrition, high levels of illiteracy, poverty, child labour, discrimination against female children and a lack of family support. Poor obstetric care causes much perinatal morbidity and neurodevelopmental disorders. There are over 18 million destitute children, all of whom are at high risk of learning disabilities, poor scholastic performance and school drop-out, juvenile delinquency, developmental delays, cognitive dysfunction, drug misuse and personality disorders. Although several national policies and programmes are targeting these children, more needs to be done.

In terms of prevalence rates of psychiatric disorders and their clinical presentation, Indian children seem to be no different from children in the rest of the world (Jiloha & Murthy, 1981; Chandra *et al*, 1993; Srinath *et al*, 1993). Even the occurrence of depression in children has been documented, with a clinical picture similar to that in adults. A family history of the disorder was common and the response to antidepressant medication was good (Malhotra & Chakrabarti, 1992). There is, however, one report of higher rates (12–16%) of psychiatric disorders in Indian school children than those found in developed countries (Banerjee, 1997).

There is an increasing number of child guidance clinics with both medical and psychosocial models; several schools in urban areas have started school mental health clinics, and facilities have been established for specialisation in child psychiatry. Books on mental health in schools have been a welcome addition (Kapur, 1995). A national programme, the Integrated Child Development Scheme, has given greater priority to emotional problems in children. However, child mental health professionals need to work alongside national policies and programmes for children such as the national policy on education and the Juvenile Justice Act to provide a multi-service yet comprehensive system of child mental health care. Research has revealed that there is often reluctance on the part of Indian families to acknowledge psychological problems in children and to seek external professional help.

OLD AGE PSYCHIATRY

The burgeoning of the population to 1 billion, increasing life span and the break-up of the traditional extended family have all contributed to the need for reform of the geriatric services, backed by a body of knowledge generated through well-conducted research. Although most earlier data emerged from hospital-based samples, (Venkoba Rao, 1987), more recent epidemiological research has focused on community-based samples in both rural and urban areas (Shaji *et al*, 1996a; Rajkumar *et al*, 1997; Tiwari, 2000; Vas *et al*, 2001). A simple, inexpensive case-finding method for studying dementia in the community has been validated (Shaji *et al*, 1996b). Two qualitative studies have examined the care arrangements of old people (Patel & Prince, 2001) and caregivers of patients with Alzheimer's disease (Shaji *et al*, 2003). The 10/66 Dementia Research Group (Alzheimer's Disease International, 2003) has been active in the past few years, and seven centres from India took part in its two pilot studies. The Indian network of 1066 has developed a manualised, home-based dementia care intervention to be administered by health workers, and its efficacy will be tested in randomised controlled trials at Goa, Chennai and Vellore. However, there has been a dearth of neurobiological work among the elderly population.

Considering the size of the problem, services for people who are mentally ill are woefully inadequate. Apart from weekly geriatric psychiatry out-patient clinics run by a few hospitals, there is no formal mental health service for the elderly in the whole of India. The urgent need for mental health care of the rapidly growing population of the elderly could be met by providing brief additional training for doctors working in primary care. Changes to the curriculum of undergraduate medical training would enable newly qualified doctors to identify and manage common mental health problems in their elderly patients. India has a comprehensive, government-run primary care service, which at present is largely oriented to child and maternal health and the control of infectious diseases. Multi-purpose health workers (MPHWs) are the mainstay of the health services, especially in rural regions. With the diminution of family carers, it will be increasingly necessary to train these MPHWs in the care of the elderly. Day care

facilities and centres for respite care are also needed.

Psychogeriatric services in the country should aim to empower families providing home-based care. This could be done by enlarging the role of MPHWs, training them to provide family and community interventions for elderly people with dementia and other mental health conditions. Non-governmental organisations such as ARDSI, which is affiliated to Alzheimer's Disease International, and HelpAge India have made significant contributions to setting up services offering dementia care facilities in various parts of India. However, without a comprehensive national plan for the elderly, these will remain as localised and fragmented efforts in dire need of replication.

INTERVENTIONS

Psychotherapy

Psychotherapy is a therapeutic process involving at least two individuals. The participants in the interaction come with their own social backgrounds, individual attitudes, values and stereotypes which are in themselves often culturally moulded. The religious and philosophical background, language, modes of affective expression, moral and social norms, mores, and culturally determined conflicts and defences could have an influence on the psychotherapeutic interaction. Hence there are bound to be differences in the practice of psychotherapy across different cultures. To be popular, psychotherapy must be consistent with the socio-philosophical background of the people (Vyas & Ahuja, 1992).

A number of variables may be important in mediating cross-cultural differences between Western and Indian models of psychotherapy. Some of these are dependency *v.* autonomy, personal responsibility, and social and religious beliefs. Earlier workers in different cultures have identified dependence as an important transcultural variable. Indian men and women are described as being more dependent on others than are their Western counterparts. During the development of an individual in Indian society, the process of individuation occurs more at the material level, less at the emotional level. Dependence, often passive, is accepted and encouraged. The independence emerging around adolescence, often mandatory in Western societies, is strikingly absent in

Indian families, where adolescents go through a long period of dependence on their parents. For young women this dependence is almost a rule, especially in rural communities. In the process of psychotherapy, dependence of the patient on the therapist is a common phenomenon; patients look to their therapist to decide what is best for them. This process has been likened to a *guru-chela* (master and pupil) relationship, in which the therapist functions as the master. This approach would preclude therapies such as client-centred psychotherapy, where the client has a more active role. It may work against a ready understanding and acceptance of Western theories and practices, in particular transference and countertransference phenomena in the therapeutic relationship.

Another construct that merits discussion with regard to psychotherapy is 'psychological sophistication' – an ability to view psychiatric problems in terms of intrapsychic processes. Absence of such an orientation would not help the psychotherapeutic process. The Indian psyche focuses the source of problems outside the self, in constructs such as *karma* (predetermined outcome), fate and astrological influences which are beyond one's scope to deal with. This leaves little to work on for a therapist approaching a traditional Indian scene with the tools and methods of Western psychotherapy. This does not make the Indian psyche 'unsophisticated', rather it is working in a different dimension of understanding. This position is bound to influence the model and content of any psychotherapeutic effort for the Indian patient. The application of Western models without such considerations might be difficult, ineffective and possibly harmful. Nevertheless, in view of the present trend towards Westernisation, Western methods of psychotherapy have their place, at least for the more modernised sections of society. Even here, traditional patterns of personality development and family organisation persist, placing obstacles in the path of any meaningful application of Western psychotherapeutic models in clinical practice.

Yoga

Yoga is much talked about as a health practice and is almost a fad in the modern world, where extravagant claims are made about its ability to resolve almost every illness of the mind and body. Yoga can

be considered as a form of cognitive-behavioural therapy; it involves many activities, including the exercise of mental control, physical movements and posture, and regulation of breathing (Grover *et al*, 1994). Although the role of yoga in alleviating physical illness has been convincingly established, scientific evidence of its efficacy in major mental illness has not been forthcoming. This may be related to the multiplicity of forms of yogic practice in vogue, and the difficulty of standardising them in terms of 'dosage'. It is a fertile field for research, as this health practice is in tune with the religious and philosophical outlook of much of Indian society.

THE FUTURE

India is a multicultural, multi-ethnic, pluralistic society with enormous socio-economic disparities. This variety on the one hand is exciting, stimulating much research into behaviour and mental health; on the other hand, it is a daunting task to provide affordable and effective mental health care, especially to the remote rural corners of the country. The low budget accorded to health and the unenviably low priority of mental health does not make this task any easier. Alternative healing practices, especially religious healing, are still the first resort for many. Health care workers have to contend with misconceptions about mental disorders and the stigma attached to them. The 'brain drain' is another unfortunate aspect of the Indian mental health scene. The silver lining of these clouds surrounding mental health care is, undoubtedly, the availability of families, who irrespective of their financial status deem it their responsibility to care for their mentally ill relatives. They are indeed a rich resource, which should be exploited, while ensuring that they receive adequate support from health professionals and the community. The increasing number of mental health professionals, the availability of most newer drugs, access to information and the presence of a few centres of excellence augur a bright future for the mental health scene in India.

ACKNOWLEDGEMENT

We acknowledge the input from Dr K. S. Shaji to the section on old age psychiatry.

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