MAT Medicine Anthropology Theory

THINK PIECES

Commentary on 'Mental Illness, Psychiatric Institutions, and the Singularity of Lives'

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Abstract

'Mental Illness, Psychiatric Institutions, and the Singularity of Lives', a chapter of *Affliction* by Veena Das (2015), illustrates the sociocultural, familial, and personal factors that determine the trajectory of mental illness from its onset to treatment. Das discusses two case histories: a young boy suffering from psychotic illness and a young girl in conflict with her father. Both of them come from families residing in the urban slums of a large Indian metropolis. Reading this chapter gave us an opportunity to ask: how are cultural issues handled in psychiatric clinical encounters in India, and how are these taught to young trainee psychiatrists? The chapter also made us curious about anthropological methods and research vis-à-vis psychiatry.

Keywords

India, mental illness, anthropology, culture

The chapter 'Mental Illness, Psychiatric Institutions, and the Singularity of Lives' (Das 2015) discerns the signs, symptoms, and impact of mental illness in relation to the everyday lives of socioeconomically disadvantaged communities residing in urban slums of a large Indian

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metropolis. As Indian clinicians with expertise in mental health, we write this commentary with two aims: establishing a dialogue with colleagues in anthropology and introducing the subject to young psychiatrists practicing in India.

The case material for the chapter, as for the book, emerged out of fieldwork comprised of observations, focus group discussions, and activities for community projects with the Institute of Socio-Economic Research on Development and Democracy, an organization founded to study health conditions of poor urban communities. This chapter recapitulates some of the main claims Das makes about the experience of illness. Her first contention is that everyday life is disrupted when a person gets afflicted with an illness, and is more pronounced if they belong to a socioeconomically deprived group.[1] This resultant disruption (the author calls it 'incoherence') necessitates seeking others who may help in naming, understanding, and alleviating this experience. The second contention is that the person with illness and their family may seek help from allopathic, traditional, or folk traditions of healing, many practitioners of which are available in these neighborhoods. There is no 'either/or' approach to seeking out healers and no inherent or implied superiority of one form of healing over the other. The third contention is that the person with illness and their family continue with diverse routine activities despite the disruption. The fourth contention is that, in the Indian context, a diagnosis is one of many ways patients and their families seek to define their experience, and this is especially true in poor neighborhoods.

'Mental Illness, Psychiatric Institutions, and the Singularity of Lives' opens by juxtaposing several diverse historical contexts of madness: for example, how madness becomes a motif for expression of creativity, how mentally ill people are excluded from society, how patients are mistreated in psychiatric institutions, stigmatization, and discontinuity of personal narratives. However, the soul of the chapter resides in two case vignettes, which feel very Indian (especially the setting, values, aspirations, and relationship dynamics of families, and the pathways and delays in reaching psychiatric treatment) and immediately establish a connection with the reader. In both cases, the protagonists and families were not bothered by the diagnosis, which is something we notice routinely in our clinical practice; stigma was not the reason for seeking help from mental health services. Like so many others, the patient in one of the case studies was 'lost to follow-up', meaning he did not continue seeking treatment. These case vignettes help us understand why so many patients drop out of treatment.

1 The everyday life of a person can be discerned through the study of their relations, encounters, activities, and experiences.

The first case vignette is of a twenty-year-old boy named Swapan who hails from a family residing in an urban slum. He had a severe mental illness (described as bipolar disorder but most likely a psychotic illness), and was frequently irritable, with angry outbursts against his mother and sister. During such outbursts, he would beat them up, sometimes injuring them badly. He suspected his mother of mixing something in his food to harm him. He also behaved oddly, staring at the mirror and the TV for hours, and expressed no elation or depression. His condition progressively worsened to the point that he stopped bathing and eating. The family believed his condition to be due to demonic possession, and sought help from several exorcists but there was no relief. Many local medical practitioners were also consulted but none of them could help. One crisis after another kept on piling up, and the recurrent violence in the home led to the involvement of the police, neighbours, and extended family. After about three years, with the help from his extended family, he was forcibly taken to a psychiatrist. He was admitted to a psychiatric ward and he improved with treatment. But after discharge, the family did not take him for regular follow-up treatment. When they did bring him, the psychiatrist would spend very little time with him because there were many other patients waiting. As Swapan improved over time, he stopped the medications on his own and dropped out of treatment.

The background theme in the story is that the family was unable to improve their socioeconomic status like their extended family and neighbours. The mother blamed this lack of progress on the father's illiteracy. The idea of literacy as a forerunner of modernity (progress) resonates across different socioeconomic classes in India. In this story, 'modernity' means young men secure a good job (and marriage) and young women secure a good marriage (and job), leading to a prosperous life. Swapan's sister continued her education, got a job, and was engaged to be married. In contrast, Swapan's behavioural problems manifested when he failed his school exam (which may have happened owing to his illness). As a result, his mother became more invested in his sister, as her achievements were aligned with literacy and progress. The theme of modernity continued to haunt the patient's recovery: instead of getting a job, which was expected of him at his age, he wanted to study English. So the value of literacy played a role in the onset, symptoms, and recovery from mental illness. This vignette also brings out clearly the why, what, and how of the trajectories of help seeking that people in a socioeconomically deprived and politically neglected setting follow when a member of their family becomes mentally ill.

The second case is of Meena, a seventeen-year-old girl and bright student from a relatively well-to-do family. She was beaten up regularly by her father for her 'defiance', which is not considered a desired value in a young girl. Although her mother was sympathetic towards her, she did not have a say in the family. The young woman's rescue came when neighbours suggested that her defiance was due to possession by a spirit. This led the family to seek help at a shrine. As the family continued to seek explanations for and solutions to her

'problematic behaviour', someone suggested that 'tension' was the reason for the problems, and ultimately a psychiatrist's help was sought. A prescription of medicines from the psychiatrist helped and Meena's father stopped beating her as she was considered 'ill'. Meena was caught in a conflict between two different aspirational forces: her aspiration to study (to be modern) and her father and grandmother's aspiration of getting her married as a chaste and docile girl (to be traditional). Medicalization of the conflict helped in its resolution.

After reading the chapter, we were confronted with many questions: How is the knowledge of culture important in a clinical encounter? What literature is available? From where does this literature emerge? What is the Indian literature on mental health and culture? We are aware that in psychiatry, there has been seminal research done on culture in the last three decades by various scholars in the West. Some literature is available from India as well, and cultural formulation/competence is part of the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, and the forthcoming *International Classification of Diseases*, eleventh edition. Most Indian psychiatrists routinely address cultural issues while managing mental illness. But issues related to culture are not part of the routine vocabulary in clinical practice, teaching, or research. The most probable reason for this is the complete disconnect between what we learn during training and the real situations we later face in our clinical practice. During our training in psychiatry, anthropology was taught as transcultural psychiatry, with a focus on culture-bound syndromes, and we would 'memorise' the chapter from a standard Western textbook as it could be a potential question to be answered in the exams. However, we found the topic of culture-bound syndromes clichéd and an extension of 'Orientalism'. One of us, Mamta Sood, was trained in the early 1990s, when operational research criteria had come into practice, investigative techniques were being modernized, and the 'decade of the brain' had been announced; this came with a promise of finding biological markers and better treatments for psychiatric disorders.

For most of the psychiatrists practising in India, a similar disconnect exists for a number of other fields, such as community psychiatry. In the West, community psychiatry is synonymous with the deinstitutionalization of the 1950s and its aftermath. However, for a country with poor mental health resources like India in those times, there was no scope for deinstitutionalization as there were very few beds for mentally ill patients. In the last six decades, the number of beds in mental hospitals has increased by 75.2 percent. There were 10,181 beds for about 360 million at independence in 1947 (Sharma 2004) and currently the number is 17,835 beds for more than one billion (WHO 2011). Community psychiatry in India should have actually been focused on how to provide mental health services in the context of scarce resources.

The same is true for psychosocial interventions that are recommended for mental illnesses. Whatever we have read during our training about psychosocial interventions is rarely applied in practice, as there is a lack of non-psychiatrist mental health workers. India has only 0.05 clinical psychologists, 0.17 psychiatric nurses, and 0.03 social workers per 100,000 people (WHO 2011). The published research is of little help for understanding how to implement these interventions in settings with limited resources. Moreover, these ideas have mostly not been replicated in India. Most of the India-specific research on these topics published in leading psychiatry journals is largely funded by the West. Although the lead authors are Indian, most publications are coauthored by psychiatrists who have limited 'on the ground' understanding and experience of how people with mental illness are taken care of in India. There is a dearth of published longitudinal studies on what happens after a project team leaves the area.

Given this disconnect between the realities and the literature, most of us end up devising our own eclectic strategies in dealing with the issues at hand. Often pharmacotherapy is offered for mental illness, due to the ease of administration. It is less time consuming and practitioners can follow evidence-based research easily, as most medications are available in India. Psychiatrists may also throw in psychosocial interventions as per their inclination, which may be determined by place of residency training, setting of practice, motivation, time, and resources.

The opportunity to review this chapter by Das came as a breath of fresh air and prompted us to engage anthropologically with how mental illness manifests and is handled in India. This chapter shows the 'on the ground' reality of how sociocultural factors shape the onset, manifestation, and course of mental illness before a patient is treated. While reviewing this chapter we came across certain cultural issues that we have long been addressing without actually being particularly aware of them. During Sood's tenure as a psychiatrist in the Indian Army, she sometimes had to look after family outpatient services, which are the first point of contact for soldiers' families. Cultural understanding led to the resolution of many symptoms: for example, nonspecific pain in a young daughter-in-law (residing in a joint family with its own sets of customs and restrictions), whose soldier husband had come home on leave, would be resolved by prescribing 'small frequent meals and going for walk daily', along with medicines. The walks provided the patient much needed time with her husband and food-specific advice ensured a healthy diet, which was essential for her as she was, like many others, of childbearing age. The medical prescription made these recommendations acceptable to her family.

The chapter also prompted us to ponder a few questions related to anthropological methods and research vis-à-vis psychiatry. What are the methods adopted by anthropologists to conduct their work? Do they intervene if they find an issue that needs intervention during

their observation? If so, what is the extent of their involvement and what are the limits of their interventions? What protocols are used to secure informed consent from the community or research participants? The realm of anthropologists extends far beyond the clinic, and they have access to crucial information about what is happening in the homes, neighbourhoods, and workplaces of patients. In the West, the gap between the clinic and the home is fulfilled by the psychiatric social worker. This help is almost entirely absent in India due to meagre number of psychiatric social workers; here, the concept of 'home visit' is a rarity.

We asked ourselves: if we were allowed to address only one issue, based on the reading of this chapter, what would it be? The information provided by the anthropological study of these two cases is crucial. It reinforces the lesson that when mental illness strikes a person, not only the patient but the whole family suffers, so management should also focus on alleviating the distress of the family, taking them along in the course of follow-up. In the first case, had the treating psychiatrist engaged with the mother, it might have changed the outcome completely. In the second case, engagement with the father might have resulted in avoiding psychotropic medications for a purely social problem.

The core strength of the chapter is its account of mental illness as enmeshed in everyday life. Elaborate descriptions of the context and factual narrative of the events help us understand how life in an urban slum in India is experienced from within. The chapter details the different trajectories traversed in the provision of care to people with mental illness. Reading this chapter whetted our appetite for more. We strongly feel that anthropologists should take the lead in writing a chapter/book for psychiatry trainees.

About the authors

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