EDITORIAL

OUR PROBLEMS: OUR SOLUTIONS

Discussion on the unique characteristics of psychiatry in a non-Western country like India, often tend to be limited to culture-bound syndrome like Koro, possession state etc. It is, no doubt, important for us to be able to recognize these problems and render effective treatment to individuals suffering from them. It is also interesting to speculate on the cultural factors which contribute to the emergence of these phenomena and be aware of the local interpretations and traditional methods of dealing with them. However, the fact remains, that some of these syndromes are rarities even in our own country, while others which are widely prevalent, are seldom brought to psychiatric attention.

The chances of an article on a rare culture-bound syndrome getting published in a foreign journal is much greater than that of a paper on a condition widely prevalent all over the world. Since we tend to value the appearance of a work in a foreign journal more than in an Indian one, the proclivity of our authors to report on rare but colorful syndromes gets reinforced. A survey of published work by Indian authors in foreign journals may give one an impression that psychiatric practice in India is centered around Dhat syndrome, Banamati sorcery and Koro. However the majority of patients seen both in psychiatric institutions and private practice in this country are those who suffer from disorders common all over the world and who can be diagnosed on the basis of criteria applicable in other cultures as well. Does this mean that the diagnostic and therapeutic approach of the psychiatrist in India need not be different from those of his Western counterpart? Findings of International Pilot Study on Schizophrenia and the study on the Determinants of Outcome of Severe Mental Disorder have shown that while psychiatric disorders seen in India are similar to those seen elsewhere, they bear a special cultural stamp with regard to their manifestations and outcome. Thus, it is the special responsibility of the psychiatrist in India to be able to maintain an international perspective, while having his feet firmly set in the social and cultural milieu of this land.

How are we to maintain this balance? One of the basic needs is to be aware of the pathoplastic effect of cultural factors on the clinical features of psychiatric disorders. Current understanding about somatization is an example which proves this point.

Somatization has been well recognized to be a common mode of expression of emotional problems in many cultures. It was often thought that a high level of somatization is a characteristic of non-western cultures, but this myth has been exploded by studies which showed that emotionally distressed patients in the West also, tended to present to their general practitioners with somatic symptoms instead of talking about their social or psychological problems. The effect of racial difference on somatization is probably less than those caused by differences in education and social class. Recent work has shown that it is important to distinguish between true somatization, where the patient presents with somatic symptoms with no underlying organic disorder or primary psychological symptoms and culturally determined abnormal illness behavior where, in addition to obvious somatic symptoms, a careful psychiatric assessment reveals presence of psychological symptoms like depression or anxiety (Cheng, 1989). Kachwaha et al report that 68% of patients with chronic abdominal pain had psychiatric symptoms and 52% had a psychiatric illness, thus supporting this view. In other words, over representation of somatization in non-western cultures is often due to a failure of the interviewer to understand the cultural idiom for emotional distress. Somatization is a positive way of communicating distress, unlike alexithymia, because unlike psychiatric symptoms, physical symptoms evoke a sympathetic response from those around.

The importance of being able to appreciate variations caused by cultural factors in the presentation of a disorder is exemplified by studies which have shown that a disorder like Anorexia Nervosa which at one time was considered to be rare or even absent in oriental cultures, is not so rare in countries like India and China. A Chinese patient with anorexia refuses to eat because of the sensation of "abdominal bloating" and not because of fear of obesity or a distorted body image as observed in the West. Such findings however do not justify the need to consider every cultural variation of a particular disorder as a separate nosological entity. Thus Lin et al (1992) showed that the Korean malady "Hwa Byung" with multiple somatic symptoms is also associated with predominant dysphoric mood and so is very similar to DSM III-R Major Depressive Disorder.
The high prevalence rate in India of socially stigmatizing diseases like leprosy makes it necessary for psychiatrists in this country to pay attention to the identification of the psychiatric problems among these patients. Verma and Gautam (this issue) report the presence of neurotic depression and anxiety neurosis in a high percentage of both rehabilitated and non-rehabilitated patients, which points to the incompleteness of our rehabilitative efforts and the importance of paying attention to the psychological aspects of the patient in any rehabilitation program. It is also interesting to examine the impact of traditional beliefs on the acceptance of treatment for these diseases. Weiss et al (1992) found that cultural beliefs on the etiology of leprosy such as magico-religious influence or effect of humoral imbalance did not interfere with patients taking a positive attitude towards bio medical treatment, thus making it unnecessary for the modern physician to spend his time in "efforts to debunk indigenous theories".

The impact of religion on psychiatric disorders is an issue which has been little studied. Religion in today's Western psychiatric concept is often made to have a pejorative connotation. For example, DSM III-R has an unfortunately large number of religious examples to explain the various criteria, resulting in an impression that religious affiliation is a sign of illness, possibly reflecting the high prevalence of atheism among American psychiatrists (Post, 1992). In Western literature it is rare to find an article like that of Larson et al (1992) which draws our attention to the positive effect of religion on mental health. A majority of psychiatrists and their patients in this country still retain strong religious affiliation. This gives us the unique opportunity to study the impact of religious beliefs on the presentation and outcome of psychiatric disorders. It is pertinent to remember in this context that the SOFACOS report showed presence of religious activities as one of the factors which contributed to a positive out come in schizophrenia.

Many recent studies from India have drawn our attention to the increasing number of attempted and completed suicides among adolescents and young adults. Many of them do not fit in to Durkheim's descriptions of anomic, egoistic or altruistic suicide, but are closer to "indignant suicide" (Holian, 1990) where a young person who subscribes to the traditional notions of entitlement and justice resorts to suicide as an expression of his rage and disappointment at the infringement of these values. Studies in U.K. have shown that overdosage serves as a communication by the least powerful people in a society, of their social distress and results in at least temporary change in the environment (Hodes, 1990). It will be useful to study these sociological aspects of suicide and attempted suicide in our culture because it may help us to deal with these problems in a more socially relevant manner.

Psychiatrists may not always be able to determine the cause of social problems or suggest remedies for them because our expertise is limited to the treatment of a small number of mental disorders. Yet those with a social perspective may be able to invite attention to the social problems in the country and give us a better understanding about them, as Kapur's D.L.N. Murti Rao oration on 'Violence in India' does. Being aware of the psychological and social basis of problems will also help us to avoid the tendency to medicalize them. Scheper-Hughes (1988) pointed out how symptoms of semi-starvation among a group of Brazilian sugar-cutters was misdiagnosed as psychiatric disorders and resulted in the dispensing of psychotropic medication, instead of paying attention to psychosocial stressors such as poverty, discrimination, role-conflict etc.

Effective utilization of existing remedies in our culture and the evaluation of their efficacy is another area which remains a special responsibility of the Indian psychiatrist. There have been many papers on the effectiveness of yoga and meditation in the treatment of neurotic disorders. Yet these methods are seldom prescribed to patients by psychiatrists, as Grover et al state in their review article.

The concept of increasing facilities for treatment of psychiatric problems is often restricted to increasing the availability of psychotropic drugs. Such efforts to spread psychiatric care 'thin' may have adverse effects. Higginbotham and Marsella (1988) reported that the net result of introducing a formal treatment system for psychological problems may prove to be less of a help for those in need. Such efforts may discredit the traditional systems of care while the new programs intended to replace them are scare and socially distant. The task ahead of us therefore is to sharpen our skills to identify and delineate our problems to modify existing remedies and to develop newer ones to benefit our patients in our cultural context.

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