MENTAL HEALTH SERVICES IN DEVELOPING COUNTRIES

PAPERS PRESENTED AT A WHO SEMINAR ON THE ORGANIZATION OF MENTAL HEALTH SERVICES, ADDIS ABABA, 27 NOVEMBER TO 4 DECEMBER 1973

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The papers in this work (with the exception of the first introductory paper) were all presented at a seminar on the organization of mental health services which was held in Addis Ababa from 27 November to 4 December 1973 under the auspices of the World Health Organization's Regional Office for the Eastern Mediterranean. The seminar was held at a time when WHO was making preparations for an expert committee which was to consider the organization of mental health services in developing countries (held in Geneva from 22 to 28 October 1974) and reflected the growing concern with the problems of mental health care in the developing world. Many of the issues raised and discussed in these papers are central to the work of the subsequent expert committee. An introductory paper has therefore been included, so that the papers which follow can be read in the context of the overall programme of WHO in mental health services. The purpose of this introductory paper is neither to summarize the papers which follow nor to pre-empt the report of the expert committee on organization of mental health services in developing countries; it is to draw together some of the key issues which face WHO (including its expert committee) as well as governments and individuals who are concerned with the problems of mental health in the developing countries.
MENTAL HEALTH SERVICES IN THE DEVELOPING COUNTRIES:
THE ISSUES INVOLVED

T. W. Harding

The law of diminishing returns operates with striking effect in medicine (Powles, 1973) and has led to the paradoxical situation in which increased efforts in the already highly developed medical services of industrialized countries are made with enthusiasm and high expectations but are then matched by decreasing returns which lead to disappointment and growing scepticism. In a situation where health efforts have been very limited, as in the developing countries, one would predict an opposite experience. Modest investment should produce a relatively large effect. This prediction is subject to an important proviso: in the initial phase of development the services must be directed at those conditions which are prevalent, which have serious, harmful consequences, and for which low-cost control measures or treatments are available with relatively high returns in terms of health effect. That such an approach is feasible and applicable to the field of mental health is shown by the success of a number of innovative efforts in various parts of the world. In most cases the key to such efforts has been to include in the care of the mentally ill those who previously had no mental health function - for example, hospital assistants in Sarawak (Schmidt, 1967), medical assistants in Zambia and Uganda (Edgell, 1970), public health nurses in Colombia (Argandona & Kiev, 1972) and the community in general, as in the Aro village system in Nigeria (Lambo, 1968). The results have been gratifying and indicate that real progress can be made even with limited resources. Although such successful programmes have been carried out in many parts of the developing world, this should not be allowed to disguise the fact that the great majority of the mentally ill in the developing countries have no access to any kind of effective mental health care and that as a result there are, today, over 40 million people suffering from serious untreated mental disorders. There is therefore a remarkable and challenging situation in which on the one hand there is an enormous human problem (co-existing, of course, with other urgent needs) for which resources are extremely scarce and, on the other hand, there do appear to be realistic and effective ways of tackling this problem. If any progress is to be made in applying such innovative methods on a wider scale, a number of obstacles have to be overcome and issues faced. These are considered in the rest of this paper as follows: the "importance" and "priority" of mental health; the structure of mental health services; the provision of manpower and training; and questions of administration (including legislation).

The "importance" and "priority" of mental health

This issue readily generates disagreement. On the one hand it is still argued by some that problems of infectious diseases and malnutrition are so great and the needs for clean water, sanitation and maternity services so pressing that it is premature to provide services for the mentally ill in the developing countries. This line of argument is often linked by implication with an assumption that mental illness is not itself a significant problem in such countries. Such an assumption is, however, no longer tenable and the public health problem posed by mental disorders has been widely recognized in recent years (Diop, 1974): reliable epidemiological studies have indicated that the prevalence of schizophrenia and the affective psychoses is remarkably constant throughout the world and there is similar information concerning mental retardation and epilepsy. The extensive harmful consequences which result from the failure to provide adequate treatment for such disorders is also becoming clear. The acutely disturbed suffer deprivation and maltreatment, which exacerbate their illness and impair recovery; those with long-standing psychosis function at far below their optimal level, which causes an unnecessary burden on the community as well as personal distress; and patients with highly prevalent non-psychotic disorders presenting somatic symptoms may seek relief from existing medical services but too often receive inappropriate treatment. Since effective treatments are available for these conditions, there is clearly a case for health action. This case must, however, be considered in the context of the overall needs of the developing countries. Special pleading for psychiatric services or

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overemphasis of the importance of mental illness or the effectiveness of available treatment would be as inappropriate as the outright rejection of the case for any mental health services. A balanced view should be sought and should take account of, on the one hand:

1. the failure in most of the developing world to provide basic health services of any kind for more than a small minority of the population;

2. the limited resources available to meet needs not only in the health field but for other services and for economic development as a whole;

3. the urgent needs resulting from diseases that threaten life; and, on the other hand,

4. the effect that public health measures have already had on such life-threatening diseases by reducing mortality and making the chronic disabling conditions relatively more important;

5. the fact that effective, relatively simple treatments are now available for a wide range of mental disorders; and

6. the prevalence of such disorders and the consequences for the individual, his family and the community as a whole.

The importance of mental health cannot therefore be assessed in isolation and one of the first aims should be to include consideration of mental health needs in any overall health planning exercise.

There is also a need to be much more specific than in the past in defining mental health services. Health planners are not likely to respond to imprecise requests for services described with a blanket reference to "mental health" or "psychiatry". They will want to know: which conditions are to be catered for? what is the coverage aimed for and how many patients will be involved? who will provide treatment? what treatment will be given? how much will it cost? and what effect will it have?

The present state of knowledge with regard to prevention, treatment and rehabilitation of the whole range of mental disorders should allow a clear description of the various service elements required, with an indication of their relative priority. Such an itemized approach may seem foreign to psychiatry but it is essential in any planning exercise, since only in this way can definite objectives be stated which can be the subject of subsequent evaluation. This approach does not, of course, imply that mental health practice should be itemized in this way; the only relevant framework for practice is the whole person and his place in the community. In the same way, while we consider a building as a functional whole, the architect must specify in detail the various materials and subsystems involved in its structure. In so doing he must make a compromise between the ideal and what is possible in a given situation, i.e. he aims to produce the "best possible design". In mental health, we need to differentiate between the problems posed by, for example, acute psychiatric emergencies, childhood behaviour disorders, epilepsy, chronic schizophrenia, suicidal behaviour, non-psychotic disorders and the addictions, and to define the service needs for each of them separately. In doing this the issue of priority and importance for mental health as a whole disappears, as it should do. Instead there should be a series of service proposals, each linked with specific objectives which can be matched with the available resources as general health services develop.

The structure of mental health services

A number of service models are familiar: the mental hospital, the outpatient clinic, domiciliary services, the general hospital psychiatric unit, day care, night care, hostels, sheltered workshops, community care, "walk-in" clinics - the list could be extended even further. The risk is that this becomes a shopping list presented to the health planner whose first thought will be the enormous expense of such a "comprehensive" service. The temptation will be to provide little or nothing.
In planning services, therefore, the total structure must be specified and the function
of each constituent part clearly defined and related to overall objectives. The kind of service
structure appropriate for mental health care should take account of the following factors.

(1) The pattern of mental illnesses - their prevalence, distribution and natural history.

Mental disorders are ubiquitous; they are characterized neither by "epidemics" nor by
striking geographical concentrations of morbidity (there are some exceptions, e.g., certain
addictions, some organic conditions, and the problems of deprived urban areas). The extent
of the problem is disguised by its low profile. Furthermore, many mental disorders are
chronic, relapsing or episodic. The problem is therefore not one that can be tackled by
time-limited campaigns or by localized and concentrated effort; services need to be continuing
and to cover all communities.

(2) The nature of treatment and management.

Treatment and management for mental disorders may vary between doing very little and a
wide range of measures provided over many years. For many conditions, however, the following
features are characteristic:

(a) treatment should be available over a long period;
(b) a variety of approaches are used; overall management may involve drug therapy,
social support, simple psychotherapy and other techniques;
(c) although inpatient treatment is necessary at times, it should be limited as far as
possible. Prolonged institutional care is undesirable;
(d) there are great advantages in continuity of care and involvement of the family in
treatment.

The implications for service structure are that treatment should be available at community
level on an ongoing basis and should be provided by regular staff with close knowledge of the
community concerned. There should be access to hospital facilities and these should be as
near as possible.

(3) The structure of existing mental and general health services.

Where mental health services exist, they are often in the form of a large centralized
mental hospital established during the colonial era and fitting the general pattern of centri-
gugal development of services. Such hospitals have been the subject of considerable criticism
in recent years - much of it justified. The hospitals tend to be custodial in nature,
withdrawing patients from the community and making rehabilitation difficult. Follow-up is
often impossible and the "apartheid" which exists between psychiatry and the rest of medicine
is further emphasized by such hospitals.

In many places there are no mental health services by name and such care as does exist is
provided by traditional healers of various kinds, religious bodies and groups, the extended
family, the police, other law-enforcing bodies and various community agencies. In some cases
such care is clearly harmful, but in others it may be effective (Harding, 1973). Since it is
likely that the development of a comprehensive mental health service in such a situation will
take many years, careful consideration should be given to such "non-medical" sources of care.
Outright condemnation and attempts to restrict established practices may induce a backlash of
negative attitudes to modern mental health care and may also create a vacuum in which neither
traditional nor modern care exists. Although the ultimate aim is to establish comprehensive
services, in the initial phases of development the structure cannot be exclusive, separate or
rigid but should allow for cooperation among and exploitation of all sources of help.
General health services are in many places absent or very limited. This clearly limits the possibility for development of mental health services. On the other hand, the fact that many countries have still to develop basic health services, and are likely to use innovative methods when they do, offers a great opportunity for mental health. WHO has stressed the importance of accessibility and acceptability of basic health services and in many countries a pattern is emerging in which modestly trained health workers provide such services at community level. The possibility of including mental health in such basic services is both exciting and challenging. Exciting because it offers a real possibility of increasing coverage substantially, but challenging because of the completely new approach to service organization that would be required. Where general health services have been developed to some extent, the structure of mental health services should take account of this. The establishment of a psychiatric unit in general hospitals, with an active outpatient service, has been shown to be an effective method of providing mental health care. Where curative services attract large numbers of new patients, the psychiatric morbidity therein should receive attention and appropriate care.

(4) The distribution and density of population.

Service structure must vary according to population density and distribution. In very sparsely populated rural areas, some degree of centralization is unavoidable. Follow-up and other community services could possibly be provided by mobile teams (these may have multiple functions, e.g., immunization, infant care, mental health and leprosy control) although the disadvantage of transport costs and time taken in travel should be carefully considered. The majority of the people of the developing world live in fairly densely populated rural areas. In such areas static community services are feasible, although problems of transport for supporting services and referral of cases may exist. Here the main organizational problem is the provision of effective supervision and stimulation of workers at community level. In rapidly growing urban areas, several possible service structures could be used depending on circumstances - services could be based on existing mental hospitals, suitably modified, or on psychiatric units in general hospitals. There might also be a case for specially trained mental health workers in urban areas.

It follows from the discussion above that the key area in the service structure is the most peripheral - at the level of the village community or urban subdistrict. Only by involving the most distal elements in health services (which will, of course, be most proximal from the patient's point of view) can ongoing treatment with continuity and involvement of the family be provided. The same applies to the use and encouragement of other nonmedical sources of care within the community. This should be the starting point in considering the structure of services. The rest will consist of supporting services and referral channels which will be necessary, for example, to provide inpatient treatment and decisions concerning drug therapy. Such an approach will necessarily involve general health services and it is difficult to see how any significant coverage can be achieved without some degree of integration of mental health with general health services. This has been shown to be both feasible and effective in general hospitals, and the implications for health centres and community services need to be carefully followed through. Attempts to establish mental health services before basic health services are available are likely to result in a centralized system with poor follow-up services. On the other hand, if basic health services develop and mental health care is not available, patients who present with psychiatric illness will not receive appropriate treatment, with detrimental consequences both for the patient and the service.

Manpower and training

Available staff with specialized mental health skills are so few that the health effect of their direct clinical work will be negligible. Only by involving others can mental health services be extended and to achieve this the possible role of all health workers should be examined: doctors, nurses, village health workers, medical assistants, dispensers and others. A general approach to the mental health function and training of such workers is unlikely to be successful. There is too wide a variation in educational level and working situation. A preliminary step must be to differentiate the tasks which various kinds of health worker could perform and then to design appropriate training methods for each category of worker. New approaches to training should be considered - including the use of manuals, audiovisual techniques and team training.
Direct experience during training of patients is particularly valuable, since many trainees will approach mental health tasks with negative attitudes. The question of sensitivity and understanding of human and emotional issues is of great importance for all health workers, particularly those working at community level. Here the village health worker might have a great opportunity to develop increasing knowledge of the community he serves and to respond appropriately to the needs of individuals. His training should therefore include human and social as well as biological aspects; for example, such workers need to be trained to listen as well as to advise.

Those with specialized skills will have an important function in training and supervision of others and this should be reflected in their own training. At present the training of psychiatrists for developing countries is usually carried out in one of the industrialized countries. Skills are inappropriate and, with a few exceptions, low morale, a high emigration rate and recourse to private practice result. If training was matched to the needs of the developing countries, this could be avoided and the problem of the low status attached to psychiatry could also be partly resolved.

Administration

The issues involved in administration follow from the discussion above. Every planning authority for health services should have access to mental health advice. All psychiatrists and senior nurses should be involved in some way in the administration of services and their various responsibilities should be clearly defined. At all levels (national, regional and district) clear objectives should be set out and revised regularly. They should be stated in terms (including time element) which allow evaluation and if possible should indicate the health effect aimed for. It follows that there is a need for collection of data, which should be simple and readily available if they are to be useful.

Little progress can be made in service development unless there is appropriate mental health legislation. Apart from providing ready access to treatment and necessary safeguards for the individual and society, legislation should be as simple as possible. Complex provisions may consume valuable time of psychiatrists in legal matters and are rarely necessary.

Conclusion

The issues outlined above run as themes through the subsequent papers. They reflect a serious situation in which, although some recognition has been given to the problems and needs of mental health, the great majority of people in developing countries have no access to mental health services. It may be thought that the approach is unduly pessimistic and that the emphasis on failure is unwarranted. If the World Health Organization is to give sound and practical advice and assistance to its Member States, the basis of such advice and assistance should be both objective and realistic. If possible it should be supported by evaluative studies of triall mental health services, planned and executed on an international collaborative basis. Where resources are severely limited, an overall rational and cautious approach will allow emphasis to be placed on key areas, likely to yield the greatest return; undue optimism and global statements of great need do not contribute to rational planning and should be avoided.

REFERENCES


PART 1. CONCEPTS OF MENTAL ILLNESS

EVOLUTION OF CONCEPTS OF MENTAL ILLNESS AND MENTAL HEALTH CARE

E. Fuller Torrey

One of the best developed parts of the human brain is that part which allows us to glorify ourselves. It is this part which man has always called upon when thinking about evolution, and the brain usually responds rather predictably by putting man at the pinnacle. Just as the cave man proudly thought he had reached the end-point of human evolution when he invented fire, we too secretly think that we have reached the highest possible perfection of man with our ideas and our institutions.

Evolution, however, belies such thoughts in its very concept. It is a dynamic process which continues on and on, oblivious of the static self-glorification which man claims along its way. Inherent in evolution are false starts and dead ends, though man perceives these with difficulty except in retrospect. To be specific, concepts of mental illness and mental health care have been evolving for hundreds of years and are still evolving. Our present concepts are not necessarily a pinnacle; in fact, they may even be a false start, or a dead end. It is important that we keep these possibilities in mind, though it is difficult for our brain to do so.

A second preliminary point which must be kept in mind is that developing countries can play a very important role in the evolution of ideas and institutions. In countries which are highly developed, ideas and institutions become set, cemented in place by tradition and the natural inertia of those who would like to think that they have final answers. Developing countries have a greater latitude for choice and a wider range of options than do developed countries, simply because these traditions and inertia have not yet become fixed.

This is certainly true in the case of mental illness and mental health care. Developed countries have arrived at rather fixed ideas during this century about who should be labelled mentally ill and what kind of care they should receive. These ideas become codified as "The Truth" in textbooks of psychiatry and in sets of regulations and recommendations such as those of the World Health Organization.

A developing country can either accept these "truths" from developed countries or it can logically think through and adopt a system for itself. Unfortunately the former is usually the case. The pressures in a developing country to adopt a model from a more developed country are great, stemming from decision-making officials who have been trained in the developed countries and are eager to apply what they have learned; the hope that by adopting ideas from the developed countries the developing country will also adopt its status and/or prosperity; and the fact that importing answers is easier than building them at home. But, if a developing country decides to go it alone and build its own system of mental health care, then it can participate in the evolution of ideas and institutions. Maybe developed countries are following a dead end branch on the evolutionary tree. Maybe the best system for providing services to the mentally impaired has still to emerge. This is both the fascination and the challenge of being in a decision-making position in developing countries. It should be kept in mind as we trace the evolution of concepts of mental illness and mental health care. There are three major streams of thought - the religious, the medical, and the psychological.

The religious stream

Religious explanations for aberrant behaviour date back to the beginning of man. At whatever point man first conceptualized devils, demons, and his own disembodied spirit, that was when he also saw the possibility of these things being responsible for strange behaviour. Religious explanations have always been widespread and continue to be very common explanations around the world.

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During the Middle Ages the religious stream became very strong. People who acted strangely, by the standards of the day, were thought to be afflicted with devils and demons. This reached a culmination in the witch-hunts and the Inquisition, during which hundreds of people were put to death. The Catholic Church staunchly supported the movement, with Pope Innocent VIII issuing a papal bull in 1484 in support of witch-hunting. In addition, two Jesuit theologians wrote the notorious Malleus Maleficarum, the tract which became the authoritative bird-book of witch-hunting telling you not only how to recognize various witches by their colour, call, and behaviour but prescribing the best torture to confirm identification in each case.

Burning people at the stake because they act strangely may seem like a cruel and absurd remedy to us, but that is only because we do not share the concepts of mental illness prevalent in the Middle Ages. If you really believe that devils and demons exist, and that they afflict people and cause them to act strangely, then a logical remedy is to drive the devils and demons out of the body. Beating the afflicted person is one way. If this fails, more extreme measures are called for, up to and including burning the devils and demons. The fact that the afflicted persons die in the process is unfortunate but incidental; you have the consolation of knowing that you saved their soul even if you could not save their body.

I emphasize this example because it makes an important point: concepts of mental health care follow directly and logically from the prevalent concepts of mental illness. This is true of all three streams that we will be discussing. The burning of witches did not arise by itself or out of a malicious, sadistic desire to hurt others. I suspect that most of the judges and bishops who condemned suspected witches to death were well-meaning individuals who actually thought that they were helping the poor afflicted souls brought before them. It is important to keep this in mind.

A variant of the religious stream is the belief that aberrant behaviour is caused by God or gods as a punishment for wrongdoing or sin. This idea is very prevalent in every country in the world. It is not usually found in textbooks of psychiatry but it is found in the thinking of people who present for help. The logical approach to this problem, if you accept a religious framework, is expiation, confession, and prayer. If, however, the God or gods are beyond the call of man, and do not listen to us, then the only logical response may be fatalistic resignation.

The medical stream

The medical stream of thought about aberrant human behaviour is almost as old as the religious stream. The two are fused at many places and times in history, as in the physician-priests of Mesopotamia and their counterparts in many parts of the world today. The medical stream assumes, in one form or another, that aberrant human behaviour is caused by disorders of the body, including the brain.

It was during ancient Greece and Rome that the medical stream reached its initial prominence. Irrational behaviour of various kinds was attributed to an imbalance of the humours, as for instance depression being due to excessive bile. Another medical explanation was that of a displaced organ, as in explaining hysteria by a wandering uterus. These are the early beginnings of the medical model that has come to dominate our thinking about irrational behaviour; the idea that "for every distorted thought there is a distorted molecule" is just a more sophisticated extension of this model. The person behaving irrationally is "sick" just as surely as a gallstone causes pain.

During the Middle Ages the medical stream went into a decline as religious explanations took over. From the Renaissance onwards the medical stream regained its dominant position as an explanation of irrational behaviour. At Geel in Belgium the word "sickroom" was written over the annex to the church where "possessed" people were coming to be "cured" in the thirteenth century (Dumont & Aldrich, 1962). A major step was the beginning of confinement for such persons. Although at first this was done just as part of a general confinement of the poor and criminal, it soon developed a medical rationale. The ships of fools came to anchor and were called "hospitals". From the end of the eighteenth century, the medical certificate becomes almost obligatory for the confinement of "madmen" (Foucault, 1965). And simultaneously religious explanations of irrational behaviour ebbed.
By the end of the nineteenth century the medical stream had become very powerful indeed. This is the century of rationalism and positivism, the belief that man was governed by natural laws and that all these laws could be elucidated through science. It is the era of Darwin, showing man in his place alongside other species, fixed there by laws of natural selection. Freud acknowledged a strong attraction to Darwin's theories, "for they held out hopes of an extraordinary advance in our understanding of the world".1

In medicine the major advances were in microbiology and surgery, both reinforcing the role of the patient as a passive receptacle for organisms, stones, and growths. Virchow, Pasteur, Lister, and Semmelweis in the 1850s and 1860s were the beginning. Then, when in 1876 Koch demonstrated the bacteria that causes anthrax, a period began which was to bring new discoveries of bacteria and other organisms almost monthly for the next 25 years. There was every reason to believe that bacteria would explain everything wrong with man, including his occasionally irrational behaviour. Further support for such thoughts came from the three most common nonsurgical diseases of the era - syphilis, tuberculosis, and typhoid. Each sometimes produced irrational thinking or behaviour in those it afflicted; other such thinking or behaviour, it was reasoned, must be caused by other diseases.

The rise of neurology in this era further reinforced the medical model. For the first time it became possible not just to speculate about brain diseases but actively to explore them. Sir Charles Bell initiated the neurological advances in 1811 with his proposal about how sensations are carried by the spinal cord. Neurophysiology received an impetus from the work of Hitzig and Fritsch in the 1860s, electrically stimulating the brains of dogs and later of man. Sechenov and Pavlov carried on this mechanistic tradition and further refined the idea that the brain was a stimulus-response machine. Advances in neuroanatomy resulted in localization of specific areas of the brain for specific function (e.g., speech). Studies in neurohistology clarified the cell structure of the brain, and brought Golgi and Ramon y Cajal a Nobel Prize in 1906. The status of eminent neurologists was very high - men like Karl Wernicke in Germany, John Hughlings Jackson in England, and Silas Weir Mitchell in America - and all believed that irrational behaviour was caused by "mental disease", disease in the brain.

In the midst of these advances in microbiology and neurology, psychiatry began to emerge as an entity. And it was firmly a medical entity. Its provenance was restricted to only a portion of people who were acting irrationally - the madmen, insane, and lunatics. Most of these people we now call "psychotics". The leaders of this emerging medical specialty were Griesinger in Germany, Maudsley in England, and Rush in the United States, and all were strongly medically inclined. Psychological explanations of irrational behaviour were anathema to them. Griesinger believed that "we recognize in every case of mental disease a morbid action of that organ (the brain)" (Alexander & Selesnick, 1966). And Rush, the founder of American psychiatry, used a spinning chair as his main therapeutic tool to counteract congested blood in the brain:

In my intended publication upon madness, I hope to satisfy you that the disease is arterial, and that without morbid action in the blood vessels of the brain no form of the disease can exist (Galdston, 1967).

The culmination of this total medicalization of irrational behaviour was Emil Kralpein. In the early years of the twentieth century he put the final medical seal on irrational behaviour by naming it and categorizing it. Irrational behaviour could now hold its head up in medical company for it had names - names like dementia praecox and paranoia. These names described everything and explained nothing. Kraepelin believed strongly that irrational behaviour was caused by heredity and constitution. He was antipsychological and a therapeutic nihilist. His classificatory system continues to dominate psychiatry up to the present, not because it has proven of value - indeed it is largely ignored by younger psychiatrists - but because it is the ticket of admission for psychiatry into the orderly house of medicine.

The psychological stream

The psychological stream is considerably newer than either of the other two, and it has never had the strength of either. Rather than fixing the cause of man's aberrant behaviour in wandering incubi (devils) or wandering uteri (disorders of the body), the psychological stream postulates that man is fundamentally in control of himself and can, given sufficient

intellect and self-understanding, act rationally. This stream has roots which stretch back into the Greek tradition of rational psychology, the belief that reason will enable a person to overcome error and irrational behaviour. New behaviour, in this system, was thought to be brought about by admonitions and exhortations. Through the ages small contributions to the psychological stream continued to appear but they were always overshadowed by the other two dominant traditions. Johann Weyer, sixteenth century physician, advocated seeing witches as "poor, miserable, old, deteriorated and melancholic women" rather than as possessed by demons. He even used a form of therapy similar to modern psychotherapy (Galdston, 1967). But his contribution is so unusual that it simply provides a relief against which to observe the dominant picture of that period.

Another contribution to this stream was the work of Pinel and Tuke. Through their emphasis on the humanness of "madmen" they focused on the person himself. When they cut the chains and freed "the insane" they were not only liberating them so that medicine could claim them as "patients", but allowing irrational behaviour to be seen as human action by human beings. This was an important precedent for the psychological stream.

Franz Mesmer, the father of hypnotism, was another contributor to the psychological stream. He believed that his powers were due to a magnetic fluid so in actuality he was in the medical tradition. However, the net effect of his contribution was to advance the psychological stream considerably. He was the first to appreciate the qualities of the person doing the "magnetizing", and by the nineteenth century textbooks on magnetism included a chapter on the personality of the magnetizer and his professional ethics (Galdston, 1967). Nor did Mesmer believe that it was necessary to be a physician to be a good magnetizer. The golden age of magnetism in the first half of the nineteenth century produced a dual concept of conscious and unconscious, exploration of the psychological dimensions of the mind, and the realization that one person could help another person change his irrational behaviour.

Magnetism exerted a powerful influence on the thought and literature of the nineteenth century. Schopenhauer said that "from a philosophical point of view, Animal Magnetism is the most momentous discovery ever made" (Galdston, 1967). Others like Poe and Balzac were similarly influenced. And it was from the writers and philosophers of the period that the psychological stream received its greatest impetus. Nietzsche, Herbart, Fechner, Stendhal, Shaw and Ibsen all wrote insightful accounts of human motivations and behaviour. Dostoevsky's brilliant description of madness, representing the psychological stream, stands out in sharp contrast to Kraepelin's sterile attempts to pigeonhole the same behaviour in the medical stream. One of the very few physicians to contribute anything to the psychological view of man was William James, and his contribution only came as he evolved away from medicine into philosophy.

One other development at the end of the nineteenth century gave brief hope that the psychological stream might achieve maturity as an independent model for viewing man's behaviour. In France two new schools of psychiatry were emerging, a Salpêtrière School under Charcot and a Nancy School under Bernheim. They both made hypnosis respectable once again, described and studied many conditions which were to be labelled as "neuroses", promoted the idea that many emotional disorders could be cured without exercising devils or brain cells, and coined the term "psychotherapy" about 1890. Pierre Janet, another major French figure of this period, added the idea that neuroses were due to "subconscious fixed ideas" and advocated "automatic talking" (a precursor of free association) as a type of therapy. These men were within the medical tradition, but clearly stood in sharp contrast to the mainstream of medicine of their time. They strained the model, but they were not to prevail.

It was at this point that Sigmund Freud came upon the scene. Though his theories have become an integral part of the psychological stream, Freud himself was clearly part of the medical stream. His principal teachers (Brücke, Meynert and Brentano) were all wedded to the medical and scientific tradition. Freud's early work was in neurology, and his early observations were conceptualized in mechanistic terms compatible with medicine. His early writings read like a handbook of physics, with mental energy (especially "libido") having the properties of an electrical charge, being blocked by "resistances", and causing havoc if it were excessively dammed up. The unconscious was conceived of as a deepseated organ operating with laws similar to those of physical energy. At some points, if you substitute the word "humour" for "libido" it begins to sound very much like the ancient Greeks. In one of his early writings on neurosis Freud says:
All that I am asserting is that the symptoms of these patients are not mentally determined or removable by analysis, but that they must be regarded as direct toxic consequences of disturbed sexual chemical processes, specifically from excessive masturbation and too numerous nocturnal emissions.¹

Late in his career Freud apparently decided that he had made a mistake in categorizing his observations under medicine. His fight to enable psychoanalysis to be performed by lay persons was the culmination of his efforts to reverse his previous work. Non-physician (lay) analysts had been very important in the development of his theories from the beginning. Reik and Sachs in the "Inner circle" were joined by Bernfeld, Reich, Pfister, Anna Freud, Melanie Klein, Aichhorn, Kris, and Walder. These people were not doctors, yet they were practising psychoanalysis and making major contributions to Freud's psychological theories. Freud logically realized that something was wrong with his medical model, and fought bitterly for the acceptance of lay analysts. This fight "most keenly engaged Freud's interest, and indeed emotions during the last phase of his life" (Jones, 1955).

Freud himself is very clear on the subject:

The internal development of psychoanalysis is everywhere proceeding contrary to my intentions away from lay analysis and becoming a pure medical speciality, and I regard this as fateful for the future of analysis (Jones, 1955).

He never changed his mind on this. One year before his death he affirmed it: "The fact is, I have never repudiated these views and I insist on them even more intensely than before" (Jones, 1955). He believed that "it was a matter of indifference whether intending candidates for psychoanalytic training held a medical qualification or not", and even urged such candidates not to bother with medical school (Jones, 1955).

Where are we now?

Freud in the end lost the fight. With his death and the decimation of European psychoanalysis during the Second World War, the field was left to American psychoanalysis. And in America the medical model had strongly prevailed.

This remains true up to the present, at least in theory. The medical stream has continued to be dominant, as illustrated by the very title of this seminar - "The Organization of Mental Health Services". It is not entitled "Organization of Services for Those Possessed by Devils" nor is it entitled "Organization of Services for Those Who Need Further Education and Insight to Control Their Behaviour". The medical stream has continued to flow swiftly and strongly. It has been aided in this century by further medical discoveries (such as the spirochete which causes neurosyphilis) which gave impetus to the hope that all mental aberrations will turn out to have a bacterium or virus behind them; by advances in genetics which have promised similar answers; by psychosomatic medicine which showed how closely the body is tied to the brain; by the mental hygiene and community mental health movement which has promised the prevention of mental diseases just as typhoid and cholera have been prevented; and (not least) by the growth of a large psychiatry-mental health consortium of professions, lay organizations, public support, and use of public tax money for their support.

Now you can, if you like, say that the present strength of the medical stream is the natural and inevitable culmination of the evolution of concepts of mental illness. This is the way most textbooks of psychiatry present history. Or you can say that the present situation is a temporary one, a way station on a much longer road. It may even be that the medical answers which are being proffered for problems of aberrant behaviour are not the best answers.

Some of us in Western countries see cracks in the medical model which may be harbingers of some basic changes coming in the next few decades. Large mental institutions such as state hospitals are being shut down as inefficient and counterproductive. Involuntary hospitalization is under question. Patients are demanding the right to treatment and the courts are setting

minimum standards of care. It is being increasingly questioned whether psychiatrists belong in the courtroom and whether persons should be denied the right to trial because of mental incompetence. Increasingly, non-medically trained individuals are doing psychotherapy and in other ways taking responsibility for mental patients. The lay public is demanding representation on boards which review psychiatrists' practice. And some professionals have questioned whether the very concept of mental illness might not be a myth.

All of this can be written off merely as growing pains of the medical model. Or it may be, as I suspect, symptoms of basic conceptual change which is underway. For a person planning mental health services in a developing country, it is important to keep the latter alternative clearly in mind. And rather than simply accept the recommendations of professionals from developed countries on what you should do or not do for mental health services, it is far better to listen politely but then go home and think it through for yourself. Ask yourself the following set of questions:

1. Who, among the people who behave strangely in your society, should be labelled mentally ill (i.e., has brain disease)? Whose problems are more likely caused by lack of understanding about themselves? Whose problems are caused by devils, spirits, or God's (God's) will? What other causes are contributing to strange behaviour?

2. Depending on your answers to the first question, what kind of help do these people need? Therapy? Education? Religious counselling? Exorcism?

3. What kind of institutions need to be set up to provide this help?

4. Which of these people should be deprived of the freedoms and civil liberties enjoyed by other members of the society?

5. Who should help these people, how should they be trained, and how should their helping activities be accredited and monitored?

6. How should the system or systems be financed?

If you ask yourselves such questions, and then go ahead and set up a system which logically follows for your country, then you will be taking the harder but the more exciting path. To import answers is easier but in the long run the answers may not be as good. Most importantly, by merely importing answers you are simply following evolution; but if you create your own answers then you are participating in evolution. This requires considerable courage.

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EXISTING CONCEPTS OF MENTAL ILLNESS IN DIFFERENT
CULTURES AND TRADITIONAL FORMS OF TREATMENT

T. Asumi

The peculiarity and special nature of the organization of mental health services in developing countries stem from poverty - of education, of trained manpower, of resources, of transportation and of communications - and from the suggestion that traditional methods of healing should be retained and incorporated in the modern system of delivery of health care. They do not derive from any difference in the spectrum of psychiatric disorders found in developing countries. On closer examination even this peculiarity and special nature of the organization tend to fade away, since developed countries also face some of the same problems, and the solution of the problems in developing countries can be applied, in modified form, in developed countries.

One of the major obstacles to the organization of a mental health service is acceptability. Since the traditional concept of psychiatric illness is that it is caused by curses, evil eye, violation of taboo, evil machination of malevolent agents, witchcraft, etc., most people in developing countries find it difficult to accept that modern psychiatry has much to offer; this is because it does not relate causation strongly and ostensibly enough to the traditional beliefs, in addition to other reasons such as the strangeness of the modern psychiatric service.

The question arises how can the service be made acceptable to the community to which it is offered. Didactic mental health education does not have much impact. It has been found that the impressive result of modern psychiatric treatment is more convincing. The people want quick results, and the more immediate and dramatic the result the more convinced they are of its usefulness and relevance. Other public health facilities such as maternity centres, maternal and child welfare clinics, surgery, etc., are being accepted and used, in spite of the traditional concepts. It may render a mental health service more easily acceptable if it is included in the other services which have gained or are gaining acceptance.

The answer to the question of whether the traditional beliefs and practices can be incorporated into the system of mental health service depends on the type and form of these beliefs and practices. If they do not conflict with modern psychiatric treatment and if the practices are not dangerous, there is no reason why they should not be incorporated into the system. The question is how? The fact is that some people still use traditional methods alongside modern methods, either with the belief that it will make modern methods more readily effective by having removed the obstacle and impediment created in their belief by the super-natural, or with the belief that it will stabilize and reinforce the improvement achieved by modern methods. There is not much difference between this practice and prayers offered for people who are receiving modern treatment.

Supplementing modern with traditional methods does not create much of a problem. It is integrating the two that is fraught with difficulties. The only way to resolve the issue is to study the traditional methods in depth. Unfortunately this has not been done to a sufficient extent and all we have are impressions and anecdotes. Even with the neuroses, which are expected to be amenable to traditional methods of treatment, no empirical study has been done to confirm this expectation. Until thorough and reliable studies of traditional healers are done, it will be a waste of time and it will be unreasonable to continue to talk about how to incorporate and integrate them into the system.

Another advantage of such studies is that they yield some epidemiological information to guide the provision of service. Since the resources are not readily available for precise epidemiological surveys on which a service can be based, we have to rely on such studies to have some idea of the incidence and prevalence of psychiatric illness in the community. In addition to the study of traditional healers, religious faith healers will need to be studied for epidemiological data, as they also render some psychiatric service (Asumi, in press).

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The reason for discussing traditional healers and religious faith healers is that a psychiatric service cannot be planned in a vacuum. The plan has to take into consideration the beliefs and practices of the community, the facilities they have been using, and other sociocultural factors. From this consideration will emerge the appropriate method of approach and the introduction of a service which will be meaningful, appropriate and relevant to the situation.

Coming down to the examination of existing concepts of mental illness in different cultures one finds many common features among them all over the world. The differences stem from geographical, climatic, economic, and religious and other sociocultural factors. The belief in witches as causative agents of mental illness is an example of a universal concept.

Despite these common features it is necessary to examine the peculiarities in some African cultures which make generalizations meaningless and even dangerous when we are considering the organization of mental health services.

J. H. Orley (1970), in his monograph on his study in Uganda, said that the Baganda ascribe diseases to certain parts of the body and also classify them according to three sets of dichotomies:

(a) those that come by themselves and those that are sent or caused by witchcraft;
(b) strong and weak;
(c) Kiganda and non-Kiganda.

"Those illnesses which are untreatable by Western Medicine or are difficult to treat, as in the case with mental illness, are thought therefore to be Kiganda diseases and are of course strong since traditional forms of therapy are not often very useful either." He makes the following observation, which is of importance in the context of this subject: "The fact that the Government provides free medical treatment means that often people attend Government clinics in the first instance before trying traditional methods of healing."

This observation is in contrast to experience in Western Nigeria, where the Government provides free service for children and civil servants, and charges others very little compared with traditional healers, especially in cases of mental illness. Here it is the traditional healer who is consulted in the first instance, even when a hospital is near at hand.

Orley further observed that illnesses that are sent may be caused in several ways by witchcraft. They include those that are considered to be brought by spirits acting on their own initiative as well as those forces manipulated by other people. The spirits are many and are related to the circumstances of the people - those from the islands on Lake Victoria or from the lake itself, and those from the dry land; there are the clan spirits, and there are those of the ancestors.

He stated also that although these are said to be diseases which result from the breaking of certain taboos, that reason does not seem to be important in these days.

Their traditional healers are usually known as Baganda doctors. Some practise only the giving of herbs or blood cupping; a large number are also possessed by the spirit. There is no recognized period of apprenticeship to healing art, since in such cases it is the spirit speaking through the doctor who diagnoses and orders the treatment, and so the doctor himself does not need to learn anything. "In practice this results in there being no well defined body of Kiganda belief about the origin and treatment of illness." This is in contrast to Prince's (1964) report on the Yorubas of Nigeria, which will be discussed later.

Perhaps it is because of this lack of defined belief about the origin and treatment of illness that Butabika, the mental hospital of Kampala, is now regarded as a natural replacement for the stocks of old, in spite of the fact that the hospital started only 10 years before Orley's study. Furthermore, Orley noted that it is rare in these days to see patients shackled in Kampala. On the other hand, in Abeokuta, Western Nigeria, a much smaller town than Kampala,
there are still a number of native healers who put their patients in shackles, even though the modern mental hospital of Aro is situated just outside the town and was established earlier.

Prince (1964) in his study of indigenous Yoruba psychiatry, comparable in some way to Orley's study in Kampala, identified two kinds of institutions dealing with mental illness in Yoruba culture. One involves treatment centres, healers, and magical and herbal therapy; the other is Orisa cult groups rather like the spirits in Uganda. The healers have names for some psychiatric and neurotic illnesses.

The causes of misfortune, including diseases are divided into three: natural, preternatural and supernatural. Natural causes include faulty diet, insects and worms, hemp smoking, and hereditary factors. Preternatural causes are malignant magical practices of sorcerers, curse and witchcraft. Supernatural factors include the concept of the "double" and the "heavenly contract", ancestors and the Orisas, minor deities.

He described the technique of the treatment as follows. Generally speaking each healer has his own standard approach to treating patients, and it is only when he sees that the patient is not responding that he changes his medicine (which includes several potent herbs). He sometimes decides on the cause in this way: he gives the patient 'epe' (curse) medicine, and if that does not cause improvement, he decides that it is Sopono's (Orisa) work and applies 'ero sopono'. Alternatively he uses divination or consults with the witches if the patient is not doing well.

Disturbed patients are usually kept in shackles, which are removed when they are better. A discharge ceremony is performed before the patient is discharged home from the treatment centre. The ceremony is aimed at preventing a recurrence of his psychosis; it usually includes a blood sacrifice, and is often performed beside a river.

He summarized the psychotherapeutic mechanisms as follows: suggestion, sacrifice, manipulation of the environment, ego-strengthening elements, abreaction and group therapy. He observed that none of these factors involves the patient's insight into his own deeper motives, with resulting expansion of self awareness and personality maturation.

Turner (1964) describes the practice of the Ndembu doctor in what was then Northern Rhodesia, where the concept of disease is not individual but group based. "All persistent or severe sickness is believed to be caused by the punitive action of ancestral shades or by the secret malevolence of male sorcerers or female witches." Therapy is a matter of sealing up the breaches in social relationships simultaneously with ridding the patient of his pathological symptoms. Ndembu do not know of natural causes for diseases. The diagnosticians are diviners and their therapists are in effect masters of ceremonies. Divination is a form of social analysis, in the course of which hidden struggles among individuals and factions are brought to light, so that they may be dealt with by traditional ritual procedures.

He comments that it is more difficult to establish whether or not the use of "medicines" confers any physical benefit, as in almost every case notions of sympathetic or contagious magic control the selection of vegetable or animal medicines.

Whisson (1964) uses two common forms of functional disease among the Kenya Luo to examine their traditional treatment. Social causes of primarily functional disorders are recognized by the practitioners, but organic origins of a disorder, if any, are not recognized explicitly. Responsibility for the disorder is laid upon the spirits and the cure is effected by their being brought under control. They are not expelled but remain with the patient forever.

Diseases may be caused by sorcery, witchcraft, evil eye, breaking a taboo, or neglecting ritual for ancestral spirits.

Some men claim to be able to cure violent lunatics. The victim would be tied up for several weeks and the practitioner would produce worms, which he claimed to have extracted from the head of the patient through his nose. The patient would be given various herbs and roots and often severely beaten. It was not thought possible to cure a violent lunatic permanently, however, although some men using the described method or that for the treatment of spirit possession claimed to be able to do so. If all means had failed in an attempt to
cure a patient, the diviner and the elders would suggest that the illness was the work of God and must be accepted. The psychotic patient would then be left to roam about. He would be treated kindly, fed and given work to do if he could do it.

Organic disorders were considered to have supernatural or mental origins. The Luo sought the motive and social causes of all disorders, rather than the organic causes. As a consequence, their appreciation of social causation and their ability to cope with functional disease was probably well developed.

The members of the tribe have tended to accept the medical services as an addition to their resources for coping with all forms of disease rather than as a substitute for the old methods. Even the better educated who treat them with amused scorn resort to traditional healers when in trouble. This observation is true for most of Africa.

Dawson (1964) observed the African population in Maraupa, in the Northern Province of Sierra Leone, in his study of the social, psychological and medical effects of urbanization.

He states that both Temne and Mende secret societies have always played a major role in the traditional treatment of the mentally ill and maladjusted. Where Islamic influence has become strong, the Muslim Alfas have taken over the role of both 'holy man' and 'doctor' while carrying out the treatment of the psychologically disturbed.

Some traditional healers reach their diagnosis by divination, sacrifice and questioning. The traditional methods of native doctors are most effective when there are psychosomatic and other psychological disturbances that have been precipitated by some social complication. The treatment is based to a large extent on prestige, reassurance and suggestion: some physical remedy is always used, and in addition social complications are analysed. The physical treatment includes herbal medicines and application of heat to the head, and the psychological treatment includes counter-oaths and confession.

The native doctors themselves do not attempt to treat the more severe cases of psychotic disturbances, who are brought to the Muslim Alfas from all over Sierra Leone. The Temner say "The Muslim Alfas use the power of God to drive craziness away." Their method is to unravel the social complications in the same way as do the native doctors; they prescribe a course of treatment and pray to God for success. Physical treatment includes prayers and daily washing in water that has been poured over a board inscribed with passages from the Koran. Special herbs are administered orally. Other herbs are boiled in water and the steam is inhaled.

M. J. Field (1960) described the shrine treatment of psychiatric disorder in Ghana among other functions of the shrines, based mainly on the idea of spirit possession. She described various beliefs like witchcraft, magic, some mythology like fairies and forest monsters, and cult of the dead, which all have to do with the causation of mental illness.

Messing (1959) described the Zar cult in northern Ethiopia but the cult exists also in the Sudan. The practitioner, usually a woman, has generally been a patient herself. The practice is possession by the Zar. The patient will be interrogated in the house of the doctor. The doctor will lure her own Zar into possession of herself, through a trance. The doctor's Zar is then used to lure the unknown Zar of the patient to reveal his identity by means of adroit cajolery, promises and threats. The demands of the Zar are then negotiated through financial bartering. Finally the patient is enrolled for the rest of his life into the Zar society of fellow-sufferers. Most Zars are never exorcised. The patient learns to accept his ailment and comes to terms with it by his group membership.

Diagnosis is made through demonstration, and treatment is aimed at mitigation of symptoms though channelling, acceptance and group membership.

The "Zar" is a catchall for many psychological disturbances ranging from frustrated status ambition to actual mental illness.
Collomb & Zempenia (1963) and Zempenia (1966) described the Rab cult in Senegal. This is similar to the Zar cult. The disturbing spirit is transferred to the patient's shrine, and subsequently the patient can talk about his problems to his shrine, thus becoming his own therapist (Pfeiffer, 1971).

From this brief examination of some traditional concepts and treatment of mental illness in some cultures, it becomes obvious that there are similarities and differences. Some recognize physical causes of mental illness; others do not. Some use physical methods of treatment; others do not. Consequently, in some cases greater emphasis is placed on social order and integration than on the individual. Some help the patient to live with his dysfunction rather than attempt a cure. Some exorcise the offending spirits; others do not, but make use of the spirit to the benefit of the patient. Some confine themselves to the psychoneuroses, others treat all psychiatric disorders.

In general, it can be repeated that each system is geared to the fulfillment of the sociocultural needs of its society and it cannot be transferred effectively to another society.

The positive points that emerge from this brief survey can be stated in terms of prevention and treatment. The cults treat mostly psychoneurosis, and also aim at prevention of recurrence or exacerbation of symptoms. The sacrifices and cleansing rituals of the Babalawo aim at making herbal treatment effective and also reinforce recovery and prevent relapses.

The most important question relates to the changing sociocultural scenes. To what extent is it possible or even wise to try to retain a practice of traditional healing and integrate it into modern psychiatric practice when the sociocultural basis from which it derives is changing? The argument in favour of integration is that even those who seem to have moved away from the traditional way of life often resort to traditional methods of treatment when in serious trouble. This is a strong argument; but then, is the situation going to remain the same? Are there not those who do not resort to these traditional methods - and is the number of these increasing or decreasing?

Lambo (1973), who has been frequently quoted as making use of traditional methods of treatment along with modern psychiatry, limits this to traditional procedures like sacrifices, confessions and other magico-religious techniques. These techniques are not different from the prayers offered by priests and clergymen for sick people, or thanksgiving services for those who have recovered. They do not interfere with the procedure of modern psychiatric practice and in fact it will be poor psychiatry to interfere with the religious beliefs, traditions and culture of patients. Indeed, some magico-religious healers are reported to be quite good and they appreciate their limitations, and some indeed refer cases to modern psychiatry.

It may be easier to negotiate some relationship with traditional healers who are well organized into guilds with codes of moral and ethical conduct, and the membership of which is based on definite terms. It will be dangerous, on the other hand, to negotiate any relationship with unorganized traditional healers, as it will be difficult to distinguish the charlatan from the serious among them. Whether traditional and religious healers can be used as auxiliaries or collaborators in the mental health service will depend on a number of factors about them and their practices, which should be thoroughly studied.
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Genesis of the question

The question of the extent of responsibility of the mental health services (out of the total spectrum of mental health problems) has been occasioned for many reasons. Experience in the United States of America with community psychiatry is perhaps one of the prime reasons why this question is being raised today with such vigour. Community psychiatry necessitates social action which, however, is not the sole concern of mental health services but also of social welfare services, educational services, legal, administrative and political agencies and so on. Mental health services, therefore, have been required to define the limits of their own specific field of concern. The mental health professional has always had a triple role - of a somatotherapist, psychotherapist and sociotherapist - one or another of those taking precedence over the others depending upon the professional's training orientation and the specific setting in which he is required to work. In the practice of community psychiatry more and more psychiatrists have been drawn to the social field and fewer and fewer left to look after psychiatric hospitals (where the bulk of psychiatric patients are still to be found) - hence the lament that "psychiatrists are least found where they are most needed".

A psychiatrist, as a member of the community mental health services, often finds himself "in an undefined role, catering to undefined needs of an undefined clientele" and so is prone to ask himself: "Am I still a psychiatrist, still a physician, or have I become an inadequately trained social scientist or some kind of a revolutionary?" (Levitt & Rubenstein, 1971).

Where it was not considered feasible for the same person to perform all the three roles, health teams consisting of a psychiatrist, a psychologist and a psychiatric social worker came into being. However, this soon led not only to status struggle within the team but also to the demand for proper role definition for the whole team as well as for each of its individual members.

The team approach, however, is an expensive endeavour. An acute shortage of mental health manpower was felt even in such countries as the United States of America, where the ratio of mental health specialists to the population is amongst the highest in the world and where the brain drain is in their direction. A solution of this problem has been sought through the production of ancillaries called psychiatric aides, psychiatric technicians, attendants, or mental health workers, etc. The new set-up has necessitated a new redistribution and redefinition of roles.

It has, therefore, become important, for the various reasons outlined above, to define the extent of the clinical responsibility of the mental health services.

While this question has universal validity - in so far as it can be raised anywhere in the world without loss of relevance - no single universally valid answer can be given to it. The answer, necessarily, has to be given in the context of local conditions relating to the characteristics of the existing mental health service and its manpower, the features of the population to be served and its expectancies, and the existence and degree of development of other public services having an interface relation with the mental health service.

Characteristics of the population

Populations vary from country to country in regard to social, cultural and technological development and organization. Some of these factors have greater relevance to mental health than others.

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Material affluence determines a country's capacity to muster resources for its mental health service - and in this regard there are wide international and interregional differences - even within the underdeveloped world. For instance, in south-eastern Asia per capita income varies from US$ 35 in India and Pakistan to US$ 85 in Malaysia. However, the upper limit in this region constitutes the lower limit in Latin American countries (Haiti has a per capita income of US$ 84) and the higher limit reaches over 10 times that (US$ 915 in Venezuela) (United Nations, 1969).

Another factor worth considering is that per capita income correlates poorly with the expenditure that States make on health care. The United States of America, for example, spends 1.2% of its gross national product on health, India 0.6%, and Sri Lanka 2.8%. While mental health is a high priority in the United States of America, draining a sizeable fraction of the health exchequer, it ranks hardly anywhere among the health priorities in India.

Literacy modifies community expectancies. Not only does one find contrasts between the modes of thinking, levels of sophistication and patterns of mental morbidity of the literate and the non-literate communities, but also between the demands these respective kinds of populations can make in regard to social action. Literacy also bears relevance to the distinctive modes of their social perception of mental morbidity as well as their ability to contain socially certain forms of mental illness in contradistinction to others - factors which would directly infringe upon the spectrum of clinical responsibility of the mental health services.

Other factors include the degree and rate of urbanization and population migrations, the degree and rate of technological development and industrialization. The age-structure of the population and the rate of change of this structure also determine to some extent what kind of demands would be made upon the mental health services and this in turn will determine the scope of responsibilities of these services. For example, where longevity is high, geriatric psychiatry will figure high among the responsibilities of mental health services. Employment facilities also affect this pattern. Where hordes of able-bodied, able-minded individuals are waiting in queues for employment, rehabilitation programmes for the mentally sick become matters of low or zero priority, but where a country has a shortfall of manpower as against its employment opportunities, rehabilitation naturally assumes high priority.

Demands and expectancies of urban populations from mental health services are different from those of rural populations, and wherever attempts have been made to reach the rural populations the scope of mental health services has had to be adjusted to the new demands and expectancies.

Predominant social problems of a community also influence to some degree the role spectrum of the mental health services. To illustrate: "the endemic manifestations of violence in Latin America can hardly be surpassed by those in any other part of the world" (León, 1972). There, for the population between 15 and 44 years of age, homicide is the first cause of death. Opiates are a great pest in Thailand (Aroon, 1971) alcohol in East Africa (German, 1972), while in Jamaica venereal diseases top the list of physical pathologies in psychiatric hospital patients (Burke, 1972). As a result of such factors, while certain psychiatric disorders will figure predominantly in the responsibilities of the mental health services in one country, they may be almost absent in another.

Characteristics of existing mental health services

The organizational pattern of the existing mental health services in a community determines for them the scope of their clinical responsibility. For example, the existence of "asylums", half-way houses, day care hospitals, child guidance clinics, walk-in clinics, suicide prevention services, deaddiction units, telephonic services and the like are a variety of commitments to certain segments, smaller or larger, of the spectrum of mental health problems. Each kind of service caters to a particular kind of clientele and the overall spectrum of clinical conditions being looked after by the mental health services, thus, depends upon the spectrum of such services. These services, once instituted, generate their own need and establish a negotiated order within themselves and within the administrative and economic structure of the communities, so that their existence becomes self-perpetuating.
At times, some of the available services demand greater inputs as compared with their outputs. Some of these services even throw up certain syndromes as "artifacts". Münchausen's syndrome is one such example. Another one is what I call "pseudo parasuicide". Such syndromes, which are by-products of the services themselves, then become a part of the spectrum of their clinical responsibility.

Another important factor that impinges upon this spectrum is the existence of a competing system of medical (and mental health) care and the spectrum of conditions that it specifically draws to itself. In countries where mental health services are relatively inaccessible, the population has to fall back upon the more readily available popular substitutes. These may be of the nature of shamanism, witchcraft, exorcism, astrological remedies or religious ceremonies. These, in turn, reinforce magico-mystical notions and foster mistrust and rejection of the professional mental health services even when they may be available. Further, they tend to draw to themselves certain special kinds of syndromes - such, for example, as "possession syndromes", "seizures", and "religious manias". Among certain populations, the folk-healers are even more adept in dealing with such syndromes than the practitioners of "scientific medicine". Prince (1962) has observed this in Nigeria; Torrey (1972) derives his "basal components of psychotherapy" from more universal observations of this kind.

In India, in spite of health centres having been lavishly established in the rural areas, only about 25-30% of all patients go to visit them, the rest either patronize Ayurveda or Unani or some other brand of folk medicine. They also tend to introduce their own peculiar "artifacts" by popularizing their "theories" as folk belief (Neki, 1971). The "Dhat syndrome" found in India appears to be the outcome of Ayurvedic theories about the genesis of semen and its place in human health preservation. Such syndromes, though artifacts of competing systems of medicare, often become the responsibility of the mental health services.

To sum up, the characteristics of the mental health service and other existing systems of medicare that compete with it in any given community determine to an appreciable extent the spectrum of conditions that would come under the care of the mental health services.

Factors relating to personnel resources

What kind of mental health personnel a community has, their number, their distribution, and their predominant scientific orientation determine what kind of clinical burdens they are likely to shoulder.

If a community has no specially trained mental health personnel (and to be sure, there are still a number of countries altogether without such personnel) it has to perform to fall back upon its general medicare and public health services to cater for mental health needs. The same applies to countries where mental health personnel are few and far between. "It is in these countries", observes Lin (1969), "that the general practitioner has to shoulder much of the mental health responsibility - yet, there is little indication so far that this is being realized by the proper quarters. That is what makes the picture grim".

Whereas the number of psychiatrists in most developing countries is very low, it differs from region to region. In most African countries, it is, perhaps, the lowest. The total number of psychiatrists in tropical Africa is but a few hundred. In 20 Latin American countries, by contrast, there are over 3000 psychiatrists (average 1.52 per 100 000 population) (León, 1972) while in five countries of South-East Asia, the number of psychiatrists is on the average about 0.1 per 100 000 population (Neki, 1973). Compare these figures with those obtained in the better developed countries. Figures per 100 000 population even a decade ago stood, for the United States of America, at 7.25; for Switzerland, at 4.72; for England and Wales, at 2.02; for the USSR, at 2.55; and for Japan, at 2.5.

Where the number of psychiatrists is small, patient load is proportionately great. The most pressing demand upon them is made by psychotics, who constitute a bulk of their clientele. Their approach becomes predominantly somato-therapeutic, and their orientation biological. An analytically trained psychiatrist becomes a misfit in such a system. He is more prone to set up private practice for the benefit of the "Westernized urban elite".
Wherever there are psychologists, psychoanalysts, psychiatric social workers and psychiatric nurses (in addition to psychiatrists), they have also to make their own niche in the mental health services, and these services then have to adapt to the specific professional proclivities of such personnel.

While in most places these categories of personnel have functioned side by side and in collaboration with the psychiatrist, in some places they have functioned apart from him, especially if he were altogether absent from the scene. For example, a psychiatric nurse virtually remained in charge of an asylum in Nigeria for a number of years until a trained psychiatrist became available.

The distribution of personnel also makes a great difference. In some places, most psychiatrists are engaged in manning psychiatric hospitals. In India about 40% of the psychiatrists are found to man mental hospitals, an equivalent proportion is engaged in teaching in medical colleges and very few are in private practice. In Latin America, on the other hand, over one-third of the psychiatrists are exclusively in private practice and about a quarter appear to be engaged in part-time practice (León, 1972). The predominant orientation of psychiatrists in these countries is dynamic - analytic, while that of the ones in India is eclectic. It appears that, wherever the ethos of American psychiatry has had its influence, the dynamic approach became the dominant orientation and private practice the principal professional commitment.

The syndromes

There are only few syndromes which are indisputably the responsibility of the mental health service. These mainly consist of the functional psychoses. Even some psychoses in many developing countries are caused or accompanied by somatic illnesses of various kinds. These may include malnutrition, chronic infections like syphilis, tuberculosis or leprosy, acute infections and communicable diseases with their sequelae, helminthic infestations, and climate calamities, e.g., heat stroke and dehydration. A psychiatrist, therefore, has to keep up his internal medicine in looking after these patients.

Persons with organic brain conditions generally go to neurological services unless they show a frank psychotic breakdown or become behaviourally unmanageable.

Those with psychoneuroses and psychosomatic conditions, even in countries with the most well developed mental health services, are being looked after predominantly by the general physicians. In the United Kingdom, for instance, 95% of psychoneurotics are being looked after by the general practitioners. It is not that the psychiatrist is unwilling to treat them. The predominantly somatic symptomatology of most of the neurotic conditions almost invariably necessitates the consulting of a physician in the first instance. Where, the number of psychiatrists is small, there is greater reason for psychoneuroses to remain almost entirely the ongoing responsibility of the general practitioner.

In the field of mental deficiency, the educable defective will be the responsibility of the educational services. However, there are cases of severer subnormality which will require institutional care and/or treatment such as, for instance, those caused by metabolic and endocrine disorders, or those that can be ameliorated by surgical intervention. However, only about 15% of retarded children are affected to such a degree that they must be considered ineducable. Thus, the main responsibility in this field would rest with the educational services, mental health services providing consultancy arrangements and care of a limited number of retarded that require professional care.

Areas such as delinquency and psychopathy, drug addiction and alcoholism, with widespread social pathology as their substratum, call for social action far beyond the limited scope of the mental health services. Clinical responsibility of mental health services in these areas can be but limited - only looking after those showing or tending to show psychotic breakdowns. Preventive services, unless strengthened by appropriate and widespread social measures and administrative and political reform, usually prove to be sterile. In many cases, they raise public expectancies without commensurate resources being available and so only thwart the effort and enthusiasm of workers. Mental health services should, however, provide consultancy expertise to planners of relevant social action. Personality counselling can be considered
a luxury - and may be left, as it always is left, to a private arrangement between those who have the resources to purchase it and those who have the expertise to sell it.

Conclusion

To conclude, one may say that no universal prescription can be given regarding the extent of clinical responsibility of the mental health services in any given community. It will be determined by a horde of factors, the more important of which have been discussed above.

In most developing countries mental health services are still rudimentary. This a happy situation in so far as they have not yet been confined to already established institutions and service patterns, many of which are of questionable utility. It is important, therefore, for the planners of mental health services in those countries to weigh the projected mental health needs of their communities against the manpower and other resources likely to be available and to predetermine what would be the spectrum of responsibilities of the mental health services in their judgement. In so doing, it would also be necessary to determine the relative responsibility of mental health services in areas where they have interface interaction with other services such as the educational, social welfare, public health, legal and administrative agencies.

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PART 2. THE NEEDS OF THE POPULATION

PROBLEMS OF ASSESSING THE NEEDS OF THE POPULATION

R. Giel

When the number of psychiatric facilities in a country is limited, few people will feel inclined to assess the exact need in the population for such services. The responsible authorities will assume that the need exists, and they will start to build institutions while being guided by the available funds and by other priorities in the field of health. This is the way in which western society must have developed its mental health services. It certainly explains the great variety in the numbers of psychiatric beds per 1000 of the population, and in the types of care available in the European Region of WHO (World Health Organization, Regional Office for Europe, 1971). There is little evidence of any attempt at planning the mental health services on the basis of an assessment of the needs of the population.

In this paper we shall try to describe some of the problems of such an assessment. The most important question will be whether it is at all possible to assess the need for psychiatric care, either with regard to its quantitative or its qualitative aspects. In other words, is it possible not only to know the required numbers of personnel, beds and other facilities per 1000 of the population at risk, but also what type of service is to be preferred in a specified situation?

When assessing the needs we generally take, or hope to take, our clues from the following kinds of investigations:

- community surveys, including surveys of high risk groups;
- psychiatric outpatient and inpatient surveys;
- general outpatient surveys.

Community surveys

As the community is our primary concern, it appears most logical to sample the population, to examine the individual members, and to classify them with respect to mental disability. From the findings, the prevalence rate of mental illness can be calculated, and an estimate of the burden on the community can be made.

A number of investigators have followed this procedure. Leighton et al. (1963) found psychopathology in 40-45% of their samples in Nigeria, and 15-19% were found to be significantly impaired. Gillis et al. (1968) reported a prevalence rate of 11.8% of the adult coloured population in the Cape Peninsula. Bash & Bash-Liechti (1969) found 10% in Iran, Giel & van Luijk (1969, 1969/70) and Giel & Le Nobel (1971) found 8.6 to 9.1% in Ethiopia and 14.4% in the Netherlands. Lin & Standley (1953) reported, in a review of epidemiological studies, prevalence rates varying from 1 to 19% of the general population.

We must conclude that the findings are too divergent to be of very much use, and that they do indicate a problem of reliability.

Most often the presence of psychiatric symptoms was determined during or following interviews with the subjects, while the investigators used their own criteria for the rating of psychopathology. Following this, they tried to estimate the degree of disability and the need for treatment.

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The problems inherent in this kind of approach can be listed as follows:

(1) It appears that, when asked about psychiatric symptoms, many people have some complaint, while it is not at all certain that they felt the need to complain about mental ill health before the interviewer entered their homes. External evidence from relatives, from the social environment or from medical agencies should confirm the presence of an illness and of a disability. After all, the responses of the interviewed person are as much dependent on his own inner state as on the specific questions he was asked. The interviewer has to some extent determined the responses by his own research preoccupations.

(2) We are not too certain about the weight to be attached to mental phenomena within a particular cultural context.

In the average urban community withdrawal and silence will be considered to indicate illness, but in a religious setting this kind of behaviour may be highly valued.

Trance states constitute almost obligatory behaviour in a situation in which a cult is being enacted. But in most other circumstances and when used by a hysterical personality trance states become a nuisance to the environment.

The above examples are perhaps too exceptional to be of much value, and to illustrate the point more common behaviour should be mentioned. Irritability is very often an early sign of an emotional disturbance. However, the irritability of the surgeon in his operating theatre is not considered a psychiatric symptom, nor is his angry behaviour thought to indicate psychopathy. Yet, a similar irritability exhibited by a psychiatrist in his consulting room would simply be disastrous.

Our problem appears to be that, except for some outright psychotic mental phenomena, most other behaviour cannot be judged according to uniformly applicable and objective criteria for the presence of pathology.

(3) Another difficulty is that we cannot be certain about the degree of disability, as perceived by the sick individual or his environment, which should suffice to initiate illness behaviour or the enactment of the sick role. There is some evidence (Dormaab et al., 1974) that under conditions of poverty the same amount of suffering is less likely to cause illness behaviour than it would in people who can afford to be ill. In summary, the evaluation of symptoms and the assessment of disability does not help us much to establish the need for treatment in a patient.

(4) The more serious cases of mental illness are relatively rare (some 2 to 3% of the samples already mentioned). In order to detect adequate numbers of cases, a sizable sample has to be screened, implying too expensive a survey to be justifiable. Even then the yield may be so limited that valid conclusions cannot be drawn.

Finally, in the developing countries, or in the large urban centres of the developed world, a community survey which is based on the sampling of ordinary homes or registered households might completely fail to trace and expose the chronically psychotic people, who usually have become vagrants. They will be the patients who are most in need of treatment but whose whereabouts will not be revealed by the survey.

In summary, community surveys for psychiatric illness do appeal to the mental health planner, as they seem helpful in establishing a basic morbidity rate for mental illness in the general population. However, such surveys are expensive in relation to the quantity and the quality of information they yield. In addition, they are unlikely to provide much information about the need of people to attend mental health services should these be available.
Psychiatric outpatient and inpatient surveys

The demands made on psychiatric services might give an indication of the needs of the population. Two kinds of investigations have been conducted in this respect:

1. point- or period-prevalence studies of all people under treatment who are residents of a circumscribed area;

2. case-registers which are kept over a number of years for patients from a circumscribed area (Wing et al., 1967).

The "Midtown Manhattan" study (Srole et al., 1962) is an example of the first kind of investigation, particularly its "Treatmenst Census Operation". The results of this survey, which also included a "Home Interview Survey", were somewhat distressing because of the high prevalence of mental disturbances. The psychiatrists judged 23.4% impaired (either incapacitated or with marked or severe symptoms), and 21.8% moderately disturbed. Another famous study of this nature is the one conducted by Hollingshead & Redlich (1958) in New Haven, USA. They established a six-months' period-prevalence of treated mental illness. They made no attempt to ascertain the prevalence of either untreated or unidentified mentally ill people in the community. The data related only to new cases coming into treatment during the study period. It appeared that 7.9 per 1000 of the population came into treatment, and that the patients were very unequally distributed over the social classes. About three-quarters came from the two lowest social classes, which make up approximately two-thirds of the population. It is not at all clear whether mental illness was more common in the lowest social classes or whether coming into treatment was related to position in the class structure. The follow-up of this study, conducted by Myers & Bean (1968) showed that admission to a mental hospital was much more likely to occur in case of lower class patients.

The annual incidence of contacts with a psychiatric service because of a new spell of illness was also studied in a Dutch province with rather scarce psychiatric services which were mainly concentrated in the provincial capital (Giel, to be published). We found an estimated annual incidence rate of 8.5 per 1000 of the population. Close to 10% were admitted following the first contact, and after a period of three months had elapsed 6% were still in hospital. The much lower rate in the Dutch province than in New Haven can perhaps be explained by a difference in the density and type of mental health services. However, no study of that nature has as yet been conducted.

Just as with the community surveys, it appears that the findings of the studies of treated patients are too divergent to establish a firm basis for planning.

A more recent development is that of the study of "case registers". Of particular interest is the one by Wing et al. (1967) involving case registers in 3 urban areas: Aberdeen (Scotland), Camberwell District (London), and Maryland (USA). The authors gave the following description of their work:

"The registers are integrated record systems for accumulating data concerning all those people living in the local geographical area who make contact with psychiatric and certain other sociomedical services during a specified period of time. Such registers have three types of advantage for epidemiological and operational research:

1. They are based on defined populations, usually on geographical areas, so that collected information can be compared with data concerning the total population of the district, derived either from the routine national census enumerations or from ad hoc local surveys or from general practitioners' records.

2. Reports are received from a wide variety of agencies and services ... always including, as a minimum, admissions to psychiatric hospitals and units of all kinds, to day-hospitals and day-centres, and to outpatient clinics. In this way, demographic, social and clinical information about each patient is collated with a full record of contacts with all the agencies and services involved. Thus correlations within the data can be studied, unduplicated counts of patients can be made, and the common bias which arises from considering only one or a few psychiatric agencies is avoided."
3. The third advantage is that registers are cumulative. The path of any patient can be traced through contacts with many agencies or services, time trends in the patterns of contacts can be studied (for example, changes in the population of mental hospitals compared with the numbers attending community services) and the effect of introducing new services into an area can be observed."

It hardly needs to be mentioned that the operation of such a register brings considerable technical and administrative problems, while its maintenance is very costly. For one thing, the availability of a computer facilitates the storage and the analysis of the information to a great extent.

Such studies begin with a census of all cases under treatment on one day (point-prevalence) and they follow with a registration of all further and new contacts.

In the abovementioned study the one-day prevalence was 0.8 to 1.1% of the general population and the annual incidence of new episodes also 0.8 to 1.1%. The overall one-year prevalence rate was strikingly similar in Aberdeen, Baltimore, and Camberwell, being roughly 1% in contact with a service on the census day, plus another 1% making contact during the subsequent year. Two other findings appear to be of great importance. The marked differences between the cities in the distribution of cases over the various types of services and the diagnostic categories did not affect the overall one-year prevalence rate of approximately 2%.

This might indicate that:

(1) Variations between countries in the numbers of inpatients and outpatients per 1000 population are a result of the availability of the various types of service.

(2) Variations of the incidence rates of particular diseases between the cities could be caused by the diverging diagnostic habits of doctors.

Although these studies are of great interest and have provided important information, it is difficult to see how their findings could serve as a basis for planning in a developing country:

(1) The investigations are too expensive and too laborious to be conducted in such a country.

(2) The scarcity of mental health services in the developing nations could cause us to underestimate the needs of the people because they are neither in a position to attend a clinic if there is none available, nor have they learned to use such a service if it has recently been established.

(3) Even in a developed country with a wealth of services it has been shown that many of the chronic patients do not attend a regular psychiatric clinic (Tidmarsh & Wood, 1972), and that they become vagrants. Therefore, the needs of these people would remain unassessed.

**General outpatient surveys**

Because of the scarcity of psychiatric services in the developing countries it is more advisable to screen general outpatient populations in order to find out whether people are accepting modern medical help to cope with their psychiatric problems, and to assess their needs. General practices, the outpatient departments of general hospitals, and the rural health centres could serve the purpose.

As has been shown (Kessel, 1960; Shepherd et al., 1966) a simple instrument for evaluating cases could be applied by the doctors who run the services. For example, Kessel's measurement of conspicuous psychiatric morbidity showed how patients attending the clinic could be classified as:
(1) those who have a purely somatic illness;

(2) those who have an explicitly psychological complaint;

(3) those presenting somatic symptoms not explained adequately by physical illness;

(4) those with indisputable physical illness but with a psychological reaction to it which is in some way abnormal;

(5) those who display personality problems without a direct relationship to their current illness.

Shepherd et al. (1966) applied rather similar standards, and found that in London general practice the annual consulting rate for psychiatric morbidity was 139 per 1000 of the population at risk. However, they also reported in their review of the literature that the rates (as percentages of all consultations) varied from 5 to 47.6%, indicating that the diagnostic tendencies of the practitioners or of the investigators must also have been subject to variation.

Similar studies conducted in Ethiopia and the Netherlands (Giel & van Luijk, 1969; Dormaar et al., 1974; Giel, 1972) demonstrated that, even in a rural area, as many as 148 per 1000 of the population at risk attended the health centre with psychiatric complaints. From 7 to 19.5% of all new cases attending the clinics did so mainly because of a psychiatric complaint.

These studies do illustrate the heavy burden of psychiatric complaints, not only on the first line of the health services in a developed nation but also on that of a developing country. Nevertheless, they do not help us to assess the real needs of the population for the following reasons:

(1) It is not known how many of the patients in a general practice need specialist psychiatric care, and of what kind.

(2) As in the other investigations, those people who need psychiatric care most, the psychotics, are unlikely to attend even the clinics in the first line of the health services. In the developing countries psychotic patients are more likely to be found in the healing centres of sheiks, Zar-leaders and other native healers, or amongst beggars.

(3) The need for help from a health service appears to vary (Dormaar et al., 1974) with the degree of medical sophistication of a community, and with its economic provisions enabling people to attend such services. In other words, given an illness, one still has to learn and to be in a position to take up the sick role.

It appears from the above discussion of the various ways of assessing the psychiatric needs of a population, that no "once and for all" answer can be expected from surveys of the community, the psychiatric inpatient and outpatient services, or the general health services. One gets the overall impression that, up to a point, the development and the increasing accessibility of mental health services may create a mounting need for psychiatric help. Our problem is that we do not yet know up to which point this happens to be the case. However, from the prevalence rates found in the developed world and from the known scarcity of mental health services in the developing countries we may safely assume that a great and unfulfilled need does exist. Does this mean that we are coming back to the strategy that was mentioned at the beginning of this paper, namely that any addition to the existing services will be desirable and acceptable? The adoption of such a policy would imply that we ignore the lessons to be learned from the adverse experiences of the developed world, i.e. large mental hospitals, overcrowded with chronic patients who do not receive much psychiatric treatment, and who get very little attention with regard to social rehabilitation; and understaffed and overworked outpatient services, which operate in isolation from the mental hospitals and other residential facilities.
Therefore, what epidemiological surveys cannot supply and what the planners need most of all is a clear statement by governments of what they consider proper mental health care and how this should be achieved. At present, it is possible to formulate such a policy and to take into consideration both the needs of the patient and his family and the needs of the people who have to provide that care.

(1) With regard to the patients, most people agree that they should be treated as much as possible in their own environment and preferably outside a mental hospital. They should be met in the early stages of their illness, while there should be continuity in the types of care they might need during the subsequent stages of their incapacity.

(2) With regard to the mental health workers it can be stated that it is no longer possible for them to deal all on their own with the problems of their patients, or in one way only. They should be able to complement their own contribution with that of other types of health workers, and they should also be in a position to call upon a variety of mental health facilities.

Once a policy is adopted it is up to the planners to develop programmes for the training of manpower and the building of the necessary facilities at a rate which is in accordance with the economic potential of the country. In other words, what can be achieved tomorrow may in itself be quite inadequate. Yet it fits in with the step by step development towards a stated objective.

Even if we should accept as a base-line Strømgren's findings in Denmark (1972) that annually about 2% of the population will be referred to a psychiatric service and that about 10% of these patients are in need of admission to a hospital, then we still have to translate these needs in terms of manpower and of inpatient or outpatient facilities. As long as we know very little about the precise effects of the different kinds of psychiatric treatment and care, and of the effects of any length of time spent by a psychiatrist or another mental health worker with his outpatients, any statement regarding the preference for a particular approach tends to be ideological. Consequently, it will be more advantageous for the planner to consider the health workers themselves and the case-load they are able to carry without neglecting the majority of their patients.

Birley (1972) tried to calculate the burden of psychiatric patients even further. Starting from a population of 60 000 he estimated that on any one day approximately 500 patients will be under the care of all combined psychiatric services in an area well provided with such services. In addition, every year another 500 patients will newly enter the services. Annually from 200 to 300 people will have to be admitted. This would mean a stay of 5 to 7 weeks in a 30-bed unit, provided that there are no long-stay cases. On reviewing the literature, Birley expects annually 265 outpatient referrals, i.e. 5 new cases per week. The total number of outpatient contacts will be 1850, i.e. 35 attendances per week. The estimated number of day-places is 40 per 60 000 population.

According to Birley's calculations the responsibilities of the mental health services will be as follows: at any one moment 500 patients, i.e. 100 chronic, institutionalized cases, 30 short-stay cases, 40 day-patients; and 4 to 6 outpatient sessions per week.

How many mental health workers and of what discipline suffice to deal properly with this case-load still remains to be defined. It is obvious that even the most skilled mental health worker can achieve very little if he is on his own and responsible for such a tremendous case-load that he has just enough time to hand his patients a new prescription of drugs every 4 to 6 weeks. Under those circumstances he could be more productive if he dedicated most of his time to the training of new mental health workers and to advising other health workers who are less experienced.

In other words epidemiological surveys are unlikely to provide important leads on how to solve the mental health problems of the developing countries. Formulating a mental health policy and stating the role of the mental health workers during the successive stages of development should at least give the planners a direction and an orientation. This would imply an ideological rather than an epidemiological assessment on the part of the government.
Fortunately, the medically unsophisticated illness behaviour of the mentally disturbed and their relatives is likely to give some respite to the authorities. But this illness behaviour will change rapidly with the development of the mental health services. To some extent the needs are bound to develop with the services.

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AN ILLUSTRATIVE PRESENTATION OF A POPULATION SURVEY OF
MENTAL ILLNESS IN SOUTH INDIA

R. L. Kapur

This is an interim report on a cross-cultural study of mental disorder among three
South Indian caste groups. The prevalence of mental disorder was investigated through a
field survey. Field work was completed between March 1970 and December 1972. In this paper
an attempt will be made to examine certain methodological issues pertinent to designing such
an investigation and this will be followed by a brief description of specific aims, methods
and some preliminary results of the study.

SOME METHODOLOGICAL ISSUES

Cross-cultural comparisons

It is generally accepted that cross-cultural comparisons of mental disorder can be useful
in testing hypotheses giving etiological significance to certain sociocultural factors, in
enriching the phenomenology of well-known psychiatric syndromes, in discovering new psychiatric
syndromes, and in providing data which would help in planning mental health services suitable
to a particular cultural setting. Cultural differences are best highlighted when vastly
different nations are compared and the tendency of the research workers in the field has been
to carry out international comparisons, e.g., the Cornell-Aro study (Leighton et al., 1963).
Kessel (1966), warning against this tendency, pointed out that international comparisons can be
of doubtful validity because:

(a) case-finding methods in two nations may be vastly different;

(b) language differences may make it impossible to standardize the instruments used in
detecting mental disorder;

(c) it might be impossible to interpret the effects of the sociocultural variables being
investigated, since the influence they exert cannot be distinguished from that exerted by
other larger differences between nations and which are unmeasurable by techniques at our
disposal.

Field surveys

The biggest problem in the field survey is the definition of a case in a non-referred
population. Field surveys based on clinical assessment are unreliable because of the lack of
standard explicit criteria for defining a case. The reliability can be improved by using
questionnaires and training the investigators to use them similarly. However, because of
the rigidity of their structure, limited range of inquiry, lack of provision for cross-
examination to clarify doubts, and the fact that they take the judgement about the presence or
absence of a symptom out of the hands of the investigator, they probably lose in validity what
they gain in reliability.

1 The study was carried out on a grant from the Foundations Fund for Research in Psychiatry.
2 Field Director, Edinburgh-Manipal Psychiatric Research Project, Department of Psychiatry,
University of Edinburgh, United Kingdom.
3 Hindus of India are divided into an amazing number of caste and sub-caste groups, the
division being based on the concept of pollution. According to this, any contact between a
member of a higher caste and a member of a lower caste results in a ritual pollution of the
former. The contact can be through touch, inter-dining or sex. Depending on the "distance"
between the two castes is the complexity of the purificatory rite the higher caste person has
to undergo to get rid of the pollution. The caste rules are much relaxed these days, but
are by no means extinct. In our own attitude survey intermarriage was almost totally
unacceptable and inter-dining was acceptable to very few.
An improvement over the questionnaire technique is the use of a structured interview schedule. It has the following characteristics:

(a) There is a standard check list of symptoms.

(b) The investigation is carried out through standard questions and cross-examination, but additional questions may be asked to clarify doubts.

(c) The decision about the presence or absence of a symptom is made by the investigator, who is guided in his judgement by an instruction manual giving standard definitions for the various symptoms in the check list.

It is obvious that structured interview schedules retain the flexibility of a clinical approach and yet, because of the standard questions and standard definitions, are also reliable (Wing et al., 1967; Spitzer et al., 1964). However, the schedules developed to date have some shortcomings. None of them provides for an interview with a close relative or a friend, which is an integral part of a clinical approach and is especially useful for uncooperative psychotics. They are long and time-consuming and are unsuitable for a field survey. Goldberg et al. (1970) have developed a two-stage procedure with a quick initial screening at the field level and a structured interview of the suspects in a realistic clinical setting. This approach is certainly more economical, but those involved in field research are painfully aware that it is difficult to contact a respondent twice. Further, it is difficult to persuade people (who, it must be remembered, never asked for an interview or any help) to come to be interviewed in a "realistic clinical setting".

Another difficulty in using already available and standardized schedules is that they have been developed in the west, and become less and less satisfactory as one moves away from the context in which they were developed. For example, none of them pays special attention to "possession states", symptoms of sexual inadequacy and the variety of somatic symptoms so commonly encountered in the Indian setting.

It is being increasingly realized that symptoms, however reliably scored, do not make a person showing them a case, if by case we mean someone who needs help and treatment. Many other factors determine this need, e.g. the distress experienced by the subject or by those around him and the fall in the day-to-day social functioning of the individual.

Much interest has been shown by epidemiologists in the measurement of social functioning. Both in the Midtown Manhattan survey (Srole et al., 1962), and the Stirling County study (Leighton et al., 1963) there was an attempt at measuring social impairment. Spitzer et al. (1970) include in their structured interview schedule a section on measurement of social functioning. However, these attempts show a confusion of aims. The greatest drawback is the insufficient realization of the fact that norms of social functioning against which the functioning of the ill person is to be measured may vary from one sociocultural group to another. In most empirical research, certainly in the Midtown Manhattan study and the Stirling County study, the yardstick for assessment of social functioning appears to be the investigators' own value orientation, which may be irrelevant to the group under study.

It was against this background that the present study was designed.

THE GENERAL DESIGN AND THE SPECIFIC AIDS

Taking into account the criticism of international comparisons by Kessel, an intra-national study was planned. South India, with its variety of caste groups who have coexisted for centuries without diluting their cultural distinctions, seemed an ideal laboratory and we planned to compare adjacent "patrilineal" and "matrilineal" castes. In the former, the inheritance is through the male and in the latter through the female lineage. This has interesting sociocultural implications which will be discussed later. To further reduce the number of variables on which the target castes could differ (and thus make the study more manageable) we decided to narrow down the geographical context and carry out the study in one village. Such a village was chosen on the south-west coast. One patrilineal caste, the Brahmins, and two matrilineal castes, the Mogers and the Bants, were chosen for comparison.
It was also decided to prepare a structured interview schedule suitable for the Indian context, and to study the dimension of social functioning along with the symptoms. The latter necessitated the preparation of a social functioning questionnaire and development of norms for the different caste, age and sex groups.

The project was divided into two stages, the first stage devoted to a number of sub-studies aimed at collecting information and preparing instruments which would be used in the second stage, i.e. the field survey.

The various sub-studies in the first stage were as follows:

1. A socio-anthropological investigation to find out the differences amongst the three target castes.

2. A study of attitudes towards modernization and attitudes towards mental health in the members of the three target castes.

3. A study of the methods and clientele of the local healers.

4. Preparation of what ultimately were called the Indian Psychiatric Interview Schedule (IPIS for hospital investigation) and the Indian Psychiatric Survey Schedule (IPSS for surveys), their standardization and the establishment of interinvestigator reliability (Kapur et al., 1974a, 1974b).

5. Preparation of the social functioning questionnaire.

6. Pilot studies with hospital data, examining statistical methods of clustering symptoms with a view to determination of "patterns" in the data collected through the field survey.

The specific aims of the field survey were as follows:

1. To compare the frequency and patterns of psychiatric symptoms (as measured by the IPSS) in the three caste groups.

2. To study the interaction between "psychiatric symptoms", "social functioning" and consultations with local healers across the three castes.

3. To examine whether the differences observed in (1) and (2) above could be explained in terms of the sociocultural differences in the three caste groups.

It was to be an exploratory study and no directional hypotheses were constructed. The study was conducted in a village named Kota and will be referred to in the following pages as the "Kota Project".

A DESCRIPTION OF THE KOTA PROJECT

We shall now proceed to give a brief description of the village and the three castes, the characteristics of the Indian Psychiatric Survey Schedule (IPSS) and an account of the field survey. The sub-studies dealing with the measurement of attitudes and the development of the social functioning questionnaire will not be discussed here.

The village and the three castes

Kota is situated on the west coast of India and is part of the district of South Kanara, Karnataka State. At the beginning of the project a complete census was carried out and the sociodemographic data collected through a short questionnaire. At the end of this exercise a directory of the village was prepared, assigning a census number to each individual and
describing him according to religion, caste, age, sex, income group, family code and address. It was hoped that this directory would help in tracing the individuals quickly and collecting population samples for subsequent studies. Further information about the village was obtained through participant observation; one member of the investigating team lived in the village all the time.

Kota had 9113 permanent inhabitants according to our census carried out in late 1970. Like the rest of the country, the village boasts of a number of religious and caste groups. Among the three target castes, Brahmins are ritually the highest, Bants the next and Mogers the lowest. These three groups form nearly half of the total population of the village (Brahmins 16%, Bants 9%, Mogers 24%). Traditionally, Brahmins were priests, Bants soldiers and Mogers fishermen. The chief occupation of Brahmins and Bants these days is agriculture, the Brahmins in the main being owner-cultivators and the Bants sharecroppers. Fishing still remains the major occupation of the Mogers.

On an income status scale constructed specially for the project, Brahmins were the richest, Mogers the next and Bants the poorest (5% of Brahmins, 36% of Bants and 25% of Mogers live below the subsistence level). Till recently Bants were richer than Mogers, but because of government help the fishing industry is being modernized and the income of the fishermen has shot up. This has resulted in a difficult situation where Bants are ritually higher but economically lower than Mogers. Tension between the two communities is perceptible and brawls are common.

Educationally, South Kanara is one of the most advanced districts in India. In Kota, Brahmins are the most educated, Bants next and Mogers the least.

Brahmins worship gods, while Bants and Mogers worship demons. Brahmins are strict vegetarians, while Bants and Mogers eat meat (but not beef) and fish. Brahmins do not drink alcohol, whereas Bants and Mogers drink heavily, Mogers more than Bants.

Brahmins do not permit widow-remarriage or divorce, while this is permitted in Bants and Mogers. All the three castes are male-dominated but Moger women have more freedom than Brahmin women, who in turn have more freedom than Bant women.

The major difference amongst the three castes is in the system of inheritance and its sociocultural implications.

Inheritance in the three castes

Brahmins are patrilineal, i.e. the property descends from father to son. Bants and Mogers practise aliya-santana, a special form of matrilineal inheritance, the property being vested in the female lineage but in practice passing from the maternal uncle(s) to the

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1 All members of one family were given a common 4-digit census code and each individual was given a 2-digit census code which followed the family code. This made it possible to categorize the population with the family as a unit or the individual as a unit, as desired.

2 It is not easy to codify the address in an Indian village. However, in a survey of this kind it is essential that the subjects be easily traceable. To make this possible the village was divided into its constituent sub-villages, each sub-village was divided into a number of blocks and each block was divided into a number of units. Well-known landmarks were chosen to define the blocks and units, each family being assigned an address code based on the geographical unit it resided in.

3 Those who had lived in the village for at least 9 months in the year preceding the census were considered as permanent residents.

4 Kota has Hindus, Muslims and Christians (both protestant and catholic). There are 12 caste groups amongst the Kota Hindus.

5 Gods are worshipped to grant favours; demons are worshipped to prevent them from causing harm to the family. There are a number of popular demons in the village, each with its own shrine and ritual of appeasement. Some are more powerful than others.
nephew(s). Traditionally the husband continues after marriage to live in his own family house. The wife spends 6 months with the husband and 6 months in her own house. Young children move with the mother but visit their father less and less as they grow older.

The law of the land has declared aliya-santana illegal and the system is in a stage of transition. Appendix 1 outlines the variations in the aliya-santana. It is apparent that this social change is causing stress to the family, especially to women and children.

THE INDIAN PSYCHIATRIC SURVEY SCHEDULE

The IPSIS is designed to inquire about the presence of 124 psychiatric symptoms and 10 items of historical information. The symptoms are those commonly observed in the Indian setting, the check list having been prepared through pilot studies at Bangalore mental hospital. The questions and cross-examination are standardized, as are the criteria for recording the presence of symptoms. The inquiry is carried out through a multi-stage procedure. Appendix 2 gives the outline of the various stages but very briefly, as the first stage, a preliminary interview schedule, is given by a non-psychiatrist to all members of the population. Besides questions about the respondent, this preliminary schedule also carries a section asking the respondent if he knows any one in the family or the village who suffers from any of the (serious) psychiatric symptoms on a given check list. Detailed inquiries with the subject and/or with a close relative are carried out by a psychiatrist in special (standardized) conditions. The psychiatrist also records his "observations during interview" when carrying out a detailed inquiry.

The field survey

This was carried out by a team of one psychiatrist (male), one trainee psychiatrist (male), and three non-psychiatrists (two sociologists, one male and one female, and one female psychiatric social worker).

(1) Sampling

We planned to examine the psychiatric symptoms in 50% of the adult population in the three castes, an adult being defined as anyone aged 14 or above in the 1970 census. One way would have been to take 50% at random. However, we wanted to examine: (a) whether there was a greater concentration of symptoms in some families as compared with others; and (b) whether geographical nearness was related to a clustering of certain patterns of symptoms. To make this possible, it was decided to take a 50% sample of families instead of individuals (hoping that such a sample would give roughly 50% of individuals); and to collect the 50% of families from a few selected geographical "units" and, once a "unit" was selected, to take all the families (of the three castes) from that unit.

An analysis was carried out to compare the characteristics of the sample with the total population. It was found that the "sample" had roughly 50% of the total adults of the three castes and resembled, more or less, the total adults of three castes in age and sex distribution.

(2) Instruments

The IPSIS was given to all the members in the sample. Social functioning questionnaires were given to every one with psychiatric symptoms, and, to provide a control group of "normals", to every second normal male and every third normal female in each age (4 categories), sex and caste group.

(3) Training and establishment of reliability

Sixty people of both sexes were interviewed from geographical units not included in the sample. This was followed by an interinvestigator reliability study with 40 persons in the field. The training session, which lasted a month, served the following purposes:
(a) The investigators learnt the correct technique of asking questions and gained confidence.

(b) The definitions of various symptoms in the check list were memorized during this period.

(c) We learnt that in the field setting an interview would take 15 minutes per person on an average and that the team could see about 20 individuals a day.

(d) The villagers (even in the sample area) came to hear about our survey and were ready for us when we went to them. They also learnt that the questioning was not prolonged and that we gave medicines when required.

(e) We got a chance to reconstruct some questions in the local idiom.

(4) The field work

The preliminary interview was carried out by the non-psychiatrists. The male investigator asked questions from the males and the female investigators from the females. Inquiry about others was limited to the males. The psychiatrists had to give a physical examination to 30% of the individuals and detailed interviews to less than 5% of the respondents and/or their close relatives. Whenever required, the detailed investigation was completed on the spot immediately after the preliminary interview. We usually tried for privacy but this was not always possible.

After completing a geographical unit we would go over it once again, searching for those who had been missed out during the first visit. The first round of the whole sample area took about 11 weeks. There were 200 persons still left - more males than females and more young than old. A second round of the village was carried out, and it took about 20 days.

Out of a possible 1244, 1237 individuals were interviewed and 7 refused; this meant a response rate of over 99%.

ANALYSIS AND SOME PRELIMINARY RESULTS

For analysis the population can be categorized in a variety of ways, depending on how the fact of having a symptom or not is manipulated:

(1) The population may be grouped into those (a) having no symptoms, and (b) having one or more symptoms.

(2) The population may be grouped into 4 categories: (a) having no symptoms; (b) having somatic symptoms only; (c) having both somatic and psychological symptoms; and (d) having psychological symptoms only (see Appendix 3).

(3) The population may be categorized into groups having different numbers of symptoms.

(4) The symptoms may be clustered by statistical techniques and the population may be categorized according to presence or absence of different clusters.

(5) The population may be categorized according to the presence or absence of each individual symptom.

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1 In a previous pilot study (not described here) we had discovered that the villagers did not like their womenfolk to be examined by men. One investigator was chased away by a woman respondent's father-in-law. The same pilot study showed that women were afraid of giving information about others without consulting their menfolk. It was therefore decided that the section on inquiry about others would be omitted when interviewing the women in the main survey.
All these methods of categorization are being used in analysing the data. The analysis has not been completed. A presentation of some of the more interesting results obtained to date follows:

Reporting psychiatric symptoms in others

As mentioned earlier, all males were asked if they knew anyone in the family or village who had one or more of the symptoms on the given check list. An analysis was carried out to examine reported behaviour and the characteristics of the reporters. In all, 152 people in the whole village were reported to have one or more symptoms and 170 people reported one or more person in the village as having one or more symptoms. These 170 will be referred to as "reporters".

It was found that:

(1) Brahmins have more reporters than Mogers, who in turn have more reporters than Bants; 51% of Brahmins, 29% of Bants and 35% of Mogers were reporters.

(2) There are more reporters among the young than among the old. The percentage of reporters was 51% for those under 20 years of age, 41% for those between 21-40, 35% for those between 41-60, and 32% for those 61 or over.

(3) The rich have more reporters than the poor; 36% of those living at subsistence level or below were reporters, as compared with 58% of those living above subsistence.

(4) The well-educated have more reporters than the poorly educated; 21% of those having primary education or below, 51% of those having school certificate and 67% of those having higher education were reporters.

(5) There were more reporters among those having symptoms themselves than among those not having symptoms (percentage of reporters: 51% and 35% respectively). The differences were more interesting when those having symptoms were divided further into three categories: the percentages of reporters amongst those having somatic symptoms only, both somatic and psychological symptoms and psychological symptoms only were, respectively, 41%, 43% and 59% - that is, those having psychological symptoms only have more reporters than any other group.

Using a chi-square test, all these differences are statistically significant with \( p < 0.01 \) or less.

Distribution of symptoms in the three castes

The "case" rate for the three castes was: Brahmins, 29%, Bants, 39% and Mogers, 33% in the case of males; and Brahmins, 33%, Bants, 43% and Mogers, 42% in the case of females. A case here is defined as one who had one or more symptoms. The matrilineal castes (Bants and Mogers) have a higher case rate than the patrilineal Brahmins both for males and females. In all castes females have a higher case rate than males.

Tables I and II give the symptom distribution for males and females respectively when those with symptoms are further divided into three categories.
TABLE I. SYMPTOM DISTRIBUTION IN THE THREE CASTES (MALES)

<table>
<thead>
<tr>
<th>Symptom group</th>
<th>Brahmans (154)</th>
<th>Bants (55)</th>
<th>Mogers (217)</th>
<th>Total (426)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No symptoms</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Somatic only</td>
<td>71</td>
<td>62</td>
<td>68</td>
<td>68</td>
</tr>
<tr>
<td>Somatic and psychological</td>
<td>6</td>
<td>13</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Psychological only</td>
<td>10</td>
<td>13</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Case rate</td>
<td>13</td>
<td>13</td>
<td>17</td>
<td>15</td>
</tr>
</tbody>
</table>

TABLE II. SYMPTOM DISTRIBUTION IN THE THREE CASTES (FEMALES)

<table>
<thead>
<tr>
<th>Symptom group</th>
<th>Brahmans (299)</th>
<th>Bants (143)</th>
<th>Mogers (365)</th>
<th>Total (807)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No symptoms</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Somatic only</td>
<td>67</td>
<td>56</td>
<td>58</td>
<td>60</td>
</tr>
<tr>
<td>Somatic and psychological</td>
<td>10</td>
<td>13</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Psychological only</td>
<td>13</td>
<td>22</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>Case rate</td>
<td>10</td>
<td>8</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

Social change and symptoms

The married members of the matrilineal castes were compared according to whether they were following the traditional residence pattern or whether they had changed over to a "patrilineal pattern" in which the husband and wife have started living together. From Table III it can be seen that the changeover has hardly affected the males, while among the females who have changed over there is a higher case rate than that among those who still follow the traditional pattern.

TABLE III. SYMPTOMS AND SOCIAL CHANGE

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Traditional</td>
<td>Changed</td>
</tr>
<tr>
<td></td>
<td>(111)</td>
<td>(94)</td>
</tr>
<tr>
<td>Case rate</td>
<td>32%</td>
<td>38%</td>
</tr>
</tbody>
</table>

NOTE: The results described on this page and elsewhere in the paper have all been subjected to statistical tests and the differences observed are considered statistically significant with p < .05 or less. The details of these tests have been left out for the sake of simplicity of presentation.
Symptoms and certain sociocultural factors

It was found that:

(1) Case rate rises with age, but amongst the older age group, when those between 41-60 are compared with those 61 or above, there is hardly any difference in case rates. Table IV shows the distribution.

<table>
<thead>
<tr>
<th>Case rate</th>
<th>-20</th>
<th>21-40</th>
<th>41-60</th>
<th>61+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Females</td>
<td>13</td>
<td>28</td>
<td>42</td>
<td>45</td>
</tr>
</tbody>
</table>

(2) The well-educated have lower case rates than the poorly educated.

(3) Those widowed or divorced have higher case rates than those married, who have a higher case rate than those unmarried.

(4) Those who had lost their parents before they were 15 have a lower case rate than those who lost them later in life. Tables V and VI show the results.

<table>
<thead>
<tr>
<th>Case rate</th>
<th>Father still alive</th>
<th>Early death</th>
<th>Late death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Females</td>
<td>22</td>
<td>28</td>
<td>42</td>
</tr>
</tbody>
</table>

TABLE VI. SYMPTOMS AND MOTHER'S DEATH

<table>
<thead>
<tr>
<th>Case rate</th>
<th>Mother still alive</th>
<th>Early death</th>
<th>Late death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Females</td>
<td>26</td>
<td>30</td>
<td>45</td>
</tr>
</tbody>
</table>

(5) Type of family (extended or unitary), size of the family, consanguinity in the parents, occupation and income had no relation to the case rate.

Symptoms and consultation

(1) Of those having one or more symptoms 58% consulted one or more agencies of help.

(2) When those having different types of symptoms were compared, 71% of those having somatic symptoms only, 71% of those having both somatic and psychological symptoms and only 33% of those having psychological symptoms only consulted one or another agency.

(3) Table VII compares the different castes as regards the consultation rate amongst those having symptoms. Bants consult more than Brahmins, who consult more than Mogers. In all castes men consult more than the women.
TABLE VII. CONSULTATION RATE IN PEOPLE WITH SYMPTOMS IN THE THREE CASTES

<table>
<thead>
<tr>
<th>Consultation rate</th>
<th>Brahmins</th>
<th>Bants</th>
<th>Mogers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td>Somatic only</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Somatic and</td>
<td>78</td>
<td>73</td>
<td>86</td>
</tr>
<tr>
<td>Psychological only</td>
<td>86</td>
<td>65</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>35</td>
<td>27</td>
<td>71</td>
</tr>
</tbody>
</table>

(4) Amongst those having one or more symptoms, 52% consulted a practitioner of western medicine, 21% a practitioner of Indian medicine, 11% consulted an astrologer, 10% consulted a temple priest, and 5% consulted an exorcist.

(5) Amongst those with psychological symptoms only, 19% consulted a practitioner of western medicine, 10% each consulted a practitioner of Indian medicine, an astrologer and a temple priest respectively, and 7% consulted an exorcist.

(6) An analysis was carried out to examine the number of agencies consulted amongst those who consulted for somatic symptoms only, both somatic and psychological symptoms and psychological symptoms only. Amongst those who consulted for somatic symptoms only or for both somatic and psychological symptoms 17% consulted three or more agencies. Amongst those who consulted for psychological symptoms only, 37% consulted three or more agencies.

**Reporting psychiatric symptoms in others**

It has been an enlightening exercise to investigate the factors which determine reporting of symptoms in others and to find that the young, the educated and the rich report more than the old, uneducated and the poor. Most interesting is the finding that those who have symptoms themselves, especially "psychological" symptoms, report more than others. These findings should have important implications in connexion with studies using "key informants" as the source of information. It shows that key informants may be biased in reporting because of their own characteristics.

**Caste differences in distribution of symptoms**

It is interesting to note that the matrilineal castes have a higher "case" rate than the Brahmins. However, the differences may be due to the fact that the three castes differ in sociocultural variables which correlate with "case" rates. A multiple standardization procedure needs to be carried out to "weight" the case rates in the three castes before carrying out a comparison. This has yet to be done. It is most interesting to observe that amongst the matrilineal castes the men are hardly influenced by change in residence patterns, but the women are. The facts that (a) the decision to change is made by men and not by women, and (b) women have something to lose by the change, in terms of their status in the family, make it unlikely that the social change is the result of neurosis in women who change the residence pattern. It seems logical to conclude that social change has been a cause of increased symptomatology in women. The stresses which women have to undergo in the changing society have been referred to in Appendix I and make the hypothesis more acceptable.

**Consultation**

It is evident that it is much more acceptable to consult for somatic symptoms than for psychological symptoms. Further, if one has psychological symptoms the tendency is to consult a greater variety of help-giving agencies. Perhaps one is forced to seek different agencies because none of them offers a satisfactory remedy for these kinds of symptom.
It is interesting to see that Bants not only have the highest case rate but amongst those who have symptoms Bants consult more than others. The implications of this result have yet to be fully understood. It is also interesting to observe that, although women have higher case rates than men, amongst those with symptoms men consult more than women.

The analysis is still incomplete and much more needs to be done before all the aims of the study are fully realized.

REFERENCES


APPENDIX 1

VARIATIONS IN THE INHERITANCE AND RESIDENCE PATTERN OF MATRILINEAL CASTES

1. Complete change over to patrilineal inheritance and residence pattern.

2. Husband and wife have started living together, though the inheritance is still matrilineal.

3. Inheritance changed to patrilineal, but the husband and wife still live separately.

4. Husband's family has changed over to patrilineal inheritance. His wife and children have started living with him. The family of his sister's husband is still matrilineal and hence the sister and her children also live with him. This gives rise to tension between the wife and sister.

5. Wife is not welcome to her brother's house because he has adopted the patrilineal residence pattern. Also she is not welcome to her husband's house as his family still follows the matrilineal residence pattern. This results in stress on the wife and children. In some cases she has to live with her children in a separate hut away from her brother and her husband.

6. Escape into a unitary family system.
APPENDIX 2

A BRIEF OUTLINE OF THE INDIAN PSYCHIATRIC SURVEY SCHEDULE
AND THE STAGES OF INQUIRY

The Indian Psychiatric Survey Schedule as it stands at present is designed to inquire about the presence or absence of 124 psychiatric symptoms and 10 items of historical information. The inquiry is carried out through a multistage procedure:

(1) All members of the population are given a Preliminary Interview Schedule, having two sections. This schedule is designed to be used by nonpsychiatrists who have had a short period of training. The first section has 26 standard questions, followed by a standard cross-examination. There are a number of cut-off points and the inquiry can be made more detailed when necessary. It is possible to elicit the presence or absence of 26 "somatic" and 36 "psychological" symptoms, the decision being made by the investigator, who is guided by an instruction manual giving standard definitions for the various symptoms. The 10 items of historical information are elicited from anyone having one or more symptoms.

To encourage cooperation, questions are first asked about more acceptable somatic items, then about sleep, appetite and other items of subjective distress and only at the end about delusions and hallucinations. Section II has 15 questions concerning distress or nuisance value to others and the respondent is asked if he has observed these in any member of his family or village.

(2) Anyone having somatic symptoms is given a general physical examination by the expert to exclude obvious physical pathology.

(3) If fits, attempted suicide, delusions or hallucinations are suspected in the preliminary inquiry, the respondent is given a detailed interview by a trained psychiatrist.

(4) A close relative who has seen the respondent for at least one hour a day during the preceding week is given a detailed standardized interview if:

(a) anyone while completing the section II of the preliminary interview schedule has reported that the subject suffers from one or more items in that section; or

(b) on detailed inquiry with the subject himself, the presence of fits, possession, delusions or hallucinations is confirmed.

(5) For every respondent who needed a detailed inquiry or whose close relative was interviewed the psychiatrist makes and records his observations.

(6) For items identified from more than one source (i.e. from the subject, his close relative or from the expert's observations) the symptom is recorded as present when its presence has been ascertained from at least one source.
APPENDIX 3

SYMPTOM CHECK LIST IN THE INDIAN PSYCHIATRIC SURVEY SCHEDULE (IPSS)

A symptom is defined as an item of behaviour, speech, mood, thinking, attitude and sensorium which (a) represents a change from the usual pattern for the individual and (b) is distressful to the individual or those around him or both. Unless otherwise specified the symptom is recorded only if it is present at the time of interview and/or during the preceding week. It is possible with the IPSS to inquire about the following symptoms:

**Somatic symptoms**

Pain in head

Burning in chest

Itching in ano-genital region

Numbness

Other odd sensations

Dizziness, nausea, indigestion, weakness, wind in abdomen, epileptic fits, hysterical fits, hysterical paralysis/parasthesia/ataxia/blindness/deafness/aphonia/other conversion features.

**Psychological symptoms**

Oversleeping, sleep delay, early waking, generalized sleeplessness, nightmares.

Increased appetite, decreased appetite.

Worried, feelings of inferiority.

Situational anxiety, free floating anxiety, panic, phobias, suspiciousness.

Muscular tension, restlessness, fugitive impulse, running away, wandering.

Subjective forgetfulness, poor concentration, pressure of ideas, poverty of thought, flight of ideas, ideas of reference, loss of memory, disorientation.

Obsessive ideas, compulsions.

Irritability, abusiveness, violence.

Depression, dullness, loss of interest, feelings of incompetence, suicidal feelings, suicidal attempt, guilt feelings, self blame, elation, grandiose ideas.

Sexual preoccupation, masturbation worries, night emission worries, loss of sexual desire, impotence, premature ejaculation, painful menstruation, other sexual problems.

Bizarre behaviour, excitement, slowness, stupor, preoccupation, distractability, catatonic features, blunted affect, incongruous affect, hostile irritability, hypomanic mood, histrionic behaviour, too much speech, too little speech, mutism, incoherent speech, irrelevant speech.

Delusions of persecution (human/supernatural), grandiose delusions, guilt delusions, other delusions, systematization of delusions.

Auditory/visual/olfactory/gustatory/other hallucinations.

Possession voluntary/involuntary.

Excessive alcohol, other antisocial habits.
AN ANALYSIS OF THE OUTPATIENTS OF A CLINIC IN CAIRO

O. Shaheen

Most people suffer from so-called nervous symptoms at some time during their life, and their activity is influenced in varying degrees by these symptoms (Abe, 1972; Agras et al., 1969; Leighton, 1956; Rennie et al., 1957; Winter, 1959). Of these, psychiatrists see only a small percentage. Inconveniences felt due to these symptoms, although differing from individual to individual, cause much misery, not only to the individual himself, but also to his family and to the community. The problem is growing, owing to the increasing complexity of human life through modernization, industrialization, increasing restrictions and legislation, extremes of wealth and poverty, monotony and social isolation.

In order to arrange treatment ideally fitted to the individual's needs, considerable flexibility of management and therapeutic care is required. Different systems are needed. The psychiatric outpatient clinic is one of the weapons in the human battle for sanity, security, tranquillity and health. Taking into consideration the low costs, one can consider that a psychiatric service programme, as a backbone, is a real need for developing countries.

In this report, it is aimed to stress the increasing importance of the role of the psychiatric outpatient clinic in psychiatric service and to answer two main questions:

1. What can a traditional psychiatric outpatient clinic offer and how it can affect the service?
2. What are the type of patients that come to the clinic?

To answer these two questions we will present the clinic attached to the Cairo University Hospitals. The statistics presented will be compared with those of the clinic attached to the Abbassia Mental Hospital.

The Cairo University psychiatric outpatient clinic started work in 1948, through the initiative of Professor A. M. Asker. The start was rather modest, with one room for consultation and treatment, very little equipment and an old electro-convulsive apparatus. During that first year it offered help to 28 patients only. Since then much has been gained. The clinic was transferred to the outpatient area, occupying 15 rooms distributed in a C-shaped manner, including two consultation rooms, another for social workers, a third for clinical psychologists, others for physical therapy, including ECT, cerebral stimulation, electronarcosis, a room for psychotherapy, one for filing and an EEG laboratory.

For educational purposes, there is a small theatre for 50 students, separated from a demonstration cabinet by a one-way screen.

Other needed physical investigations, including X-ray, are at hand in the nearby medical outpatient laboratory.

The service is run by two teams, each working three days a week. Each team comprises 4 psychiatrists, 2 residents, 4 house officers, 2 clinical psychologists and 3 social workers. If the patient is admitted he continues to be in contact with the same team personnel.

The programme of this clinic, as it has finally evolved, is as follows. All new patients are received by a social worker and after a careful social history has been taken, are referred to the psychiatrist for examination and diagnosis. At this time, an attempt is made to evaluate the psychodynamic factors in operation, taking the social background obtained by the social worker into consideration. The initial psychiatric work may be amplified by psychological tests, physical laboratory investigations, and a social field study of the social milieu, including the relatives of the patient. Then the plan of treatment is recommended, including

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physical therapy, psychotherapy and social therapy. The treatment programme and follow-up procedure are planned specifically for each patient so that the highest level of secondary prevention can be maintained. In the follow-up, the patient is seen twice a month for 10-15 minutes by a psychiatrist. The concern in these interviews is with old and recent symptoms, adjustment of medication and the evaluation of toxicity or improvement. During the interview, the patient brings up problems such as difficulties on the job or at home, etc., which are dealt with.

Occasionally, patients need emergency hospitalization, which is made readily available to them.

To demonstrate the size and variety of work in this clinic, a few tables will be presented.

From Table 1 it is easy to observe the ascending number of patients (new or follow-ups) in the last 10 years. The same observation is noticed in the number of patients frequenting the mental hospital outpatient clinic in Abbassia, which started in 1960.

**TABLE 1. NUMBERS OF OUTPATIENT ATTENDANCES IN THE LAST TEN YEARS**

<table>
<thead>
<tr>
<th>Year</th>
<th>University outpatients</th>
<th>Abbassia outpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New</td>
<td>Follow-up</td>
</tr>
<tr>
<td>1963</td>
<td>7 793</td>
<td>24 973</td>
</tr>
<tr>
<td>1964</td>
<td>7 090</td>
<td>25 474</td>
</tr>
<tr>
<td>1965</td>
<td>7 263</td>
<td>26 025</td>
</tr>
<tr>
<td>1966</td>
<td>8 537</td>
<td>27 145</td>
</tr>
<tr>
<td>1967</td>
<td>8 836</td>
<td>31 236</td>
</tr>
<tr>
<td>1968</td>
<td>10 948</td>
<td>37 022</td>
</tr>
<tr>
<td>1969</td>
<td>11 904</td>
<td>37 304</td>
</tr>
<tr>
<td>1970</td>
<td>12 588</td>
<td>30 417</td>
</tr>
<tr>
<td>1971</td>
<td>11 077</td>
<td>41 120</td>
</tr>
<tr>
<td>1972</td>
<td>12 315</td>
<td>32 231</td>
</tr>
</tbody>
</table>

Other types of services are demonstrated in Table 2, from which we can deduce the following:

1. There is a gradual increase in the number of admissions to the hospital, and in the application of EEG and psychometry.

2. There is a diminution in the number of patients transferred to the mental hospital.

3. There is also a diminution in the number of patients transferred to other specialities, denoting the importance of the outpatient clinic as a centre for propaganda, increasing the popular awareness of psychiatric illness.
TABLE 2. NUMBERS OF PATIENTS REFERRED TO OTHER SERVICES

<table>
<thead>
<tr>
<th>Year</th>
<th>Admitted to University Unit</th>
<th>Admitted to Mental Hospital</th>
<th>Referred to other specialities</th>
<th>Referred for EEG</th>
<th>Referred for psychometry</th>
</tr>
</thead>
<tbody>
<tr>
<td>1963</td>
<td>73</td>
<td>456</td>
<td>673</td>
<td>30</td>
<td>28</td>
</tr>
<tr>
<td>1964</td>
<td>73</td>
<td>391</td>
<td>602</td>
<td>54</td>
<td>35</td>
</tr>
<tr>
<td>1965</td>
<td>93</td>
<td>363</td>
<td>594</td>
<td>156</td>
<td>32</td>
</tr>
<tr>
<td>1966</td>
<td>77</td>
<td>396</td>
<td>523</td>
<td>161</td>
<td>73</td>
</tr>
<tr>
<td>1967</td>
<td>82</td>
<td>315</td>
<td>495</td>
<td>229</td>
<td>109</td>
</tr>
<tr>
<td>1968</td>
<td>234</td>
<td>334</td>
<td>549</td>
<td>219</td>
<td>176</td>
</tr>
<tr>
<td>1969</td>
<td>311</td>
<td>351</td>
<td>596</td>
<td>223</td>
<td>465</td>
</tr>
<tr>
<td>1970</td>
<td>271</td>
<td>248</td>
<td>548</td>
<td>299</td>
<td>802</td>
</tr>
<tr>
<td>1971</td>
<td>321</td>
<td>271</td>
<td>303</td>
<td>288</td>
<td>2 787</td>
</tr>
<tr>
<td>1972</td>
<td>308</td>
<td>231</td>
<td>426</td>
<td>383</td>
<td>1 869</td>
</tr>
</tbody>
</table>

The second question to be answered is what are the types of patients coming to the clinic?

Sex distribution. We can observe that there were more males than females in both the University clinic (55% males) and the Abbassia clinic (62% males), a fact that can be attributed to the cultural habit of caring for the male (the breadwinner) and of hiding psychiatric ailment of the female as a shame, substituting medical treatment by some sort of traditional healing. However, such restraining forces are less in the University psychiatric outpatient clinic.

Age distribution. The patients in the University clinic are of lower age groups than patients of the Abbassia clinic as proved by the following.

(1) The peak in the university clinic is at 10 years and above, while it is at 30 years and over in the Abbassia clinic.

(2) Most of the patients are under 30 years (61.1%) in the University clinic, while only 40.0% of those of the Abbassia clinic are below 30.

(3) The average age of the University clinic patients is 28.1 years, while in the Abbassia clinic it is 33.7 years. However, we can notice a higher percentage in the University clinic in the age group over 60.

TABLE 3. AGE DISTRIBUTION OF PATIENTS AT THE TWO CLINICS

<table>
<thead>
<tr>
<th>Age in years</th>
<th>University clinic %</th>
<th>Abbassia clinic %</th>
</tr>
</thead>
<tbody>
<tr>
<td>under 10</td>
<td>6.2</td>
<td>0.2</td>
</tr>
<tr>
<td>10 - 20</td>
<td>30.2</td>
<td>8.3</td>
</tr>
<tr>
<td>21 - 30</td>
<td>24.7</td>
<td>31.5</td>
</tr>
<tr>
<td>31 - 40</td>
<td>19.0</td>
<td>35.3</td>
</tr>
<tr>
<td>41 - 50</td>
<td>10.7</td>
<td>17.6</td>
</tr>
<tr>
<td>51 - 60</td>
<td>4.2</td>
<td>6.0</td>
</tr>
<tr>
<td>over 60</td>
<td>5.0</td>
<td>1.6</td>
</tr>
</tbody>
</table>
Education levels of psychiatric and non-psychiatric outpatients. In Table 4, we compare the group of University clinic patients with a random sample of 100 medical cases coming to the chest clinic in the same hospital. We can conclude that, although the illiterate groups are comparable, there is a higher percentage in the psychiatric unit in the groups with higher education.

<table>
<thead>
<tr>
<th>Education level</th>
<th>Psychiatric outpatients</th>
<th>Medical outpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td>III grade</td>
<td>43.8%</td>
<td>46.0%</td>
</tr>
<tr>
<td>Primary</td>
<td>26.2%</td>
<td>42.0%</td>
</tr>
<tr>
<td>Preparatory</td>
<td>17.1%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Secondary</td>
<td>8.6%</td>
<td>6.0%</td>
</tr>
<tr>
<td>University</td>
<td>4.1%</td>
<td>-</td>
</tr>
<tr>
<td>Postgraduate</td>
<td>0.2%</td>
<td>-</td>
</tr>
</tbody>
</table>

Occupation. Nearly three-quarters of the females were housewives. Of the rest, students came to the top, followed by the unskilled worker group. Of the male patients, most were skilled workers, followed by unskilled workers, then by students (Table 5).

<table>
<thead>
<tr>
<th>Occupation or status</th>
<th>Males %</th>
<th>Females %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housewife</td>
<td>-</td>
<td>73.4%</td>
<td>34.1%</td>
</tr>
<tr>
<td>Peasant</td>
<td>6.2%</td>
<td>-</td>
<td>3.3%</td>
</tr>
<tr>
<td>Unskilled worker</td>
<td>19.2%</td>
<td>6.0%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Skilled worker</td>
<td>30.6%</td>
<td>2.4%</td>
<td>17.6%</td>
</tr>
<tr>
<td>Clerical worker</td>
<td>5.4%</td>
<td>2.0%</td>
<td>3.9%</td>
</tr>
<tr>
<td>Professional</td>
<td>4.1%</td>
<td>2.0%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Tradesman</td>
<td>4.7%</td>
<td>-</td>
<td>2.5%</td>
</tr>
<tr>
<td>Student</td>
<td>19.0%</td>
<td>12.9%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Unemployed</td>
<td>9.0%</td>
<td>-</td>
<td>4.9%</td>
</tr>
<tr>
<td>Child</td>
<td>1.7%</td>
<td>0.6%</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

Diagnoses of patients seen at University, Abbassia and Ras-El-Teen clinics. From Table 6 we can conclude that more schizophrenics, epileptics, and anxiety patients are in the mental hospital clinic, while those with organic brain syndrome, hysteria and other categories present more to the University clinic. Comparing these results with those obtained from Ras-El-Teen clinic in Alexandria Province, we notice that Ras-El-Teen recorded the highest incidences of mania, hysteria, and senile dementia and the lowest of depression, mental subnormality and obsessions. Whether these differences can be attributed to cultural differences is a question that needs further investigation.


<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>University %</th>
<th>Abbassia %</th>
<th>Ras-El-Teen %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychoneuroses:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>14.0</td>
<td>24.1</td>
<td>13.9</td>
</tr>
<tr>
<td>Hysteria</td>
<td>12.1</td>
<td>4.0</td>
<td>26.2</td>
</tr>
<tr>
<td>Obsessions</td>
<td>0.9</td>
<td>0.6</td>
<td>0.4</td>
</tr>
<tr>
<td>Functional psychoses:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>8.8</td>
<td>32.5</td>
<td>23.6</td>
</tr>
<tr>
<td>Mania</td>
<td>1.5</td>
<td>1.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Depression</td>
<td>26.8</td>
<td>22.3</td>
<td>5.7</td>
</tr>
<tr>
<td>Organic brain syndrome</td>
<td>5.7</td>
<td>0.8</td>
<td>3.9</td>
</tr>
<tr>
<td>Senile dementia</td>
<td>1.3</td>
<td>0.1</td>
<td>4.3</td>
</tr>
<tr>
<td>Drug addiction</td>
<td>0.7</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>5.4</td>
<td>6.5</td>
<td>8.4</td>
</tr>
<tr>
<td>Mental subnormality</td>
<td>6.3</td>
<td>5.0</td>
<td>4.2</td>
</tr>
<tr>
<td>Psychopathy</td>
<td>0.8</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Psychosomatic disorders</td>
<td>6.5</td>
<td>-</td>
<td>3.1</td>
</tr>
<tr>
<td>Other diagnostic categories</td>
<td>9.2</td>
<td>1.8</td>
<td>4.0</td>
</tr>
</tbody>
</table>

Did the increase in the outpatient service modify the service in the mental hospital?

The answer to this question may be found by observing the relation between the outpatient and inpatient services (Table 7).

**TABLE 7. COMPARISON BETWEEN ADMISSIONS TO HOSPITAL AND NEW ATTENDERS AT OUTPATIENT CLINICS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Abbassia Hospital New outpatients</th>
<th>Inpatient admissions</th>
<th>University Clinic New outpatients</th>
<th>Inpatient admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1963</td>
<td>610</td>
<td>3 132</td>
<td>7 793</td>
<td>73</td>
</tr>
<tr>
<td>1964</td>
<td>761</td>
<td>3 151</td>
<td>7 090</td>
<td>73</td>
</tr>
<tr>
<td>1965</td>
<td>866</td>
<td>3 370</td>
<td>7 263</td>
<td>93</td>
</tr>
<tr>
<td>1966</td>
<td>8 995</td>
<td>3 563</td>
<td>8 537</td>
<td>77</td>
</tr>
<tr>
<td>1967</td>
<td>9 511</td>
<td>3 240</td>
<td>8 836</td>
<td>82</td>
</tr>
<tr>
<td>1968</td>
<td>10 948</td>
<td>3 320</td>
<td>10 948</td>
<td>234*</td>
</tr>
<tr>
<td>1969</td>
<td>11 904</td>
<td>3 699</td>
<td>11 904</td>
<td>311</td>
</tr>
<tr>
<td>1970</td>
<td>12 588</td>
<td>3 577</td>
<td>12 588</td>
<td>271</td>
</tr>
<tr>
<td>1971</td>
<td>11 077</td>
<td>3 496</td>
<td>11 077</td>
<td>321</td>
</tr>
<tr>
<td>1972</td>
<td>12 315</td>
<td>3 436</td>
<td>12 315</td>
<td>308</td>
</tr>
</tbody>
</table>

* A new section with more beds was added.
It can be observed that in the early years, admissions to the mental hospital greatly outnumbered new outpatients, but that after 1967 the ratio was reversed. At the University clinic, new outpatients always greatly outnumbered inpatient admissions.

It can also be noticed that the number of admissions to the mental hospital is less than the expected rise with the increase in the population in the last 10 years. If we take into consideration that more beds were sanctioned in the last years and that the turnover was more rapid, we can conclude that the outpatient service has helped to improve the service in the mental hospital, by contributing to a reduction in the number of inpatients.

Another point is that the presence of a regularly functioning outpatient service assures the psychiatrist, when considering early discharge of his patients, that they will be taken care of, while leading their ordinary lives. This has led to earlier discharge from the mental hospital as can be seen in Table 8.

<table>
<thead>
<tr>
<th>Year</th>
<th>Female patients</th>
<th></th>
<th>Male patients</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under 6 weeks %</td>
<td>6-12 weeks %</td>
<td>Over 12 weeks %</td>
<td>Under 6 weeks %</td>
</tr>
<tr>
<td>1963</td>
<td>32.3</td>
<td>19.9</td>
<td>45.4</td>
<td>28.8</td>
</tr>
<tr>
<td>1964</td>
<td>34.3</td>
<td>18.4</td>
<td>44.1</td>
<td>32.3</td>
</tr>
<tr>
<td>1965</td>
<td>35.4</td>
<td>15.2</td>
<td>46.9</td>
<td>35.9</td>
</tr>
<tr>
<td>1966</td>
<td>61</td>
<td>8</td>
<td>28.7</td>
<td>40.5</td>
</tr>
<tr>
<td>1967</td>
<td>63</td>
<td>3.3</td>
<td>32.2</td>
<td>42</td>
</tr>
<tr>
<td>1968</td>
<td>69.9</td>
<td>5.2</td>
<td>22.5</td>
<td>40.5</td>
</tr>
<tr>
<td>1969</td>
<td>54.8</td>
<td>16</td>
<td>27.1</td>
<td>46</td>
</tr>
<tr>
<td>1970</td>
<td>46.4</td>
<td>25.3</td>
<td>26.8</td>
<td>64.7</td>
</tr>
<tr>
<td>1971</td>
<td>57.3</td>
<td>32.6</td>
<td>9.1</td>
<td>65.3</td>
</tr>
<tr>
<td>1972</td>
<td>59.8</td>
<td>31.8</td>
<td>7.7</td>
<td>66.8</td>
</tr>
</tbody>
</table>

Note: The remainder of the patients (to complete 100%) either died or were the victims of accidents.

The short stay (less than 6 weeks) is increasing in frequency in both sexes, while the long stay (more than 12 weeks) is diminishing. This diminution in the length of stay coincides with increased use of the outpatient services. However, we must also take into consideration that the use of tranquillizers was generalized in the same period, with more consolidation of the improvement.

Discussion

It is evident from the above-mentioned data how important and diversified is the service offered in the psychiatric outpatient clinic, the work of which is increasing to surmount the magnitude of work in the mental hospital.

However, this does not mean that the outpatient service will replace the inpatient service completely. The key to the system of community mental health centres is the integration of these varied services, including inpatient and outpatient services, emergency centre, walk-in centre, and day and night hospitals. The essential quality is that these services are so organized as to form a coordinated system of care. The outpatient clinic can act as a complementary and preventive modality. It can be of great help in alleviating family anxiety,
especially with regard to the stigma associated with hospitalization. Patients attached to the outpatient clinic live in their homes and continue to relate to family members and friends while engaged in intensive treatment. Such a programme offers effective treatment for patients suffering even from depressive and schizophrenic reactions, especially those whose personality traits or family relationships facilitate cooperation with medical personnel.

Many questions arose when the University clinic was first started. These included:

(1) How often must patients be seen for evaluation and adjustment of medication?
(2) Would psychiatric hospital care be required frequently for these patients?
(3) What frequency of clinic appointments would be best for the patient and at the same time permit the clinic to handle an adequate volume of patients?
(4) Would an outpatient visit of 10 to 15 minutes duration be sufficient to allow careful re-evaluation of the psychiatric status of each patient?
(5) What psychiatric medications would be most desirable for what patients?
(6) What type of procedure for the discharge of these patients could be employed?
(7) What are the medicolegal problems in this type of programme and how can they be solved?
(8) Can this type of clinic be staffed with resident physicians working under the supervision of senior psychiatrists?
(9) Being attached to a university, can the clinic be a field for research?

Some of these questions have been answered during practice and some have yet to be answered as experience accumulates.

I must stress that not all the problems are defined or solved, as some are problems of evolution. An example is the problem of the relationship of the clinic, with its complicated and growing structure, to the general hospital. A related question is whether such clinics can be distributed all over the country, independently of general hospitals, to meet society's needs. Both dependence and independence can work. In Egypt we use only the dependence programme in constructing new clinics (we have nine in Cairo and 20 distributed all over the country), attaching a few beds to the clinic whenever necessary for emergency needs. In the Soviet Union, outpatient clinics are more independent and are known as dispensaries.

Another problem was the possibility of offering psychotherapy. Unfortunately, in a large public clinic the requests for assistance far exceed the capacity of the staff to administer psychotherapy individually. However, a type of compromise was reached in our clinic by administering supportive, superficial, and group therapy, reserving insight psychotherapy to a few selected cases.

Even drug therapy introduced the problem of financial support and till now this problem has not yet been solved.

REFERENCES
PART 3. THE DELIVERY OF MENTAL HEALTH CARE

PRINCIPLES OF PREVENTIVE ACTION IN MENTAL HEALTH CARE

A. Kamal

I often recall with a great deal of instructiveness one of my experiences as a preclinical student. This was a statement in a lecture delivered by a visiting professor to the medical school. "A doctor", he said, "ought to have the mission of working himself out of business". At the time, with future medical practice still years ahead of me, I found his statement paradoxical, discouraging, and to some extent incongruous with what was impressed upon us in the field of pathology and related subjects. Understandably, this attitude persisted throughout the clinical years, with the greater emphasis given to disease processes and to treatment. The attitude was no different after many years of training for the neuropsychiatric speciality or involvement in it. It is only in the past few years, having been overwhelmed by the magnitude of mental illness in the community, and becoming overworked by the demands to meet the therapeutic needs, that I have become aware of the necessity of enforcing measures of prevention, with the hope of reducing the incidence of mental breakdown. At times, however, I have entertained feelings of pessimism concerning the positive value of any such measures. Justification for this recurring pessimism comes partly from the steady increase of cases observed in developing as well as less developed countries. It comes partly also as a result of the pressing need for treatment of patients already present - a need we find very difficult to meet in view of our limited resources. There is also the added source of pessimism which comes from the feeling that it is most difficult to change the personality structure in predisposed individuals, rendering preventive measures of questionable value. Experience with child guidance clinics with follow-up appears to support that notion.

So much for the negative side of prevention. On the positive side, however, is the close relationship between the incidence of mental disturbances and physical diseases or nutritional disorders, particularly in less developed countries. There is also the group of genetically determined disorders, a few of which are preventable or could ultimately be preventable.

Issues of prevention in mental health

Before one attempts a formalization of principles of preventive action in mental health, it is necessary to contemplate a number of issues such as what it is we are preventing; what is the aim envisaged; whether this aim can be accomplished; and whether it is really necessary to achieve the aim; as well as the difficulties likely to be encountered in any scheme of implementation. Particular emphasis should be given to the situation in developing countries.

Dr Bror Rexed, commenting in a discussion on the subject of prevention, emphasized "that we must make clear what we are trying to prevent, by what kind of actions and based on what values". He went on to say: "Is it more important to prevent psychotic reactions? Or do we rather want to take up how to get on with the general malaise of modern society, the feelings of tension, anxiety and alienation? Or do we want to prevent psychiatric diseases - neuroses, psychoses and behaviour disorders? Should we centre on more specific factors on the stimulus side, or on rather specific psychiatric or psychosomatic disorders, or should we centre on more general traits ...?"

In prescribing further the aims of mental health, one may refer to the statement in the WHO Constitution: "Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity." We must also refer to the attempted definition by the Preparatory Commission of the Third International Congress of Mental Health in London in 1948, of which paragraph 1 reads: "1. Mental health is a condition which permits the optimal development - physical, intellectual and emotional - of the individual, so far as this is compatible with other individuals." Both statements clearly indicate the positive values of mental health. Other definitions, notably that of Dr Lawrence Kubie, who states that "basic

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mental health as distinct from the absence of neurotic symptoms is not so much something we ordinarily enjoy, but rather an ideal towards which we might conceivably evolve", suggest a nearly utopian ideal. The difficulty of attaining it does not detract from the need to aim at it.

The second issue is what we are trying to prevent. On this issue there is more disagreement than unanimity. The psychoses, no doubt; but the neuroses, the psychosomatic disturbances and the behaviour disorders pose a different problem and one finds it difficult at this point of our knowledge to give an absolute judgement on where to stop in the evaluation of such disorders.

The third issue demands an answer to the question of whether prevention in the context of the aims declared can be done. The facts of science seem to indicate a good chance of achievement of some of our set aims. As Dr Stewart Wolf strongly emphasized "our efforts towards the development of a science of man will require research focused at regulatory processes, extending from the synapse to sociocultural organizations". This, he went on "entails, perforce, an interdisciplinary effort and will require the development of interdisciplinary people".

Finally, there is the dialectic issue of whether it is really necessary to prevent mental illness! Measured in terms of individual and community suffering, there is very little doubt about its desirability. But can humanity do completely without some measure of deviation from "normalcy"? There are also those who hold the view that the process of development and progressive change in the human situation and of mankind depends to a large extent on the existence of this factor of deviation from the accepted "normal". And finally there are those people who, like Michel Foucault and R. D. Laing, question the validity of separating madness and reason and argue that both are "inextricably involved: inseparable at the moment when they do not exist, and existing for each other, in relation to each other, in the exchange which separates them". Such arguments are clearly intended for a different level of philosophical and theological consideration and it will be pointless to deal with them further at this moment.

Difficulties of preventive action in mental health

For measures of preventive action to be formulated and applied with a good potential of success, those measures must take into full account the difficulties inherent in the problem of mental health. It is abundantly clear to everybody engaged in this field that these difficulties are very numerous and difficult to isolate.

One group of difficulties stems from the very nature of mental disorders, their multiple forms and variable symptomatology involving the full range of the physical, psychological and behavioural aspects of an individual. There is also the difficulty of quantifying the manifestations of these disorders, especially in the borderline states. The second group of difficulties emerges from the still undetermined etiology of most mental disorders. Many theories and hypotheses about the etiology of mental illness are still prevalent with little chance of agreement between the diverse interpretations suggested by various schools. Although many disorders have been genetically or biochemically determined, we are still unclear about the details of such an organic etiology, the genetic laws governing its transmission, the influence of a changing environment on this manifestation and the means through which it is expressed.

The third group of difficulties stems from the extent of the problem, which is unequalled by any single physical illness or group of such illnesses. This difficulty is probably raising the issue of whether we are seeking to eradicate mental disorders or simply to limit their expansion in our developing society.

Finally there is the difficulty of how to apply preventive action in a moving and changing situation. It is clear that the stage for preventive action in both the advanced and in the less developed countries is not a static but a dynamic one. Aspects of this moving situation include technological advance, industrialization, urbanization, overcrowding, education, communication, world conflict and an environment rapidly becoming polluted, not only in the physical but also in the psychological sense. These difficulties, and others not mentioned, render preventive action a most exacting field of work and an unparalleled challenge to those undertaking its formulation and application.
The problem of prevention in developing countries

Not infrequently, on betraying my identity as a psychiatrist in a developing country, an acquaintance from a western country will remark with surprise, "I didn't think that you had nervous patients in your part of the world". This is perhaps the experience of many of my colleague psychiatrists in this part of the world on similar occasions. The implications of such a remark are double-edged. On one side there is the belief that mental disturbance is the outcome of civilization and therefore to be found mainly in technologically advanced and industrialized countries. The other edge of the remark seems to indicate that we, in this part of the world, leading a simpler and less complicated life, must therefore enjoy happier and sounder mental states. Superficial impressions and crudely collected statistics tend to support this impression of the problem of mental health in developing countries. The facts of the situation are totally different. Explanation of this discrepancy is to be found in the very inadequate psychiatric services in most developing countries, and in the reluctance of the majority of patients to seek proper psychiatric treatment, either because they have no faith in it yet, or because of the social stigma still attached to this form of illness among the population as a whole. But wherever proper and efficient services exist and people are made aware of their value, and there is less prejudice against mental illness, one is bound to find a much higher incidence of mental illness of the various categories than had been thought to exist.

Better and more comprehensive psychiatric services

There is an undoubted need for better and more comprehensive psychiatric services all over the world. The need in developing countries is much greater than elsewhere, as in many instances some of the communities are not far removed from witchcraft, priesthood and lay medicine. In practice emphasis is put almost completely on therapy. This is easily understandable in view of the shortage of experienced personnel and of the general orientation in psychiatric training. It is, however, through the medium of therapy, and being overwhelmed, that we become ultimately aware of the need for prevention. It is also through the medium of therapy that we gain both the contact with and the insight into the mental life not only of our patients but also of their families and life situations, and this will inevitably serve a preventive role, however limited.

Integration of psychiatric care with general medical care

The advantages of integrating psychiatric and general medical services, at least at some level, are many. They include the removal of the stigma attached traditionally to mental illness; integration also implies a better dissemination of knowledge about mental illness. In developing countries in particular such integration will give psychiatric experience to the general physicians and vice versa, a fact that amplifies the effectiveness of psychiatric care and gives wider opportunities for preventive advice.

Research projects

It is not likely that any planning for mental health, both in the therapeutic and the preventive fields, will yield good results without research into the incidence of mental illness, the forms it takes and the factors operative in its causation. This calls for surveys involving such factors as the social, economic, cultural and religious factors. Such surveys must by necessity establish the effect of change in the life situation of the individual and of the community in general and the incidence and forms of mental illness. The question of change here does not simply mean measuring the degree of departure from pre-existing levels of the traditional ways of living, but also the rate of change and the extent of disorganization it produces in the life of the individual. It is also necessary to examine the conditions under which this change takes place and the ultimate form it takes.

It is suggested that in every country or region where this research is carried out it must be conducted at various levels of social, economic and cultural development. It is also necessary to make transcultural comparative studies on similar lines and with similar factors of reference. The results of research will undoubtedly yield information as to what elements in the life of the individual and the community tend to preserve mental health and what incidental factors of change lead to mental disturbances in one form or another.
**Integrated national action**

It is becoming increasingly realized that the care of the mentally disturbed, as well as the preventive aspects of mental health, are a national issue in the wider sense. The close relationship between mental health and ecology in its most comprehensive sense makes it necessary to plan preventive measures on a multidisciplinary basis, involving integrated planning and implementation by all the governmental and nongovernmental agencies concerned. These must include the social, economic and cultural agencies. Educational guidance and youth authorities are also closely involved. The role of the psychiatrist in such integrated planning and action could be enormous and give far-reaching results and much depends on his capacity to grasp the multifactorial nature of his vocation and equally on his ability to influence and orientate all those concerned in the plans aiming at control and prevention in mental health.

**Environmental planning**

With an ever-increasing percentage of the population living in cities, it has been questioned whether urbanization carries a higher risk of breakdown in mental health. This calls for the examination of the total urban environment and its impact on the normal psychological as well as the physical life of the individual. Here one must recall Dewey’s phrase: "In attempting to solve the problems of our cities, we cannot separate the behaviour of men from the space in which they live." It is only through this realization that it becomes possible to formulate plans for the cities of the future. Architectural planning taking the essential needs of healthy environment into consideration will aid a great deal in promoting what Kubie calls the "new creation". Developing cities have the advantage that they do not have to remodel their old cities to meet these requirements; they start from scratch in most instances, which makes the process of creation much easier.

**School psychological services**

Schoolchildren and adolescents form an appreciable percentage of the population and this percentage is increasing rapidly in developing countries (in Iraq, for instance, they account for nearly 25% of the population). It is through this easily documented section of the population that we can detect early cases of deviation from normal. It is also through this medium that we can introduce some of the preventive measures outlined in this paper. The establishment of a psychological health service for schools within the school health service gives the opportunity not only of integrating the physical and mental aspects of the health of the student, but makes it possible to influence the educational policies of the community in such matters as planning of schools, curricula, selection of teachers, nutrition of students, recreation and vocational training, taking into consideration aptitudes, abilities and possibilities for future employment.

**Genetic and eugenic methods**

The role of genetics is not fully understood in relation to mental health, and it is too early to lay down the principles governing mental diseases; therefore the adoption of precise eugenic preventive schemes is a premature undertaking. We know, however, a number of facts about the strong genetical basis of some mental illnesses, particularly schizophrenia and cyclothymia. There is also a marked hereditary factor in an appreciable percentage of mental defectiveness and retardation. Knowledge of the precise contribution of heredity to mental illness and mental wellbeing must await further studies of the genetic factors and the means through which these factors express themselves. In the meantime we have to content ourselves with the simpler facts available to us. From a eugenic point of view it would be wise to counsel against marriages heavily laden with mental and defective heritage or with severe psychosocial clusters including behavioural disturbances. It is also of considerable preventive value to avoid all those factors in pregnancy that might affect the mental and physical status of the newborn. Factors to be considered include anything from the age of the mother, her physical and mental state, and the number of children she has to exposure during pregnancy, etc. What measures to take in such circumstances is difficult to state categorically, but the
collaboration of the maternity clinics, the clinics of child and mother care, the family
planning units, the community social workers and health visitors and the consulting services of
the qualified physician will undoubtedly yield a considerable amount of preventive advice.
Resort to euthanasia and sterilization are issues frequently raised in connexion with mental
disorders, including mental defectiveness and gross forms of antisocial behaviour. It is
evidently difficult to come to any recommendation in this matter, which has a wider implication
than pure medical expediency, as it is deeply involved with social, legal, religious and moral
considerations as well. These considerations must not obliterate the facts of science, nor
the need to search for every possible way of enhancing and preserving the mental health of the
individual and the community.

Bridging the gap

Gaps of varying depth and form exist in the modern world between the developed and the
developing countries. The signs are that the gap is continuously widening. Comparative
studies put the ratio of technological progress between the developed and the less developed
countries a hundred years ago at 5:1, while it is calculated today at the ratio of 50:1; and
the signs are many and indicate that technological progress in the advanced countries is pro-
ceeding at a rate higher than the present rate of progress in developing countries. Will the
gap ever be bridged? Perhaps, if the more advanced countries give up the race for technolo-
gical progress for a while and settle down to digest the benefits and integrate them sanely
into human life. It is also possible if less developed countries speed up the pace of progress.
Neither method is easily accomplished; international cooperation aiming at bridging the gap is
of paramount necessity. The relationship of this gap to mental health should be clear. It
springs from the fact that the individual in the modern world is seeking identity and fulfilment
and, therefore, is bound to be frustrated and resentful of anything that interferes with his
legitimate attempts at realizing himself as a citizen of the world. Frustration and resentment
are conducive to mental disturbances and behaviour disorders. This has been observed earlier
in advanced countries; it is more striking in developing countries now. The problem is world-
wide, and the challenge is universal and must be met if we are to anticipate a world of reduced
tension fit for all to live in harmony.

Preservation or replacement of tradition

Developing countries have been and are enthusiastic about obtaining all possible fruits
of progress in modern life - schools, hospitals, factories, means of communication, houses and
other expressions of modern technical progress. In many instances this change has brought about
some disruption of the traditional way of life and of the social and psychological processes of
adaptation. It is not intended here either to criticize progress or to offer a plea for
tradition as such, which is, in many instances, equated with ignorance, illness and human
bondage. What I have in mind is the observation common to all developing countries that we
are, by the necessity of change, abandoning some of the stable traditional ways of life that
gave the individual identity, security, and to some degree immunity from breakdown. It
becomes, therefore, pertinent to ask whether it is possible to preserve some of the spiritual
elements of our traditional life - such as the community identity, religious convictions and
family ties - without influencing the needed rate of progress. Should such a preservation be
scorned as reactionary and out of date, it follows that we must stress the necessity of
replacing tradition with new ways of life and new ideals suitable for our adaptation and for
the promotion of our mental health. I am afraid we are not providing intelligently for that.

An ideal way of living for the promotion of mental health

All men throughout the ages must have attempted at one time or another to attain what they
imagined to be an ideal existence. That they have not achieved it is only a confirmation of
the countless variations in individual outlooks as to what is ideal in life and the best way of
realizing it. Many ideals and many ways of realization have been formulated and attempted by
various individuals belonging to various disciplines, whether philosophic, religious, social,
cultural or economic. Failure to achieve unanimity is an index not only of the variability of
the human factor, but is also an indication of the continuously changing environmental factors.
Despite all these difficulties, it is evident that man has always proceeded in the direction of realizing his needs within a human framework. It is this positive realization of the needs of the individual in a human set-up that holds the key to an ideal life, whatever colour or form it takes. It is only this ideal of living that is likely to be compatible with an optimum state of mental health.

Perhaps we have in this present age individuals and communities who satisfy the basic requirements of an ideal existence and who enjoy a minimum of mental disturbance. These are worthy of detailed study. There are indications that a simpler way of living, with fewer needs to satisfy, holds a better prospect for a less disturbed mind. There are also indications that more primitive communities suffer less anxieties, less breakdowns and less behavioural disturbances or their compensatory equivalents than is known in any average society. Could this observation, after reliable confirmation by research studies, indicate to us the necessity of reducing life in more complex societies to simpler forms? At the same time we must examine how to develop life in the primitive, less developed or developing countries without the necessity of completely disorganizing the processes of adaptation to a simpler life which they have gained over many generations in a stable environment. Is it really impossible to realize the positive needs of the individual and the community in such countries without having to destroy the past completely? This issue is a fundamental one in the developing countries, its resolution carries either hope or disaster, in terms of mental health among other things, to every human being on earth. Without fully meeting the issue, we are not likely to achieve much in the direction of preventing mental illnesses, to say nothing of the hopes of promoting better and more constructive states of mind.

Education in mental health

It is correct to assume that the best way to educate people in matters of mental health is primarily through performing effectively the services needed in this field. Such services, in addition to providing the possibilities for treatment, also give many opportunities for preventive advice aiming at preventing recurrence of illness and the reduction of the general incidence of mental disturbances.

In developing countries, only a small percentage of those mentally or psychologically disturbed seek the services of qualified psychiatrists. Much of the needs of the community remains undeclared, and the majority of the declared needs are either met by the general practitioner, the health assistant or lay medical practice. This last medium is still prevalent in many communities and is undoubtedly a great limiting factor in the therapeutic and preventive aspects of mental health. Reflecting on this, one finds it difficult to accept suggestions made by qualified psychiatrists in some developing countries recommending working through or with the cooperation of such agencies.

A great deal depends on the psychiatrist's abilities and interests in the field of information, guidance and education in mental health. Through carefully planned programmes, it is possible to instruct and orient medical students and interns in the field of psychological medicine. Through intimate collaboration with other physicians, in general medicine or other specialities, it is possible to integrate psychiatry with general medical practice. The failure of psychiatry in many instances has been the result of the attempt by some psychiatrists to build up an incomprehensible cult which can only help in isolating and discrediting the profession.

Educational programmes in mental health should be introduced whenever possible in the curricula of nursing schools, health officials' institutes, the training of social workers, guidance for graduates and students of psychology, sociology and education. For the past 4 years we have carried out this plan in Iraq, and although the immediate results are not noticeable I am sure they will be substantial in the long run.

Other forms of education must aim at utilizing all available channels of information such as newspapers, magazines, and radio and television programmes. Such media are of an enormous potential in developing countries where selective reading is severely limited for the general public. An intelligent use of these media will aid tremendously in facilitating not only the
therapeutic aims of mental health, but its preventive aspects as well; and it will be a great pity if psychiatrists abandon this medium to the misuse of individuals misinformed in this most delicate field of medical information.

One other form of education must be that directed to individuals and bodies of authority in public life. No effort must be spared, or opportunity given up, to influence them. It is never the fault even of health planners if they place mental health and mental illnesses low on the list of health priorities; for to them mental health is an invisible entity and mental illness is still equated with asylums for the insane needed for the socially banished few. It is, therefore, the psychiatrists' sustained duty to impress upon men in authority that the real magnitude of the mental health problem is of different dimensions. This can only be done by repeated attempts to translate the problem of mental health in terms of real number of patients, number of crimes and cases of delinquency, and of school dropouts, and of the extent of alcohol and drug addiction, loss of work, and disqualification from national service, not to mention the social and economic problems created by psychiatric and psychological disorders.

Training the psychiatrist

We have earlier postulated that there are no possibilities of prevention in mental health without the existence of psychiatric services. It is equally valid to postulate next that there are no psychiatric services without psychiatrists. This brings us to the important issue of the training of the psychiatrist, how to select him, what is needed in preparing him, where and how to train him. At this point I must make reference to the enlightened chapter written on this subject by Professor Carstairs in the companion to psychiatric studies published recently, as well as to his recent paper in the Journal of Psychiatry. The writer's experience with the training of psychiatrists from developing countries and their difficulties both in foreign countries and on their own ground is both comprehensive and instructive and he leaves little room for additions. I would like, however, to squeeze in one or two points. Firstly, the psychiatrist's field in a developing country as a "nerve doctor" is perhaps the most comprehensive medical role possible and his training prior to taking up psychiatry proper must acquaint him with all fields of medicine related to his future profession. Unfortunately, we tend to overlook this point in selecting or accepting psychiatrists for training. The result of this neglect is witnessed in the tendency of psychiatrists to isolate themselves from the usual stream of medical life and, not infrequently, in errors of judgement. The second point is concerned with who is suitable for psychiatry? The answer to this question becomes clear when we realize the role the psychiatrist must play in his own country. It is a role of cultural leadership, the influence of which permeates into the physical as well as the psychological aspects of the lives of every member of the community. It is therefore necessary that he must have the talent for the acquisition of knowledge on a much wider scope than any other physician. He must be acquainted with the arts as well as the sciences, with philosophy and psychology, just as the sociologist is familiar with economics and anthropology. Without this versatile disposition and acquisition, he is not likely to play his role effectively. This is why we must select our psychiatrists very carefully. But how do we find them initially? We must scout for them, detect, them, entice them and lure them into the field at all costs. Only then does it become possible to realize the hopes inherent in the spirit of our profession. One final point about the training of psychiatrists from developing countries concerns the place of training. I do not feel that developing countries are at present equipped to carry the full range of training. Although the special demands of every region must be considered separately, yet one must agree with Dr. J. S. Neki in a recent paper in the Journal of Psychiatry in which he calls for a bifocal orientation of the psychiatrists of developing countries. Through such an orientation we become capable of grasping not only our local psychiatric problems, but also the core of psychiatric knowledge, which is undergoing explanation and interpretation by western research methods.

Conclusion

This paper attempts to orient the psychiatric planner towards the need for prevention in the field of mental health. The difficulties of any preventive action are outlined. Principles for preventive action in mental health have been postulated and discussed with particular reference to developing countries.
OBJECTIVES AND POLICY

In striving to deal with the difficult and complex problems of mental illness, the first principle to be considered is the setting up of realistic objectives and the drawing up of a feasible programme for the proper development of psychiatric care.

Ideally, the aim of psychiatric care should be the promotion of mental health (WHO Expert Committee on Mental Health, 1950) and the development of preventive, therapeutic and rehabilitation services. Operationally, while placing due emphasis on the importance of a total approach in mental health work, and of improving the quality and range of services and training possibilities, the psychiatric care programme should be well fitting into the local conditions, and developed as part of an all-round national health plan.

Time and again one is struck by the lack of objectives in mental health services and the absence of policy in psychiatric work. Indeed the conceptualization of what has to be achieved in psychiatric care, how would it be achieved, and by whom it is to be achieved may be rather hazy and often vaguely envisaged.

In a recent questionnaire, for example, circulated to 22 countries of the WHO Eastern Mediterranean Region for appraising the current situation regarding the state of psychiatric care, one of the questions read: "Has a statement of a national policy on mental health services been formulated?" The majority of the countries answered in the negative. This was not surprising as the development of mental health services, in general, has been rather slow and far behind that of other health services. On the whole, experience has repeatedly shown that in countries where there is no well formulated policy, based on clear and accepted principles of psychiatric care, it is often the case that such services suffer from basic inherent defects. The relevance of this point becomes eminently important when it is known that serious efforts to develop mental health services have been frustrated owing to lack of sound planning policy and deficiency of organized programming.

Again experience shows that in some countries, although the objectives of psychiatric care may be generally defined, the steps to be followed may not be clearly set out, and the subsequent programming meets with disruptions and disappointments. In one of the countries, for instance, in spite of the fact that there was an acute shortage of qualified personnel to staff a newly constructed centre, the building programme continued all the same and two other centres were also built. It was clear that the obstacles which would be encountered had not been foreseen, and that the necessary action to overcome them was not taken at the right time.

INFORMATION AND SPECIFICATION OF PSYCHIATRIC PROBLEMS

The importance of having adequate information in order to specify the extent of the psychiatric problems, assess the current needs, monitor the progress of services, and help in future development should be considered at the foremost of the general principles.

One might quote here an example from one of the countries where the question was raised (and this was by medical professionals) whether mental illness in developing societies constituted a problem that warranted active intervention comparable to that warranted by other medical conditions.

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As a matter of fact, the dearth of knowledge on common psychiatric morbidity and on the extent of mental health problems has weakened the case for proper development of psychiatric services. It is therefore important to affirm that various epidemiological studies in traditional societies indicate a substantially higher incidence of psychiatric morbidity than was previously thought. Quite apart from cultural variations, one is often impressed by the similarity in general, rather than by the differences between psychiatric illness in technically advanced and so-called developing countries; and this has to be made known in order to do away with the unwarranted complacency which may still be found in some countries.

PHILOSOPHY OF PSYCHIATRIC CARE AND CHANGING CONCEPTS

The search for more effective models

It is not intended here to go into the historical perspective of psychiatric care, nor to recapitulate the significant movements in the mental health field. However it can be stated as a general principle that the philosophy of psychiatric care must be properly conceived to ensure effective implementation.

For the sake of discussion several questions may be posed in this connexion. For instance, what is the psychiatric worker trying to accomplish? What should be the philosophy on which the premises of psychiatric care should be based? Should the treatment be focused on the removal of symptoms only, or on modification of the personality structure of the patient? Or should it involve his interpersonal relationships and extend beyond individual therapy, the clinical setting, hospital confinement, into the social structure? And with what purpose? What should be the boundaries of such a trend? What social institutions or community groups should be involved? To whom should the therapy be entrusted? Should it always be the full members of the well-known psychiatric team? And if such qualified workers are not available, as is the case in many parts of the developing nations, to whom should such responsibility be delegated? What methods or techniques should be used?

In raising these questions one had to bear in mind the present-day differences in the levels of psychiatric standards between the various countries. Notwithstanding recent advances in psychiatry, there are certain countries where the care of mentally ill patients is still practised in the custodial era. Several countries are just starting their services and would like to find out where to start, and how to start. However, as a matter of principle psychiatric services should be built from the base to the top, and not the reverse. A serious mistake which has been committed in some countries was that they borrowed the model of the traditional psychiatric hospital, and failed to move from there, whereas others started - and rightly so - with an outpatient unit or a mental health centre and expanded the base of psychiatric care within the total health resources. Generally speaking, the search for new models has been increasingly felt, and organized research in this respect is most needed (Heseltine, 1969; Huessy, 1972).

Population coverage

In general, it has been realized that treatment of individual patients in mental hospitals proved to be ineffective for the overall care of psychiatrically ill patients and for the adequate control of mental illness in the community, and hence new approaches had to be developed.

Among the central concepts which have influenced modern trends in psychiatric care is the shifting of emphasis from the traditional clinical practice of individual care to the population-oriented approach, and the placing of more emphasis on the preventive and rehabilitative aspects of mental health work. The new movement embodied in comprehensive community psychiatry, in spite of the criticism levelled against it (Kubie, 1968), should be regarded as a significant attempt in this direction. However, it is to be remembered, as has been rightly pointed out by Caplan (1965) and others, that there are several problems which confront the extension of psychiatric care into the social structure and into the community at large. Apart from the need for working out general theories, effective community techniques, and new models, an organizational framework for comprehensive psychiatric care has to be developed.
There is no doubt that community mental health has found readily available theoretical models in public health teachings, but achieved relatively less progress in its practical applications.

As an illustrative example it may be of interest to examine, especially in developing countries with their limited resources, the implication of the principle of population coverage in the mental health services. In this connexion it is worthwhile to refer to the proposed health plan by the WHO Regional Office for Africa to provide full geographical coverage for African communities. Realizing that the existing health structures were inadequate, the establishment of "health centres and posts capable of providing 75% of the population with acceptable and accepted services", was proposed. This seems to serve mainly the rural population "in the framework of an integrated approach to community health". The health centre, which would be staffed by a physician, a nurse, a midwife, a sanitarian and some auxiliaries, is supposed to cover 20,000 - 25,000 population. If this plan is taken as a basic model, one has to think of the place of psychiatric care in such a health system. The best approach in this regard seems to evolve out of the psychiatric training of the staff of the health centres. However, the acute shortage of qualified personnel and lack of training facilities in developing countries in general is considered to be the most serious constraint in the development of psychiatric care. It is, therefore, exceedingly important that the first priority in psychiatric activities should be given to the training of mental health workers.

In brief, the major issues which face new trends in psychiatric care are manpower development, the effective implementation of new concepts, and the bridging of the gap between the provision of services and the total population needs.

INTEGRATION OF PSYCHIATRIC CARE INTO GENERAL HEALTH SERVICES

Leading from the last point, it has been generally found that one of the important principles in the development of psychiatric care is the integration of mental health work into the general health services. It may be conceived that in an affluent society with exceptional economic support psychiatric care may be developed separately from other health services. But in many of the developing countries, even if the material resources could be made available, the manpower bottleneck may constitute so difficult an obstacle that it will not easily be surmounted for many years to come.

Apart from the pooling of resources, and removal of the stigma of mental illness, the integration of psychiatric care into general health services would help in early diagnosis, early treatment, follow-up, training, etc.

Furthermore, social agencies and public health services for maternity and child care, for family planning, for marriage guidance, for the care of special groups such as students, for law enforcement, for medical rehabilitation and others have a prominent mental health role to play. These examples indicate the necessity for close cooperation and coordination, at both the planning and operative levels, between mental health, public health, and social services.

As a matter of fact a great deal of extremely interesting mental health work carried out by general social workers attached to schools in one of the countries has been observed. Other personnel also found to be interested in mental health work were the school health officers and the general duty doctors working in community health centres. However, for an all-round development of psychiatric care in the context of general health work, and for effective integration with community services, two major requirements have to be taken into consideration:

(a) the importance of training programmes in mental health for general health workers (Bleuler et al., 1961; WHO Expert Committee on Mental Health, 1961 and 1962) and public orientation;

(b) the need for a central administrative machinery for proper implementation of an integrative policy.
Incorporation of psychiatric care in the general medical services, for instance in countries of the Eastern Mediterranean Region in the form of psychiatric inpatient and outpatient units has proved to be generally promising and effectively helpful, not only for therapeutic purposes but also for training and research. Such services are generally located in closer proximity to the community with easier accessibility and relatively relaxed administrative procedures, and hence are more acceptable to the people.

CONTINUITY OF CARE

For achieving proper management of psychiatrically ill patients an important principle which has to be followed is the continuity of care to provide early treatment within the shortest possible time, to prevent deterioration, and to help in a quick return to normal active life. It is commonly known that defects in the psychiatric system may lead to psychosocial complications and to chronicity, and that a series of organized efforts are needed to maintain psychiatric care during the various stages of mental illness. It has been reported that since the recent advent of the potent psychotropic drugs and the adoption of the open-door policy greater numbers of patients are being discharged from the mental hospitals than hitherto. Nevertheless, it has also been observed that in places where there are no provisions for continuation of psychiatric care the number of readmissions has increased equally.

The most common factors causing disruption in the continuation of psychiatric treatment seem to be:

(a) lack of psychiatric facilities, especially extra-hospital services;

This is rather obvious in many of the developing countries, where an isolated psychiatric hospital may be the only existing psychiatric institution in the country, and the patient has to cover a long distance to pursue his treatment. Added to the physical distance, there may also be the difficulties of communication, poverty, and lack of familiarity with the modern medical system. In such circumstances one has to be imaginative and utilize whatever help is available in the community. In this regard traditional healers, for example, have been utilized in remote and rural communities for the early referral of patients, and for support in encouraging the patients to continue the prescribed course of treatment, and to report for follow-up.

(b) failure of communication between the mental health workers or with other health workers.

The team approach in psychiatric care is now universally accepted, but to ensure its effectiveness communications between its members should be facilitated and maintained.

Lines of communication between the staff of psychiatric institutions, other health services, the family doctor, the social agencies and so forth must also be well developed, to foster all possible continuity of care and make full use of available resources.

RANGE OF FACILITIES

General

It is commonly known that at the different stages of illness psychiatric care should vary to meet the patient's needs. Together with the development of community psychiatry the need was felt for the establishment of a range of facilities, for improving the accessibility of services, increasing the utilization of public resources, and augmenting the psychiatric programme for the control, treatment and rehabilitation of mental illness.

It is important that the whole range of services be viewed as complementary to each other, and that due emphasis be placed on the social as well as on the medical aspects of treatment. Where this important principle has not been observed, it has been found that the psychiatric services suffered badly from disjointedness and lack of coordination. Indeed, the range of facilities must be well integrated to enforce joint efforts and ensure the effective use of available material and manpower.
On the whole this recent trend in psychiatric care has broadened the base of action, and provided new opportunities for alternative deliveries and diversification of mental health services, and over the last decade psychiatric care has witnessed significant changes in this direction.

To meet the patients' needs the range of facilities which has been currently developed include a variety of services, e.g.,

- emergency services;
- outpatient services;
- partial hospitalization in the form of day or night hospitals;
- inpatient services, in mental or general hospitals;
- rehabilitation services, training centres, educational programmes, industrial therapy;
- domiciliary services;
- after-care services such as hostels;
- village system.

Type of psychiatric facility

In general the type of facilities to be developed in any particular country depends on the local conditions and on the determinants of psychiatric care, which are notably the manpower resources and the money allocated for such services. With few exceptions, psychiatric care in developing countries has been mostly confined to mental hospitals, with relatively fewer outpatient services.

The number of psychiatric beds per 1000 population varies tremendously from one country to another. In the Eastern Mediterranean Region it ranges from 0.01 in Pakistan to 1.3 in Cyprus, while in the European Region (WHO, Regional Office for Europe, 1971) it varies from 0.2 in Turkey to 5.9 in Ireland. While it has been found that quite a number of countries, even those with low ratios, have reached the target (set by the WHO Expert Committee on Mental Health, 1953) of a minimum of one bed per 10 000 population for the care of the mentally sick who are a danger to themselves or others, deficiencies are generally obvious in the psychiatric resources, in the organizational structure and in the development of efficient sociotherapeutic techniques and good models of care.

Through the administration of early treatment, intensive care, family support, and social manipulation, it has been found possible to keep quite a number of mentally ill patients in the community. However, there are overriding factors which may necessitate inpatient treatment, such as:

(a) severe psychotic reaction and personality disorganization;
(b) violent behaviour which may constitute a danger to the patient or to society;
(c) suicidal tendency;
(d) absence of a responsible family of a deteriorated patient;
(e) serious medical complications which warrant hospitalization.

In spite of all recent developments, the care of chronic patients in all countries, developed or developing, still constitutes a major problem which has to be faced (British Medical Journal, 1971). It calls for intensive efforts, especially in the field of prevention and rehabilitation programmes. The need for further research is obvious and schizophrenic disorders, which form approximately 60% of the chronic hospital population in many countries, merit special consideration.
Serious efforts have been made in several developing countries to forge a more advanced psychiatric care programme out of the old hospital-based services and to establish a network of facilities. For such countries and for those starting afresh, an integrated community mental health service with outpatient facilities, emergency beds and inpatient services in general hospitals could form a good initial basis for developing a psychiatric care programme. Such a service, apart from providing diagnostic and therapeutic care at outpatient and inpatient levels, should aim at:

(a) domiciliary care;
(b) supervision of care given in other institutions;
(c) collaboration with general health workers;
(d) provision of psychiatric consultation for social agencies and community services (e.g., school services, industrial and labour organizations, special institutions for the delinquents, the handicapped, etc.);
(e) public education;
(f) collection of information;
(g) training.

Differential treatment for certain groups of patients such as the mentally deficient, the mentally ill offenders, and drug-dependent persons seems to be generally needed.

In 1961 the WHO Expert Committee on Mental Health gave examples of the type of mental health units which would provide services for a catchment area of 150,000 inhabitants, and recommended that the staffing in the first place should be 1-3 psychiatrists, 3-9 trained nurses, and secretarial assistance. In the United Kingdom the Tripartite Committee (1972) proposed that the multidisciplinary mental health team for every 62,500 of the population should be composed of 2 consultant psychiatrists, and 2 junior psychiatrists, with supporting staff. Such staff/population ratios appear rather high in the light of the serious shortage of qualified psychiatric workers in developing countries, but they should not be discouraging. There is certainly a great challenge here which has lead to a lot of innovative work, and there are several examples of efficient deployment of a limited number of mental health workers, and of community involvement.

Need for a central administrative machinery

Only a very brief reference will be made here to emphasize the importance of an underlying general principle for the proper management of such a range of psychiatric facilities. As has already been stated in the foregoing sections, mental health work involves rather complex and varied activities which call for a central administrative machinery. This seems to be lacking in many of the national mental health programmes, and this deficiency has to be remedied.

Countries differ in their background of health services, in their needs and demands for psychiatric care, and in the administrative relationships in the health field. In general more than one ministry is involved in mental health work. Commonly these are the ministries of health, local government, social affairs, education and justice. In the United Kingdom, on the other hand, it is interesting to take note of the recent development in the unification of the mental health service (Tripartite Committee, 1972), and the establishment of psychiatric departments in the district general hospitals.

The main function of a central administrative organization will be collection of information, planning, coordination, follow-up, evaluation, setting up of standards, training, research, formulation of administrative and legal regulations, etc.
COMMUNITY, CULTURE, AND PSYCHIATRIC CARE

In principle, three important issues should be considered with regard to psychiatric care and the community:

(a) that community attitudes, which are often neglected, should be studied and relevant information for programme development and decision-making should be made available;

(b) that a healthy community attitude towards the psychiatric care programme should be sought and fostered;

(c) that the community should be influenced to play an active role in mental health work.

It must be realized that stigma of mental illness and the prejudice against psychiatric institutions are still commonly seen. In brief, bias against institutions could be attributed to three major factors: the organization, the personalities, and the culture.

There is no doubt that in the past custodial psychiatric institutions with isolation from urban life and insulation from the community have perpetuated the sense of alienation and the rejection of psychiatric care. It is only recently, after the adoption of an open-door policy, the development of therapeutic community expansion in outpatient clinics, day care, domiciliary services, etc., that the community has become closely associated with psychiatric care and the public attitude has changed favourably towards it. To bring about a desirable change is not easy and can indeed be painstaking and tedious. In one country, for example, it took two years to convince the director of a general teaching hospital to accept the idea of establishing an inpatient psychiatric unit, and even later, when the building construction was completed, there was strong pressure to transfer the project to another isolated area. This example and several others demonstrate clearly the strong resistance to change by certain personalities; nevertheless, once the inpatient unit was established in that particular hospital it proved to be instrumental in bringing about significant changes in community as well as professional attitudes towards psychiatric care.

It has also been observed that medical students trained in old and dilapidated hospitals and exposed to the experience of seeing only chronic and deteriorated patients showed a strong feeling against psychiatry. Not surprisingly the impression they got was a sense of hopelessness concerning mental illness and a disinclination to consider specializing in psychiatry in their future professional careers. Obviously the development of psychiatric institutions to acceptable standards will go a long way to change such attitudes.

Community attitude and behaviour towards mental illness are enmeshed in the cultural heritage, and great efforts are needed to change centuries-old beliefs and wrong concepts. It is only through continuous health education to the public, and the demonstration of the efficacy of modern treatment, that harmful concepts such as demoniacal possession will be shaken out of community thinking.

Community involvement for the promotion of mental health care could be enhanced through joint cooperation with voluntary organizations and social institutions and by the effective use of mass media. The support of community leaders such as ministers, top-level administrators, religious leaders, trade unionists, journalists, teachers, etc., together with that of associations of patients' families, and of social agencies, is most important for the identification of the community with the psychiatric care programme, and for its active participation. Various techniques could be developed in this connexion (WHO Expert Committee on Mental Health, 1959) within the context of available means, and with due awareness of the local conditions and the potentialities of the culture.

CONCLUSIONS

(1) The setting-up of realistic objectives, and the formulation of a national policy with clearly delineated principles are considered of central importance for the proper development of psychiatric care.
(2) It is essential that the steps to be taken in programme development should be well defined, that attention be drawn to the possibility of obstacles being met, and that timely preparations be made to overcome them.

(3) Reliable information on psychiatric problems, the state of the services, and the current needs should be made available to monitor the progress of work and help in future programme development.

(4) Psychiatric care should be based on an accepted philosophy. Because of the complexity of mental illness and the mounting needs, the search for new models and more effective techniques has to continue. There should be a change of emphasis from hospital-based care to community-oriented services and to the endeavour to achieve population coverage.

(5) The need for integrating psychiatric care with public health work and social services has been underlined, and the major requirements to implement such a policy have been considered.

(6) The continuity of psychiatric care to provide early treatment, follow-up, and sustained support until a successful return to normal life takes place is regarded as a fundamental principle. Lack of extra-hospital facilities and failure of interprofessional communication are considered the two most common factors which lead to discontinuity of mental health care.

(7) The establishment of a range of facilities to cater for the needs of patients at the different stages of illness constitute a basic principle in psychiatric care programmes. The network of facilities should be flexible and the services should be harmoniously designed with the available resources, and well fitted with the local conditions.

(8) Intensified efforts are still needed for the development of more effective preventive models, for the care of chronic patients and of special groups, e.g., the mentally deficient, the mentally ill offenders and drug-dependent persons.

(9) A central organizational set-up for efficient administration and development of an all-round psychiatric care programme is always needed.

(10) Training of personnel must be given top priority in the psychiatric care programmes, and a lot of innovative work is needed for local training in developing countries.

(11) Educational programmes and public orientation in mental health work are essential components of psychiatric care; and the study of the cultural background is generally important for fostering favourable community attitudes and enlisting public support.
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