

East vs West: Psychiatry in the Himalayas

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Introduction

“We have become not a melting pot but a beautiful mosaic. Different people, different beliefs, different yearnings, different hopes, different dreams.”

- Jimmy Carter (1)

Globalisation has transformed the modern world, creating a melting pot of cultures and beliefs. We have picked up food and clothing, beliefs and values from multiple cultures. From a healthcare perspective this sociological change has an impact on the care we offer to our patients; treatment that is offered to a young boy from Devon may not be culturally appropriate to the 30-year old recently married South Indian woman who has just moved to the UK. The way people view themselves and their bodies will influence how they view disease, illness and the healthcare profession. Nowhere is this statement more relevant than in mental health care.

This essay covers my medical elective in a Psychiatry Ward located in the Himalayan Mountains of North India over a six-week period. The essay looks at the dichotomy between Western and Eastern culture and Global Mental Health as a whole, illustrated through fictional case presentations based on patients I spoke to.

East vs West

The East-West dichotomy is a philosophical concept of ancient origin which claims that the two cultural hemispheres, East and West, developed diametrically opposed, [...] the East is more inductive while the West is more deductive. Together they form an equilibrium. (2)

The dichotomy between East and West has been with us since Ancient Greece, emphasising cultural differences rather than the geographical boundaries. Despite centuries of wars and political upheavals this division continues to be present in our minds, painted as the industrialised West and spiritual East (2). Through this division we have tried to dissect these different worlds in the same way that Cartesian dualism tried to separate the mind from the body.

There is no doubt that there are very clear differences between the United Kingdom (UK) and India. Yet it should be noted that any statements I make will be a generalization for it is impossible to describe a population of 1.252 billion people (3) within a paragraph.

The main difference to note is the collectivist vs individualist cultures. India may be described as a collectivist country, placing emphasis upon the needs of the group and the family rather than the individual. The UK, on the other hand, may be described as an individualist country, with emphasis placed upon the desires and goals of the individual (4).

These ways of thinking, while broad terms in themselves, have a significant impact upon the health care of their respective countries. Those from individualist countries are more likely to

view the physical health of their bodies as a personal responsibility while those from collectivist countries see disease as an obstacle that will prevent them from carrying out their obligations to society. Thus a healthy body - and indeed a healthy mind - can be viewed either as a vehicle for oneself to fulfill one's life goals or as a resource to facilitate social order (3).

A Typical Day

A typical day in the Psychiatry Ward in Himachal Pradesh in India runs in a similar fashion to the UK. It begins with a ward round at 9:30am where the team of doctors review every patient on the ward, followed by a small break and then the afternoon is spent speaking to families, initiating treatment and clerking new patients. The Ward consists of thirty beds, the majority of which were occupied during the six-week period I was there, but it was rarely full. There was also an outpatient department which ran from 9am-5pm. The ward is run by a group of dedicated mental health nurses, junior doctors and two consultant psychiatrists.

I typically organized my day by following the ward round – an experience in itself given its quick pace, the vast number of doctors and nurses involved in the round (10-15) and the overemphasis on medication resulting in an under-emphasis of everything else including the patient's mental state and distress. After the ward round I would speak to patients and their families using a structured approach via a full psychiatric history and mental state examination to form my own differential diagnoses. Alongside this clinical structure I also enquired into the patient's beliefs about their illness and their perception of the care they received. I would also spend my days talking to both nurses and doctors, discussing patients

but also the structure of the system in which they worked in, their thoughts on mental health and on their role as healthcare professionals.

This led to not only an unforgettable experience but an abundance of qualitative data, which combined with my own research, I was able to divide into a number of themes that stood out to me the most. These are covered in this essay under two broad headings:

- Community Psychiatric Care
- Human Rights: Physical Restraint in Psychiatric Practice

My aim is not to recite what I observed but to integrate my experience with current research in the areas of global mental health and medical anthropology, looking at the similarities and differences between the two countries and what we can learn from each other.

Community Psychiatric Care

“Mental health services have gone through a radical transformation over the past 30 years - perhaps more so than any other part of the health system.”

- The King’s Fund (5)

There has been great emphasis on the community mental health services in the UK, with the closure of hospitals a frontpage topic of the newspapers. Roles such as Occupational Therapists (OT), Community Psychiatric Nurses (CPN) and Social Workers have become well-worn cogs of the mental health system in the UK.

Being familiar with such forms of care, my time in India was a stark contrast. During my six weeks in India I was informed that they had no OT or Social Worker and was met with incredulity at the idea of a CPN. Instead, these roles of community care - involving activities such as encouraging medication compliance and supportive care - were taken over by the family member. The family is a vital resource in the management of mental health problems in India, particularly given the fact that the deficit of Psychiatrists reaches 90% in most parts of the country (6).

In India there is still a strong emphasis on family, especially in the rural areas where I was working. The self is defined in relation to others in terms of belonging and reciprocity; a sharp contrast to the overvalued ideas of personal goals and achievements that we hold in the UK. Personal autonomy, one of the foundations of medical ethics, comes secondary to the relationships one has with others. Research has shown that terms such as confidentiality do not seem to exist in the socio-cultural setting in India as such privacy can instead be perceived isolation of the individual. Treatment is therefore not only aimed at the patient but at the family as a whole and these have been found to lead to more lasting outcomes (7).

Many of the patients I spoke to lived in houses with at least eight or nine other people, consisting of in-laws, cousins, children and grandchildren. This family dynamic was important in both the identification and management of mental health problems. Family education was identified as a vital part of the recovery of patients by many of the doctors I spoke to. Yet families were also responsible for identifying when their loved one became unwell and it was clear from first presentations of psychiatric illnesses, particularly of psychosis, that there was little awareness that such behavioural symptoms could be

considered a medical disorder. Instead, families would first try to view such behaviour through the framework of Religion and Spirituality in an attempt to explain the erratic behaviour of their loved ones. The majority of the patients I spoke to with first-episode psychosis had first gone to the local temple to pray for forgiveness, believing there to be a curse upon the family. The role of the family in the management of patients with serious mental illness can therefore have both positive and negative consequences depending on local awareness and understanding.

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Abhishek (Abhi) was only nineteen when he was first admitted to the psychiatric ward after almost two years of gradually worsening behaviour that neither his family or friends could understand. It eventually culminated in the police being called to the house after Abhishek became physically aggressive towards his mother and younger sister. After spending two weeks in hospital he was diagnosed with schizophrenia and the nature of his illness was explained to his parents.

Thus, Abhishek's father became his main carer. He made sure his son went to his job every day, that he took his daily medications at the correct time and that any little signs of illness were followed up. He also made sure his son ate all his meals and took him on walks around the beautiful mountainside, encouraging his son to get out of the house as much as possible.

It was therefore thanks to the father's diligence that the slight signs of worsening illness - isolation, absence at work, lack of appetite - were picked up quickly and Abhi was brought back into hospital before things became worse. It was at this time that I met both Abhi and

his father and discussed the nature of his illness. His father admitted that he had had little knowledge of mental health problems in the past and it had been a steep learning curve.

I discussed the role of carer that Abhi's father played. It was clear from the start that without such a caring family Abhi would have succumbed to his illness long ago, regardless of the medications he had received. Without the family there would have been no support available - social services simply didn't exist. 'I have a duty to my son,' Abhi's father once told me and I felt this illustrated the family dynamic that I had seen amongst many of the patients on the ward.

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Human Rights: Physical Restraint in Psychiatric Practice

'All doctors must be held to the same ethical standards no matter where they practice.' (7)

Psychiatry deals with some of the most vulnerable people in society and holds significant power in its hands. There is a strong link between Psychiatry and the Law to ensure that the rights of the patient are upheld. This is what I found the most different and indeed the most difficult to adjust to during my time in an Indian psychiatric ward.

The Mental Health Act 2007 in the UK is an Act of Parliament that allows mental health professionals to detain patients who are displaying signs of mental illness and are at significant risk of harm either towards themselves or others. Despite its controversies it is there to uphold the rights of the patient, allowing patients to appeal their detainment and

offering clear rules on what health care professionals can and cannot do. It is a vital tool for any British psychiatrist.

Contrast this to the Indian mental health care system. India recently introduced the Mental Health Care Act 2017 which was hailed as ‘progressive and rights based’ (8). Yet the legislation makes no comment on the care that is provided in the community - a significant portion of mental health care - and has been noted to be ‘Westernised’ (8) in its values, focusing on the autonomy of the individual with few comments on the importance of family support. This is just one example of how culture-laden and value-specific mental health care and legislation can be across the world; even psychiatrists in India have noted the importance of family members in caring for the psychiatrically unwell given the significant lack of Psychiatrists in the country (8).

But the Act has brought about some significant changes. In India, attempting suicide is still a crime under Section 309 of the Indian Penal Code (9). The Mental Health Care Act 2017 goes against this by stating that an individual who attempts suicide shall be presumed to be under stress and should not be tried under this code unless proven otherwise (8). It further places a duty of care on the government to provide treatment for such an individual to reduce this stress. Thus, there is hope for change.

Yet from my observations during my six-week period I saw little evidence of any upcoming change. Indeed, my experience left me querying whether such an upheaval across such a vast population was even possible. For such a change requires not only an amendment of the law, but a change in the education of healthcare professionals and the provision of social care out in the community. This not only involves a tremendous amount of resources, it also requires a

shift in belief, making it acceptable for family members to be cared for by clinicians in their own homes; a role that has been embedded within the family structure for generations. I am not sure how this change will come about and my experience of the use and abuse of human rights in Indian Psychiatry left me shaken.

Almost everyday I witnessed patients being physically restrained, either by healthcare staff as inpatients or by family members when admitted onto the ward. Everyday I witnessed the free use of physical restraint with little thought or reflection; the recent guidance introduced by the new Mental Health Care Act 2017 on physical restraint to be used only as a form of ‘emergency intervention’ (10) was nowhere to be seen. Doctors did not have to explain their use of physical restraint to the patient or their families. They were given free reign of their rank and power as part of a rigid hierarchy, with families unable to raise concerns because of the god-like status given to the clinician and the patient having no knowledge of their rights or an advocate they could turn to for help.

There did not seem to be any boundaries as to what a doctor could and could not do. I regularly saw the use of physical restraint as a means of behaviour control, used on patients who were being ‘annoying’ to staff yet did not show any signs of physical or verbal aggression.

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Priya had been admitted to the ward after being found strolling the streets at 2am, waving her hands in the air and screaming at occasional passersby. The police had brought her straight to the ward where she was admitted and observed over a number of days, until it was agreed

that she was displaying signs of psychosis. Despite her bizarre behaviour, she was an endearing young lady. She made friends with the other young women on the ward and always greeted us by name as we walked through in our large teams exuding importance. It was clear that when her illness took over, she was in great pain. Her brief period on the ward was by no means short of tears, but it was also filled with a young lady who was kind and generous.

Priya was also anxious to go home. We knew little about her family, but it was clear that she missed them. She would often be seen standing outside the doctors' office, trying to catch the eye of the occasional white coat that brushed her side to ask about her leave. The doctors would give an answer every now and then, often trying to step aside the question through comments such as 'we'll discuss it later.'

It was one of these fine mornings on the ward when Priya was back in her usual position outside the doctors' office. The ward round had been intense that day, with the consultant barking out orders left, right and centre. The juniors were stressed and Priya was not helping matters. Her incessant pleas to leave the ward for an hour could be heard over the quiet discussion the rest of the junior doctors were having about another patient.

'Nurse, tie her up,' barked one of the doctors, his eyes never lifting from the page on which he was writing copiously.

Fifteen minutes later and four nurses had dragged Priya to her bed and tied her hands and feet with ropes, with Priya screaming furtively that she had done nothing wrong.

Slightly put out, I asked the doctor during one of the quieter moments of the day why he had

physically restrained her.

‘She wouldn’t shut up and she needs to be taught a lesson.’

Such was the power of the doctor. And such was the power of the patient. There was no law in between.

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Conclusion

It is important to note that this essay revolves around my experiences in one small hospital over a short period of time, in a country that is vast in both geography and culture. My perceptions on the care and treatment that patients received were no doubt clouded by my own beliefs and prejudices, coloured through a Western lens.

This essay does not aim to paint a ‘true’ picture of Indian Psychiatry. Instead, it offers just one perspective and urges the reader to reflect upon their own practices in their respective country. Mental Health Care is reflective of the society it treats. It can be argued that there is no one way to offer mental health care, for it is a topic that covers areas of individual beliefs and values as well as societal norms and practices.

Yet surely there are some aspects of healthcare which are universal regardless of location or culture: human rights, the right to treatment, the right to be treated with dignity. Where do we

draw the line and deem some practices as quirks of human diversity, and others a violation of humanity?

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