Brit. J. Psychiat. (1973), **123**, 257–69

Psychiatry in South-East Asia

By J. S. NEKI

The Region

For the purposes of this paper the South-East Asia region has been taken to include India, Ceylon, Burma, Thailand, Indonesia and the Philippines.* The region thus demarcated is not merely an area of geographic contiguity but also comprised almost entirely of developing countries involved in a process of social change as a result, principally, of exposure to the West. The traditional economy of agricultural self-sufficiency in all these countries is coming to be replaced increasingly by an industrial economy which is essentially tied up with world trade. Most of the countries in the region have emerged from a colonial status into independent states with a renascent and sensitized nationalism. There is in these countries abundant enthusiasm for new goals set up after achieving independence; but this is dampened with a sense of self-doubt that prevails as much amidst the leaders as amidst the led. Thus in this region a generation of people appears to be trying to outlive its history and live on hopes for a new future.

From the beginning of recorded history, the area has received wave after wave of migration bringing in new religions. In fact, emigrations from India to the rest of the region began the first process of acculturation or sanskritization of this region into what has been called 'Farther India' whose apparent uniqueness carries 'the imprint of Indian genius which gives the countries . . . a family likeness' (Coedes, 1968). The Portuguese and the Spanish, the British and the Dutch, the French and the Americans have been only the latest to leave their stamp on different parts of the region, which has thus been a melting pot of diverse cultures. 'There is probably no other area of the world so richly endowed with cultural strains' (Du Bois, 1949). The appearance of a new culture, however, has always helped the immediately preceding one to become more deeply ingrained and thus appear to be a part of the 'traditional culture'. The Indonesian national slogan *Bhinneka Turrggal Ika* (unity in diversity) aptly applies to the whole region.

The patterns of Western impact in the region have been more or less uniform. Under this impact new roles have emerged in the political, social and economic spheres which have eroded the traditional system of roles without displacing them; they continue to be especially operative in the villages. The West gave this region bureaucratization and industrialization, and so increasing urbanization. There has been a restratification of the communities into a small westernized elite and the traditional peasant population, cutting across traditional stratifications such as caste.

The region has seen an enormous population growth. While a century and a half ago it could not have had more than 20 million people, today the population stands well over 750 million. Since World War I alone, the population must have risen by over 300 million. The density of population varies from about 40/sq. mile in Burma to 1,600 per square mile in Thailand. High density in most parts of the region stands in vivid contrast to other developing areas of the world such as the Latin America and Africa; in Africa 25 per cent of the world's habitable land surface houses only 14 per cent of the world's population. Urban population density is highest in Calcutta—80,000 per square mile—which is over three times that of New York (Almond and Coleman, 1960). In the whole region, 70 to 80 per cent of the population lives in the rural areas (by contrast, in the U.K. only 5 per cent and in the U.S. 10 per cent of the population is classified as rural). Nearly a third

* On account of the tragic events of 1971, it was not possible to circulate the questionnaire referred to later in this paper to colleagues in Pakistan and Bangla Desh.

https://doi.org/10.1192/bjp.123.3.257 Published online by Cambridge University Press

of the population in the region is under ten years of age, which is 2 to 3 times the proportion to be found in most industrialized countries.

These countries thus share several socio-cultural and demographic conditions in common and so can be profitably considered together for an appraisal of psychiatry in this region.

Asian psychiatry has only come into focus rather recently. This first began with the International Conference on Mental Health held in Sydney, Australia, in 1953, which centred on the theme 'Child Development in Asia'. A series of international meetings on Asian psychiatry have followed since. Lin (1969b) lists the whole series up to 1968.

The Enquiry

The present enquiry began when I became associated with the organization of the W.H.O. South-East Asia Regional Seminar on Psychiatric Education held in New Delhi in 1970, where I was forcibly reminded of the communality of problems in the various constituents of the region. Discussions with the delegates both inside and outside the Seminar provided me with a framework of data about the state of psychiatry in the various countries. Subsequently, I circulated a questionnaire among 45 prominent psychiatrists of the region to supplement and cross-check information already gathered. In the following year, I had the opportunity of participating in two more regional meetings: the WFMH Workshop on 'Priorities in Mental Health Care in Developing Countries' (1971) held in Madurai, India, and the Panel Discussion on 'Past, Present and Future of Psychiatry in Asia and the Pacific' (1971) held in Tokyo, Japan. These meetings gave me the opportunity to further validate and elaborate the information previously gathered.

Magnitude of the Mental Health Problem in the Region

Well-conducted representative surveys of mental morbidity in most countries of the region are scarce.

However, a one-day survey conducted in Ceylon in 1961 put the prevalence rate of crude mental illness at 10 per thousand (quoted by Sen-Gupta and Chawla, 1970).

In India, a number of surveys, large and small, have been conducted. Surya (1962–63) from Pondicherry (South India) reported a mental morbidity prevalence rate of 9·3 per thousand. Dube (1970) from Agra (North India) found a 1½ year period prevalence figure of 17·99 per thousand from a mixed urban and rural population. Prevalence rates by diagnosis as found by this author are reproduced in Table I.

Table I

Prevalence rates by diagnosis in Dube's survey

Category of mental disorder	Active cases		Total cases	
	No. of cases	Rate per 1,000	No. of cases	Rate per 1,000
Schizophrenia ..	44	1·49	64	2·17
Manic-depressive psychosis	15	0·51	37	1·26
Organic psychosis (excl. epilepsy) ..	19	0·64	25	0·85
Epilepsy	66	2·24	94	3·19
Mental deficiency ..	109	3·70	109	3·70
Hysteria	179	6·07	201	8·86
Other psychoneuroses plus other disorders..	98	3·33	111	3·77
Total	530	17·99	701	23·79

Elnager *et al.* (1971) from a rural Bengali (East India) population reported a prevalence rate of 27 per thousand. Sethi and Prasad (1971) from Lucknow (North India) urban population, and Verghese *et al.* (1971) from Vellore (South India) mixed urban and rural populations report much higher prevalence rates of 65 and 58·5 per thousand respectively.* This disparity of rates has resulted not only from dissimilar case-defining and case-finding criteria but also from real differences in the characteristics of the populations surveyed; for example, unlike those of others, nearly one half of Elnager's figures represented alcoholics and drug addicts.

In Singapore, the estimated prevalence of insanity in the community in 1900 was reported to be 3·01 per 10,000 as compared to 31·38 per 10,000 in England, but by 1954, 50 per cent of

* Prevalence rates in all these studies include cases of mental deficiency.

https://doi.org/10.1192/bjp.123.3.257 Published online by Cambridge University Press

all hospital beds were occupied by psychiatric patients (Jin, 1971). That indicates that recognition of mental disorders as well as demand for psychiatric treatment facilities depends upon social perception of the disorders and the availability of the facilities.

Choosing to err on the lower side, if one accepted a mental morbidity rate of 10 per thousand, the region would have over 8 million psychiatric patients requiring active treatment, the country-wise breakdown being: Burma, 0·3 m.; Ceylon, 0·15 m.; India, 5·4 m.; Indonesia, 1·2 m.; Malaysia, 0·1 m.; Philippines, 0·4 m.; Thailand, 0·4 m.; and smaller countries like Nepal, Sikkim, Singapore, etc. together, 0·1 m.

Psychiatric and Mental Health Services

In all the countries of the region, public health seems to occupy a low priority in terms of allocation of public exchequer moneys, which ranges from 0·6 per cent (Indonesia) to 8·0 per cent (Ceylon), with India (7·0 per cent) and Burma (6·0 per cent) nearer the higher figure and Thailand (2·7 per cent) nearer to the lower.

Mental health is, further, a poor priority in public health, because, understandably, infections and malnutrition receive the foremost priority in these countries.

Mental hospitals

Psychiatric services until quite recently were centred entirely in the mental hospitals—previously called asylums.

In India 'lunatic asylums' were established almost a whole century earlier than anywhere else in the region—Waltair in 1767, Calcutta in 1787 and Bangalore in 1788 (Verma, 1953). In most other countries of the region the first asylums came to be established late in the nineteenth century. In Malaysia as well as in Singapore, the first asylum came up in 1862 (Tan and Wagner, 1971), and in Ceylon in 1870 (Wijesinghe, 1971). In Thailand as well as the Philippines, however, the first mental hospital was not established up until early in the twentieth century (Lapuz, 1971).

While most of these hospitals have now become reasonably active therapeutic centres, very many of them still continue to carry a large backlog of chronic and incurable patients (see Table II).

Turnover rates for mental hospitals in India have been reported as 1·96 admissions and 1·72 discharges per bed. In fact, the discharge rate (including deaths), has always lagged behind the admission rate (see Fig. 1); hence the population in these hospitals has always continued to be on the increase. This increase in population has never found a matching increase in bed-strength; the result has been tremendous overcrowding in these hospitals (see Table II).

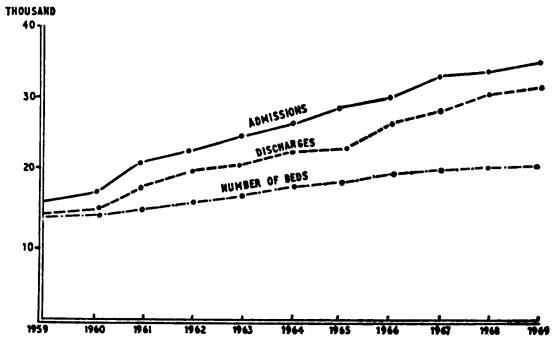


FIG. 1.—Mental hospital admissions, discharges and number of beds in India, 1959–1969.

Average fatality rate in the Indian mental hospitals has steadily decreased from 6·06 in 1960 to 3·90 in 1969 (Sen-Gupta and Chawla, 1970). This seems, perhaps, to be due more to a reduction of the length of stay of patients in the hospitals owing to the use of the newer drugs, rather than to improved physical conditions or medical care (which have been minimal) in these institutions. The fatality ratio differs widely from State to State—from 0·29 in Rajasthan to 9·98 in Assam, showing how widely conditions in mental hospitals vary from State to State.

General hospitals

Lately, psychiatry has found an increasing place in general hospitals. In India, the first general hospital to start a psychiatric unit was the J. J. Hospital, Bombay, which did so over a quarter of a century ago. In Thailand, the first general hospital psychiatric clinic was

https://doi.org/10.1192/bjp.123.3.257 Published online by Cambridge University Press

TABLE II

Mental hospitals in the S-E Asia region

	No. of mental hospitals	Mental hospital beds Total and per million population	Proportion of 'Incurable' patients	Long-stay patients	Short-stay patients	Children	Over crowding
Burma ..	1	1,200 0·43	13	40	45	2	
Ceylon ..	3	3,587 2·7	30		70	0	
India ..	33	20,000 0·36	10	50	40	0·2	200%
Indonesia	26	8,500 0·74	15	70	10	5	
Malaysia	2	6,500 0·65	50		50	—	30% (1962)
Philippines	1	4,000 1·03	30	60	5	3·5	250%
Thailand	10	6,320 1·71	20	48	30	2	150%

opened in the mid-thirties (Sitasuwan, 1969), in Malaysia one was opened in the General Hospital, Penang, in 1959 (Tan and Wagner, 1971); in Philippines it is only during the last decade that such units have been opened (Lapuz, 1971). In India, so far, of the 101 teaching hospitals 58 have established psychiatric units. In non-teaching general hospitals, however, such units are scarce—having been established in only about 25 of the 380 district hospitals (Chakraborty, 1970).

Other services

Other psychiatric services are even more scarce—there are very few day or night hospitals or half-way houses. Child psychiatric services are rudimentary: in India, there are about 40 child guidance or child psychiatric clinics; in Indonesia 5, in Thailand 4, in Malaysia and Ceylon one each, while in the Philippines they are reported to have been established 'in most schools'.

Special schools for the mentally retarded and the handicapped are coming up. In India, there are about 35 such schools (Chakraborty, 1970); in Burma 8, in Ceylon 6, in Indonesia 10, in Malaysia 5, in the Philippines 4, and in Thailand 6. The average annual turnover from these services is presented in Table III.

There are hardly any geriatric psychiatry services. Even in mental hospitals the proportion of patients over the age of 60 is extremely small. This stands in vivid contrast to the situation obtaining in the West, where anything between 40 and 50 per cent of psychiatric beds are occupied by geriatric patients. This cannot be entirely explained by the higher life-expectancy in the West; the family structure and status of elders in a family seem to be the most predominant factors underlying this difference.

Reaching the rural communities

Almost all the above-mentioned services are located in urban areas, while it is only a small fraction of the total population that lives in cities. Vast tracts of population thus remain unserved. In India, many rural areas are hundreds of miles away from any established psychiatric centre. Rural areas have thus continued to depend on whatever folk medicine or traditional indigenous systems of medicine have to offer them (vide section below).

It is only lately that thought has been given to the needs of the rural communities, and some

https://doi.org/10.1192/bjp.123.3.257 Published online by Cambridge University Press

TABLE III

Turnover of psychiatric services

	Mental hospitals (in-patients)	General hospitals (in-patients)	Out-patients units M.H. & G.H.	Child guidance clinics	Mental retardation homes	Day/night hospitals	Mobile units	Total
Burma ..	2,000	600	2,800	—	—	—	—	5,400
Ceylon ..	7,000	1,000	12,500	250	550	—	—	21,300
India	39,000	12,000	100,000	8,000	3,000	1,000	500	163,500
Indonesia ..	9,000	2,000	30,000	?	700	1,000	—	42,700
Malaysia ..	3,000	3,000	6,000	100	700	500	—	13,300
Philippines ..	15,000	2,000	4,000	?	?	500	—	21,500
Thailand ..	10,000	2,000	8,000	2,000	500	1,000	70,000	93,500

experiments have been made to bring some kind of psychiatric service within their reach.

In Thailand, mobile psychiatric units have been established which serve rural areas. These units are reported to be serving a patient population three and a half times as great as that served by all other psychiatric services put together. In Indonesia, Kusumanto (1969) has proposed the setting up of 'rural clinics' which he holds could relieve overcrowding of mental hospitals, develop better public understanding of the basis of maladaptation, and foster understanding of supra-individual relations and cultural value orientations.

In India, at the All-India Institute of Mental Health, Bangalore, a pilot-study called 'The Mandya Project' has been conducted to evolve a pattern for comprehensive mental health care to cover at low cost both rural and urban areas by utilizing the existing resources (Sen-Gupta and Chawla, 1970).

Vidya Sagar, in Amritsar and Rohtak (India), has experimented with allowing relatives of patients to stay in a tented camp within the compound wall of his mental hospital. Patients coming to the hospital from rural areas are invariably accompanied by relatives who are unwilling to abandon the patient, yet generally have nowhere to stay. Permitting them to stay in the camp in the hospital grounds has proved conducive to improved care of the patient; it keeps the family integrated and obviates the anxiety of severance among the relatives and apprehension of being abandoned in the patient. It also provides opportunity for the family members of the patient to be educated in mental health and thus shed prejudices and superstitions (WFMH, 1971).

Rural clinics and mobile units on the one hand and camps in the hospital on the other are developments which symbolize two ways of bringing psychiatric services to the community —centrifugal and centripetal. Besides these, some other measures such as involving the village level health workers in mental health programmes, and creating a cadre of mental health ancillaries to work in rural areas are also being studied in some quarters (WHO SEARO, 1970).

INDIGENOUS AND FOLK PSYCHIATRY

It has already been observed that a vast majority of the population, especially in rural areas, make use of folk healers. Even before the advent of any formal system of medicine, people had developed concepts about mental illness and devised ways of coping with those who were afflicted with it. These included the use of charms, magic, and invocation of divine intervention. These methods, along with exorcism and anti-witchcraft measures, still continue to hold sway, and in rural areas people generally bring their sick relatives to indigenous healers first. Gwee (1969) observed that in Singapore 90 per cent of the Chinese patients coming to an acute general hospital had already been to traditional Chinese healers. Tan (1971) observed the same with regard to psychiatric patients in Malaysia. In Thailand, Aroon (1971) observed

https://doi.org/10.1192/bjp.123.3.257 Published online by Cambridge University Press

that 99 per cent of patients had gone to country healers.

In India and Ceylon, Ayurveda, the Indian system of the 'Science of Life'—a system of medicine dating back over 2,000 years—considered psychiatry as an integral part of medicine. Phenomenology of mental illness is described in the texts of Charaka and Vagbhatta, and an attempt is made at classifying them from an aetiological point of view. While certain mental disorders were considered to be 'disease processes' *sui generis*, others were considered to be due to the influence of supernatural agencies and unfavourable stellar positions. Hence demonological and astrological remedies are prescribed side by side with drugs. This system of medicine seems to have effected a compromise between the practice of medicine and the prevalent cultural beliefs; that is why the practice of an Ayurvedic specialist has had the reciprocal support of other community institutions like the priest and the soothsayer, the exorcist and the astrologer, all of whom have worked in unison (Wijesinghe, 1971). Some of the 'treatment' methods employed by the exorcists are merciless and a patient may well be beaten almost to the point of surgical shock.

In Malaysia, Gwee (1971) has reviewed the traditional Chinese methods of mental treatment which date back from 2000 B.C. Like Ayurveda, the Chinese medicine also classifies mental illness aetiologically; the classes include 'windmadness', 'ghost evil', 'possession by devil', 'anxiety due to animus', 'convulsive madness', 'puerperal insanity' and 'mental deficiency'. Treatment methods also resemble those of the Indian system.

The practice of indigenous specialists flourishes everywhere in the region even at this time. In India, the Ayurvedic system is even accorded official government recognition. It is estimated that 80 per cent of all patients in rural areas still visit the indigenous practitioners. The same applies to psychiatric patients. Even in the Philippines where the doctor-population ratio is the best amongst all the countries of the region, 'the indigenous healer is the primary provider of psychiatric therapy to the vast majority of Filipinos who are geographically or culturally remote from psychiatric treatment administered by physicians' (Shakman, 1969).

A cultural and social barrier thus continues to exist between the psychiatrist and the community, and modern psychiatry so far has made little dent on the cultural beliefs and attitudes of the community. Psychiatry remains an out-group so far as indigenous practice is concerned.

Manpower

One of the reasons why modern psychiatry has not been able to make an impact on the community in most areas of the region is because of the paucity of mental health manpower (Table IV) and 'it is men and not the walls that make a city'.

Lin (1969), commenting on the appalling shortage of psychiatrists in vast stretches of Asia and Africa, observed that 'vast numbers of people in these countries have no access to psychiatric treatment. The problem is such that it is impossible to think of any way to cope with it'. The Indian National Committee for the World Mental Health Year (1960) observed that 'even if almost all the Five Year Plan effort in the field of health were only geared to increasing the number of (psychiatric) hospital beds and to increasing the number of psychiatric doctors, it would be impossible to provide an adequate number of hospital beds and mental specialists in the country in the next 50–100 years'.

The situation is further complicated by the 'brain-drain' which afflicts some countries more than others. In India it assumes appalling dimensions. The country itself has only about 400 psychiatrists, while Indian psychiatrists working overseas (principally in the U.K. and U.S.A.) may well be several times this number.

The paucity of psychiatrists has led many a health administrator to advocate that it is the basic doctor (the G.P.) who should carry the main burden of mental health programmes (Anand, 1971), while the psychiatrist should provide leadership in the field of mental health. However, the number of basic doctors in some of the countries is also far from satisfactory (Table V). In fact, brain-drain afflicts the basic

https://doi.org/10.1192/bjp.123.3.257 Published online by Cambridge University Press

TABLE IV

Mental health manpower in S-E Asia

Country	No. per million population					
	Psychiatrists	Psychiatric nurses	Clinical psychologists	Psychiatric social workers	Others	Total
Burma	0·3	0·4	0·01	0·01	0·01	0·73
Ceylon	2·1	1·7	0·0	0·17	0·0	3·97
India	0·8	0·4	0·6	0·6	0·01	2·41
Indonesia	0·9	0·9	0·15	1·8	—	3·75
Malaysia	1·3	2·0	0·2	—	1·5	5·0
Philippines	5·0	2·0	1·2	2·0	1·0	11·2
Thailand	3·4	0·9	3·4	0·9	1·0	9·6

doctor as much as it does the psychiatrist. In Great Britain there are close on 10,000 doctors who were born in Asia and Africa—primarily in the Indian subcontinent; and in the United States there are 25,000 medical graduates from schools in developing countries (Gish, 1970, 1971).

TABLE V

No. of basic doctors in the S-E Asian countries

Country	Total no. of doctors (thousands)	No./ million population	Population/ doctor
Burma (1971) ..	35	130	7,700
Ceylon (1971) ..	40	330	3,000
India (1971) ..	100	190	6,500
Indonesia (1967)	40	40	27,500
Philippines (1971)	200	513	1,950
Thailand ..	54	160	6,400

Barring the Philippines, the doctor-population ratio in most of the other countries is so low that the basic doctor cannot afford to fully accept the time-consuming responsibility of mental health of his clients. Moreover, the training received by him is so unevenly weighted against mental health that he is poorly equipped and ill-motivated to accept the responsibility of looking after the mentally sick.

PSYCHIATRIC EDUCATION

Lin (1970a) has observed that 'psychiatry in the Universities of most developing countries is given the lowest priority; while it is in these countries in particular that the general practitioner has to shoulder much of the mental health "responsibility"—there being so few trained psychiatrists'.

Table VI sets forth the average quantum of teaching in psychiatry given in the medical schools in the various countries of the region.

Indonesia seems to be on the top, where mean teaching time excluding clinical clerkship devoted to psychiatry is 179 hours and where in many schools, out of the total 8,000 hours, 800 are devoted to neurology and psychiatry. Neurology and psychiatry, in Indonesia, are still under one roof. In that country it is considered extravagant from the point of view of public services to have two specialists, instead of one who can handle both neurological and psychiatric problems (WHO SEARO, 1970). The same spirit pervades undergraduate teaching. In the countries where British influence has reigned, namely, India, Burma, and Ceylon, psychiatry has the poorest status, though in Malaysia its status has been raised in recent years.

Kolb (1970) has said 'we think that a school putting in less than 10 per cent into the speciality (psychiatry) is perhaps defective in its teaching abilities'. Except Indonesia, or perhaps, Malaysia, none of the other countries in the region fulfils this criterion.

So far as postgraduate training in psychiatry is concerned, most countries in the region still continue to have most of their psychiatrists trained abroad. It has been observed that 'there

https://doi.org/10.1192/bjp.123.3.257 Published online by Cambridge University Press

TABLE VI

Undergraduate teaching in psychiatry

	Length of course (years)	Mean hours allotted to				Clinical clerkship	Optional courses
		Behavioural sciences		Psychiatry			
		Exclusive	Collaborative	Exclusive	Collaborative		
Burma	7	—	—	20	5	—	—
Ceylon	5	12	—	30	—	1 month part-time	
India*	5½	10	—	15	—	2 weeks part-time	—
Indonesia	4–5	40–60	0–20	60–100	—	6 4 weeks time	—
Malaysia	5	50	—	—	20	300 hours	Yes
Philippines	4	—	—	40	—	80 hours	To be available shortly
Thailand	4	54	—	68	72	1 month full-time 3 weeks part-time	Available in one university

* Vide curricular recommendations by Medical Council of India.

isn't an international psychiatry in the same sense in which there is international surgery'. Hence psychiatrists trained in an alien culture cannot be as effective as those trained within the native or an allied culture. Peter Baan has been quoted as having said, 'it is preferable for psychiatrists to get their specialist training in their own country' (Walton, 1969). However, in some countries of the region, such as Burma and Ceylon, post-graduate training facilities in psychiatry do not exist at all. In some others, such as the Philippines and Thailand, such facilities do exist but are not considered adequate —and 'most prospective psychiatrists go abroad' for training. India has developed its own post-graduate training centres in psychiatry, and the facilities available are expanding fast. Courses are given leading to two kinds of degrees: D.P.M. and M.D. In Indonesia, however, four kinds of postgraduate programmes are available: (i) a four-year programme for speciality in neurology and psychiatry, (ii) a three-year programme for speciality in psychiatry, (iii) assignment programme for doctors working in mental hospitals, and (iv) short term refresher courses in psychiatry. Even now, however, quite a number of doctors from India and Indonesia go abroad for psychiatric training. A psychiatric training programme should aim at developing not only the relevant clinical skills but also a meaningful communication with the community. Training in the setting of a foreign culture and through the medium of a foreign tongue jeopardizes both. The recent shift of emphasis from the purely clinical to the social role of a psychiatrist necessitates that our training programmes be rooted in the cultures for whom they are designed.

CLINICAL PATTERNS OF MENTAL MORBIDITY

It is often overlooked that 'a man is insane relative to a given culture' (Beguin, 1952). It is true that cultural relativism has its limitations. A few basic forms of mental illness such as idiocy, dementia, delirium, etc., are considered abnormal all over the world and are characteristically similar in phenomenology. However, outside the group of organic disorders such ubiquitous similarity of patterns is not always discernible. Even in the group of functional psychoses, the patterns of disease vary from culture to culture. There is a larger proportion of catatonics among the schizophrenics admitted to Indian mental hospitals than in most

https://doi.org/10.1192/bjp.123.3.257 Published online by Cambridge University Press

Western countries. On the contrary, the proportion of simple schizophrenics is comparatively much smaller in India (Dube, 1971).

As an explanation for a larger proportion of catatonic schizophrenics, it is surmised that delayed consultation is the chief reason. A majority of patients in India, as also in most other countries of the region, come to a psychiatrist a considerable time after the onset of their disorder, and this may be due to ignorance, superstition, prejudices against modern medicine in general or psychiatry in particular, non-availability of psychiatric services at close quarters, and/or reluctance of the family to suffer severance from the patient if he is admitted to hospital. Delayed consultation makes for the appearance of those symptoms which appear later during the natural history of disease. Catatonic features are believed to be rather late manifestations of schizophrenia and hence are seen more often among untreated schizophrenics of long standing.

The lower prevalence rate of simple schizophrenia is ascribed to high social tolerance among the community for this type of illness. The simple schizophrenic is easily sheltered by the joint families within a simple pastoral agricultural economy. In fact, he even gets positive community support if, motivated by his seclusion-seeking, he chooses to live the life of a religious mendicant. No wonder, then, that one discovers a good number of simple schizophrenics amidst the bands of Sadhus (Vahia, 1967).

Depressive illness, it has been reported, presents a more variegated picture from culture to culture. Agitation has been reported more commonly among the depressives from Java (Kraepelin, 1921), South India (Venkoba Rao, 1966) and North India (Teja *et al.*, 1971), which contrasts with a greater prevalence of retardation seen in the West. Feelings and delusions of guilt are again less common among Indian patients, while fugitive impulse is more common. The following Table (VII), from Neki (1972b), gives a comparative picture of depression across three cultures.

The clinical patterns of psychoneuroses vary far more from culture to culture than do the organic syndromes or functional psychoses. In general, the neuroses take a more somatized form. Conversion reactions are encountered very frequently. In one survey in India, 'hysteria' constituted 34 per cent of all psychiatric disorders (including mental defect) in the community (Dube, 1970). This is about four times the prevalence rate for schizophrenia and almost twice that for the other neuroses in the same community. Conversion reaction is reported over twenty times more frequently in females than in males (Sen-Gupta and Chawla, 1970). Next to conversion, the commonest form of somatization is hypochondriasis. The most frequent manifestations of hypochondriasis are reported to be bowel consciousness and concern about sexual potency and the genital organs. Koro (first described in Celebes and N. Borneo) or the Chinese 'Shook yang' (Still and Strong, 1945), in which the subject is afflicted with the

TABLE VII

Patterns of depression in three cultures

	West	Nigeria	India
Incidence	Common	Rare (artifact?)	Common
Sick role	Acknowledged	Not acknowledged (no word for depression)	Acknowledged
Hypochondriasis	Less common	Common	Common
Paranoid symptoms	Uncommon	Most frequent	Rare
Guilt feelings	Frequent	Almost absent	Rare
Retarded/agitated	R > A	A > R	A > R (artifact?)
Fugitive impulse	Not described	Common (wander into jungle)	Frequent (renunciation)
Suicide	Common	Rare	Less common

(Neki, 1972b)

https://doi.org/10.1192/bjp.123.3.257 Published online by Cambridge University Press

morbid belief that there is a serious risk of retraction of the genitals which if unchecked is going to be fatal; and the Indian 'Dhat' syndrome, in which nocturnal emissions lead to a morbid picture of severe anxiety and hypochondriasis, are both manifestations of concern about the genitals and sex. These syndromes may assume epidemic dimensions (Ngui, 1969). Another syndrome which seems to be a manifestation of concern with the control of sexual impulses is the 'Ascetic Syndrome' appearing in adolescents and young adults and leading to psychosocial withdrawal, severe sexual abstinence, practice of religious austerities, lack of concern with personal appearance, and considerable loss of weight (Neki, 1972). It is interesting, however, that Koro has been found only in areas where the Chinese culture holds strong influence; no cases have been reported from India or Ceylon.

Latah is another culture-bound syndrome which has been reported on very frequently in the literature. For the Indonesian the concept of Latah is a familiar one, and the Indonesian psychiatrist considers it as a culture-specific syndrome (Kusumanto, 1970). However, those who would like to see the cultural gaps bridged have remarked on the similarity between Latah and 'the Jumping Frenchmen of Maine' or the 'barkers', 'shakers' and 'pollyrollers', and consider them to be examples of 'the same clinical entity' (Yap, 1952).

Perception of abnormality is a social function in any given community (Colson, 1971). Social perception determines not only who is considered abnormal, but also who will be consulted for a given kind of abnormality. In the countries of this region a psychiatrist is consulted only rarely for personality disorders, behaviour problems in children, drug addictions (acute or chronic somatic complications are no doubt, taken to general physicians, but to the psychiatrist an addict comes but rarely) or sexual perversions. There is no strong reason to believe, however, that these conditions prevail infrequently among the populations concerned; in fact, it is believed by many psychiatrists that many psychopaths and retardates (besides simple schizophrenics alluded to above) live as social parasites (Vahia, 1967).

Some Outstanding Problems

Student mental health seems to be a burning problem in almost the entire region. In India, which has 70 universities, 4,000 colleges, and 1·1 million college students, there occurred around 2,000 student uprisings in a single year (1966). Wijesinghe (1970) from Ceylon, Wig (1970) from India, Wong (1970) and Abisheganden (1970) from Singapore, Patrick (1971) from Malaysia, Perfecto (1969) from the Philippines, and Meesook (1970) from Thailand have all dwelt on different aspects of this problem, which goes to show the serious concern these countries must be having about the problems of the student population. Only when one knows that 40–45 per cent of the total population in the region consists of boys and girls of school or college-going age (5 to 24 years), can one appreciate the high potential of this already alarming problem.

Self-sought 'chemical solutions' to human problems also pose another vexing problem in many parts of the region. It assumes an alarming dimension in Thailand, where there were 70,000 known addicts in 1952; in 1955, the number rose to 250,000 and by 1970 to 400,000 (Aroon, 1971). A large proportion of these are heroin addicts; opium addiction is also rampant. Alcoholism is another vexing problem in Thailand—in spite of the fact that 'we are a Buddhist country' (Aroon, 1971). It is interesting to note that alcoholism is rare among the Chinese in Thailand; it is the population of Thai origin that has the highest prevalence rate. Aroon also expresses surprise over the fact that while narcotic addiction is such a major problem in Thailand the problem is almost non-existent in the neighbouring Malaysia, where the use of cannabis indica is more prevalent. In India also, chronic use of cannabis indica has been endemic in select communities such as certain sects of 'sadhus' and 'nihangs'. Drug abuse, almost ubiquitously, is raising its head in university campuses as a result of the influence of the Western student community and the touring 'hippies'.

Another problem to have attracted the attention of psychiatrists, sociologists and criminologists in the region is that of suicide. Reckoning that approximately 4,000 works on suicide

https://doi.org/10.1192/bjp.123.3.257 Published online by Cambridge University Press

have been produced the world over since Durkheim's classic study, the handful of studies from this region appear insignificant. Yet, Wood's study from Ceylon (1961), Hassan's from Singapore (1970), and those of Shah (1960), Sathyavathi and Murtirao (1961), Gopinathi and Venkobarao (1966) and Singh (1968) from India have presented many cross-cultural contrasts and call for a reappraisal of some of the extant theories of suicide.

In all the studies in India, barring that of Gopinathi and Venkobarao, female suicides are found to outnumber males. This is in contrast with the situation in such countries as the U.S. and Norway, where males outnumber females by 4 to 1. In Japan, male suicides are slightly less than twice as frequent as the female. In Gopinathi's study, they are in the ratio of 3 to 2. In Singapore, males outnumber females by 5 to 3.

In the Indian study by Singh (1968) suicide rates are higher amidst the married than amidst the single, the widowed, or the separated.

In the Singapore study, there are significant ethnic group differences in the suicide rates. The Chinese have the highest rates (males 14·9, females 9·0 per 100,000), Malays have the lowest (males 1·7, females 1·4), while Indians and Pakistanis come in between (males 11·4, females 9·9).

These and other differences, such as those of age structure, mode of suicide and precipitating and predisposing factors, have raised a whole set of new questions which will have to be articulated on the strength of confirmatory studies and answered by building new hypotheses based on cross-cultural data.

Conclusion

In the words of Gunnar Myrdal (1968), 'The tendency to think and act in a diplomatic manner when dealing with the problems of the underdeveloped countries of South Asia has in the new era of independence become a counterpart to the "white man's burden" in colonial times'. This is but one, and perhaps the latest of the biases that have entered the Western accounts of Eastern social phenomena. There have been equally strong biases of the opposite kind. One of these has been to make evaluations from the standpoint of the Western culture, considering the latter as *essentially* 'normal' and holding any departures from its prevalent patterns as 'deviant' or 'abnormal'.

For this reason, a growing awareness has arisen amongst psychiatrists of this region for a reappraisal of mental health problems of the region with a 'native' vision untainted by Western influence. The justification for this view is obvious, yet one must not ignore the fact that one often takes the phenomena of one's own culture so much for granted and as a matter of course that one tends to overlook its oddities unless someone from outside that culture mirrors them back to one.

It should therefore always be essential to let the psychiatric problems of developing Asiatic countries be looked at bifocally. While the Eastern psychiatrists would do well to provide explanations for the unique native behaviour patterns and their dynamics, they will often be in debt to their Western counterparts for having pointed out what calls for an explanation.

Acknowledgements

Thanks are due to the numerous responsive colleagues from the various countries of the Region who were kind enough to complete and return the circulated questionnaire.

References

Abisheganden, E. (1970). 'Mental health in schools', in *Mental Health in Developing Society*. Proc. WFMH SE Asia Workshop (Singapore).

Almond, G. A., and Coleman, J. S. (1960). *The Politics of Developing Areas*. Princeton: Princeton University Press.

Anand, B. K. (1971). Opening Address at the WHO *Seminar on Organization and Future Needs of Mental Health Services in India*. New Delhi: WHO-SERO.

Aroon, S. (1971). 'Psychiatry in Thailand', in *Panel Discussion on Past, Present and Future of Psychiatry in Asian and the Pacific*. In press.

Beguin, A. (1952). 'Qui est fou?' *Esprit*, **20**, 777–88.

Bowman, K. M. (1956). 'Psychiatry in the Far East.' *Amer. J. Psychiatry*, **112**, 919–22.

—— (1959). 'Culture and mental disease, with special reference to Thailand.' *Arch. gen. Psychiat.*, **1**, 593–9.

Chakraborty, A. (1970). *Directory of Mental Health Activities in India*. Calcutta: Indian Psychiatric Society.

Coedes, G. (1968). *The Indianized States of Southeast Asia* (trans. Susan Brown Cowing; ed. Walter F. Fella). Honolulu: East-West Centre Press.

https://doi.org/10.1192/bjp.123.3.257 Published online by Cambridge University Press

COLSON, A. C. (1971). 'The perception of abnormality in a Malay Village', in *Psychological Problems and Treatment in Malaysia* (eds. N. N. Wagner and E-S Tan). Kuala Lumpur: Univ. Malaya Press.

DUBE, K. C. (1970). 'A study of prevalence and biosocial variables in mental illness in a rural and urban community in Uttar Pradesh, India.' *Acta psychiat. Scand.*, **46**, 327–59.

—— (1971). Personal communication.

DUBOIS, C. (1949). *Social Forces in Southeast Asia*. Minneapolis: Minn.

ELNAGER, M. N., MAITRA, P., and RAO, M. N. (1971). 'Mental health in an Indian rural community.' *Brit. J. Psychiat.*, **118**, 499–504.

GISH, O. (1970). 'Health planning in developing countries.' *J. Develop. Stud.*, **6**, 67–75.

—— (1971). 'Health planning in developing countries.' *Development Digest*, **9**, 67–76.

GOPINATHI, M. N., and VENKOBARAO, A. (1966). 'A study on suicide in Madurai.' *J. Ind. med. Assoc.*, **46**, 18–23.

GWEE, A. L. (1971). 'Traditional Chinese methods of mental treatment', in *Psychological Problems and Treatment in Malaysia* (eds. Wagner and Tan). Kuala Lumpur: Univ. Malaya Press.

—— (1969). 'A study of Chinese medical practice in Singapore.' *Singapore med. J.*, **10**, 2–7.

—— (1963). 'A cultural disease.' *Singapore med. J.*, **4**, 119–22.

HASSAN, R. (1970). 'Some sociological aspects of suicide in Singapore', in *Mental Health Trends in Developing Society*. Proceedings of WFMH SEA Workshop, Singapore, 29 March to 2 April 1970.

INDIAN NATIONAL COMMITTEE FOR MENTAL HEALTH YEAR (1960). *Report*. Bombay: Indian Council for Mental Hygiene.

JIN, E. T. (1971). 'History of institutional psychiatric care in Singapore 1862–1967', in *Psychological Problems and Treatment in Malaysia* (eds. Wagner, N. E., and Tan, E. S.). Kuala Lumpur: Univ. of Malaya Press.

KOLB, L. C. (1970). 'The demand for psychiatrists—Discussion', in *The Training of Psychiatrists* (eds. Russell, G. F. M., and Walton, H. J.). *Brit. J. Psychiat. Special Publication No.* 5.

KRAEPELIN, E. (1921). *Manic Depressive Insanity and Paranoia* (trans. Mary Barelay). Edinburgh: Livingstone.

KRAPF, E. E. (1959). 'On ageing.' *Proc. Roy. Soc. Med.*, **46**, 957–62.

KUSUMANTO, S. (1969). 'Rural clinics', in *Proceedings of WFMH S-E Asian Seminar on 'Education for Mental Health'*. Hong Kong: Roche Far East.

—— (1970). 'Latah in Java', in *Mental Health Trends in Developing Society*. Proceedings of WFMH S-E Asia Workshop (29 March–2 April 1970). Singapore.

LAPUZ, L. V. (1971). 'Psychiatry in Philippines', in *Past, Present and Future of Psychiatry in Asia and the Pacific*. Panel Discussion in Tokyo. (In press).

LIN, T. Y. (1969a). In *Mental Health Service in the Developing World* (ed. Neki, J. S.). London: The Commonwealth Foundation.

—— (1969b). 'Epilogue', in *Proceedings of WFMH SE-Asian Seminar on Education for Mental Health*. Hong Kong: Roche Scientific Service.

—— (1970a). 'The demands for psychiatrists—Discussion', in *The Training of Psychiatrists* (eds. Russell, G. F. M., and Walton, H. J.). *Brit. J. Psychiat. Special Publ. No.* 5.

—— (1970b). 'Note on desirability of establishing local training centres for psychiatrists in developing countries', in *The Training of Psychiatrists* (eds. Russell, G. F. M., and Walton, H. J.). *Brit. J. Psychiat. Special Publ. No.* 5.

LINTON, B. (1956). *Culture and Mental Disorders*. Springfield, Illinois: Charles C. Thomas.

MEDICAL COUNCIL OF INDIA (1971). *Recommendations on Undergraduate Medical Education*. New Delhi: Medical Council of India.

MEESOOK, K. A. (1970). 'A school mental health programme in a developing society', in *Mental Health Trends in Developing Society*. Proc. WFMH S-E Asian Workshop (Singapore).

MYRDAL, G. (1968). *Asian Drama*, vol. I, p. 15. London: Allen Lane, The Penguin Press.

NEKI, J. S. (ed.) (1969). *Mental Health Services in the Developing World*. London: The Commonwealth Foundation.

—— (1971a). 'Psychiatric education and the social role of the psychiatrist.' Paper read at the *V World Congress of Psychiatry*, Mexico City (29 November–4 December).

—— (1971b). 'Psychiatry in India', in Panel Discussion on Past, Present and Future of Psychiatry in Asia and the Pacific. *Clinical Psychiatry* (Japan). (In press.)

—— (1972). 'The ascetic syndrome' (unpublished article).

—— (1972a). 'Patterns of neuroses in developing communities and the relevance of Western psychotherapy in their treatment.' Paper read at the *WFMH Workshop on Mental Health Services in the Developing Countries*. Edinburgh, 1968.

—— (1972b). 'Patterns of depression—a comparative study' (unpublished).

NGUI, P. W. (1969). 'The Koro epidemic in Singapore.' *Australia and New Zealand J. Psychiat.* (Special issue on studies of anxiety), II **3**, 263–66.

PATRICK, E. (1971). 'Emotional stresses in University students', in *Psychological Problems and Treatment in Malaysia* (eds. Wagner, N. N., and Tan, E. S.). Kuala Lumpur: Univ. Malaya Press.

PERFECTO, W. S. (1969). 'Conflict in university and college students', in *Education for Mental Health*. WFMH S-E Asian Seminar (Hong Kong).

RATNAKORN, P. (1957). *Studies of Mental Illness in Thailand*. Bangkok.

SATHYAVATHI, K., and MURTIRAO, D. L. N. (1961). 'Suicide in Bangalore.' *Trans. All-India Inst. ment. Health*, **2**, 1.

https://doi.org/10.1192/bjp.123.3.257 Published online by Cambridge University Press

SEN-GUPTA, S. K., and CHAWLA, D. R. (1970). *Mental Health in India*. New Delhi: Central Bureau of Health Intelligence, Min. of Health, Govt. of India (mimeographed).

SETHI, B. B., and PRASAD, B. G. (1971). *A Psychiatric and Epidemiologic Study of 2,000 Families* (mimeographed report). New Delhi: Indian Council of Medical Research.

SHAH, J. H. (1960). 'Suicide in Saurashtra.' *Ind. J. soc. Work*, **21**, 167.

SHAKMAN, R. (1969). 'Indigenous healing of mental illness in Philippines.' *Internat. J. soc. Psychiat.*, **15**, 279–87.

SINGH, K. (1968). *Suicide in Delhi*. Ind. Counc. Med. Res. (mimeographed report).

SITASUWAN, C. (1969). 'Introducing mental health concepts into Thai Medical Education', in *Education for Mental Health*, Proceedings of WFMH S-E Asian Seminar. Hong Kong: Roche Far-East Ltd.

STILL, E. R., and STRONG, R. (1945). *Diagnosis, Prevention and Treatment of Tropical Diseases*. New York: Blakiston.

SUBRAMANYAM, M. (1971). 'Mental health: present and past problems in Malaysia', in *Souvenir, Centenary Celebrations, Govt. Mental Hospital, Madras*. Madras: Govt. Mental Hospital.

SURYA, N. C. (1962–63). 'Mental morbidity in Pondicherry.' *Trans. A.I. Inst. ment. Health*, **4**, 2–13.

TAN, E., and WAGNER, N. N. (1971). 'Psychiatry in Malaysia', in *Psychological Problems and Treatment in Malaysia* (eds. Wagner, N. N., and Tan, E.). Kuala Lumpur: Univ. of Malaya Press.

TEJA, J. S., NARANG, R. L., and AGGARWAL, A. K. (1971). 'Depression across the cultures.' *Brit. J. Psychiat.*, **119**, 253–60.

VAHIA, N. S. (1967). 'Psychiatry in India', in *Contributions to Comparative Psychiatry, Tropical Problems of Psychiatry and Neurology*, vol. 5 (ed. Petrilowitsch, N.). New York/Basel: Karger.

VENKOBA RAO, A. (1966). 'Depression—a psychiatric analysis of thirty cases.' *Ind. J. Psychiat.*, **8**, 143–54.

VERGHESE, A., BENJAMIN, V., and SUNDERRAO, P. S. S. (1971). 'A social and psychological study of a representative group of families in and around Vellore, North Arcot District.' (*Mimeographed Report.*) New Delhi: Indian Council of Medical Research.

VERMA, L. P. (1953). 'History of psychiatry in India and Pakistan.' *Ind. J. Neurol. & Psychiat.*, **4**, 26–53, 138–64.

WAGNER, N. N., and TAN, E. (eds.) (1971). *Psychological Problems and Treatment in Malaysia*. Kuala Lumpur: Univ. Malaya Press.

WALTON, H. J. (1969). 'Priorities of training and research in the developing countries', in *Mental Health Services in the Developing World* (ed. Neki, J. S.). London: The Commonwealth Foundation.

WFMH (1971). *Priorities in Mental Health Care in Developing Countries*. Report on the Workshop held in Madurai, India.

WIG, N. N. (1970). *A Study of Mental Health in Failing University Students*. New Delhi: Indian Council of Medical Research (mimeographed).

WIJESINGHE, C. P. (1970). 'Mental health in schools and colleges', in *Mental Health Trends in Developing Society*. Proceedings of WFMH S-E Asia Workshop (Singapore).

—— (1971). 'Psychiatry in Ceylon', in Panel Discussion on the Past, Present and Future of Psychiatry in Asia and the Pacific. *Clinical Psychiatry* (Japan). (In press.)

WHO-SEARO (1968). *Place of Psychiatry in Medical Education. Report on the Regional WHO Seminar*. New Delhi: SEARO.

—— (1970). *Teaching of Psychiatry*. Report on the Regional Seminar. New Delhi: WHO-SEARO.

WONG, R. (1970). 'Some problems of adolescents in Singapore', in *Mental Health in Developing Society*. Proceedings of WFMH S-E Asia Workshop (Singapore).

WOOD, A. L. (1961). 'A socio-structural analysis for murder, suicide and economic crime in Ceylon.' *Amer. sociol. Rev.*, **28**, 744–53.

YAP, P. M. (1951). 'Mental diseases peculiar to certain cultures, a survey of comparative psychiatry.' *J. ment. Sci.*, **97**, 313–27.

—— (1952). 'The Latah reaction: its pathodynamics and nosological position.' *J. ment. Sci.*, **98**, 515–19.

—— (1965). 'A culture-bound depersonalization syndrome.' *Brit. J. Psychiat.*, **3**, 43–50.

This paper is the last of a series of three invited articles under the general heading, 'Pyschiatry in Developing Countries'. The first by Professor Carlos A. León on *Psychiatry in Latin America*, was published in the August issue 1972 (**121**, 121-36) and the second, by Professor G. Allen German on *Aspects of Clinical Psychiatry in Sub-Saharan Africa*, in the November 1972 issue (**121**, 461-79).

J. S. Neki, M.A., F.R.C.Psych., *Professor and Head, Department of Psychiatry, All-India Institute of Medical Sciences, New Delhi-16, India*

(*Received 9 June 1972*)

https://doi.org/10.1192/bjp.123.3.257 Published online by Cambridge University Press