"Deviance from some established norm" is the literal meaning of the term abnormal. Abnormal is simply a label given to behaviour that is deviant from social expectations, according to Ullmann and Krasner (1975). They maintain that behaviour cannot be considered abnormal so long as the society accepts it. According to this view, behaviour is abnormal if and only if the society labels it as such. In other words the behaviour of an individual is considered abnormal if it results in poor adaptation to the culture in which one lives.

Normal behaviour is not something which is just accepted by the society but it must also foster the well-being of the individual and ultimately of the group. Well-being means not simply survival but also growth and fulfilment - the actualization of potentialities.
Even conforming behaviour, according to this view is maladaptive if it interferes with optimal functioning and growth (Coleman, 1976).

Offer and Sabshin (1967) have formulated an operational definition of normality. This is not an absolute one but is descriptive of one type of middle class population. The criteria are: (1) Almost complete absence of gross psychopathology, severe physical defects, and severe physical illness. (2) Mastery of previous developmental tasks without serious set backs. (3) Ability to experience affects flexibly and to bring their conflicts actively to successful resolutions. (4) Relatively good object relationship with parents, siblings and peers; and (5) Feeling a part of larger cultural environment and being aware of its norms and values. After a comprehensive survey of the field of mental health, they suggest that there are four current perspectives of normality. They are: (1) normality as health, (2) normality as utopia, (3) normality as average, and (4) normality as process.

The first perspective is clearly illustrated by Romano (1950) who states that a healthy person is one who is reasonably free from undue pain, discomfort and disability. The second perspective considers normality
as that harmonious and optimal blending of the diverse elements of the mental apparatus that results in optimal functioning. The third view is based on the mathematical principle of the bell shaped curve. This approach considers the middle range as normal and both the extremes as deviant. Normality as process perspective stresses change as process.

WHO (1987) Expert Committee on Mental Health in its comprehensive report says that "Mental health, as the Committee understands it, is influenced by both biological and social factors". The Committee's conception implies the capacity in an individual to form harmonious relations with others and to participate in, or contribute constructively to changes in his physical and social environment. It implies in addition an individual whose personality has developed in a way which enables his potentially conflicting instinctive drives to find harmonious expression in the full realization of his potentialities.

Culture and Mental Illness

Culture is the sum of what the individual members of a community - be it a small group or a large industrial nation - have learned from generations of accumulated social experience. It includes customs, manners, tastes, skills, language, beliefs and all other patterns of behaviour that
are part of organized social life. Activities of human beings, their sentiments and interactions are to a great extent determined by cultural patterns handed down from generation to generation. Therefore a person can be considered mentally healthy or unhealthy only with reference to the social and cultural milieu in which he is born and brought up. Just as cultures differ in kinship practices and religious practices so they differ in the behaviour considered as normal and abnormal. So, for any valid consideration or understanding of mental illness, cultural factors also should be taken into consideration.

According to Kiev (1972) cultural factors interact with a number of variables in the development and natural history of psychiatric disorders. In the opinion of Kiev, mental illness like tuberculosis are multifactorially determined. Unlike the Tubercle bacillus, which is a necessary but not a sufficient cause of tuberculosis, cultural factors are not so very necessary for mental disorders but they may be sufficient causes of it. According to Klineberg (1940) there are fewer distinct ways in which culture and abnormality can be considered related. First of all the very concept of normality and abnormality may vary from one community to another. Secondly, there may be variations in the frequency of
abnormality. Thirdly, the situations precipitating mental disturbance may vary because of social patterning. Fourthly, there may be difference in the nature of maladjustment.

Biological factors influence all aspects of our behaviour, including our intellectual capacities, basic temperament, primary reaction tendencies, stress tolerance, and adaptive resources. Thus a wide range of biological conditions such as faulty genes, diseases, endocrine imbalances, malnutrition, injuries and other conditions that interfere with normal development are important causes of abnormal behaviour. In comparison with the variables associated with biological causes of maladjustment those associated with psychological and socio-cultural are less well understood and more elusive. However, a good deal has been learned about psychological, interpersonal and cultural factors that appear to play significant roles in psychopathology.

In his "Ego and the Id", Freud (1923) examines the relationship of cultural factors to mental health. The relation between culture and psychopathology is expressed well in his Totem and Taboo (1913), Moses and Monotheism (1939) and the Future of an Illusion (1927). This field has been developed and refined by a number of
later scholars, particularly Devereux (1938; 1957; 1961), Kardiner (1939), and LaBarre (1946). A more systematic approach is found in the works of Hallowell (1938), Kluckhohn and Murray (1953), Opler (1956), and Wallace (1958). Contributions of Malinowski (1927), Honigmann (1954), Hsu (1961) and Kaplan (1961) are also very important in this field.

**Norms of Behaviour vary in different cultures**

Behaviour that is acceptable in one society may be reprehensible in another. Therefore the behaviour of individuals cannot be interpreted as ordered or disordered unless its meaning in a given society is understood. Maslow and Mittleman (1951) point out that various cultures favour the development of individuals in different directions. Majority of the individuals in all groups are able to adapt to these requirements, but others are not. This may then result in deviant behaviour or in psychopathology.

People from a particular region or nation are sometimes characterized as friendly, lazy, stingy, hard-working, trusting, warm, hospitable, reserved, etc. Eventhough these sayings may not be accurate it shows that common origin will produce similarities in traits.
and behaviours. Through many observations and studies the realization has emerged that an individual's socio-cultural environment is an integral part of his behaviour and personality (Lloyd-Jones and Rosenau, 1968).

The behaviour and personality differences in different cultures are due to the peculiar experiences and practices through which individuals in those groups go through. This fact is well illustrated by Spiros' (1959) study of Ifaluk. Among them there is no economic competition either for subsistence or for prestige goals. Property and capital goods are either commonly owned or are held by co-operative kinship groups. There is little of anything in their economic system to evoke feelings of hostility, insecurity and anxiety. This holds good for its political system as well. They are governed by five hereditary chiefs who initiate and direct all important group activities, economic, social and religious. These leaders exhort the people to conform to the traditional values of Ifaluk culture. Respect and love are the attitude of the people toward these leaders. But inspite of these they seem to be anxious. The first threatening experience, which begins at birth and continues for the duration of infancy, is the daily washing of the infant at dawn in cold water. Another threatening experience
of this group is the rejection by elders of children when younger ones are born. These two factors may be contributing to the anxiety observed in this group.

Among the Japanese of the 19th century laughter was not necessarily a reaction to amusement but frequently a social duty. Individuals are taught to express a happy appearance so as not to burden others with their grief (Weinberg, 1952). In some cultures, for example, among the Sunis, ambition is frowned upon and discouraged, whereas in others such as U.S. it is encouraged. Wolfgang and Feracutti (1972) indicate that in the American Negro sub culture violence is evaluated highly and its avoidance adversely criticized. The rate of homicide was also found to be directly related to the degree of integration of violence within the sub-culture.

There are cultures in which dissociative psychic states or hysteria have been one qualification of religious leadership. But there are societies where there are no culturally approved channels for the expression of such mental phenomena. Western culture is quick to favour the sick role for paranoid behaviour, hallucinations and depressive states, while traditional societies are quick to set up sanctions against behaviour patterns,
such as adolescent unrest and lack of respect for elders, that threatens the status quo (Kiev, 1972).

In ancient Greece, an oracle who would fall into trance was held in great respect; and the Bible also records many instances of seizures, trances and visions that were thought to be divine in origin. In various societies, unusual mental states, like hallucinative, hysterical seizures and trance states, have held a central role in religious beliefs and practices. Such mental states have been regarded as prerequisite experiences for aspiring priests in a number of north American Indian tribes, as well as in African and Asiatic tribes. Stimulants as alcohol, Indian hemp, peyote and mescaline have often been used to induce such mental states (Kiev, 1972).

Dreams are differently treated from culture to culture. Lee (1958) points out that for the Zulu, dreams are links to their ancestors. Devereux (1938, 1957) and Wallace (1958) give accounts of cultures where dreams are considered important.

**Attitudes to Sex**

Variations are evident in the attitude of different societies toward sex. Each society approves or disapproves of certain sexual patterns and calls
certain individuals as deviant, but only a few patterns are universally condemned. For many patterns including polygamy, prostitution and homosexuality, sharply contrasting attitudes are found (Coleman, 1976). Carstairs (1964) reports that homosexual behaviour was more or less condemned in twenty seven out of seventy six societies, while in forty nine of these societies such behaviour is regarded as normal and socially acceptable for certain members of the community. Where it is not approved the individual is likely to develop conflicts and those secondary complications that are generally associated with stigmatized behaviour. Benedict (1934) considering cultures as integrated wholes has shown how they operate with gross selectivity in respect to encouragement of certain human temperaments and psychological trends and the consequent discouragement of others.

Sex and all that pertains to it is accompanied with a sense of secrecy and guilt because the cultures have always described it as something bad or dirty. The fact that neuroticism develops due to restrictions and repression in the area of sex has been stressed by many workers. According to Freud (1905), sex plays a unique role in normal and pathological behaviour. This topic has been a question of study and discussion by later
psychologists also. Linton (1956) points out that neurosis may result not only from the suppression of sex but also of any primary drive. The universal presence of neurosis raises interesting theoretical questions regarding their genesis. Neurosis are known to occur even in societies in which free expression of sexual drive is limited only by a few object taboo, defined in terms of the incest barrier.

**Sex Information**

According to Brij Mohan (1972), there is a painful lack of positive attitude toward sex. Even an enlightened family hates giving sex education to youngsters. Added to this difficulty is the confusion and disagreement the young people see around them concerning what is unacceptable. When the child becomes interested in the problems pertaining to sex and birth his questions are not answered frankly, truthfully and without embarrassment. It seems clear from numerous studies that many of the sex problems in adolescence are not due to desire for sexual contact, nor to a greater sexual hunger, but due to curiosity which would have been alleviated if the subject had been treated frankly and straight forwardly in childhood. For the sake of more adequate personality and better social
adjustment and as a help in the prevention of neurosis, psychosis and psychopathic personalities the subject of sex should be dealt with frankly by the parent (English and Pearson, 1947). It is not sexual information that leads to promiscuity or to illegitimate pregnancy or venereal disease. It is often rather the lack of proper information that leads to these results. Durant (1953) points out that a man should speak of sex as he would speak of digestion or respiration. In a study of over 800 sex offenders including a large percentage of rapists and pedophiles, Cohen and Seghorn (1969) point to both inadequate information and the relative absence of even the most basic social attitudes and values or social skills. Kaplan (1975) reports that many offenders have rigid ideas about the sinfulness of sex which tend to deny them access to normal sexual outlets and to lead them to the use of deviant and disapproved ones. Coleman (1976) reports that mothers of schizophrenics have rigid and moralistic attitude toward sex that makes her react with horror to any evidence of sexual impulses on the child's part. Kirkendall (1961) notes that those who are reared with rigid attitude toward sex are likely to experience guilt reactions in either pre-marital or marital intercourse. Masters and Johnson (1970) consider faulty learning to be primary cause of frigidity in females.
Masters and Johnson (1975) conclude that most sexual dysfunctions are due to crippling fears, attitudes and inhibitions concerning sexual behaviour, often based on faulty learning exacerbated by later aversive experiences.

Sexual Perversions

Sexual perversion is a sexual activity that defeats the aims of procreation. People feel it is un-aesthetic and conflicts with their idealistic values. If all sexuality are carried out in perverse behaviour, the aims of procreation would be defeated and we would soon die off as a race. Each society approves of certain sexual patterns, and labels others as "deviant". But few patterns appear to be universally condemned. When a certain behaviour is not approved and when a person commits it or becomes a victim to it, he becomes anxious and guilt ridden. Studies on the causes of sexually perverse behaviour show that it is the same as that of neurosis. The sexually perverse individual, English and Pearson (1947) point out, is often hated, lonely and in conflict about his problem.

Homosexuality is considered as one form of perverse sexual behaviour and a character disturbance. It is having sex with persons of the same sex. In the first
place, homosexual has his sexual curiosity stifled as a maturing child. Second, sexual activity such as masturbation has been prohibited.

Premarital and extramarital sex are also not approved and is looked down upon in many cultures, and when this relationship is incest (sex relations with close relatives) it is greatly condemned. Murdock (1949) in a cross-cultural study of 250 societies reports that in no society is it conventional or permissible for father and daughter, mother and son or brother and sister to have sexual relations or to marry.

Based on their studies, Kinsey et al. (1948, 1953) estimated that 83 per cent of males and 50 per cent of females had sexual relations before marriage. Although the incidence today is not known the figure will be higher as a result of more "enlightened" views of sexual behaviour and availability of the pill which has removed much of the fear associated with pre-marital sex (Kaplan, 1974, 1975; Masters and Johnson, 1975; Verner and Stewart, 1974). Extramarital relations at sometime during marriage were attributed to 50 per cent of men and 2.3 per cent of women. The number of homosexuals according to them is about 2.6 million men and 1.4 million women in the United States.
The actual incidence of incest is unknown since it takes place in a family setting. However, Kinsey et al. (1948, 1953) report an incidence of five cases per 1000 persons in a sample of 12,000 subjects, and Gebhard et al. (1965) find 30 cases per 1000 subjects in a group of 35,000 imprisoned sex offenders. In both these studies brother-sister incest was more common with the father-daughter incest as the next most common pattern. Mother-son incest is thought to be relatively rare.

Marital Adjustment

Intimate relationships are an essential factor for mental health. For many this intimate relationship takes the form of marriage. In an extensive survey of Americans, including over 2000 personal interviews, more than 80 per cent of those questioned selected a happy home life as their most desired goal (Eldrich, 1974). Unfortunately this goal seems to be illusive one for many to achieve.

Sexual adjustment and compatibility is perhaps the most important factor in marital interaction. The sexual communication is a function of the total personality. Truxal and Merrill (1957) find three important attitudes that determine the successful operation of the
sexual role viz., agreement, desire and reciprocity. It is a tragedy that the average man and woman are terribly ignorant about the mission of sex. The sexual maladjustment gets aggravated when there are incompatible temperaments, habits, interests, attitudes and beliefs. According to Brij Mohan (1972) to an average Indian sex is a means of recreation or a tool of procreation. The essential and desirable components of a healthy sexual interaction are often missing.

Marriage and child rearing, English and Pearson (1947) state, are two of the most important fields of human relations and yet up to the present time they are the least prepared for human activities. Less is said about them in the home, in the school, in the university, than about any other subject of half the importance and all because of shame and prudery. We will never have a better world until we have happier marriages, happier homes, happier and emotionally more stable children.

In a study of 48 adult males with a disorder of sexual potency, Cooper (1969) found anxiety to be the contributing factor in 97 per cent of the cases and the main problem for those whose potency problems had started early. Kaplan (1974) concludes that a man who suffers from impotence is often almost unbearably anxious, frustrated
and humiliated by his inability to produce or maintain an erection. Males who suffer from premature ejaculation may also experience acute feelings of inadequacy and often feelings of guilt as well stemming from their lack of control and inability to satisfy their sexual partner. Masters and Johnson (1970) consider the reason for premature ejaculation as the first sex experience with a prostitute or other situation in which hurried ejaculation was necessary. Once this pattern is established, the individual is unable to break the conditioned response. Brij Mohan (1968) reports that most of the patients in his study did not enjoy wholesome, normal sex life. Insincerity on the side of either partner can bring about a hell in the home and as a result much doubt and tension are also brought about.

In an Indian family, usually a girl is not only brought to her husband by marriage but to the in-laws as well. She has to adjust to the in-laws also who expect much perfection from her (Brij Mohan, 1972). A man is forced to select between his mother and wife. Even though among the educated and working girls this is not a problem many of the girls even today suffer a lot due to the existing system. According to Khatri (1970) the mother-in-law who had to suffer under her mother-in-law uses the
daughter-in-law to relieve her tension. Afterwards the new one also gets an important place. But by that time she may become a neurotic.

Dowry system also creates many problems. Many girls are not able to get married out to lack of money. Even after marriage if the desired sum is not brought there are many problems (Brij Mohan, 1972). Making money for dowry also is a great event of tension to many families. Even though there are love marriages, most of the marriages are arranged by parents. Those who marry according to their liking will have to face many problems in their daily life, specially if they are not economically independent. Forcing to marry a relative is also not infrequent. This also can produce tension.

Family planning is stressed very much today. But many Indians consider it immoral or in some way harmful to them and hesitate to accept the artificial family planning methods. Even after accepting them they will be worried about it, and attribute many of the physical and mental ailments to the family planning practice (Sreedevi, 1977). Indian culture after the advent of Buddhism and Jainism attaches too much importance to Ahimsa. This sentiment is deep rooted in the Indians. Therefore the adoption of these measures act as a shock to the person concerned.
Culture and Stress

Mental illnesses are generally considered to be the result of a person’s inability to face the stresses that come in his life. This makes him anxious, fearful, doubtful, perplexed and confused. In this state of mind he cannot act constructively.

Anxiety is a major component of a high percentage of cases diagnosed as neurosis (Lief, 1967). According to him, about one fourth of a given community includes persons with anxiety reactions severe enough to warrant professional aid. Coleman (1976), stresses that neurotics are typically anxious, ineffective, unhappy individuals. Anxiety, according to Sarason (1976), is an effect of a breakdown of defenses. Anxiety is also an indication of an inability to cope with personal threat and danger.

Adler (1927) conceives of the individual as constantly striving toward the goals, seeking self-actualization and fulfilment. Adler contended that all persons naturally strive to attain their concept of superiority. However, an individual's concept of superiority can range from realistic to grossly distorted. He interpreted behavioural aberrations as due to self perceived inferiorities which lead to obvious and devious compensatory mechanisms. Cameron (1963) points
out that the feeling of inferiority, worthlessness, self-disparagement and hopelessness are the chief among the cardinal neurotic depressive symptoms. When a person cannot do things others do, he feels inferior to them. He is forced to compensate for this inferiority by developing other modes of obtaining success in life. Sometimes not desirable, as when a child compensates for a weak leg by making himself the leader of a delinquent gang or by giving up all physical and social activity and spending all his time reading and studying (English and Pearson, 1947).

Kiev (1972) says that it is culture that determines both the nature and perception of the stress, as well as the kinds of responses that have been developed for coping with it by members of the particular culture. However, which particular disorder develops depends on the individual's constitutional make up as well as his early experience and family history. It is the individual's perception of the stress that leads to maladjustment. Whether stress then leads to maladaptive response depends on the individual's general susceptibility as well as his ability to adjust to a particular kind of stress. Psychological as well as cultural defenses may succeed in preventing stress from acting upon the individual's psychological or psychosomatic integrity.
According to Montagu (1961), conflicting values are minimal in those cultures that give institutionally sanctioned means of expressing aggression, reducing anxiety and supporting dependency needs. When symptoms are tolerated, encouraged or reinforced, individuals appear not to suffer from them and are not labelled as 'sick'. Such support from the culture is a great help in preventing the development of disability.

Al-Issa (1968) says that there is possibility for some cultures to be more stressful than others and cultural-pressures and stress may differently predispose individuals toward mental illness. The situations or the stress resulting in maladjustment will be different in different cultures. Hallowell (1941) points out that when a Saulteaux Indian does not readily recover from an illness, he interprets his disease as a penalty for some past deed. Not knowing the specific cause of his illness, he is faced with a particular crisis which frightens and overwhelms him.

Mental diseases seem to be more prevalent where population is mobile and heterogeneous than where it is stable and homogeneous and where life situations are complex and difficult rather than simple and secure (Maslow and Mittleman, 1951). Similarly the exposure to sudden changes
in the life pattern is found to interfere with the normal life of the individual making them maladjusted. The changes made quickly by itself can contribute to unrest and dissatisfaction. Migration is one example of his sudden change. Reusch (1948), Mead (1947), Murphy (1955) and Seguin (1956) give examples of the relationship between sudden change and mental illness.

Social change, as suggested by Murphy and Leighton (1965) and Hughes (1969), is accompanied by increase of social and cultural sources of psychological conflict, by new stresses and new adaptation requirements and by the loss of stabilising effect of old cultural patterns. The best example of this type of stress is that which is experienced by the educated yet semi-primitive marginal African. The African gets tremendous support from both the living group and the spirit group. Such support fades fast in urbanising world. According to Amara (1967), the African child is brought up in an atmosphere which emphasizes group activity. The African tends to regard personal problems as group problems and feels protected by it. But today due to the exodus from villages to the city, the family is disrupted. The migration to the city takes away the group protection and he feels isolated and open to illness and maladjustment. By change a shake is caused in the
existing system. Improvement in living conditions may also have its negative effects. In the United States, revolutions in automation, communication and transportation are highly valued and considered progress but they are all clearly associated with discontent and turmoil.

People who will be able to function in socio-cultural situations of less stress may become victims of conflict in situations that emphasize competitiveness and achievement. Lambo (1964) found in Africa that a higher incidence of drug addiction, abnormal sexuality and antisocial behaviour in industrial areas, than in the entire population of the region. Women, old people and adolescents experience particular difficulty in urbanizing cultures.

Culture and Symptoms

Linton (1956) points out that all the fundamental types of psychosis which are recognized by Europeans also occur in other societies. But the particular symptom may differ considerably from one society to another.

Significant differences between Japanese and American schizophrenics are observed by Schooler and Caudill (1964). Americans show greater disruption of reality testing and are more likely to show hallucinations
and bizarre ideas. Physical assaultiveness is found more prevalent among the Japanese. Opler (1959) reports that there is more hostility, acting out, elation and bizarre mannerisms among Italian paranoid schizophrenics than among their Irish counterpart. Opler further notes that although Irish patients have sin and guilt concerning sexuality, Italians have no feeling of guilt and sin in this area. Social withdrawal is rare among schizophrenic patients in Iraq and Italy. They are more expressive and aggressive than patients in the United States and other Western countries (Bazzouli and Al-Issa, 1966). By comparing Japanese and Filipino paranoid schizophrenics, Enright and Jaekle (1963) show that ideas of reference, thinking disturbance, suspicion and withdrawal are significantly more frequent among the former, Filipino patients showed significantly more delusions of persecution and violence.

Eaton and Weil (1955) show that unlike their counterpart in the West, the Hutterite schizophrenics do not show severe regression, excitement or any extreme anti-social behaviour. The absence of extreme anti-social acts among the Hutterite patients is attributed to the good custodial care and affective regard for the patients.
African schizophrenia is claimed to be a poor imitation of the European forms; showing less violence and aggression than in the West (Benedict and Jacks, 1954; Marinko, 1966). According to Lambo (1955), delusions among rural non-literate Yorubans are related to supernatural concepts and ancestral cults while in literate Africans hypochondriical delusions are common. He also notes that schizophrenia in non-literate Africans is manifested in anxiety, depression, hypochondriasis, magico mythical projection symptoms, episodic twilight of confusional states, depersonalization, emotional lability, retrospective falsification of reality by transitory and ill-defined hallucinatory experiences and transient delusions.

According to Lambo (1961), African culture is characterized by belief in supernatural forces; faith in the magic of symbols; expectations of supernatural punishment; orally preserved tribal legends and mythological concepts with an emphasis on animism; complete identification with the group; lowering of ego boundaries and thought processes; ancestor worship; belief in the existence of idealized good objects; a tendency to regard dream life as objective reality and strong religious beliefs. These characteristics suggest fixation at the oral level of development because of heavy individual reliance on the
support of the community. It is quite likely that such undifferentiated ego patterns are related to the high frequency with which hysteric and schizophrenic form of illness occur among the Africans, when they experience the social change of urbanisation.

Careful study of the delusions has frequently revealed their close relationship to the belief system that is prevalent in the culture. Laubscher (1937) found that schizophrenic symptoms among Africans in Queensland included auditory and visual hallucinations with mythological content as well as delusions of grandeur and of being poisoned or bewitched. The delusions of Europeans, on the other hand, included influences operating from a distance through electricity, telepathy and hypnotism. Tooth (1950) pointed out that delusions of 'bus' people in the north of Ghana was associated with the idols they worship, Among the urbanised people of the South Ghana and specially in Accra it included ideas of influence and control by electricity and wireless.

Deithelm (1956) has described several changes in the characteristic symptomatology of schizophrenics with the passage of time. In Vienna, Linz (1964) found changes in symptomatology during the last one hundred years. His study shows that ideas of grandeur and
aggressive behaviour were less frequent in the nineteenth century. During the period of the study, while auditory hallucinations increased during that period, the visual hallucinations decreased.

Lorr and Klett (1968) have observed an 'anxious depression syndrome' characterized by anxiety, self-blame, apprehension, guilt, hopelessness, sinful feelings, self-devaluation and suicidal impulses in a number of highly developed societies, including the United States, England, France, Germany, Italy, Japan and Sudan.

Kraepelin (1909) shows that, in Java depressive reactions rarely contained any elements of a sense of sinfulness. Carothers (1947) and Loudon (1959) have found that while manic depressive psychosis occurs in non-western cultures, its depressive type is very rare, and this type is believed to be confined to the westernized part of the population. It is reported by many authors (Eaton and Weil, 1955; Pfeiffer, 1966; Collomb, 1966; Bazzouia and Al-Issa, 1966), that non-western depressive patients show no feeling of guilt, self-accusation or ideas of unworthiness. Even where depressive reactions are relatively common among the primitive peoples, they seem less closely associated with feelings of guilt and self-accusation than in the
highly developed countries (Kidson and Jones, 1968; Zung, 1969). Among several groups of Australian aborigines, where depressive reactions were common, Kidson and Jones (1968) found not only an absence of guilt and self-recrimination but also no incidence of attempted or actual suicide. Linz (1964) explains differences in psychopathological pictures by the fact that primitive man has no conscience and is therefore inherently incapable of experiencing feelings of guilt. Suicide also seems to be rare among these patients (Loudon, 1959; Bazzouï and Al-Issa, 1966; Collomb, 1966). Similar characteristics have been found in a study of Jewish depressive patients in East London (Fernando, 1966) but their hostility tended to be directed toward the outside environment rather than toward the self. Prange and Vitols (1962) have shown that admission of depressive Negroes to hospitals and the incidence of suicide among them are lower than among the Whites.

Linton's (1956) observations support the view that the behaviour of neurotics is much more thoroughly conditioned than is the behaviour of psychotics. Cultural values and social relations are far more widely accepted as significant factors for the causation of psychoneurosis than of psychosis (Eaton and Weil, 1955).
In phobic states cultural beliefs, rather than individual's bitter experiences with objects of fear appear to be important. Hallowell (1938) points out that the American Indians he studied were not afraid of dangerous animals such as Wolves and bears but were afraid of harmless animals like toads and frogs. These fears were related to local beliefs. Sometimes the similarity between these two viz., cultural background and neurotic reaction makes the latter unnoticeable to the community. Hallowell (1934) reports a case of zoophobia that was not recognised by Berens River Indian because of their abnormal fear of animals.

In India, hysterical convulsions, numbness, paralysis, blindness, deafness, vomiting, aphonia, and associative reaction are seen to be common symptoms of hysteria among the lower classes, the less educated and women. According to Vahia (1962), joint family system and the lack of emancipation contributed to the pathogenesis of hysteria in women. In so far as marriages are arranged, a woman is virtually in bondage for life; to improve her condition, her only recourse is illness. Hysterical fits attributed to supernatural powers are socially acceptable ways for the troubled wife to gain attention, as well as relief from her duties.
Acute anxiety states of short duration appear to be common in primitive societies. Such behaviour seems to occur as a result of disturbing events such as migration to the city or passing through a place occupied by spirits. Carothers (1953) calls it the frenzied anxiety. There is a strong but largely unrealistic anxiety associated with the possibility of food deprivation in the Trukese society (Gladwin and Sarason, 1953). Neurotics among the Hutterites react to most stressful events with depressive rather than with anxiety symptoms and paranoid or obsessive tendencies as patients often do in America. Eaton and Weil (1955) explain the rare incidence of free-floating anxiety of the Hutterites to be the result of the individual's close interpersonal relationship and the social and psychological support he is getting from the group.

Religious Values, Beliefs and Practices

Religious beliefs, values and norms of a society are very important to the social group and these factors are part and parcel of their everyday life. Religious teachings, if followed sincerely, are usually found to foster mental health. But modern man finds it difficult to understand the inner meaning of these teachings and he finds them in conflict with scientific knowledge. The result is conflict and tension. Even those who practice
religion regularly are often compelled to act against their will and the spirit of religion is often neglected. This creates tension both in the leaders as well as in the followers. The tension and conflict in a practising Christian who is doing a particular crime will be much more than in another who is not so particular to practice his religion but committing the same crime. Hunt (1938) describes a peer group in which two conflicting activities contributed to schizophrenia as well as other disorders. Here, while the boys who practise sex perversions and who regularly attended church revivals (prayers) broke down, the other boys who practised perversions but who did not participate in religious revivals did not breakdown.

Religious faith as a means of fostering mental health has been stressed by Jung (1934, 1938). Akhilananda (1952), Foster (1961), Prasad (1961), Ligon (1961) and many others. The opportunity for confession and the assurance of forgiveness in some religious appear to meet a deep human need to be able to get rid of guilt feelings and make a new beginning (Coleman, 1976). The belief of a Hindu to cure any type of illness by prayer is stressed by Sethi and Trivedi (1979). The Upanishadic teaching that each one is part of God or God himself, is great help in keeping mental health and self-confidence.
In India, many of the practices and customs are related to the religious beliefs (Brij Mohan, 1972). Many of the causes of mental illness are attributed to supernatural powers. Treatment methods are also to a great extent based on these beliefs. Cultural colouring can always be observed in the symptoms. The compulsive fear of some of the Christians whether sins are forgiven or not and the washing ritual of some of the Muslims before prayer are all culturally based compulsive behaviour. The belief that mental illness is due to some poisoning (Mantravada) and the compulsive repetitive removal of the object also is culturally based.

Religious taboos concerning suicide as well as the attitude of a society toward it are important determinants of suicide rates. Both Catholicism and Mohammedanism strongly condemn suicide and suicide in Catholic and Arab countries is also correspondingly low.

Vahia (1962) and Kiev (1968) point out that persecutory ideas commonly centre around mothers-in-law, members of the extended family, and the spirits of the dead. Examination of the socio-cultural system does indeed reveal that these constitute stress points.

In the opinion of Wittkower (1969), social and emotional withdrawal, which are common among schizophrenics
in Asia, can be related to the Hindu and Buddhist teaching of withdrawal as an acceptable mode of reacting to difficulty. The high frequency of catatonic rigidity, negativism and stereotype among Indian schizophrenics have similarly been related to the traditional Indian passive-aggressive response to a threatening world.

Parker (1962) suggests that hysteria may prevail in groups in which there is a greater degree of dependency-need satisfaction and less stress on early independence and individual achievement. In such situations, emotional expression is quickly recognized and rewarded. This formulation does to some extent account for the high frequency of hysterical disorders in pre-literate societies, females, ethnic minorities, and the lower classes. Parker has also suggested that hysterical behaviour may be more prevalent in societies where the process of early socialization is not severe, and there is minimal repression of dependency needs and sexual drives. Hysterical behaviour may also be more prevalent in societies that provide models of it in such institutionalized religious practices as spirit possession.

One of the prevalent ideas among mental patients is the conviction that they have committed unpardonable sin.
Christianity's teaching that man is above all a sinner has mainly evoked his inferiority and misery (Jacobs, 1961).

Akhilananda (1952) tells in a direct manner of the integrative value of religion for mental health. He says that the human mind is peculiar. It will not give up anything unless it has something else to take its place. If the mind is to give up sense pleasure then, something higher than that must be given to it for mental satisfaction. A vacuum does not give satisfaction. He says religion properly understood has this power. Religion helps to strike at the root of ego-centricity which is the cause of maladjustment, because religion says that various people are the manifestation of God or self and consequently their interests are not basically different. Repetition of the name of God, as suggested by Tanthrikas, Vaishnavas and Saivas is helpful in the beginning of the practice of concentration. Roman Catholic church and Eastern Orthodox church also advocate this prayer method. These and such other exercises of a religious nature are found to have a healing effect in removing the mental disturbances.
Culture Bound Disorders

Apart from the differences observed in symptomatology and the concept of normality and abnormality in different cultures, some illnesses are found to occur only in some particular cultures. They are mostly variants of the severe functional psychosis and of various neurotic syndromes which are commonly referred to as culture bound disorders.

'Koro' is an anxiety state found in South East Asia (Yap, 1964) particularly among those Southern Chinese who have migrated to this region. Van Wulffen Palthe (1936) says that it is particularly prevalent among the Buginese and Macassarese of Indonesia. It has also been reported from West Borneo. 'Koro' is the name given to an anxiety state in which the patient is afraid that his penis will withdraw into his abdomen and that, as a result of this he will die. This anxiety has a very sudden onset, is very intense and sometimes lasts for days. The Chinese call this illness 'Shook yong' meaning 'penis shrinks'. This anxiety is related to the belief that the corpse has no penis because it could not have one. Rin (1965) gives a detailed account of the central features of Koro. A Koro like symptom has also been observed by Carstairs (1956) among Indian males. He considers this
to be the result of unresolved oedipal tensions and the fear of the all powerful father.

'Susto' is another anxiety syndrome found in Spanish American culture. It is considered to be caused by sudden fright, evil eye, bad air, black magic or witchcraft, all of which produce 'soul loss'. It is characterized by irritability, asthenia, anorexia, nightmares, trembling, sweating, tachycardia, diarrhoea, vomiting and other symptoms of anxiety and depression. It is believed that, when the fright reaches the heart, death will occur. Describing cases of susto observed among the Mexican Americans, Rubel (1964) says that various magical substances are believed to enter into the body and alter its natural balance.

Among Yoruba males, sexual difficulties are frequently attributed to witches. 'Bewitchment', Prince (1961) observes is a neurotic syndrome found here. Impotence which is common among Yoruba males is believed to occur when a witch uses an individual's penis in order to consort with his wife or with another person's, and returns it in a changed, now functionless form. The women who have been seduced by the witch may as a result become barren. Witches are also thought to control the menstrual flow of women and the expulsion of the new born child from the womb.
Doi (1962) describes an obsessional neurosis of young Japanese, 'shinkeishitsu' characterized by anxiety, obsessive compulsive symptoms, hypochondriasis, fear of meeting people and feeling of inadequacy. This develops when the basic need to be loved and protected has been frustrated. This condition is considered to be caused by the stress of urbanization and social change, the young people in Japanese culture have to face.

'Frigophobia' is an obsessional neurosis. It is characterized by fear of cold, preoccupation with the belief that heat deficiency is detrimental to vitality, fear of the wind, and obsessive need to wear several layers of clothing in order to protect oneself from cold. These patients are pre-occupied with fear of death. They are inhibited and socially withdrawn (Kiev, 1972).

'Latah', a strange Malayan malady is reported by Yap (1952). There are several varieties of it but all of them have one symptom in common. This is a type of hysteria characterized by hyper-suggestibility, automatic obedience, coprolalia, disorganization, depression and anxiety. Latah is known by a variety of names in different cultures.

'Evil-eye' or 'mal-ogo' is a phobic reaction found among Mexican Americans. Here the look of 'evil-eye'
involves controlling of another person by way of strong glances. To avoid the 'evil-eye' people refrain from boasting of their good fortunes.

'Voodoo death' as described by Kiev (1972) is the most dramatic result of taboo violation in Africa. Voodoo death, Cannon (1957) says, results from excessive sympathetic activity which produces, vasoconstriction and damage to the capillary endothelium of the blood vessels, loss of blood plasma, volume and pressure and ultimately death. This illness is supposed to be the result of curse. Even if no history of curse exists, the symptoms can be taken, it is believed, as proof that it has occurred. The pattern of curse varies from culture to culture. Prince (1961) reports that there are several types of curses. The Yoruba believe that curses can produce psychosis, illness or death, even when the victim is unaware of the curse.

A depressive syndrome 'Hiwa: Itek' or heart-break syndrome is found among elderly Mohave men who have been deserted by young wives. Some people alternate between depression and excitement. This is caused by too much worrying. Among this group, there are cases of men loving their women so much that it causes their death - their hearts break. Men marry those whom they love very much.
If the women then start going after someone else, it breaks their heart (Devereux, 1961).

Guinard (1930), Cooper (1933), Hallowell (1938) and Parker (1960) report cases of a disorder known as 'Windigo' psychosis. It is seen among the Algonkian speaking Indians of Central and North Eastern-Canada, the Ojibwa, the Saulteux, the Cree, the Beaver and others. This disorder is characterized by an inordinate desire to eat human flesh. These people suffer from limited food supplies and they seem to have developed in them elaborate myths about hunger and cannibalistic monsters that influence their response to depressiveness.

'Amok' is an acute homicidal form of mania specially found in Malay. Carothers (1953) suggests that it is a primitive reaction similar to the outbursts of psychopathic persons in developed countries. The amok phase or condition is characterized by automatism, amnesia, psychomotor overactivity and screaming, along with violent attack on people, animals and inanimate objects. This is followed by exhaustion, calm, depression and return to consciousness.

'Hsieh-Ping' or 'double sickness' is a trance like state found in China in which the individual identifies
with the dead. In this condition, the patient is considered to be possessed by dead relatives or friends to whom he has shown disrespect. Lin (1953) points out that belief in the power of dead relatives to cause mental illness leads to these abnormal reactions. Usually this illness occurs among the uneducated females from religious homes, who are exposed to conflict.

'Piblokto' is a form of dissociative state found among Eskimo women. It is characterized by depression with brooding, tremours and anxiety, screaming and crying, wild running in the snow and jumping into the water. The patients may also show violent homicidal behaviour. According to Gussow (1963), it is the consequence of an attempt to restore balance to an ego that has been threatened by severe cultural (typical) stress. It provides a defence against sudden fright, feeling of being lost, brooding over dead relatives, fear of the future, threat of starvation and accidents. These symptoms have been attributed to the quietness and the sense of impending doom that are characteristic of Arctic climate.

An acute confusional psychosis found among the Haitian peasants is known as 'Boufee delirante aigue'. This usually turns into chronic schizophrenia. This is a
type of spirit possession which is a sought after event by these people. It is a useful and culturally sanctioned form of role playing. For those who are out of touch with voodoo, or when possession lasts longer than expected, it is not accepted. Among them ritual possession is an acceptable form of going crazy (Kiev, 1972).

Most of these illnesses as observed by these investigators are often found to be peculiar to the cultural setting in which they occur. In certain cultures they are not regarded as manifestations of illness. Modernization has led to a change in the incidence and highly visible and dramatic forms of these conditions. An understanding of these disorders while throwing light on both the stress points and the susceptible groups in a particular culture, helps us in increasing our knowledge of how cultural factors in general contribute to mental illness and the form they take.

Attitude toward Mental Illness and its Treatment.

Beliefs and practices are not only found to show some relationship with the types of mental disorders and the development of symptoms but they are also found to determine to a large extent the attitude of the people toward mental illness and the methods of treatment.
In some primitive societies, Linton (1956) reports that mental patients who cannot take care of themselves are just allowed to die. Norbeck (1961) points out that in some places they fall into the group of wandering beggars. There are cultures where mentally ill are put in prisons and jails just like genuine deviants. Margetts (1965) gives a description of restraints that are used by healers in Nigeria. Norbeck (1961) reports instances where these patients are considered to be divinely appointed and are chosen as medicine men. The Hutterite outlook on mental illness is generally optimistic. They are treated with consideration and love. Mental patients are kept away from situations which seem to disturb them (Eaton and Weil, 1955).

Several studies indicate that the concept of mental illness shows a more or less uniform pattern (Tylor, 1958). Clements (1932) finds four basic concepts of disease causation in most prescientific, preliterate and underdeveloped cultures. They are: (1) Loss of vital substance from the body (soul loss), (2) Introduction of foreign and harmful substances into the body (intrusion or possession by evil spirits), (3) Violation of taboos, and (4) Witchcraft. In most societies these concepts provide the logical foundation for the treatment techniques
that are used there. For example, where sorcery is suspected, countersorcery measures are employed. Where harmful substances are believed to have entered the body, extraction of the supposed substance is done by ritualistic exercism. To coerce unwanted spirits that have taken possession of the sick, man has used prayers, sacrifice, fumigation, starvation, heat, fright, blood letting, catharsis and scape-goats. The recovery of lost souls (of a lost vital substance) has been undertaken with techniques of confession, expiation and purification of the sinner as well as by counter sorcery and threats against the sorcerer. Magic has also been used as treatment against mental illness (Frazer, 1948).

According to Sigerist (1954), cultures where insanity is considered as an indication of bewitchment the sufferer may be cruelly punished in order to protect the community from the evil with in him. For this reason, the mentally ill in Fiji and New Hebrides who are believed to be possessed by evil spirits are often burned alive while victims of bewitchment among the Bengala of the Belgian Congo are put to death. Bewitchment which does not respond to ordinary medical treatment, Yonebayashi (1964) states, is cured by visiting the famous Shinto Shrine, Susa Jingu in Japan.
Among the treatment methods, techniques of excorcism were quite common in olden days, because of the belief that mental illnesses are caused by evil spirits. Satan's pride was considered to be the cause of his downfall. So in medieval Europe when treating people possessed by devil, the first thing to do was to strike a fatal blow, at the devil's pride, to insult him. This consisted of calling the devil some of the most obscene epithets and the insults were supplemented by litanies of cursing (White, 1896). In Nepal (Kiev, 1972) evil spirits are exorcised by squeezing the patients' fingers, forcing him to lick the sole of a shoe, exposing him to irritating fumes in a closed room, or applying a heated spatula to his body. These methods are practised on the belief that only the spirits suffer from these tortures. According to Persians perpetual exorcism was the road toward the good life and the way to defeat the evil influence of 'Ahriman' the spirit of evil and darkness (Alexander and Solesnick, 1966).

Exorcism of evil spirits is usually performed in dramatic, excited settings which help to arouse a variety of positive emotions in the patients and the onlookers. The devil dancing ceremony of Ceylon is an example of this. Here, Senanayake (1961) points out that,
psychoneuroses are thought to be caused by the influence of nine evil spirits, or invisible powers, and treatment is possible only through invocations, offerings, and rituals to these devils.

There are many cults that serve rehabilitative and prophylactic purposes in many of the developing societies. Cults contribute to group integration and to the reaffirmation of various psychodynamically significant ends (Kiev, 1972). In his study of Iroquois, Wallace (1958) discusses the psychodramatic opportunities that are present in cult participation for expressing in socially approved ways impulses and desires that are ordinarily inhibited. The interpretation of dreams was the nucleus of Iroquois treatment.

Cults are usually made up of individuals who have themselves suffered from mental disorders, and who now attain high status through their cult roles and their ability to become possessed. Sopono possession cult in Nigeria is one such cult. Its members are Yoruban women who have previously suffered from mental illness. Possession by their particular spirits during the annual festival is prophylactic for its members (Prince, 1964).

In Japan, it was considered good for people who had mental difficulties to go and sit near the waterfall
and drink the water at the temple at Iwakura village near
Kyote. In addition, there was a large Buddhist rosary
around which the patients sat and prayed and this type
of treatment reminds one of the early example of 'group
therapy' (Caudill, 1959). This type of treatment was
found in other temples also, usually in connection with
a water-fall under which patients were placed as a sort
of primitive shock therapy. This system has similarities
with similar situations in Europe, such as the care of the
mental patients in the village of Gheel in Belgium
(Kilgour, 1936).

Some of these treatments are conducted as religious
ceremonials. In Haiti, hungans or voodoo priests play an
important role in preventing and treating of mental illness.
In order to remove an evil spirit he counteracts the sorc­
erer's black magic with magic of his own. These treatments
are conducted as religious ceremonials and the entire
community participates in it. Here animals are sacrificed,
patients are placed over hot flames, a variety of magic is
performed, and exorcism is practised by burning and flogging.
The hungan makes use of certain universal psychotherapeutic
principles, his faith in himself, his method and his religion,
all foster hope and expectation of relief. Community par-
ticipation in the temple setting adds to the efficacy of
his methods. It is difficult for modern methods of treatments to compete with these established voodoo practices, not only because of the inclination the people have to stick to the familiar, but also because of the hungan's dominance over his followers. The people have had little opportunity to develop reality testing skills, being exposed from infancy to a system of beliefs and practices that are focused on the Hungan's authority and the power he derives from the Gods. The hungan has the last word on all questions. Success in business, health or love depends on the benevolence of the deities and all are supposed to go to the hungan for advice, support and comfort. Thus the religo-medical practices of voodoo reduce tensions eventhough it suppress ego development (Kiev, 1972).

Sacrifice of different types are seen in different areas as a treatment for mental disorders. The theory behind sacrifice is the notion that human problems as evil, sin and illness can be transferred on to an animal. Frazer (1948) considers this assumption to be prevalent among the primitive groups who practised vicarious sacrifices. He shows many instances of this phenomenon in which animals are used as vehicles for the transfer of evil. Freud (1938) has also emphasized the transfer aspect of sacrifice.
Tylor (1958) concludes that it constitutes an effective procedure for injuring an enemy.

Incantation was considered to be the most effective treatment in Mesopotamia. According to Sigerist (1954), it was a powerful psychological tool and a system of medicine dominated by magic and religion. Its purpose was to rehabilitate an individual.

In pentacostal prayer groups of some Christian sects, healing is directed toward physical ills, emotional problems, and social difficulties. The members get a lot of psychological help through group support and prayer. The members pray for the gifts of the spirit such as 'tongues' and 'healing'. Through repetitive prayer, clapping of hands, confession of one's sins, music, etc. a very excited atmosphere is usually created. During these services there is a reduction of self-identity and awareness. Also there is a feeling of merging with the group. Such prayer methods seem to contribute to an increase of positive good feeling, elation and sometimes exaultation. It is believed that the holy spirit will enter the troubled individual, bringing strength to the individual as well as expelling the devil if he is present. Calley (1962) points out that the West Indians including those who are not
members of this sect, are in support of the effectiveness of these methods.

During many of the healing rituals drugs of different types are used in order to reduce emotional stress and to avoid inhibitions. The drugs help to reduce defensiveness, heighten suggestibility and faith in the ritual and lead to increased confidence and psychological integration (Efron, Holmsted and Kline, 1967).

Doi (1962) describes Morita therapy, which is developed in recent years in Japan for 'Shinkeishitsu', the syndrome characterized by neurasthenia, obsessions and anxiety. Moritha therapy is to help the patient to accept the symptoms rather than fighting them or trying to forget them. This approach is compatible with the Japanese focus on present time, and their non-acceptance of the cause and effect frame of reference that dominates Western psychotherapy.

The main feature in the Indian contribution to psychiatry is the Buddhist emphasis on the withdrawal of the interest from the external world to the inner self. This method of withdrawal is helpful not only for cure, but also as a help in managing the problems of everyday life. Gaitonde (1961) says that Hindu philosophy is
greatly related to some of the principles of contemporary psychotherapy. Both are systems of anxiety reduction and search to understand deeper psychological forces through introspection. Recognizing the general tendency to project responsibility on to forces outside the self the Hindu doctrine of 'Karma' focuses training on the development of individual responsibility. This type of introspective approach places significance on the past as a determinant of the present and on the individuals' responsibility for growth and development.

Mental Illness in Developing Countries

Esquirol (1830) and Georget (1820) attribute an increase in the rate of mental illness to progress of industry, commerce and civilization in general. Leighton, et al. (1963) have attributed culture change as the cause of increase of mental illness. Field (1960) has attributed detribalization in Kenya as a cause of increase in psychiatric disorders. Kraepelin (1909) suggests that the stresses of civilization have led to an increase in psychotic disorder. However, the evidences are not conclusive. Psychiatric disorders do indeed occur, with varying frequencies in preliterate and developing societies.
In contrast to the Western world, a very substantial portion of patients in Indian hospitals suffer from mental disorders associated with nutritional deficiencies. Rarity of senile psychosis in the Chinese population has been reported from both Hong Kong and Formosa (Opler, 1959). The rarity of psychosis among the Bantu in Congo has been reported by Faris (1937). On the other hand, Laubscher (1937) notes the rates of psychosis among the tribal Bantu in South Africa to be similar to those in Western nations. Manic depressive psychosis seems to be especially frequent in Denmark and rare among African Negroes and in New Foundland. Obsessional neurosis have been reported as rare in Formosa and as exceedingly rare in Kenya (Carothers, 1947).

Rate differences in manic depressive psychosis have been attributed to constitutional factors, social class, education and differences in diagnostic criteria among depressive disorders and failure to distinguish psychotic from neurotic disorders. Myerson and Boyle (1941) and Jacon (1959) point out that Hispano Americans acculturating to American culture have lower rates of mental illness than Anglo Americans. Mohoney and Biddle (1945) note that Okinavans in Okinava had less than the average rate of psychosis, whereas Okinavans in Hawaii had a high rate of hospitalisation. Gans (1922) points out that Western trained
Javanese doctors had higher psychosis rates than Javanese in the army. A study by Murphy (1934) shows that British trained, aged twenty to forty-nine, had a much greater hospitalization rate for all disorders than did Chinese-educated males in the same age group. Depression is extremely rare in Java, Kenya, South Africa and on the Gold-Coast.

These incidence rates, however, are not dependable because many never come to outside attention or they may be treated by native healers, who do not report their finding to the public health authorities.

As regards, the incidence of mental illness according to sex in developing countries, the rate of male and female patients is about the same as the rate given for Occidental countries by Henderson and Gillespie (1956). In Africa, by contrast hospitalized male psychotics greatly predominate over females especially in backward areas (Linton, 1956). Regarding age of incidence, Carothers (1953) points out that 78 per cent of all institutionalised patients are admitted between the ages of ten to forty, while in the U.S.A. in Dayton, only 42 per cent of the new admissions belong to this age group. Eventhough there are many sources of error here, he feels that the young adult group constitutes a larger proportion of first
admission in Africa than it does in the U.S.A. even after being corrected.

**Prevalence of Mental Illness**

A careful study in the last few years in different countries has revealed that 17.03 per 1000 population was mentally ill; 8.5 per 1000 population was under psychiatric care, while an additional 8.5 per 1000 population came in contact with psychiatric services. (Lin, 1967). In the United Kingdom, it has been reported that 3 per 1000 are receiving inpatient care, 4.7 per 1000 out-patient care and 86 per 1000, care of the general practitioners (Lin, 1967). In 1956, it was estimated that in the U.K. one person in 20 was likely to enter mental hospital during his life. The prevalence of milder forms of mental disorders, including neurosis, is probably much higher (Mayer-Gross et al., 1960). In the U.S., 9 million are estimated to be mentally ill in addition to 1.5 million (1 per cent of the population) who are mentally deficient. Approximately 50 per cent of the total beds are occupied by mentally ill patients (National Association for Mental Health, N.Y., 1952). The overall incidence of psychosis in Western countries turns out to be approximately 4 per 1000 and psychoneurosis
approximately 15 per 1000. Mental deficiency of all grades accounts for 5 to 8 per 1000 population (Prasad, 1961).

Age

Malzberg (1967) reports that the rates of admission for manic depressive psychosis are maximum in the fourth decade and then decline rapidly, for schizophrenia, rates rise up to late twenties and early thirties and then decline steadily and for senile and arterioschertotic psychosis rates of admission begin with the fifth decade and rise steadily to a maximum in old age. The average age of admission to hospital in African studies (Shelly and Watson, 1936; Carothers, 1947; Tooth, 1950) is 33-35 years. Lin (1953) in his survey of the Chinese population observes that schizophrenia and manic depressive psychosis occur with more frequency in the age group 20-59 years, whereas epilepsy, mental deficiency and psychopathic personality disorders appear more frequently in the younger age group. The rate of total mental disorders per 1000 population is highest in the middle age group and lower in the younger and old age groups.

Malzberg (1967) observes that each period of life is susceptible to certain characteristic type of
mental disease. From a study of first admissions to mental hospitals in the U.S. in 1950 he says there had been an increase in admission rates in respect of the aged. Sundby and Nyhus (1963) in their study of first admissions in Oslo, find that neuroses occur mainly in early adult life whereas behaviour disorders are common in youth. Bille and Nielson (1963) in their study of neurosis in Arhus, Denmark report that the age of occurrence is 30-44 and 40-54 years for females and males respectively. Rosen, et al. (1964) in a study of psychiatric out-patients in the U.S. observe that more women attend hospital upto the age of 35 years, but beyond this age male figures are generally higher.

Lemkau and Crocetti (1958) emphasize the relation of morbidity to age, pointing out that age differentials are among the most striking and consistent findings. Many more than half of the hospitalized cases – about 59 per cent – are under 35 years of age. Less than one per cent are over 65 years of age. Findings with regard to sex differentials are more ambiguous. However, there seems to be general agreement about a somewhat later age of onset for women than men (Norris, 1959). Although schizophrenic disorders sometimes occur during childhood or old age, about three fourths of all first admissions are between the ages
of 15 and 45, with a medium age of just over 30 (Coleman, 1976).

Kaplan and Freedman (1967) conclude that there is a relationship between mental health and age, but it is not a direct and simple relationship. The best mental health, after observing a few studies, they say occurs in the youngest groups, but in some populations there is a peak of psychiatric disorder in the middle ages, followed by a subsequent decrease, in others there is a steady increase with age. The differences in these two findings might be understood, they say, if enough are known about the life circumstances of the various age groups in each population. Sethi et al. (1967) in their study in India do not find age to be a significant factor in mental illness.

Urban/Rural Differences

Various studies show that rates of mental illness, as assessed by hospital admissions, are greater in urban than in rural areas, but the opposite holds true for mental retardation (Tietze et al., 1941; Dayton, 1940). Malzberg (1967), from a study of the differences in admission rates in urban and rural areas of New York during 1947-1951, finds that the ratio of admission rates of urban and rural
areas is 2:1 for all major illnesses and for old age psychosis. Odegaard (1945) and Buck, et al. (1955) show that this difference is due to the ease of getting admission to mental hospitals in urban areas. The nationwide surveys in Japan in 1954 and 1963 (Kato, 1969) reveal that the prevalence of mental illness is higher in the agricultural and fishing areas than in the commercial and industrial areas. In 1963, the prevalence in the metropolitan area, urban area and rural area were 0.8, 1.2 and 1.7 per cent respectively. Lin (1953) in his Taiwan study finds that there is a higher concentration of schizophrenics and neurotics in the central areas of the town and of epileptics and mental defectives in the peripheral areas. Faris and Dunham (1939) are the first to show the differential admission rates from various parts of the city. In Chicago, they find a high rate of psychosis, except manic depressive psychosis, in the central areas of the city. These findings have also been confirmed by other workers (Clark, 1948; Lin, 1953; and Hare, 1956).

Family

Family is found to play an important role in the development of abnormalities. The first social environment for every human being is his family. Usually family
provides its members with both his biological and cultural heritage. Scientific study and knowledge of the family have a rather recent history, but pre-occupation with family as a socio-cultural institution is as ancient as human history. Because of the family's central importance many scholars in different fields have studied about family. Eventhough these studies were conducted systematically only in the last few decades, there has been a rapidly increasing clinical and scientific interest in and appreciation of the family as the most significant social force in human development, and hence as a potent agent in personality disorders.

The early works of Ribble (1944, 1945) show that rejecting, indifferent, or punishing mothers may cause tense, unsatisfied and negativistic behaviour among their infants even at a very early age. In a study of 379 mothers of five year olds, Sears, Maccoby and Levin (1957) find that cold and rejecting mothers reported a background of feeding problems, persistent bed wetting, aggressiveness and slow conscience development in their children. Lefkowitz, et al. (1973) on the basis of their investigation suggest that parental rejection plays an important role in making children aggressive. Poznanski (1973) says that parental rejection is a key factor in
children suffering from excessive fears. Pemberton and Benady (1973) show an association between parental rejection and lying and stealing on the part of children. Many adults who have been rejected in childhood have been found to have serious difficulty in giving and receiving affection, by Pringle (1965). In a study of a wide variety of psychological disorders among urban children, Langner et al. (1974) observe that parental coldness is a causal factor in these disorders.

In a study of the family background of children referred to a child guidance clinica, Jenkins (1968) observes that those youngsters characterised as 'over anxious' are likely to have over-protective mothers. According to Poznanski (1973), a dependent relationship upon an over-protective mother is one key reason for such fears. Becker (1964) holds that while restrictiveness may foster well-controlled, socialized behaviour, it also tends to nurture fear, dependency, submission, restricted hostility and some dulling of intellectual striving. Extreme behaviour on the part of the adolescent is often a way of rebelling against severe restrictions.

Sears (1961) finds that high permissiveness and low punishment in the home are correlated positively with
anti-social, aggressive behaviour particularly during middle and later childhood. Investigations on children, carried out by Coopersmith (1967), have shown that high expectations are both common and helpful for the child's development. Yet such expectations need to be realistic, and take into consideration the capabilities and temperament of each child. He reports that the children of such parents are significantly lower in both achievement and self-esteem than are children whose parents have high but realistic expectations for them. These parental attitudes create in children a feeling that they can capture their love and affection only by superior performance and achievement. Their failure to achieve this makes them unworthy of their love leading to undesirable consequences.

When severe discipline takes the form of physical punishment of the child for breaking rules - rather than the withdrawal of approval and privileges - the result tends to be increased problem behaviour on the part of the child (Lefkowitz, et al., 1973; Steinmetz and Straus, 1973; Eron, et al., 1974). Normal families, Alexander (1973) says, tend to show a much higher incidence of supportive interactions and communication which tend to foster the unity of the family and well being of the family members. In his extensive study of emotional
disturbances in children, Jenkins (1966) observes that nearly half of a group of children diagnosed as 'over-anxious' and 'neurotic' had mothers described as neurotic because of extreme anxiety, nervousness and related symptoms.

Disturbed homes have been found to be associated with a high incidence of psychological disorders among children and adolescents (Glueck and Glueck, 1962; Wolkind and Rutter, 1973; Langner, et al., 1974).

The pathology of one parent may be compensated for by the wisdom and concern of the other, or an alcoholic parent may serve as a "negative model", showing the child what not to be like. Kadushin (1967) has cited a number of studies in which children coming from homes with undesirable models have grown up to be successful and well-adjusted adults.

Recent longitudinal studies by Block (1971), Block, et al. (1973) demonstrate that the best adjusted adults are those who in childhood, had warm relationship with effective mothers and fathers, in the context of a happy marital relationship. The fathers' interest and consistent participation seem to contribute strongly to the child's self-confidence and self-esteem (Sears, 1970). Mussen, et al. (1963) present data showing that adolescent
boys with negative relationship with their fathers are particularly likely to feel rejected and unhappy. Rosenberg's (1965) results suggest that the early father-child relationship is particularly important for the child's self-esteem.

Slater (1962) examines the relationship between college men's personality characteristics and their perceptions of their parents. Students who score high on questionnaire measures of ego strength and social competence are likely to perceive their fathers as affectionate and emotionally supportive. Inadequate fathering is often associated with high level of anxiety and maladjustment in children. Investigations by Lockwood and Guernsey (1962) reveal that fathers as well as their adolescent sons are likely to perceive strong father-son similarity.

Neurotic behaviour in children has been linked to maternal over-protection, domination and rejection. Retrospective accounts by neurotics have shown that as children they perceived their mothers as demanding, antagonistic and overly perfectionistic (Frank, 1965). Boys who have positive relationships with their fathers are likely to engage in constructive and prosocial gang behaviour (Crane, 1955; Thrasher, 1927). Such findings indicate
that the quality of fathering a boy receives greatly influences his peer relationships. The absence of a warm, affectionate relationship with an adult male can seriously interfere with the boy's social development (Biller, 1971). Considerable evidence indicates that the males' adjustment to marriage is related to his relationship with his father and his parents' marital relationship (Barry, 1970).

Becker, et al. (1959), Peterson, et al. (1959) and Becker, et al. (1962) observe that children who had conduct problems frequently have dictatorial fathers. Block (1969) also attempted to distinguish between paternal characteristics of children in different diagnostic groupings. Here also paternal inadequacy is found to be a major factor. Liverant (1959) mentions that fathers of disturbed children responded in a much more negative fashion on MMPI than fathers of non-disturbed children. The responses of the fathers of disturbed children show that they are impulsive, anxious, depressed and concerned with bodily complaints.

Trunnell (1968), studying children at an outpatient clinic, reports that severity of psychopathology vary with the length of father absence and the age of onset of the absence. Oltman and Friedman (1967) observe particularly high rates of father absence in childhood.
among adults who had chronically disturbed personalities and inadequate moral development. In addition they find above average rates of father absence among neurotics and drug addicts (Wood and Duffy, 1966).

Brill and Liston (1966) report that loss of father due to death in childhood is not unusually high among mental patients. However, the frequency of loss of father due to divorce or separation in childhood was much higher for individuals suffering from neurosis, psychosis or personality disorders than for a number of different comparison groups.

In families with non-disturbed sons, the fathers are most often ascendent figures, and mutually acceptable decisions are much more common (Schuham, 1970). Research on interactions in disturbed families has pointed out several sub-types of inappropriate fathering (McPherson, 1970). Paternal hostility toward the child and mother and lack of open communication among family members are very common. Leighton, et al. (1971) compare the interactions of families that have disturbed children. In general, fathers in normal families are in a dominant position and their role is accepted by family members.
A number of investigations have suggested that a warm and nurturant mother-daughter relationship is important in positive feminine development (Mussen and Rutherford, 1963; Mussen and Parker, 1965; Hetherington, 1965; Hetherington and Frankle, 1967). The results obtained by Sopchak (1952) and Lazowick (1955) support the proposition that inadequate fathering is related to the development of psychological problems among females. Poffenberger (1959) describes some of the adverse effects of paternal rejection on the child's self-concept and general attitude toward life.

Hoffman (1961) reports that girls from mother dominant homes have difficulty relating to males and are disliked by boys. Biller and Sung (1972) report data suggesting that very strong maternal control and dominance hampers girls' as well as boys' personality development.

An investigation by Fish and Biller (1973) suggests that the father plays a particularly important role in the girls' personality adjustment. Findings from other investigations have also pointed to the influence of positive paternal involvement in the girls interpersonal adjustment (Torgoff and Dreyer, 1961; Baumrind and Black, 1967). Blocks' (1971) analysis of data collected from the
Berkeley Longitudinal Study, highlights the importance of both the father-daughter and father-mother relationships in the quality of the females' personality functioning.

Inappropriate and/or inadequate fathering is a major factor in the development of homosexuality in females as well as in males (Bene, 1965; Apperson and McAdoo, 1968; Saghir and Robbins, 1973; Thompson, et al., 1973). Fathers of the homosexual women, according to Kaye, et al. (1967), tend to be puritanical, exploitative and feared by their daughters, as well as possessive and infantilising. In another study, Lesbians described their fathers as less involved and affectionate than heterosexual women did (Gundlach and Riess, 1968).

One of the most nearly comprehensive and the best controlled studies of father absence and girls' development was that conducted by Hetherington (1972). He concludes that the difficulties are manifested differently for the daughters of divorcees and the daughters of widows. Although their behaviour is very different, both the father absent groups reported that they are very insecure with males.

In their extensive studies, Lidz, et al. (1956) find a high incidence of inadequate fathering for female
as well as male schizophrenics. Hamilton and Wahl (1948) report that almost 75% of the hospitalized schizophrenic women they studied have experienced some inadequacy of fathering in childhood.

Early investigators like Partridge (1928), Knight (1933), and Haller (1942) consider rejection, usually by mothers, as a causative factor in the development of psychopathy. In one of the comprehensive studies of criminal behaviour by McCord et al. (1959), a strong link between the emergence of psychopathic behaviour and emotional deprivation, as indicated by parental conflict, cruelty, erratic punishment and neglect, is found. Bender (1947) concludes that all psychopathic children have experienced emotional deprivation and neglect. Bowlby et al. (1956) conclude that children who are isolated at a very young age are unable to relate to others in adult situations.

The Effect of some of the Traumatic experiences in childhood and adult life

Most people have shocking experiences that temporarily affect their feelings of security, adequacy, and worth. They are, however, found to be important in influencing their later evaluation of themselves and their environment. Such experiences are apt to leave psychological
wounds that never completely heal. As a result, later stress that reactivates these wounds is apt to be particularly difficult for the individual to handle. These shocking experiences often explain why one person has difficulty with a problem that is not especially stressful to another. The after-effects of sad or shocking experiences depend heavily on the support and reassurance given the child by parents or other significant persons. When a child is exposed to repeated stresses he is likely to show disruption in normal personality development. It should also be noted that hurtful experiences at any age may adversely affect adjustment. But early traumas are considered to have far reaching consequences than later ones, largely because the child has not developed his understanding and defenses (Coleman, 1976).

There are several authors who have investigated the changes in family functioning resulting from a member falling sick. Parsons and Fox (1952) describe that when a father gets sick, he claims attention from his wife, who in turn, withdraws attention from the children causing them to erupt with symptoms of neglect. Similarly the sickness in other members of the family can also affect the whole family. Anthony (1969) portrays the picture of the results of his study on the effects of illness of
one parent due to mental or physical disorder. These studies also show the ways in which different families dealt with the impact of illness.

Frequent, prolonged, painful or crippling illness may seriously interfere with a person's development. It is observed that in a great percentage of cases the beginning of neurosis follows immediately after a prolonged illness or a succession of illnesses within a short period of time (English and Pearson, 1947). When a child gets sick the parents develop a new reaction pattern. Their concern tends to continue even after the child is well and they become alarmed when he shows any slight symptom of illness. Often adults who have suffered a serious prolonged illness in childhood continue to show this pattern. If they meet with some disappointment they react by becoming ill, often with much the same symptoms they had when they were children. This encourages the child to continue his way of behaviour.

Any change in a child's circumstances may tend to have a traumatic effect on his development. Traumatic effects of all changes in the child's life—separation from parents, deaths, illness, the birth of new brothers or sisters would be reduced if there are full and free discussion of them before and with the child.
When a new baby is born in a family, the older child is naturally deprived of a certain amount of parents' time and attention. So much is being done for the new baby, that the older child feels neglected. The older child reacts to this feeling of deprivation by strong feelings of jealousy. There is often the possibility that he will make his adjustments simply by repressing his reactions and that these repressed reactions will continue to interfere with his ability to adjust to the numerous situations he will meet later.

Too much of anxiety and distress can be caused by separations from loved ones. Many of the troubles in the patients can be traced, at least in part, to a separation or loss that occurred either recently or at some earlier period in life. Chronic anxiety, intermittent depression, attempted or successful suicide are some of the more common forms of troubles that can be traced to such experiences (Bowlby, 1961; 1968). Although losses occurring during the first five years are probably especially dangerous for future personality development, losses that occur later in life are also potentially pathogenic (Lindemann, 1944; Marris, 1958).
Maddison and Walker (1967) from their studies suggest that most women take a long time to get over the loss of a husband. Bowlby (1960) emphasizes that young children not only grieve but that they often do so for much longer than sometimes supposed. Even for grown ups it is sometimes very difficult to grasp fully that someone near to them is dead and will not return. For children, it is clearly much more difficult still (Wolfenstein, 1966; Barnes, 1964). Interpersonal losses are probably more stressful than material ones for most people. Holmes and Holmes (1970) find death of spouse, divorce or marital separation to be the three most stressful events reported by adults in American society.

Socio-economic Status

The research investigations on the relationship between socio-economic status and mental illness are numerous, even though the workers have obtained somewhat different results. This has received widespread attention in recent years as a result of the work of Hollingshead and Redlich (1958). In their study on an American urban community of about 240,000 people in New Haven, Connecticut, these authors suggest that the type of mental illness is related to the social class. In the case of neurosis the
findings were that the higher the class, the higher the rate. With regard to the relationship between the social class and the type of neurotic disorder they suggest that anxiety neurosis and character neurosis are more prevalent in the upper classes, whereas hysteria is more in the lower class. While depressions are scattered, obsessionals are practically non-existent in the lower classes. From the study of a Norwegian village, Bremer (1951) concludes that neurosis is more frequent among the financially secure people.

Parker and Kleiner (1966) find that the incidence rates of neuroticism are high among those who have the lowest and the highest occupational statuses and are low among those in the medium status positions. With regard to neurotic disorders in Baltimore, Pasamanick, et al. (1959) show that there is a U-shaped curve, the rates being high in the low status group, declining in the middle status group and rising once more in the highest status group. However, Primrose (1962) fails to find any significant relationship between prevalence of neurosis and social class in a community in Northern Scotland. A combination of neurosis and 'some' character disorders, however, reveals a U-shaped distribution - higher prevalence rates both in the highest and lowest classes.
Many of the recent investigations, however, show that there is an inverse relationship between status position and mental disorders (Cassel, 1966; Dohrenwend, 1966; Roman and Trice, 1967; Turner and Wagonfeld, 1967). Investigations by Thomas and Locks (1963) suggest an inverse relationship between levels of education and hospital admissions for all mental illnesses for both the sexes. Leacock (1957), referring to various studies, states that the incidence of mental illness on the whole increases as one goes down in the social scale. Abramson (1966), from a survey of random sample of a predominantly immigrant section of population of Jerusalem, concludes that mental illness is common among persons of lower socioeconomic status. Highest rates of admission occurred among occupation of lowest social prestige in a Norway study made by Odegård (1956). In an investigation on the relationship between class position and symptoms of neurosis and anxiety on a sample of 1,462 elementary school children by Sewell and Haller (1959), it was found that the lower status students were more nervous and anxious compared to those in the upper class group. This finding is consistent with Auld's (1952) comprehensive review of the literature dealing with the relationship of status position and neurotic symptoms as gauged by the Rorschach, the T.A.T.,
the M.M.P.I., and other psychological tests. He notes that almost all of the studies show either a significant inverse relationship or a tendency in this direction.

Leighton, et al. (1963) find that high status communities have more "low symptom" individuals (less neurotic) than low status communities. In a study of automobile workers in Detroit, Kornhauser (1965) finds that men in low status occupations have higher neurotic symptoms than in the case of skilled workers.

Lin (1953) finds psychoneurosis to be fairly evenly distributed among all the status groups. In England, Stein (1957) fails to confirm the inverse relationship between status and psychoneurosis. A study, by Pond, et al. (1963), on the relationship of neuroticism and social factors in a working class population reveals no significant association.

Numerous studies suggest that lower social class position is a significant determinant of severely disordered psychological functioning. A recent and extensive review of the most important studies on social class and hospitalization for schizophrenia and other psychosis, point out that a large majority of the studies (eight of the nine studies reviewed) show that the highest incidence of psychiatric hospitalization occurs in the lowest social
class groupings (Misher and Scotch, 1963). Numerous other findings provide further evidence for this conclusion with few contrary results. It is also noted that higher rates of psychiatric disorder are observed at the lowest educational levels. In contrast to most other studies, on social class and psychiatric disorder, Jaco (1960) distinguishes the unemployed from all other occupational categories and finds that the rates of treated psychiatric disorders are disproportionately high in this group. The lowest status groups by occupational or educational criteria, have by far the highest rates of unemployed (U.S. Department of Labour, 1963). Thus the strong association of low socio-economic status and treated psychiatric disorders could result largely from the fact that unemployment is higher in the lowest status levels and is also markedly associated with psychiatric hospitalization or treatment.

A number of studies have also indicated that a high incidence of schizophrenia is associated with low socio-economic status. Faris and Dunham (1939) in their studies of the distribution of mental hospital first admissions in the Chicago area during the 1930s find that the low status areas of the city send much larger proportion of their residents to the mental hospital than do those areas designated as middle or upper status.
Although schizophrenia conforms to this pattern, manic depressive psychosis shows a relatively uniform distribution throughout the various status groups. This findings in Chicago is also confirmed in a subsequent study in that city, by Clark (1949). Similar findings have subsequently been reported for a number of different areas. According to Tietze, et al. (1941) high rates of schizophrenia in Baltimore are associated with lower class status, though the manic depressive disorders are slightly more common in upper class groups. Kaplan, et al. (1956) report a higher incidence of undifferentiated hospitalized psychosis in a lower and lower middle class area of Boston than in an upper and upper middle class section. The inverse relationship between the incidence of schizophrenia and social class is also found in England and Wales (Morris, 1959). Significant concentration of schizophrenia in the lower class is also noted by Goldberg and Morrison (1963). In an extensive prevalence survey of the non-hospitalized population in an area of New York city, Srole, et al. (1962) report that when severity of psychiatric disturbance is considered, the usual inverse relationship is found. High status individuals have fewer representatives in the 'impaired' group and more in the 'well' group. In a study by Pasamanick, et al. (1962) in
Although schizophrenia conforms to this pattern, manic depressive psychosis shows a relatively uniform distribution throughout the various status groups. This findings in Chicago is also confirmed in a subsequent study in that city, by Clark (1949). Similar findings have subsequently been reported for a number of different areas. According to Tietze, et al. (1941) high rates of schizophrenia in Baltimore are associated with lower class status, though the manic depressive disorders are slightly more common in upper class groups. Kaplan, et al. (1956) report a higher incidence of undifferentiated hospitalized psychosis in a lower and lower middle class area of Boston than in an upper and upper middle class section. The inverse relationship between the incidence of schizophrenia and social class is also found in England and Wales (Morris, 1959). Significant concentration of schizophrenia in the lower class is also noted by Goldberg and Morrison (1963). In an extensive prevalence survey of the non-hospitalized population in an area of New York city, Srole, et al. (1962) report that when severity of psychiatric disturbance is considered, the usual inverse relationship is found. High status individuals have fewer representatives in the 'impaired' group and more in the 'well' group. In a study by Pasamanick, et al. (1962) in
Baltimore, it was found that except for the lowest group, psychotic disorders generally decreased as income increased. The exception is explained by the fact that Negroes, who have lower rates of psychosis than their White counterparts, are concentrated in this group.

Clausen and Kohn (1960) find no relationship between the incidence of schizophrenia and socio-economic position in a small city in Maryland. Kleiner, et al. (1959) show that Catholics in Pennsylvania (1951-56) have significantly higher incidence rates of schizophrenia than Protestants, despite the similarity of their status positions. These investigators also find no relationship between occupational status and incidence of schizophrenia among Negroes in Pennsylvania (1951-56). Dunham (1965) reports no systematic relationship between social class and schizophrenia. Incidence studies in Australia (Cade, 1956) and Norway (Bremer, 1951; Odegaard, 1956) also fail to confirm the inverse relationship between status and schizophrenia or manic depressive psychosis.

An analysis of 2,000 consecutive admissions to the psychiatric clinic, Irvin hospital, Delhi, according to education, occupation and social class revealed that a vast majority of the patients were illiterate of with
elementary education, semi-skilled and unskilled workers and came from social classes III and IV (lowest classes) (Ray, 1962). Results obtained by Sethi et al. (1967) in India show a greater occurrence of neurosis in the lower income groups and low educated groups. But Bhusan et al. (1967) in a study of 50 neurotics, observes that neurosis is more among the upper classes. It is also observed that obsessional neurosis is mostly in the upper classes, anxiety in the middle classes, hysteria in the lower classes and depression to be evenly distributed among all socio-economic classes.

Indian Situation

In India, religion, ritual and morality had always been interfused. Hindu society is based on caste-system and joint family. Sociologists more or less agree that, inspite of industrialisation and social change, these two basic structures are holding fast, though the pattern is undergoing modification. Individuals in the family live a pooled and shared life. They share pooled material resources and are guided by group decisions and are supervised by group vigilance, share group security and are completely immersed in group life. They live a rich affective life in the family which determine their
satisfactions and sorrows. Their emotional and psychological existence is tied with their family life and they grow up and mature within the framework of their family.

The role of the various members of the family is determined by tradition. A son is expected to show proper respect to the opinion of his father even when he is old enough to make independent decisions. The relationship between the siblings, the special position of the eldest son, his obligations towards his younger siblings, the privileges of the married daughters - are all determined by tradition. The behaviour of the daughter-in-law towards her parents-in-law and other members of the husband's household is more or less clearly indicated. When there are rules and regulations governing the behaviour of one individual toward other members of the family, it is only natural that a sense of security is fostered among all (Ramanujam, 1967).

In spite of all these role assignments, there are chances of conflict. Traditionally the decision about education, vocation and marriage were made by parents, especially the father. In a way this was an easy way of ensuring the authority of the head of the family. The children perhaps found it easy because they did not have
to make a decision. As long as this arrangement continued it was found to be mutually satisfactory. But today, especially in urban areas, the older generation is not so sure about its competence in deciding on matters of education and vocation. At the same time they are not ready to trust the judgement of the younger people and let them decide their own destiny.

It is generally felt that parents, because of their age and experience, are very efficient in arranging marriages. They make the best possible choice for their children. But the existence of marital difficulties, in spite of the care taken, indicates the prevalence of marital disharmony. Sexual adjustment in marriage is one of the areas in which difficulties occur. Unfortunately, due to cultural inhibitions and taboos, patients do not talk much about this aspect of the problem.

Inspite of exhortation by leaders one sees a tendency on the part of younger generation to imitate and adopt western social customs. One has only to look at Indian films and advertisement media to discern which way the wind is blowing. One can overlook this intergenerational conflict only at the risk of facing a greater degree of social upheaval than we see at present. The
prevailing indiscipline among youngsters is a testimony of their conflicts and frustrations.

The state, through legislation and other means, is trying to provide equality and freedom to the individual. But this attempt to create a new social order has met with strong obstacles as it is difficult for people to reject the past and turn away from the traditional values derived from the different socio-religious systems of Hindus, Muslims and Christians. The individual's social life is controlled by his family, caste and religion and he in turn is loyal to the group to which he belongs (Balasundaram, 1967).

The role of the girls in the present day society is different from the traditional pattern. Even though the elders do not particularly like the idea of educating the girls, they are forced to give in because the boys prefer literate girls as their mates. Because of this as well as the necessity of getting some employment the number of women going for higher education is steadily increasing (Kapadia, 1966). Instead of being the subordinate members of the family they want to be recognised in their own right. Women are entering all walks of life. In contrast to the past women are coming more and more in contact with
men in all walks of life. There is also an increase in the number of intercaste and inter-religious marriages (Kannan, 1964) with which the earlier generation find it difficult to reconcile.

India, like many other developing countries, is fast becoming industrialised. But this transformation is not being brought about without tension, strife, and discontentment (Thacker, 1963). The Indian peasant migrating to urban areas for employment is caught between two cultures. Industrialization all over the world, without exception conforms to a general pattern. Industrialization leads to value change that is not in conformity with the old. Anyone who has seen the transformation in the large areas in India surrounding the mighty steel projects and the colossal and the mighty multipurpose river projects will have an idea of the impact of technology on the social, cultural and educational life of the people, as Thacker (1963) says.

In a review of the changing scene in India, Prasad (1961) asserts that many factors are appearing in the psychological environment of India today which are having their adverse effects on mental health. The security that was provided by the joint family system in
India is being rapidly disintegrated under the impact of industrialization resulting in individualism. This has resulted in an increase in crimes and delinquent tendencies. This is substantiated by Rustomji (1960). He observes that, industrialization means a new way of life, means conflict with an older way of life and in consequence means crime. "In the stagnant society of village, there was very little crime, although there was a certain amount of hunger and mental satisfaction. But in the steel town there is crime because of the conflicts that have arisen in society. There may be less hunger than there was, but there is more struggle, more to wish for and more to fight for, and there is more opportunity for crime".

The insecurity and failures, physical and moral, caused by the modern way of life are bound to be great in India, which for centuries had collective and low individualistic structure of society. This in turn will result in frustration. These consequences generally reduce the healthy functioning of the whole personality and disrupt his successful adjustment to the society.

With the breaking of the joint-family and increase in the expectation of life, the number of insecure
and isolated aged are bound to increase in India, and aggravate the problem of mental ill-health (Prasad, 1961). The social intercourse of the aged people is possible in a village set up but not in an industrialised society. Lemkau (1956) has rightly observed that, "very often the aged do not fit well into the social situation and are lonely because they have too little opportunity to see others whose cultural background is that of their generation rather than that of their children". The problem is aggravated because they are also deprived of the love and respect enjoyed under the joint family system. Prasad (1961) says that even the best run home for the aged does not provide the same satisfying psycho-social environment as probably the poorest family shelter.

Unemployment is a source of stress for many persons in India. Unemployment has been found to produce self-devaluation in many. Periods of extensive unemployment are usually accompanied by an increase in certain types of maladaptive behaviour, such as apathy, suicide and marital conflicts (Brenner, 1973). The evil effects of unemployment and under-employment on mental health have been substantiated by many studies (Williams, 1933; Eisenberg and Lazarfeld, 1938; Ginsburg, 1942; Moore, 1942; Adiseshiah, 1963; Veil, 1970; Gracy, 1974; Pillai, 1977).
Culture bound disorders in India

Mental illnesses found elsewhere are also found in India. But some investigators have identified certain types of disorders that are not found in other cultures.

Carstairs (1956) believes that 'jiryan', a type of 'sex neurosis', is the commonest form of anxiety he observed in a community in Rajasthan. In North India, this malady is commonly known as 'dhat' syndrome (Varma, 1971). Possession states is another culture bound disorder found in India. Another disorder observed by Chakraborty and Banerji (1975) is 'Suchi-bai' as it is called in Bengali language, and translated in English as 'purity mania'. This is a condition similar to obsessional neurosis.

Attitude towards mental illness and its treatment in India

The public attitude towards mental illness is one of fear and rejection. Neki (1965) in his study observes that a sizeable section of the public in India fears and strongly tends to reject the mentally ill. Many sick people hesitate to reveal it and their relatives hesitate to say that they have a mentally ill relative. Most of the patients find one or other physical reason for their trouble.
The causes attributed to the origin of mental illness by Indians include many natural and supernatural forces, the latter being more common. When the causes are not clear and when there is clear sign of mental disorder the causes attributed include evil-eye; possession by devils, spirit of relatives or enemies; black magic; poisoning; curse; result of one's own 'Karma'; the effect of bad time; fate; the anger of Gods; and so on.

The healers include sorcerers, pujaries, priests, 'manthravadies', astrologers, fortune-tellers and many others. The treatment techniques include a variety of rituals such as prayers, laying of hands, 'pujas', tying of 'Thakidu' (metal piece folded with prayers inscribed on it against evil influence), getting the poison vomitted, exorcism, taking out the magic or manthravada object from the house or property of the person getting sick, manthravada, casting of spells, flogging, beating, etc.

Many of the patients approach the local healers before going to the psychiatrist. Brij Mohan (1968) found that a majority of patients treated by him, 90 out of 140, had received some kind of local treatment with exorcistic methods before their hospitalization.
Sethi and Trivedi (1979) point out that the people consult these healers because of a belief that the healers are 'gifted' with magic powers. They therefore occupy a prestigious position in this society. Another reason may be their availability. They are usually elderly and experienced people who have the ability to give a type of counselling to the anxious person. The problem of communication between the Western trained doctor, which acts as a barrier towards development of proper relationship, has also been found to be a factor that makes the patients approach the healers. With the faith healers who belong to the same community and cultural background, this is not so. Another notable feature is that patients belonging to one religion do not hesitate to seek help from healers of different religions.

Among the Hindus, there is a widely prevalent and powerful belief that all illnesses can be cured by prayer and worship at certain temples. Similar beliefs are current among followers of other religions also. This faith acts as a powerful suggestion in effecting cures when these patients visit certain temples, where the presiding deity is believed to have curative powers. In the temples, patients are kept engaged almost continuously from morning till night. The ritual involves considerable strenuous
physical exercise by way of climbing steps, pradakshanams (going round the temple), etc. usually done in an empty stomach. This roughly corresponds to modified insulin therapy. These shrines also have temple tanks (Thirtha). Frequent baths in these tanks and the continuous pouring of the holy water from the tanks have physiological role in treatment.

A fatalistic outlook, the assumption that whatever happens is the will of God or Allah, is the best adjustment the individual can make to an apparently hopeless situation (Foster, 1961). According to Prasad (1961), faith still acts as a great soothing balm for our people in calamities such as epidemics. It also acts as a great restraining and correctional force.

The religious outlook of Indian people is considered an asset to mental health. 'Dharma' in Sanskrit means, that which holds, and it is no exaggeration that the spiritual and social norms prevailing in the society, have held fast the moral fibre and maintained the society healthy, mentally and spiritually. Prasad (1959) observes that "Religious faith and social values, deeply embedded in our social relationships and structure are mainly
responsible for maintaining the mental health of the
nation". With industrialization and increased materi­
alistic craving, there is, however, likely to be a dege­
eration of moral health leading on to increase in mental
ill health.

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