CHAPTER ONE

Introduction
CHAPTER I

INTRODUCTION

Mental disorder, as we understand it today, is essentially the result of the influence of multiple dynamic forces. It includes a wide range of abnormal states of mood, thought, and behaviour, ranging from mild anxiety and tension to severe disorganizing psychosis.

Attempts to cope with the problems of the mentally ill have existed since ancient times, but only in the last two centuries have systematic and rational treatments been employed; and only in the past fifty years has psychiatry developed as a scientific discipline.

Most of the Scientists of today agree that human beings, like all other animals, like to live in a state of equilibrium. Temperature, light, sound, food, the condition of the mind, the inherited and acquired characteristics must be optimum to maintain the proper functioning of the body. When this homoeostasis is disturbed, they believe that the body's defences try to restore the equilibrium. However, if the body is unsuccessful in its attempt, various forms of somatic and psychiatric disorders result.

It has been aptly said by Hinkle (1973:43) that, "to be alive is to be under stress." To analyse the causes and the nature of stress and tensions, a study of the human
psyche in relation to the socio-cultural factors is vital. Most tensions, be it individual, social or international, are the results of the actions and reactions of men living together, to which both the inherent and the acquired characteristics of the individual, who is the basic unit of society, contribute. To quote Slatkin, (1955: 67-70) "Man inherits a limited repertory of responses. Most of his responses are learned and the majority of these are learned from others, that is, culturally acquired. Consequently, it is to be expected that the individual's responses, abnormal as well as normal, are greatly influenced by his cultural milieu." Rather than the unfolding of an immutable biological process, the Neo-Freudians took the position that many of the emotional disturbances of man are the result of the conflicting demands a culture imposes on the individuals. In their book, "The Making of a Mental Patient," Price and Denner (1973:1) has stated the following: "The process of becoming a mental patient can be thought of as the product of the complex interaction of biological, experiential and social factors that we are only beginning to understand.

Anthropological research (Carstairs, 1976:9) has indicated "that mental disturbance occurs in every society, without exception, but varies in its frequencies of occurrence in different societies: hence, attention has turned towards a study of cultural factors which are associated with higher or lower prevalence rates for mental disorder."
The picture within the walls of Mental Hospitals is saddening. Great numbers of the mentally ill still live shut away behind walls by the prejudices and incomprehensions of society. The efforts of the most advanced psychiatrist to have the mentally ill treated as other sick people, who can be cured, are likely to remain fruitless as long as the irrational fear of "madness" is not conquered.

Today the battle for mental health is being fought on many fronts. The psychiatrist has ceased to be merely a "doctor for the insane." With the help of his colleagues from other disciplines like genetics, biology, medicine, psychology, anthropology and sociology, he now tries to disentangle the multidimensional mental syndromes to bring about relief to the suffering millions.

STATEMENT OF THE PROBLEM

In the last decade mental disorder has been recognized as one of the most serious unsolved health problems facing our country. A perusal of epidemiological research of mental disorders in India reveals that contrary to opinions expressed by some people, it should be stated that the extent of mental morbidity in India is no less than that reported in the developed countries of the west. Considering the very large population of our country the figures for mental illness assume staggering proportions. Based on mental health surveys, it is estimated that the number of
mentally ill people needing institutional treatment in India is 1.5 million and the minor conditions requiring psychiatric treatment about 3 million. There are only around 300 qualified psychiatrists in India for treating nearly 4.5 million patients who are recognized as needing help by Western standards (Mathew, 1976:574). The scene is still incomplete! There are only 36 mental hospitals with accommodation for about 20,000 patients. For a population of over 626 million it is well nigh impossible to provide effective psychiatric services to the general public. It is also to be noted that all the psychiatric facilities in the country are located in the cities and towns, serving predominantly only 15% of the urban population. The vast rural segments of the country comprising 85% of the total population do not have any psychiatric facilities near their settlements. They have to travel long distances to approach the psychiatric centres or go without any help.

The rural folk depend primarily on traditional resources. When these fail, they approach the local healers or priests for help. Treatment by these local healers is cheap and within the economic means of the rural sick. These healers also have great empathy with the local people being one amongst the group. After having failed in all traditional or local methods of cure, only a small number of the rural patients come to the cities for psychiatric help. These folk undergo great inconveniences and expenses when
they are forced to come into the cities for psychiatric help. It is also to be noted that owing to the isolation of mental hospitals, from the general medical services, many psychiatrists who might have commenced their profession with all good intentions of helping the general population now develop a certain degree of professional isolation and uneasiness.

Psychiatric units in general hospitals have opened relatively recently and these clinics are making a steady progress in helping the public.

Maharashtra has the largest number of mentally ill in the country in its four mental hospitals with a total strength of 5,655 beds (Illustrated Weekly of India, Sept. 12, 1971:16-19).

According to the majority of physicians, the etiology of mental disorders have been broadly categorized in the following areas: Hereditary or Genetic, Somatic or Physiological and Socio-Cultural or Environmental. Of the above categories, in India, only negligible work has been done in the Socio-Cultural area. Frustrating situations that precipitate mental disorders have yet to be isolated.

With the hypothesis that our society breeds different types of mental maladies conditioned by the cultural patterns in it, an attempt has been made in this study to determine the socio-cultural dimensions of mental disorders within the Maharashtrian culture.
SIGNIFICANCE OF THE PROBLEM

In the light of the existing knowledge, the growing problem of mentally ill people, is not only practical but also timely. This problem has received very little attention in our country. Even in the present century man's attitudes and societal reactions towards mental patients continue to be most irrational.

While the physiological and genetic factors do play an important role in the development of abnormal behaviour, they are incomplete in themselves. It is necessary also to consider the socio-cultural matrix in which personality disorganization develops and expresses itself. This systematic isolation of the socio-cultural factors will constitute a valuable addition to, and afford a new method of approach in the study of mental disorders. It will also enrich the phenomenology of well-known psychiatric syndromes, assist in discovering new psychiatric syndromes, provide data to help in planning mental health services suitable to particular cultural settings and result in a deeper understanding of the causes of some of the more subtle and elusive forms of mental disorders, and thus, embody a vital research gap.

In a humble manner, vividly aware of the inadequacies a venture into this dynamic field of medical anthropology has been made. The facts recorded expose the complexity of the problem, emphasize and interpret its importance and establish for it a statistical validity.
DEFINITIONS AND CONCEPTS

Concept of Mental Health

The very conception of mental disorder or abnormal behaviour involves an understanding of its normal counterpart, mental health. Both aspects are equally significant—the former is the problem and the latter is the goal. We have no typical model of man to help us in distinguishing mental health from mental disorder. However, a few operational definitions are needed to clarify and present the position of this work.

The widely accepted definition of health as stated in the constitution of the World Health Organization, formulated in 1947 is as follows: "Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."

In 1948 the International Preparatory Commission of the International Congress on Mental Health, considering mental health more specifically, proposed a definition which states: "Mental health is a condition which permits the optimal development, physical, intellectual and emotional, of the individual, so far as this is compatible with that of other individuals. A good society is one that allows this development to its members while at the same time ensuring its own development and being tolerant towards other societies."
This definition is important in that it brings into consideration the relationship of the individual and society. In an extended description of individual mental health, Soddy, (1950:72) suggested, among other points, that the healthy mind can meet with ease all normal environmental situations and that the healthy minded person has the capacity to live harmoniously in a changing environment.

According to Fromm (1955:69), "Mental health is characterized by the ability to love and to create, by the emergence from incestuous ties to clan and soil, by a sense of identity based on one's experience of self as the subject and agent of one's powers, by the group of reality inside and outside of ourselves; that is by the development of objectivity and reason." Menninger (1946:2) says, "Let us define mental health as the adjustment of human beings to the world and to each other with a maximum of effectiveness and happiness. Not just efficiency, or just contentment, or the grace of obeying the rules of the game cheerfully. It is all these together. It is the ability to maintain an even temper, an alert intelligence, socially considerate behaviour, and a happy disposition. This, I think, is a healthy mind."

Rajkumari Amrit Kaur, a former Minister of Health of India, referred to a mentally healthy individual as one who is: "in harmony, not only with himself, but also with his environment. He is, therefore, able to work happily and efficiently by making the fullest use of his natural talents."
Apart from having his own emotions under control, he is free from prejudice and tolerant and broad-minded in his dealings with his fellow men. His judgements are objective and without bias and he is able to accept responsibilities and adjust himself to changing conditions. In consequence of such harmonious functioning in all aspects of his personality, the mentally healthy individual makes a good friend, a good worker, a good marriage partner, a good parent, a good citizen and a good leader." (Stoller, 1968:50). From these definitions it is clear that a mentally healthy person will obviously be able to come to terms with himself and with others.

Concept of Mental Disorder

"Every society, without exception, recognizes that some of its members are 'not right in the head,' and consequently are incapable of playing their part among their fellow men and women" (Carstairs, 1973:4). In common parlance certain derogatory terms like "insane," "lunatic," "mad," and "crazy" are used to characterize people with serious mental disorders. In many languages, there are also disparaging epithets given to such people, "but many cultures have also developed kinder euphemisms, such as "the innocents," or "the afflicted of Allah," or the old Scot's expression "he's no' wise," in order to denote persons whose behaviour is so peculiar that it becomes socially unacceptable" (Carstairs, 1973:4).
In some of the Western countries, "Even the institutions society has developed to care for the mentally ill are designated by pejorative terms, such as "bug house," "booby hatch," and "loony bin," and psychiatrists are called "nut-crackers" and "head shrinkers." (Hollingshed and Redlich 1958:629). All these labels connote a negative state of the human mind and behaviour and also the attitude of the so-called normals.

Mental illness is a very vast discipline, broad in its limits and more difficult to define precisely than the colours on a mountain at sunset. Mental disorder, to quote Parsons (1957:109), is "a state of impaired psychiatric functioning of the individual which is institutionally defined as not the individual's 'fault' or responsibility, which exempts him from various ordinary obligations but which is also institutionally described as an undesirable state." It "includes the whole range of disturbances of human emotion, action, judgement, and personality, whenever this disturbance is sufficiently profound to be considered abnormal" (Stafford-Clark, 1959:11). Mental disorder is primarily manifested in behaviour and the terms 'mental disorder,' 'mental illness' or 'mental disease' refer to a large number of disorders. Some of them are quite distinct from others and some merging almost imperceptibly into others in the behaviours and feelings exhibited by the patients who have difficulty in getting along with others, and who lack the ability to live a useful life.
Kluckhohn's three anchor points deserve mention so far as is known that all cultures define as ill persons those: 1. Who are permanently inaccessible to communication, 2. Whose behaviour is steadily and drastically at variance with cultural norms, and 3. Who do not have a certain age, a certain sex, in a certain social setting and with a particular cultural background.

**Concept of Culture**

In the present study, the term 'socio-cultural' refers mainly to those factors involving the life, welfare, relations of human beings in a community and the ways of living which are transmitted from one generation to another. Krober has said in his outstanding work, *Culture: A Critical Review of Concepts and Definitions*, "The most significant accomplishment of anthropology in the first half of the twentieth century, has been the extension and classification of the concept of culture" (Manners and Kaplan, 1968:15).

Culture, as the term is generally understood, includes the whole material environment man has made for himself, besides the traditions, values, attitudes and symbols that have been handed over to him through his parents as well as society at large. Malinowsky (1931) does not differentiate between society and culture, and according to him, society also is a part of the vast culture. In the opinion of Linton (1956) and Mead (1959), culture as a whole provides the
members of any society with an indispensable role in all the affairs of life. Culture is not a mysterious entity floating in the air, but a process. A good operational definition of culture is given by Frank (1956:335). According to him, "culture is the sum total of ways by which individuals pattern their behaviour into conduct and transmit it to their children." Opler (1956) too emphasizes that culture is acquired and transmitted in the form of tradition. Cultural influences are felt throughout life and, as John Myers has put it, culture is what remains of man's past, working his present to shape his future. Culture, as understood in this study, is the way of life as influenced by tradition.

Each culture has four basic assumptions which have allowed man to order events, to organize experience, and to give meaning to his life and the world around him. All human beings in a culture view and interpret objects and events in the light of these four basic assumptions, which according to Lawrence K. Frank (1950) are:

1. The nature of the universe, how it came about, how it functions, and who or what makes things happen, and why?
2. Man's place in that universe, his origin nature, and destiny - his relationship to the world.
3. Man's relationship to his group - the individuals' rights, obligations, and interests.
4. Human nature and conduct, his self-image, what he wants and should have, how he should be trained and socialized.

Culture is universal in man's experience in that all groups have one, but paradoxically, each particular culture has unique manifestations. Herskovits (1960) is of the view that, culture plays a major role in determining our lives, yet it rarely intrudes into our conscious thought because it remains at the common sensible, taken-for-granted level of experience.

The universals of culture reflect the similarities found in all cultures and include such aspects of human existence as: technological equipment to sustain life, a distribution system of materials produced, kinship arrangements, such as the family, political systems, a philosophy of life usually expressed in a religious system, language to convey ideas, art forms for aesthetic satisfaction, and a system of sanctions and goals to provide meaning to life. The socialization of individuals into their culture through a process of conscious and unconscious conditioning helps them achieve functional competence in their particular culture. Anthropologists refer to this process as enculturation. The enculturation of a person during his earlier years provides the basic mechanism for culture stability, while the same process, as it operates on more mature individuals become a major factor in inducing cultural change. By the time
most persons reach maturity, they have been sufficiently conditioned so that they function without difficulty within the limits of accepted behaviour set by their group. "Deviance and mental illness, to say nothing of creativity, can be considered to result when the individual is improperly enculturated and hence is unable to perform conformingly as a member of his culture" (Beals, et al. 1977:573). The individual's range of conscious acceptance or rejection of certain aspects of his culture expands later in life and this may induce culture change. It can be seen, then that not only is the individual conditioned by his culture, but in turn he can condition it. There exists a ceaseless interplay between tendencies toward standardization and tendencies toward variation.

According to Linton (1956:67-69), the cultural influences exerted on the individual early in life can be grouped into three categories:

1. What others in the culture do to the individual, including child care and child training practices.

2. What others in the culture consciously teach the individual, which includes all those activities referred to as instruction, e.g., manners, rituals etc.

3. The behaviour of others in the culture as observed by the individual, which includes the
emotional tone characteristic of the adult performing the culturally standardized child training.

India has a distinct culture, peculiar to herself, with a rich traditional life handed down through generations. Caste system, joint family and self-sufficient village economy have contributed to the continuation of the traditional way of life. Kuppaswamy (1961) gives the idea that the socialization process in India is concentrated around the basic concept of "Dharma". A philosophy of life with detachment from worldly materialistic pursuits, a religion mysteriously mingled with mythical ancestral worship, an absolute faith in a pantheon of gods and goddesses, an infallible faith in the law of "Karma", the great epics of Ramayana and Mahabharata providing models for specific roles in life and a passive attitude to material gains. These are perhaps some of the features still influencing the Indian way of life today.

Concept of Culture and Mental Disorder

Human behaviour, normal as well as abnormal, is conditioned by culture. Every culture lays down certain customs, mores and values which are interiorized by its normal adequate members.

Benedict (1934) emphasizes that the normal individual conforms to the group, while the abnormal deviates from the customs and mores of the group. Foley (1936) points to
deviation from the average as the criterion of abnormality. Masserman (1943) directs our attention to the fact that the abnormal individual gratifies his motives by ineffective behaviour, while Hacker (1945) stresses the disorganized personality in the mentally ill person. Mental disorder in this study applies largely to those mental disorders in which the disability is of such a degree as to interfere seriously with social adaptation, forcing the individual to seek psychiatric treatment.

Culture not only defines mental illness, but is also viewed as a potential generator of mental illness. In the opinion of Freud (1930), Gorden, et al. (1933), Mead (1959), Eaton and Weil (1956), and Spiro (1959), there are fewer stressful conditions in simpler cultures and it is unlikely that mental disorders are there in such great proportion as is found in the more complex cultures of the West. Much of the psychiatric crises in the world today is attributed to the cultural transition and the disorganization of old-established sanctions with disastrous consequences to the individual personality.

Trans-cultural studies of mental disorders by Tooth (1950), Yap (1951), Carothers (1953), Ratnakorn (1959), Spiro (1959) and others have indicated that culture not only influences the incidence of certain mental disorders in certain cultures, but also explains the low incidence or even absence of certain syndromes in others. Though the major
mental disorders like schizophrenia, manic-depressive or involutional psychoses are found in almost every culture, the content of a particular illness is provided by the prevailing culture, as indicated by the work of Seligman (1935) in Japan, of Hallowell (1936) among Hutterites, of Carothers (1953) in Kenya, of Yap (1951) in China, of Lambo (1955) in Nigeria, of Carstairs (1955) and Bhaskaran (1959) in India, of Ratanakorn (1959) in Thailand, of Stainbrook (1952) in Bahia and of Field (1950) in Ghana. Further, some mental disorders are peculiar to certain cultures. "Koro", analogous to anxiety state, is observed in China, "Latah" with specific fear symptoms in Malaya and Siam, "Amok", a sudden outburst of unrestrained violence with homicidal attacks, in Polynesia and the Sahara, "Windigo", characterized by excessive fear of being converted into a cannibalistic giant is peculiar to Cree, Ojibwa and Saulteaux Indians. Wittkower and Fried (1959) contend that these are culture-bound variants of hysteria.

According to Lemert (1951), Stainbrook (1952), Nurnberger et al. (1961) and Klef and Hamilton (1961), cultures differ in the recognition and even evaluation of symptoms—the outward signs of gross inner disturbance of personality. As Stainbrook (1952) notes, while aggressive behaviour stamps an individual as abnormal in Bahian society, hallucination is a culturally accepted behaviour. Slotkin (1955) even mentions that a man who had "revelations" or a
"call" from God in the rural areas of the Ozark mountains was venerated there, while when he proceeded to a neighbouring city, he might be placed under psychiatric care and diagnosed as paranoid schizophrenia. He thus points to the interesting difference between low-class rural and middle-class urban culture, in the recognition of symptoms as indicating mental illness. Hallowell (1936) states that there are cultures in which dissociative psychic states resembling hysteria have been qualifications of leadership or even sainthood, while in many other cultures such a phenomenon in the individual entails hospitalization.

Again, there are different degrees to which deviant or inadequate behaviour is tolerated in different societies, as pointed out by Hallowell (1936), Kubie (1959) and Field (1960). This point is well illustrated by the hypothetical case of an individual who wears no clothes in a society in which clothes are normally worn. He will almost undoubtedly be thought of by the others as mentally ill; but the same individual in a nudist group might not be so regarded by the others. There, are cultures in which homosexuality has been culturally integrated, others in which it is tolerated, and yet others in which it is vigorously suppressed. Such is also the case with senile disorders. Further, symptoms like anxiety, visions, hallucinations, delusions or hysterical seizures are meaningful only in their cultural context, and often indicate the stresses the culture imposes on the
individual. The fact that there is a correlation between the cultural values and symptoms of mental illness has been stressed by Seligman (1929), Cooper (1933), Demerath (1942), Carothers (1947), Tooth (1950), Yap (1951), Honningman (1954), and Carstairs (1955).

It has been recognized by cultural anthropologists like Mead (1959), Benedict (1934) and Linton (1956) that child-rearing practices differ from culture to culture. Bowlby (1940) emphasizes that the period of infancy, handled differently in different cultures, may be critical in producing differences in predisposition to mental illness, pointing to a basic relation between culture and incidence of mental disorders. According to Newcomb (1950), childhood experiences afford the essential link between personality and culture. After the advent of Freud, defence mechanisms like repression, first recognized by him, have been usefully employed in discussing differences between cultures as regards weaning, toilet-training and other processes during the socialization of the child. Repressions during socialization are thought to be the basic factors in influencing the child's maladjustments to new situations in later life.

The symptoms of the patients are meant to resolve his inner conflicts, through defence mechanisms. The way in which the patient uses defence mechanisms is governed by the prevailing cultural values. While Freud (1936) directed attention to the fact that in middle-class society, mental
breakdown occurred because of repression of sexual motives. Slotkin (1957) has emphasized that breakdown among Menomins occurred from repression of social competition. Possession by demons, which used to be a common form of mental illness in medieval Europe, is unheard of in the West today, but it is still prevalent in many Asian and African countries, where possession by evil spirits is even today culturally meaningful. On the other hand, delusions in the scientifico-technological culture of the West are characterized by persecution through electricity or radar, while such a content is never reflected in delusions among less scientific cultures.

Every culture has certain customs, norms and values which the conforming member learns as an adequate member. The same individual, when confronted with a new culture with different customs, values and norms, may react with a mental breakdown, if his adaptive mechanism fails. This is referred to as acculturation stress, inherent in conflicting goals and values. Malzberg (1959) and Fried (1959) have reported an increased incidence of mental disorder among migrants. Leighton (1959) contends that acculturation, when rapid and extensive, may have damaging effects on mental health and increase mental illness.

Again, no culture is homogenous. Even within the same culture there are different classes and age-sex groups, characterized by specific customs, mores and social roles.
Interesting differences in the frequency and distribution of mental illness in the sub-cultures characterized by different socio-economic levels are reported by Hollingshead and Redlich (1958) and Ruesch (1956). Religious affiliations are found to influence the incidence of mental disorders, as reported by Bichler and Litzman (1956). Also, cultures are dynamic. The mores and customs of dynamic societies change with time, and the individual is in a constant struggle to conform to the changing values. Frank (1936) says that individual maladjustments are symptoms in the disease of the larger organism—the social group.

Cultures provide not only the stress system and tension potential in the precipitation of mental disorders, but also outlets for the resolution or minimization of tensions. This partly explains why only some react with mental breakdown, though everybody is under cultural stress. Perhaps constitutional and genetic factors also determine the predisposition to mental breakdown. Even the recognition, evaluation of the symptoms and hospitalization of the individual have a functional relation to the cultural values. Man inherits only a basic repertory of responses, while most of his behaviour is learned or culturally acquired. Cultural milieu influence his interpersonal relationships. So the study of cultural influences provides insight into the failures as well as the successes in adaptation and harmonious integration of the individual's personality. Thus it is
clear that no single act should be taken out of context and no single criterion of behaviour used in judgment of mental health or mental disorder. It is the whole meaning of behaviour in the social situation over a period of time that should be considered.

AIMS OF THE STUDY

The central focus of this study is to determine the socio-cultural dimensions of mental disorder in the Maharashtrian Culture.

Specifically, the four-fold research objectives may be listed as follows:

1. To find the relationship between culture and mental health.
2. To determine the socio-cultural characteristics of the mental patients admitted into the Central Mental Hospital, Pune, India.
3. To unfold the socio-cultural, psychological and related factors fostering mental disorders in Maharashtra.
4. To suggest correlations of etiological significance directed towards the promotion of mental health.
LIMITATIONS OF THE STUDY

The scope of the study is delimited in accordance with the objectives of the research. While the genetic influence or purely physiological factors are in no way denied, the emphasis is placed on the socio-cultural factors to bring out their role in the present study. Longitudinal genetic and physiological studies before, during and after the outset of the disease combined with a study of the patients physical and cultural milieu would certainly bring much better scientific results. However, in the present study, the technical aspects of diagnosis and treatment are not emphasized.

Inasmuch as it was not always possible for the researcher to examine the total environment of the patient due to various reasons, this work has to some extent reduced some of the true content from life. However, to talk to that cured patient, to hear his voice and to see through his problem, has filled the researcher with curiosity, and compelled him to scientifically examine the complex and comprehensive interpretations and interrelations of man and his socio-cultural environment.