

Attitudes in Psychiatry at the National Institute of Mental Health and Science in Bangalore, India

Gated from the bustling Bangalore streets, fresh information technology firms, and even fresher fruit vendors, the campus of the National Institute of Mental Health and Science is at once beautifully serene and unbelievably hectic. The clinical, research, administrative, and dormitory buildings are nestled amongst colorful flowers and foliage which grow wonderfully in the temperate southern India climate. Dress shirts are short-sleeved, and I dropped both my tie and starched white coat after the first day. White coats are worn in Neurology and Neurosurgery, the other two clinical departments that exist here, but this is out of utility as exam rooms carry only plastic chairs and a wooden table. I did see a tie on my way to morning didactics, but, given its bearer's bag of samples and general aloofness to the growing throngs of patients, I suspect that he was a pharmaceutical representative.

There are twenty-six residents per year in Psychiatry here (the best in the country I am told), and the inpatient unit boasts around 500 beds. The outpatient numbers are no less staggering, and, in a word, we have to "see patients fast". A week on general adult psychiatry is structured thusly: Monday is senior resident rounds, Tuesday is outpatient specialty clinic, Wednesday is attending rounds, Thursday is electro-convulsive therapy, Friday is general outpatient for new patients, and Saturday is general outpatient for follow-up patients. Days start around 9:00 AM, coffee is around 11:30AM, afternoon lectures are around 4:00PM, and residents may be admitting emergency patients and completing clinical duties until 9:00PM. The lectures were all excellent and show the current of research and scientific rigor underlying the great clinical work of this institution. Some of my favorite topics include informed consent ethics in psychiatric populations and mental health issues surrounding assisted reproductive technologies. Equally impressive to the didactics is the interdisciplinary approach; our team of MDs is often accompanied by School of Social Work and M.Phil students who are training to be therapists. To ensure adequate training, the Psychiatry residents will rotate for the next three years through general adult, child, de-addiction, and family psychiatry, a fascinating therapeutic model where the entire family is admitted and treated as a whole.

I came to India to see how the modern psychiatry establishment here interacts with integrative, complementary, alternative, or as they sometimes say out here in the East, traditional medicine. Both sides of my family hail from Bangalore, and I credit my philosophical mother's side with my ample exposure to meditation and yoga in my youth. More than the specifics of the ancient traditions and wisdoms, I sought to comprehend the way the patients

and physicians use, misuse, reject, and embrace these teachings. With the increasing interest in America towards herbalism, Ayurveda, and homeopathy medicine, I wanted to be prepared to infuse the best and more scientific practices while effectively educating against potentially dangerous misconceptions. I quickly realized that my conception of the practice of psychiatry in India was quite limited.

Let me start by emphasizing how pharmacologically minded the practice of psychiatry is here. Residents are frequently asked the level of evidence for the first three of four pharmacological options for mental illnesses. I overheard several mechanisms of action questions, and it was assumed that incoming residents had a strong handle of side effect profiles and optimal dosing for each disease. The doctors here were being trained to be very comfortable with tricyclic antidepressants and first and second generation antipsychotics. Doctors were sensitive to pricing and wary of pharmaceutical industry influences. They were appropriately aggressive with medication, treating side effects as they arose but pushing doses to the upper ends of therapeutic ranges. The patients seemed to be less averse to medication than Americans; the stigma of mental illness was not usually further compounded by having to take medications. The overarching attitude of the patient was that the doctor has prescribed a medication that he or she believes is most appropriate for my illness, so I will take it.

What, then, was the attitude towards therapy? The Cognitive-Behavior Therapy heavily utilized for anxiety disorders, namely in Obsessive Compulsive Disorder clinic, seemed to be very structured and rigorous. Patients moved to Bangalore for 3-6 months just to get the therapy, often taking their families with them. Therapy was not oversold, but the efficacy statistics for psychotherapy, pharmacological, and combined approaches were frankly discussed with the families. Many patients had already sought meditation or some sort of mindful awareness therapy from spiritual sources. It was insisted that this therapy was completely distinct from Cognitive-Behavior Therapy and, while not detrimental to their well-being, would be unrelated to the skills and approach they would be utilizing from here on out. Thus, like the pharmacology, the psychotherapy here at the National Institute seemed very scientific and informed by western medicine. It should be noted again that individuals came from all over the country seeking this care and that advanced psychotherapists are nearly impossible to come by in India, being fewer in number than psychiatrists themselves. As for psychoanalysis, there was no mention of formal psychoanalytical therapy sessions. Furthermore, the terminology of psychodynamics, such as repression and projection, rarely made their way into patient discussions. It seems as if Freud and Jung were historical figures studied by literature and arts students rather than by therapists or psychiatrists.

If anything, my first impressions had me feeling that on the spectrum of art to science, psychiatry at the National Institute of Mental Health and Science was more evidence-based,

methodical, and systematic than my experiences in the United States. There seemed to be more room for personal cultural preferences, acupuncture and complementary therapies, and for questioning the hospital-based modern psychiatric methodology in America. Granted I was working at a very modern and scientific academic center in a modern Indian city, but this was still a stark surprise. Whatever makes the delivery of mental health care here unique, it is not “traditional” medicine.

I will leave you with one crucial difference. A difference which explains why psychiatric practice and the mentally ill patient in India are completely divergent from the practice and the patient in America. India lacks resources financially, structurally, and in terms of sheer number of mental health providers. It is still wrestling with charlatans and alternative medicine is a hodgepodge of natural cures and pseudoscience. India’s trump card, however, and this was my ultimate epiphany, is that it has the amazing resource of family. During intake interviews for inpatient care, a routine question is to ask which family member will be staying with the patient. At every single outpatient visit I attended, the patient was accompanied by a family member. Family members were expected to provide lifelong care to afflicted spouses, children, or parents; it was assumed that a family member would administer medications daily and watch closely for signs of relapse or disease progression. At first, the emphasis on family seemed excessive to my unaccustomed American mindset. Interviews would often directly and almost entirely be conducted with family members of the patients. I wondered what would happen if family members were contributing to a patient’s mental illness, but I quickly realized that by and large family did much more good than harm. Family-centered therapy was embraced given limited public resources to look after the mentally ill and given the existing value of family in society. And even though family “was all they got”, it should not be minimized; a quick Pubmed search reveals that India boasts at least equivalent cure rates for mental illness at a lower cost and with less hospital-based care. I will not speculate on the various other contributing factors, but I believe the family fabric definitely contributes to the success of mental health efforts in this and other developing countries. The family psychiatry unit, where I watched an entire family receive intense inpatient psychotherapy, was a truly unique experience. Reflecting back on inpatient psychiatry in the United States, I can hardly imagine parents and siblings taking leave of work and school to gather around one of their mentally ill members. So often it seems that many of those inpatients are estranged from their families or a strong loving network of any kind. Even in an individualistic and autonomous society like America, I am not convinced that this needs to be the case. I have always felt that these patients do no need to be fighting alone.

As I pack my bags and eat my last supper with my uncle, an industrious and selfless endocrinologist who has stopped and made ten house calls before finally breaking for dinner, I am suddenly aware that family is everything here and often is not limited by blood. Yes, my

uncle has been the family doctor for years. He has also through charity and his own earnings, a small sum by any American standards, put several of his Type 1 diabetic patients through nursing, pharmacy, and graduate school. He has employed several of them and has helped others get married. He tells me how they have been there when my grandmother got sick and how they acted as an extra set of eyes and hands in the busy ICU to insure she got appropriate clinical attention. He challenges me to find more trustworthy and devoted humans. Our driver eats with us, refusing every item and then being forced to try each dish by my uncle. My uncle calls them all, his driver, his teaching staff, his secretary, his clinic nurses... he calls them all exactly what they are: family.