Speaking for Myself

Psychiatry as I saw it

M. SARADA MENON

My first introduction to mental illness was at the lecture demonstration I attended at the Government Mental Hospital, Madras as part of my training for my MBBS degree in the Madras (now Chennai) Medical College during my final year. The Professor of Mental Diseases was presenting a number of cases, mainly inpatients in the hospital. They were all men, ill-clad, haggard, gesturing, posturing, laughing and with a tendency to be violent. No explanation could be given for their behaviour. They were restrained in the ward and controlled with indigenous methods and painful injections. Their environmental aspects, accommodation, clothing, nutrition, personal care and occupation needed attention. I was at a loss, distressed seeing for the first time an illness that had no cure. I was interested and I decided to enter into the virgin forest and pick my way through it. But I first needed to complete my course and graduate and get trained to undertake the work I desired.

Plans to do a residency in the USA were aborted and the education advisor in the UK advised that I complete my specialist training in internal medicine before venturing into psychiatry. During the next 8–10 years, I completed my internship in Irwin Hospital, New Delhi, worked in small centres to keep engaged, completed my MD General Medicine and, after joining the government service, had a short training at the Maudsley and Cane Hill Hospital in London. On return to Madras, India after this brief training experience, I was posted in the Department of Medicine of Stanley Hospital.

In 1957, I was deputed for training at the All India Institute of Mental Health (AIIMH), Bangalore (now Bengaluru). The important development in psychiatry by that time was the introduction of a new drug—chlorpromazine in 1955. It proved to be useful and continues to do so even now. The training provided a good introduction to the subject. The principles and practices of good history taking, application of new methods of treatment, for example electroconvulsive therapy (ECT), insulin coma therapy, pharmacotherapy, were all ingrained in us.

Research in the field of psychiatry in India had not developed much. Psychotherapy, psychosocial treatment, work and recreation—the importance of engagement of the patient—were not included. Planning the patient's future related to work, employment and independence were not on the agenda and there was little involvement with the family. There were hardly any thoughts on rehabilitation of patients with psychiatric illness. Treatment had not progressed beyond control of symptoms. This was also evident from the fact that patients were taken out of the register in the hospital as soon as they become manageable with alleviation of symptoms. There was minimal training in other areas of neurosciences. Later, however, electroencephalogram (EEG), radiology, neurology and neurosurgery were included in the curriculum. This meant that the importance of neurology for the specialty of psychiatry was recognized in India as early as 1958.

Psychiatric outpatient services had been established by that time and were functioning well. The AIIMH, being the premier institute in the country undertaking postgraduate training, it was presumed that what was current in the centre could apply to India. There were pockets of development in other parts of the country but this was the first centre holding out future action in an organized manner. In 1955, we had outpatient services, inpatient services, treatment as followed in the UK and other developed countries, recognition of neurology as an important component in psychiatric training, improved management with open wards and better attitude towards the mentally ill. What was lacking and needed to be promoted were psychosocial treatment and psychotherapy carrying forward the improvement in clinical status to motivation to work, pre-vocational training, vocational training, sheltered and open employment, social and financial independence, rehabilitation, involvement of families, research, stigma reduction and social integration.

After I completed my training, I was posted to the Government Mental Hospital, Madras—first as an assistant and later as superintendent. I spent the next 19 years working in that hospital. As a specialist and a superintendent, I entered the virgin forest with a few more tools, a better understanding of the illness, drugs to sedate and control symptoms and the motivation to carry out the original ambition, namely to help these innocent persons regain their original state and integrate them with the family and society.

The Government Mental Hospital with a sanctioned strength of 888 beds had on its rolls 2800 patients; provision for food and clothing were there, but accommodation was of poor standard—bare floors, poor toilets, large wards, and cells with barred doors comprised the accommodation. Clothing had to be laundered mechanically and change could be given only once or twice a week. Food was served in the wards at 7.30 a.m., 12 noon and 5 p.m. Supervision was required, else the patients may not get their quotas or refuse to eat. It was rarely practised, hence the quality of the food left much to be desired.

The totally closed atmosphere, lack of recreational facilities, very little or no communication—all set the stage for lack of improvement in their condition, or even worsening. The one saving grace was the occupational therapy centre with its technical staff, which was functioning well. It should be noted that this facility was not available even in the AIIMH where I was trained. In the UK and USA, this was very much in practice. It has been reported that weekdays were welcome but Sundays were a problem because the patients were idle and likely to be disturbed on that day. We had several crafts—spinning,

[**To cite:** Menon SM. Psychiatry as I saw it. *Natl Med J India* 2022;**35:** 364–8.]

weaving, tailoring, mat weaving, mattress making, book binding, carpentry, smithy, gardening, etc. All objects that were manufactured were used in the hospital. I presume such elaborate facilities were not available in most centres in the country then.

My first plan was to start the outpatient services. This would offer better results as the patient was in his home with family and the bed strength of the hospital would not increase. Arrangements were made by vacating a ward, reorganizing requirements and rescheduling staff duties. Outpatient services were started with case records being maintained according to the methods followed in AIIMH, Bangalore (now Bengaluru). Simultaneously, I sent proposals for the construction of an outpatient department on the land available to the hospital. I must acknowledge that the government was very cooperative and I had no administrative hurdles. Outpatient services reduced admissions, and led to fewer number of inpatients, reducing the overall burden to the hospital.

Another project that I adopted was to start a day hospital. Relatives would bring patients and request for admission stating that there was none to look after the patient. If the residence was reasonably near to the hospital, and served adequately by the public transport, I would request them to bring the patient in the morning, leave him with us and pick him up when the caregiver was returning home after work. We would attend to his treatment, food and other requirements and sedate him adequately before sending him home in the evening. One week's management obviated the need for admission as he would become manageable and could be left under the care of neighbours. This was a unique model which was quite successfully implemented in Chennai.

Training at AIIMH Bangalore was not only for medical professionals but also for psychologists and social workers. We therefore worked as a team—a doctor, psychologist and a social worker. We examined patients, studied the progress and presented them at clinical conferences; each one presenting their aspect of the case (social worker—history of the case, psychological assessment by the psychologist, and the doctor—clinical status and management). This aspect of multidisciplinary approach to care was missing in Chennai, and a decision was taken to appoint social workers.

There were no schools of social work then, nor were qualified social workers available. The Indian Red Cross Society was training persons who had completed 10th standard in general social work for 9 months. These persons were available for appointment. I did that and gave them in-house training. Their training so far had given them just an idea of what social work was and the responsibilities involved. They were given all the help required to assist us in our work with the mentally ill, namely history taking, relating with the patient and the family, reporting to the doctors and nurses as required; every interaction with the patient and family to be laced with kindness, compassion and understanding. After a few months, I discovered that they were very good, quick at the uptake and eager to work to our satisfaction. Schools of social work came up later in many colleges. Departments of social work were started with full opportunities for postgraduation. Students were referred to the mental hospital for field work. The duties of the social worker were to elicit a detailed history of the illness from the relatives (in case the relatives were absent, cull out information from the patient as and when possible, and fill in relevant facts when relatives were available), establish links between the patient and the relatives, and between patient and the psychiatrists, and continue the link throughout. The social worker became a responsible facilitator. If the address was not available on admission, that must be secured to prepare and ensure discharge. The social worker arranged to send the patient home as soon as the doctor approved discharge, and helped in follow up. The golden rule was never to keep a patient too long, as interest from the hospital staff wanes; relatives feel dissatisfied and the patient becomes a long stay patient and probably a permanent resident. Inputs from the social worker helped in preventing this 'fatigue'. I was happy to have social workers in the treating team, and could recruit 25 of them for a patient strength of 2800.

Having secured the services of social workers, I needed other supporting staff and psychologists. The latter were required for testing (intelligence, personality, cognition) and psychological treatments. Psychotherapeutic treatments such as cognitive behavioural therapy had not become popular during the 1960s and 1970s in India. We managed to get sanction for two qualified psychologists, which was later increased to five trained psychologists. However, training in clinical psychology left much to be desired.

Other supporting staff that we recruited included an occupational therapist, recreation therapist, and a physiotherapist. The occupational therapist would instruct, guide the craft supervisor and report to the psychiatrist regarding problems—suggestions for improvement, progress in the various departments, etc. The recreation therapist would organize indoor and outdoor games, select patients as suitable, train them in the games and hold tournaments. The products and results of these two activities would be exhibited at the annual sports when a special guest would be present and distribute prizes. This was usually a grand event to which the patients looked forward with great enthusiasm. The preparations and practices were exhilarating for them. The physiotherapist would attend to physiotherapy when indicated, otherwise he was in charge of regular exercises for the patients as referred by the medical officer. Since health and requirements to remain physically and mentally healthy were not included in any education programme, I thought that those who came into contact with the mentally ill should be able to understand the deviations from normality to modify their approach, reactions and behaviour towards the sick person.

I thought I should first work with the class IV staff of the hospital since they interacted closely with the patients. I called for a meeting to address them on the subject and they assembled in the large hall provided for entertainment in the hospital. They were welcomed. I was glad to see them and explained the purpose of the meeting. After listening to me, one of them said, 'We have been here for so many years; you have joined only a few months ago. Do you think you could teach us anything that we do not know?' I was quite amused by the remark, but managed to save the situation with a friendly explanation of my desire to educate them.

Similar programmes were held for nurses and paramedical staff. Persons working in general hospital, nurses, other staff from the health department (health visitors, auxiliary nurse midwives [ANMs], nurse aides) also were given orientation lectures, especially to recognize mental illness, develop the right attitude to the patients and management of mental illness, and referral as necessary.

There were very few trained psychologists in the hospital. Two had trained in AIIMH Bangalore and two were under training. Additionally psychiatry training programmes were not

there to produce qualified specialists in the field. It was necessary to start our own training and thus the DPM and later MD Psychiatry training programmes were commenced. The syllabus and other requirements were prepared by the existing staff. It was mandatory for every student to spend 3 months in general medicine and 3 months in neurology during the 2-year course. The examination pattern was as in AIIMH Bangalore, and examiners included a neurologist in the 2nd year. The training programme went off well and soon we had trained staff in the hospital. Strangely, I did not attempt to give in-house training to medical officers working in the hospital; I do not know the reason.

In 1966, the new outpatients building started functioning. It had all the requirements and facilities: patient waiting rooms, interview rooms, treatment centre, day hospital, laboratory, X-ray room, record section, class rooms, separate section for child guidance and adolescents, psychologist's room and library. Special clinics such as Child Guidance Clinic, Neuropsychiatry, Epilepsy, Neurosis and Psychogeriatrics were organized with a psychiatrist in charge of each and a teacher for the Child Guidance Clinic.

Psychiatric outpatient services in other general hospitals

The superintendent of the Institute of Mental Health (IMH) had additional duties at the Madras Medical College as Professor of Mental Diseases, and conducted outpatient services in the Government General Hospital. When I took over, outpatient services were functioning three days a week from 10 a.m. to 12 noon. A medical officer from the mental hospital was deputed for this work. Accommodation and staff numbers were satisfactory (a nurse, clerical staff, and attenders). The number of hours needed were far from sufficient. I changed the same: outpatient functioning to 6 days a week, and from 9 a.m. to 4 p.m. The superintendent would visit daily after 11 a.m. (until 1 or 2 p.m.). Students (3rd year MBBS) would be posted 3 days a week for 1–2 hours in the morning. Clinical demonstrations and brief lecture would be conducted by the superintendent.

Inpatient beds were provided—6 for males and 6 for females—but they were situated in the general wards. When we admitted a patient, who was often disturbed, the physicians objected because mentally ill patients were disturbing them and used to demand the Professor of Psychiatry take the patients to the large mental hospital which had been provided. These patients were young, working and with an acute illness of short duration. A week or 10 days of intense treatment would get them well enough to go home and continue treatment as outpatients. If they were admitted into the mental hospital, care would be gradually reduced. The family would lose track of the patient, many lose interest, and the patient, when he recovered, would receive little attention and might relapse to chronicity. There were many first episode psychosis (FEP, as we call it now) patients who were treated there, who benefited from the less stigmatizing environment of the general hospital and had a good recovery. The importance of outpatient services in psychiatry cannot be overemphasized and was firmly ingrained into my thinking and practice. This was the beginning of community psychiatry in these parts of the country.

Deinstitutionalization

Having seen the improvement in patients working in our Industrial Training Centre (ITC), I thought I could try and experiment in organizing independent living with some of the better recovered patients. I wanted to build an apartment on the land available to the hospital and accommodate 6–8 of our patients there, with sufficient resources and provisions to live independently. They would have to look after themselves, clean the place, cook their own food, attend work at the ITC, maintain accounts, etc. But before venturing into this, I wanted to do a pilot project. A cottage vacated by one of the staff was available. It was refurbished and readied for living for four patients. They soon shifted and explanations were given about what we expected from them and how they could gain by that project. Food was served in the cottage, they would come and work in the ITC, and maintain their premise. After a few days, we found them back in their old wards, where they were more comfortable. They were used to a certain routine and felt derailed when outside the boundary. That project required more work from our side and would have been a success, but I retired soon after and the plan died a natural death.

Operation Restore

The experience at the AIIMH Bangalore related to the committee of visitors to the hospital made me realize the limitations of the discharge process of patients. A cursory inspection followed by reading out the names of discharged patients, with no focus on post discharge support or follow-up were responsible for many of them wandering about, relapsing and coming back to the hospital. This was the same scenario when I was in the committee of visitors of the Institute of Mental Health after retirement. There would be no relatives to take the patient home once they were declared fit for discharge. Other ways to ensure their safety at the time of discharge was needed, and 'Operation Restore' was the outcome. This involved securing the address of the patient recorded in the case sheet, sending reply paid postcards to the relatives, the village administrative officers and the local police station. This would be done three times, informing the readiness to discharge the patient. If no relative came forth, a final intimation would inform that the hospital would resettle the person as best as possible.

Those who remained unwanted, homeless, would be placed in a separate category. Attempts were made to scour the town to locate care homes, religious residential centres, convents, care homes for the disabled, wherever opportunities arose to place them safely. When a positive response came, not more than 4–5 recovered individuals were placed in each centre.

Other non-governmental organizations (NGOs) such as Anbagam, exclusively caring for homeless mentally ill patients, were a big support. They were able to trace out the address of patients across India and reintegrate patients with the family. Similar work was done by 'Shraddha', run by a psychiatrist couple, helping particularly patients from northern India. They had social workers from every region of India, who could come and converse to the patients in their local language and identify the details and reintegrate them with their families. Mentally unwell persons were also accommodated, resettled and restored in senior citizen homes, such as Vishranthi, and two other homes with occupational therapy and vocational training in place and also in smaller centres like convents.

World Association of Psycho-social Rehabilitation

The first meeting of the World Association of Psycho-social Rehabilitation (WAPR) was held in 1986 where I participated as an invited delegate. It was a memorable event for me, where I felt for the first time that needs of the mentally ill persons were being

discussed. Dr Oliver Wilson was elected president and I was elected vice-president. Subsequently, the Indian Chapter of WAPR was started with members from the Schizophrenia Research Foundation (SCARF) and the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru. The idea was to provide various modes of rehabilitation from around the world and apply those suitable for the Indian context. This involved research, training, consumer-focused training in activities of daily living, skills training, pre-employment counselling, vocational training, financial independence, social integration, etc.

Disappointments

Many subspecialties in psychiatry were conceived and proposals were sent to the principal of Madras Medical College, which included child psychiatry, neuropsychiatry, forensic psychiatry, community psychiatry and psychosomatic medicine. Only two subspecialties were successfully established; however, those who were selected for the post were not keen on pursuing to develop the branch. No serious research or work happened in these areas for many years. Similar attitude prevented active research being pursued by the faculty.

The other major factor that impeded social inclusion and equal opportunities for the mentally ill was in the area of disability. Much work with NIMHANS was needed to convince the Ministry of Health and Social Welfare to take up mental health disability on an equal footing as other disabilities.

Schools and awareness

Attempts to create awareness about child and adolescent mental health issues in schools were met with no acceptance and there was no willingness to take it up for 25 years.

Bureaucratic indifference

Soon after SCARF was started, I went to visit a senior official in the Social Welfare Department of the Central Government to discuss about disability due to mental illness and the need for rehabilitation of those affected. After detailing to the extent possible on the subject, the officer curtly replied, 'Oh, you are talking about mental illness? That is all a grey area. We are not interested.' This response from a senior official was extremely painful and traumatizing, but I guess we have come a long way from those times due to the efforts of many over the years.

Navajeevan

In the 1960s and 1970s, while working in the IMH, I came across women in the age group of 20–25 who had been treated for mental illness and had recovered sufficiently to manage their own affairs and do whatever work was given to them. While investigating their background for discharge, I found that no family could be traced and families had written off the patient from their care. These young women would have to spend the rest of their lives in the hospital and this would have led to deterioration through relapses. A thought came up to organize a better environment and care for them.

Through some of my close friends in YWCA especially Mrs Zubeida Asgar Ali Dala, I requested the YWCA to take up 10 patients and organize accommodation and food for them. The hospital would arrange for check-up if necessary and a social worker would visit weekly to supply medicines. This was a success as the organization was proactive and provided a two-bedroom building to accommodate them and also provided employment to two of them. This has developed much today, with a two-storey building, some inmates working outside and some engaging in handicrafts, tailoring, computers and other useful work. Another similar project was conducted in Madras Seva Sadan and 10–15 women were provided a humanitarian approach to recovery. This predated the much acknowledged social support housing schemes in countries with much better infrastructure for mentally ill persons, and remains a right approach for social inclusiveness of the mentally ill.

Rehabilitation and recovery process of the mentally ill in the IMH from 1960s to 1970s

Occupational therapy has always been an important armamentarium in the rehabilitation of mental illness. It has been effectively used since the 1950s and 1960s in some of the world's leading treatment centres. The IMH too had a thriving occupational therapy centre and there were several useful crafts being taught and practised, e.g. spinning, weaving, tailoring, gardening, mattress making, mat weaving, book binding, carpentry, smithy, gardening, and minor handicrafts; these were done by men and women. Linen required for uniforms of patients, bed linens, mattresses, mats were manufactured in the occupational therapy (OT) section, apart from binding case sheets, small repair jobs, vegetable produce for the kitchen, etc. This promoted a feeling of satisfaction and there was an overall sense of achievement seeing patients engaged in work. However, a closer review of the process revealed many lacunae related to how the patients managed the strict time-schedule between breakfast, lunch and medication. There was hardly any communication between warders staff or the patients. There was no way the patient could clear doubts about a particular skill; he just observed and tried to imitate. There was no recognition of his work, no incentives by gesture, kind or cash. He would only ask for tea or cigarettes or *bidi*. There was an instance where a patient who was a capable weaver, suddenly stopped weaving while at work, and the supervisor who came much later corrected something on the machine, and he was back to weaving soon. This showed the urgent need to improve communication, and change the environment to help the patients engage with the larger society effectively once they recovered and moved out of the hospital. Group therapy sessions, social skills training, recreation therapy, indoor and outdoor games were all introduced soon after to address this, as well as better incentives for those who excelled in their skills. This considerably increased the socialization and overall well-being of the patients.

Based on this experience and having been convinced of the benefits of better communication and incentives, I started the ITC in 1971. The best patients from each OT section were selected and they were housed in a separate vacated ward, 30 of them would meet everyday at 8.30 a.m., and then carry on a regular work schedule with adequate breaks in between till 4 p.m. Their products as embroidered clothes, small crafts, wooden articles, were sold through government outlets, and the remuneration deposited in their bank accounts. This progressed to diverse products—vibhuthi covers for temples such as Tirupathi and Thiruthany, small furniture and a bakery, which supplied bread to the mental hospital and two major government hospitals in the city. This provided the hospital and patients a good income and it helped both inpatients and outpatients in their recovery process.

Attempts were made to further develop this centre. A golden opportunity to procure funds from the Boston Centre for

Psychosocial Rehabilitation through Professor John Beard was lost in the red tape of the Central Government. He had personally visited the centre and was impressed by the work done there, and had requested me to send an official letter for providing the necessary funding and support. This made me learn further the importance of regular communication with the authorities and ensuring that the work done was being informed to the concerned people regularly so as to benefit the larger community of patients and society.

They also serve who only stand and wait

After my retirement in 1978, I was requested to serve in the Red Cross, Tamil Nadu branch by the Governor who was the president. Mrs Sarojini Varadappan, a social activist and prominent figure in the state was the vice-president executive and I became the second vice-president.

One of the projects allotted to our branch was organizing static and mobile dispensaries in flood-prone rural areas in Tamil Nadu. Perungulam in Ramanathapuram, Nagapattinam and Chidambaram were selected. One of the outpatient clinics in Perungulam had patients coming in and informing that they had even been to Erwadi for treatment for mental illness and not gotten better. Curiosity made me visit that place and what I saw there was unacceptable to me. There were many tenements and in the centre was a dargah. Families came and stayed there for months with the mentally ill, praying and partaking the holy water from the place hoping for a miracle cure. There was a sense of optimism and peace in the air. After visiting the dargah I was taken to a place within the campus where 20–30 men and women were kept in chains, in abysmal conditions. There was a spokesperson who was apparently mentally normal, who stated that he was with those patients for quite some time. Many of the relatives were sending him money monthly to keep the patients there. He recognized me as Dr Sarada Menon and even told me that he has been giving these patients largactil (chlorpromazine), which I had prescribed him earlier. He was very talkative. I requested my colleagues to take me to the Collector soon after I came out of the premises. I was disheartened by the sight and wondered what the relatives expected from leaving the patients there. There were many questions which propped up in the mind: Were they receiving only magico-religious treatment? How was their welfare being ensured including food, medications and living conditions? How could the relatives trust recovered mentally ill patients to handle the unwell patients? Who was in-charge of the whole exercise?

We visited the Collector, and he was informed of the visit and the inhuman conditions and the grave risks those posed. I highlighted the danger that existed, and that even though we need not interfere with religious treatments, one has the moral, ethical and legal responsibility to ensure proper food, accommodation and care to the patients and not keep them chained. Our team was informed that nothing could be done as they were under the care of dargah personnel. No visits by the administration or investigations were allowed and the government had allowed such activities to be continued without any questions. I pleaded for some talks with the dargah administration and the government officials, but it was not considered.

Not one to back off, I arranged *India Today* to make a visit and write about the place with the help of two of my friends in the media. However, their investigative article came out as very casual and it was concluded with the wishful statement, which I paraphrase, 'and so they are all waiting for Allah to help them'. Unfortunately, it took a terrible tragedy in 2001 for authorities to open their eyes. Around 40 patients chained to their beds died in a fire accident, charred to death, and destroyed the government apathy. This prompted the government to quickly take action by banning all such centres, and to take over patients under its care.

Erwadi was a symbol of not one particular religion, but the regressive and inhuman ways by which mentally ill patients were treated in our society. That it took many years for authorities to open their eyes to the plight of the unfortunate patients, and to develop newer rules to ensure the basic human rights of the mentally ill, will remain a blotch in our collective conscience as a nation.

Conclusions

My journey into and through the virgin forest is ending though given the time and energy, there is more to do and further to go. Over the years, from 1957 to date, I have seen the life of mental illness from the vision of an alien crowd, animals in human form to better silhouettes, and clearer understanding. I have also felt the change myself, from utter helplessness to optimism and hope through the light at the end of the tunnel. The advent of pharmacological therapies led to a favourable relationship between the healer and the healed. Communication was established. The service providers were becoming more confident, but the family and society had to be handled. Family education improved cooperation. Education on the subject in every possible manner to all concerned had reduced the stigma, a major hurdle in the overall management and further plans for the mentally ill. But discrimination, rejection, neglect, social and governmental and political apathy needed serious attention.

The pharmaceuticals have a delectable buffet for the expert with a tempting choice of drugs in various forms and combinations, enough to result in confusion. Psychiatrists have their own way of finding the right therapy, aided by the doctors' skills and clinical acumen, and sometimes serendipity. The invasion of technology into the practice of medicine has not only mechanized it, but also deprived it of the art that was part of the discipline. Though many breakthroughs have been useful, the material understanding and treatment approaches in medicine have left human values and sentiments and the psychosocial emotional aspects far behind. In whatever model the expert visualizes the patient, be it biological, psychological or social, or through the bio-psycho-social model of illness, the further application of new scientific methods cannot convert a therapist into just an investigator and the patient into a laboratory specimen.

We could also look at the situation more favourably. The possibility is that the new entrants into this world, steeped in technology, not having experienced the discomfort of previous practices may never miss anything and may even do better without the powerful effects of emotions and its emissaries. The probability is that the older folks with their traditional beliefs and obstinacy may weave a thread of the same into the fabric of the future for their inheritors!