CONCEPTS OF MENTAL ILLNESS: AN ETHNOPSYCHIATRIC STUDY OF THE MENTAL HOSPITAL'S IN- AND OUT- PATIENTS IN THE KATHMANDU VALLEY[1]

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Introduction

First of all I would like to outline those prior experiences which caused me to work on the concepts of illness prevalent in psychiatric patients in Nepal.

While working in a psychiatric policlinic in Giessen, Germany, many of my Turkish and Southern European patients told me after a certain treatment period that they had consulted a traditional healer before treatment or even during it (cf. RÖDER, 1987). The healer's recommendations sometimes conflicted with the therapy I had started and in some cases caused the patient to discontinue my therapy. At first I was unable to gain any insight into these culturally-rooted illness concepts that are significant in overcoming psychic decompensations: Turkish patients were often reluctant to criticise the German therapist by confronting him with different ideas on cause and therapy or even to demonstrate their own backwardness. Uncertain resonance and unsuccessful therapeutic efforts compounded the insecurity and annoyance.

The confrontation with traditional concepts of illness entails appreciable difficulties during psychiatric and psychosomatic treatment. It always constitutes a challenge to the therapist's disease model and role perception. Lack of security when dealing with traditional illness concepts is fuelled from many sources. A descriptive consideration of psychic illness on the basis of classical psychiatric nosology (eg. the Heidelberg School) leads to a seemingly sober, distanced attitude. It reflects neither the social power

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incorporated by the doctor-patient relationship in each illness theory nor the culture-specific "cognitive patterns"[2].

Examining mental illness in traditional societies is thus limited- in this view- largely to the quantification of psychiatric phenomena and the influence of culture on the so-called "pathoplastic".

On the other hand, for the therapist who is working on the basis of a psychodynamic illness conception, problems can crop up when he/she has to deal with the magic-projective elements of traditional forms of curing, and also with the patient's very marked wish to be dependent.

I would now like to consider a few more aspects of this field of tension between traditional and scientific concepts of mental illness by outlining some ethnopsychiatric experiences made in a psychiatric clinic in the Kathmandu Valley[3]. I am presenting the first results of a study of mental illness concepts in psychiatric patients and their relatives, commenced in September and October 1989 in the Government Mental Hospital Lagnakhel/Lalitpur.

Traditional concepts of mental illness and psychiatric institutions in Nepal

Nepal's society is characterized by an extraordinary richness in ethnic, religious and linguistic variety (cf. Bista, 1987; Föhre-Haimendorf, 1987). This variety is reflected in a tolerant co-existence and co-operation between differing forms of therapeutic practice (of. Hitchcock, Jones, 1976; Hawran, 1981; Shrestha et. al., 1983; Stone, 1976). In this paper it is only possible to note briefly the traditional treatment concepts of the numerous ethnic groups in Nepal. They are influenced by "great traditions" of the ayurvedic medicine and Tibetan healing practice that tend to eclipse their own "small tradition" of local healing.

In their epidemiological study of a Brahman-Chhetri village in the Kathmandu valley Shrestha et al. (1983) described two traditional concepts of psychic illness that determine the family's and the community's perception and reaction to a large extent: *Bahulapan* (madness) and *Chopuwa* (consciousness disorder). The different attributions of causes are determined by the cultural patterns of interpreting these disorders, and they are crucial in choosing the healing approach (cf. White, 1980).

Madness baulahapan (*baulahapana*) is accompanied by bizzare behaviour, incomprehensible language and frequent outbursts of violence; as is the case in fits (*chare rog*) indicating a loss of consiousness, they are initially regarded as the consequence of being possessed- either by an attack of personal enemies and witches (*boksi*) or spirits of deceased people (*bhut*).

The traditional illness models also presuppose a physiological imbalance of the natural physical elements: lunacy is regarded as an excess of heat in the brain, caused by certain foods or types of behaviour likely to provoke illness (e.g., not adhering to the rituals). The ayurvedic treatment methods aim at restoring the balance of the "hot-cold components" of food that had been disturbed in favour of the "cold" foods; the "hot-cold components" being regarded as "elementary qualities" (cf. Hawran, 1981). They are considered effective in the long term illness, less so in acutely occurring disturbances in behaviour and severe physical diseases. In these cases as well, the ayurvedic treatment rules (diet and natural remedies) are also observed, but are often supplemented by medication of the western type.

In their study, Shrestha et. al. 1983 underline the different affinity to the various medical institutions: If they think madness *(Bahulapan)* is the problem, then not only the local ritual healers are consulted but in many cases also medical assistance is sought-provided such is available. If the patient is suffering from fits or unconsciousness *(Chopuwa)*, the treatment is often left entirely up to the ritual healer, irrespective of his success. People behaving in a "crazy" manner were diagnosed as being "schizophrenic" or "manic depressive" by Shrestha and his team. In comparison with these two groups it was observed that villages who had been diagnosed as having "depression" had been treated by a traditional healer in only an extremely few cases. The bundle of symptoms that were often mentioned, like appetite disorders, sleeplessness and apathy, indicated a high level of somatisation. Most of the people concerned were women whose husbands worked elsewhere, women who had been left or whose marital relations, relations to parents-in-law or neighbours were tense.

In the following section I am going to describe the institutional framework in which psychiatric treatment as per western concepts in carried out in Nepal. In view of the great range of medical-political problems (the infant mortality rate in 1986 was 130 per thousand; the average life expectancy is 47 years) and a catastrophic lack of medical care (in 1988 a doctor has to look after an average of 20,100 people), any psychiatric care within the national health service is accorded only secondary importance in Nepal.

The Government Mental Hospital Lagankhel/Lalitpur, opened in 1984, is thus far the only psychiatric clinic in Nepal. In addition there are three smaller psychiatric departments in general hospitals and the university clinic, and a few psychiatric out-patient units outside Kathmandu. About a hundred people who tend to have chronified psychoses are housed in Dhulikhel, an asylum strongly resembling a prison (cf. Shrestha, 1988).

It is only possible to be admitted for in-patient treatment in the Mental Hospital on condition that at least one relative looks after the patient all the

time during his/her stay in hospital. This family-oriented approach grew out of financial necessity, but it is useful in preventing the isolation that threatens the patient because of institutional mechanisms, and it affords the clinic a more communicative climate.

The patients tend to stay for only a short time: a few days to a few weeks. Many patients are suffering from schizophrenia and manic-depressive illnesses, also the post-epileptic twilight. Drug Addicts are hardly treated at all, although the number of drug abusers has increased appreciably in the past few years. Drug addiction is seen at the moment as one of the greatest social-psychiatric problems in the Kathmandu valley (cf. Bhandari, Sharma, 1988).

Basic questions of professional identity are touched upon in connection with the discussion about a further extension of psychiatric care in the "National Mental Health Planning" and a possible integration of traditional healing methods (cf. Blustain, 1976; Miller, 1979; Shrestha, R.M., 1980; Stone, 1976). These concern the problematic of transferring illness models that developed outside one's traditional culture.

Follow-up examinations of patients treated for psychiatric problems (Shrestha, N.M., 1987) revealed that many of them did not follow treatment through to the end. In view of these communication disturbances in the doctor-patient relationship, the study of illness concepts in patients and their relatives gains special significance.

Questions and results

The questions asked in the study and the results thus far are now to be presented:

- How does a psychiatric patient's "career" develop in Nepal?
- Which conditions contribute to a decompensation of the family and induce someone to seek help in a psychiatric institution in the traditional Nepalese society?
- Which illness concepts structure the perception of mental disease?
- What is the family members' attitude towards their mentally ill relative?

These questions are going to be discussed on the basis of the interview's results and exemplary case histories.

A semi-structured interview was used to collect the most important social and anamnestic data. In a second step, characterised like a "narrative interview", the relatives were asked questions about their experiences when dealing with the patients and traditional and western medical institutions.

A total of 110 interviews were performed with relatives of out-patients (80) and in-patients (30) of the clinic. 16 in patients attended without any relative. The interviews were carried out in rooms at the clinic and were assisted by an

experienced psychiatric nurse and frequently by an interpreter *(2)* who did not belong to the clinic. Both interpreters were *Newar*: for this reason the interviews were performed in *Newari* for the *Newar* patients; in all other cases the language was Nepali.

Social, demographic and anamnestic data

Unlike the male/female distribution in western psychiatric hospitals, there was a preponderance of men among both the outpatients (45 men, 35 women) and the in-patients (17 men, 13 women). Most of the patients in both groups were in the age range of 21-30 years: the mean age of the out-patients being slightly higher at 32.1 years, the in-patients at 29.03 years.

Table 1: Age of the Patient

	Out-Patients		In–Patients	
Age	Number	Percentage	Number	Percentage
<15 :	8	10 %	0	0 %
15-20 :	12	15 %	6	20 %
21-30 :	21	26.25 %	14	46.7 %
31-40 :	15	18.75 %	5	16.7 %
41-50 :	15	18.75 %	4	13.3 %
51-60 :	5	6.25 %	1	3.3 %
>60 :	4	5 %	0	0 %
Mean-Age:	32.1		29.03	

Most of the patients were Newar, Chetri and Bahum, with only a very few members of other ethnic groups.

Table 2: Ethnic Group/Caste

	Out-Patients	In-Patients
Newar :	31	5
Chetri :	24	12
Bahum :	1	8
Tamang :	1	3
Gurung :	1	0
Magar :	1	1
Vaishya (from India) :	1	1

As expected, most of the patients lived in settlements in the Kathmandu valley. About half of the interviewed in-patients came from districts that were often quite far away.

Table 3: Locality of the Patient

Region	District	In-Patients	District	Out-Patients
Central Nepal	Kathmandu	5	Kathmandu	41
	Lalitpur	4	Lalitpur	10
	Bhaktapur	3	Bhaktapur	3
	Nuwakot	1	Nuwakot	2
	Dhading	1	Dhading	2
	Kabhre Palanchok	3	Kabhre Palancok	6
	Makwanpur	1		
	Citawan	1	Citawan	2
	Sarlahi	1	Mahottari	2
	Bara	1		
	Dhanusa	2		
Eastern Nepal	Jhapa	2	Okhaldhunga	2
			Sankhuwasabha	1
			Sunsari	1
Western Nepal	Gorkha	1	Gorkha	1
	Kaski	1	Lamjung	1
			Kaski	1
			Baglung	1
			Tanahu	1
			Syanja	1
			Palpa	1
Mid Western Nepal	Salyan	1	Dang Deukhuri	1
	Rolpa	1		
India	Bihar (State)	1		

Most of the patients were married, but among the out-patients there was a relatively high proportion of single people:

Table 4: Marital Status of the Patient

	Out-Patients	In-Patients
- Single:	30	9
- Married:	47	21
- Widow:	0	0
- Divorced:	0	0
- Left by husband:	0	1

In random tests it was established that patients without any schooling are under-represented (rate of illiteracy in Nepal in 1985: ca. 75%); on the other hand patients with high-school or university degrees are clearly over-represented (cf. total area of Nepal: High-School degree: 1.2%, college and university degree 0.4%).

Table 5: Educational Status of the Patient

	Out-Patients	In-Patients
- Illiterate	25	13
- Primary Education	22	3
- Secondary Education	13	8
- High School	6	2
- Above High School	14	4

Most of the patients are farmers, but considering the proportion in the whole Nepalese population employed in farming (1981: 91.4%), they are markedly under-represented. Students and employees are over-represented in our sample.

Table 6: Occupational Status
(Multiple answers possible)

	Out-Patients	In-Patients
- Agriculture	40	24
- Business	11	4
- Student	13	1
- Scholar	4	0
- Labourer	5	4
- Service	21	0
- Housewife	3	0
- Others	2	0

On whose advice or recommendation did the patients or their families refer to the hospital?

The decision to seek help in a clinic was mostly prompted by family discussions; in fewer cases health workers or a previously consulted healer made the suggestion. In case of the acutely occurring and often difficult symptoms found in in-patients, the decision was also discussed with neighbours (cf. table 7):

Table 7: Source of Referral

	Out-Patients	In-Patients
- Family Members	26	13
- Relatives	5	4
- Health Personnel	18	4
- Neighbours	12	13
- Friends	7	0
- Traditional Healers	2	1
- Others	9	0
- Self	4	0

What occasioned the families to seek psychiatric help?

In most cases, the first signs of mental disorders were changes in their relative's behaviour which meant that he/she no longer observed his/her duties towards the family: "she only did what she wanted without taking any notice of anyone"; "she cooked meals with only her own ideas in mind and didn't pay attention to the eating rules, didn't look after the family" or: "he didn't do what his father told him any more". This strange behaviour was often agressive and often observed in connection with alcohol or cannabis abuse. The change of behaviour was attributed to "withdrawal from the family" and "lack of comprehension": "she did nothing but play with her hands and hair" and "he just went on laughing".

At first the family thought it best to "wait and see". Later, however, if the sick relative started to question religious rules and social or political taboos, the attitude towards the patient changed: "she kept calling out sexual words at the top of her voice and wanted to be naked". A Brahman described the first time he noticed odd behaviour in his son: "He wanted to eat everything."

The relatives were also alarmed by serious and lasting disorders in eating and sleeping:

Table 8: First Symptoms of the Mental Illness Noticed by the Family Members or Others

	Out-Patients	In-Patients
- Altered Behaviour	47	27
- Eating Disorder	23	15
- Sleeping Disorder	37	23
- Aggression/Violence	15	14
- Anxiety	9	8
- Loss of Drive	28	10
- Excess of Drive	5	1
- Fits	16	2
- Abnormal Talk	17	19
- Did not speak at all	5	3
- Not taking physical care	4	1
- Suspicious	3	2
- Use of hashish	2	1
- Fever	2	1
- Depressive Feelings	4	0
- Confusion	8	0
Physical Complaints	1	0
- Pat. herself/himself came to the opinion to be ill	1	0

Although the first indications of illness were noticed by other people in the family due to behavioral changes the patients themselves complained in the main about physical ailments that were socially more acceptable: The language of mental suffering has recourse to that of bodily disease. Perception by the family and perception by the patient differ greatly. 20% of the out-patients and 33% of the in-patients had never complained of disorders or never tried to communicate anything of this kind:

Table 9: Complaints Mentioned by the Patients

	Out-Patients	In-Patients
- Headache	42	11
- Other Pains	23	12
- Loss of Drive	20	3
- Loss of Appetite	18	5
- Anxiety	15	2
- Sleeplessness	14	0
- Moodiness	12	3
- Irritation	10	0
- Menstruation irregularity	3	1

- Epistaxis	3	1
- Constipation	2	0
- Loss of memory	2	0
- Fever	2	0
- Diarrhea	1	3
- Skin disease	1	0
- Blindness	1	0
- Pulsation in the heart/ Swelling of testes	1	0
- Paralysis	0	1

The Patient Complained of any Symptoms

- Often	28	9
- Hardly	36	11
- Never	16	10

How do the other people in the family react to the onset and continuation of the illness?

The onset of the patient's illness was, in half of the cases, described as a "sudden beginning" (out-patients: 40, in-patients: 14); some quoted a "creeping beginning" (out-patients 37, in-patients 16). As the illness often lasted a long time (mean duration in out-patients 5.48 years, in-patients 3.08 years), the relatives were often able to distinguish between different courses of illness:

Table 10: Course of Illness

	Out-Patients	In-Patients
- Rapidly progressive	10	5
- Gradually progressive	37	9
- Several Phases/Episodes	20	16
- Stationary	13	0
- Improving	14	0
- Number of Phases:		
1	0	0
2	4	9
3	6	5
4	2	1
>4	8	1

Table 11: Duration of Illness

	Out-Patients	In-Patients
- <1 Week	0	0
- 1 week - 1 month	1	4
- 1 month - 6 months	7	7
- 6 months - 1 year	10	3
- 1 year - 2 years	20	5
- >2 years	42	11
Mean Duration of Illness (years):	5.48	3.08

What were the reasons that caused the patient to come to the clinic *now*? (or in the case of out-patients without anyone to accompany them: why did you decide to come now?)

It transpired that the communication difficulties that the patient had experienced within the family, accompanied by the incomprehensible, in some cases aggressive or auto-aggressive behaviour, was the prime motive for the family to seek in-patient psychiatric help.

50 of the 80 out-patients were there for follow-up examinations. A large sub-group of out-patients suffered epileptic fits (ca. 20%) that were treated with anti-convulsants:

Table 12: Reasons Bringing the Patient/Coming himself/herself
(Multiple answers possible)

	Out-Patients (n = 80)	In-Patients (n = 30)
- Follow up	50	0
- Abnormal Behaviour	37	25
- Sleeping Disorder	18	11
- Fits	15	2
- Loss of Drive	12	4
- Dangerous to Others	10	9
- Eating Disorder	6	8
- Depressive Feelings	6	0
- Irritation	7	0
- Suspicious	6	8
- Anxiety	5	1
- Pains	4	0
- Dangerous to Self	3	6
- Drug Addiction	2	0
- Alcoholism	2	1
- Loss of Concentration	2	0
- Retardation	1	0
- Nobody to look after	0	1

The family's concepts of illness

The second part of the study focussed on investigating the illness theories prevalent in the families. Which conceptions of illness did the families apply when reacting to the illness of the patient and trying to cope with it?

When asked if there was a situation that triggered the illness, most of the relatives answered in the affirmative:

Table 13: Precipitating Factors for the Onset of Mental Illness

	Out-Patients (n = 80)	In-Patients (n = 30)
- Present	56	20
- Absent	8	5
- Not known	16	5

The most common precipitating factor quoted was that there were family conflicts (in each group 10). Marital conflicts, trouble with the parents or parents in law, separation or death of close relatives, neglect, childlessness or miscarriage were mentioned.

Other possible precipitating factors were quoted as financial difficulties (8 of the out-patients) or failure at school or university (out-patients: 5, in-patients: 3). Apart from alcoholism (5) and drug addiction (4), the onset of mental illness is seen in connection with preceding physical illness, brain damage, pregnancy, operations or pharmaco-therapeutic treatment. In isolated cases the relatives (and the out-patients) also quoted work-related stress, loneliness and disorders in bodily development as triggering off mental illness. Considerations about temporal and causal connections before the first signs of illness usually became evident when related to specific points in the development and life-situations of each patient. For example: a very conscientious and reliable Brahman was arrested in a matter that the local community considered quite unjustified. His relatives viewed this arrest as the precipitating factor in his deep depression that was accompanied by a torturous guilt complex. The relatives of an elderly woman thought that the conflict in which she was involved with her daughter-in-law and with neighbours, compounded by her unsuccessful efforts to put a magic spell on her opponents, had triggered off her mental illness.

The importance of culture-specific psychosocial strains was emphasised by the relatives themselves when trying to come to terms with the illness (the interview was carried out with the patient's son). This level of importance can be demonstrated with the following vignette: "The interethnical marriage."

A 51 year-old Chetri woman had suffered chronified depression since her 48th year. She lacked energy and let herself go, withdrew more and more. In the end she only conversed with herself and the gods.

Her husband had left her for a younger woman. Therefore her oldest son didn't feel bound by the marriage rules and married someone from a different ethnic group, a Newar girl. The daughter also left the family. When the joint family breaks up the patient is stigmatised an forfeits every kind of social security.

Most patients do, of course, first seek help from traditional healers. 17 of the out-patients and 6 of the in-patients had also consulted a general practitioner, 24 of the out-patients and 9 of the in-patients had also been treated in a general hospital. About a third of both patient groups had previously had in-patient psychiatric treatment. Another third of the out-patients had been given out-patient treatment for psychiatric illnesses on previous occasions (mostly patients suffering from fits of one kind or another).

Table 14: Previous Treatment Sought

	Out-Patients (n = 80)	In-Patients (n = 30)
- Treatment not taken before	4	2
- Medical Treatment (Physician)	17	6
- Health Post	2	3
- Psychiatrist	6	0
- General Hospital	24	9
- (out-Patients)	24	4
- Mental Hospital In-Patients	29	7
- Ayurvedic Medicine	5	4
- Traditional Faith Healers	63	18

What was the attitude of the relatives to the sick person? How does a family try to explain the illness?

The answers of most relatives are orientated to two categories. Just like the assessment of possible precipitating factors, the categories are specifically formed according to the individual situation of each patient.

30% of the relatives of out-patients and 20% of the in-patients' relatives thought that "being possessed" was the cause. This illness model was individually elaborated by the families and was also in some cases used to solve social problem:

"We had some trouble with the neighbours about a rice field; they're jealous of us and that's why they've put a spell on him-the patient. After he had been to the healer he got better'. or: "She (the patient) is under a magic spell put on by her boyfriend's family as her parents don't like him."

It is not regarded as contradictory to think that the patient is possessed or under a magic spell and nevertheless to consult a medical-psychiatric institution: "He's possessed but the healer can't help him so he's got to be treated with medicine."

On the other hand, another large group (a quarter of families of out-patients and half the families of in-patients) concluded that something physical was wrong ("from inside", something wrong in the body"). These physical factors were only partly specified (e.g., "puss in his ear", "swelling of tester," "high blood pressure", "hare-lip", "he'd just given blood")

A further appreciable cause of excitation and confusion among patients was rooted in the occurrence of "fever", though no difference was made between psychological or physiological parts (each about 10%). In addition, and in connection with these concepts, psychosocial conflicts in the families and in the patient's environment, financial worries, heredity (e.g., "the father's venereal disease"), stress at work and bad influences (especially alcohol and drug addiction) and incorrect prior treatment were regarded as possible causes (cf. tab. 15):

Table 15: Conceptions of Mental Illness Expressed by Family Members
(Multiple answers possible)

	Out-Patients (n = 80)	In-Patients (n = 30)
- Possession	26	6
- "Something wrong in the body"	20	10
- Fever	7	3
- Family conflicts	5	8
- Separation of the family	4	3
- Mother-in-law- Daughter-in-law-conflict	3	0
- Financial problems	8	2
- Stress (at school or university)	9	4
- Epilepsy	6	2
- Heredity	6	2
- Bad Influence (alcoholism, drug abuse)	3	1
- Head injury	4	1
- Infertility	1	3

- Conflicts with neighbours (Jealousy)	1	4
- Conflicts with colleagues	1	0
- "Saw dead body's face"	3	0
- Nightfall	2	0
- Over-protection	2	0
- Alcoholism (drinking habits)	3	0
- False medical treatment	3	0
- False treatment by faith healers	1	0
- Death of family member	2	0
- Lonesomeness	1	1
- Musing	0	1
- Climate	1	0
- Malnutrition	0	1
- No idea	3	3
- Different conceptions in one family	18	1

The interviews provided the relatives with sufficient time to talk about the illness among themselves. This revealed a very varied assimilation of differing conceptions and a clear tendency to individualise the suffering. For example, the assumption that the patient was possessed, or the signs of physical disorders did not prevent them from emphasising the significance of conflicting circumstances in the family and social environment. This approach result in more pragmatic attitudes when choosing the therapeutic institution: It must be accessible, the treatment must be within their means (medication is beyond the means of many families, in contrast to the cheaper forms of traditional healing treatment. The latter is often paid for in kind). Consulting a traditional healer, resorting to traditional treatment models and coping strategies in the sense of a re-acculturating - and simultaneous consultation of a medical-psychiatric institution are not mutually exclusive. On the contrary, the simultaneous or consecutive recourse to different healing types is logically rooted in the complementary character of these therapeutic institutions an example: "The golden water".

Sushil, an 18 year old Chetri comes along with his father. He is said to be a quiet boy. His behaviour has, however, changed completely in the past six weeks. He is unsettled, walks around, leaves his parent's home and goes to India. A few days later he is brought back by his friend after a suicide attempt. Sushil is suspicious, no longer sleeps for fear that something could happen to him. He tells his father that even he cannot avert the danger. In the end he hardly eats anything for fear of being poisoned. Although he did not use to be religious, he now resorts to traditional forms of overcoming fear: He makes sacrifices to the gods very regularly, tried to cleanse himself with

the "golden water" that he pours over three points in strict sequence. In the clinic he is diagnosed as having "Hebephrenia". Sushil's father continues to believe that his son is possessed and attributes his son's changing behaviour to the effect of poison. He has sought help from three traditional healers who all endorse his opinion. Nevertheless, he takes Sushil to hospital as he expects medication to have an immediate effect. He observes his son calming down after administration of medication. Then he concludes that the medication has neutralised the poison. For him, the efficacy of medication proves that his son is possessed. He claims that he will take Sushil to a healer again when he is calmer and less suspicious, as only a healer is able to get to the bottom of the illness and cure it.

The experience made with the various medical institutions contribute to a modification of the patterns of explanation they had originally assumed. For example a man married to a Newar woman explains his wife's illness (she and her children all suffer from epileptic fits) by saying that someone had put a magic spell on her as a child when she had been at the neighbours'. She had sought help from a traditional healer over a period of nine years, but no improvement was forthcoming; in fact she had several fits during this time. Her husband maintained that after the initial attempt had been fruitless and the spell had still not been removed, the illness had penetrated into her brain and done physical damage. As a result of this physical change, his wife's behaviour had also altered at times (after the fits she had been in a post-epileptic twilight for many days which had troubled the family considerably). As the illness had changed its course, he believed that only medicine could now help (one year after anti-epileptic treatment the patient had had no more fits).

Another man whose 46 year-old wife had suffered frequent depression was at a complete loss as to what to do, torn between different explanation patterns: He attributed her shaking movements to magic, she was possessed by an evil spirit (ched). After his wife had withdrawn entirely, refused food and expressed feelings of guilt and a wish to die, he paid more attention to the neighbours' opinion that it must be an illness coming from the inside. Even the traditional healers recommended him to seek hospital advice as the illness was chronic. He had often been advised to leave his wife as they had had no son. Now he had to face great financial difficulties. It seemed that his waivering between the two illness models also showed his ambivalence towards his wife and the tension between his individual wishes and social and economic pressure (e.g., to have sons).

A change in the illness concept during the course of chronic diseases was often observed in the interviews with relatives. Added to this, there was often a generation gap reflected by different opinions within the family-especially

among the out-patients. The in-patients' families' opinions only diverged once. This may be explained by the fact that the seriousness and acuteness of the in-patients' complaints entail much greater inter-family pressure to find one explanation to satisfy them all.

As may be expected, young people with academic degrees tended to account for mental illnesses by considering medical or psychological explanations to a greater extent than their parents or grandparents, who referred to traditional concepts. The frequently differing affinity to the numerous facets of illness concepts within one family can thus be interpreted as an indicator of social change.

One Brahman family constituted an exception to the more homogenous concepts held by relatives of in-patients; in this family the generation gap was illustrated in the different illness concepts. I would like to summarise this case with the motto "Larita's unanswered-rebellious message".

Larita is a pretty 19 year old who grew up in a Bahun family. On the occasion of a memorial service for her grandfather, who had died 6 months earlier, she fainted and had to be taken to the hospital by her brother. Once having regained consciousness, she demanded respect from her family as befitted a goddess; then everything would change for the better. She refused all food and didn't sleep. She rejected the advice of the traditional healer who had said she was possessed and she ran away. Acute psychosis was diagnosed in the clinic, and Larita was given neuroeleptic medication, tranquilizers, antiepileptia and finally electric shocks. When I got to know her she was very "clingy" and seemed in a way "broken". What had precipitated this crisis?

It came out that Larita had had a strong desire to be autonomous in puberty and that this had conflicted with her parents' views. Her casual behaviour did not find the approval of her family with their strict moral ideas. At the age of 14 she contracted bronchial asthma. Tensions grew after she had fallen in love with one of her cousins whom she could not marry on account of the marriage regulations. She failed some tests at schools and eventually left her parents and went to live with relatives. Her brothers and sisters regarded her resistance as the main reason for her illness, her parents were however adamant that it was because she was possessed that she was so troublesome and restless.

My encounter with the patient I called "Larita" made me think of the "unanswered-rebelliousness", described by Israel (1983) in the message of hysteria, and of the connection between individual "hysterical" suffering and social power. "Larita's unanswered-rebellious message" portrays the message of the "resisting subject" in this view (cf. Erdheim, 1982). The subject gets into a hopeless crisis within the framework of normative rules and on the

ground of individual psychodynamics and sociodynamics of the family environment. The crisis is then given the label of"acute psychosis with hysterical traits" with the terminology of psychiatry on a descriptive phenomoenological level.

As the illness often persisted over a period of years, the family's attitude to the different types of treatment is of special interest. The traditional healer's failure to cure the illness was in some cases explained by his not being in a position to remove the acute excitation.

When asked what else should be done for the patients, the relatives of 77 out-patients and 21 in-patients were in favour of psychiatric treatment or administration of medication being continued. Traditional healers were advocated by families of 9 out-patients and 3 in-patients. Families of 7 out-patients and 3 in-patients maintained that work would help to cure the illness; four families (out-patients) believed that marriage would help. In individual cases, it was suggested that family conflicts should be settled, addictions should be given up, an operation, family worries or change of environment might be significant prognostically speaking.

77 of 80 out-patient families and 28 of 30 in-patient families were prepared to continue their support of the sick relative. Three out-patients had no family support whatsoever in the Kathmandu valley. One in-patient was looked after by a neighbour, one family had decided that if in-patient treatment brought about no improvement they would no longer accept the sick person in their family but would put him in prison.

When asked about the efficacy of psychiatric treatment, most of the families responded by mentioning the calming effect of medication (26 out-patients, 12 in-patients), soporific and behaviour-controlling functions of the medication (27/9) and changes within the body (6/2) caused by medication. In some cases, they mentioned effects like improvement of appetite, boosting spirits, giving more drive and anti-epileptic effects. Only 3 out-patient families and 2 in-patient families thought that medication was useless. 12/10 families had no idea if the treatment was effective or not.

As is revealed by the complaints mentioned above, the psychopathology of the treated patients was grave. Most of the in-patients were suffering from schizophrenia or manic-depressive psychoses. Tab. 16 gives an impression of the psychiatric diagnoses made in the clinic.

Table 16: Psychiatric Diagnoses (Partly Overlapping of Diagnostic Categories)

	Out-Patients (n = 80)	In-Patients (n = 30)
- Neurosis	14	0
- Psychotic Episode	5	3
- Schizophrenia	20	12
- Schizo-affectice Psychosis	1	0
- Manic-depressive Psychosis	20	13
- Depression (unipolar)	13	3
- Mania (unipolar)	3	6
- Alcoholism	4	1
- Drug Abuse	2	0
- Organic Psychosis	2	1
- Epilepsy	12	1
- Intellectual Retardation	3	0
- Diagnosis not clear	1	0

Discussion

An attempt was made to investigate models developed by families of psychiatric patients to explain mental illness. To this end, interviews were conducted with these relatives of patients in a clinic in the Kathmandu valley. A total of 110 interviews were made (80 out-patients, 30 in-patients). Nearly all the patients had been treated for a long time by a traditional healer (*jhākri* or tantric healer or by means of ayurvedic methods) before beginning out-patient psychiatric treatment. In most cases, the relatives had only tried contacting medical-psychiatric institutions when the families' own compensatory mechanisms to overcome the illness had been exhausted, they had no longer been able to withstand the strain and confrontation with the patients' fears, and after diverse healing attempts had failed.

The patients were only admitted for in-patient treatment if they showed serious dissociative conditions. The psychic background of somatic complaints, especially in the case of depression, had often been overlooked - even over a period of years - by the general practitioners consulted thus far.

The therapeutic offer of the psychiatric clinic was identified as a part of "western hospital medicine" by the families, "something which wants to precipitate changes in our bodies", as one relative stated. Essential fields of application were acute excitation and fear and serious physical or vegetative symptoms (e.g., disorders in sleeping and eating).

The relatives' definition of mental illness emphasised the sudden; seemingly inexplicable negative changes in habit and behaviour shown by the patient. These changes were often associated with withdrawal from duties and responsibilities. Thus they made a gradual differentiation between being confused (dimak bigreko) and being mad (baulaha).

On account of the selective combination of the interviewed families taken from the whole clientele of the clinic, it is not possible to generalise. Evaluating the results only allows us to establish trends. The present study confirms to a large extent what was stated in a comparative study (cf. Skultans, 1988) between patients of the psychiatric clinic and those who had consulted a healer in the Kathmandu valley who had specialised in mental illness:

1) The sex distribution showed a clear preponderance of men. In my opinion, this can be explained by the fact that in patriarchally organised families men have easier access to treatment possiblities considered good or necessary.
2) Both in and out-patients had relatives who were strongly involved. Skultans assertion that patients in psychiatric care were not given much support and help by their families was based on the small number of persons accompanying them. His opinion cannot be endorsed by us.
3) Resorting to traditional patterns of explanation (possession) makes it possible for the family to assume collective responsibility for the illness, to stabilise the inter-family relations and to relieve the individual.

The traditional concepts were often used more like an outline that was often individually filled in and adjusted to the conditions of each psychosocial environment. Thus multi-facetted connections were the result whose accents might be placed on projective-relieving explanations, or the explanations emphasising the conflicting aspects of the patient or the imbalance of physical factors.

The variety and wealth of nuances found in interpretation patterns reminds one of the "oscillation between different interpretation patterns" described by Pfleiderer (1982) as characteristic for societies in transition. Even if the younger relatives with a good education tended to see the illness as a consequence of a physical defect or psychosocial conflicts (the variable "education" and "locality in cities of the Kathmandu valley"), this by no means ruled out the application of a traditional understanding of illness or prevented them from emphasising the significance of treatment as practised by traditional healers.

Overcoming mental illness and the fear and worry it causes in the family is managed in the main with the help of the traditional "sense-giving" healing

methods. Traditional illness concepts guarantee rather the continuity of co-existence in the community: they make mechanisms to overcome illness available - like healing rituals. Fear-precipitating Id-impulses, feelings of shame and guilt are taken up by the group in which the suffering individual remains integrated.

The limits to this integration are, however, found where the deviating behaviour is regarded as anti-social, defined as doubting the essential institutions and taboos. This is then given a negative response - in some cases by excluding the individual from the group. The integration performance of traditional healing instances often described in anthropological and ethnopsychiatrical literature (cf. Hitchcock, Jones, 1976; Oppitz, 1982; Waxler, 1977) proved to be limited, especially in the case of illnesses that provoked behavioural alterations.

Some of the families resident in the Kathmandu valley found the explanations and measures offered by traditional healers inadequate (e.g., after years of treatment to cure fits that never had any success). In these cases, the traditional therapeutic potential was obviously limited, but another reason for the families to turn their backs on traditional methods might be that the healers in the Kathmandu valley changed their style of treatment. Skultans (1988) has already described this increasingly limited and mechanical approach to the patient. It was said that the city healers did not have the specific social and psychological background knowledge that the rural healers had at their fingertips. The therapeutic practice of a city healer was said to resemble that of a medical and psychiatric institution, as far as speed and impersonal ambience were concerned.

The individual concepts held by the families were hardly considered at all in the psychiatrical clinic's therapeutic approach. The clinics treated by administering psychopharmaca and - in case of serious stupor- an electro-convulsive therapy was applied as a supplement.

If we pick up Skultans observations, i.e., that a tendency is developing for traditional culture's repertoire to be modified towards a more mechanistic healing practice, and if we reconsider the de-communicating model of descriptive psychiatry, then this might give an explanation for these comparable developments: a change in the defence constellation of the social institution "healing instance". Mentzos (1988) showed that institutions are predestined to take over psychosocial defence tasks as well: institutions serve neurotic psychosocial defence. By means of "institutionally rooted patterns of behaviour and relationships" (Mentzos, 1988:) regressive drive needs are satisfied and defence behaviour is secured against unreal, phantasised, not unfounded fears, depressions, feelings of shame and guilt.

It can be assumed that the noticeable social and cultural changes prevailing in Nepal's transitional society go together with changes or the decline of institutionalised defence systems (e.g., in religion or in the strictly patriarchially structured families). Within this process a uniforming of therapeutic practice is noticeable. As a result of these developments, the fear potential is heightened, and this is encountered on an individual and family level in some cases by resorting to "proven" mechanisms to defend and overcome.

To improve communication ability - to the interior as well as to the exterior - presents itself as an essential therapeutic challenge. To overcome it is, in my opinion, bound to "translation work" that respects the culturally rooted pattern of interpretation. In this process the therapist's sensitivity towards the individual modifications in culturally prescribed explanations of meaning is heightened.

Notes

1. This is an extended version of a lecture held at the "International Symposium on Cultural Psychiatry", August 26-28, 1991.
2. HELLER (1977:47) defines the "culture-specific cognitive schemes" that encompass the causality relationship between systems and their causes, between exterior and interior according to the patterns of explanation rooted in language and culture: "these schemes are formed in such a way that the sensual experience keeps confirming to the ill person the truth of his conceptions in the form of evidence experiences".
3. At this juncture I would like to thank the director of the clinic, Dr. D.M. Shrestha, and Dr. N.M. Shrestha for the work possiblities that they generously placed at my disposal and for the many stimulating discussions we had together. The study would not have been possible without the sensitive interview guidance of an experienced psychiatric nurse, Mrs Sarasvati Shrestha, and the helpful elaborations on sociological connections and mythological background presented by Mr Bishnu P. Shrestha. May I give them both a special thank you.

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