Mental illness in Goa, India

Vikram Patel

While waiting for a delayed departure at Goa airport recently, I engaged in conversation with a fellow frustrated passenger who happened to be an American tourist. Upon discovering that I had spent eight months in Goa initiating a field study on common mental disorders in primary care clinics, she expressed amazement exclaiming "but surely there can't be mental problems in this place. . . it's so beautiful and everyone seems so happy!". After a brief moment wondering whether my companion was joking, I realised that my work in Goa could in itself seem a bit of a joke to colleagues and friends who associated Goa with being a holiday destination. Not only is the view that living in an apparent paradise is somehow conducive to better mental health a smokescreen, I had come to realise that mental illness was a considerable problem in this coastal state. Perhaps this essay could be an opportunity to explain why.

The youngest and smallest state of the Indian republic, Goa's history is as chequered as any ancient culture. After long periods under Hindu and Muslim rule, 450 years of Portuguese domination ended with its liberation in 1961. Colonial influences have left an indelible mark on Goan culture, making it very distinct from that of its neighbouring Indian states. A third of the population profess a Roman Catholic faith and the remainder are mainly Hindu. Despite numerous differences between the cultures of the two groups, for example in their food and clothing habits, Goa has witnessed one of the most harmonious coexistences of religions in Indian history. The local language, Konkani, can be written in both the Romanic script preferred by Catholics and the Devanagari script preferred by Hindus. Since independence, Goa has seen a relatively stable political climate which has fostered enormous improvement in its living standards; in the 1992 Family Health Survey, Goa scored near the top of the league of Indian states on a range of indicators of health. For example, the infant mortality rate was 20 per 1000 live births (as compared with 79 for India) and literacy rates in women are 67% (as compared with 39% for India) (Population Research Centre, 1995).

Its economy is based on agriculture, fishing, mining, the export of Goan labour and tourism. Agriculture and fishing provides employment to the majority of Goans, although much of the former relies entirely on the seasonal rains and tends to be of a subsistence nature. The regular export of manpower to the Middle East provides a steady source of valuable foreign exchange to their families at home. The latest and arguably most lucrative industry is, of course, tourism. After being a secret haunt of the flower-children of the 1960s, Goa has emerged as a major destination for plane-loads of charter tourists from Europe. This flood has led to huge changes in lifestyle of Goans in the coastal belt of the state (unknown to most visitors, the rural essence of Goa lies hidden away from the ocean beaches, in villages nestled between plains of paddy fields fringed by coconut palms and frontiered by the forested hills of the Western Ghats). While the inflow of cash dollars has seen a huge rise in living standards, there are serious concerns about the impact of chaotic development on the environment and the culture clash of tourists who may expose more flesh than is acceptable or seek out pleasures of substances not familiar to the traditional lifestyles built around fishing, coconut and paddy farming.

Blessed as she is by her rich cultural heritage, enviable environment and comparatively high standard of living, my fellow passengers' remarks may have seemed to be quite understandable. However, there are many signs that psychological disorder is at least as common in Goa, if not more, than in apparently less salubrious parts of India or abroad. The Institute of Psychiatry & Human Behaviour in Panjim city is the central psychiatric hospital of Goa and has about 275 beds. With a population of about 1.2 million, this means that Goa has an average of one psychiatric bed per 4500 population, a ratio impressively higher than the mean for India which stands at 1:20 000. The average admission rate is in the region of 2500 per annum, which reflects that about one in 300 adult Goans are admitted to the hospital every year. Given the fact that the admission rate represents only the very tip of the iceberg of mental disorder in most countries, and that in India in particular, only those with severe behavioural disturbances are brought to psychiatric hospitals, this figure is a worrying marker of the potential scale of morbidity in the community. Although there are few epidemiological data on mental disorder in Goa, there is anecdotal evidence that learning disabilities and major mental illnesses, such as schizophrenia,

appear to be frequent. This is an intriguing issue and may be linked to the 400 years of relative isolation from the neighbouring Indian population. Consanguineous marriages are not uncommon; according to the 1992 survey, 14% of marriages were consanguineous with such marriages being acceptable to both religious communities. Indeed, intrafamily marriages were often a choice in Goa for numerous reasons, one being to avoid the splitting of family wealth and property, since Portuguese inheritance laws provided for equal partitioning between all siblings irrespective of gender (unlike the rest of India where the male offspring often have greater rights).

Alcohol has always been an integral part of Goan lifestyle. Traditional brews derived from the cashew fruit and coconut are popular tipples. Tavernas, pubs and bars abound in the state, which has the somewhat dubious distinction of having the lowest taxes on alcohol in India. Unfortunately though, this drinking is not without its damaging effects. Recent reports in a leading daily recorded a huge increase in cirrhosis deaths in Goa Medical College; the staggering toll of death and injury on Goan roads is also partly attributable to alcohol. Ethnographic studies with primary care clinic staff and traditional healers and priests have repeatedly brought up alcohol as one of the key problems leading to the breakdown of the fabric of family and community life. Domestic violence is frequently associated with male drinking. Yet, other than isolated efforts for detoxification and counselling, there are no public health initiatives to examine the extent of problem drinking nor to ameliorate its effects. Instead of billboards advertising the dangers of drink-driving, the highways of Goa are littered with blatant (and illegal) liquor advertisements.

Drug misuse, in particular cannabis, opiates and more recently, LSD and esctasy, is of concern in the coastal areas where tourism is the main industry. To date, despite the apparent scale of the problem, there are no reliable epidemiological data on the extent of problem drinking or drug misuse and their impact on the health and economy of Goa. From a public health perspective, drug misuse is far less common than problem drinking, but it attracts much more public attention and government condemnation. Perhaps as with many problems in India, it is easier to blame a foreign influence for the ills of society. Nevertheless, the concerns are real, although anecdotal evidence suggests a shift from the more worrying use of opiates in the 1980s to the recreational use of stimulants in the 1990s. There is a steady trickle of European tourists brought usually by the police to the Institute of Psychiatry and Human Behaviour (IPHB) with drug-induced psychoses; most are short-lived and are associated with stimulant misuse.

We have recently completed a study of common mental disorders such as depression and anxiety in attenders at two government primary care clinics in Goa. Such disorders were frequent (more than 40% of attenders scored above the cut-off score of a psychiatric interview) and were strongly associated with female gender and poverty. Recurrent themes from this and other studies showed that other than alcoholism, poverty and loneliness were exacting a severe toll on the mental health of Goans and that women were particularly vulnerable. Despite the relatively better position of women in Goan society, poverty may affect their health as much as women in other parts of India, since traditional gender roles often discriminate against women in a variety of ways, for example by dictating the pattern of food distribution in the household (Shira, 1992). Further, loneliness is particularly a female companion since it is often related to absent men working overseas or outside Goa in jobs which are either not available or do not pay as well in Goa. Primary health centre (PHC) doctors make a brave effort to recognise psychological morbidity but confess to feeling overawed by the prospects of acknowledging disorders of which they understand very little, and providing treatments about which they know even less. Thus, as in many PHCs around India, patients are provided with a medley of symptomatic drugs, vitamin injections, and for a few, benzodiazepines.

Goa is indeed a paradise. Its culture is a dynamic blend of Indian and Portuguese flavours and its people are warm and welcoming. However, it would be naïve to extend this superficial homily to mean that mental health is assured. Paradise it may be for those who arrive for two weeks to escape the winter cold of Europe or the chaos of urban India, but for those who live here the struggles, aspirations, concerns and life events remain as significant as for any other community. Perhaps, therein lies a lesson for me; psychological disorder is truly universal. How we classify it or what we call it may vary considerably, but no one can deny the essence of suffering: not even a package holiday company nor an anthropologist's vision of paradise.

Acknowledgements

The project in Goa is supported by Wellcome Health Services Project Grant 045281/Z/95/Z. I am grateful to Gauri Divan for her comments.

References

POPULATION RESEARCH CENTRE, JSS INSTITUTE OF ECONOMIC RESEARCH AND INTERNATIONAL INSTITUTE FOR POPULATION SCIENCES (1995) *National Family Health Survey (MCH and Family Planning), Goa 1992–3*. Bombay: PRC, Dharwad & IIPS.

SHIVA, M. (1992) Women & Health. In *State of India's Health* (ed. A. Mukhopadhyay), pp. 265–302. New Delhi: Voluntary Health Association of India.

Vikram Patel, *Clinical Research Fellow, Institute of Psychiatry, London and Institute of Psychiatry and Human Behaviour, Goa, India*

Correspondence: *Section of Epidemiology and General Practice, Institute of Psychiatry, DeCrespigny Park, London SE5 8AF*

https://doi.org/10.1192/pb.21.5.299 Published online by Cambridge University Press