*Psychiatry in Pakistan (1947–1994): the balance sheet

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Beginnings

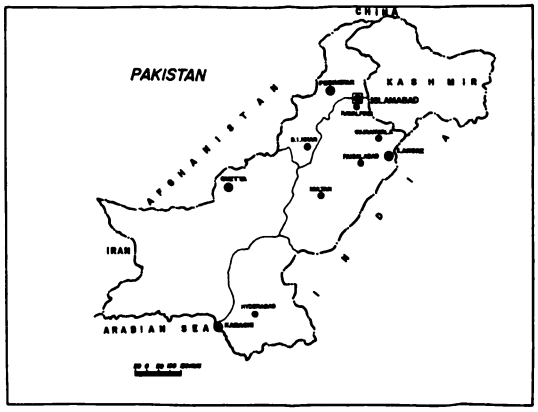
At the time of independence (1947) Pakistan with a population of 40 million had three asylum-like hospitals with a total of less than 2000 beds. The hospitals were prison-like and they provided custody with little care. Patients were mostly brought in chains. Detention and reception orders were used for admission as provided in law and the law was and continues to be the Lunacy Act of 1912. The common man referred to them as *pagal-khanas* (mad houses) or jail hospitals. The doctors appointed were mostly general duty doctors with no training and often no interest in psychiatry and their average stay was two to three years. In place of nurses there was a cadre of attendant staff, most of them illiterate, untrained and acting more like police sepoy or jail warder than nurse.

Public attitudes were steeped in ignorance and superstition, ranging from fear, contempt and indifference at one extreme to veneration at the other. At this stage, psychiatry had little to offer beyond barbiturates and bromides and a crude ECT machine.

With the newly created state of Pakistan facing gigantic problems and its very survival at stake, psychiatry could not find its place even at the bottom of the list of national priorities of that period. The first five or six national 'five years' plans' did not contain even an oblique reference to mental health.

Psychotropic revolution

The face of psychiatry started to change world-wide with the introduction of psychotropic drugs. Pakistan did not remain unaffected.



Many doctors on their own initiative availed themselves of training opportunities in the UK and elsewhere. Some returned home and obtained jobs created for them. They also started demanding better conditions for the mentally ill.

The attitude of officialdom was that, with the exception of insanity, Pakistan had no psychiatric illness like neurosis and depression. They believed, and some of them continue to believe, that these categories of disease occur solely in the West as a by-product of industrialisation and urbanisation and other social changes affecting the family. Many learned physicians are unable to comprehend that there could be endogenous mental illness. However, newly returned psychiatrists continued to press their demands. The government promised to build new mental hospitals in major cities like Karachi, Lahore and Peshawar. But plan after plan was made and scrapped because hospitals for the mentally ill were not considered to be worth spending large

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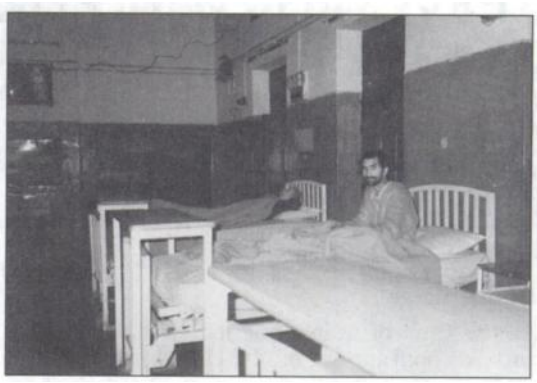
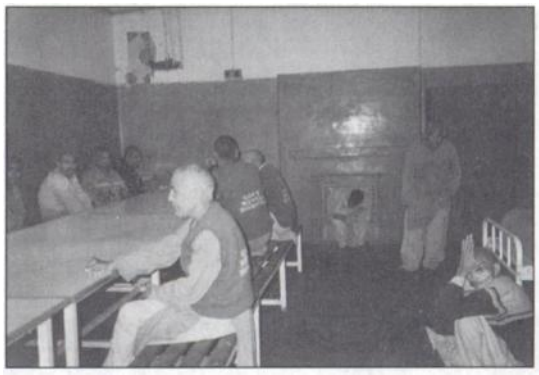
amounts of funds on. Here it may be conceded that psychiatrists erred by giving ambitious lists of building, staff and equipment which considerably increased the cost and thus deterred the government from undertaking any plan. Also, decision-makers believed that the best location for such hospitals was away from major cities in the peace of the countryside. An abortive attempt was made in Dhodial, a remote corner of North West Frontier Province, to build a 500-beds hospital. But this project was abandoned after the completion of only 80 beds for a variety of reasons. In places like Hyderabad, Lahore and Peshawar where old hospitals existed, the action was restricted to repair, partial reconstruction and face-lifting of the buildings.

Psychiatrists were appointed. General nurses were brought in to improve standards of nursing care but, without training in psychiatry or experience in the care of the mentally ill, they were misfits. The attendant staff reacted with hostility as they (the nurses) were a threat to their corrupt practices. Neither did the image of these institutions improve in the eyes of the general public for whom they were mad-houses all the same. But, it may be conceded, conditions inside did become more tolerable and turnover of patients increased.

After the arrival of psychiatrists who had worked in psychiatric units in general hospitals in the UK, it was proposed that these units be set up in teaching hospitals. Because the proposal cost little to the exchequer it was happily accepted by the government. In the mid-'60s the first two psychiatric units were added to the Mayo Hospital, Lahore and the Jinnah Hospital, Karachi. During the 1970s and '80s almost all the teaching hospitals, 20 in number, got a psychiatric facility. Later this policy was extended to some district headquarter hospitals. The armed forces also followed suit and combined military hospitals which are present in many cities of the country have set up such units. These hospitals, in addition to armed personnel and their families, also provide a service to the civilian population. At present, almost all cities have psychiatric facilities of one kind or another.



Interior of new ward of Mental Hospital, Lahore.



Dining Hall, Mental Hospital, Lahore.

Newly constructed part of Mental Hospital, Peshawar.

The problems of the rural areas

The above-mentioned developments and improvements have eased the situation in

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most cities but the rural population, which comprises 70% of the total, remains deprived of even minimum facilities, although the same can be said about the general health care delivery system. A few schemes implemented to provide medical care to the rural population have failed to achieve their objective. This unmet challenge is common to most developing countries and it must be added that any attempt to provide psychiatric care separately is not feasible and has to be tied in with general health care.

Psychiatry in medical education

Psychiatry has so far failed to make any headway in medical education at undergraduate level with the exception of Agha Khan Medical University. In the rest of the medical colleges a few lectures in behavioural sciences in pre-clinical years and a few more in psychiatry in clinical years, plus eight to ten demonstrations in the ward, are all that is done. There is no separate paper or section on the subject in the medicine theory paper and psychiatry is not included in the clinical and oral examination, hence students do not take the subject seriously. Teachers of psychiatry are to be blamed for their failure to achieve necessary modifications in the curriculum in spite of having representation on the Pakistan Medical Dental Council, the watch-dog of medical education in the country. Without adequate training in psychiatry medical education remains incomplete.

Postgraduate psychiatry

The College of Physicians and Surgeons of Pakistan, which is the examining body of postgraduate medical education, included psychiatry in its list of specialities in 1975. At present there are two diplomas, a minor MCPS and a major FCPS. But the irrelevance of FCPS–I to the discipline of psychiatry deterred many a young aspirant from making this speciality their career for 15 years. Recently the curriculum of FCPS–I has been modified after repeated pleas by the Pakistan Psychiatric Society, and made more relevant. However, the examination in this part still remains to be standardised. Another deficiency is that, except for the DPM classes at Lahore, there are no formal and structured training programmes in any centres, even in basic subjects. Most teaching institutions have only one or two trainers and trainees are left to fend for themselves. Without attention to this deficiency, the training cannot match international standards.

Sub-specialities

The absence of sub-specialities such as geriatrics, forensic psychiatry or child psychiatry (except in the Mayo Hospital, Lahore), is a major deficiency and has implications for services and training, particularly at postgraduate level.

There is also a case for making female psychiatry a separate sub-speciality. Women's biological make-up and psychosocial roles are very different from those of men, especially in conservative societies. From puberty onwards to marriage, pregnancy, puerperium and menopause, women have special problems. Socially from birth through upbringing, education, marriage and adjustment in a joint family system of in-laws, they suffer discrimination and excesses of being in a male chauvinistic culture. Because of sexual segregation and purdah, a female patient is unable and unwilling to communicate freely with a male doctor. Fortunately psychiatry is popular among women doctors who constitute a high percentage of psychiatrists and are best suited to specialise in female psychiatry.

Psychotherapy and the psychosocial framework

At present treatment consists largely of chemotherapy or ECT. Psychotherapy is scarcely practised and whatever is done is not standardised. It is based on theories of personality postulated in the West or improvised by local psychiatrists according to the patient and situation.

Psychiatry without psychotherapy is hollow and incomplete. Psychotherapy is indispensable for psychiatric problems determined by disturbed interpersonal relationships or adverse life situations. But to be effective psychotherapy has to be based on the philosophy of life and belief and value systems of the society. Western theories are alien in spirit and content and not suited to the needs of our psyche.

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Much of modern Western philosophy is agnostic, secular and individualistic. Whatever religious content it has is rooted in Judeo-Christian teachings.

The West prides itself on emphasising the rights and privileges of the individual. But it can go too far and that individual can find himself alone or in conflict with society.

Our people on the other hand are largely inspired by religion, more so in periods of distress or hardship. The source of our philosophy is the holy *Quran* and the *Sunna* with hundreds of volumes of detailed commentaries written over the centuries. Intellectual giants, whose work has been acknowledged by the Western orientalists include Al-Ghazali Ibn-e-Rushd, Ibn-e-Sina, Rumi, and in the contemporary times Iqbal of Pakistan and Ali Shariati of Iran. We can construct a psychosocial framework to serve as the basis of psychotherapy which has as its salient feature that the individual and the community are not in conflict or competition. There is symbiosis between the two. The individual is innocent not sinful. He has freedom of choice and is therefore accountable and responsible for his actions and not the helpless victim of determinism having infinite potentialities for growth and actualisation.

Psychometry

Another deficiency of Pakistan psychiatry is the lack of original psychometry. This is mainly due to the low literacy rate and multi-linguicity of our people. Mere translation or adaptation do not result in valid instruments for measurements. To prepare our own instruments demands herculean efforts which we have been shirking so far.

Drug abuse

Until 1979 drug abuse (mainly opium eating and cannabis smoking) was limited to the fringe of our society. Heroin use was unheard of. But the transformed geopolitical situation since has jolted the foundations of our society. But the attitude of decision makers in high position has been ostrich-like. Even after the number of local users of heroin passed the million mark, they continued to insist privately that drug addiction is a Western problem. The little action the government has taken so far has been to silence international criticism as most of the heroin reaching Europe originates from Pakistan. And now Afghanistan tops the list of opium producing countries in the world.

As for the local addicts the facilities available reflect only a fraction of the need. They largely consist of detoxification without rehabilitation, a superficial approach which does not address the underlying psychopathology of the individual or the basic ills of the society. A model of rehabilitation appropriate to our country is a pressing need which has not so far received the government's attention.

Pakistan psychiatric society

The sole professional body of psychiatrists was formally founded in 1973. It has some achievements to its credit, for example the holding of annual and biennial psychiatric conferences (e.g. Bhatti *et al*, 1995) and getting the curriculum of the FCPS–I changed. But much still remains to be done. The body needs to do more than passing resolutions. The best example (or the worst) is of our having failed in the last three decades to get the mental health legislation updated and amended to reflect the advances in psychiatry. The fault that the resolutions are not followed up lies with the government and legislature; not enough pressure has been built up on the concerned authorities.

In conclusion, in a country of 120 million people, a little over 200 qualified psychiatrists with the facilities described above do not present a very rosy picture of psychiatry in Pakistan.

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