problems of child rearing and handling; to give this same parent the sanction for, and confidence in his or her own handling techniques; to indicate the very wide range of normality in child development and, through this, help the community to see, and avoid, the many well-intentioned, but often disruptive, social pressures which society puts upon parents in this day and age.

Thus, without minimising in any way the specialist therapeutic tasks of the Child Guidance Clinic, perhaps the greatest contribution that we in these clinics can make to the mental health of the child (and the future adult) lies in our increasing provision of good consultative services to the Child Welfare Centre, to the paediatrician and the family doctor, to the family case-work agency and the marriage guidance counsellor, to the probation officer and the children's department, to teachers and education authorities. And in the help we can give, both through these other agencies and directly by ourselves, to that remarkably common, but rarely publicised, figure, the fundamentally good parent.

# Mental Illness in Cross-Cultural Perspective

By G. M. CARSTAIRS, F.R.C.P.E., D.P.M.

In August 1959 I had the privilege of taking part in an international conference of epidemiologists in the new Rockefeller-sponsored medical school at Cali in Colombia. The principal topic of the early sessions of this conference was coronary heart disease, which is now claiming such a high toll among the ablest and most highly trained middleaged men in all industrially developed societies. This illness is attracting a great deal of attention in Europe and America because it has been increasing in recent years, and because, unlike many other diseases, it strikes hardest at men who can be regarded as belonging to the elite—up-and-coming business men, scientists, doctors.

The conference was treated to the three principal hypotheses about the cause of the remarkable increase in the frequency of this condition, namely lack of exercise, diet and emotional stress. The psychiatrists present were especially interested in reports of work done by Dr. Meyer Friedman of San Francisco, who claims to be able to predict, by a combination of psychological and biochemical tests, which of a group of physically healthy men must be regarded as a "high-risk group" with a more than average chance of premature death from heart failure.

Our South American colleagues listened to this debate with mild interest. In their countries, the high-risk group of driving, time-obsessed career men whom Dr. Friedman had described, represent a minute fraction of the community, and coronary thrombosis does not yet rank high among causes of death.

When it was their turn to speak, physicians from Mexico, Brazil, Peru and Colombia made it quite clear that their most pressing medical problems were of a different order.

"Our first epidemiological problem", said Professor Moran of Mexico, "is starvation; and our second one is death in the first year of life. We shall be glad when the expectation of life of our people increases so that illnesses of the fifth decade can become of relatively greater importance in our work." Other speakers in turn reminded us of the major infective diseases which, together with malnutrition, present such serious medico-social problems in their countries.

A session later in the programme of the conference was to be devoted to papers and discussion on the epidemiology of mental disorders. Before this took place, Dr. Carlos Léon, the Professor of Psychiatry, took his colleagues out to see the mental hospital, whose deficiencies he made no attempt to conceal. It was a truly deplorable building, set in the countryside some three miles outside the city of Cali and surrounded by a high wall. In its two cramped and insanitary compounds 180 men and women patients were crowded together, some severely ill, some incontinent and all unoccupied. During his few years of office, Professor Léon had not been idle. When he first came to the hospital, conditions were still worse: the hospital's budget for food and drugs was totally inadequate, medical care was rudimentary—it was only under his leadership, in 1955, that psychiatric histories began to be recorded for each patient; and it was then, too, that he called a halt to the practice of chaining disturbed patients to the wall.

A new, more spacious 200-bed mental hospital is now being completed, and Dr. Léon already has a psychiatric ward in the main teaching hospital: but a little calculation served to show that if the population which looks to Cali for its medical care were provided with psychiatric beds at the same rate as was the case in England and Wales one hundred years ago, then the mental hospital beds would number over 3,000.

Under these conditions, what type of patient is brought to the hospital? Here it has to be admitted that admission is still regarded as the last resort and is equivalent to despairing of the patient's recovery. While the visitors were inspecting the San Isidro hospital, a new case was admitted. He was a youth in his late 'teens, thin and undernourished, in a catatonic state so that he appeared only dimly aware of his surroundings. His legs were chafed by ropes which had been used to bind him, and his body showed recent burns where local healers had branded him in an endeavour to dispel the evil spirits to which they attributed his affliction. He had been abandoned on the steps of the medical school. Dr. Léon said that this was a frequent practice. When all other remedies had been

tried without avail, the mentally ill patient would be brought by night and deposited at the gate of San Isidro hospital.

With these evidences fresh in mind, it was impossible next day to devote one's paper to the methodological niceties of differential diagnosis or of techniques of case-identification in surveys of mental illness as these have been carried out in Western Europe and America. The question rather was this: when confronted with such overwhelming problems, where can one begin? Dr. Léon is understandably concerned in the first place to achieve a radical transformation in the standard of medical and psychiatric care for those patients who come to his service; but he is also looking ahead to the time when he can undertake a realistic appraisal of the many cases who do not receive any form of treatment—at least in our terms. The magnitude of such an undertaking is enough to daunt anyone, but fortunately there already exists one excellent example which shows that this *can* be done. A few years after the second world war, Dr. Tsung-yi Lin of Formosa screened a population of 20,000 inhabitants of that island, some of whom lived in a seaport, some in an inland town and some were members of indigenous tribes living in the jungles.

The merit of surveys like this lies not only in their practical usefulness for the planning of future treatment services, but even more in showing the unequal distribution of particular conditions in subgroups of the population, and so prompting further inquiries into associated factors which may play a part in the course, if not the cause, of the several forms of mental illness. This is the beginning of epidemiological research.

A few days after this conference, I found myself in Jamaica, visiting a rural parish where Dr. Miall, an epidemiologist on the staff of the Medical Research Council, had just completed a very thorough survey of high blood pressure, enlisting the co-operation of over 95 per cent of some 4,000 country people. We walked for a mile or two along the narrow footpaths which slant down the sides of the steep tree-covered gullies, pausing to greet his friends and patients in many of the little shacks. As we talked with these cheerful courteous kinsfolk of the West Indians whom we have come to know in our own cities, I was still mindful of Dr. Léon's problem and began to consider whether in this island which shares our language and many of our traditions we could not embark upon an equally thorough psychiatric survey. I soon learned that it would prove much harder to assess these people's mental state than it had been to take their blood pressure. The first obstacle would be language. Sometimes the broad West Indian accents were difficult to understand, but more often one was at a loss to catch the true meaning of a local idiom. It was impossible, however, to mistake their cordiality. One old man, nearly blind, who still tended an orchard of cocoa, coffee, breadfruit, yams and coconut trees insisted

that we should refresh ourselves with "jellies" on this hot afternoon. (Jellies are green coconuts whose milk is particularly cool and delicious). Unfortunately, none of us relished the thought of climbing up the tall straight tree which towered above our heads. Just then a small boy appeared, and our host exclaimed: "See, the Lord send a climber!" A few moments later, I was tasting the juice of a jelly for the first time.

In this congenial company, a visitor would soon learn the local turns of speech; but before he could go on to take a psychiatric history his next task would be to learn as much as he could about *obea,* or spirit possession; and this would not be so easily done. Among the relatively uneducated sections of the Jamaican people (and that still includes the great majority) the obea-man is a figure of very great importance. It is he who is consulted about every form of illness, misfortune and anxiety. His speciality is to diagnose the actions of evil spirits, and like most specialists he tends to extend this expertise to cover a very wide field. It is certain that most cases of mental illness (and indeed of all other forms of illness) are taken first to the obea-man, and only if his costly—but reassuringly familiar—exorcisms fail, will recourse be made to the Government dispensary or the more distant hospital. An essential preliminary, therefore, to any psychiatric survey in Jamaica must be a careful study of the beliefs and practices concerning obea.

This is a particular case of a very general finding. In every country, the recognition of mental illness is partly determined by local traditions. "Insanity" of course has always been defined in social rather than medical terms; it refers to conduct which transgresses a particular community's limits of what it regards as tolerable behaviour. In the course of time, the definition of these limits may change—in Britain to-day, such a process of re-evaluation is currently under way; the old concept of a patient's being "Not fit to be at large" is being replaced by a widespread concern for the many harmless psychotics who are now seen to be "Not fit to be kept locked up in hospital".

Cultural traditions not only contribute to the recognition of mental symptons but also in many cases to the form of their expression. In different societies schizophrenic patients will report with remarkable regularity that they have been possessed by a magic snake, or by a malignant ghost, or that they are being played upon by means of electricity, or radio or television: the basic subjective experience is similar, but it is clothed in the imagery of their time and place. This is still more apparent in neurotic disorders: anxious people *learn* how to be ill and obey the fashions which prevail at a given moment. It is therefore evident that any attempt to assess the true prevalence of mental disorders must start with a thorough appraisal of the attitudes and beliefs surrounding mental illness in the chosen population at the time of the investigation.

The World Federation of Mental Health has chosen the study of attitudes to mental illness as a principal subject for investigation in many different countries of the world. These studies, if they are carried out with scientific rigour, will contribute in turn to the major research undertaking of the Mental Health Section of the World Health Organisation which consists in promoting epidemiological surveys of mental illness in as many countries as are able to undertake this type of inquiry.

Recognising as we do the gulf that already exists between the best available knowledge about psychiatric treatment and rehabilitation and its very imperfect application even in Britain and the U.S.A. we must expect that some people will ask why psychiatrists in the developing countries are being invited to divert part of their man-power and brain-power to research of this kind instead of concentrating upon improving their still very inadequate treatment services. The answer is that such research may contribute to a better understanding of the causation of mental disorders, and so may indicate preventive measures which could be of greater importance in the long run than a generation's work in building up treatment facilities.

No one appreciates better than those who have actually taken part in surveys of mental illness in a total community how arduous, complex and time-consuming these can be. At this moment, two major American field studies, Professor Alex Leighton's project in Nova Scotia and the late Dr. T. A. C. Rennie's survey of Midtown, a section of Manhattan, which were begun more than ten years ago, have been reported only in part: their "write-up" phase is only now nearing completion. One reason for the increasing complexity of such surveys is that there has been a growing awareness of the importance of the time dimension in psychiatric illness. It is a striking fact that several of the most outstanding cross-sectional surveys (those of Leighton, of Hollingshead and Redlich in New Haven, of Essen-Moller in a Swedish rural community and that of Lin in Taiwan) are being repeated after an interval of ten years in order to ascertain what has been the mental health of all the respondents during the intervening period. The appreciation of the time dimension is also apparent in the numerous longitudinal studies which are now being undertaken, in order to contrast the health experience of people who have been given different types of therapy.

It is a sobering thought that still, considering the world as a whole, the majority of mentally ill persons receive no psychiatric treatment. Exorcism is still more widely practised even than electroshock (and who is to say which is the less scientific, which in the long run less detrimental?) and counselling is still for the most part in the hands of priests, soothsayers and well-intentioned relatives. Before we hasten to sweep these traditional remedies aside

we should do well to make sure that our "rational" alternatives are demonstrably and indubitably better; and before we pour scorn on medicine-men we should perhaps reflect on some of the excesses of various types of baseless physical treatment and wholesale tranquillizing which have been observable in Western psychiatric practice. Nor is it wise to impute base motives to every unorthodox practitioner. Dr. Paul Sivadon has described his experience in attending a midnight ceremony in the West African bush where a witch-doctor specialising in mental cases practised his art. Dr. Sivadon was tactless enough to ask, after it was all over, what happened to the silver coins which were bathed in sacrificial blood and buried in a hole in the ground. The witch-doctor looked at him thoughtfully, and then asked in reply: "And you, how do you earn a living?"

It is a tribute to Dr. Sivadon's sense of humour, and also to his understanding of the many possible contexts of psychiatric healing, that he is fond of telling this joke against himself.

# Industrial Mental Health in Britain

By R. F. TREDGOLD, M.D., D.P.M.

**The Influence of the Past**

Up to the second world war, the industrial medical services in this country had paid a great deal more attention to the field of physical health and illness than to psychiatry, and much progress had certainly been made. Various occupational diseases had been discovered and some diminished, either by better conditions of work, by eliminating dangers, by better selection of work, or by earlier detection of illness. It is a paradox that the real success achieved has tended to keep the attention of many managers and industrial doctors focused on physical matters and so has made them less aware of the psychological problems that have always existed, and apparently are now increasing. It may well be that the latter are easier to study where industrial physical medicine is less advanced. It is remarkable that in 1007 pages of a comprehensive text book on "The Diseases of Occupations", for instance, by Dr. D. Hunter, neurosis is only mentioned on seven pages; though the same author's "Pelican" book, "Health in Industry"—which will no doubt be widely read—devotes a page to neurosis and goes on to discuss human relations and morale. Credit must, however, go to various organisations who introduced intelligence and aptitude tests into certain industries before the war. Their results were often of great practical value in developing the system of personnel selection, which was provided for every recruit from 1942 onwards.

The stresses of war on soldier and civilian alike were soon seen to be as important in their psychological effect as in their physical;