PSYCHIATRY IN THAILAND : A SOCIOLOGIST'S VIEW

by

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When a sociologist confronts the problems of mental health in developing countries and non-Western cultures, he can hardly 'bypass' the approaches already founded by psychiatrists and cultural anthropologists. On the one hand the terrain has been mapped out in the classification systems of clinical psychiatry. On the other hand, cultural anthropologists have developed concepts which stress what is typical and characteristic for a given culture. It is not surprising, then, that the interrelation between mental health and society has been studied primarily in terms of the relationship between mental illness and culture, wherein a connection is sought between 'typical' cultural elements and 'typical' forms and frequencies of certain clinical pictures — the *pièce de resistance* of this approach being the discovery of 'culture-bound syndromes'.

It is not my intention to discredit the utility or justification of this work. It seems nonetheless worthwhile to take a critical look at certain weaknesses and limitations of the 'culture and mental illness' approach:

(a) The area of mental health/mental illness is primarily seen and conceptually formulated in terms of the classifications of (Western) clinical psychiatry. The obvious question here is whether, in advance, important aspects are excluded which may be relevant for an understanding of the relationship between **society** and mental health in a non-Western country.

(b) When the manner in which society shapes mental health is seen as the effect of 'cultural factors', one runs several risks. In addition to the inherent danger of regarding the explicitly formulated values of a culture as the effective behavior-determinants, there is also the danger of regarding the values of the culturally dominant group as valid for the whole society. Moreover, every developing country is experiencing social change which necessarily has profound consequences for the area of mental health. These changes in social structure, which originate primarily in the economic sphere, cannot be adequately clarified by focusing on their cultural correlates.

In 1976-1977 I spent a research year in Thailand.[1] My intention was to investigate the

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1. I would like to thank the University of Amsterdam for granting me a year's leave of absence. My acknowledgments extend primarily to a number of persons and agencies in Thailand in gratitude for their kind cooperation, above all to the staff and patients of Roongphajabaan Prasaat in Bangkok and Srithanja in Nonthaburi. I would like to mention in particular Dr. Pramote Chaovasilp who succeeded in creating conditions which made my research activity also an important learning opportunity. The responsibility for what is written is of course my own. I am obliged to Marjorie Hanzlik for her help with this English version. The present article is the revision of a paper presented at the 9th World Congress of Sociology (Uppsala, Sweden, 1978; Research Committee on the Sociology of Mental Health).

actual functioning of a modern system of psychiatric care, based on the Western model, in this non-Western — in many respects traditional — setting. I further hoped to obtain a general, if tentative, picture of the nature and scope of the psychiatric problems experienced in contemporary Thailand. An investigation based on these very general goals (and carried out in the Thai language) is of course exploratory and can scarcely hope to be more than preparation for further and more finely focused research.

I want to report a number of my own observations of the characteristics of psychiatric practice and psychiatric problems in Thailand. I cannot offer an alternative to the above-mentioned problems of defining the work area and perspective of the sociologist (as distinguished from the psychiatrist and the cultural anthropologist). I have had to depend to a large extent on the work already done by psychiatrists and cultural anthropologists. At the same time I have tried insofar as possible not to commit myself entirely to their perspectives. It should be possible to illustrate in which sense these two disciplines, however necessary to 'path-finding', miss — or tend to miss — certain relevant aspects of the relation between mental health and society.

I will first present some general information about psychiatry in Thailand (in part I). Secondly, I will discuss the functioning of the Western-trained psychiatrist (part II). Finally I will attempt to evaluate a number of impressions and data concerning the nature of psychiatric problems in Thailand (part III).

I

While Thailand has never been dominated by a Western colonial power, the kings of Siam have pursued an active policy of adopting Western knowledge and techniques since the middle of the nineteenth century. Western medicine was first introduced in 1826 by missionaries and quickly received the support of the king and his court, and by the end of the century it had gained general and vigorous government support. A gradual expansion of health facilities was effected in the form of public hospitals in Bangkok and provincial cities, as well as public health stations in the rural areas. A medical school was founded in 1892 where, after 1907, indigenous Siamese medicine was no longer taught. "In the contest with indigenous medicine in Thailand, Western medicine had the advantage not only of whatever efficacy it possessed, but also of strong government partisanship" (Riley, 1977, p. 550).

At the present time medical care is predominantly in the hands of the government and is set up according to modern Western criteria. Outside the public health system, most doctors do carry out a private practice in addition to their work in government hospitals.[2] And there are also privately-operating traditional healers, 'injection doctors', and sellers of all sorts of

2. Traditionally only a few religious congregations operated private hospitals. In the last decade, however, there has been a rapid emergence and proliferation of a new type of private, profit-oriented hospital. This appears to have been determined by, among other things, the growing number of Thai prepared to pay more for better services, the initiating and supporting activities of international pharmaceutical and medical instrument companies, and the possibility of better remuneration for experienced doctors.

drugs and pills. Together, however, they do not seem to comprise a homogeneous, indigenous, medical tradition presenting a viable competition or confrontation with modern medicine. A systematized tradition of indigenous medicine, such as in India or China, does not appear to exist. "The confrontation is more between **old-fashioned** and modern. This viewpoint is understandable among modern physicians, but is also widely held by 'ancient' doctors and the urban and rural public. 'Ancient' elements of Thai culture are respected . . . but modernism is in vogue, and naturalistic scientific medicine is an important part of modernism" (Cunningham, 1970, p. 2; emphasis mine). It is not clear as to whether a vigorous indigenous medical tradition has ever existed or if, as Riley suggests, it has been eradicated in the course of the last 100 years (Riley, 1977, p. 554).

The characteristics of Thai medical care are also applicable to the system of psychiatric care. All the developments have been initiated by the government, all the facilities are government facilities, and all the psychiatrists working in Thailand (with the exception of one naturalized foreigner) are civil servants, even if they also carry on a private practice. The first psychiatric establishment in Thailand was set up in 1889 in Thon Buri, now — together with Bangkok — the combined administrative district of Bangkok Metropolis. This was primarily a facility for locking up socially uncontrollable people who either had no family or no family willing to care for them, as is illustrated by reports on the numerous Chinese immigrants found there. The 'treatments' consisted of confinement with chains, traditional herb therapy and magic spells. Before 1930 this establishment was under the guidance of a Western doctor, but since then it has been entirely under Thai control. At approximately the same time, the first Thai doctor went to the United States to study modern psychiatry. Shortly before World War II there were three or four psychiatrists working in Thailand who had been trained in the West. Thanks to their influence, the three psychiatric institutions operating in Thailand at that time were modernized according to the then-prevailing Western norms. In the meantime institutions similar to the Bangkok-Thon Buri hospital had been set up in the south (Surat Thani) and in the north (Chiang Mai). Further, a large hospital was established directly outside Bangkok, specially designated for chronic patients. The intention was to unburden the older hospital, thus releasing manpower for the training of pyschiatric personnel and for the treatment of patients showing prospects for cure or improvement.[3]

During the past 25 years the system of psychiatric care has expanded very rapidly. The new facilities are in nearly every case more specialized: a child guidance center set up under the auspices of the World Health Organization (WHO), a home for the mentally retarded, a hospital for neurological and neurotic patients,[4] an establishment for the practice of forensic psychiatry, and a special institution for the treatment of drug addicts. All these new facilities are located in Bangkok or in the immediate vicinity. The only general psychiatric hospital of

3. Most of the above information is taken from the memorial volume *paedsib pii khoong cidtaweed nai pratheet thai* (Eighty Years of Psychiatry in Thailand), especially from the interesting contribution of Phon Saengsingkaew whose article is also printed in English translation.

4. Due to the ambiguity of the Thai word *prasaat* (nerve) which appears in the name of this institution, both neurological and neurotic patients are in fact served by one and the same facility. This hospital is intended and mainly equipped for neurological patients; in actual fact, the patients it attracts are mostly psychiatric, pesecially neurotic, patients.

the 'old' type was set up in the east. Specialized hospitals for 'neurological and neurotic' patients have been also built in Chiang Mai and in Songkhla in the south, and the new university hospital in Khon Kaen was given a psychiatric division with facilities for both in-patients and out-patients.

At the moment there are more than 80 psychiatrists working in Thailand who have been trained according to Western standards. Most of them studied psychiatry for several years in the US after their medical training in Thailand. Some were trained in Europe and a small number were trained at home in Thailand, a possibility which has only recently become available. Since 1955 there has been a Psychiatric Association of Thailand which also publishes its own periodical (in Thai, with occasional contributions in English).

From the annual statistical data published during the last decade by the Division of Mental Health, it is clear that the greatest concentration of facilities is located in Bangkok. This is hardly surprising since all government activities are concentrated in Bangkok. The number of available beds for in-patients in Greater Bangkok, where approximately 10 per cent of the national population lives, is about the same as the total for the rest of Thailand (*ca.* 3,700 beds). The same demographic picture emerges from the figures for total number of out-patient consultations and in-patient admissions in 1976.

TABLE 1

	Greater Bangkok	*Rest of Thailand*
Consultations (out-patients)	184,567	147,157
Admissions	10,201	7,988

Note: These data are taken from *sathiti koong sukhaphaabcid 2519* (Statistics of the Mental Health Division, Ministry of Public Health, 1976).

The discrepancy between Greater Bangkok and the rest of Thailand is even greater when measured in terms of the distribution of highly-trained personnel.

TABLE 2

	Doctors	*Psychologists*	*Social workers*	*Staff nurses*	*Practical nurses*
Greater Bangkok	81	32	37	276	225
Rest of Thailand	22	17	21	165	213

Note: From Kiernan, 1976, p. 5.

It is noteworthy, however, that the facilities in Bangkok are used by patients from all over Thailand. The idea is widespread that the best and newest, also in regard to medical care, is found in Bangkok. In Bangkok hospitals one regularly finds patients from the distant north and south (1,000 kilometers or more). From my own data I would estimate that slightly more than half the patients using Bangkok facilities come from outside the Bangkok area.

A clear trend which emerges from the available figures is the relative increase in the number of out-patients as opposed to in-patients. The following data refer to the whole country.

TABLE 3

	1957	*1965*	*1970*	*1976*
Consultations (out-patients)		71,588	184,328	331,724
Admissions	3,313	9,326	13,226	18,189

Note : These data are taken from *sathiti koong sukhaphaabcid 2519* (Statistics of the Mental Health Division, Ministry of Public Health, 1976).

There is a clear difference between in-patients and out-patients in the ratio between men and women. All the available data from all sources display the same tendency: in-patient men outnumber in-patient women, and out-patient women outnumber out-patient men.[5]

Already in the 1950s and regularly thereafter, various WHO consultants reported a strikingly high percentage of schizophrenic patients. According to their data this percentage obtained for nearly all facilities. At the present time the figure has dropped to 40 per cent of the total number of admissions; only in hospitals of the older style, oriented mainly toward chronic patients, is the number of schizophrenic-diagnosed patients still very high (approximately 70 per cent).[6]

The available figures are in many respects selective. The general trends noted here can be safely deduced from the figures, but as an indication of the real scope and nature of psychiatric problems they offer no insight whatsoever. Among other things, one must bear in mind the following factors which are not expressed in the statistical data:

(a) Not all psychiatric patients, nor all patients treated as such, appear in the statistics compiled by the Division of Mental Health. Many general hospitals have psychiatric units where patients are admitted and treated. These hospitals fall under another Division of the Ministry of Public Health (sometimes even under a different Ministry when, for instance, an army or police hospital is concerned), and their data are not processed with the psychiatric statistics. The limitations of the official data are illustrated by the fact that less than 1,000 cases of drug and alcohol addiction are reported. Other estimates of the number of drug addicts in Thailand vary between 300,000 and 600,000.[7] The number of patients who utilize the private practice of psychiatrists is also unknown. It is even more difficult to estimate how

5. What is especially impressive is the regularity of the difference in proportion of men and women in both patient groups. In the over-all statistics as well as in the hospital statistics the same trend always prevails : male in-patients outnumber female in-patients, female out-patients outnumber male out-patients. In the administration of one particular hospital I failed to find a single month in the last 10 years wherein male out-patients outnumbered females.

6. Data from same source as tables 1 and 3.

7. Ratanakorn (1975, p. 38) and Shaowanasai (1975, p. 75) cite the figure as 300,000; the *Bangkok Post* (1977) gives a figure of 600,000.

many potential psychiatric patients use the more traditional forms of 'treatment' such as spirit doctors, traditional healing practices, faith healing, etc. And it is especially important to consider the extensive service administered by drugstores where all kinds of medicines are sold over the counter to people with extraordinarily high expectations of the efficacy of pills and injections. The seller of drugs and pills, with a vast array of modern medicines on his shelves, has probably developed into the most frequently consulted 'medical' authority. It can be assumed that an overwhelming number of people with neurotic, psychosomatic or depressive complaints are treated by this type of self-made 'pharmacist'. Reports of doctors on addiction to tranquilizers and sleeping pills bear out this assumption.

A further indication of the selectivity of patients which are actually admitted or which visit the out-patient department is that—whether a patient is brought to the hospital or seeks it out himself — there is nearly always a history of personal contact with the hospital which can be traced: a member of the family who was once treated there, a friend of his brother who works there as a doctor, a niece employed there as a nurse, etc.

(b) The tolerance in Thailand toward deviant behavior of a psychiatric nature is beyond any doubt greater than in the West. One could probably say that it is still at a pre-modern level. Tolerance seems to be especially great with regard to psychological manifestations such as delusions, hallucinations, delirious speech and depressions. This tolerance appears to stop whenever patients constitute a threat to the functioning, or good functioning, of family life. The limits of tolerance appear in many cases to be exceeded as soon as repeated physical or verbal aggression is expressed toward older family members, especially parents. It is also important to bear in mind that a great number of Thais are engaged in types of work wherein a slackening of work-tempo is not very serious or where another family member can easily take over. In one group of approximately 40 admitted patients there were only four whose work had played a role in their problems, and who were all engaged in a modern form of work discipline, namely factory or bank work (author's data).

(c) The decision over admission is rarely determined by considerations of the nature and seriousness of the illness. During consultations over admission, I observed that the following considerations were often decisive factors:

(i) whether or not the patient had family which was willing or able to care for him;
(ii) whether or not he lived far from Bangkok (patients who live in Bangkok or the immediately surrounding area are more often treated as out-patients);
(iii) whether or not the case was interesting for the psychiatrist;
(iv) whether, if the patient or the family desired admission, there were relatives or acquaintances working in the hospital;
(v) whether the patient could pay the price, if there was more space available in a higher class (with the same medical care but better food and accommodations).

In summary, those who make use of the various psychiatric services represent not only a very small but a highly selective segment of the Thai population. The probability of using these services is greatest when one lives in one of the central provinces of Thailand and already

has some familiarity with a psychiatric facility. From my own impressions, there is no apparent reason to suppose that only elite groups and the well-to-do make use of these services; the great majority of patients (in my experience) were people with four to six years of schooling and an income between 1,000 and 3,000 baht per month (between US$50 and $150) — a group which seems to represent the majority of the present-day Thai population.

The sharp distinctions between in-patients and out-patients seem important to me. Most in-patients are uncontrollable, and the actual reason for admission is that the family cannot cope with the problems and disruptions. It is generally the family which decides on the hospital. Out-patients usually make their own decisions. They have complaints which are primarily unbearable for themselves. The most frequently encountered out-patient is the female diagnosed as neurotic; the most frequently encountered in-patient is still the male schizophrenic. The borderlines are not as sharp as I suggest, but this does not alter the fact that the distinctions are important to consider; they reflect relevant differences between an older type and a more recent type of patient as well as differences between male and female patients.

II

Having presented some psychiatric data against the background of the system producing these data, I now want to concentrate on the obvious 'bearers' of this system of psychiatric care, the psychiatrists themselves. To understand the functioning of psychiatrists in Thailand the following points seem important:

1. Every Thai psychiatrist is a civil servant and works under the Ministry of Public Health. While status difference plays an important role in Thai society in general (as seen, for instance, in the many pronouns and 'particles' used to articulate and distinguish differences of status), one finds the status hierarchy even more formalized in the Thai civil service system with its complex ranking system and emphasis on seniority. Questions of status come easily into conflict with criteria for psychiatric or medical competence. It is very difficult for a younger psychiatrist to question or criticize an older colleague, even if the difference in seniority is only two or three years (and even if the commentary is formulated with scrupulous objectivity). Possible conflicts are skirted or prevented by compartmentalizing responsibility and competence. In this way, a situation in which a younger man has higher rank than an older colleague can be made bearable by giving the older man his own sphere of autonomy. Whenever a younger psychiatrist occupies a high place in the formal hierarchy, great demands are placed on him to behave with exaggerated politeness and respect toward older colleagues. The tenacity of these traditional forms leads to a situation in which decisions are not always based on the criteria of professional psychiatric knowledge and competence. (The same is, of course, not unknown in the West; it is more a difference in degree.)

The phenomena described here also exhibit themselves with regard to professional aspirations. The ambitions of older, more experienced psychiatrists are seldom exclusively oriented toward the acquisition of greater psychiatric knowledge and competence; senior psychiatrists are more often oriented toward a position of administrative power and the accompanying

prestige. Some of the most distinguished psychiatrists are hospital directors or occupy high positions within the Ministry, maintaining no contact at all with either the patients or the actual clinical activities. The cynical observer might conclude that the ideal of a Thai psychiatrist is to distance himself as far as possible from the patient.

Psychiatric practice as such does not appear to offer significant personal or professional satisfaction in Thailand. This is not surprising when one considers that psychiatry itself does not appear to be very highly esteemed within Thai society in general. Only a very few medical graduates (less than 1 per cent) even consider a psychiatric career, as was noted by a WHO consultant (Miller, 1975, p. 6). Another WHO consultant pointed out an "apparent indifference ...to mental health problems", making it extremely difficult and unlikely for an individual to choose a psychiatric career unless he is unusually perceptive and independent (Kiernan, 1976, p. 8). Psychiatrists who have just returned to Thailand from Western training report that one of their readjustment problems arises from the inability of friends and acquaintances to value or even understand the relevance of their profession. The most obvious compensation is administrative status and, in some cases, the opportunity to earn an additional income through private practice.

A Thai civil servant, doctors and psychiatrists included, receives a salary of approximately 50 per cent of an equivalent position in the business and commercial sector. On the other hand, he enjoys greater security, more prestige and a number of privileges such as free hospital treatment, pension, etc.—reasons why a Civil Service post is regarded as extremely attractive in a country which offers no other form of social welfare. To earn enough to pay for his children's studies, to buy a house, or to own an auto (which is certainly no luxury in the chaotic Bangkok transportation system), a psychiatrist must also carry on a private practice—and this is generally the rule. The main exceptions are psychiatrists with private resources and some women psychiatrists who also have responsibilities for young children.

When a psychiatrist wants to open a private practice he must begin very gradually; he cannot simply hang a sign on his door. Usually he begins as a general practitioner and then gradually tries to orient this practice toward patients with psychiatric complaints. Another possibility is to recruit patients via the hospital where he works and then to expand his practice through recommendations. Psychiatrists who carry on a private practice—and nearly all of them do—must work for a total 12 to 14 hours a day (not including an estimated two hours of commuting time in Bangkok traffic). This rigorous work schedule cannot fail to influence the quality of psychiatric care in general. In addition to the lack of stimulus for broadening professional knowledge and scientific research, there is a serious lack of time. Most psychiatrists hardly have the opportunity to follow the foreign literature on developments in their own professional area. Even if the time is available, there is very little well-organized documentation and easily available literature. In short, the conditions necessary for the continuous and autonomous pursuit of psychiatry as a science, the most important conditions for a truly professional practice, appear to be absent.

2. The content of Thai psychiatry is entirely Western. Thai psychiatrists have had a Western training and insofar as discrepancies exist, they correspond to discrepancies within Western

psychiatry. Still it is incorrect to conclude that there is an enclave of Western psychiatry functioning in Thailand. Not only does psychiatric care function predominantly under the auspices of the Civil Service system; one must also bear in mind that the influence of other traditional elements asserts itself—perhaps less on the content of psychiatric ideas and concepts than on the more formal aspects. I am referring here to repeated and continuing observations which I can best summarize as **the influence of traditional cultural patterns on the manner in which psychiatric knowledge is dealt with, especially in regard to the acquisition and transfer of this knowledge.** This can be illustrated by the following three points:

(a) The traditional idea of knowledge as a unity of factual and moral components is still operative in Thailand. Knowledge is attached to norms of what is morally good and bad. The Western idea of knowledge for the sake of knowledge, so important to the origins and development of Western science, is rather alien in Thailand (as in most other traditional cultures). In psychiatric care, especially in the attitude toward patients, there is a great deal of emphasis on 'positive thinking': the implicit idea is that the patient can be 'cured' if he can be convinced of what is good. The same tendency can also be seen in the readiness to believe that suffering is caused by irresponsible or morally reprehensible behavior. I was surprised by the ease with which dubious family circumstances (a father who drank or had a 'minor' wife, divorced parents, etc.) were seen as the obvious source of the patient's problems (just as I was surprised to hear, more than once, **in a psychiatric context** that 'a happy life comes from a happy family').

(b) In the transfer of knowledge in psychiatric education and training, one recognizes the following traditional tendencies:

(i) knowledge is preferentially formulated in ground rules which are easy to recite and memorize;

(ii) knowledge is preferably taught in an oral form;

(iii) the transfer of knowledge takes place within a dyadic pupil-teacher relationship, wherein the authority of and respect for the teacher is the most dominating element.

The implications of this last point are especially striking when contrasted with psychoanalytically oriented ideas over the patient-therapist relationship. What is particularly absent in the traditional pupil-teacher relationship is the necessary condition for a therapeutic alliance, the common denominator wherein absolute honesty is not only possible but also makes sense.

(c) One or another form of culture-conflict is unavoidable for the Thai psychiatrist during his training abroad. An editorial in the *Journal of the Thai Psychiatric Association* points out the extremely difficult acculturation problems of Thai psychiatric residents in the US and the implications of these problems for their training (*Journal of the Thai Psychiatric Association*, 1970, pp. 176-86). The author notes the unusual susceptibility of this group to neurotic anxieties and depressions. The Thai psychiatric resident feels severely handicapped. He has to adapt himself to the fact that an important part of the psychiatric tools are culture-dependent, and this is especially true in the area of effecting a good relationship with patients. The Thai's own language tools appear to be unsuitable for work in the US, and the required skill in English can only be learned slowly and with great difficulty. In the Thai language all sorts of nuances

of respect, status, and affect are expressed through the use of special pronouns, reference terms, and particles (e.g. special manners of expressing a discreet desire, a gentle summons, friendly indications of status difference, intimacy based on equality as opposed to fatherly intimacy, etc.). English simply has no corresponding possibilities. The English equivalent is provided by inflection and intonation, but this form of expression is extremely difficult for a Thai to handle with emotional nuances since his own language uses inflection and intonation to express differences in meaning. It is not surprising, then, that such cultural differences restrict the possibilities for establishing a good relationship with patients—thus also restricting the opportunity during the training period to learn counselling and psychotherapy through practical experience. The editorial referred to above also notes that there are no adequate facilities or opportunities within the internship program for dealing with these problems. Furthermore, overcoming the language barrier is in itself a very considerable problem for most Thai residents. Even though they have already studied English for a number of years, mastery of the language within the training program is quite difficult. It involves the mastery of a polysyllabic language with various grammatical forms against the background of an almost monosyllabic, tonal language without declinations. It is understandable, then, that many Thai psychiatrists exhibit a preference for studying the verbally less sensitive areas of psychiatry (neurology, electroencephalography, psychopharmacology), and that interest in training for psychotherapy is relatively small. Furthermore, an interest in psychotherapy is hardly stimulated by the prospects of future work in Thailand. One knows in advance that one will return to a work-day in which 30 to 40 patients must be treated.

The same editorial points out other implicit cultural discrepancies in Western training which are difficult for a Thai. Among other discrepancies, the author notes the following: a completely different value is placed in the West on 'being on one's own' and working autonomously: the acceptance of gifts from patients is a taboo in the West, but to refuse such a gift in Thailand would be regarded as a serious affront to the patient and could lead to a break in the patient-psychiatrist relationship; in the West a psychiatrist must refrain in general from behaving familiarly toward his patients, while in Thailand he must use the familiar idioms of kinship (he has no neutral professional language at his disposal for avoiding the private sphere and still maintaining the possibility of a relationship of trust). In other words, one learns therapeutic ideals (most of which are related to the idea of 'self-realization') which are almost impossible to carry into practice in Thailand. Insofar as these ideals **can** be adapted to the Thai situation, enormous effort and motivation are required from the psychiatrist.[8]

III

The treatment of Thai patients consists mainly in the prescription of psychotropic medicines and, for in-patients, the change in environment to quieter surroundings. On a limited

8. I noted that some psychiatrists who had a strong interest in psychotherapy were also engaged in the reformulation of Buddhism for modern times. They were trying to live according to Buddhist ideals in their own lives, eschewing, for instance, money and administrative power.

and more experimental scale one also finds occupational therapy, group therapy, etc. There are even a few privileged wards which function according to the principles of a therapeutic community. In general, psychotherapy is only occasionally used, and predominantly in cases which are unusually interesting for the psychiatrist (and/or in the context of a private practice). In addition to the multitude of institutional barriers, psychotherapy also encounters barriers from the patient's side. Patients expect some form of somatic intervention, especially in the form of strong medication (pills or injections). One psychiatrist formulated the problem as follows:

> In my private practice, if I spend a lot of time talking to a patient or listening to him or giving advice then I find it practically impossible to bill him for the actual time I spend. He would think he was being cheated. I can only ask money for dispensing pills.

Another psychiatrist reports that when psychotherapy is used a great number of sessions are required just to teach the patient the 'rules of the game'. The general estimate here is between 5 and 30 sessions.

Neither my material, my impressions, nor my observations offer the possibility of a well-founded statement (or even speculation) on differences between Thai and Western patients which can be formulated in terms of differences in frequency or manifestation of the various forms of mental illness. Research on this question which conforms to solid methodological criteria usually comes to the conclusion that 'no difference can actually be discerned' even when allowance is made for cultural variations in superficial manifestations (e.g. the content and character of schizophrenic delusions). The argument of Kleinman over the limitations of this kind of research seems convincing. According to him, it is based on psychiatric categories which by their very nature exclude the possibility of tracing what is culturally specific (Kleinman, 1977a). My own preference here is to present a number of observations which are not specifically tied to groups of patients with the same diagnosis, but which reflect more general psychological characteristics (relevant to, but not specific for, psychiatric patients). These observations and impressions are based on consultations, interviews and dossiers of out-patients.

(a) The largest group of out-patients in all facilities (varying from 50 to 80 per cent) are diagnosed as neurotic with predominantly somatic complaints. Even for a layman, the pattern of complaints is strikingly stereotypic: one or another sort of headache, fatigue, and palpitations of the heart—and these complaints already chronic for a year or two. It is paradoxical that most patients insist that their problems are somatic (the suggestion that there might be a connection with 'problems' is often vehemently repudiated), and still their presence in a hospital for 'nervous diseases' betrays some recognition of the psychic connections.

(b) The stereotypy of the complaints indicates that there are available cultural patterns for the verbal presentation of somatic experience (the Thai language is rich in descriptive terms for all sorts of physical sensations; there are a number of different terms for different types of headaches, for feelings of fatigue and tension, etc.). In contrast to this, it is extremely difficult to verbalize psychological conflicts. My own guess is that the culture offers no patterns or idioms for articulating or understanding psychic afflictions and distress. The only cultural patterns available appear to be mechanisms of evasion and denial, which are of course not well-suited for articulating and gaining insight into one's feelings and emotional problems.

(c) The development of a relationship of trust with the doctor/psychiatrist is also hindered by the patient himself in his own authority-fixated definition of this relationship. The problem comes sharply into focus in repeated reports over the course of the transference process. In a large number of cases (an estimated 50 per cent) the patient breaks off the therapy as soon as the first signs of transference manifest themselves. The transference process appears to be nearly unbearable in that it implies exposing one's innermost feelings to someone of much higher status. The Thai culture teaches one to present oneself in scrupulously good form to a superior and, especially, to try to anticipate his expectations. The cultural pattern in this respect also implies a certain subtle manipulation of one's superior through gestures of servitude: the counterpart is hiding one's personal feelings, holding one's own inner world in reserve.

These observations cannot be interpreted exclusively in terms of the Thai culture. Similar characteristics have been reported for other cultures. Compare, for instance, the description of a group of German patients refused for psychotherapy, most of them from non-urban milieus: poverty of fantasy, lack of introspection, fixation on symptoms, a perseverance of primitive defence mechanisms such as denial and projection, lack of ego-strength (Becker and Lüdeke, 1978). At first sight this description could also be seen as 'typical' for Thai patients. This would indicate that there are factors related to the social aspects of mental health which cannot be formulated in terms of the characteristics of a given culture; these factors can be better understood in terms of a specific **level** of societal (and cultural) development. Such a perspective appears to me to be a correction to the culture-fixation of most transcultural psychiatry. In any case, the advantage of this point of view is that it provides a common denominator between social psychiatry (orientation toward differences within a society) and transcultural psychiatry (orientation toward differences between societies).

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