

Psychiatric services in Myanmar

A historical perspective

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Myanmar, until recently known as Burma, is a developing nation in south-east Asia. Burmese kings and emperors ruled this land until 1885, when it fell into the hands of the British. It gained its independence in 1948. Burma has a mainly agricultural economy and has a rich fertile soil. At one stage in the post-war history Myanmar was renowned as 'the rice bowl of the world'. It is blessed with abundant natural resources such as teak and precious stones. Myanmar covers a land area twice that of the British Isles with a population of around 42 million.

Traditionally doctors from my country have undertaken their postgraduate training in the UK as World Health Organization (WHO) fellows. The Maudsley Hospital is world-renowned and some eminent Myanmar psychiatrists received their training there.

Historical perspective

The care of the 'insane'

The earliest history of services for the mentally ill in Myanmar goes back to 1886. The British authorities felt that a national facility was required; however, its function was to be merely containment. Sadly, the prime motivation for this was that the mentally ill caused a public nuisance. It was called the 'prison for the insane' and was built close to the City Prison in Rangoon (now known as Yangon). Initially with some 50 'inmates', by 1914 the numbers had risen to around 750 and yet more space was needed to accommodate the unfortunates.

Soon after the First World War, foundations were laid for a new purpose-built facility eight miles from Yangon in a village called Tadagalay. Tadagalay translates as 'a small bridge'. With this development, Tadagalay blossomed. The asylum was completed in 1926 with the first 250 residents arriving soon after, and the numbers steadily grew to about a thousand. Little is known of how the 'insane' were treated. It appears that its purpose was merely for containment for life, and it soon took on the name 'Tadagalay'. Tadagalay became the local

equivalent of 'Bedlam', not only in its function but also in its fame with the laity. The translated saying of 'you need to go to Tadagalay' means that one's head needs examining!

During the Second World War, over half of the buildings of Tadagalay were destroyed, the site having been occupied by the Japanese army.

The concept of the 'insane' as mentally ill

Psychiatry as a branch of medicine, and the concept of the 'mentally ill patient', was introduced to Myanmar in 1945 using temporary accommodation with provision for 45 patients. This was in close proximity to a large prison ten miles out of Rangoon in a suburb called Insein. After about a year, Tadagalay once again became functional, and the patients at Insein were transferred back to Tadagalay. Soon after Burma gained her independence, the name was changed from the 'prison for the insane' to the Mental Hospital, marking a new and important phase in the history of psychiatry in Myanmar. Having achieved the status of a hospital for 14 years, the name was again changed to the People's Psychiatric Hospital. However, among the populace the name 'Tadagalay' lives on. In 1967 it achieved the status of a specialist hospital, a few years later becoming the main teaching hospital for undergraduate psychiatry.

Structure of Tadagalay

The complex consists of many formidable brick buildings and high walls. There were three sections: female (acute and chronic), male acute and male chronic. Male chronic also accommodated within its wings the 'criminally insane'. Some patients slept in large dormitories, whereas others occupied locked cells.

In the early to mid-1960s the hospital accommodated up to 1500 patients. The 1963 figures reveal the total number of admissions as 2237. The number discharged that year was 1926, the average length of stay being six weeks for acute admissions. At the same time about 400 patients

were in long-term rehabilitation, the majority of them working on the hospital farm.

Psychiatric conditions

The range of psychiatric disorders catered for was very broad, patients suffering from psychoses (schizophrenia or otherwise) and severe affective disorders being the majority. Neurotic, somatoform and stress-related disorders were also found, as well as those suffering from organic psychiatric states and epilepsy. Occasionally 'uncommon psychiatric syndromes' would lead to fascinating discussions and lively debates. The Myanmars had their fair share of the 'culture-bound syndromes' such as the equivalent of koro. Inhalation of specially prepared fumes, together with physical restraint of the affected part, was the folklore antidote for the mystery of the 'shrinking penis' which if allowed to shrink further would cost the life of the sufferer. Some manifestations of conversion/dissociative disorders, 'the possession states', could be extremely colourful but self-limiting, for example lasting as long as the 'Festival of Spirits'. But there were unfortunate ones whose symptoms persisted well beyond the expected duration and some of them eventually found their way to Tadagalay. A sizeable proportion of them had been ill for substantial periods of time, while various indigenous treatments, such as casting out evil spells or spirits, had been tried before arriving at Tadagalay. Relatives brought along their nearest and dearest with florid symptoms some having to travel for several days in the process. Usually the presenting mental state had to be crippling before help was sought. This reflected local beliefs that even the symptoms of a moderately severe depressive illness were to be accepted as part of life's suffering. The social and cultural stigma attached to mental illness was substantial.

Tadagalay was also the home of many who suffered from epilepsy. The popular lay belief was that this was a form of psychosis – something to do with 'swine'. Patients with epilepsy were thus not given any pork dishes by the attendants to avoid risking the frequency and intensity of the seizures.

Treatment teams

Psychiatric teams have traditionally been led by psychiatrists, and Tadagalay was no exception. Members of the team included psychiatrists, clinical psychologists, trainee psychiatrists, nurses, occupational therapists and social workers. Ward staff included psychiatric nurses, general nurses, nursing assistants and attendants.

Before the local postgraduate training programme started, there were three senior psychiatrists who each led one of the three teams. Three middle grade psychiatrists were their immediate deputies, and a couple of juniors were attached to each team. There were also four others who were preparing for their trip to the UK. This was the entire medical force who carried out all the clinical, teaching and administrative work that needed to be done. Everybody practised general psychiatry and the age range covered was enormous. There were no subspecialties except for substance misuse, alcohol and drug dependence units functioning somewhat separately.

Medication

The phenothiazines, small doses of butyrophenones (in particular haloperidol), depot injections, tricyclic antidepressants, imipramine and amitriptyline, benzodiazepines (notably diazepam and chlordiazepoxide), short and long-acting barbiturates, and electroconvulsive therapy (ECT) were among the treatments used.

Service provision

The Emergency Unit located just outside the grounds of the hospital functioned 24-hours-a-day, all year round. Out-patient clinics ran morning and afternoon, Monday to Friday, as well as on Saturday mornings. Trainees and specialists took part in the rota, providing one qualified doctor at all times outside working hours. Every patient who needed admission was accepted. There were no restrictions on numbers to be admitted in any one day, space being created somehow or other. A figure of 10 in-patient admissions and 20 out-patients was not unusual. The medical officers at the Emergency Unit for the day also catered for the physical health needs of the staff and their families.

The out-patient department functioned as a filter for those to be admitted and those to be followed up as out-patients. It also provided out-patient assessment, treatment and follow-up for those discharged from in-patient care. There were also out-patient clinics in the community, one in the east of Rangoon and the other as part of the out-patient department of the Rangoon General Hospital, the major university teaching hospital. The numbers seen at these out-patient clinics were huge! These two clinics were appointment clinics with morning and afternoon sessions, but whoever showed up without an appointment was also seen, the session ending with the last patient who turned up. The afternoon sessions were somewhat lighter.

In addition to Tadagalay, the Armed Forces had psychiatrists based at the military hospitals. One psychiatrist with an interest in neuropsychiatry was based at the Department of Neurology at Rangoon General Hospital. Another psychiatrist started up a service in 1966, providing an in-patient and out-patient service in Mandalay. Mandalay had been the capital during the reign of the Myanmar kings and is now the second city.

Specialist psychiatric nursing

This began with two Myanmar nurses being sent to Bangalore in India in 1957, their training lasting one year. A nurse educator under a WHO plan worked with the local mental health professionals from 1965–1968, also adding impetus. In 1968 the return of a psychiatric nurse tutor trained in Canada prompted a series of post-basic psychiatric nursing courses for new recruits. Alongside this, nurses were sent for psychiatric training to other countries including the UK and India. In 1974, following a short course organised and sponsored jointly by the Myanmar Government, the WHO and the United Nations Development Programme, a nine-month certificate course on psychiatric nurse training was organised locally. This was attended by district nurses and a few from Tadagalay. Nursing assistant courses soon followed.

Teaching of psychiatry to medical undergraduates

For a period before the Second World War, the successive medical superintendents were British Indian Medical Service (IMS) Officers. After the war the first Myanmar medical superintendent was appointed. He was followed by a series of local non-psychiatrically trained medical superintendents. It was not until 1959/60, with the appointment of an academically-minded, young and dynamic medical superintendent, that modern Myanmar psychiatry took root. He had been to the UK, received his training at the Maudsley and achieved the DPM. By the mid 1970s a further eight doctors received their training and DPM in the UK, one of them achieving his MRCPsych. This group formed a core of psychiatric (medical) teachers for undergraduate and postgraduate training.

Formal teaching for medical students was established in 1960 by the then medical superintendent, who was also a clinical lecturer, with lectures and case demonstrations. A visit to Tadagalay, including witnessing ECT being administered, was part of the course. Clinical and academic training was also provided for those who were to continue their psychiatric training in

the UK. This provided a stimulating academic atmosphere for the more junior medical staff.

By the early 1970s there were formal lectures and clinical case presentations for the medical students during their few weeks' attachment in psychiatry. Small group interactive teaching started at around this time. The demystification of what went on behind the high walls in terms of the treatment of the mentally ill was an eye-opener for the medical students. The increase from a few hours visit to a clinical attachment of a few weeks at the level of basic medical training was quite an achievement by those teachers.

There was also a postgraduate library with some relevant texts like Slater & Roth and the first editions of *Companion to Psychiatric Studies* and *Recent Advances in Clinical Psychiatry*. There were some American texts as well. Among the journals were the *British Journal of Psychiatry*, *Psychological Medicine*, the *British Medical Journal* and the *Lancet*.

Other local academic activities

There appeared to be some semblance of British psychiatry in Myanmar psychiatry. This is not surprising as many of the founding members of Myanmar psychiatry were trained in the UK. Even before the advent of formalised local training programmes, there were regular journal clubs and case presentations from different teams within the hospital. There was also a local equivalent of the *Bulletin* called *News and Notes*. The Medico-Psychological Association was active with annual meetings and lectures. Some members presented their papers at the Annual Research Forum of the Rangoon Arts and Science University (previously Rangoon University).

Professional visitors

During the 1970s a few British and American psychiatrists visited. Among them was Professor D. Goldberg from Manchester University, who helped to put together the programme for the MMedSci. Professor C. Aitkens and Dr P. Kennedy from Edinburgh, and Professor Neki from India, under the auspices of the WHO, came specifically for a symposium on 'Care of the Mentally Ill in the Community'. Professor K. Monsour from Claremont College in California, on a cultural exchange programme, gave further ideas about the local postgraduate scene.

Postgraduate psychiatric (medical) education

In 1977, with the opening of the Department of Psychiatry at the Institute of Medicine (formerly the Medical College under Rangoon University), local postgraduate medical training in psychiatry began. This began with an MMedSci course with

three trainees. Towards the end of 1978, an 18-month DPM course started with 11 trainees. Since then, the numbers enrolling each year for the DPM have varied between 2 and 11. The current course is the fourteenth. At present there are around 100 locally trained psychiatrists. A few have been posted to different parts of the country, thereby allowing expansion of psychiatric treatment and care in the community.

The current situation

There is now a Professor of Psychiatry in the University Academic Department of Psychiatry at the Institute of Medicine 1 in Yangon. Tadagalay has been given a professorial ward. There are senior lecturers and others assisting the department in its teaching programmes. The local DPM course continues to produce home-grown psychiatrists. The department plays a crucial role in the local DCH, DPTM and MMedSci (Internal Medicine) courses. Psychiatry now has a firm footing among the medical specialities and medical education: a major achievement.

The local postgraduate programme has produced specialists in general psychiatry but is still lacking in subspecialities. A couple of psychiatrists have developed an interest in paediatric liaison, and there appear to be formal links established with paediatricians. There has been substantial interest in child psychiatry by paediatricians and psychiatrists alike. The various child psychiatric syndromes that come their way have created the feeling that there is a need for further training. Despite the differences in cultural and religious beliefs, there may be substantial gains in terms of organising sub-

speciality training for the trainers through periods of attachment to well-established centres abroad. This will eventually allow the required breadth of training to take place locally for future generations of Myanmar psychiatrists. This arrangement would also allow a more formal exchange of ideas and expertise between Myanmar psychiatrists and others.

Conclusion

I began a career in psychiatry in Myanmar some 25 years ago and have been in the UK for the last 18 years. Having visited part of the services in Myanmar recently, I hope that Myanmar psychiatrists will share their clinical, teaching and research experiences with others through journals and attendance at international conferences. I was most impressed by the quality of the papers and the enthusiasm with which they were presented at the Annual Meeting of the Myanmar Medical Association I attended two years ago.

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