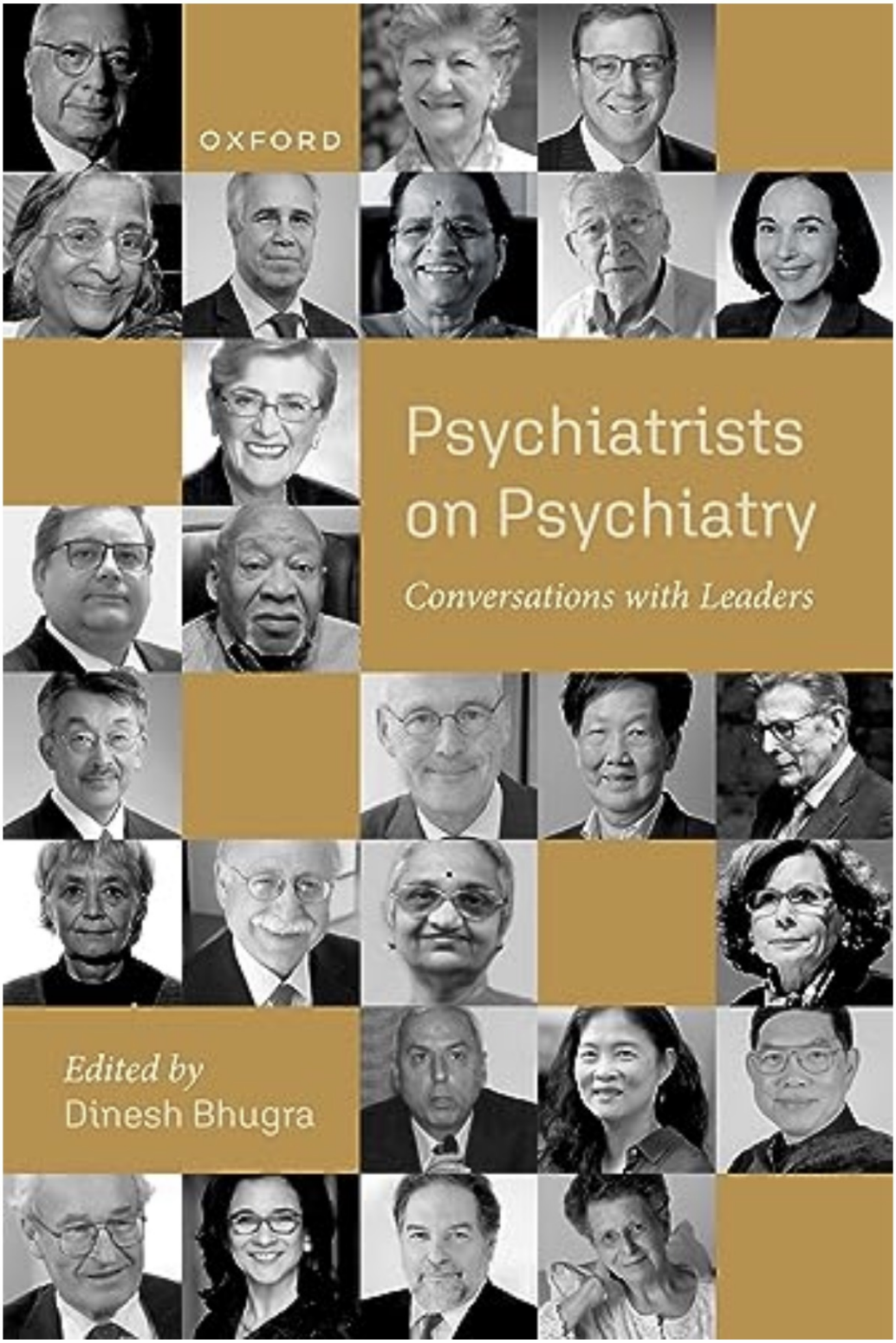

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Thara Rangaswamy

Biography

Dr Thara Rangaswamy is a trained psychiatrist and the co-Founder and Vice Chairman, of a non-governmental organization, the Schizophrenia Research Foundation (SCARF), based in Chennai in Tamil Nadu which provides care for outpatients, inpatients, rehabilitation services, and care homes. As an internationally reputed research centre, SCARF also provides extensive community outreach programmes. After having led SCARF as its Director for over 23 years, she stepped down to become the Chair of Research and Vice Chairman.

With her PhD on the subject of disability, Thara lobbied hard for the inclusion of mental disability in the Disabilities Act in India. She was also responsible for the development of a tool called IDEAS which is officially used to measure disability in schizophrenia. Dr Thara has pioneered the use of mobile tele psychiatry which is now serving more than 1,500 patients in Tamil Nadu.

She has collaborated with premier institutions around the world such as the Johns Hopkins in

the United States, the Institute of Psychiatry in the United Kingdom, and others in Australia, Canada, etc. She has served on the many task forces of the World Health Organization (WHO) and the National Institute for Mental Health (NIMH) and has over 180 peer reviewed publications.

She is on the Advisory Committee to the Director General of the WHO and is on the editorial Board of several reputed journals including the *Schizophrenia Bulletin*.

She initiated two major programmes, an international conference, ICONS, and a film festival, Frame of Mind, which have been successfully held on eight occasions.

She has won several awards including, some from the state government. She was awarded the Honorary Fellowship of the Royal College of Psychiatrists in 2014 and also the President's Gold Medal from the Royal College in 2012. She is also an Honorary Member of the World Psychiatry Association. In 2020, she was the recipient of the outstanding award for Outstanding Clinical and Community Research from the Schizophrenia International Research Society.

Interview

I: We can start by talking about how it was like growing up in Chennai. What was your childhood like?

TR: I had a pretty uneventful childhood in Chennai. I grew up in a fairly large family where I had grandparents, great-grandparents, and of course my parents as well. I went to a normal English medium convent school where we had to go and pray in the chapel every week. I was really interested in sports and I was a table tennis player, I represented the University in table tennis. I am a great lover of animals; we had three dogs at home. Being born into a conservative Brahmin family, there were some restrictions. I was not allowed to learn swimming since it was not acceptable for young women to wear swimsuits. My grandmother, who was very orthodox, was totally against the fact that I brought dogs into the house, and she even threatened to leave home. So, it was an environment where there were a lot

of restrictions but perhaps that made me feel the need to be more independent and strong-willed; I had to fight all these restrictions that my grandmother threatened to impose on me. To be fair, though, I should say that my life has not been really affected by all this. I just look upon these restrictions as experiences and issues that one has to deal with while one grows up.

I: I'm really interested to know about your orthodox Brahmin childhood and particularly your grandmother and her response to animals. How did you deal with it?

TR: Our home was large and I made it clear to my grandmother that the dogs would not bother her. She was losing her eyesight due to diabetes and was also apprehensive that she might tread on them. I think after a couple of months, she got used to the idea and then things became fine and in fact I remember when the female dog delivered puppies, she was very anxious, and she kept asking me whether the puppies were OK, whether the mother was OK. In those days, we had no dining table and our food was spread onto banana

leaves on the floor. After we ate, the whole floor was swept with cow dung in order to sanitize it!

I: Were there other youngsters in the household? how many brothers and sisters were there?

TR: I have only one brother and he was absorbed with his friends and games.

I: And any cousins in the household?

TR: Cousins would come and go but did not live with us.

I: Was your need to be independent what attracted you to medicine?

TR: Probably, yes. I was thinking of law as well, at some point in time. But in those days, medicine was considered to be a more secure profession for a lady. But it was my choice, not my parents' choice or my family's choice. I chose to get into medicine and to be honest, it was not to help suffering humanity. It was because I wanted to make sure I had a profession and I was financially independent. Although my father was a rich man, I felt strongly about this.

I: Were there any doctors in the family?

TR: No, none. I was the first doctor in the family.

I: Right. And what was their response when your parents heard that you wanted to be a doctor?

TR: They were very happy, they thought I was doing the right thing. I must mention that at I was born with a hare lip and a cleft palate and those days there was no plastic surgeon to repair my palate. I still have a cleft in my palate which is closed with a denture. My birth was very traumatic for the entire family. They had not seen anything like that and then I had to go to CMC Vellore many times; even the American surgeon there didn't know how to operate on the palate, and I had to go for speech therapy. My maternal grandmother had offered bells in many temples to pray that her granddaughter should be able to speak well. This was one of the factors that made me feel I should not be dependent on anybody. I did not want to get married. Even then, I started thinking of people who were disabled in many ways and how they would cope with their disabilities.

I: At what point did you decide that you wanted to do psychiatry?

TR: Well, after medical school.

I: What attracted you to psychiatry?

TR: I wasn't sure if I really wanted to do it. I just thought I would try it out and so I applied for a senior residency which was an honorary position in the psychiatric department in General Hospital (attached to the Madras Medical College) with Dr Rajkumar. After three months, I found myself liking it and I continued. I found that I was getting increasingly absorbed and so I decided to go on and applied for my post-graduation.

I: You've been really terrific and amazing in what you have achieved, and building SCARF and making it an internationally known organization, both for research and but, more importantly, for service delivery. You also expanded the work to dementia and child youth mental health. What kind of obstacles did you face?

TR: When we started SCARF in 1984, people didn't know much about schizophrenia. I'm talking of the general public; they wondered what the organization was and many couldn't even pronounce the word schizophrenia. In fact, our friends from the National Institute of Mental

Health (NIMH) had suggested that we change the name call it the Mental Health Foundation. But both Dr Menon (founder of SCARF) and I felt that only if we use the word 'schizophrenia' would people really understand it (also see Chapter 12). Therefore, raising money for it was also difficult because people had no idea what it meant. We were able to get initial funding purely because people trusted us. There was always the question of what we should do. Should we deliver care only or also do research?

I was very passionate about research but there were some members of the Board who felt that service delivery was more important. I decided to raise funds for research as an independent stream. The biggest challenge those days was that people around the world thought that research in India was of poor quality and all data were fudged. One of my main tasks was to convince people that we can do credible and ethical research at SCARF. At the World Health Organization (WHO), I spoke to John Orley and convinced him to accept my ongoing work on the outcomes of schizophrenia as part of the WHO's ISOS. I

had to do this with other organizations like the NIMH, Johns Hopkins, etc. It took many years but eventually this happened and now we are in a position where people seek us out for collaboration. I think we have reached a stage where we have built a lot of credibility; people know we deliver and carry out high-quality research. It was a long battle hard won.

I: What drives you?

TR: It's largely from inside. I am 68 now. I don't need the money, I don't need to travel, I don't need to go to meetings, I don't even need publications to further my career. So, it's not so much external factors. I don't discount them totally; it's nice to go and meet people, to publish papers. Even today when I was listening to Robin Murray talking about his work, I said to myself 'Oh my goodness! Why didn't we do this kind of research?' I immediately went to my junior colleagues in the hall and said, 'Can't you guys think of doing work like this?' So, I think it is something deep within me which drives it all.

I: Being the first woman in an orthodox Brahmin household going into a profession and having to

overcome the disability, do you get the feeling that somehow you have to prove yourself much more than others?

TR: Maybe initially it was like, that although not at a conscious level. It's not like I was saying I had to prove myself in any way. I don't mean to blow my own trumpet but I was top in my school, I was second in my university, I was a gold medallist, I was a good table tennis player. I excelled in most things I did fairly naturally without too much effort. I'm fiercely independent. This did not mean I broke rules; it's just that I need my space, I need my thought processes.

I: Do you have any regrets choosing psychiatry?

TR: Not at all. I think I did the right thing. I mean I'm certainly enjoying it; I just couldn't have been an obstetrician or a paediatrician. In those days you know, a woman doctor had to be either an obstetrician or a paediatrician, And I cannot stand kids who shout and cry all the time, I just can't. I just don't have it in me, and I hated obstetrics because I hated the way some obstetricians were so rude to their patients. I could never have worked in such an environment.

I: You have chosen to stay away from leadership at a national level in the sense of getting involved in Indian Psychiatric Society or getting into obstetrics and challenging obstetricians from the inside, so what was your hesitation?

TR: If I get into something, I have to contribute and the contribution has to be substantial, not just for one or two years. You really have to make an impact; you need to change something, and I knew that was difficult in a Society with a leadership tenure of a year. It's not that I don't respect the Society. I know a lot of good things are happening, but I don't think I will fit in there.

I: When you were going into psychiatry, who were your role models and heroes and heroines?

TR: Definitely Dr Sarada Menon, who selected me for the postgraduate course. She was such a strict disciplinarian and very particular that we wrote good case notes of our patients. Her dedication and commitment were very inspiring; she is the role model for many of us (also see Chapter 12). However, my interest in research was fuelled by Dr Rajkumar who was Professor of psychiatry at the Madras Medical College and gave me my first

job in the ICMR study SOFACOS. Then, I've also met along the way people like Dr NN Wig who inspired me in his own way, but I did not have the chance to work with him.

I: In your experience, how has psychiatry changed in your time?

TR: It has changed quite a bit because when we first started, the stigma of seeking help was much greater but now people have much less hesitation in seeing psychiatrists. Young people working in the software industry seek help for sleep, marriage, and sexual problems. This would have been unheard of even 10 years ago. Now people don't mind seeking help for depression and anxiety, although psychosis is still not well understood.

I: What do you think of the current state of psychiatry?

TR: Where? In India?

I: Yes, you can talk about India or internationally or both.

TR: A lot is happening internationally including at the WHO. Much more funding is available for research, although it is still limited in India. But we still have a long way to go in terms of service

delivery in the low and middle income countries (LAMIC). Even in the state of Tamil Nadu, which is one of the better states for healthcare, we still have many untreated patients in rural areas with the Duration of Psychosis (or illness) (DUP) of 10 years, 12 years.

I: You've been doing some fascinating work in terms of telehealth. How did that come about? How did you decide that you wanted to send a van around the villages and offer healthcare on the Web or via Skype?

TR: The first tele-psychiatry initiative happened soon after the tsunami in 2004, which affected the two southern districts of Nagapattinam and Cuddalore. Oxfam came to us and requested us to do tele-counselling to the people there. The government of Tamil Nadu was also very encouraging. After the tsunami, we were left with a group of untreated patients with psychosis for whom we gave some support for a few years. I had seen some tele-mobile initiatives of an eye care foundation, Sankara Netralaya, and a few others. I decided we too should have a mobile facility—I'd never heard of one anywhere in the

world. That's how it came about. The TATA trusts supported us and Ashok Leyland designed the bus.

I: What do you see as the problems with psychiatry at present?

TR: I don't think the profession works together; I think we don't speak with one voice in many places. There are too many dissenting notes within the profession and now we also have the family groups, carers' groups, the users of services. We should be consistent in the messages we send out to the general public and not confuse them—about medication and its safety, the need to continue treatment, the services available, etc. Then there is the fact that we are still not able to improve the lives of our patients. Even if you take major psychosis, we know that only 30–40% are really functionally improved. And more importantly we don't know what causes schizophrenia. We know that tuberculosis and malaria are caused by organisms/mosquitoes. With mental illness, we give patients a cocktail of factors which may have caused the disorder. This is not convincing enough.

I: You think psychiatry is brainless or mindless?

TR: No, I won't say it is either. I think there are very bright people in psychiatry now. Around the world I see some really intelligent and bright people in psychiatry but I think we don't work together, we have our own agendas. So, this not coming together and not speaking with one voice is the problem. That is what is going to make a difference at the society level.

I: What do you see, apart from the fact of us not speaking with one voice, are the other characteristics of a good psychiatrist?

TR: I think the first thing is empathy. I mean you really need to understand your patient. You need to understand his problems in life as much as his symptoms; it's his life situation which is so critical, I think that's what we fail to do. We focus on the symptoms and we act more as clinicians, but I think we should really focus more on the patient's family life, on his social life. Or get the case managers to attend to this aspect. When you actually ask the family what causes the burden for them, they don't always talk about the hallucinations or the delusions. They say, 'He's not doing

anything; he's not earning or not able to support his family.' But these are not generally addressed by most mental health professionals.

I: Do you think one of the problems may be that in psychiatry, like in most of medicine, we focus too much on symptom reduction rather than social functioning?

TR: Absolutely. One reason is our teaching and curriculum which focuses only on medications.

I: Is it still two weeks of psychiatry training at undergraduate level in India?

TR: Yes, undergraduate training in psychiatry is still only two weeks in most places and everybody goes on leave during those two weeks. I'm even talking of post-graduates' psychiatric curriculum, say in MD psychiatry or a DNB, we don't teach enough of all these social measures or recovery and rehabilitation. I think again the focus is on medications.

I: One of the things that intrigues me is the lack of training or teaching on ethics and probity. Is that a universal phenomenon in India? I don't see it in postgraduate courses.

TR: Nothing. Well, I was not taught any ethics at all. My standard of ethics was partly derived from my family and partly being taught by people like Drs Menon and Rajkumar. It was imbibed, but we didn't have formal teaching in it.

I: I know people who are seeing 100 patients a day; how will they make social contact with their patients?

TR: They have time only to make a diagnosis and prescribe medicines. I also think the onus is on the government to do such things at a macro level. We should have community teams like you have in the United Kingdom. Unless that is done, I can't blame the individual psychiatrist. I think the responsibility largely rests with the government. We should have community outreach teams, trained to deliver psychosocial interventions. We certainly have a manpower crunch but what our community work has clearly shown is that we do not always need highly trained professionals. We need an empathetic brand of volunteers from the community who can be sufficiently trained and who can deliver good treatment of the mentally ill. I would really love

to see the day when we have a lot of community teams in rural areas going out and reporting back to the psychiatrist if something is required. Considering that we have so many people who are looking for jobs in rural areas, we can easily use them, but where's the money? Where is the political will? People argue that it is top priority to have psychiatric drugs available from primary health centres, or from district headquarter hospitals. For example, we are now collaborating with a study on antenatal women in Bihar in north India. When we go there we find there are very few psychiatrists. If you want to counsel women on perinatal issues or antenatal issues, who is going to do that?

I: If you were looking back and talking to your younger self, what would you say?

TR: I'll say what you did was great. I have no regrets either personally or professionally. I mean, there are always things you could have done better, but I think under the circumstances I'm very happy with what I have done.

I: What would you have done differently?

TR: I am not sure now, but not many things, I guess.

I: And what are the achievements you are most proud of? What do you want to be remembered for?

TR: When I was just over 30 years of age, we started the non-governmental organization (NGO) Schizophrenia Research Foundation (SCARF), I wrote its constitution and its by-laws, with very little knowledge at that point in time. For 23 years I was the Director—stabilizing the organization, making it financially secure, innovating in terms of starting the international conference ICONS and tele-psychiatry, and building a wonderful team to take it all forward. Now, as you know, SCARF is well known nationally and internationally.

I: What would your advice be to the trainees of today?

TR: I think they first have to be sure of what they really want to do and then pursue it relentlessly.

I: What if you are to redesign the undergraduate curriculum. What would you do?

TR: I would give them at least three or four months in psychiatry and I would definitely expose them not just to the state mental hospital but to other NGOs, good NGOs if there are any in the area. They should learn about community outreach and the social psychological aspects of illnesses. I would tell them how research is really exciting because I don't think at undergraduate level anybody talks to students about research.

I: Have there been any memorable occasions that you can think of either in a clinical setting or in research that you look back and say it had been one of those Eureka moments?

TR: No, no Eureka moments as such. I think my work and my achievements have all been very gradual. No, I really can't think of anything.

I: You touched upon problems in psychiatry, the way it's too medicalized and some so-called anti-psychiatrists would agree with you What would your response be to them? They think that medications should never be given; everything is society's fault, and this is a very Laingian way of thinking.

TR: In some international meetings over 10 years ago, I had a chance to interact with some who felt this way. I gave them case illustrations of how a strong 23-year-old with paranoid symptoms has beaten up his elderly parents to the extent that they had to be hospitalized. Of course, the patient did not think he was ill and he refused treatment. We need to strike a balance.

I: I believe in the bio-psycho-social and anthropo- and spiritual model but it goes back to what you were saying earlier about lack of unified voice. How do we change that? What can a leader do to try and bring about that unified vision?

TR: I think we have to start with the younger cohort of doctors and psychiatrists who may be open-minded and not fixed in their views. If we are able to bring in all these elements starting from ethical factors to social, family, and community factors apart from the genetic and biological, then I think at least the next crop of doctors and psychiatrists will have a much better overall understanding and vision.

I: Thanks very much for your time.