

PSYCHOTHERAPY FOR THE ECONOMICALLY LESS PRIVILEGED CLASSES (WITH SPECIAL REFERENCE TO INDIA)

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A question has invariably been asked whether psychotherapy as practised in the abundant west is applicable or possible in countries or communities which are developing very fast but have a deeply ingrained tradition of both the patterns of disease and the format of treatment. Among the many myths that are to be explored is the notion that the poor somehow are happier than the affluent. It is often mentioned that the materially prosperous westerner is more severely affected with mental illness than an economically inferior but spiritually richer Indian. This should lead to a revelation that mental illness is rare in poor countries because life is simpler to live and where urbanization and industrialization are not yet at the very peak. Furthermore that emotional and mental tensions arise more from the degree of complexity which the society has developed for itself. It is however safe to state that dimensions of mental illness are bigger in economically poorer countries as compared to rich countries. Mental illness is just about equal in developing and the developed countries. Absolute figures for the rich countries are higher than the poor ones. This may be so because of stigma attached or inadequacy of the facilities or inaccessibility of the professional units or greater availability and utilizations of alternative but ineffective traditional facility.

In India it is said that 30-40 million people suffer from psychiatric problems, one person in 10 suffers from a serious mental illness some time in his or her life

and at any given time 1% of the population suffers from severe mental disorder.

A discussion on psychotherapy for the economically less privileged is particularly relevant so far as India is concerned. India has been included in the group of "developing countries" by the WHO, whereas the "least developed countries" and the "developed countries" constitute the two other groups (W.H.O., 1981). The least developed group, "the poorest among the poor", is comprised of 31 countries with an approximate population of 283 million people. Eighty-nine countries have been designated as developing, with an aggregate population of about 3001 million people. These two groups, and especially the latter, form the bulk of the population subserved by the WHO. This conference serves well to highlight the problems faced during psychotherapy with the underprivileged and to deliberate over ways and means to overcome such impediments in order to be effectively able to contribute towards eradication of mental illness.

Although comparatively more better off than the LDC³, the developing countries, in terms of socio-economic status and especially provision of health care, are yet a far cry from the status achieved by the developed countries. In these countries, the population per qualified doctor has been assessed to be about 2700, as compared to 520 in the developed countries. The adult literacy rate for the developing countries is 55%, which is approximately half of that of the developed countries (98%).

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Life expectancy is only 60 years, compared to 72 years in developed countries, and the infant mortality rate is much more in developing countries. These and other general figures indicate that there is a wide gulf in the developmental status between the western (developed) nations and the developing countries.

India is a vast country, covering an area of approximately 1250 square miles with a population of about 684 million people. Indian economy has a basic agrarian base and the methods of agriculture are, for the majority of farmers, quite primitive. The per-capita income, according to latest figures (at current prices) is Rs. 1,163 (US \$ 130), literacy rate is as low as about 36%, as compared to 98% for the developed countries. 80% of Indian population is rural based. Apart from these statistical data, there are certain other characteristics typical to India which may be considered to be relevant in terms of our topic of discussion. For instance, India is a land with multiple religions, numerous subcultures and innumerable languages major and dialectical. The status of women, marriages, characteristics of the family unit, sibling position, importance of the male child, superstitions and population growth are a few of the less tangible but equally important forces which leave their imprint upon the personality development of an individual and consequently upon the mode of acceptable/effective therapy. Mental health services have been accorded a low priority in most national plans till recently, and it is only in the recent past that due emphasis is being placed in the development of mental health services. Our data indicate that there are 42 mental hospitals in the country with a total number of approximately 20,000 beds. In addition, general hospitals account for another 1,500 in-patient beds (Sharma, 1976). India has about 900 qualified psychiatrists, 500 psychologists, 200 psychiatric social workers and 200 psychiatric nurses (Sharma, 1976)—

which figures illuminate the regrettably inadequate status of psychiatric services in the country. We, thus, realize that India is basically an agricultural country with a generally poor socio-economic status, low literacy rate and inadequate facilities for health care. Therefore one has to plan for delivery of mental health services in such a manner that a maximum number of those in need for help are provided facilities which they can afford and accept.

India has three major traditional psychotherapeutic systems as legacies from the past : Yoga, Vedanta and Buddhism. These systems, though often shrouded in mysticism and folklore, do have a distinctive philosophy of their own which contrast with those of the modern, western, psychotherapeutic systems. They have their own particular relevance to our culture, being products of the same. The Western individual model of psychotherapy may fail to provide results where traditional therapies may succeed. Subjective culture is an important aspect for any psychotherapeutic intervention (Neki, 1975 ; Vassilion and Vassilion, 1973).

Apart from the above non-feasibility of individual psychotherapy in our culture would also relate to economic status of the individual. The doctor patient ratio is rather large in India and even if trained analysts were available, it would be virtually impossible for them to handle the enormous needs of the community. Moreover, economic resources would rather contribute towards malnutrition, anaemia and avitaminosis than an insight oriented psychotherapy. Persons reared up in such an environment of scarcity have a different kind of psychological make-up and their demands and preferences are vastly different from those of their more affluent western counterparts.

Psychotherapy with patients from the low socio-economic status (SES) is therefore a controversial subject (Karon & Vandenbos, 1977 ; Coli *et al.*, 1962 ;

Albronda *et al.*, 1964). A premature termination and consequent lack of effectiveness of psychotherapy with patients from the low SES are not infrequently observed (Imber *et al.*, 1955; Shen & Murray, 1981). Some mental health professionals have therefore considered psychotherapy as an ill-advised therapeutic modality for this group of patients (Riessman, 1976). The relative failure of psychotherapy with the disadvantaged has been variously explained. Patient for example, is characterized as having poor verbal prowess (Siassi *et al.*, 1976), and awareness of the concept of psychotherapy (Heine & Trosman, 1960; Overall & Aronson, 1963). The latter seems to be related to the broad concept which the low SES patients hold with regard to mental illness, its treatment and the therapist. The low SES patient generally expects the therapist to follow a medically rather than psychologically oriented approach towards the management of his problems. This expectations seems to stem from a physical or medical concept of mental illness which is quite prevalent in the low SES. It is important to mention here that such a concept of mental illness as well as latter's expression in a somatic language are frequently observed in oriental cultures such as India. In view of these deep-rooted concepts of mental illness it is not surprising that a "talking" or any other form of treatment which is far from the "pills and needles" type is not very effective in the low SES patients. Further, the low SES patient expects the therapist to play an active and authoritarian role, which is a significant departure from the basic premise of "therapeutic neutrality" in psychotherapy.

And the therapist, with a variety of attributes has also been found to be an impediment in conducting psychotherapy with the low SES patient. A low SES patient is perceived as a helpless person with a relatively primitive ego (Siassi & Messer, 1976). The low SES patient is,

more often than not, seen by the inexperienced therapist in out-patient clinic where the therapist attempts to perfect the technique of psychotherapy.

Does the foregoing account indicate that psychotherapy is contraindicated in the low SES patients and that the therapist must undergo special training in order to do justice with this class of patients? The low SES patient is certainly not unsuitable for psychotherapy. He does, however, present a challenging task for the therapist. Though strictly speaking, a special training of the therapist may not be required, a thorough appraisal of the ethnodynamic characteristics of the specific group of patients is essential. We maintain that the use of physical language with medically oriented concept of illness characterizes the patient of Indian culture, a characteristic generally shared by the patients of low SES. Besides, the latter seem to have a strong preference for the traditional methods of healing which are specific to their cultures or subcultures. In addition, it is important to educate the patient as to what psychotherapy is about.

It would be appropriate, at this point, to briefly review the types of existing traditional psychotherapeutic services in India. Reliable data on the various types and extent of psychotherapy conducted in India is hard to obtain. Many activities—apparently "non-therapeutic"—have been compared to 'therapy' in terms of technique.

The traditional Indian therapists include faith-healers, religious personalities, exorcists, Hakims, Homoeopaths and Vaidis etc. The services of these persons can be scientifically evaluated and utilized for an acceptable mode of delivery of mental health services to the general populace. It is obvious that these persons are involved in frequent so-called therapeutic practices.

Professional manpower required for a direct thrust at the community level in India is urgently needed. In order to cope

with the enormity of the task of delivery of health care at the grass-root level, it is envisaged that community health workers be trained in the recognition of certain common illnesses and stressful events. They may, thereafter, be able to provide at least supportive psychological care to the mentally troubled at their place of residence only. Further, psycho-therapeutic programme should be evolved for the economically underprivileged communities with full regard to cost as well as cultural factors which may not hinder such an approach. Detection of those who need psychotherapeutic intervention should be prompt and effective. Management of basic mental illness requiring psychotherapy may have to be assigned to primary health centres. Medical and paramedical staff shall have to be trained in the fundamentals of imparting psychotherapy. Psychotherapy will have to be of specific nature tailored to the needs of the afflicted with a sharp focus on the availability of a rehabilitation programme. Traditional and family support system must be strengthened. This particular approach becomes more relevant in most of the 3rd World countries. Psychotherapy therefore has equal applicability for the patient belonging to lower SES and such patients must not be deprived of the same.

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