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PRESENT STATE OF PSYCHOTHERAPY IN INDIA

V. K. VARMA[1]—M.B.B.S., M.Sc. Psychiat., D.P.M., M.R.C. Psych., M.A.M.S., F.A.P.A., Diplomate, American Board of Psychiatry & Neurology

WHAT IS PSYCHOTHERAPY ?

"Psychotherapy is the treatment, by psychological means, of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient with the object (1) of removing, modifying or retarding existing symptoms, (2) of mediating disturbed patterns of behaviour, and (3) of promoting positive personality growth and development" (Wolberg, 1967).

The above is perhaps the most widely accepted definition of psychotherapy. Do all people define psychotherapy in the same way, or are there important differences? As this question may be highly relevant to the question of psychotherapy in India, let us look at some of the other definitions :

"For a very simple realistic definition, one can say that psychotherapy is the utilization of psychological measures in the treatment of sick people" (Romano, 1947).

"Psychotherapy may be defined as the treatment of emotional and personality problems and disorders by psychological means". (Kolb 1968).

"....psychotherapy is a form of help in which a trained, socially sanctioned healer tries to relieve a sufferer's distress by facilitating certain changes in his feelings, attitudes and behaviour, through the performance of certain activities with him". (Frank, 1961).

It is quite apparent from the above definitions that there is a wide agreement amongst them that by psychotherapy are meant those therapeutic manoeuvres which can be called psychological (as opposed to organic) in the treatment of problems of an emotional or psychological nature. The differences are primarily in two areas; namely the nature and qualifications of the therapist, and whether and to what degree the relationship must be deliberate and structured to qualify as psychotherapy.

In the Indian context, as we shall see later, a number of persons who may be categorised as Faith Healers or Religious Healers attempt to treat psychiatric patients by what may be considered psychological methods. Is this psychotherapy? We shall consider this question a little later when we discuss the supposedly therapeutic activities of such healers. Torrey (1972a, 1972b) has drawn attention to significant similarities between Western psychotherapy and faith healing and has argued that in spite of apparent differences in the technique in the two cases, the therapeutically active ingredients are remarkably similar. Wittkower and Warnes (1974) have drawn attention to the similarities between psychotherapies practised all over the world. In spite of the superficial differences, they feel that such therapies around the world have got the following important similarities : (1) There is an intense emotional confiding relationship between the therapist and the patient. (2) The therapist and the patient share an identical world view.

WHAT IN PSYCHOTHERAPY HEALS ?

There have been several attempts to isolate the therapeutic ingredients from the large number of inter personal and emotional experiences that constitute psychotherapy. As a matter of fact, there has been a shift in the last two decades in the studies of the

[1]Professor & Head, Department of Psychiatry, Postgraduate Institute of Medical Education & Research, Chandigarh-160 011.

efficacy if psychotherapy, that is to study the efficacy of each one of the various techniques and factors rather than to study the efficacy of the therapy as a whole. Earlier workers, since the beginning of the century, have been emphasising the specific techniques peculiar to psycho-analysis or psycho-analytically oriented psychotherapy which purportedly heal. However, lately, attempts have been made to bring into sharper focus the therapeutic role of the inter personal relationship of the psychotherapy that is perhaps common to all psychotherapies. Frank (1968) and Abroms (1968) have emphasized the role of persuasion as a therapeutic ingredient. "We must a sume that most, if not all, psychiatric patients are influenced to some extent by the demand character of the therapy situation and the implicit or explicit expectation of the therapist .... " (Frank, 1968). Abroms (1968) however, qualified the role of persuasion as follows : "In a sense, persuasion or suggestion plays an important role in promoting therapeutic change. But the claim that it is the sole or primary agent has been shown to constitute a methodological assumption rather than an empirical assertion". Torrey (1972b) has named four ingredient common to psychotherapies around world. These are (1) A shared world-view, and the therapist's ability to name the offending agent (the principle of Rumpelstiltskin), (2) the personal qualities of the therapist, (3) the high expectations with which the patient approaches the apparently exalted position of the therapist, which he calls the "edifice complex", and (4) the technique. He feels that the contribution of the so-called technique in the Western psychotherapy towards a favourable outcome has been over-emphasised. Bolman (1968) emphasises the importance of a world-view shared by the patient and the therapist. Snyder (1963, page 3-6) has under-scored the importance of understanding the role of dependency in psychotherapy. Goldstein (1962) feels that the therapist's expectation of the outcome of the psychotherapy is an important factor in its outcome. "..psychotherapist attitudes, personality characteristics and in-therapy behavior significantly influence the course and outcome of treatment". Again, "Evidence was presented of a significant effect on patient improvement of therapist prognostic expectencies".

APPLICABILITY OF THE WESTERN MODEL PSYCHOTHERAPY TO INDIA :

Comments and reservations are often expressed, formally and informally, by Indian psychiatrists and other mental health professionals regarding the place, the relevance for India, of psychotherapy, as it is understood in the West. For example, Neki (1975) feels : "Western psychotherapy, as it is, is hardly applicable to the multitudes in India—except for a handful of Westernised Indians living in large cosmopolitan cities". Commenting on the difficulties in rendering Western psychotherapy suitable to the Indian context, Surya and Jayaram (1964) comment : "Words, by their very nature, are loaded with powerful motivation and conative aspects. It is in this respect that the Western trained psychiatrist finds himself ineffective in the local setting". Commenting on some of the difficulties in this area, they say : "As compared to his Western counterpart, the Indian patient is more ready to expect and accept dependency relationships,....less ready to seek intrapsychic explanations,....more ready to discard ego-bounds and involve the therapist in direct role relationships; and finally his ideal or idelized support is the good joint-family elder.....(Indian patient) more readily alludes to conceptual references like Karma, Dharma, and traditional figures for orientation. ....".

The position taken by Surya and Jayaram, has been supported by many other authors who have voiced reservations reggarding practicability of transposing psy-

chotherapy developed in one culture to some other culture. However, Berne (1960) takes the contrary stand that the psychotherapeutic methods are universally applicable. He takes the extreme stand when he states, "Psychhotherapeutic manoeuvres can be readily transferred from one culture to another. The principles learned in the treatment of young women in Connecticut or California are just as effective in South Pacific."

It can be argued that people around the world are not alike and those of one culture differ from those of other cultures in many important ways which may have direct relevance to psychotherapy, such as the religious philosophical background, the experciential repertoire, language, modes of affective expression, moral and social norms and mores, and the culturally determined conflicts and defences. The concept of modal personality is helpful here and it can be said that the modal personalities differ from culture to culture. It is only reasonable that psychotherapy as practised should be consistent with it. Wittkowar and Warnes (1974) have emphasised that, to be popular, psychotherapy is to be consistent with the social-philosophical background of the people. Psychoanalysis became popular, in the U.S.A. because of emphasis on individualism, rational thinking, free expression and tolerance of dissent. So became work-therapy in the Soviet Union, autogenic training in Germany and Morita therapy in Japan; in each case because it was consistent with the respective social values.

Chessick (1969) has drawn the correlation between the practice of psychotherapy and the socio religious philosophical traditions of the West. He feels that Western psychotherapy is consistent with the Western philosophy of dialectics of Plato, where truth has to be reached or approached by the debate between two enquirers or within the heart of a single enquirer.

What then are the imporant reasons because of which the applicability of Western type psychotherapy in India is questioned? Let us discuss some of these.

(1) Dependence : It is said that an average Indian is more dependent on other people as compared to an average Westerner. The growing child is literally dependent on his parents. There is greater amount of interdependence in case of adults. And finally when the person becomes old, he comes to become very much dependent upon his children. Hence, we have got a beautiful system of a great degree of mutual interdependency with everybody leaning on everybody else. It can be questioned as to how far the Western psychotherapy, with its high emphasis on autonomy and personal responsibility, can be prescribed for such a people.

(2) Psychological sophistication, verbal facility and expectations:—
Psychological sophistication, atleast to the extent of considering possible psychological reasons for the illness and ability for introspection, are considered essential for psychotherapy. It is said that the Indian patient lacks in these attributes. His orientation rather than being psychological, is more likely to be either physical and concrete on one hand *or* metaphysical and mystic on the other. Also, although non-verbal communication is not irrelevant to psychotherapy, much of the communication and interaction in the Western model psychotherapy takes place at a verbal level. Does an average Indian possess adequate verbal fluency to gainfully interact in therapy based on it. Also, an average Indian patient may expect

too much from therapy, a kind of magical expectation. He may expect immediate and total cure, as if by miracle. This would again impose serious limitations on the efficacy of psychotherapy.

(3) Social distance between the patient and the doctor :

The Indian society, at least for the last 2000 years or so, has been greatly class-conscious. The Varna system, although probably originating for division of labour, quickly degenerated into a class system whereby people of the various Varnas, got arranged in clearly systematised hierarchy. Hence, the patient quickly identifies the doctor with a superior class. He comes to assume an obsequeous and submissive position in relation to him. It is quite possible that proportionally greater number of psychiatrists and doctors in general come from upper classes with feudal backgrounds. Western model psychotherapy requires that the therapist and the patient should meet at a relatively equal level and that they should jointly try to find out solutions to the patients' problems. It is questioned if such psychotherapy is applicable where the social distances between the patient and the doctor are so wide.

(4) Philosophical—religious beliefs in re-birth and fatalism :—

A question is sometimes raised if the Hindu concept of re-birth and re-incarnation can have important implications as regards psychotherapy. It is too well-known to need a repetition here that the belief is that one's life does not terminate at his death, but that he is re-born again and again in some form. One is impressed while seeing some depressed patients, by the manner in which they ascribe the illness to sins or misdeeds committed in a previous birth. In other words, the guilt feeling is ascribed not to sins committed earlier in life, but those in previous births. It can be said that it replaces past for present accountability for one's actions. It can, therefore, be that this may have some repercussions on the conduct of psychotherapy. However, a question may be raised, whether such a people only pay lipservice to those beliefs and use it at their convenience, or is it deeply in-grained in the core value system. In support of the hypothesis that it is not deeply assimilated in the core value system, it can be said that this belief is not manifested in the day to-day life and does not make any noticeable difference in conduct of every day pursuits.

The concept of fatalism is closely related, in Hindu philosophy, to that of re-birth. It is said that not only your misdeeds of an earlier birth make you suffer, but that they also impair your wisdom so that you continue to commit sins even in the next birth . It is said, nevertheless, that in spite of this, a person can try to redeem or improve one by one's efforts. In this respect, Hindu philosophy and religious system demonstrates the same ambivalence that all religious system demonstrate towards the question of free will vrs. determinism, perhaps of bit more so. It is perhaps not incorrect to say that an average Indian assumes a more fatalistic attitude towards life and future, and that this can have some deleterious effects on the

conduct of psychotherapy. However, it is not clear whether this fatalism is a part or the function of the religious system or it is more dependent on other factors like poverty, etc.

(5) Guilt vs. shame :—

It has been said by numerous workers that the so-called primitive cultures are relatively free of guilt and that they show more of shame than guilt. Shame said to be directly related to immediate social disapproval whereas guilt is said to be dependent on identification and on values which have become deeply internalised and assimilated. However, people are becoming more and more aware lately that this is an over simplified conclusion, and that the primitive cultures also demonstrate guilt. As to the Indian context, in study after study on the psycho-pathology of depression, authors have found that the Indian patients also demonstrate a significant amount of guilt (Venkoba Rao 1973, Teja et al., 1971). It may be perhaps true that in case of the Indian patient, the guilt feeling may be related to certain values other than those important in the Western culture and may be thought to be based sometimes on misdeeds of an earlier birth.

(6) Confidentiality and the dyadic relationship :—

Some authors have suggested that confidentiality in psychotherapy is not so important to the Indian patient, and that he does not mind discussing his illness with the psychiatrist in front of friends and family members. The friends and family members may actually be perceived as therapeutic allies. This raises questions regarding the relevance of confidentiality and the strictly one-to-one relationship that are hallmarks of Western individual psychotherapy.

(7) Decision making and personal responsibility :—

In the Western-type psychotherapy, the therapist and the patient came together as responsible adults and each one is considered to be responsible for his own behaviour and capable of making his own decision. Perhaps in the Indian setting, the patient expects more to be told by the therapist and is often hesitant to exercise his own choice. It is said that this is related to greater amount of altriciality and dependency that we have earlier discussed. The question is, if this attitude makes the Indian patient unsuitable forpsychotherapy or if it requires modification in the technique whereby the therapist has to assume a more directive attitude. In a study, Varma and Ghosh (1975) found that the Indian psychotherapist led a relatively more active role than that the Western counterpart, suggesting, sympathising, manipulating the environment, teaching and reassuring. The Indian psychotherapists, in suggesting departures from the Western model, pleaded for greater flexibility, greater activity on the part of psychotherapist and greater use of suggestions and reassurance.

HISTORY OF PSYCHOTHERAPY IN INDIA

If psychotherapy which can be determined as "the interpersonal method of mitigating suffering," has had a long history in India. In response to a question by a mendicant Potthapada, Lord Buddha replied, "I have expounded, Potthapada,

what is suffering; I have expounded what is the origin of suffering; I have expounded what is the cessation of suffering; I have expounded what is the method by which one may reach the cessation of suffering." In this regard, the Exalted One can be said really to have concerned himself with propounding a psychotherapeutic system (Neki, 1975). Further history of psychotherapy, however, till the early days of this century, are not documented in any detail. This is not surprising, as perhaps even in the Western countries, psychotherapy did not come to be identified as a specific science till around the turn of the century.

It is, therefore, not possible to say as to what course psychotherapy, as expounded by Lord Buddha and various others, took in India. If one were to conjecture, perhaps the Indian brand of psychotherapy over the centuries differed from the modern Western concept in a number of ways :

(1) Psychotherapy practised in India was not limited in its applicability only to the sick, but was also perceived as much, if not more so, to be useful in inculcating insight in those not afflicted by mental illness and thus effecting fulfilment and self-realization.

(2) The giver of such ameliorative and enriching experience assumed a highly exalted and reversed position in the society. In such a situation, it was neither possible nor considered desirable for the therapist and the patient or client to meet and interact as equals. The relationship was perhaps akin to the teacher-disciple relationship.

(3) Psychotherapy was, therefore, not a dialectical process where truth was reached or approached by a debate between the two or within the heart of the recipient, but was more of a situation where truth was revealed by the therapist and accepted by the patient/client.

(4) Not everybody was considered fit for such psychotherapeutic relationship. "Another common feature of these ancient therapeutic systems is their esoteric nature—their tenets and practices have been considered mysteries of the highest order that cannot be made accessible to any except the most worthy (*adhikarin*). Thus they have remained the exclusive domain of the spiritual elite and the people in general have remained bereft of their benefits" (Neki, 1975).

A historical account of psychotherapy since the second decade of this century has been given by Sinha (1956). Girindrashekhar Bose, the founder of the Indian Psychoanalytic Society, can be considered to have brought modern psychotherapy to India. In addition to stimulating other people in psychoanalysis, Bose also propounded a theory of "opposite wishes", and published a book, "The Concept of Repression." He entered into a lengthy correspondence with Sigmund Freud which lasted from 1921 almost to the time of Freud's death in 1939. Freud must have been delighted with this relationship and the support that it represented. However, going through the correspondence, one gets the feeling that Freud's attitude was that of benevolent indulgence, but he was never greatly impressed by Bose's idea and formulations, and he never gave anything resembling a clear seal of approval to them.

The Indian Psychoanalytic Society still continues, although its membership has never been large, partly, no doubt, due to their own stringent requirements. It is based in Calcutta does accept doctors as well as non-doctors for training analysis, and publishes a journal, called *Samiksha*.

Another aspect of history of psychotherapy in India is the resurgence of in-

terest in a types of therapy of great antiquity, Yoga and T.M. In addition to numerous lay groups trying to promote it in the various parts of the country, there have been scientific attempts to define and interpret it, and to test its value as a therapeutic tool. Vahia and co-workers have been, perhaps, most active of all in this modern analysis of Yoga. In numerous publications, they have presented Yoga to the professional and especially to the Western workers, and using relatively stringent and scientific methods, have attempted to test its therapeutic efficacy in psychiatric disorders (Vahia *et al.*, 1966 ; Vahia, 1969 ; Vahia *et al.* 1972, 1973). The results, so far, indicate that, for cases of of psychoneuroses, Yoga is superior to "pseudo-treatment", i.e. where they "were asked to relax and do some postures resembling Asnas, and breathing practices resembling Pranayama" and to "write all the thoughts that came to their mind during the treatment (similar to Dharana and Dhyana)".

Finally a word about transcendental meditation. This therapeutic modality which possibly was derived from the Vedantic Psychotherapy of ancient India and existentialism of modern-day Europe, gradually started to be noticed in late 1950's ; and considerably reinforced by neurophysiological research, quickly gathered momentum so much so that by early 1970's it become a phenomenon of incredible popularity and global impact. This 'phenomenon' which almost defies attempts at its interpretation is too recent to be analysed and understood yet.

THE PRESENT STATUS OF PRACTICE OF PSYCHOTHERAPY IN INDIA :

Reliable objective data on types and extent of psychotherapy conducted in India are extremely scarce and hard to come by. Part of the difficulty lies in the definition of psychotherapy adopted. If by psychotherapy we mean a deliberate relationship between a professionally trained person and a patient (Wolberg, 1967), naturally we shall have to direct our enquiry to those psychiatrists who possess a basic degree in modern medicine and have had further training/qualification in psychiatry, and to perhaps a few psychologists who are engaged in therapy. Obviously, our scope will be rather limited. On the other hand, if we take psychotherapy to mean "the treatment of emotional and personality problems and disorders by psychological means" (Kolb, 1968), it may be assumed to include many other therapeutic activities, e.g. the psychological element of presumed therapeutic value in the casual contact between a doctor and his patient, the treatment activities of non-medical professionals such as psychologists and social workers, and the activities of faith healers and religious healers.

For the purpose of this section, we shall adopt a more liberal definition of psychotherapy, meaning thereby, "the treatment of emotional and pesrsonality problems and disorders by psychological means" (Kolb, 1968), and would review all therapeutic activities going on in India which seem to operate through psychological means. Such activities can be best described in terms of the therapists involved. *Although precise and detailed information in this area is glaringly inadequate.* The following general comments can be made. The therapist involved can be roughly classified as follows :

(1) *Religious and faithhealers* :

Such healers are quite widespread all over the country, although it is impossible to be sure of their number or affiliations. A strong faith in the tenets of religion and supernatural phenomena and powers, on part of both the therapist and clients, is a necessary prerequisite for the success of this kind of therapy. It will perhaps

not be incorrect to say, that most of the practitioners and patients are Hindus, however, many Muslims are thought to be endowed with great healing properties. The usual method of operation is that the patient seeks the therapist, and comes to him for help. The latter in turn gives him a sympathetic hearing, involves greater religious faith and reverence in him and jointly invokes the mercy of God on him. In the process, he may give the patient some sacred ash (Bhabhuti), ask him to make certain offerings at the altar, and give him verbal reassurance and suggestion that the problem would be over. Certain other religious rituals, like periodic offerings and worships over long periods of time, observation of fasts and other restrictions may be prescribed. Sometimes the therapist names some offending spirit or the patient's sins or misdeeds (including those ascribed to an earlier birth) and prescribes the remedial measures as earlier noted).

The healer generally enjoys very high reputation in the local area as a holy man ; good-intentioned, helpful, compassionate and possessive of extraordinary powers. Although, we have given him the generic name, here, of faith healer or religious healer, he is not conceived of as such by the population but as a learned and wise man. The vernacular name for him varies from one part of the country to another, but some typical examples are Peer, Sayana, Babajee and Ojha, literally meaning a divine, a learned man, an elder respected man and a Brahmin respectively. In most cases, he is also the village priest (although not all priests are conceived of as healers).

The patient who seeks his help generally comes to him with high hopes and expectations. Both he and his family have heard a great deal about him and hold him in high esteem and reverence. He shares with the therapist his views about the supernatural genesis of maladies, and the beneficial values of faith, reverence and rituals. Thus, the therapeutic situation contains three important ingredients, i.e. a shared world view, personal qualities of the therapist, and the high exceptations of the patient described by Torry (1972b).

What is the extent of this type of therapy ? Again, very little information is available on this point. If the general impression that one gets in his practice of psychiatry while elucidating history of previous treatments of his patients, and the overall picture of pshychotherapeutic activities in a general and especially rural population that one is familiar with, is any guide, such faith-healing activities must go on a very large scale. It is perhaps safe to assume that a great many patients who do not or who can not avail of modern psychiatric facilities utilize the services of faith healers to a large degree. Their services must be solicited quite frequently for conditions like hysterical neurosis, epilepsy, mental retardation and even many cases of frank psychosis.

Can we call this type of activity as psychotherapy? One can say that these healers cannot be called "professionally trained", and that the relationship is more haphazard than "deliberate", hence this activity does not qualify as psychotherapy according to Wolberg's definition. On the other hand, one can argue that, although these, "healers" did not receive any training in formal psychology, or psycho-analysis, they have had methodice training under their Gurus for this kind of treatment, hence they can be considered to be "professionally trained".

Does this type of therapy help? It may seem that since this therapy does not conduct itself along the lines of modern psychotherapy, and does not utilize certain "techniques" of it, it may not be able to effect ameliorative change. However, the evidence, though patchy and inadequate,

strongly suggests that this therapy almost certainly helps those suffering from certain types of neurotic problems, especially hysterical neurosis ; and possibly those with many other types of neurotic problems. Psychiatrists often comes across in their practice, hysterical patients who had earlier been treated by a faith-healer with satisfactory remission of symptoms, the reoccurrence of which has brought him to a psychiatrist this time. It is quite likely, that the faith healer may also have adversely harmed certain patient, both by using unsatisfactory techniques and by delaying proper medical treatment. There is not much doubt that many patients are unaffected, one way or the other, by their intervention. Incidentally and fortunately, however, there is a growing awareness amongst the religious and faith-healers, especially the ones who treat psychiatric patients fairly regularly and sometimes commercially, that their competence is limited to certain types of mental aberrations. They classify mental illnesses into two groups ; first, that they can help, and the second, where medical (psychiatric) intervention is needed. They have been known to refer certain patients, considered to be belonging to the second category, to psychiatrists.

(2) *Exorcists*—The group named as "exorcists" here have got important similarities with the group of faith healers and religious healers described above. However, there are important differences between the two groups, because of which it may be more convenient and useful to consider them separately. For one thing, although *the exorcists share the religious halo and reverence with the faith-healers, they are generally not considered to be holy or religious people, tubare thought of as possessing supernatural or magical powers which may both be benevolent and melevolent. They are looked upon by the general population more with fear than with reverence.* As with religious healers, it is impossible to make any reasonable guess about the number of such healers or the extent of therapy practiced by them, but it must be considerable.

Typically the patient suffering from a psychatric illness, which may range from hysterical neurosis, to depression, to schizophrenia, comes or is brought to the healer, who typically is a middle-aged or old woman, and his problem is stated to the exorcist. She then names a particular offending spirit or influence. The therapy primarily consits of a trance induced by the therapist through magical dancing and chanting, in which both the therapist and the patient participate. The exorcist, thus, attempts to drive away the offending spirit or influence. Producing noxious and unpleasant smoke and gases, beating or branding the patient, engaging into franzied dancing, and many similar techniqus may be adopted in the process.

The same arguments as advanced in case of faith-healers would apply to the question whether this activity qualifies to be categorized as psychotherapy. As with faith-healing, it will be unfair to say that there are no differences between this and conventional psychotherapy conducted by psychiatrists, but at the same time, it must be conceded that it has several characteristics of psychotherapy.

Does it help ? Here, again, it will be hard to sustain that it never helps. We come across many cases of hysterical neurosis earlier treated by exorcists, as by faith-healers, with good remission. The fact that many of these patients relapse subsequently is another thing. Perhaps, we modern psychiatrists also are not more effective in many such cases.

However, it must be kept in mind that the exorcists also inflict harm to a number of patients. I have earlier referred to the fact that they often beat up or even brand their patients with hot iron. Such disfigured patients are often seen by us subse-

quently. The psychological effects of such physical torture and punishment can be catastrophic. Attempts must be made to stop such undesirable incidents.

(3) *Psychotherapy as practised by the Indian psychiatrists* :

An attempt in the direction of compiling objective information on the extent and nature of psychotherapy practised in India was undertaken by Varma and Ghosh in 1974. (Varma and Ghosh, 1975), in which they set out to ascertain the nature and extent of psychotherapy practised by the Indian psychiatrists. Wolberg's (1967) definition of psychotherapy was accepted for the purpose of this study, and psychotherapy was further specified to mean a deliberate contract with structured and scheduled therapeutic sessions whereby the patient was seen at least once a week, each session was of a minimum duration of 20 minutes, and the total time deovted to the patient was at least 30 minutes per week. This survey was conducted amongst the Fellows of the Indian Psychatric Society, resident in India (A fellow generally has had at least 4 to 5 years of training and/or experience in psychiatry with or without a postgraduate qualification in psychiatry). Out of a total of 182 psychiatrists available for this survey, 48 (26.4 %) responded to the questionnaire. 16 of them were not treating any patients with psychotherapy at the time of the study. The remaining 32 years treating 180 patients at the time of the study. However, they provided complete information on only 153 of their patients of which 132 fulfilled the criteria for psychotherapy adopted for the study. Out of these 132 patients, males outnumbered females (58:42). The findings did not, furthermore, support the notion of a young (and ? attractive) female as the prototype of psychotherapy patients. As expected, the higher socio-economic brackets seemed to be over-represented in the total patient sample. However, 8.3% were unemployed, 16.7% students, 17.4 % housewives, 15.1% had not completed high school and 28.0% had a monthly income not exceeding Rs. 300/- per month. As expected, a vast majority of patients (65.2%) were suflering from psychoneuroses. Strangely, however, 15.9% were diagnosed to be suffering from schizophrenia. In most cases, therapy was not what can be termed long-termed, intensive psychotherapy. However 15.2% of the patients had been receiving psychotherapy oftener than twice a week, 9.1% had been in psychotherapy for over two years, and 6.8% had had over 100 sessions each. The finding regarding the seating arrangements was also consistent with the above, in that the majority (80.3%) of patients sat in chair facing the therapists, and that couch was used in case of only 10.6% of them.

The therapist was found to play a rather active role in psychotherapy, perhaps more so than what goes on, on an average, in psychotherapy in the West ; suggesting, sympathising, manipulating the environment, teaching and reassuring. However, in fully 38.6% of cases, psychotherapy was considered to be of reconstructive variety. In addition to the psychodynamic and eclectic approaches, rarer techniques like psychodrama, play thereapy, milieu therapy, Pavlovian therapy, hypnosis and Yoga therapy were also reported as being used.

28.0% of patients were receiving psychotherapy as the sole treatment. Psychotherapy was considered to be the primary treatment in 60.6% of patiets and ancillary in the rest.

The attitude of the participating psychiatrists were also explored through the questionnaire. All felt that psychotherapy is a useful mode of treatment. A large majority, however, recommended departures from the Western model. The various modifications suggested were that it should be briefer, crisis-oriented, supportive,

flexible, eclectic, and tuned to be cultural and social conditions. Greater activity on part of the therapist, greater use of suggestion and reassurance, lesser use of dynamic interpretation, religious blending and entering into a Guru-Chela relationship were the other departures from the classical model suggested. However, no comprehensive and well-crystallized model of psychotherapy suited for this country was suggested.

The above study, although perhaps representing a significant addition to our factual knowledge as regards the state of psychotherapy in our country, and being the first study of its kind reported ; must be viewed as encompassing perhaps a relatively small fraction of all psychotherapeutic activities in the country, using the term in its widest sense. The authors, themselves, have correctly pointed out these limitations of the study. Firstly, the study pertains to "psychiatrists", namely those people who are doctors (thus excluding "lay" therapists) possessing as a medical degree in "modern" or a"allopathic" medicine (thus excluding Vaids, Hakims, and other practitioners of the indigenous systems of medicine), with formal training or certification in psychiatry (thus excluding general practitioners of "modern" medicine). Of course, faith-healers and religious healers of the various sorts are also excluded. At the same time, the definition of psychotherapy adopted for the purpose of the study should be kept in mind in assessing the significance of the data gathered. The definition chosen was a relatively specific one, and included only those therapeutic manoeuvers of psychological nature which were deliberate and structured, as opposed to casual contacts of presumably therapeutic effectiveness.

The question may be asked, what about quantifying the other psychotherapeutic activities in the country not covered by Varma and Ghosh's study ? Several great, possibly insurmountable, difficulties come to mind at the prospect of a study to answer the above question. Briefly, these difficulties can be summarised as those of defining and identifying the population (of psychotheraphists), of drawing out a representative sample thereof, and of adopting an operationally sound and at the same time conceptually meaningful definition of psychotherapy (where do we draw the line? How casual can the interactions get and still be called psychotherapy?)

Hence, the expected data that may merge from such an enquiry are likely to be more 'soft' and difficult to interpret. Such a research may even degenerate into impressionistic and highly biased accounts of psychotherapy in India as visualised by the author.

Going back to Varma and Ghosh's study, 32 psythiatrists reported that they were doing psychotherapy at the time of the study. This represented 17.6% of the 182 psychiatrists who were available for the study, and 66.7% of the 48 psychiatrists who responded to the questionnaire. Thus, it can be said that psychotherapy is practised to a significant, but a somewhat limited degree by the Indian psychiatrists. Considering the findings that the lower socio-economic brackets were also well represented amongst the patients and that exploratory and reconstructive techniques were also used quite often ; serious questions are raised as to the relevance and applicability of the limitations hypothesised earlier as regards psychotherapy in the Indian setting. The study, however, was neither designed nor expected to answer this question, for which different strategies must be employed.

How do the findings of this study compare with the situation in the West. Wing and Wing (1970) reported on the characteristics of patient seem in 'specialised' (at least once a week) for at least six months by a psychiatrist mainly or exclusively doing psychotherapy) and 'supportive' (anyone seen 20 or more times in

one to two years) psychotherapy. They found clear differences in the demographic and clinical characteristics of the two groups. Older age-groups (35% vrs. 5% above 45 years), and females were clearly over-represented in the supportive psychotherapy group, and single patients 26% vrs. 57%) and social classes I and II (4% vrs. 41%) underrepresented. As regards the diagnostic labels, personality disorders (25% vrs. 6%) and sexual disorders (17% vrs. 2%) were over-represented in the specialised psychotherapy group, and psychoses (3% vrs. 32%) underrepresented. In Varma and Ghosh's study, by comparison, 4.5% of patients were above 49 years of age, males out numbered females in the ratio of 58.42 and 18.2% were psychotic. These figures more closely approximate Wing and Wing's figures for the specialized psychotherapy patients.

In another study, Mowbray and Timbury (1966) collected the opinion of Scottish psychatrists on certain aspects of psychotherapy. 76% agreed that the term psychotherapy should be used only for a "deliberate undertaking". 20% followed-"a classical or recognised school". 88% of psychiatrists combined psychotherapy with other forms of treatment ; 86% with drugs and 53% with ECT (of 64.4% and 7.6% respectively of patients in Varma and Ghosh's study).

(4) *General practitioners, indigenous doctors and lay therapists :*

Almost nothing is known regarding the characteristics and the quantum of psychotherapy that may have been practised by these categories of people. By the expression, "general practitioners", here, is meant those with a qualification in modern medicine (allopathic medicine) who are engaged in general or family practice. Perhaps the modern doctors who are specialists in some branch of medicine other than psychiatry can also be considered in the same category. By the term, "indigenous doctors" is commonly meant those who practise other system of medicine prevalent in India, e.g. homeopathic, Unani or Ayurvedic medicine and they are generally referred to as homeopaths, Hakims and Vaids, respectively. Some such practitioners have had a formal course of training and credentials in the respective discipline, but the overwhelming majority have picked up the skills informally. Although no reliable estimate of the total number of indigenous practitioners is available, it is guessed that it is several times the number of those practising allopathic or modern system of medicine.

As regards psychotherapy practised by these practitioners, perhaps very few, if any, practise a formal, structured psychotherapy based on a deliberate contract. However, it can be safely guessed that a sizeable proportion engage in what can be termed as "helping situations". The effectiveness of any practitioner in such therapy depends upon his personal qualities of warmth and concern and on his psychological sophistication and sensitivity. Many general practitioners, many family doctors and many Vaids and Hakims demonstrate these qualities to a commendable degree, and their effectiveness and involvement is, no doubt, greatly enhanced and facilitated by their personal knowledge of and involvement with the patients.

By the term 'lay therapist', here, is meant a non-medical professional like a clinical psychologist, a psychiatric social worker, or a psychiatric nurse engaged in psychotherapy. A lot of debate has been going on regarding the role of a psychologist in a clinical setting, that is, whether he is primarily to help the psychiatrist by administering psychological tests, or is to be mostly utilised in research activities, or is to act as a psychotherapist. Similar, though not so intense, discussion goes on regarding the role of a social worker and how he or she should apportion his or her time and efforts

between writing a social history, exploring social and financial support for patients and clients, and doing psychotherapy of some sort or the other.

As regards the nature and extent of psychotherapy practised by the lay therapists, considerably more is known regarding the clinical psychologists than the other non-medical professionals. There are many clinical psychologists engaged in the work of psychotherapy. In a recent survey (Sharma et al., 1975), it is reported that approximately 80% of the clinical psychologists practise counselling and guidance, about 3/4 of them supportive and electic therapies, others are engaged in behaviour therapy, psychodynamic psychotherapy and play therapy. Approximately 1/3rd of their time is taken up by this type of therapy. Sen (1974, 1975a, 1975b) advocates behaviour therapy and therapies based on learning therapy and other psychological approaches also for the clinical psychologists of the eighties. Sharma (1970) mentions that projective tests could be used therapeutically and feels the trend nowadays is to go from brief to "briefer" psychotherapies to "first aid" and "emergency" and "crises" therapies. Dhairyam (1975) advocates "Guru psychotherapy" and "Karma yoga psychotherapy" based mainly on the "Gurukula" and "Guru-Sisbya" systems. Naug (1975), Majumder (1975a, 1975b) etc., have also reported case studies where yoga and other forms of psychotherapy have been successfully carried out. In fact, therapies from almost all schools of psychology are being practised by the clinical psychologists in India.

It can be said that, by and large, in actual practice, at present, the other non-medical professionals do very little psychotherapy. This is partly due to the role expected of them by the psychiatrist, who usually assumes the position of group leader or administrator, and partly due to their own lack of initiative, and on account of confusion within their own ranks regarding their role.

THE FUTURE OF PSYCHOTHERAPY

As regards the future of psychotherapy in India, at least three trends can be expected.

(1) It is inconceiveable that the further development of psychotherapy in India will be in isolation of the *trends and innovations in the West.* The practice of psychotherapy has undergone numerous changes in the United States and Western Europe since the beginning of this century, since the advent of psychoanalysis, with new schools being propounded, new orientations suggested, and gradual but important changes in the technique of psychoanalysis effected. The following are some of the trends currently important in the West :

(1) There is not much doubt that the classical "Freudian" psychoanalysis is undergoing significant changes. Marmor (1973), a noted psychoanalyst and the present President of the American Psychiatric Association, commenting on the future of the psychoanalytic therapy, predicted that psychoanalysis will move increasingly towards an open-system biosocial perspective, incorporating aspects of field theory, communications and information theory and general systems theory. Pointing out serious limitations to the purely dyadic free-associational method, he has underscored changes that the technique of psychoanalysis has been undergoing for the last few decades, in that it has been gradually moving towards a therapeutic relationship in which the therapist assumes a more active and intervening role, and predicted that "....as time goes on, this (classical) approach will be relegated primarily to investigative and training pursuits and that it will be used less and less frequently for therapeutic purposes". Marks (1971) feels that there are trends towards unification between the various approaches. Priest (1972), however, answers in negative

to the question , "is a glorious unity of disparate therapeutic approaches taking place?" that he himself posed, and warns against simplistic eclecticism, and combination therapies. Marks (1971), in the same paper, enumerates other trends in psychotherapy as :

(a) use of meditation, biofeedback,
(b) use of less highly trained personnel
(c) a pragmatic approach involving cost effectiveness analysis
(d) use of each type of psychotherapy more specifically for limited indications
(e) greater attention being paid to the active ingredient of each type of therapy.

In addition to greater emphasis being given to group therapies and behaviour therapies in general, interest has been generated in newer therapeutic models like encounter groups, transactional analysis, transcendental meditation, Yoga, and Morita therapy.

(2) Several authors have elaborated on the conflict, especially in the contemporary America, between the traditional, dyadic, individual psychotherapeutic models and the activist, social system psychotherapy. Social system psychotherapeutic model has been elucidated by Pattison (1973) as a multiple-person, multirelational interaction, an "open" model" psychotherapy, rather than a one-to-one interaction. Patient seeks to return to the social system which is the venue of the psychotherapy, and on which it is focussed. Dicks (1969), Kubie (1971), and Brenneis & Laub (1973) however, raise important doubts regarding the relevance and utility of the activist model. Defining psychotherapy as "..not only a set of skills but especially an attitude toward sick or suffering persons....", and psychodynamic viewpoint as "....an attitude of mind rather than a mere technique", Dicks (1969) sees psychotherapy as essentially a way of handling the experience of illness. Kubie (1971) feels that an awareness of one's own fallibility and limitations is the most important training experience for a therapist. Brenneis and Laub (1973) see the surging interest and emphasis on the activist, social system approach as fulfilling narcissistic needs of the therapists so interested. The conflict between the "new" radical psychiatry and "old" professionalism is seen as a conflict between action and reflection; a choice between being a good human being which is seen as fashionable and being a good therapist which is outdated. They feel that a "crucial aspect of becoming a psychotherapist is the positive acceptance of one's finite and fallible means for effecting change in patients", and that, "one way out of this dilemma is to abandon psychotherapy as a relevant activity and to pursue the narcissistic goal in some other clinical area."

II. *Adapting western psychotherapy to suit the local needs :*

Numerous changes and adaptation may have to be made to suit psychotherapy to the Indian setting. As already mentioned most of the Indian psychiatrists surveyed by Varma and Ghosh (1975) recommended departures from the Western model. If that is any guide, it can be predicted that psychotherapy in India will gradually move towards briefer contacts for specific crisis and problems, in which the psychiatrist will play more of active, directive, intervening and nurturing roles. Then, there is also the *question of professional manpower.* The total number of psychiatrists is so small in relation to the population that it is inconceiveable that they will come anywhere near being adequate for all psychotherapeutic needs. Certain strategies may be evolved to tackle this problem. Persons other than those designated as psychiatrists may have to be recruited. This may include non-medical professionals like clinical psychologists and social workers; general practitioners, practitioners of indigenous systems

of medicine, and perhaps even the faith-healers and religious healers. Serious impediments with regard to utilizing the services of each category may have to be overcome. As regards clinical psychologists and social workers, there is widespread reluctance to use them for therapeutic purposes. The arguments against using them for therapy by and large, are too well known to stand repetition here. There is a growing dissatisfaction however with the value of psychological testing, the traditional job of clinical psychologists, and a feeling that they should be better utilized in some other fashion. As regards social workers, because of differences in social systems (especially with very few financial and social support systems available in India) the traditional Western model of utilizing their services for tapping financial resources for patients' support is not applicable here. Hence, they also can be more profitably utilized in therapeutic activities.

As regards the other categories mentioned above, there is not much doubt that they are engaged in a great amount of therapeutic work. How well they do it is another matter. General practitioners who are practitioners possessing degrees in modern (allopathic) medicine, are, by the nature of their job required to see a lot of patients with emotional problems. It has been variously estimated that, of the patients who report to general practitioners for help, at least one-fourth to one-third are not suffering from any organic illness, but from a primarily psychiatric disorder; and perhaps an equal number, though suffering from an organic disorder do show significant amount of psychopathology independent of or secondary to the physical illness. It is inevitable that, knowingly or unknowingly, the general practitioners will attempt to render psychotherapeutic help to these patients. However, the general practitioners will be required to be given proper orientation towards psychiatry in general and psychotherapy in particular to better carry out their work. A few, rather feeble, attempts have been made in the country to provide this orientation. Fortunately, because of professional bond and association between the psychiatrists and the general practitioners, it may be relatively easier to achieve a significant progress in this area. Many prominent psychiatrists feel that it is possible to impart a practical, working knowledge of psychiatry to general practitioners is a brief period of time, training them in recognition of common psychiatric illnesses and use of certain drugs. Short courses in this direction have also been suggested and tried out. It may not be all that difficult to teach them the basic principles and practical aspects of supportive psychotherapy and "helping" situation. Here, again, it may be added that general practitioners and "family physicians" quickly develop a more understanding and empathic attitude towards their patients, perhaps more than the specialists do. This can be nurtured and further developed and crystallized into more acceptable therapeutic skills.

When we consider the situation regarding the indigenous practitioners, things are considerably different. It will be more difficult for psychiatrists to establish relationship with them because of lack of a common professional bond and difficulty on our part to understand their methods and philosophy. However, the conclusions is inescapable that they treat a large bulk of the population, especially in the rural areas and that rightly or wrongly, they exercise their psychotherapeutic skills. It will be impossible to stop this. Then, why not collaborate with them to increase their effectiveness and to decrease any possible harm that they might be doing? Unfortunately, we know so very little about them that it may be foolhardy to jump into any such programme without knowing the level of cooperation expected from them and our

effectiveness in enlarging their orientation.

Finally, the faith-healers, religious healers and exorcists. Here, again, there is not much doubt that they are engaged in large-scale supposedly therapeutic activities; and that it will be impossible to check or contain it. Then, why not at least establish some liaison with them so as to limit harm done by them and perhaps to increase their effectiveness? The task is much too enormous to feel very optimistic about it at this time, and a lot of research and experience will be needed to know the various problems that may be encountered in such an effort. For one thing, it is not clear if, and to what extent, they would cooperate with the modern doctors and psychiatrists in any programme where they can be guided and reoriented as regards psychotherapy. Many of them would, doubtless, feel threatened that they may lose the financial and prestige gains that their present vocation gives them.

III. *Evolving and developing indigenous systems of Psychotherapy :*

Another trend that can be predicted for the future, would be the development and propagation of the indigenous psychotherapeutic approaches, like Yoga, transcendental meditation, Guru-Chela relationship and faith-healing.

As mentioned earlier, some professionals have been actively scientifically studying *Yoga* as a therapeutic modality. Unfortunately, however, it is unusual to find an Indian psychiatrist who would have an open and unbiased attitude towards Yoga. Majority of them are perhaps negatively biased against Yoga which they try to reject, consciously or subconsciously, deliberately or otherwise, as they reject much of the ancient cultural heritage and philosophy. Some, on the other hand, overvalue Yoga and many even look upon it as some sort of panacea for all maladies—mental as well as physical. Such attitudinal problems are likely to retard objective and unbiased research in Yoga. *Transcendental meditation* (TM) although having originated here, has now reached much wider clientele. The future of TM is likely to be decided not on the Indian scene, but at the international arena. Part of this battle will, no doubt, be fought in neurophysiological laboratories, but the main determinant of the final outcome will be the attitudes, beliefs and philosophy of the people at large, which again are perhaps functions of a large number of socio-political variables.

Neki (1974), discussing the *Guru-Chela* relationship has concluded that "the Guru-Chela relationship as a therapeutic paradigm appears to be particularly tenable where self-discipline rather than self-expression is to be inculcated among the clients and where a creative harmony is sought between the individual and the society." It is impossible to predict at this time, with any amount of certainty if and to what extent Guru-Chela relationship, or psychotherapy patterned after such a relationship would enjoy popularity in the future. If the attitudes of psychiatrists as gathered by Varma and Ghosh (1975) is any guide, it is likely that some concepts and technique of Guru-Chela relationship, e.g. more activity and direct guidance and advice by the therapist, may influence and adapt Western psychotherapy for India; although it is unlikely that a new school of psychotherapy along these lines will be propagated.

Whether or not *faith-healing* will receive scientific sanction and be accepted as a separate approach to psychotherapy is not very clear. It is quite unlikely that it will. What is more likely to happen, not only in India but on the world scene at large, is that an analysis of faith-healing vrs. psychotherapy may help us develop a more scientific, realistic and objective attitude towards these, help us see the common grounds between them, and to adopt some principles and practices of faith-healing for psychotherapy, especially for hysterical and

other simple neuroses.

To conclude, we may say that a formal, "Western Type" psychotherapy is practised to a small but significant extent in India. Other therapeutic interpersonal relationship, operating through psychological means, are much more widespread. There are serious limitations to directly implanting Western psychotherapy into India on account of differences in psycho-socio economic variables and philosophical tradition. "The future of psychotherapy in India, though hard to predict, can be seen to lie in discovering the strengths (and weaknesses) of her traditional psychotherapeutic techniques and elaborating them more scientifically into clinically serviceable therapeutic systems" (Neki, 1975).

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