

Some Basic Considerations in the practice of Psychotherapy in the Indian setting.

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Mr. Chairman, Ladies and Gentlemen.

The paucity of papers submitted on psychotherapy at this Conference gives some food for thought. True, a few Indian psychiatrists in isolated pockets or centres do claim to practice psychotherapy. However, this does not seem to interest the general run of psychiatrists and still, it is more often Western psychiatrists who seem to be much keener about the theory and practice of psychotherapy in the Indian setting, rather than their Indian counterparts. In this paper and in the brief time at our disposal we shall try to highlight some items of interest.

The present-day Indian psychiatrist is still a product of Western training. Over a length of time he has learnt his medical and psychiatric lessons in a language, and in conceptual frameworks which are wholly foreign to the milieu of his birth and habitation. A language is much more than a simple, objective cognitive function. Words, by their very nature, are loaded with powerful motivational and conative aspects. It is in this respect that the Western trained psychiatrist finds himself ineffectual in the local setting. The local patient simply does not react to the words and concepts thrown at him even if he understands English. Even for the psychiatrist himself, the English words he uses have more often, only a desicated, cognitive significance and more often a prestige value. As for the patient, these have very little interactional significance or at best only a very distorted significance.

A language sums up the whole distances of an individual and the people in all the three tenses. We should deeply ponder on the implications of what would have been the story of

psychiatric thought in this country if English were not the language of our transactions. I understand that Professor Lin and his wife in Formosa have made it a practice to publish their papers simultaneously both in English as well as in Chinese. I wonder if this has any lesson for us. Anyway I do believe that in the interest of our science, we will pay attention to the signals of the time and consider the wisdom of devoting a few pages of our journal for writing in Hindi.

In all earnestness we repeat that Indian psychiatry would contribute very little original to the body of psychiatric theory if attention is not paid to the question of language. If we do not do this we will end up as ineffectual caricatures of Western psychiatric thought and either fail in psychotherapeutic theory and practice or succeed in reducing our living patients into a set of prestige-loaded foreign jargon. Some even take delight in making value judgments such as our patients are not fit for psychotherapy; they are not sophisticated enough and so on.

The next item of interest is the average Indian patient and his anticipations. We have already pointed to the Indian psychiatrist who remains Indian in his daily life, but adopts Western anticipations and values as soon as the setting becomes professional psychiatry. We have also seen the resulting frustrations. In this context we might be permitted to sum up the anticipations of the Indian patient. His anticipations are a natural product of his upbringing in a joint family setting. True, the traditional joint family, is losing form, but it continues to operate in matters of personality development. This is not the time or place to go into the details of joint family except to sum up its

influence.

As compared to his Western counterpart, the Indian patient is more ready to expect and accept dependency relationships; more ready to accept overt situational support, less ready to seek intrapsychic explanations; more insistent and importunate with regard to personal needs and time; more ready to discard ego-bounds and involve the therapist in direct role relationship; and finally his ideal or idealised support is the good joint-family elder.

We wish to emphasise that unless the Indian therapist consciously understands and fulfils this role he will succeed neither as a therapist, nor in his role as a teacher for Indian students, teaching being one aspect of group interaction and hence needing psychotherapeutic insights.

Another item of interest which we wish to draw to your attention is that the (Indian patient from whatever class he is drawn, more readily alludes to conceptual references like Karma, Dharma, and traditional figures for orientation and identification than his Western counterpart with regard to concepts like conscience, super-ego, or to Greek mythology.

We also wish to point out that implied in the Western concept of ideal mental health is the search for intrapsychic integration whereas in the Indian, the implied ideal is dissociation between the different aspects of thinking, feeling and acting. Rigid, mutually exclusive consistencies are a product of Western thought.

Time does not permit the citation of appropriate examples. However the legend of Savitri sums up the therapeutic situation, and its central principles in the Indian setting. Briefly the story is of Savitri, wife of Satyavan. It was foretold that Satyavan would die on a certain day within a short period of their marriage. She keeps this a secret from her husband and on that day accompanies her husband to the forest. Yama, the Lord of Justice and Death arrives to take away Satyavan's soul and is in fact taking it away. The story centres around the interactions between Savitri and Yama. Savitri pleads intensely. Then she begins walking alongside of Yama. A little while later, walking seven steps together she claims that

as evidence of friendship, uses this as sufficient foundation to make Yama deviate from his duty without making it too obvious; she asks from one boon which was granted; she chooses the one boon "let me be the mother of a hundred children;" yama cannot break his word. He grants the wish, soon to discover the absurdity of her becoming a mother without a husband, and had at last to give back Satyavan's life. One can discern the concepts of walking initially alongside of the patient, then the concept of implied or latent goal where an overtly acceptable goal implies the fulfilment of an unacceptable but necessary intervening step. Time does not permit expounding the role of Yama here, as a family elder and the conflicts between a limited personal Dharma and an impersonal social legal Dharma. We hope this stimulates some serious thinking.

Another item of possible interest which we wish to present for your consideration is the question of religion and faith. There is a tendency on the part of some psychiatrists all over the world to adopt a somewhat supercilious and pseudo scientific attitude to this question. We wish to submit that this is a fundamental question of profound scientific, neurophysiologic (human) and philosophic import.

Man unlike an animal is a axiomatic animal. His perception of the world of stimuli is mediated through highly selective processes and neurophysiologic mechanisms are available for such selection. In man, this selection, which automatically implies points of reference and internal correction are mediated through sets of faiths transmitted through one's culture. If we but realise that our so-called normal perception is a combination of positive and negative hallucinations, approximating to areas of reality meaningful for a particular culture. We submit that religion of faith are a necessary and implied neurophysiologic function fulfilling the role of inner corrector signalling system. To those who are sceptical we should like to point out that without exception it would be difficult to point out to the most effective leaders of any country, in any field who have not at the same time given evidence of strong conscious-

ly held faith. It is strange that psychiatrist who are seriously concerned with questions of mental health should adopt a cavalier attitude, a sort of shy and resentful attitude or a very shallow supercilious attitude to this question of religion and faith. A person who does not pay attention to these profound corrector mechanisms in himself or his patients is not likely to go very far either as a person or as a colleague or as a group leader or even as therapist of serious effects.

We are preaching no particular religion, but are high-lighting the need for a more serious understanding of its mechanisms, something more than a mere explanation in psychological jargon of phenomena that have deeper import. When in doubt of this, we request attention be paid to the point we already made-give us the names of the most effective, creative persons throughout

history who at the same time did not consciously hold and uphold a faith! Neglect this aspect and see if we are doing serious justice to the science of mental health.

Very sketchily and imperfectly we have placed before you some thoughts. No originality is claimed. If something of this paper moves us towards further thought that is sufficient for us. In the interest of Indian psychiatry we commend some of these point for discussion. For fear of becoming chauvanistic, we should not end up as caricatures of something we are not and never will be. The world expects a great deal more from us.

Our acknowledgment is to the numerous colleagues who had stimulated us both positively and negatively in this thinking, and especially to Professor Lindeman and Dr. Hoch for having stimulated clearer formulations.

Thank you.