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Research Paper

Therapy in India: A look into the History of Indian Psyche and Therapy

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ABSTRACT

This paper sets out to understand some Eastern healing cultures and to understand the important integration of Western ideals with this history to create an integrative model of therapy that allows Indian clients to feel heard, understood and belonged. It is also an attempt to understand the importance of context with not just culture but also what space does therapy hold in an individual's life. The paper explores the balance between universality of therapy with subjectivity that is much needed too.

Keywords: *Therapy, Decolonizing Therapy, Healing in India*

Recently my mother went to a "face reader," she isn't particularly religious, but she went in anyway. When she narrated her experience to me, it seemed very generic. The man asked her if she has any stressors in her life, that she looks stressed out and asked her to elaborate more on her experiences. My mother, a 52 year old homemaker, who I am sure deals with death anxiety, asked this face reader about her future, to quote "meri life end ki taraf kaisi hogi" (towards the end, how will my life be). The face reader told her with surety, you will never go with unpaid debt, and will have a peaceful end. When my mother came back home, and told us about the whole thing, I was waiting for her to also mention how this was all stupid. Instead, my non-religious mother who had been battling with stress for the last few weeks looked calmer. The question is not of whether it gave her true belief in the "prophecy" but the fact that a stranger listened to her talk about her life, she found that private space where only he could hear her and where she could verbalise things, she couldn't with us. Irvin D. Yalom, an existentialist psychotherapist has famously said, "It is the relationship that heals." This small engagement, while not being a formal therapy session, proved to be surprisingly therapeutic for my mother.

Therapy in India is a roughly 75 year old discipline, which means it is still fairly new. The lack of available professionals and resources not only make it inaccessible, but also deeply misunderstood. One researcher estimated that there are approximately 20 million Indians in need of mental health services, but only 25,000 of them are able to receive service within the current system (Rajkumar, 1991). With India being one of the most populated countries in the world, there is a corresponding need for more services and more research. In this paper, we are not exploring the desire for help, but questioning the very nature of therapy as

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presented in India. A 2011 World Health Organisation-sponsored study found that 36% of Indians suffered from a Major Depressive Episode (MDE) within their lifetime. That means India has the most number of people in the world who suffer from some form of depression at some point in their lives. The social pressure to be "normal" manifests in unhealthy stigma and pressure against getting help.

Availability of such data revolves highly around presence of technical terms. To look beyond the diagnostic and medicinal quantity of healing and understanding psychological pressure, distress and emotions is what I will be focusing on in this paper.

Eastern cultures are inherently focused on healing. If we look at traditional understanding of mental "illness" it stems from hearing stories about the "wise" ones in towns/villages, or the presence of "evil" in people; colloquially referred to as "maata aa jaana" or "shaitan" (presence of god/dess or evil spirit) in a person. It is the earliest definition of epilepsy as heard in folk stories. Mental health/illnesses are not very detached to the culture of India. We have talked about these things, read about them in anthropological accounts and from our ancestors. It is through the Western lens that we have labelled them. Therapy and all its forms have been understood and studied exclusively in Western lenses till now. Traditionally, psychoanalysts have put a firm divide between a scientific and a pre- or non-scientific human experience, but human experiences have existed long before this verbalisation. Foucault (1965) considered mental illness to be historically situated within the cultural definitions of a particular time and place. Many anthropologists have also written extensively about how madness, by its very definition, is a social construct and psychoanalytic concepts vary across cultures finding their validity in the symbolic structures in which they are embedded. So, a shaman who is highly respected in a tribal society because of his visions, may be treated like a schizophrenic with hallucinatory disorders in modern culture.

The main problem in this categorised, "scientific" view of psychology presents itself in the space of therapy: People come with their subjectivities. These theories & exercises, tested and developed on European/American people, not only alienate the Indian clients, but often make them feel invisible and therapy, feel obsolete. It is a recent inclusion but the West has slowly incorporated the importance of body movement as Yoga, mindfulness and meditation which are a big part of religions like Hinduism, Buddhism, Sikhism and Islam anyway. The early view of therapy work strongly dissociated itself from religion, perhaps to carry over the learnings from the Enlightenment era (Immanuel Kant), of how science and beliefs can't go hand in hand. Oxford English Dictionary, in its third entry under "healing," defines it as "to restore (a person, etc.) from some evil condition or affection (as sin, grief, disrepair, unwholesomeness, danger, destruction); to save, purify, cleanse, repair, mend. Taking an excerpt From: Kakar, Sudhir. "Shamans, Mystics, and Doctors": "[...]Like very few other people, Indians have long been involved in constructing explanatory systems for psychic distress and evolving techniques for its alleviation. Besides the few psychiatrists of modern medicine, there are the traditional physicians—the *vaids* of the Hindu Ayurveda and Siddha systems and the *hakim* of the Islamic unani tradition—many of whom also practise what we today call "psychological medicine." In addition, there are palmists, horoscope specialists, herbalists, diviners, sorcerers and a variety of shamans, whose therapeutic efforts combine elements from classical Indian astrology, medicine, alchemy and magic, with beliefs and practices from the folk and popular traditions. And then, of course, we have the ubiquitous sadhus, swamis, maharajas, babas, matas and bhagwans, who trace their lineage, in some fashion or other, to the mystical-spiritual traditions of Indian antiquity and claim to

specialise (whatever else they might also do) in what in the West in a more religious age used to be called "soul health"—the restoration of moral and spiritual well-being. […]"

For the longest time the universality of psychologies played a huge role in the perpetuation of the science, but as a practitioner, I see the cultural context becoming more and more important as people understand what healing means to them, as an individual. I borrow from Sudhir Kakar's work the term "cultural psychology" which brings the importance of cultural relativity, while also holding the psychological universality in it's hand. Maybe it becomes important to hold these contradictory thoughts together, as Lionel Trilling does when he writes of his own response toward literature: "Generally our awareness of the differences between the moral assumptions of one culture and those of another is so developed and active that we find it hard to believe there is any such thing as an essential human nature; but we all know moments when these differences, as literature attests to them, seem to make no difference, seem scarcely to exist. We read the Iliad or the plays of Sophocles or Shakespeare and they come so close to our hearts and minds that they put to rout, or into abeyance, our instructed consciousness of moral life as it is conditioned by a particular culture—they persuade us that human nature never varies, that the moral life is unitary and its terms perennial, and that only a busy intruding pedantry could have suggested otherwise."

Holding this contradiction, we are to be looking at what the West understood of therapy and how decolonizing can look like, in the Indian context.

LITERATURE REVIEW

People experiencing mental health problems are often labelled as "pagal" or "pagla" ("mad" or "crazy") and are teased (Chowdhury, Chakraborty, & Weiss, 2001). A literature review on stigmatisation and discrimination of people with mental illness in India by Lauber and Rossler (2007) revealed that there is a widespread belief in Asian countries that those with mental illness are dangerous and aggressive or "unreliable." The stigma often comes with experiences but also exaggeration of truth. The medicalization of "disease" shifts the focus from human condition and pathologizes the pain. Pathologies are important, so is medication, yet in a collectivist society like India, the stigmatisation is often more harmful because it becomes a family issue and not an individual issue (Lauber and Rossler, 2007). Leong, Kim, and Gupta (2011) labelled this shame "loss of face" and studied its contribution to help-seeking behaviours in Asian American college students. A study of non-psychotic mental health outpatients in Jordan by Al-Krenawi and Graham (2000) shows that some clients attribute psychological illnesses to spiritual or supernatural causes. Many individuals attributed their illness to "evil eye" or the presence of spirits. Another belief amongst Muslim clients is that any kind of suffering is a test from Allah, and thus, seeking help is a form of spiritual failure (Aloud & Rathur, 2009). In line with this, much traditional Indian spirituality considers suffering a natural part of life (Arulmani,2007). The Bhagavad Gita, a central Hindu scripture, describes suffering as a natural component of human life caused by faulty perceptions and beliefs (Yogi, 1969). In her paper on "Help Seeking Attitudes," Ashlee M. Beck writes: "These beliefs may lead many clients to seek religious healing or other indigenous sources of care rather than formal mental health services."

But these romantic ideals of pain and suffering in indigenous religions often seem like propaganda. In the Indian subcontinent, the suffering in Bhagwad Gita or Muslim beliefs of Allah testing His subjects allows some clients to ACCEPT change and pain as a part of life instead of denying or enjoying it. The spiritual healing paths are often laid down with

therapeutic practices (amongst other things). As Silvia Federici wrote, "Magic is refusal of work in action." If people just "believe" in things, healing cannot be privatised. In today's day and age, a human value like empathy is often marketed as a "skill." Values develop but skills are "acquired," often by a course that is worth just INR 999/-

The acceptability of Western psychotherapy and counselling professionals has not diminished the popularity of older healing practices (Arulmani, 2007). The Eastern approach cannot conceive of a separation between psychology and spirituality since both are concerned with the study and understanding of human nature (Varghese, 1998). Western psychotherapy offers a way to address the panic in the journey towards the unknown and strengthen an ego, which can only then be surrendered in the spiritual quest, as articulated by Varma (2004). Instead of viewing it as spirituality vs science, perhaps integrating the practices can make therapy a more accessible, understandable process for people in India.

In Sudhir Kakar's book; Shamans, Mystics and Doctors (1982); Kakar explores a lot of Indian healers and their methodologies. For example, a core fantasy according to Kakar in Indian culture is of a female demon personifying forbidden female sexuality that sucks and drains even the most powerful men to death. Thus, we have the story of a wrestler who is killed by a female demon who sucks out his life energy. Thus, a good female in Indian culture is not supposed to be overtly sexual yet men have unconscious desires to possess such a woman. It is this forbidden desire that takes the form of a chudail or female ogre. Kakar also creates the imagery of healer as the one of an ideal therapist, "The major requirements of the traditional forms of healing is that the healer is not simply any person who dispenses medicines but a special person who is different from others not simply by having more knowledge and skills but by being transformed from inside. He is a superior moral and ethical being and his powers are not acquired from outside but come from inside." The idea is not to denounce the Western healing, but to step away from the ethnocentric views to socially and culturally attach therapy as a part of life and not just a once in a lifetime process.

METHODOLOGY

The interest in the topic started from a personal space for me, and reading Kakar's work strengthened my beliefs. Yet, when I stepped into the practice is when I could truly see the difference between theory and practice.

I spoke to 10 people who have been to therapy, the same therapist. Out of these, I have shared below experiences gathered from 4 people, let's call them A, B, C and D. The goal was to take these four people, from similar socio-political backgrounds and compare their experience in therapy, working on their understanding of therapy. Before the interview, they were just told about the paper and a brief background of my work. They were asked the same primary question, "How was/is therapy for you?"

Data Analysis

Person A is a 57 year old woman, she is a Muslim woman, residing in Delhi. She went to therapy for 3 sessions. She left, stating that she doesn't feel "ready" for the process itself at the moment.

Shaifila: "Hi A, I want to discuss the process of therapy with you. I want to understand, how was therapy for you?"

A: "What does that mean? Are you asking if it was good?"

"*A*" primarily thought it was a review process for the therapist. However, in further questioning, she revealed what made her leave. Talking about how her therapist seemed like a good therapist, but the solutions she gave were not groundbreaking. "She suggested I do some mindfulness activities like drawing lines on a paper and focusing on the lines for a minute. But I can't focus if I can't, right?" *A* went with issues related to her anxiety. "I only went because my daughter asked me to. She thinks "therapy is good, just not good for her." Yet, after leaving the process, she joined a support group after just one month. It is a society collective of women from her apartment complex which she describes as a helpful space for talking. The primary objective of the group is to learn English together and play some games, like a kitty party.

Person B is a 27 year old woman, living in Delhi. She identifies as an atheist but was brought up in a Jain family. She is still in therapy. She has had 19 sessions, on and off.

For "*B,*" therapy was an intentional choice. She had recently broken up with her partner and was feeling lonely, angry, confused and sad. Therapy for her was "a safe space, like advertised!," she exclaims. B seems to talk of her breakup nonchalantly, which surprises her even now. B was fairly educated in what therapy was supposed to be like for her. She did her research, chose the therapist and planned her visit. Even though she has achieved a certain level of closure with her relationship, she continues to come because "she likes being heard." B thinks the fact that her therapist sits, listens and only shares insights if needed is very important to her. She calls it "passive therapy" where she gets the space and the trust but doesn't worry about how she needs to wait for the therapist's reaction. The communication is clear.

Person C is a 45 year old man, who is also based out of Delhi. He works in the petrochemical industry and came in with complaints related to anxiety. He has been in therapy for 8 sessions and is regular.

"She speaks too little," C exclaims as soon as we sit down to talk. He is someone who is not very talkative and therefore wants the conversation to be a more equal playground than just him talking. He thinks the therapist talks too little and the silences get awkward sometimes but they have talked about it a little bit. C also expresses how sometimes he feels angered by the therapist. "Is she just going to listen and witness?" This isn't the first time C is in therapy, he has been to a life coach for anger management before and he thinks that objective was met and therefore the relationship did not continue. C holds therapy as a space to process and verbalise his past. The traumas, the good parts: everything. He wants a stable narrative about his life and therefore speaks with a fervour and desire to unfold the past. He knows it will take time, but he feels ready for it. C wants to be in this "bond" till he feels that this objective is being met.

Person D is a 24 year old man who works in an NGO. He never thought he needed therapy but he tried it for 3 months and then stayed on for a year. He believes therapy helped him shift the relationship with his parents and partner and shape him into a "better" person who is now not repeating the generational patterns of neglect and reckless behaviour.

"I never thought my childhood had neglect. Or that my parents could be at fault." D talks about how therapy created a space for him to understand the role his parents played. While

he got angry once he realised their "flaws," he also could work on relating to his parents differently. To see them as people and not ideals. The acceptance of this new kind of a relationship allowed him to create boundaries. Boundaries laid by family exercises that the therapist recommended. D believes that therapy allowed him to reparent himself and confront the fears he had. To make the narrative of understanding and not just of "emptiness" in the family.

RESULT & DISCUSSION

In the Indian context, religion plays a central role in our lives. More than belief, this cultural upbringing is something that often influences how we see things, what we believe in and form relationships and so on. We can also not negate the role of religion in sociability. The social rules influence exclusion, inclusion and the spaces we (are allowed to) take. To detach from these identities to make healing just about individual growth is not very beneficial. For example, it seems maybe in the case of A, the therapist could have asked for mindfulness in a way which was more attached to her routine. We often say that more than what happens inside the room, therapy is what happens outside the safe space. To make therapeutic a habit more than a compulsion. To make therapeutic acts accessible, doable and something that is a part of the client's life can make healing more sustainable. This is why ancient/traditional healing works, because it is a part of the routine, the belief, the central point of their lives. This view that religion and spirituality indicate primacy, is perhaps an unfair representation of the concepts. Keeping aside the belief, religion is highly community based activity. It provides a community, sense of belonging and feelings of care; among other things. The common Western understanding that these traditional approaches are primitive and unscientific reflect a suspicion of methods that are culturally alien. The loyalty of the masses to these methods has been routinely attributed to ignorance and the lack of knowledge. Some scholars, however, have attempted to draw a balance and argue that it is the scientists who are not able to transcend the boundaries of their education to examine these alternate methods with equanimity (e.g. Watts, 1975). Others have pointed out that these are ancient practices, distilled over hundreds of years from the collective experience of the community, that in fact have a high degree of efficacy at the practical and every day level (e.g. Kakar, 2003).

Another important example becomes of the therapist herself, the same person is experienced so differently by Person B and C. Do either of them have the "right" version? Probably not. Does it make their version of her less correct? No. This difference exists in all realms of life. Culturally, children in the West are often made to sleep in a different room as a baby. Sleep and separation anxiety are some themes that have been well explored. At the same time, in India, it is not a custom. Babies sleep in the parents' room, and mostly in the parents' bed too. Sleep for them can be seen as a peaceful reminder of the parent. Sleep is a common phenomenon, the response is different. It is also important to acknowledge that these generalisations allow us to understand some things that haven't been asked yet. It should not obscure the fact that perhaps the central mechanism, the relationship between the patient and the healer, is common across cultures and there It is, after all, based on what evolution has created: humans embedded in a web of human connectedness.

Kakar specifically puts forward his views on knowledge and recognises that there are four levels of knowledge; common sense, rational knowledge of the scientist, the imaginative knowledge of the artist and the spiritual knowledge of the mystic. All four have their relevance and none is to be discounted.

CONCLUSION

The study is definitely limited in how qualitative interviews need to be done with a larger sample. However, in the theoretical understanding of therapy, culture plays not much of a role and it holds importance in how we see the work most definitely. Historically, psychology in the West actively sought to distinguish itself from theology and metaphysics, separated itself from its earlier preoccupation with the "soul," and oriented itself instead to the study of "behaviour." It committed itself to the epistemology of logical positivism and chose as its tools the inductive process of scientific reasoning. The discipline of counselling psychology emerged from within this framework, in direct response to psychological needs that had their roots in the Western socio-cultural milieu. This continues to be an ethos that is founded on materialistic individualism: a culture that celebrates the individual's freedom for self-determination. This responds to the cultural needs of the West. Whereas in India, it often feels like there are so many more factors that need to be taken into account. Caste, Class, Gender, Religion, Sexuality to name a few, are some identifiers or points that need to be acknowledged and understood. The untethered idea of "self" seen from just one perspective is often incomplete and may leave the client feeling unexplored, misunderstood. The desire to create a new language of therapy would be foolish considering the entire point is to make therapy subjective for each client, but what becomes extremely important is to have space and structures for cultural knowledge. For budding therapists to be culturally aware and open. In a divisive space that is often seen in Indian politics, therapy needs to be cohesive. We need to understand psychology from not just the texts, but also to see what WE bring into the room. Our experiences, subjectivities, biases, knowledge and skills create the unsaid environment of the room we offer to the client. It becomes extremely important to ask what that space looks like and to be clear with the client about the space we can provide.

It also means to be able to step out of the stoic and disengaged image of a therapist. Most of this cultural understanding is not something that can be immediately learned, but to inculcate the possibility of these learnings seeping into the therapeutic space.

This piece of work is my attempt to build the bridge between theory and practice, but also to reiterate the importance of the client being the leader in the sessions. To know that it is their story and that the primary desire of being heard becomes important in this world of loneliness.

I hope we are able to approach our work with intentional humility and use the scientific, subjective and cultural knowledge in the space of therapy for ourselves and our clients.

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Conflict of Interest

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