Western Science, Eastern Minds

"I'm going crazy!" Would such an exclamation have the same meaning in Calcutta as it does in Chicago? Freud believed that psychoanalysis expressed laws that were scientific and as universally true as the laws of physics. But the patients whom analyst Sudhir Kakar sees in India have an understanding of the the mind and body totally unlike Freud's—and most Westerners'. The "psyche" has had different histories in the East and West. The practice of psychotherapy in Asia shows what happens when those two histories collide.

by Sudhir Kakar

Ramnath is a 51-year-old man who owns a grocery shop in the oldest part of the city of Delhi. When he took the unusual step of coming to see me, a Western-trained psychoanalyst, he was suffering from an unspecified anxiety which became especially acute in the company of his father. He did not call it anxiety, of course, but a "sinking of the heart." This condition was less than three years old, a relatively new development.

Ramnath had, on the other hand, long suffered from a number of other complaints, in particular a nervous stomach. It is now never quite as bad as it was in the months following his marriage some 30 years ago, when it was accompanied by severe stomach cramps and an alarming weight loss. His father had taken him to the hospital, where he was X-rayed and tested. Finding nothing wrong with him, the doctors had prescribed a variety of vitamins and tonics which were not of much help. Older family members and friends had then recommended a nearby *ojha*—"sorcerer" is too fierce a translation for this mild-mannered professional of ritual exorcism—who diagnosed his condition as the result of magic practiced by an enemy, namely his newly acquired father-in-law. The rituals to counteract the enemy magic were expensive, as was the yellowish liquid emetic prescribed by the *ojha*, which periodically forced Ramnath to empty his stomach with gasping heaves. In any event, he was fully cured within two months of the *ojha*'s treatment and the cramps and weight loss have not recurred.

Before coming to see me about his more recent anxiety, Ramnath had been treated with drugs by various doctors: by allopaths (as Western-style doctors are called in India) as well as homeopaths, by the *vaids* of Hindu medicine as well as the *hakims* of Islamic tradition. He had gone through the rituals of two *ojhas* and was thinking of consulting a third who was highly recommended.

His only relief came through the weekly gathering of the local chapter of the Brahmakumari (literally "Virgins of Brahma") sect which he had recently joined. The communal meditations and singing gave him a feeling of peace and his nights were no longer so restless. Ramnath was naturally puzzled by the persistence of his anxious state and its various symptoms. He had tried to be a good man, he said, according to his *dharma*, which is both the "right conduct" of his caste and the limits imposed by his own character and predispositions. He had worshipped the gods and attended services in the temple with regularity, even contributing generously toward the consecration of a Krishna idol in his native village in Rajasthan. He did not have any bad habits, he asserted. Tea and cigarettes, yes, but for a couple of years he had abjured even these minor though pleasurable addictions. Yet the anxiety persisted, unremitting and unrelenting.

At first glance, Ramnath's understanding of illness and well-being seems incredibly cluttered. Gods and spirits, community and family, food and drink, personal habits and character, all seem to be somehow intimately involved in the maintenance of health. Yet these and other factors such as biological infection, social pollution, and cosmic displeasure—which most Asians would also acknowledge as causes of ill health—only point to the recognition of a person's simultaneous existence in different orders of being. To use Western categories, from the first birth cry to the last breath, an individual exists in his or her *soma*, *psyche*, and *polis*. In other words, a person is simultaneously a body, a self, and a social being. Ramnath's experience of his illness may appear alien to Westerners only because the body, the self, and the *polis* do not possess fixed, immutable meanings across cultures.

The concept of the body and the understanding of its processes are not quite the same in India as they are in the West. The self—the Hindu "subtle body"—is not primarily a psychological category in India, though it does include something of what Westerners mean by "psyche." Similarly, for most Indians, the *polis* consists not only of living members of the family and community but of ancestral spirits, other "spirit helpers," and the gods and goddesses who populate the Indian cosmos.

An Indian is inclined to believe that his or her illness can reflect a disturbance in any of these orders of being. If a treatment, say, in the bodily order fails, one is quite prepared to reassign the cause of the illness to a different order and undergo its particular curing regimen—prayers or exorcisms, for instance—without losing regard for other methods of treatment.

The involvement of all orders of being in health and illness means that an Indian—and this holds true for the Chinese or Japanese too—is generally inclined to seek more than one cause for illness in especially intractable cases. An Indian tends to view these causes as complementary rather than exclusive and arranges them in a hierarchical order by identifying an immediate cause and then more peripheral and remote causes.

To continue with our example: Ramnath had suffered from migraine headaches since his adolescence. Doctors of traditional Indian medicine, *Ayurveda*, had diagnosed the cause as a humoral disequilibrium—an excess of "wind" in the stomach which periodically rose up and pressed against the veins in his head—and prescribed *Ayurvedic* drugs, dietary restrictions, as well as liberal doses of aspirin. Such a disequilibrium is usually felt to be compounded by personal conduct—bad thoughts or habits which, in turn, demand changes at the level of the self. When a disease like Ramnath's persists, its stubborn intensity may be linked with his unfavorable astrological conditions, re-

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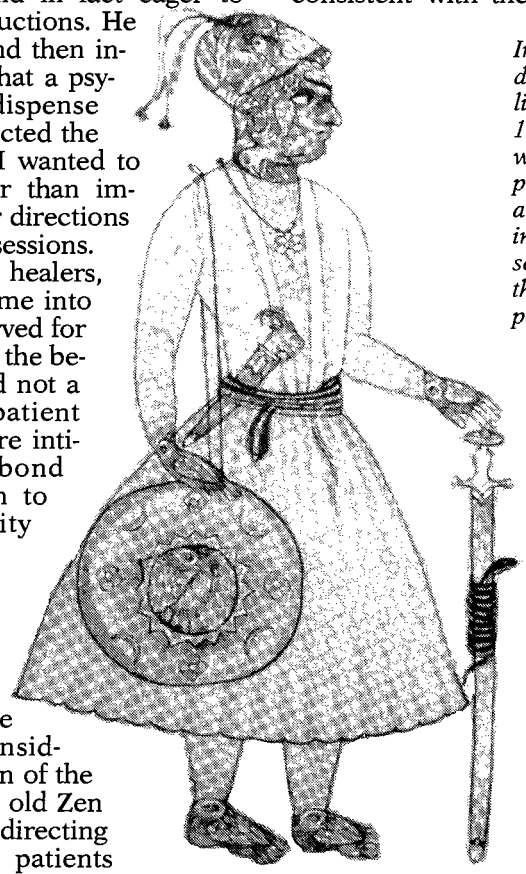
quiring palliative measures such as a round of prayers. The astrological "fault" probably will be further traced back to the bad *karma* of a previous birth about which, finally, nothing can be done—except, perhaps, the cultivation of a stoic endurance with the help of the weekly meetings of the "Virgins of Brahma" sect.

Ramnath had turned to me, a representative of Western psychological medicine in an Asian country, not knowing what to expect but willing and in fact eager to carry out all my instructions. He was at first puzzled and then increasingly dismayed that a psychoanalyst did not dispense wise counsel but expected the "client" to talk, that I wanted to follow his lead rather than impose my own views or directions on the course of our sessions.

In the universe of healers, Ramnath had slotted me into a place normally reserved for a personal guru. From the beginning, he envisioned not a contractual doctor-patient relationship but a more intimate guru-disciple bond that would allow him to abdicate responsibility for his welfare. This is, of course, not uncommon in modern psychotherapeutic practice in other Asian countries. In Japan, for instance, the therapist is often considered the personification of the wise old sage—like an old Zen master—benevolently directing sincere, hardworking patients toward happiness, in the tradition of the Buddha who rewards devotion with mercy.

We can understand Ramnath's dismay better if we remember that the guru model also demands that the therapist demonstrate his compassion, interest, warmth, and responsiveness much more openly than is usual or even possible in the normal model governing Western psychotherapeutic relationships. Furthermore, the emphasis on therapeutic communication through words runs counter to the dominant Indian idiom in which words are only a small part of a vast store of signs and symbols. The pitch and intonations of voice, facial expressions, hand gestures, and bodily movements are expected to play a large role in any close interpersonal encounter. From Ramnath's viewpoint—and I tend to agree with him—my clinical detachment (though leavened with a subversive Indianness we both shared) was inconsistent with the way a guru ought to behave.



In the West, a person is defined, confined, and outlined by his body. This 18th-century drawing of a warrior with head and appendages made up of birds and animals shows how, in India, each person is seen as a microcosm of the whole natural and supernatural world.

As Ramnath discussed his illness, there was a striking absence of the psychological terms which roll so easily off the lips of most Western middle-class patients. Ramnath, as I mentioned, complained of a "sinking of the heart" rather than anxiety. He would talk of a burning of the liver rather than rage. Here he is similar to the Chinese patient who talks of his *shen-qui* or "waning of the kidneys" and his *qi-ji* or "frustrated breathing." The absence of psy-

ASIA'S HIDDEN HEALTH PROBLEM

For health conditions, the 20th century has been the proverbial best of times and worst of times in Asia. Infectious diseases, such as tuberculosis and typhoid fever, which once swept in mortal plagues across the Asian continent, have dramatically declined. Today, in industrialized East Asia, the death rate from infectious disease is among the lowest in the world. Even in India and in China, where the rate remains high, it has nonetheless dropped to less than half of what it was earlier this century.

But because of "modernization," and the changes in behavior and diet it has brought, Asian death rates from chronic disease have risen alarmingly. Consider only the "small matter" of cigarette smoking. In China, nicotine consumption increases by 10 percent each year; more than 60 percent of adult men now smoke. From 1957 to 1984, deaths from cardiovascular diseases rose by 250 percent, while deaths from cancer and stroke registered similar increases.

Yet it is in the realm of mental health and behavioral problems that modernization has had the gravest consequences. A "just-say-no" American politician could scarcely envision in his worst nightmare the increase in drug use—and drug-related violence—in the past few years in Asia. Fifteen years ago Pakistan had fewer than 50,000 heroin addicts; today it has more than one million. More than 10 percent of all adults in Thailand are addicted to some form of opium. As with drugs, so with drink: Alcohol consumption is rising, even in Japan and China, whose populations were once considered almost immune to alcoholism. The rise in drug and alcohol abuse is accompanied by increasing juvenile delinquency, family breakdown, abandonment of children, suicides, and widespread mental illness.

There is a fallacy or myth that mental illness is a "luxury" of advanced societies. In Asia, depression and anxiety account for more visits to primary-care providers than do infectious diseases. From 10 to 20 percent of all outpatient visits in Asian countries are for depression and anxiety, which, however, are usually neither diagnosed nor treated effectively. Even when a mental illness is no more common than in the past—as with schizophrenia—the sheer numbers of cases in the populous Asian nations are daunting. There are six million schizophrenic patients in China, and one million in Pakistan. To treat them, Pakistan has perhaps 100 psychiatrists—one for every 10,000 schizophrenics. China may have, all told, 3,000 mental health experts and less than 80,000 hospital beds for the mentally ill. One fact is thus indisputable: Asia cannot follow the Western model for treating mental health problems.

And often what could be done is not done, so powerful is the stigma attached to mental illness. In Taiwan a $70-billion trade surplus has financed the creation of outstanding medical facilities for all disorders—except mental illness. The mentally ill in Taiwan, as in mainland China, are simply locked up in appalling institutions. For patients seeking help on an outpatient basis, the prospects are hardly brighter. The length of the first visit to a health-care provider averages less than five minutes; the length of the typical return visit is only two minutes. In many Asian societies, the biomedical care system is thus as much the problem as it is the solution.

Economists tend to see modernization as an unalloyed good, but the psychologist must acknowledge that, in Asia at least, modernization has been accompanied by a grave worsening of mental health. What is to be done? Individual psychotherapy can help somewhat but is hardly available except to a narrow group of affluent Westernized elites. Beyond that, what good does it do when psychology or psychiatry defines problems but has nowhere near the resources needed to treat them? Does it help to label the victims of ethnic violence in India or in Sri Lanka as sufferers of "posttraumatic stress disorder?" Such medicalization trivializes the social and political sources and moral consequences of suffering, while it offers no health benefit to the millions who suffer.

—Arthur Kleinman, Professor of Anthropology and Psychiatry at Harvard, has conducted research in East Asia since 1968. He is the author of Patients and Healers in the Context of Culture *(1980),* Social Origins of Distress and Disease *(1986), and* Rethinking Psychiatry *(1988).*

chological language has led some Western psychiatrists to conclude that the Chinese or, for that matter, Indians tend to make psychological symptoms somatic. This may be a hasty conclusion. One reason for the physical presentation of symptoms by Asians is the greater shame associated with purely psychological complaints. Even more importantly, both the Chinese and the Indians do not distinguish as sharply between psyche and *soma* as Westerners do. M. L. Ng, a Hong Kong-based psychiatrist, remarks, "When a Chinese complains of *sinn i*, which literally means a pressing discomfort over the chest or heart, a fellow Chinese immediately understands that he is not just complaining about a heart or chest discomfort but also about a feeling of depression, worry, or loss." Similarly, in India if one tries to determine whether a patient who says "my heart does not feel up to it" or "my liver is not doing its work" actually means the physical organ or some emotional disturbance, it often evokes puzzlement, for the patient has never distinguished between the two aspects (body and emotion)—that is, if he or she is not Westernized.

The very word for health in Hindi—*swastha*, from the root *swa* (I) and *astha* (stable)—implies something which is present or stable in the "I": not in the body, not in the mind, not in the various organs, but in the underlying self.

As an analyst, one of my chief concerns is the personal, life-historical dimensions of Ramnath's symptoms, especially of the anxiety which gets worse in his father's presence. Ideally, I would like him to be biographically introspective, which I know is not a natural process in Indian or, for that matter, Chinese or Japanese culture. It is rarely recognized that such introspection—a *sine qua non* for psychoanalytically oriented therapies—is a peculiarly Western trait, deeply rooted in Western philosophical and literary traditions. It can be traced back to later Greek thought where the definitions of the self and of identity became contingent upon an active process of examining, sorting out, and scrutinizing the "events" and "adventures" of one's own life. This kind of introspection is simply not a feature of most Asian cultures and their literary traditions. Indian autobiographies, for instance, with rare exceptions, are evocations of places and accounts of careers—records of events from which the self has been excised. The meditative procedures involved in Indian "self-realization," to which introspective activity might conceivably be compared, are of a different nature altogether and aim at radically different goals. The Indian injunction "Know thy Self" (*atmanam vidhi*) refers to a self very different from the one referred to by Socrates. It is a self uncontaminated by time and space and thus without the life-historical dimension which is the focus of psychoanalysis and of Western romantic literature.

An Indian analyst knows that his patients who are not highly Westernized will usually not recognize their emotional problems as having a genesis in a "psyche" or in their personal histories. If not attributed to possession by malevolent or unsatisfied spirits who definitely lie *outside* the individual, the disorders and conflicts are often seen as the product of the *karma* of a previous life. A woman in her early thirties, becoming aware of her rage against her husband as revealed in a dream, spontaneously exclaimed to me, "Ah, these are due to my *samskaras* [the karmic traces from a past life]. However hard I try to be a good wife, my bad *samskaras* prevent me." Introspection in the Western sense may have to be taught, so that an Indian analyst is often more didactic than his Western colleague, skirting perilously close to the analytical sin of suggestion. Yet heightened didactic activity on the part of the Indian or Asian analyst need not be *ipso facto* suggestive, which would be to go against his professional identity. The analyst can exhort, encourage, and interact, so long as he refrains from suggesting the content of an unconscious conflict and lets the patient discover it for himself.

The conflicting demands of an Asian culture and of Western psychotherapy, however, are not always so easy to reconcile. The reconciliation becomes much more difficult if the therapist and the patient do not share—as they often do not in Asian countries—fundamental cultural assumptions about human nature, human experience, and the fulfilled human life.

PSYCHOTHERAPY IN JAPAN: *HAMLET* WITHOUT GERTRUDE

Can psychotherapy, laden with its "Western" assumptions about the individual, be directly imported into Asia? Japan would seem the ideal country to test this question.

Psychotherapy works best in a secular culture, and the Japanese are at least as secular as Europeans and Americans. Individual psychotherapy is also an expensive proposition, but Japan is the one Asian nation sufficiently affluent to support psychotherapy on a wide scale. Even in the West, many intellectuals, from D. H. Lawrence to Jean-Paul Sartre, opposed the psychoanalytic understanding of the unconscious, but Japanese writers and novelists have explored the workings of an inner mind as irrational and perverse as anything in Freud. And the Japanese have certainly integrated every other Western social science—anthropology, political science, sociology—wholeheartedly into their culture.

The supposed affinity of the Japanese for psychotherapy proves, at first glance, justified: Graduates of Buddhist seminaries talk about Freud, and the popular "new religions" hire psychologists to conduct group-therapy sessions. Yet when it comes to individual psychotherapy, there seems to be a resistance to many basics of Freudian psychology. The reasons for this, according to George De Vos, a psychologist in the anthropology department at Berkeley, are not hard to find.

The Japanese may have largely dispensed with a religion of the gods, De Vos observes, but they still have a religion—that of the family. Because of the family's sacrosanct character, Freudian investigations into its workings—such as ambivalence toward a parent or a parent's role in a patient's neurosis or, especially, the ways in which a maternal figure may not be all-loving and good—are practically taboo. "Such concepts," De Vos writes, "cannot be pursued by a Japanese who wishes to remain Japanese."

A Japanese, instead of investigating his past, romanticizes it: Instead of analyzing his early childhood, he creates fictions about it. The Japanese, De Vos says, learn to control their thoughts hypnotically: "One comes to reinterpret past behavior of parents as possible expressions of love, perhaps previously ignored or misinterpreted because of one's immature selfishness."

Even for adults, expressions of individuality are often considered signs of selfish immaturity. Freud's definition of psychological health described an autonomous individual. But for most people in Japan, De Vos writes, "autonomy is anomie—a vertigo of unconscionable alienation leaving life bereft of purpose." Consequently, the Westernized

For psychotherapy depends upon how health and maturity are defined in a particular culture. Even Sigmund Freud conceded this point when he wrote, "In an individual neurosis we take as our starting point the contrast that distinguishes the patient from his environment, which is assumed to be 'normal.'" In other words, psychotherapy is the practical application of cultural myth that is normally shared by both the patient and the therapist.

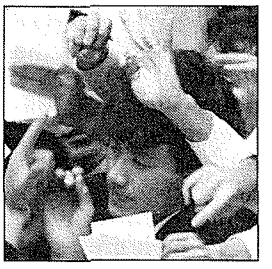
The model of man underlying most Western types of psychotherapy is uniquely a product of the post-Enlightenment period in Western history. In the psychological revolution that occurred during this period, the older ideas about the metaphysical scope of the mind narrowed and the mind came to be viewed as an isolated island of individual consciousness, profoundly aware of its nearly limitless subjectivity. The perspective of almost all varieties of modern psychotherapy is thus informed by a vision of human experience that emphasizes man's individuality and his self-contained psyche. Each of us lives in his own subjective world, pursuing personal pleasures and private fantasies, constructing a life and a fate which will vanish when our time is over. Together with other value-laden beliefs of the Enlightenment—in individual autonomy and individual worth, in the existence of an objective reality that can be known, in the possibility of real choice—the individualist model of man has pervaded contemporary psychotherapy.

The goals of Western forms of psychotherapy are then very much related to the

understanding of mental illness and healing is, in Japan, often stood on its head: A neurosis, for example, is not the person's inability to achieve "individuation" but his incapacity to fulfill role expectations.

Alan Roland, the author of *In Search of Self in India and Japan* (1988), agrees with many of De Vos's conclusions, but he nonetheless finds that psychotherapy is slowly taking hold in Japan. The Japanese Psychoanalytic Association alone has over 1,000 members, 80 percent of them psychiatrists. Roland says that Japan was never burdened by a colonial legacy which denigrated its indigenous culture. Japanese psychotherapists have thus found it easy to maintain the uniqueness of the Japanese psyche, and they have re-written classical psychoanalytic theory with an unFreudian lack of inhibition.

The all-important Oedipus complex, for example, has been transformed into nearly its opposite—the Ajase complex (named after a Buddhist myth). The Oedipus complex tells of an irreconcilable conflict among father, mother, and son; in the Ajase complex, the father is absent from the picture—and so is the irreconcilability. Although in adolescence the son may rage over the "loss" of his mother's unqualified love, he finally repents after realizing her great sacrifices for him. Japan's most famous psychoanalytic theorist, Takeo Doi, has gone even further and challenged the entire Freudian framework, in order to justify dependency. In *The Anatomy of Dependence* (1973), Doi argued that Western vocabularies lack even the terms to understand, much less to appreciate *amae*—the healthy Japanese "need" for psychological dependency. Indeed a pathological condition, *hinikureta* (warping), is produced when one's sense of dependency is frustrated. Concepts like *amae* undercut traditional psychotherapeutic goals, but, as Roland points out, "a psychoanalytic world view that guides the person in a world of crumbling cultural and social supports is not at this point very appropriate to the Japanese."



Japan—when and if it experiences the individualism and family strains of other advanced societies—could well revert to more traditional Freudian therapy. Now, however, Japan is in the unusual position of welcoming Western psychotherapy but, because of its inability to scrutinize family life, changing it into something else. Psychotherapy in Japan resembles, if not quite *Hamlet* without the Prince of Denmark, then *Hamlet* without Gertrude, the suspect mother.

individual even in those instances where the therapy, in its techniques, addresses the group. All Western therapies talk, in some fashion or other, about the growth, development, and self-actualization of the individual. They talk of increasing the individual's environmental mastery, his positive attitudes toward himself, and his sense of autonomy.

By contrast, in India I had the case of a 28-year-old engineer who came to the initial interview accompanied by his father and sister. Both relatives described his central problem as one of "unnatural" autonomy. As one said: "He is very stubborn in pursuing what he wants without taking our wishes into account. He thinks he knows what is best for himself and does not listen to us. He thinks his own life and career more important than the concerns of the rest of the family."

Indian patients, like Chinese and Japanese, have in their minds what might be called a *relational model* of the self, which is quite different from the individual model of the post-Enlightenment West. In Asia, the person derives his nature or character interpersonally. He is constituted of relationships. His distresses are thus disorders of relationships not only within his human—and this is important—but also his natural and cosmic orders. The need for attachment, connection, and integration with others and with his natural and supernatural worlds represents the preeminent motivational thrust of the person, rather than the press or expression of any biological individuality.

The tendency to look at a person in transpersonal or relational terms is re-

flected in all aspects of Indian culture, from astrology to medicine to classical poetry. The Indian image of the body, for instance, emphasizes its intimate connection with nature and the cosmos. It stresses an unremitting interchange taking place all the time between the person and the environment, in which the location of the self, so to speak, is not circumscribed by the boundaries of the skin. This is in marked contrast to the typical individualistic Western image of a clearly etched body, sharply differentiated from the rest of the objects in the universe, with the self "inside" the body. Similarly, traditional Chinese culture conceptualizes man as an integral part of nature, as a microcosm of the universe, with his functioning dependent on the smooth circulation of the Yin and Yang forces which are part of the universe.

The Asian psychotherapist is acutely aware of this conflict between two sets of psychotherapeutic assumptions. The Western assumptions—stemming from an individualistic model of man and crucial in the formation of the therapist's professional identity—are epitomized in classical psychoanalysis. These include, in the words of psychologist Kenneth Kenniston, a "limitless respect for the individual, faith that understanding is better than illusion, insistence that our psyches harbor darker secrets than we care to confess, refusal to promise too much, and a sense of the complexity, tragedy, and wonder of human life." The other set of assumptions, which derives from the relational model and is absorbed in the therapist's very bones from his culture, stresses that surrender to powers greater than the self is better than individual effort. The source of human strength, in the Asian view, lies in a harmonious integration with one's group, in entering into the living stream, naturally and unselfconsciously, of the community life, and in cherishing the community's gods and traditions.

Fortunately for the Asian psychotherapist and his patients, the conflict between the two models of man is not, in practice, a simple dichotomy. Both visions of human experience are present in all the major cultures, though a particular culture may, at times, emphasize one at the expense of the other. Relational values, which were submerged during the 19th and first half of the 20th century in the West, now increasingly inform Western modes of psychotherapy. Similarly, stirrings of individualism have not been completely absent from the history of Asian societies.

The Asian psychoanalyst has a choice, for instance, whether to orient his practice more toward the newer "object-relations" therapy which concerns the internalization of early family relationships—an approach which does not run counter to the dominant cultural orientation of his patients. Or he can resolutely stick to Freud's classical individualistic model, confident that, because of modernization throughout the world, he will find enough patients who will see him as their best ally in the realization of their full individuality.

In his more helpless moments, though, when confronted with the cultural incomprehension of his patients—an incomprehension the Asian analyst is often tempted to confuse with personal obduracy—he can always console himself with the thought that Freud himself called psychoanalysis one of the impossible professions. Unfortunately, it is impossible for the Indian, Chinese, or Japanese analyst to repeat Freud's words with the same saving sense of irony.