IS WESTERN TRAINING RELEVANT TO INDIAN PSYCHIATRY?

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Western training has been a highly cherished goal of a number of physicians in India. During the days of colonianism, training in the United Kingdom was provided to the intelligent and capable physicians and thus was considered an ostrich feather. However, the aspiration to obtain Western training continued even after independence because of the privileged position the Western trained physicians enjoyed in India as well as the lack of facilities in our universities. During the 50's and 60's, a large number of physicians left India for obtaining western training. In addition to training itself, another prime motive was financial as well as better opportunities. Many of those who left did not return. The brain drain that has been noticed is a part of universal migration of the more restless, more ambitious and more capable to areas which promise greater rewards. Although such a movement is advantageous to the west, it has been a serious obstacle to Indian psychiatry. However, during the past 20 years, many post-graduate training centres have been created and more and more specialists are being produced.

WESTERN TRAINING

Quite a few psychiatrists have returned to India after western training. The number of people that stay out are determined not only by the motives of the trainee but also by the sociopolitical decisions of the host country. As the need for medical manpower in the western countries are by and large met with, most of the western trained psychiatrists return to India to practice the skills they have acquired during their training. At the same time, Indian psychiatry has developed and has been looking into the indigenous methods of conceptualizing and treating mental illness (Neki, 1976; Surya, 1966; Pandc, 1968). At a time when the upsurge of imparting Indian thinking to psychiatry has started earnestly, an increasing number of western trained psychiatrists have returned home to practice. Under these circumstances it is appropriate to scrutinize the following: relevance of western training to Indian psychiatry; impact of western training on the growth of Indian psychiatric thinking; and the advantages as well as problems.

Problems to the trainee: The trainee has to go through an acculturation process during three to five years of his training period (Ananth, 1976). During the training the concepts he learns are so much bound up with the views of the west, that it necessitates that he evaluate his social values and learn and accept new values. Many succeed in the acculturation process and complete their training successfully. However, when these physicians return home, they face the problem of going through reverse acculturation process which may take a year or two. Hence, some hostility towards his own culture and discontent within oneself may occur as a result of the anxiety generated by the reverse acculturation process.

PSYCHIATRIC TRAINING

Biological aspects:

Psychiatric illnesses, like all other illnesses reflect the outcome of an interaction between biology and social organization mental illness depending on socially determined convention. Each social group must
with culture in a mediating role. The biological aspect of psychiatry has more universality than other aspects. Thus, phenomenology, genetics, clinical features, prognosis, response to treatment, as well as classification of illness, are the same all over the world. Biochemistry and other basic sciences related to psychiatry are similar across cultures as well. In a western psychiatry setting, the biological aspects of psychiatry are well taught to a resident, who rotates through various hospitals, sometimes in different cities and thus obtains a broad clinical perspective. This area of training provides him with diagnostic skills, ability to proceed with relevant investigations and utilization of the information for clinical judgement. All residents learn biochemistry relevant to psychiatry as well as biochemical methods. Those interested in the biological fields can pursue further in these areas with the biochemistry, pharmacology or physiology colleagues during their third or fourth year of their training. Thus western training in psychiatry has therefore more options to offer than to be found in Indian settings at present. Furthermore, facilities for teaching, demonstrating and providing experience in biological basic sciences are not readily available in India. Thus western training in the biological "disease" model of psychiatry helps rather than hinders the Indian trainee.  

Sociocultural aspects:

Medicine is a cultural institution and hence disease and treatment must be viewed within a cultural context. Specially in psychiatry, biological data base is non-existent and the psychiatrist's tool for diagnosis and treatment is verbal interaction. The diagnostic skill to interpret the verbal production as well as behaviour of the patient depends heavily on the sociocultural context. Hence, it is useful to go through some of the cultural problems that an Indian trainee would face in his western training and the impact of this western culturally oriented training on his therapeutic and diagnostic skills (Ananth, 1979).

Trainee: The trainee will face a cultural shock in the new country. Being from India, which is a stable society with rigid value system, he finds it difficult to adjust to the new culture with entirely new set of values. He starts his training in psychiatry at a time when his ego resources are being spent in dealing with the turbulence caused by the demands of western society. Basic habits and values, including the way to eat, dress and talk, are to be changed. Definitely, this itself causes an impact on his learning (Ananth, 1971). During his learning process of psychotherapy, Indian trainees find it difficult to accept western norms but gradually assimilate and ultimately accept them so that he can treat western patients effectively. This patient was experiencing a great deal of difficulty because of hostile dependency relationships with his parents. The resident was instructed to help the patient separate from the parents. The resident found this extremely threatening as he had opposite views because of his own past experience. The Indian psychiatric trainee faces similar difficulties. He finally succeeds in learning and this learning will equip him only to treat western patients in western cultural context. What will happen if he returns to India to practice psychiatry? He has to go through a period of adaptation and learn to treat patients in his own cultural context. While the acculturation process to a western society takes about five years (Ananth 1976), re-adjustment to his own country occurs in one to two years. The process of readjustment may remind him of the difficulties, he went through in the past and thus may leave India again to escape the anxieties of a few more years adjustment. However, if he decides to stay in India, he may re-adjust gradually.

Disease: Deviant behaviour is labelled
deal with deviance in order to ensure continued existence and stability. One way a culture has of doing this is to call a person exhibiting deviance mentally ill, and apply special methods for controlling the deviance. Since the standards of deviance and acceptability are relative, no single aspect of behaviour can be considered inherently deviant. Social context in which a behaviour occurs is crucial in calling a behaviour a disease and abnormal. Belief in ghosts and supernatural influence is a normal shared belief in India and is a sign of sickness in western countries. Sexual relationships of adolescents with many partners is considered a normal healthy growth promoting behaviour in western countries and the same is considered as gross deviance in India. In western society, a person not attaining his potential can be treated as a sick person and in India that is not a disease. Thus, a western trained physician may see sickness when not present and fail to recognise sickness when present at least initially.

Sick role: Special considerations and exemptions from responsibility accorded to sick people, vary from culture to culture. In western society, special considerations are provided readily for people suffering from mental illness, while in India similar considerations are not always provided. Under these circumstances assigning sick role for patients who are just depressed or anxious would be difficult for the physician and accepting sick role for "not facing their problems" is uncomfortable and shameful for the patient. Therefore, patients with anxiety or depression present themselves with multiple somatic complaints with hidden affective symptoms. Even though this is in part an adaptive mechanism to obtain a sick role with culturally acceptable passport (physical symptoms) a western trained psychiatrist may be carried away by the patient's symptoms and attend to physical illnesses with elaborate investigations or miss the diagnosis and treat the patient as a hypochondriac.

Doctor-Patient relationship: The role of the physician varies from culture to culture. Physician is considered as omnipotent who can make an accurate diagnosis and cure all illnesses. He is treated with respect and reverence. Going to a physician is somewhat similar to going to a place of worship. Both places are visited when one has problems and both provide hope. The western trained physician expects his patients to treat him like a learned competent man and look for patient's cooperation and participation in treatment. He is accustomed to patients talking for an hour and is prepared to support, direct or interpret. He may not accept the role his Indian patients accord him and may be at a loss when his patients do not participate by talking. The Indian patient may worry as to why his psychiatrist does not behave like other doctors. In addition, they feel ashamed to reveal their problems and difficulties to a man whom they respect so much. They also feel that revealing their problems may make the physician think low of them and may put their family into shame. Hence, initially a western trained physician and his patient may both be frustrated and disillusioned with each other. Psychotherapeutically, an impasse is reached. Western psychotherapeutic relationship is an exclusive therapeutic alliance between the patient and his doctor. During this relationship the patient discusses his past, present and future problems, difficulties, aspirations, fantasies and deeds without guilt or fear of censor and punishment (in a permissive environment), while so discussing he understands his own feelings, and defensive manoeuvres and thereby develops insight. Indian patients do not enter into an exclusive relationship. They may not like to discuss their family conflicts with their psychiatrist. The sexual and aggressive feelings are totally suppressed. And a nonexclusive family-doctor relationship may produce an atmosphere of compromise between the need to discuss
and the social censor.

The setting: In India, communication and transportation systems are not well developed. Patients do not phone or make an appointment prior to their arrival at the hospital. Some even travel for a day on a bullock cart to reach a psychiatrist. Hence, the psychiatrist learns to accept the situation and see patients as and when they come. Furthermore, he also adopts to the local needs by accepting the shortage of manpower and assuming responsibility for more than one service. He learns to understand and accept that his patients receive simultaneous treatment from him, temples and from indigenous medicinal men. A western trained physician will require a period of desensitization to cope with these problems.

Psychosocial aspects:

Dynamic understanding of the patient and the meaning of his behaviour are part of psychiatric diagnosis. Asian patients have certain characteristics which are different from western patients. The most important feature of Indians similar to other Asians (Toupin, 1980) is their deference to others and verbal devaluation of self and family. This is in contrast to the ostentatious self presentation of a westerner. A westerner is proud of himself whereas an Indian is proud of his family. While a westerner does not hesitate to express his pride, an Indian wants others to assess and acknowledge his worth on their own. The absence of verbal aggression, and avoidance of direct expression of one's feelings are qualities esteemed in Indian society whereas competitiveness and individualistic attitudes are valued in western society. In fact one's livelihood in the American economy is based on assertive behaviour while lack of assertiveness of Asians fits with their culture. Therefore, less spontaneous and timid Indian patients look like unmotivated or passive patients to a westerner. Asian has a feeling sense shared with his family. Therefore he strives to achieve goals set by family. Failure to fulfill these goals produce severe inferiority. An individual's attributes derive from his affiliations with family, religion and village. Thus a person who follows the established norms and strives for the goals set by family and not the dynamic vibrant individual is healthy. In addition, a person's rank within a group structure defines roles, governs behaviour and even determines speech. Where one sits, to whom one bows, and whom one may marry are predetermined. In this context western psychotherapy with emphasis on the growth of the individual and his individuality may alienate the patient from all his resources and do more harm than helping him. Toupin (1980) has described the problems of complex perception during an interview by a western interviewer. Easterners feel that eye contact is shameful. While articulateness and assertiveness are requested, an easterner plays her or his diminutive role. An easterner does not like to talk about his or her own achievements.

Feelings are discussed freely in psychotherapy, analyzed and finally appropriately dealt with. In Asian family, the family name or honour is further reinforced by the rule of not discussing personal problems outside of the family. The Asian family may well be in tune with its feelings, but its immediate expression does not necessarily bring gratification. It may indeed be negative by endangering stability of the family, by the shame induced by revealing and by the reproach by the family members. An Indian is expected to meet the needs of others without being asked. As shame plays an important part in his life, it has far reaching therapeutic implications. For example, exposing oneself to shame also places the others in the uncomfortable position of causing embarrassment. Hence, an Indian may nod in agreement so as not to risk embarrassment by disagreeing (Kitano, 1976). Therefore, the western
Dependence: The concept of dependence is important in an Indian's living. Socially, it has its origin in authoritarianism. The parents know everything and the children should obey them blindly. Even an older boy or girl accepts parental opinion in choosing a career or a lifetime. In addition, seniority bestows power, status and authority. Thus authority not only of parents but of all superiors in the hierarchically organized society is accepted without any reservations. However, such a social dependence is healthy and adaptive. The same person when promoted will accept the power and responsibility and expects others to be dependent on him. Similarly in a role assigned to an Indian, he performs very well without any sign of dependence. Thus he keeps within the boundary of cultural norms even if he has further abilities to excel in other areas not assigned to him. Indian parents have been considered authoritarian. However, they do not fit into the western concept of authoritarianism which include a preference for a dominant-submission in social relationships, an aversion to insight into one's own personality and a tendency to externalize. Similarly, children do not develop developmental defect as seen in dependent personalities. Hence this unique social dependence restricts the individual to excel in his given role and not to exceed the limits of his role. Therefore, the Indian has a well developed personality, well adapted for meeting the cultural needs of family stability. Neki (1973) emphasizes that even in doctor-patient relationships the patient assumes a dependent role like in teacher-student relationships. Hence he hypothesizes that dependence is cherished in Indian society. However, total dependence is not seen in Indian society. Dependence is selective and is in the services of the ego. While an Indian boy accepts parental decision regarding his education, he independently carries the burden of college education; while a resident looks for job assignment and description, he functions well and independently within the assigned role. Whether pathological or not, this dependence creates a lot of problems. Rado (1956) has described three stages in the doctor-patient relationship during psychotherapeutic process. They are the initial magical relationship, parental relationship and realistic relationship. To achieve realistic relationship during which the patient can work through most of his problems is the successful therapy. Indian patients bestow omnipotence on the physician because of the reverence towards the physician. The cultural norm of respect for the elderly and authoritarianism of the hierarchically oriented society with consequent dependence on elders, or those with higher social status, can prolong the parental stage of relationship for a long time. In some, this stage may be continued without any disadvantage. Even though a realistic relationship is possible, it should foster interdependence and balance individual growth within the bounds of family welfare.

Self-fulfilment: Fulfilling one's goals and potentials is one of the goals of psychotherapy. However in Indians the technique has to be different. As an Indian is always the ambassador of his family, his achievements, ambitions and aspirations are merely the reflections of those of his family. This is not unconscious and not related to identification but conscious and deliberate. He cannot get away from this behaviour as he feels ashamed. In western psychiatry, helping the patient to achieve autonomy and to separate his needs from that of his family is the goal of psychotherapy and the goal is the opposite in Indian psychotherapy.

Many other culture specific problems such as mother-in-law, daughter-in-law problems, joint family and marital problems are easy to identify for an Indian psychiatrist, mindboggling to a western psy-
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Western Training Programs

In North America psychiatry is a well developed medical speciality with certain respectability. American Psychiatric Association has a membership of about 40,000 and in the Province of Quebec in Canada, there is a psychiatrist for every 600 persons. As such the profession is well organized and such an organization has yielded a well balanced effective training programme. The training programme not only provides for basic clinical training, but also for subspeciality training.

Manpower for teaching is well provided. In McGill University, department of psychiatry, there are approximately 223 teaching faculty members supplemented by an equal number of nonfaculty staff. Each staff has a small clinical load and enough time to devote for trainees. The trainee is well supervised with graded responsibility based upon his capability and initiative. For each subject, a specialist is generally available to teach.

Workload is tolerable. A resident generally looks after six to eight patients under supervision. As service requirements are not primary considerations, resident will have ample time to study. As the workload is minimal, other expectations are enforced on the resident. He will continue long term psychotherapy, short term psychotherapy, family therapy and group therapy under seekly supervision by a psychiatrist with psychotherapy as the subspeciality. In addition a 20 hour a week teaching programme is provided in each hospital. Centrally all residents receive a three hour seminar weekly. Clinical experience is provided by rotating the candidates through out-patient, inpatient, emergency, chronic and children's services in the first two years. Subspeciality training, research experience as well as leadership and administrative experiences are provided. Thus in a course of four years, the candidate will have experience in various clinical aspects without skipping any major area with a subspeciality training if he so wishes.

The training is again unique in that each training centre has many affiliated institutions. Each institution generally hypertrophies in a particular area and residents choose these centres depending upon the requirement by the certifying body and their interest. Such availability provides a healthy competition among hospitals to excel which in itself may provide good setting for residents to learn.

Problems and advantages of western training:

Western training is systematic organized learning experience. Clinical training with direct supervision, experience in all modalities of treatment in different settings with graded responsibility is provided. No doubt that such a training will make an excellent clinician. The added training in administration and research will assist the person to assume administrative and research responsibilities. A training in India is not well organized. In most institutions only a few teachers struggle with teaching responsi-
ibilities. Furthermore, in a two year period, rotation through all services is difficult. Many departments do not have child psychiatry and general hospital rotations and thereby the vision of psychiatry of the Indian psychiatrists may be restricted.

CONCLUSIONS

One could ask the provocative question that whether western training is desirable. While the western trained psychiatrist learns to treat a patient in a western environment with western resources, the Indian psychiatrist learns to treat his patients in an Indian environment with Indian resources. Furthermore, during western training the trainee learns to understand western values, assimilate and use them in treatment. Upon his return, he has a further learning process of reacquiring his own societal value systems and use them psychotherapeutically. Indian training at least theoretically should provide psychotherapeutic skills useful for treating Indian patients. In these respects Indian training appears to have some advantages. So western training is not a necessity.

Overall is it desirable having western training? Are western trained psychiatrists misfits to Indian psychiatric scene and inadequate in treating Indian Patients? My answer is definitely negative. They are, on the contrary, assets to Indian psychiatry. These are the privileged group who have experienced the problems of living in another society with different value systems and treating patients with an understanding of the importance of psychosocial implications. They therefore are in tune with the important sociocultural and psychosocial implications in psychotherapy more than the locally trained group.

In fact, currently the heads of the department in almost all the universities in India are western trained and they are all known to be excellent clinicians, researchers, as well as administrators. Specially the psychiatrists already trained in India will find the western training an invaluable asset.

Should there be a separate method of Indian psychotherapy? The need for psychotherapy is enormous in western society. In India it is up to the psychiatrists to establish priorities and systematize either an entirely new method or adopt the available knowledge to local needs. However, allopathic medicine always flourished and provided the best care by incorporating knowledge from wherever it comes and whomever it comes from. If a new method of Indian psychotherapy will arrive and will be found useful, world psychiatry will be richer.

Indian society has many unique features. In this society, stability is more important than dynamism. Self aspirations is submerged in family needs. Compromise and resignation are favoured instead of competition. Understanding patient's need alone is not sufficient in helping the patient. Family's needs require to be understood. As India is a hierarchically organized society, authoritarianism is built-in in certain aspects of living. A socially endowed authority provides power and power, rather than achievements, gives prestige. Lack of spontaneity is an adaptation towards cohesion and conformity and not an inability to express feelings. Selective interdependence is the essence of family structure. All these factors have to be considered in psychotherapeutic process in an Indian setting irrespective of the school of psychotherapy.

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