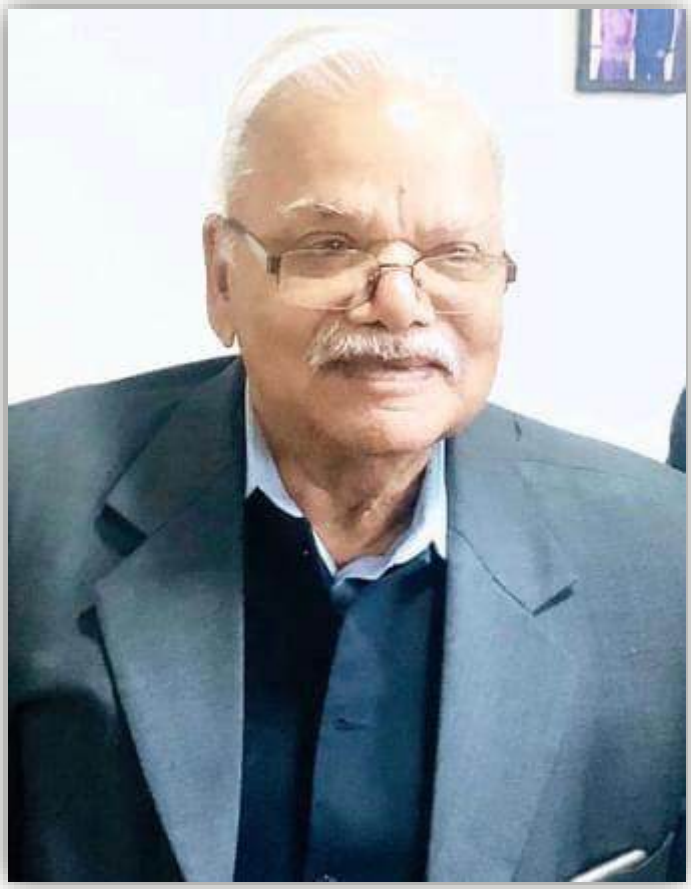
A Collection In Memoriam Prof. Vijoy K. Varma

Department of Psychiatry

Postgraduate Institute of Medical Education & Research, Chandigarh

Sept 14th 2024



Dr Vijoy Kumar Varma

6th Nov 1937 – 11th July 2024

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स्नातकोत्तर चिकित्सा शिक्षा एवं
अनुसंधान संस्थान,
चण्डीगढ 160 012 (भारत)
आर्त सेवा सर्वमद्रः शोधश्च

सत्यमेव जयते

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Research, Chandigarh 160 012 (India)
"Service to the Community, Care of the Needy &
Research for the Good of all"

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Prof. (Dr.) Vivek Lal
MD (Med), DM (Neuro)
Director
&
Head, Department of Neurology

No: DP(1-41)24)-773

Date: 15/07/2024

CONDOLENCE RESOLUTION

A meeting of the PGI faculty, including serving and retired, was held under the Chairmanship of Prof Vivek Lal, Director, PGIMER, Chandigarh on Saturday the 13th July, 2024 at 01:00 PM in the Lecture Theatre – 1, to condole the sad demise of Prof Vijoy K Verma, Former Professor and Head, Department of Psychiatry.

The Faculty expresses its solidarity with the family in this hour of grief and prays for the peace of the departed soul.

[Prof Vivek Lal]

Remembrance

Glimpses of Condolence Meeting Held at the Institute on 13th July 2024

Remembrance

DEPARTMENT OF PSYCHIATRY

POSTGRADUATE INSTITUTE OF MEDICAL EDUCATION & RESEARCH, CHANDIGARH-160012 (INDIA)

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No. : Psy/2024/234 Date : 22/07/2024

CONDOLENCE

The Department of Psychiatry, PGIMER, Chandigarh, India (hereafter "the Department"), expresses its profound condolence at the sad demise of Professor Vijoy K. Varma (6th November, 1937 – 11th July, 2024), Former Professor and Head of the Department.

Professor Varma will always be remembered with utmost respect as the chief architect of the academic ethos and infrastructure of the Department from its nascent days when he joined the Department in 1969, guiding it like an expert navigator to help it grow to a national and even internationally respected stature in terms of teaching, service and research. In one sentence, the Department would not the same without his pivotal and consistent inputs over a period of 27 years.

May God grant him eternal peace and grant the bereaved family courage and resilience to bear the loss.

Debasish Basu
On behalf of the Department

Remembrance

Professor Vijoy K. Varma (known to his many generations of students as "VKV") passed away peacefully in sleep today (11th July 2024) in Illinois, USA, at local time 4:45 AM. He had been unwell for a while.

Professor V K Varma was a "teacher of teachers". After his higher studies abroad, he joined the Department of Psychiatry at PGIMER, Chandigarh in 1969 during the formative years of the institute, where he later became the Head of the Department of Psychiatry from 1980 till 1996 December. Along with his famed predecessor, Prof. NN Wig, Prof. Varma was the true architect of the Department. In many senses, he shaped the department's academics, raising generations of students who became eminent psychiatrists themselves in India and abroad.

An excellent teacher and an illustrious proponent of psychodynamics and psychotherapy, he also utilized his phenomenal organizational skills to contribute substantively to Indian professional societies. He was the Founding Secretary-General of the Indian Association for Social Psychiatry (and later President, with a lifelong association with it), and became the President of IPS in 1989. His publications are a pleasure to read, and many are published in the Indian Journal of Psychiatry. His contributions to the then-nascent field of Addiction Psychiatry in India are also well known.

Importantly, he was not just a "dry academic" - those who had known him will vouch for his vivacity, joviality, congeniality, and wisdom. He was, truly, a 'multi-dimensional' man. And, clearly, above - or beyond - the average.

He is survived by his wife, daughter, son, and their families.

Let his soul reunite with the Infinite.

Department of Psychiatry

PGIMER, Chandigarh

Department of Psychiatry, 1974

Sitting (left to right): Dr K.L.Garg, Dr M.A.Basit, Sr Kamal, Dr A.Ghosh, Dr N.N.Wig, Dr V.K.Varma, Dr D. Pershad, Sr Kulwant Walia, Dr R.S.Murthy

Standing First Row (left to right): Dr A.Misra, Late Dr S.S.Raju, Medical Resident, Dr S.Gupta (Malhotra), Dr Manju Arora (Mehta), Sr Rajni Sharma, Mr Ravinder Kalra, Sr Baldev Saharan, Sr U.Sidhu, Mr Jagmohan (receptionist)

Standing Second Row (left to right): Mr Deepchand, Mr Jodaram, Mr Gujara Ram, Dr K.Mangalvedhe, Mr S.K.Garg, Dr Sohrab, Dr N.K.Kutty, Late Dr A.A. Beg, Mr D.C.Chhabra, Dr N.R.Raju, Mr Mohinder Singh,Mrs. Omwati

Remembrance

From the Family

Remembrance

From the Family

Obituary for Dr. Vijoy Kumar Varma (July 11, 2024) 04:43am; recorded time 05:50am

Our father, VIJOY KUMAR VARMA, was born on November 06 1937 in village MAUR, in north Bihar, the fifth son in a major Kayastha Zamindari family. He completed his MBBS from Patna Medical College (Prince of Wales Medical College), and in 1965 he completed his Masters of Science in Psychiatry from the University of Michigan, Ann Arbor. After many years in the United States, he stopped in England en-route to India to earn his DPM which led to his Membership to the Royal College of Psychiatrists (MRCPsych) and eventually FRCPsych. He worked in the Department of Psychiatry in Post Graduate Institute of Medical Education and Research (PGI MER) Chandigarh from 1969 to 1996, ascending to the position of Department Head in 1980. In these years he became the preeminent and most recognized psychiatrist in India, regularly representing his profession in the international arena. Our father has been a Visiting Professor at Guy's Hospital Medical School, London, UK; Al-Arab Medical University, Benghazi, Libya; Banaras Hindu University, Varanasi, India; Vilnius University, Vilnius, Lithuania; and Columbia University, New York, NY, USA; and a Clinical Professor of Psychiatry, New York University, New York, USA. He was a Diplomat of the American Board of Psychiatry and Neurology; and is a Fellow of the Royal College of Psychiatrists (UK), American Psychiatric Association, and National Academy of Medical Sciences (India).

Contd.....

Remembrance

He had won virtually all awards in psychiatry and mental health at the national level in India. He had executed 37 funded research projects, including ten WHO projects. He had, to his credit, about 250 publications, including six books, ten monographs and 30 book chapters.

Of the major professional organizational responsibilities, Daddy had been the President of the Indian Psychiatric Society (1989-90), and the Indian Association for Social Psychiatry (1992-94). He was the President of the 13th World Congress of Social Psychiatry (1992). He had been bestowed with the title of the Patron of the Indian Association of Social Psychiatry and is the Patron of the 22nd World Congress of Social Psychiatry, 2016. He is survived by his dear wife, Nirmala Varma; they celebrated their 66th wedding anniversary just 3 weeks ago. He is survived by his children, Rina and Raveesh, both of whom followed in their father's footsteps in studying for their Masters degree from the University of Michigan. He is survived by his loving daughter-in-law, or "daughter-in-love" as he preferred to word it, Anjul Varma. He is survived by four grandchildren, which include a Michigan alumnus, a successful financial adviser, a Junior at Michigan, and an Eagle Scout. He is survived by four lovely great granddaughters. In accordance with his wishes, his organs and body have been donated for medical transplant, research and education. Our father accomplished a lot in his life, he was considered a mathematical genius by many.

Contd.....

Remembrance

He was a voracious reader who passed his love for books to his children; erudite, witty and well-mannered, with an apt quotation in English, Hindi or Urdu always ready at his lips. He is a role model for many and an example to his family. As profoundly painful as this time is, I cannot help but think that the following lines by Mohammad Iqbal (1877-1938) are fitting; in fact, I daresay he would delight in their quotation:

"Sitaron se aage jahaan aur bhi hain
Abhi ishq ke imtihan aur bhi hain

Tahi zindagi se nahin ye faza'en
yahan saikdon kaarvan aur bhi hain

qana'at na kar aalam-e-rang-o-buu
par chaman aur bhi ashiyaan aur bhi hain

agar kho gaya ek nasheman to kya gham
maqamaat-e-aah-o-fughan aur bhi hain

tu shahin hai parvaaz hai kaam tera
tere saamne aasman aur bhi hain

issi roz-o-shab main ulajh kar na rah jaa
ki tere zamaan-o-maqaam aur bhi hain

gaye din ki tanha tha main anjuman main
yahaan ab mere raazdaan aur bhi hain"

Rina Sahay Raveesh & Anjul Varma (Anushi & Shubhaang)

Abhishek & Mai Sahay (Jasmine & Kaiya)

Aashna & Christopher Cross (Leela & Sheela)

Annual Conference of Indian Psychiatric Society, 1978

Remembrance

By

Faculty Colleagues of Department of Psychiatry, PGIMER, Chandigarh

Department of Psychiatry, 1983

Chairs(left to right): Dr B.M.Tripathi, Dr A.Malhotra, Dr S.D.Sharma, Dr V.K.Varma, Dr B.B.Sethi, Dr I.C.Pathak, Dr N.N.Wig, Dr S.Malhotra, Dr D.Pershad, Dr S.K.Verma

Standing (1st row): Dr M.Mehta, Dr S. Jain, Dr R.Narula, Mrs Gurbachhan, Mrs. V. Pillai, Mrs Harjinder, Mrs S.G upta, Mrs C. Reddy, Mr H.Kumar, Mr S.C. Mudgail, Dr A.A.Beg, Dr G.Gopal Kroshnan

Standing (2nd row)(left to right): Dr L.N.Gupta, Mrs. M.Khan, Dr K.Chandiramani, Dr R.Chadda, Dr S.Kherda, Dr S.Girimajhi, Dr R.C.Sidana

Standing (3rdrow) (left to right): Dr R.S.Lamba, Dr K.R.Abraham, Dr S.Joseph, Mr A.Jain, Dr S,Bhave, Dr P.S.Gill, Dr S.K.Mattoo, Mr A.K.Misra, Dr S.Mittal
Standing (4th row) (left to right): Mr DeepChand, Dr A.Avasthi, Dr S.K.Chaturvedi, Dr S.Sharma

Remembrance

Nostalgic Farewell to Prof Vijoy Kumar Varma

Way back in 1969, I would often greet and meet Prof. V.K. Varma in corridors, staircases, ramps and lifts of the Nehru Hospital of the Institute. He had recently joined the Institute as Assistant Professor in Psychiatry and I was a houseman in medicine. At that time, he was famously known for two things - his blue-coloured clip-on dicky bow that he often wore in the OPD, and his regal Mercedes-Benz automobile which he drove to the Institute every day.

My first formal encounter with him was in January 1970 in Psychiatry OPD when I presented my first OPD patient to him for consultation after work-up. I had no experience in psychiatry; hence, my history of the patient, examination and presentation were very flimsy. The patient was an elderly gentleman and I all could tell him was that the patient was crying inconsolably, was uttering *"everything is finished, nothing exists, and I do not exist"*. He was aware of the circumstances of my entry in the department as a Psychiatry Resident, gave me a solemn meaningful look and pronounced three words which sounded Greek-Latin mumbo-jumbo to me: *"involutional melancholia, nihilistic delusions and Cotard's Syndrome".* He exhorted me to read psychopathology and phenomenology. This was a divine command, pursuit of which led to reading Frank Fish and Karl Jaspers and in years to come, led to modest research in phenomenology and teaching nuances of the same to residents.

Contd.....

Remembrance

He excelled in teaching of psychodynamics and psychotherapy. When we were residents, he had an orange brown coloured hard cover notebook containing notes on the subject. He gave wonderful discourses on these subjects, mostly extempore, occasionally squinting at the notebook. When I re-joined the Department in 1983, he still had the same notebook and continued to do so till he sought voluntary retirement. Although, with passage of time, the colour of the notebook faded and its pages became tattered, yet his teachings of psychodynamics, psychotherapy and psychopathology became more and more sophisticated and scholarly, His ideas on these subjects crystallized in the publication of his most famous paper in the IJP on the nature and meaning of *"epistemology"*, a term many of us (self-included) cannot even pronounce properly!

He was highly intelligent and possessed immense knowledge in wide ranging subjects like philosophy, culture, religion, socio-sciences, natural history, science and technology. It was a rare treat for us to witness Prof. Wig and him in lively breath-taking discussion on any of these subjects in the coffee room. One learned so much from these discussions and many of us became aware that psychiatry was not limited to just reading textbooks but to be a good psychiatrist one had to possess knowledge about these subjects as well.

Contd.....

Remembrance

He was a sober, serious and dignified person in professional settings, therefore, to watch his other persona of a jovial, jocular, friendly and *shayarana* individual in social settings away from work defied imagination. On many such occasions, he was one of the last persons to partake dinner, but more amazing than that was the sight of him holding the dinner plate at an obtuse angle yet not allowing a morsel of food to spill out!

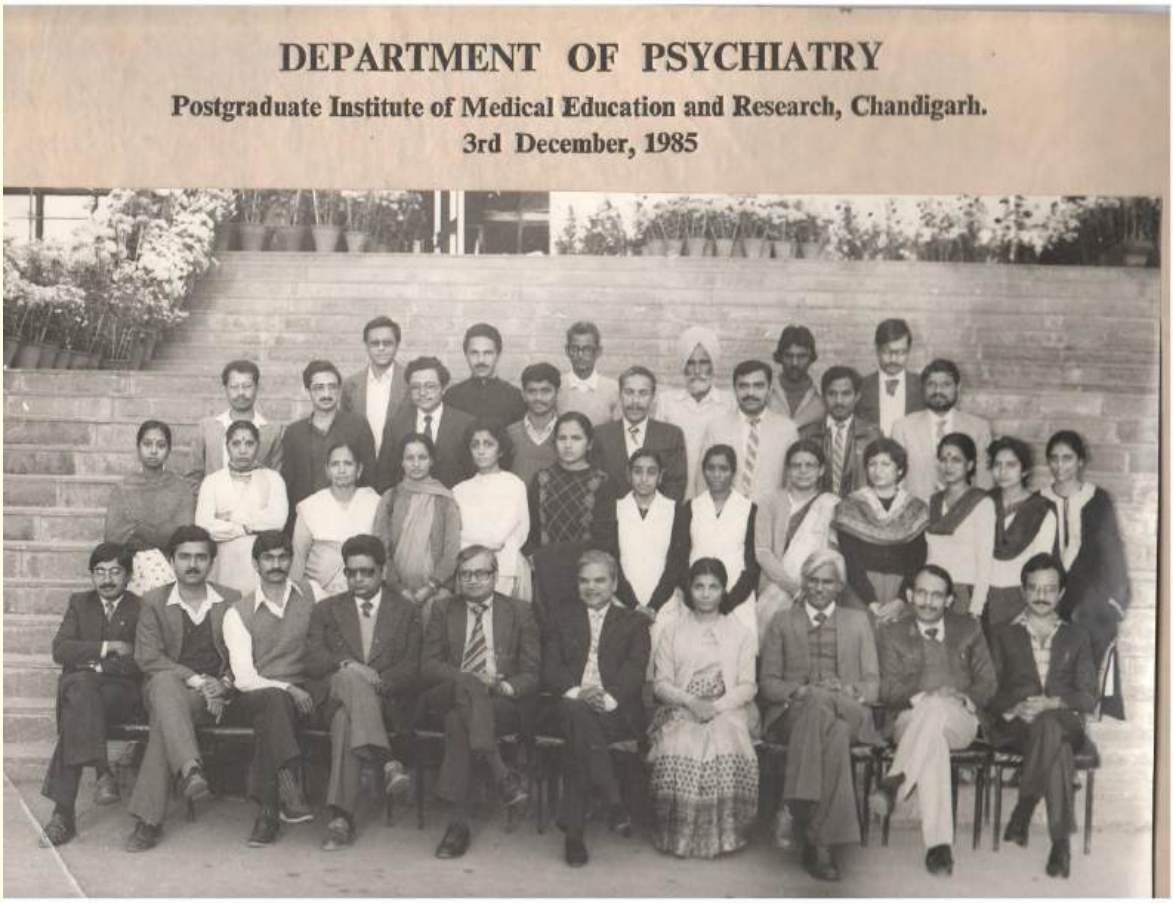
He was extremely hard working, meticulous and orderly. He followed his goals and tasks with tenacity. His command over English was superb and his delivery of talks and lectures was impeccable. He had immense capacity to generate work for others and for many such blessed individuals like me, it was a blessing in disguise. For instance, he passed on many research projects for financial support from various funding agencies like the ICMR, DST received by him for evaluation to me for my comments and as a junior faculty under his guidance I acquired the skill to assess scientific works.

He was a charismatic personality who will be missed by innumerable people and the void created by his departure will remain forever.

***Adios,* Sir.**

Parmanand Kulhara

Department of Psychiatry, 1985



Department of Psychiatry, 1986

Remembrance

I convey my deep feelings of shock and sadness at the passing of my revered teacher Prof Vijoy K Varma. I feel a sense of personal loss and a void in the realm of academia. His sharp intellect, clarity of thought, wide horizon and phenomenal memory reflected in discussions would be an intellectual's delight and could leave anyone spell bound. I have had the pleasure of having a very close and a long association with him, spanning over 22 years first as a student when I joined PGI in 1974 as a house physician, then as a faculty colleague from 1979 till 1996 when he took voluntary retirement from PGI. He was my teacher in MD Psychiatry and also my PhD guide.

When he became the head of the department in 1980, he handed me down the full charge of the then Child Guidance Clinic which was a weekly clinic at that time run on Tuesdays in psychiatry OPD. This opportunity became my area of specialisation over a period of time and Dr Varma was highly supportive of all my efforts and plans in developing the discipline of child psychiatry in PGI. He whole heartedly supported my proposal of starting of DM in Child and Adolescent Psychiatry in 1993 which was announced by the then Director PGI on the occasion of 30 years celebration of the Department. Unfortunately Dr Varma took early retirement before this proposal could see the light of the day. Contd...

Remembrance

He designed a robust and structured teaching program for MD psychiatry in PGI which has stood the test of time for over five decades. He was an excellent teacher, great researcher, orator with excellent writing skills. He possessed great command over language, had highest linguistic sophistication, and he would invariably correct us during our communications and presentations over wrong expressions or wrong use of words. In addition to his erudition in the subject of psychiatry, he was highly knowledgeable in Urdu poetry, Hindi literature, Indian cultural and caste system. He had special penchant for the social dimensions of human life. He was basically a humanist who believed in human equality, dignity and autonomy. His interest in social aspects of mental health and illness led him to initiate a new professional society namely "Indian Association for Social Psychiatry" of which he was the founding fellow and remained as lifelong patron. He was highly respected in psychiatry circle at the national level and had been the President of Indian Psychiatric Society in 1989-90.

No one ever heard him lose his temper. He was a mathematics wizard and had a great sense of humour.

Contd...

Remembrance

Apart from working as a faculty colleague in the department of psychiatry at PGI, I had the good fortune of working with him very closely in the Indian Association for Social Psychiatry and in several WHO funded research projects which led us to travel abroad together for many meetings and conferences. These experiences were opportunities for continuous learning of not just psychiatry but also of how to organise conferences, how to interact and act in international events and gatherings, how to excel and maintain dignity of self, others and of the profession. I was introduced to international scientific community in psychiatry very early on in my professional career and these learnings have been invaluable in my professional life.

Dr Anil Malhotra, my late husband shared a very close relationship of mutual trust and friendship with Dr Varma. We had umpteen informal evenings spent together with recitation of Urdu poetry which I will always cherish. I always spoke to him on phone during my yearly visits to USA. Last time I met him in person was in the year 2019 December, before Covid, which was his last visit to Chandigarh. Attached is the last photo with him taken at my home on 26th Dec 2019 in Chandigarh. In June 2024, I was in USA and tried calling him but I could not speak to him. I knew he was unwell.

Contd...

Remembrance

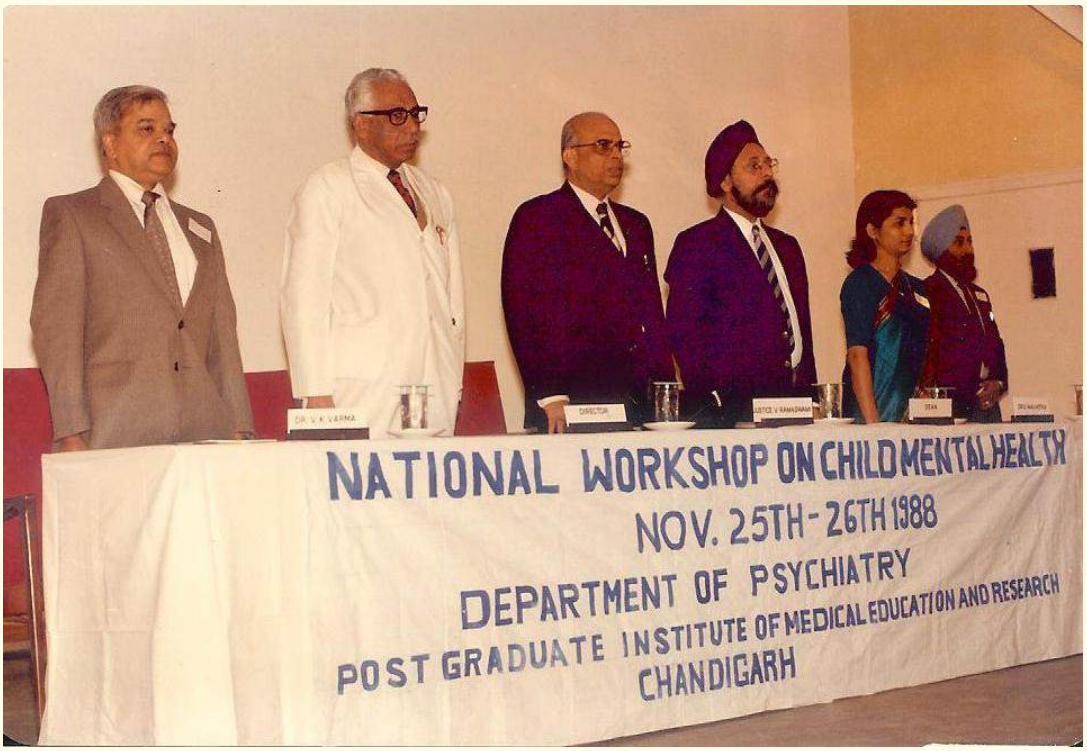
Dr Varma lived a full life, taught and mentored generations of students, and I believe he will continue to live in the legacy he has left behind in all the students he taught and mentored and also in the department of psychiatry at PGI that he shaped and nurtured. He will continue to inspire future generations of psychiatrists for a long time to come. Though Dr Varma loved Urdu poetry but his writings were all in prose. His thoughts and writings will outlive him for long as expressed in the following couplet by famous poet Mir Taqi Mir about himself:

"जाने का नहीं शोर सुख़न का मिरे हरगिज़,
ता हश्र जहां में मिरा दीवान रहेगा"
मीर

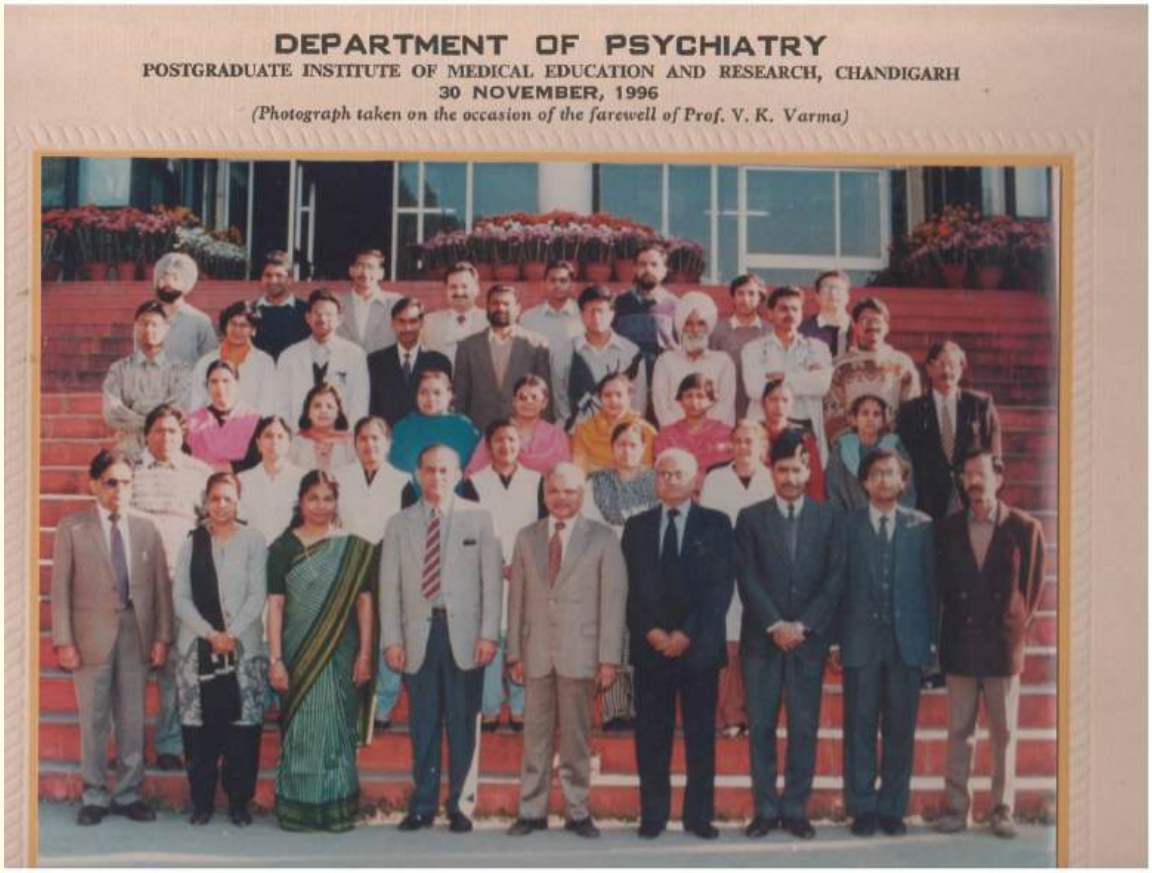
We love you Dr Varma and we will miss you always.

Savita Malhotra

National Workshop of Child Mental Health, 1988



Department of Psychiatry, 1996



First Row: (left to right): Dr Anil K. Malhotra, Dr Adarsh Kohli, Dr Savita Malhotra, Dr B K Sharma, Dr V K Varma, Dr P Kulhara, Dr Ajit Avasthi, , Dr Debashish Basu , Dr Pratap Sharan

THE WATERSHED YEAR - PROF. V.K. VARMA'S VOLUNTARY RETIREMENT

Remembrance

Tribute to My Guru

I first met Prof VK Varma a few months before joining the Department at PGI during the Annual Conference of Indian Psychiatric Society-North Zone held at Patiala. I was then doing House job in Psychiatry at Govt. Medical College, Jammu. His presence was awesome during the Conference, yet he was so friendly with everyone including me at the Banquet dinner. That characterizes VKV, as he was popularly known, a serious and reserved teacher during the working time and and a man full of fun and frolic at social gatherings who would regale you with stories, anecdotes, jokes and poetry. He would transcend all boundaries of his position, age and stature to relate with you as a friend. He was an intellectual giant and even pygmies like me would feel so comfortable in his presence. I have no hesitation to state that he possessed the superior most intellect among all the Psychiatrists that I have known so far.

He was a dedicated teacher with remarkable ability and patience to listen and would make apt, brief and crisp comments towards the end. His lectures on psychodynamics and psychotherapy reflected his command on the subject. We all as his students wished to somehow get an access to his personal notebooks that he referred to while delivering those lectures. I do not know to whom, if any, he bequeathed those notebooks! I was fortunate to be allotted to Psychotherapy Group that VKV supervised and still more fortunate to discuss a case in the group for full six months of posting which received his patient listening. A few weeks later, one afternoon I ran across him in the Ward corridor. As usual, he first saw through me not even acknowledging my respectful greeting, but to my surprise turned back and asked me to hand over the psychotherapy case notes. I was elated with the thought that finally I have succeeded in impressing VKV with my work and had the temerity to know why he needed those notes. He softly replied keeping a poker face, " I want to keep your notes to illustrate how not to do psychotherapy".

Contd...

Remembrance

He was generous, fair and kind towards his students. In our academic interest, he issued a dictate that all exam going Residents ought to write and submit for publication a data based research paper before appearing in final exams. In those days, there was 1 + 2 years system of Residency programme with no requirement to write Thesis. Residents in the Institute were resisting the move to introduce Thesis in this programme. I was President of the Residents' Association, hence, I felt compelled to defy this departmental dictate and told him so. He did not like it but had to permit me as per the rules to sit for the exam. Against all the apprehensions, I was declared successful on merit with flying colours!

He trusted me as a Senior Resident and invited me to join the Faculty upon my return from a stint abroad. Now, I saw him still more closely. I learnt so much from him. None of my teachers has impacted me as much as Prof Varma. He taught me how to draft letters and articles. He was a master craftsman of words. It was amazing to watch him dictate to his stenographer full articles, complete with punctuation. He had a large repertoire of original quotes and wisecracks that reflected his astute observations and impressions of life around him. He was so punctual that one could set the watch by seeing his movements in the Department. He valued good manners and etiquettes. He could tolerate dissent and even criticism. But, he expected complete loyalty!

He was a grand and perfect host, of course, with the full cooperation and involvement of Mrs. Varma. I still carry warm and pleasant memories of dinners at his home that I often attended with my family. Travelled extensively with him and never for once he allowed me to pay anywhere. He was fond of good life with superb taste for food and drinks. Always immaculately dressed. A true aristocrat!

Contd...

Remembrance

He would often surprise me, unexpectedly walking down to my office and taking me along for lunch and beer at Chandigarh Club or walking up to my house and taking me out for an evening walk together. His last but most pleasant surprise was his unannounced appearance at the wedding of my elder son. That was the last time I met him and received his blessings!

That is how I remember my Guru!

Ajit Avasthi

Departmental Picnics

Departmental Picnics

Remembrance

"VKV": Some imprints

Professor & Head Vijoy K Varma ("VKV") was introduced to me in 1980 even before I had met him. Dr Surinder Dabgotra, who had then recently passed out from our Department, had become a Registrar at my *alma mater* Government Medical College Jammu, and had agreed to tutor me for the entrance test for MD had said – even if 'extremely angry' his scolding will be of just 2-4 words. The entrance test involved meeting him over the last part - the viva, when he smilingly corrected me for the 9 of ICD-9 standing for a 'revision.... not edition'. When I reported to him for joining on the 9th of January, an hour-long wait outside his office made me realize that he could be a stickler for the 'rules' - he thought the administration had flouted the rules in permitting me to join late.

From that day to 1996 when he completed his tenure in the department it was an unending series of lessons that extended from professional knowledge and skills to the basics of life. He was as unsparing in expecting my best as he was generous in forgiving my failings. As a man of psychodynamics, he surprised me by correcting me on the steps to conduct a dexamethasone suppression test. Beyond academics, he would detail how to chaperone a chief guest to the venue and the dais in a social event.

Contd...

Remembrance

Once he had a series of correspondence with a junior faculty in another department, ending in a complaint to the head of the department, till that faculty stopped misspelling his surname (Verma vs. Varma) in periodic official notices. Another time he displayed the power of the word/s to show a person his place: In a team meeting when a member said 'We had decided', he pointedly asked 'What do you mean by.... we', and that member was forced to acknowledge 'I.... had decided'. I also fondly remember his oft-repeated gem - 'I don't take a no unless repeated a hundred times'.

My career as a faculty member in the department too had his blessing as a Head. For an ad-hoc post of a Lecturer, I applied from CIP Ranchi. Soon after I was visiting the department when I was told the interview was slated for just a few days away. I pleaded with him that I could not stay for the interview. He just said "*Theek ji*", and my application/candidature was considered and approved 'in absentia'.

The fraternity will always remember him as a brilliant academician, a great teacher of psychiatry in general and psychoanalysis in particular, professional globe-trotting, and for excellent hospitality finished with a topping of Urdu *Shayari*.

S K Mattoo

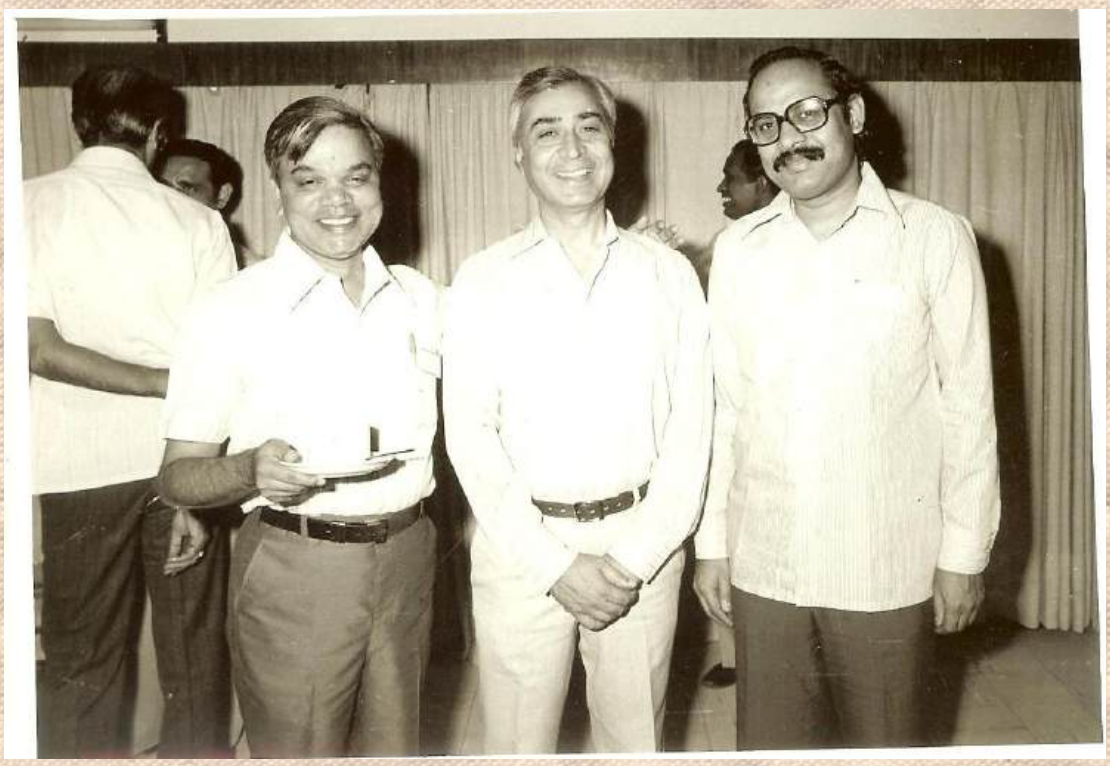
Remembrance

I am extremely shocked to hear the sad news that our beloved Guru is no more. Please convey my heartfelt condolences to my Guru, Prof Varma's family

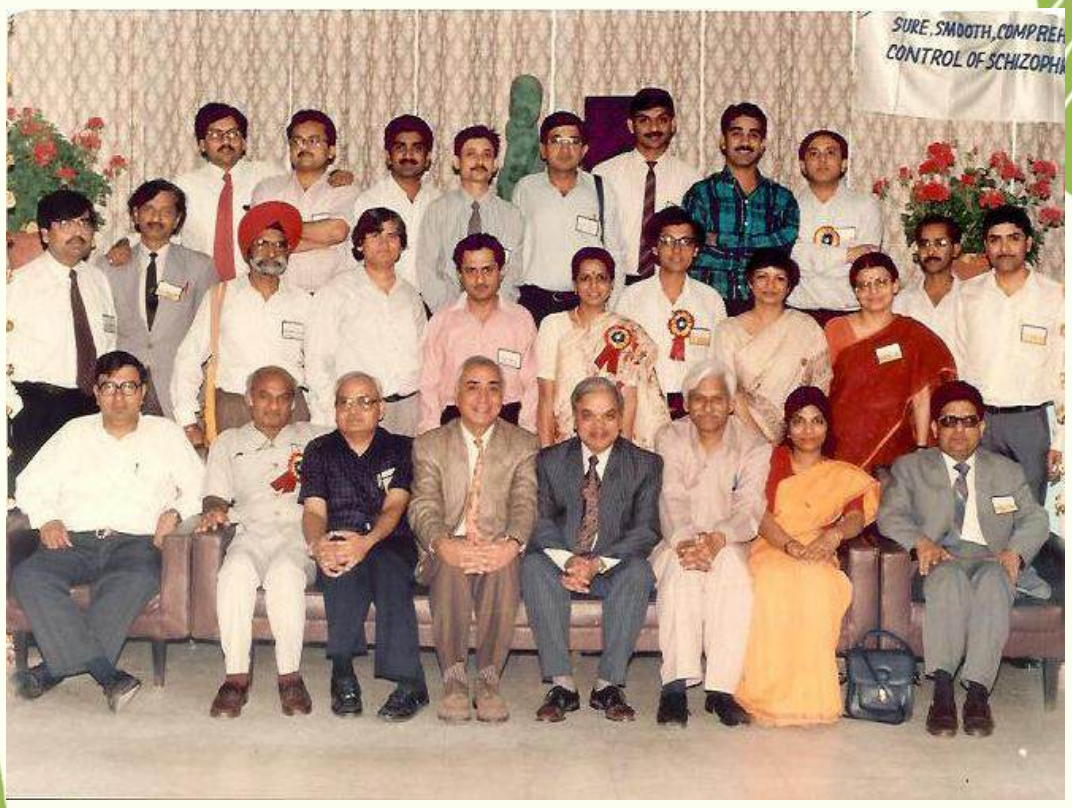
Arun Kumar Misra

WHO Research Centre in the Department

WHO Research Centre in the Department



Transcultural Psychiatry Conference, 1995



Remembrance

So sad to know that Dr VKV is no more. A fine gentleman, true academician, a thorough researcher, greatest teacher of Psychoanalysis, Psychodynamics. He had a wonderful sense of humour and wit. Would recite tables of 2.5 and 3.25 in coffee room (cannot forget) the arithmetic skills he had. Was an all rounder on various topics in geography, anthropology and Urdu poetry. He was very democratic and a wonderful human being. Will miss him a lot.

I lost my guide, my philosopher, my mentor, and a father figure.

May his soul rest in eternal peace.
Condolences to his family.

Adarsh Kohli

Enjoying dinner at the 13th World Congress of Social Psychiatry, Delhi, 1992

Golden Jubilee of the Department, 2013

4 Former HOD's in One Frame
Date: 22.09.2013

Golden Jubilee of the Department, 2013

From left to right: Savita Malhotra, Dr V M Katoch, Dr Yogesh Chawla, Dr P Kulhara, Dr N N Wig, Dr V K Varma, Dr Ajit Avasthi

5 Former HOD's in One Frame

Remembrance

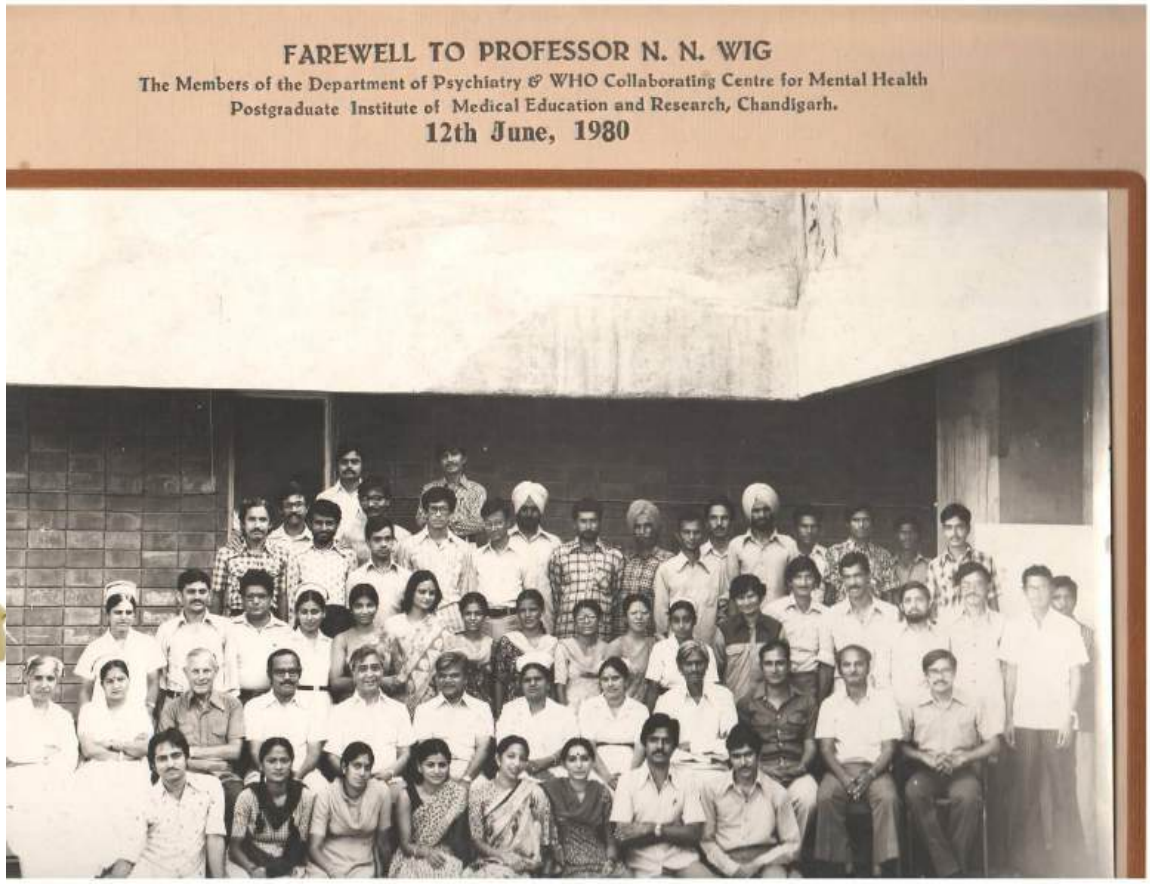
Sorry to learn about the sad demise of Dr Varma. I learnt a lot from him.

My condolences to family. May his soul rest in peace.

Ritu Nehra

Farewell of Prof N N Wig, 1980

Farewell of Prof N N Wig, 1980



Remembrance

The news of Prof. V.K. Varma passing away comes as a shock.

Prof. Varma was very important in my professional development. Though it happened, 52 years back, I still value the way he encouraged/supported Dr. Anindya Ghosh and myself to undertake a follow up study of behaviour disorders in children, present it at the 1973 Annual Conference of IPS at Chandigarh and publish it, with Dr. Ghosh and myself as the first and second authors, with him being the third author.!!This was when we were only residents. This was only the beginning our publication journey with him.

He was also my personal psychotherapy supervisor and shared my clinical skills of psychotherapy. I have rich memories of his guiding me to be a caring professional. He took pride in the progress of his students and colleagues.

His contribution to psychiatry is monumental. He was one of the founders of Indian Association of Social Psychiatry.

His range of interests and his ability to see the 'bigger picture' was very very special.

I want to recall Prof.Wig's writing, the following as part of the Foreword to the book: ' Culture, Personality and Mental Illness: A Perspective of Traditional Societies' (Varma, VK, Kala AK, Gupta N, Jaypee,2009)

'What impressed me most about Vijoy Varma, right from our early years, was his amazing range of interest within psychiatry, and Allied Sciences as well as beyond psychiatry, in Literature, General knowledge, Geography, Urdu poetry, Law and many other subjects. He is gifted with excellent memory and can bring out at the spur of the moment long forgotten references to score points in any discussion' .

Contd....

Remembrance

Further, he noted,

' It is true that I started the department in 1963, but Dr. Vijoy Varma's tenure of 27 years (1969-1996) was much longer than mine and most of the credit for the present eminence of the department as a leading center for research and training in psychiatry, is due to him'

I would like to recall his valuable observation of about culture and mental health in the book I have referred above:

'Overall, we live in an increasingly shrinking world, which is rapidly reducing the world virtually to a global village. The ease of travel, exploration and migration have resulted in increasing familiarity with an interest in other societies, other cultures, other religions and other philosophies. Differences across countries have been taken note of-from differences in personality to social organization, to mental illness and its treatment. This is the reality. As professionals, we must be aware of it, and adapt to it!'.

It was only last year in September 2023, we heard his video message.

Prof. Varma lived a rich life and influenced mental health of India in a number ways.

I will miss him.

May his soul rest in peace and the family have the strength to bear the loss.

OM Shanthi.

R. Srinivasa Murthy

Remembrance

By

Alumni
of
Department of Psychiatry, PGIMER, Chandigarh

Remembrance

VIJOY K. VARMA, MD (1937- 2024)

Dr. Vijoy Varma and I joined the Department of Psychiatry at PGIMER, Chandigarh within a few months of each other towards the end of 1960s. I arrived as an awkward, fumbling, a little unkempt, and wild but talented, studious and ambitious young resident. He joined the faculty as an Assistant Professor who had recently returned from the United States. Hailing from Bihar, married into a politically powerful family on the national scene, not knowing a word of Punjabi language, owning a Mercedes, and adorned with American and British degrees after his name, Dr. Varma seemed as foreign to the modern heart of Punjab as I, an Urdu speaking Muslim boy from a distinguished literary family from Lucknow, was. We had the ' kinship of aliens' that was palpable and yet forever remained unspoken between us.

Over the next four years that I spent at PGI (1969-1973), Dr. Varma and I had numerous interactions. The professorial triumvirate of Drs. Narendra Nath Wig, Jagdish Teja, and Vijoy Varma influenced me greatly but with each of its members caused a different impact and imprint upon my career. Restricting my comments to Dr. Varma here, three significant memories readily emerge. With only a slight exaggeration, the interactions these memories involve turned out to be life changing. *First,* it was upon his encouragement that I read my first book by Sigmund Freud, a work that affected me deeply and forever. *Second*, he and I co-authored a paper that was published in a 1972 issue of *Samiksa*, the journal of Indian Psychoanalytic Society in Kolkata; this was my first psychoanalytic publication, so to speak. It is not a great paper and perhaps not even good. But it was my introduction to the psychoanalytic scene in India. The memory of these two interactions fills my heart with gratitude for Dr. Varma.

The *third* and truly memorable interaction involves our collaboration on study of anti-Muslim sentiment in India.

Extrapolated from the celebrated Adorno-Brunswick study of antisemitic attitudes on the University of Berkely,

Contd.....

Remembrance

VIJOY K. VARMA, MD (1937- 2024)

California campus, our study involved a survey of over 2,000 students at Punjab University across the street. Employing Likert items on the scales of Ethnocentrism, Politico-economic Conservatism, Anti-Democracy Attitudes, and Anti-Muslim prejudice, our study revealed a striking and sadly reassuring concordance with those of our North American counterparts. I presented the paper based upon this study at the 1972 IPS meetings at the twin cities of Miraj and Sangli. There was quite an angry uproar from the audience which I bore with a patience and fortitude that made the highly respected Mumbai-based psychiatrist Dr. Shanti Sheth (who was in the audience) to tell me later that evening that I had displayed mental capacities of becoming a good psychotherapist in the future. The question, however, remains why did Dr. Varma himself not go to present this controversial paper (published in 1973 Indian Journal of Psychiatry). My memory is vague. I think he said that he was not feeling well. Or, did he say that there was a major family event which conflicted with the dates of the IPS meeting? Frankly, I do not recall clearly. However, far more important than the reason behind his deputing me for this arduous task or my being unable to recall the explanation he had given me for it, is the fact that I never asked him about it though we met numerous times afterwards: here in the United States, in England, and back home in India. Like our early 'culturally-alien-to-Punjab' kinship, this dynamic too remained unspoken between us. But such is life. We say somethings and we do not say somethings. We understand somethings and we do not understand somethings. The hermeneutic and ethical tension in the resulting void adds both mental pain and authentic creativity to life. An embodiment of such polarities was Dr. Vijoy Varma's life and now is the life of my interactions and memory of him.

Salman Akhtar

Remembrance

We are saddened by the loss of Dr Varma. I have had the privilege to know Dr Varma since January 1969, as a superb teacher. He brilliantly directed my MD thesis. Based on our research findings he presented a paper at Indian National Psychiatry Conference resulting in Marfatia Award.

I invited him as a visiting Professor at my Department of Psychiatry at Creighton University School of Medicine three different times. All his presentations were scholarly and comprehensive which earned him accolades from faculty, residents and students.

The last time I talked to his son and him was when he was admitted to a nursing home care facility in a suburb of Chicago .He was always warm, compassionate and caring clinician with deep understanding of human psyche specially in context of culture.

Shashi and I convey our heartfelt condolences to his family and wish for his soul to find an abode in eternal peace

Subhash Bhatia, MD

Remembrance

I am deeply saddened. I have always admired, indeed loved him as a Guru. He leaves a lasting legacy, including this group.

Swaranpreet Singh

It is indeed a very sad news of passing away of prof. V.K. Varma sir. We have learnt so much from him. He was my psychotherapy supervisor. My interest in psychodynamics and personality theories is exclusively for him. An exceptional teacher and a father figure. My deepest condolences at his sad demise.

H. R. Phookun

Remembrance

My training in psychiatry at PGI (July 1979) started with the psychodynamics module for six months, followed by psychotherapy module for another six months. Of course, these were led by Prof VKV, which just made me more passionate about psychiatry. I, like others, made notes, during his classes. I kept these notes till I retired from NIMHANS in December 2020. I would read these often and used the knowledge in my clinical teaching of my residents. As an examiner too, I would ask topics noted in my notes, taught by Prof VKV.

Thinking back, it is so amusing that for many years as a faculty, I had imbibed Prof VKVs mannerisms – brushing the back of hand, sitting cross legged at an angle, looking up at students gently and questioning – *ye kya hai ji*!

My first job after passing MD was with him as a Research Officer in the ICMR Project on Chronic pain and illness behaviour. Most of my future work followed this and has been on Chronic Pain, Somatization, Cancer Pain and Psycho Oncology. I was impressed by his mental calculations of the data, which made me so interested in statistics, that I always did statistical analysis myself, even before the statistical software existed. I wrote many papers under his guidance in the early part of my career and picked up useful skills in writing and publishing.

Contd.....

Remembrance

I had the pleasure to spend good time with him when he visited NIMHANS. He gave me many snippets of *gyan*. One I cannot forget. In early 1980s there were not many of my contemporaries who published regularly. I was probably prolific (by that era standards), when Prof VKV wrote to me to 'slow down'. He told me later that I would get noticed 'unnecessarily' and antagonize people. Initially, I did not understand and of course got into all types of problems and 'victimization'. Later, I followed his advice, and focused more on reading and teaching than 'writing'. Enjoyed my life and career on a low-profile route.

Thank you, Sir, for your hand in shaping my life and career.

You had many students, but I had only one teacher like you, Sir.

You will always be with me in my mind.

Santosh Chaturvedi

Remembrance

From the very first time I saw Dr VKV in 1980, I looked at him with awe, respect and reverence. His breadth and depth of theoretical knowledge of psychiatry and allied disciplines was awesome. He was instrumental in nurturing my intrinsic interest in psychotherapy, which has left its mark to this day.

Saddened by his passing away.
Condolences to his family.

Satish Chandra Girimaji

Remembrance

Yes, I saw the sad news early morning today. Following is my brief write up in honour of late V. Varma.

With a heavy heart I write this memorial in honour of late Professor Vijoy K Varma. I learned about his passing away early in the morning whilst browsing through my email.

Vijoy Varma was an exceptional, multitalented and humble individual. I joined PGI as a resident a year after he joined the faculty in 1969 as an assistant professor. He was my supervisor for my MD thesis. He had this remarkable ability to patiently guide me through the intricacies of research, me being an impatient man. I could not have asked for a better mentor and latterly my friend.

I still remember his lectures on psychodynamics and psychotherapy. He had a large, long note book which he used for his lectures. I along with my peers always wanted to get his notes to copy but he guarded them obsessively. He had a fantastic memory of various Urdu poetry and I vividly recall him reciting them during social meetings. I have fond memories of several enjoyable evenings at his house.

Professor Varma will be sadly missed. My prayers are for his surviving spouse, children and grandchildren.

Raja Ghosh

Remembrance

It's a huge loss for all of us....
During my early days in the US (2005-06), Dr. Varma involved me in some scholarly work, thanks to Professor Dr. Savita Malhotra for connecting me with him! I fondly remember him describing his rich notions about many intricate aspects of the ' Indian Personality' (vs the Western one): totally extemporaneously.

RIP Dear Dr. Varma...

Basant Pradhan

Remembrance

Indeed it is sad to hear his news.
Professor VK VARMA WAS THE LEADERSHIP TEACHER.
I remember every events when we meet him.
All of us will not forget his interest on us and how he presented the knowledge of psychiatry to us.
May his soul Rest In Peace prof. Varma
Condolences to his family

Asad Abughalyoun

Remembrance

Very sad to know about the demise of Professor V.K. Varma, former Professor and Head of the Department of Psychiatry, PGIMER, Chandigarh. He was a great teacher and an erudite orator. His lectures on psychodynamics unravelled the depth of the personality and were extremely exhilarating. He was my teacher, guide and mentor, who exhibited deep forbearance during examination of patients. It is an immense loss to all of us and the discipline of psychiatry. I extend my deep condolences to the family of Professor Varma who lived a full life, and contributed a lot to the society. Let us all cherish his memory as he lives in our hearts.

Col (Retd.) Rajinder Singh

Remembrance

It is indeed the end of an ERA. There is no parallel to his lectures on Psychodynamics. After 40 years I still carry his notes on psychoanalysis as a proud possession. May he rest in peace in his heavenly abode. Exemplary act in the service of the people. During his lifetime as well as after death he dedicated himself to the cause of education. There can be no better contribution to the society.

RC Jiloha

Remembrance

In a department full of outstanding brilliant people, VKV was the shining star, outshone everyone. Rest in peace Sir, no one in PGI who came in contact with you (as residents, colleagues and patients and families) will forget you. Last saw Sir in 2013 Golden Jubilee reunion. He remembered my health problems that had happened in early 1990s in UK though I had never told him (someone in the department must have mentioned to him). Such was his amazing memory.

Sudip Sikdar

Transgenerational Photo, 2009

At the 25th Year National Conference of IASP, Lucknow

Sitting (L to R): Arunima Mahajan, Savita Malhotra, Roy Kallivayalil, VK Varma, RC Jiloha, Adarsh Kohli

Standing (L to R): Nitin Gupta, Santanu Goswami, Rakesh Chadda, Sudhir Khandelwal, Anirudh Kala, Rajiv Gupta, Debasish Basu, BS Chavan.

Remembrance

Deeply saddened to hear about the demise of our dear Professor Vijoy K Varma. He was a living legend in psychiatry. For his students like us, he was not only a great teacher, but also a tall leader and a dear friend. Although he was somewhat strict in the department, outside of it, he was full of fun and humour. I had the privilege of hosting him when he came to Calicut for the annual conference of Indian psychiatric society in 1991 and later at Geneva. During an APA meeting in New York, he volunteered to arrange accommodation for us,his students. We will always deeply miss him. Heartfelt condolences and prayers. May his soul rest in peace. We join the grief of his family.

Roy A Kallivayalil

Remembrance

Sad to hear that, a great teacher, very knowledgeable and intelligent man with a good heart, dedicated to his profession and democratic in his approach. My thoughts and prayers are with him.

Kishore Chandiramani

Deeply saddened. May his soul rest in peace. He will always be remembered for his profound knowledge, a unique and eloquent articulation, great teaching qualities and superb analytic abilities. We lost a great philosopher and beloved teacher. ॐ शांति

Vimal Sharma

Remembrance

Very sad to learn. I was in my last year as resident when Dr Varma joined the Department as second teacher.

He was not only my teacher, but a great friend, I can cherish those moments of having Dinner and gossip with him.

Roshan Lal Narang

Remembrance

Really sad to hear about the sad demise of respected teacher Prof V K Varma , he was a great teacher and his teaching in psychodynamics , psychotherapy and transcultural psychiatry has been the backbone of our basics in practice. His command over English language and his choice of words had no match. He will always be alive among his students for his teachings.

Heartfelt condolences to the family.

May his soul rest in peace.

Roop Sidana

Remembrance

A great teacher is physically no more. As many have noted here, his wonderful lectures on psychodynamics, his penchant for using accurate language, his democratic values, and his almost contradictory penchant for having fun, sher-o-shayari outside the department will be remembered for ever and ever. Apart from psychiatry, I, like many of my peers, can attribute at least a part of our knowledge of the English language to him. With his teaching and linguistic excellence, he will continue to live amongst us.

Sudhir Bhave

Remembrance

Extremely sad news. I have lost my teacher, mentor, guide and role model. He was a stalwart in psychiatry not only at national level but at global level. Heartfelt condolences to the family members. May God grant peace to the departed soul.

Ravi Chand Sharma

Remembrance

Deeply saddened to hear of Dr Varma's passing. He was my professor from 1979 till 1981 during my postgraduate days in PGI. He taught me psychotherapy and even suggested I should pursue this as my career. He often visited me at home when I moved to Delhi and brought gifts for my daughter who was born during my days in PGI. Who knew that one day when she grew up she would get married to a young man from Bihar. And that her father in law would be related to Dr Varma! He was quite amused when I told him that we were now related by marriage of my daughter to a member of his family ! He was a thorough gentleman who taught me what was important in life to be a good human being and psychiatrist. I will miss him immensely.

Om shanti

Rashmi Parhee

Remembrance

My guru passed away

I remember him in a unique context. I appeared for the interview having travelled from Pune overnight in a leather (bomber) jacket. Terrible dress sense I had a very bad stammer Could hardly articulate a sentence without stammering. The interview because of my stammer and dress sense (everyone was in suits)

I felt had gone South

He was a perceptive man

Rajesh Nagpal

Remembrance

Dr V K Varma was respectful teacher

I have very long association from 1971 he was very good friend since I am settled in Chandigarh. I participated in most of department dinner.

My heartfelt condolences to family.

Om Shanti

Kasturi Lal Garg

Remembrance

By

Colleagues from other Departments, PGIMER, Chandigarh

Remembrance

Very sad news.

I had the opportunity to learn fundamentals of psychiatry during IM rotation. He was a wonderful teacher and later a very dear colleague. May God give strength to the family to bear his loss and may his soul rest in peace.

Subhash K Varma
Ex Prof & Head Internal Medicine and Dean
PGIMER, Chandigarh
Prof Emeritus, PGIMER Chandigarh
Director Medicine and Hematology
Fortis Healthcare Mohali

Remembrance

By

Psychiatrists & Mental Health Professionals Across the Country

Remembrance

Remembering my friend Vijoy K. Varma (not Vijay K. Verma)

I am very fortunate to have been a very close friend of **Vijoy K. Varma** (***not*** **Vijay K. Verma**) ..... I am mentioning it as I remember how particular he was about how he was addressed whether in speech or writing.

Much has already been written by his colleagues in the department. I have been co examiner with him while in lady Hardinge Medical College, and was also associated with him in organizing international conferences as secretary, as chairperson, and a number of events. I was impressed by his honesty in handling accounts and ability of leadership. While going around with him to raise funds for organizing of an international seminar he surprised me in following a file which was already negated and meeting a minister. He said I don't believe the file is dead and can't be revived.

While I was a WHO national consultant in the Ministry of Health, the Secretary Health received invitation about starting World Mental Health Day on 10th October from the World Federation of Mental Health and WHO.

Contd.....

Remembrance

I discussed with Prof. Varma about starting this at national level. He was the first one to suggest and implement 'Mental Health Week' starting various programs and activities centered around mental health to reach a common man. These activities were to be culminated on 10th October. I am glad many institutions and centres took this idea seriously and the practice continues to this day and I wish it continues as a legacy to his well thought out initiative.

Much has already been written about his intellectual capabilities, especially his mathematical skills to which I have been a witness. His skills as an orator and instilling life and humour in any activity he participated in needs a special mention. I particularly recollect how he arranged a marriage reunion of Jules Masserman and his wife at Ashoka hotel lawns with all the Indian ceremonies to mark their 60th anniversary.

Having had a long association with him and his family, I will miss him of course. But I am sure Indian psychiatry will miss him more, particularly as there are very few psychiatrists left who can teach or practice psychoanalytically oriented psychotherapy and psychodynamics.

Satish C. Malik

Remembrance

Prof.Dr.V.K.Varma Sir's demise is a very sad news for us. He is a great academician, extraordinary research scholar with sound clinical acumen. He was my examiner for my National Board of Examination in 1978 at AIIMS. Thereafter, whenever I met him in conferences he used to immediately recognise me and enquire about my welfare and academic activities. It is indeed a great loss not only for our IPS but also for the field of psychiatry.

May His Soul Rest in Peace.

R.Ponnudurai

Remembrance

No one settle, until final departure from this world--- Prof Vijoy Varma

I first encountered the name Prof. Vijoy K Varma in 1980, through the ICMR study on the socio-demography of psychiatric disorders in India, a multicentric trial with PGI Chandigarh as the main coordinating center. At that time, I was a nascent student of mental health, and this marked my initial exposure to psychiatric research. For any student, a key ingredient in crafting an academic career is having a mentor and a teacher who embodies complete trust and dedication. Prof. Varma, affectionately known as 'Vijoy,' was that mentor for me. As I reflect on my memories, I can recall numerous meetings and moments of companionship where his guidance and wisdom profoundly impacted my journey.

One such memorable instance was at the WPA meeting in Athens in 1987. Prof. Varma, then the President of the Indian Psychiatric Society (IPS), represented the organization on the global stage. During a lecture on the disposal of nuclear waste, he passionately reminded the world of its social responsibility, famously stating, "...there is no place like the 'other place' in this world." This statement exemplified his deep social consciousness and unwavering commitment to the community, values that he dedicated his life to, whether in the realm of social psychiatry or general psychiatry.

As time passed, our professional relationship grew closer. Prof. Varma's reputation as an author and scholar is well-documented, but his dedication to his students and colleagues went beyond that.

Contd.....

Remembrance

I vividly remember sending him a paper for review when I was an editor of a journal. He returned it with a four-page review, which resembled a fully developed article, complete with suggestions for eight additional papers for the authors to read. Such was his seriousness as an academician, his compassion as a teacher, and his dedication as a mentor. He was not just a guide but a friend, philosopher, and source of inspiration to many of us who aspired to follow in his footsteps.

Prof. Varma also had a poetic soul. His love for Urdu ghazals often provided a literary feast for those fortunate enough to be in his company. There is so much more to say, but it is difficult to capture the essence of a man who was a composite of so many admirable qualities, and who exhibited such unwavering commitment to his work, his students, and the world.

Later in life, I migrated from Mumbai, while he moved to United States. Despite the physical distance, our connection remained. I once requested him to contribute a chapter to a book I was working on, and during that conversation, I asked, "Sir, are you settled now?" His crisp and philosophical reply was, "One only settles after leaving this world." Those words have stayed with me.

I sincerely pray that his soul rests in peace. Prof. Vijoy Varma was, and will always be, someone who will be deeply missed, not just today but for all time to come.

Amresh Shrivastava

Remembrance

The passing away of Prof VK Varma is a great loss to his patients, students, colleagues, in India & abroad, his family, & to many others.
He was a teacher of teachers.
We Pray to Lord Vishwanath to give strength to his family bear the great loss, and to rest his soul in peace.

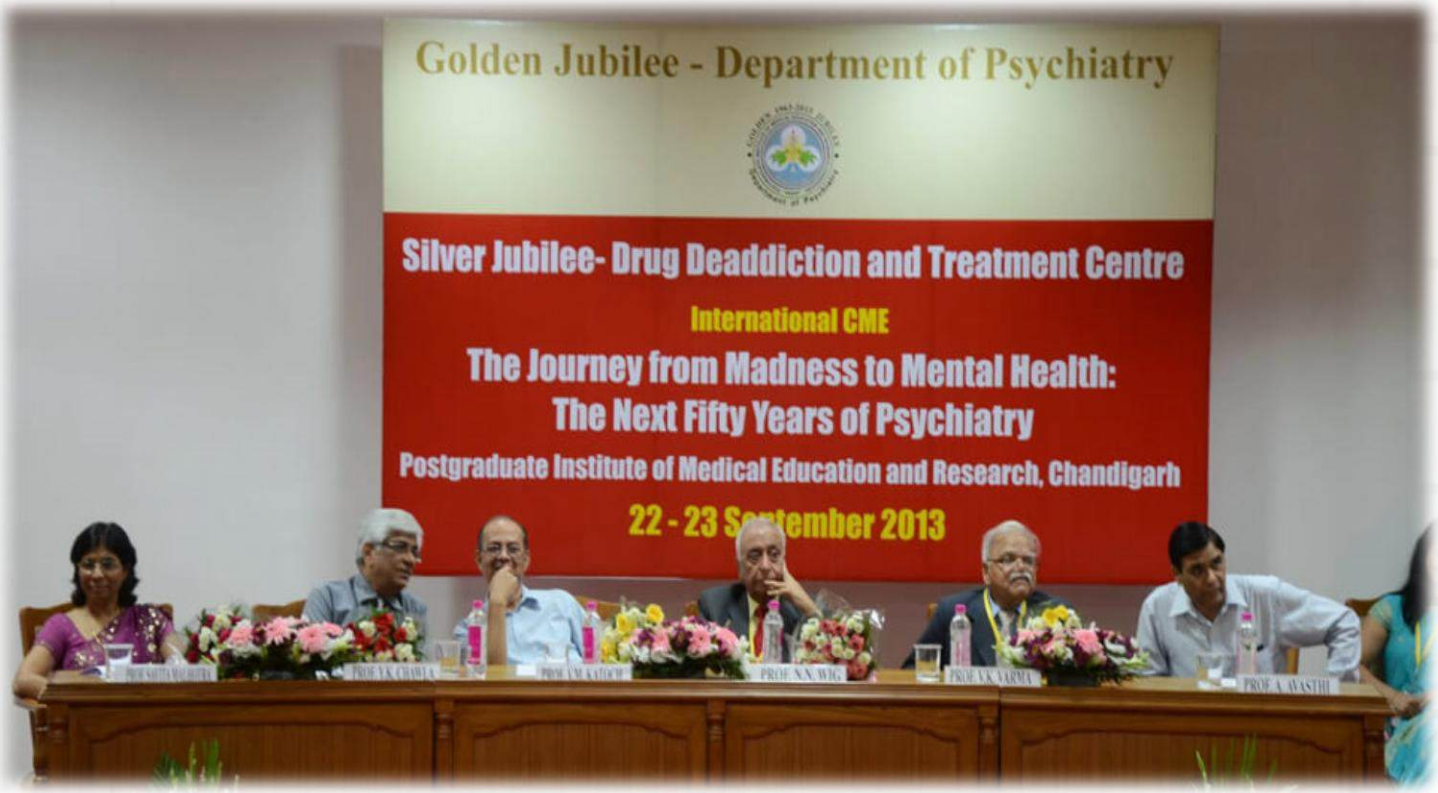
Indira Sharma

Remembrance

Very sad to know that dear VKV, beloved teacher and mentor of many students of Psychiatry and allied disciplines of mental health is no more; who are great leaders and trainers in the field of Mental Health in India and abroad . I had the opportunity to interact and learn from him various aspect of Social Psychiatry for nearly two years. That was my first job after completion of my training at CIP.

He was a great teacher, Clinician and researcher. His jubilant nature we always enjoyed especially on Social occasions celebrated at PGI Club. In his shero..Sayari he will quote his friend Prem Bara Bartney reciting and translating his couplets ,....horizon to horizen... still vivid in our memory .But now all that is a story now. Good bye Dear Dr.VKV. You will always be remembered by your students, near and dear ones. I pray God to rest his soul in peace and to grant the courage to his family to bear this loss.

Tej Bahadur Singh


Golden Jubilee - Department of Psychiatry
Silver Jubilee- Drug Deaddiction and Treatment Centre
International CME
The Journey from Madness to Mental Health:
The Next Fifty Years of Psychiatry
Postgraduate Institute of Medical Education and Research, Chandigarh
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Published Obituaries in Journals

Vijoy K. Varma – A Legend in Social Psychiatry

Professor Vijoy K. Varma, who passed away on July 11, 2024, was a living legend in social psychiatry. For his students like us, he was not only a great teacher but also a tall leader and a dear friend. Although he was somewhat strict in the department, outside of it, he was full of fun and humor. Among his manifold academic, research, and organizational activities, his contributions to psychotherapy and social psychiatry stand apart. Besides being a great teacher, he was one who modified the Western model of psychotherapy to be suitable to the Indian context. He noted that many faith and religious leaders were employing their psychological methods for healing.[1]

His contributions to social psychiatry in India and abroad and to the formation of the Indian Association for Social Psychiatry (IASP) will always be remembered. When the IASP was launched at Ranchi on June 14, 1984, he was its founder and secretary general (with A Venkoba Rao as President). Later, the IASP became a member society of the World Association of Social Psychiatry (WASP) under his leadership. He was the secretary general (1984–1992), president-elect (1991–1992), and president (1992–1994) of IASP. The 13th World Congress of Social Psychiatry, organized under his leadership in November 1992, was a big success. It was his wisdom and foresight which culminated in IASP joining as a member society of the World Psychiatric Association.[2] In appreciation of his contributions, he was designated as the patron of IASP in the 2013 annual conference held in November 2013 at Kolkata.

When I left PGI Chandigarh in January 1985, it was he who encouraged me to become its member. In 2002, I became the Vice-President of IASP and in 2009 its President. He was present on all these occasions with his guidance and blessings. He was the happiest person when I was elected the Secretary General of WASP in 2010 and its President in 2016. Former WASP Presidents like A. Guilherme Ferreira (Portugal) and Jorge A. Costa e Silva (Brazil) had great appreciation for him. During the 22nd WASP Congress New Delhi, he was conferred the highest honor of Hon. Fellowship. On December 2, 2016, he wrote to me, "I am grateful to the WASP for having bestowed the high honour of Hon. Fellowship on me and feel flattered and honoured. It is my pleasure to accept it with much gratitude." After the conclusion of the 2016 New Delhi Congress under the leadership of Rakesh Chadda, he wrote to us on December 5, 2016, "I congratulate you for a very successful and landmark professional event. You and your colleagues produced a very creditable congress. It will stand out as a memorable event in the entire Indian medical history." Thus, he always had kind and appreciative words for people working for the organization.

He once wrote to me, "As far as I remember, WASP always stood for World Association *FOR* Social Psychiatry. Apparently, FOR has been replaced by OF. I do not know if a similar change has taken place in IASP. The Congress was always named World Congress *of* Social Psychiatry." It just shows his diligence for everything.

As his student, it was my privilege to present symposiums with him at many events across the world notably, the European Congress of Social Psychiatry, Geneva, July 1–3, 2015, Annual Conference of the IASP in Chandigarh, 2012, and APA New York in 2014. He had treated us with generosity and kindness on all these occasions.

Vijoy K. Varma was a great teacher, a remarkable leader, and a pioneer of psychotherapy who propounded social psychiatry vigorously and was against biological reductionism, ignoring the complexities of the mind.[3]

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Conflicts of interest

There are no conflicts of interest.

Roy Abraham Kallivayalil

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References

1. Varma VK. Present state of psychotherapy in India. Indian J Psychiatry 1982;24:209-26.
2. Kallivayalil RA. Lessons in social psychiatry at unexpected times! Indian J Soc Psychiatry 2018;34:263-4.
3. Kallivayalil RA. Psychiatry – From biological reductionism to a biopsycho- social perspective. World Soc Psychiatry 2020;2:3-6.

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Professor Vijoy K. Varma

Professor Vijoy K. Varma, fondly called Varma ji in the Department of Psychiatry at the Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh, was a highly revered teacher in psychiatry. My association with Professor Varma goes back to January 1983, when I joined as junior resident in psychiatry at the PGIMER. Both the institute and the city of Chandigarh had a glamour attached to it for a person coming from a state medical college. I distinctly remember my first one-to-one interaction with him around the 1st week of May 1983, when I went to him for feedback on my case conference. He told me that I had made two common spelling mistakes in my slides, having misspelt alcohol and habit, though my presentation was fine otherwise. I presume that due to my punctuality and regularity and some other obsessive qualities, I was liked by him. He was an excellent teacher and would be able to extract answers from the student, if the student was getting anxious. He was an astute clinician as well as an excellent researcher and organizer. He was able to explain principles of psychodynamics and psychotherapy in surprisingly simple language. He also had extraordinary knowledge of statistics and was able to teach complex statistical concepts in very simple and understandable way. I also fondly remember visiting his home on different occasions like Holi celebrations and others.

I left the Department of Psychiatry in January 1987 and gradually grew over in my career ladder. He was a subject expert in 1988, when I appeared for the post of lecturer at the University College of Medical Sciences, Delhi. I can very well recall that he had asked me to explain to the interview board about the concept of negative symptoms in schizophrenia. My interactions with him continued till 2017–2018. He was present in the audience, when I had presented my paper for Bhagwat award at Annual National Conference of Indian Psychiatric Society, Calicut, in January 1991. Prof. Varma was very particular about the protocols. I remember having organized the EC meeting of the *Indian Association for Social Psychiatry* (IASP) at the Institute of Human Behaviour and Allied Sciences, Delhi, sometime in 1996. While I was sitting in the meeting, Dr. Varma cross checked whether I was entitled to attend the meeting, since he was not aware that I had become a member of the IASP EC by then. In August 1999, I happened to meet him at World Psychiatric Association Congress, Hamburg. He invited me along with another Indian delegate for dinner at an Indian restaurant. Prof. Varma was there at IASP conference at Ranchi in November 2001, when I took over as Secretary General, IASP. I also happened to attend his son's marriage at Delhi around 2001–2002. He was a regular in IASP conferences and attended the IASP conference organized by me at AIIMS in November 2008 and the World Association for Social Psychiatry (WASP) Congress at Delhi in December 2016. Dr. Varma gave very useful suggestions for our proposed book on social psychiatry during the WASP congress. His health had started deteriorating by this period, though he delivered an address virtually in September 2023 in the diamond jubilee alumni meeting of the Department at Chandigarh. Prof. Varma's teachings will always remain in our memories and be a guiding force for the coming generations.

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"Of Psychodynamics and Psychotherapy:" My Personal Journey with Professor VK Varma

"The Man" Himself

Dr. Vijoy Kumar Varma was born on November 6, 1937 in Village Maur in North Bihar, India. He completed his MBBS from Patna Medical College (Prince of Wales Medical College), and in 1965, he completed his Masters of Science in Psychiatry from the University of Michigan, Ann Arbor, USA. Thereafter, he earned his DPM which led to his Membership to the Royal College of Psychiatrists and eventually FRCPsych from England. He worked in the Department of Psychiatry in Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh, India, from 1969 to 1996, ascending to the position of Department Head in 1980. In these years, he became a preeminent and one of the most recognized psychiatrists in India, regularly representing his profession in the international arena.

During his professional career, he additionally held the following positions: Visiting Professor at Guy's Hospital Medical School, London, UK; Al-Arab Medical University, Benghazi, Libya; Banaras Hindu University, Varanasi, India; Vilnius University, Vilnius, Lithuania; and Columbia University, New York, NY, USA; and a Clinical Professor of Psychiatry, New York University, New York, USA.

Among his professional affiliations, he was a Diplomate of the American Board of Psychiatry and Neurology; and a Fellow of the Royal College of Psychiatrists (UK), the American Psychiatric Association (USA), and National Academy of Medical Sciences (India).

He had executed 37 funded research projects, including 10 WHO projects. He had, to his credit, about 250 publications, including 6 books, 10 monographs, and 30 book chapters. It is noteworthy that he had won virtually all awards in psychiatry and mental health at the national level in India.

Of the major professional organizational responsibilities, he had been the President of the Indian Psychiatric Society (1989–1990), and the Indian Association for Social Psychiatry (1992–1994). He was the President of the 13th World Congress of Social Psychiatry, India (1992), and the Patron of the 22nd World Congress of Social Psychiatry, New Delhi, 2016. Most importantly, he was the Founding Secretary-General of the Indian Association of Social Psychiatry and subsequently had been bestowed with the title of the Life Patron of the Indian Association of Social Psychiatry.

In this regard, it will be important to quote one of the leading world psychiatrists (and former Treasurer, World Association for Social Psychiatry [WASP]): *"Dr Varma's significant role and great importance in promoting Indian Psychiatry internationally in general and in WASP particularly cannot be over-emphasized. WASP owes a great deal of its success to his hard work. Indian Psychiatry today has a leading position in international organizations and will play a pivotal role in the years to come"* (Marianne Kaastrup, personal communication).

On the nonacademic front, he was a voracious reader with a penchant for mathematics. In interpersonal interactions, he was erudite, witty and well-mannered, with an apt quotation in English, Hindi, or Urdu always ready at his lips.

Dr. Varma had not been keeping good health for a while and passed away peacefully in sleep on July 11, 2024 in Illinois, USA, at local time 4:43 AM. He is survived by his wife, Nirmala Varma; two children, Rina and Raveesh; daughter-in-law, Anjul Varma; four grandchildren; and four great granddaughters.

My Experiences with "The Man"

Although my journey with him started from 1994 onwards, but it did not have a consistency of contact with Dr. Varma. I can safely divide it into three phases.

Phase I (1994–1996): I joined my postgraduate residency training program in PGIMER, Chandigarh in January 1994 when Dr. Varma was the Professor and Head of the Department. He was away on a foreign assignment at that time and Dr. Parmanand Kulhara was the Acting Head. Hence, I had only heard various anecdotes and snippets of information about him, but the common theme was that the department becomes "different" (a bit more formal, a bit less relaxed-but in a positive manner) when Dr. Varma is around. From March 1994 onward, I got the opportunity to learn directly under his tutelage. He had his own unique way of teaching-he would prefer "not too long" presentations, was very organized, meticulous, adhering to time (and time limits and time frames), punctuality being his forte (the departmental teaching program would start at 8 am, and whether his presence would be required or not, one could see him making his way to the lecture theater/his office at/around 7.58 am), having an inherent dislike for long sentences and/or verbal responses, and would prefer things being said in a

simple and succinct manner. One of my favorite memories as his student was his "interesting" problem-solving approach. He would always say - "you are most welcome to approach me with any problem, but come along with a (potential) solution for it." He had a penchant and eye for details and minutiae, especially related to psychological and social aspects (psychological > social); though I daresay not that he was in any way deficient in his grasp about the biological constructs related to mental health and mental illnesses. (Psychodynamic oriented) Psychotherapy remained not only his forte but his passion and the teaching schedule was heavily loaded with theory classes and individual practical teaching sessions by him. My foundation and interest in the field of Psychotherapy can be safely attributed to him as I tried to understand not only the intricacies but also the nuances of *Psychodynamic oriented Psychotherapy* (Why I am using this term will be made more clear later!). Dr. Varma took premature retirement in November 1996; just before when I was to sit for my postgraduate residency final examinations.

Phase II (1997–2005): Dr. Varma relocated to Fort Wayne, Indiana, USA where he worked as a Clinical Professor of Psychiatry but continued to travel a lot internationally for conferences, and spend quite a bit of time in India. My contact remained somewhat sporadic to intermittent; mainly restricted to academic interactions.

Phase III (2006 onwards): I can still vividly recall my in-depth interaction with Dr. Varma in mid-June 2006 when I met him at my home (in Burton upon Trent, United Kingdom) during his lecture tour to the UK. This led onto putting together many of his ideas about transcultural psychiatry and psychotherapy in a book form; wherein I persuaded Dr. Varma to put into action his once previously uttered words "I want to put in black and white, before it is too late, before I am gone."[1] Hence, the book: *Psychotherapy in a Traditional Society: Context, Concept and Practice*[1] [Figure 1]. This book focused on Psychodynamic principles but with the proviso of how to adapt psychotherapy across cultures. This was based on Dr. Varma's long standing observation that it was not easy to carry out psychotherapy by Western rules. Hence, the focus on *Psychodynamic oriented Psychotherapy* (as mentioned earlier)!

This book took nearly 1½ years to complete, and involved myself spending approximately 3 weeks in the company of Dr. Varma; where I got a first hand experience of "the man" himself. Apart from reinforcement of my understanding of the "academic" side of his personality, while working with him, he showed his caring and compassionate nature with a spattering of erudite and witty comments.

Subsequently, due to Dr. Varma's main interests in trans-cultural psychiatry and psychotherapy, alternative models of treatment, philosophy of science, and social issues and problems, I got the opportunity to co-work on another book project initiated by Dr. Anirudh Kala and him[2] [Figure 2].

Our interactions were frequent and consistent, but centered predominantly around psychotherapy. During the period of 2007–2016, we made numerous joint presentations in form of symposia and workshops (at various conferences across the globe), and even conducted a few 3-week duration teaching courses. It will be fair to say that though it was two professionals working jointly, but it was a student (myself) continuously learning from his teacher-cum-mentor (Dr. Varma; in psychotherapy) and evolving as a psychotherapist.

Sadly, his health started deteriorating gradually from 2017 onward, and he withdrew from his academic pursuits.

My Reflections of "The Man"

Considering what I have penned above, my association with Dr. Varma spanned across three decades; though in a waxing and waning manner. Every individual is unique in him/herself and understandably Dr. Varma was no different. I can probably view him as a somewhat "enigmatic person" as he could shift gears within his personality and level of inter-personal interaction with not so great a difficulty. I personally saw the change from a "strict" and "stern" teacher to becoming a "humane" and "caring" elder as per need of the situation, yet he remained a no-nonsense man. He had a way with words; probably due to his love and in-depth knowledge of languages and literature. He was able to convey succinctly and effectively. We all have

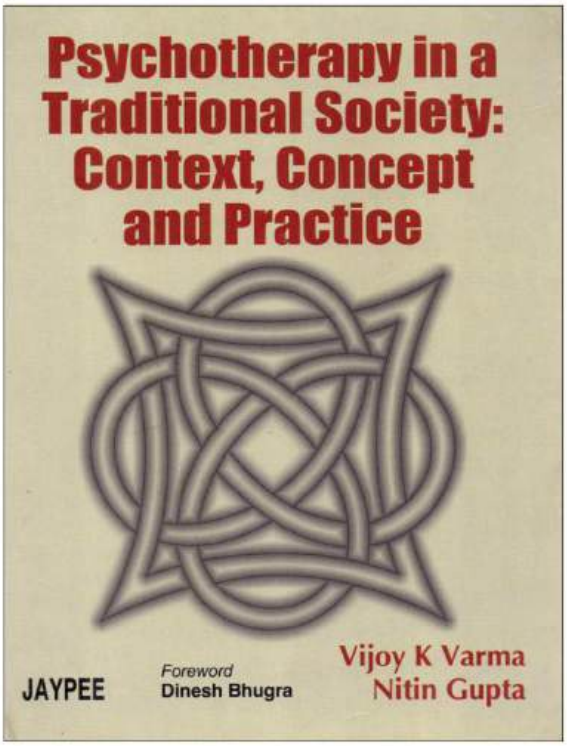

Figure 1: Psychotherapy in a traditional society: context, concept and practice

our limitations and he was no different; but I do ponder over his words - *"an awareness of one's limitations and fallibility" is actually a hallmark of a psychiatrist* and wonder about my imaginary conversations with him on this aspect. He was a social psychiatrist in the "true sense" BUT, for me, he was and will always remain my primary teacher and mentor for psychodynamic (oriented) psychotherapy.

As I sign off, I am reminded of a beautiful award-winning song from the Hindi Movie Sharaabi (1984) which was sung by the Late Kishore Kumar. I reproduce part of the lyrics as below:

manzile apni jagah hai
raaste apni jagah
jab kadam hi saath naa
de to musaafir kyaa kare

yoon to hai humdard bhi
aur humsafar bhi hai meraa
yoon to hai humdard bhi
aur humsafar bhi hai meraa
badh ke koyi haath naa de
dil bhalaa fir kyaa kare
manzile apni jagah hai
raaste apni jagah....

doobne waale ko tinke
kaa sahaaraa hi bahot
dil bahal jaaye fakat
itnaa ishaaraa hi bahot
itne par bhi aasmaan
waalaa giraa de bijaliyaan
koi batlaa de zaraa yeh
doobtaa fir kyaa kare
manzile apni jagah hai
raaste apni jagah.....

This is probably my "psychodynamic oriented" tribute to Dr. Varma due to his love for poetry (and shayari) and the bond which we developed during the production of the book on psychotherapy[1] where each chapter starts with a couplet.

Acknowledgments

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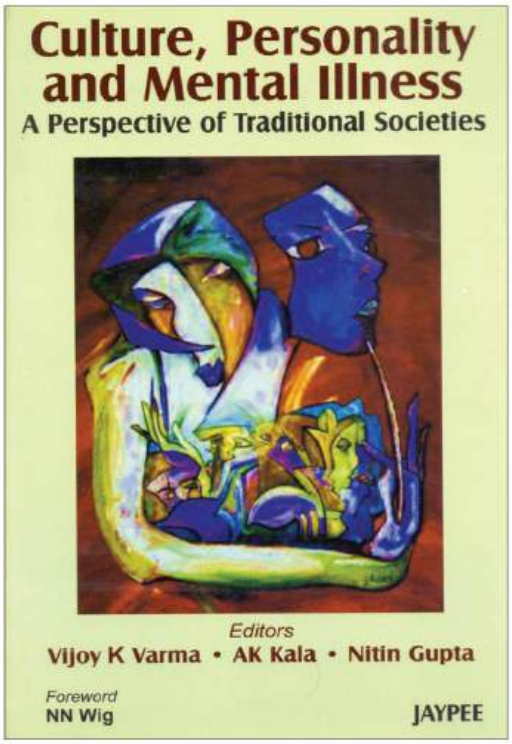

Figure 2: Culture, personality and mental illness: A perspective of traditional Societies

References

1. Varma VK, Gupta N. Psychotherapy in a Traditional Society: Context, Concept and Practice. New Delhi: Jaypee Brothers; 2008.
2. Varma VK, Kala A, Gupta N. Culture, Personality and Mental Illness: A Perspective of Traditional Societies. New Delhi: Jaypee Brothers; 2009.

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Autobiographical Write-up by Prof V K Varma for the Departmental Book "The Journey of the Department" (Golden Jubilee of the Department)

A Short History of the Department

A personal account of the first 25 years of the Department

By

Prof Vijoy.K.Varma (1969-1996)
Head of the Department:1980-1996

A PROFESSIONAL ODYSSEY

THE DEPARTMENT OF PSYCHIATRY POSTGRADUATE MEDICAL INSTITUTE, CHANDIGARH, INDIA

Winston Churchill, who wrote the multi-volume history of the Second World War, as also the History of the English-speaking People, is said to have remarked: "History will be kind to me, as I intend to write a large part of it myself."

PROLOGUE

I joined the Department of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh, India (PGI), on the cold wintry morning of 14 February 1969, as an Assistant Professor of Psychiatry. I was promoted to Associate Professor in August 1971.

Professor Wig resigned from PGI and moved to the AIIMS, New Delhi in June 1980. I took over as the Head of the Department of Psychiatry of PGI in mid-June 1980 on the conclusion of my summer vacation. It took another two years for me to become the full Professor.

I finally retired from PGI on 30 November 1996. The following is my semi-autographical reflection of my 27 years at PGI.

Culture and psychotherapy: A personal journey

It is a moot point as to what determines the individual's choice of a vocation. Many times, the person may be just forced into an occupation, to earn a livelihood. Certainly, this happens much more often than we would like to acknowledge. Often times, a vocation is chosen not on the basis of one's personal liking but on the value system of the society and its financial gains. In medical sciences, it is often debated why someone becomes a surgeon, a cardiologist, a neurologist, a pediatrician, a psychiatrist. No one knows for sure. The real reasons may be quite different from what one thinks were and what he or she would like to believe.

I went into medicine because it was socially valued and was considered to be financially rewarding and because I could compete to get into it. On completing the medical degree, came the issue of the choice of a specialty. This became a more complex exercise. My initial interest was probably for internal medicine, with specialization in cardiology or neurology. Following my role models, the obvious route was to go abroad. America was chosen largely as a route to England and to the coveted MRCP.

Perhaps what attracted me to psychiatry was that, within the confines of this discipline, I could develop and enjoy my interests in philosophy and social sciences. Or could do so without feeling guilty. Where your hobby and your vocation merge, you have real bliss. What is the nature of science? What is the place of an individual in the society? The development of the individual. The development of the society and nation and its problems. Social problems and issues. World peace. Poverty. You can pontificate on all of these. The nature of external reality and how to understand it. What motivates us in doing what we do? What makes us tick?

Apparently, I went into Residency training in psychiatry, because it was more readily available and was better paying. Or the real, "unconscious," motivation may have been my attraction for the functioning of the human mind. In psychiatry, you can move beyond the narrow biological, medical model.

To a large extent what attracted me to psychiatry was psychotherapy. I trained mostly at the University of Michigan graduate programme, which was acclaimed as a major centre for Residency training and a proponent of a psychodynamic approach to psychiatry.
In those days, as a part of Residency training, each Resident had to 'do' quite a large amount of psychotherapy. We all had up to half a dozen patients, carrying out 2 to 4 sessions a week with each, 40-50-minute sessions. This was supplemented by weekly individual psychotherapy supervision and psychotherapy case conference.

On completion of training and certification, when I returned to India and was fortunate to get a faculty position at the Postgraduate Medical Institute in Chandigarh (PGI), I started what was actually the University of Michigan model. As at Michigan, the training programme at PGI included theoretical courses in psychodynamics and psychopathology.

The practical training in psychotherapy had several components. It included actual conduct of psychotherapy, individual supervision by a faculty member, and psychotherapy case conferences.

The Route to PGI

I initially went to the U.S. on an Exchange Visitor visa. In those days, that was the norm. Immigration was very difficult to achieve. On the Exchange Visitor visa, you were expected to leave the U.S. on the completion of the purpose of the visa, namely completion of the graduate/residency training – you were often allowed a year or two beyond that. Many Indians went to Canada for a few years to try immigration from there.

Accordingly, my Exchange Visitor visa expired in the summer of 1967. I got a matter-of-fact letter inquiring my departure date. We Indians made a joke of such a letter; "are they coming to see me off?"

In any case, when the time arrived, I got busy planning my return to India. The 1967 annual meeting of the American Psychiatric Association (APA) was being held in Detroit, the large city next door to where I was located. As a matter of fact, I was in the host committee and was given some exalted title; something like sergeant-at-arms or something.

Of course, for my return to India, I considered the major institutions. AIIMS, New Delhi and PGI, Chandigarh, were uppermost in my mind. CIP, Ranchi and King George's in Lucknow were on the immediate second tier. Actually, on a train trip from Delhi to Patna, I stopped and met Professor Sethi in Lucknow (over scotch) to inquire about a possible job. The overall thinking in my mind was that if I got a faculty position at AIIMS or PGI, I shall take it and settle down in India.

At the 1967 APA, one of the delegates that I met was the director of the missionary hospital called Nur Manzil in Lucknow. I spent an afternoon with him in a quasi-official interview.

The going rate mentioned was Rs. 700-800 per month; I was hoping for something like 1500.

On leaving America, I spent a full 12 months in Wales and England. This was part of my original obsession for MRCP and I even tried for it. As I was already Board certified in America, the plan was altered to MRCP with Psychiatry. My battle plan was to hoodwink my way through general medicine part of it; feeling confident that if I could do that, psychiatry will be a cinch. MRCPsych had yet to arrive. In the process, I did DPM which was instrumental in me getting the MRCPsych and, subsequently, FRCPsych.

Almost at the Doors of PGI

I finally returned to India in the early days of July 1968. I remember that I landed at Delhi still wearing a woolen suit. Within days of my arrival, there was the interview at AIIMS, and a couple of weeks later, at PGI. My main rival and competitor was Dr. J.S. Teja. He is my contemporary and we hit off in a friendly manner. Neither of us was selected for AIIMS. When at the conclusion of the PGI interview, I said to him, see you again soon, he retorted, no not again.

We did not know at the time that both of us had been selected for the PGI Department, for the post of an assistant professor. At that time, there was only one position of assistant professor; there was another lower post, that of a lecturer which – not known to me – they were trying to upgrade to that of an assistant professor. Dr. Teja was higher in the selection, so he was immediately selected for the existing post of assistant professor which he joined. I had to wait about three months before the other post could be upgraded and offered to me.

I joined the Department of Psychiatry, PGI, on 14 February 1969. I was started at the starting salary of Rs. 1,000 per month, with Rs. 100 per month dearness allowance (D.A.). It was the starting salary in the scale of Rs. 1,000 to 1500. To start with, I took up residence with a distant relative, sort of a brother-in-law who was a forensic scientist in the U.T. administration. I used to travel to PGI by pedal rickshaw. The fare used to be Rs. 1.25. Our flat was in Sector 22, in a row of houses just behind the bus station in Sector 17. My evenings would be spent in a stroll of Sector 17, in the area around Neelam Cinema. I also got very used to mutton and pork *tikka* and chop. This continued for many years in Chandigarh. I lament that the quality of *tikka* and chop gradually deteriorated; it is no longer what it used to be.

Chandigarh already presented something like a culture shock, so different from Bihar, as also from most of India. The harsh north Indian winter was also an experience. It was not till June 1969 that my wife and our daughter joined me in Chandigarh, in my own residence allotted by PGI. About April of 1969, I was allotted a PGI flat (98, Sector 24- A). I got myself some basic furniture (a pair of beds, a sofa set and a dining set) and moved into the flat by myself. I had hired a servant from Himachal Pradesh who was an excellent cook. My experience with him is memorable because he misappropriated all of Rs. 16 with our confectionary store (Sapra's in Sector 24 market). That kept hanging for years till I paid it off.

The Early Days At PGI

Perhaps, my very first encounter with Professor Wig illustrates his sensitivity to socio-cultural factors. The very day after I joined the P.G.I., Chandigarh, Professor Wig took me home for lunch. In course of conversation, he remarked: you are a Varma, and are from Bihar; you must be a *kayastha*. (*Kayasthas*are one of the castes of Hindus.) On my response in the affirmative, he gave me a task, to name the 12 sub-castes of *kayasthas*. (*Kayashtas* are supposed to have originated from the deity *Chitragupta,* and have 12 sub-castes named after his 12 sons.) I gave up after naming 6 or 7; whereupon, he completed the list.

Dr. Teja, being about 3 months senior to me at PGI, was already well settled by the time I arrived, with his house, car and driver. The

second or the third day, he took me home to lunch. My introduction to Punjabi was listening to him giving driving directions to his driver, *sajje, khabbe,* etc. Being non-Punjabi speaking created its own challenges for me. Early during my job, I was once asked to head the Department when both Professor Wig and Dr. Teja were away. One of our staff, Mr. Mohinder Singh wanted a leave. Why, "my *maj* is ill." When he returned, I inquired, "how is your Maa Ji (respected mother)?" My mother, what happened to my mother. I told him, he had said she was ill. "No, Doctor sahib, my *maj,* my buffalo was ill." I said to myself, "Vijoy Varma, either learn Punjabi, or get out."

When I joined PGI, Professor Wig was the professor and head. He was already very well regarded in PGI. Dr. Gurmeet Singh and Dr. Harish Verma had already left. Dr. J.S. Teja was an assistant professor. Dr. Dinesh Shah, having passed the M.D., was a Registrar. Dr. R.L. Narang was a Resident. I cannot say that he was my student. A couple of months after I joined PGI, he successfully appeared at the M.D. examinations in psychiatry. Those days, I was living alone; I vividly remember his making rounds of my flat on bicycle to inquire about the examination results.

The subsequent residents included a straggling group of Dr. B.R.S. Nakra and Dr. B.C. Khanna. They were followed by the first full batch of five; Dr. Salman Akhtar, Dr. Subhash Bhatia, Dr. Param Kulhara, Dr. Harish Malhotra and Dr. Sarbjit Singh. Although I was their teacher, being only 7-8 years older, we developed an easy familiarity. We often had lunch together and had many common interests. Many of us nurtured literary interests, in poetry and literature. A number of jokes were making rounds. Salman's favourite was a riddle: *Humanyoo Babar ke bête ka kya thaa?* Another was how to find the correct direction to a destination by asking one question to one of twins, one of whom always lied and the other always told the truth. He also had an anecdote of the interaction between Alexander's army general Selucus and the Indian King Porus whom he defeated. "How should we treat you?" "Just like a king treats another." It ends with Selucus announcing his intent to come back next morning and "to drink up your blood with breakfast." My favourite was the riddle about a teacher, his three pupils and 3 red and 2 blue caps. I 'selected' Param Kulhara for residency over jokes at a cocktail party at Harish Malhotra's cousin's.

The first time that I served as an M.D. examiner was at the December 1971 examinations. In those days, you had to be at least an associate professor to be an examiner; something that I had achieved in the shortest possible time of two and one-half years. Subhash Bhatia and Salman Akhtar were the candidates. Their examinations fell right during the Indo-Pak was which had started on 3 December. I am sure, their preparations suffered due to the war with its blackouts, etc. I created a commotion when I backed my car at Neelam parking lot, as back-up lights turned on. After the examination was about to end at the viva, to lighten the atmosphere, they were asked questions about the war; Khulna, Comilla, Dhaka; and the surrender of General Niazi with 100,000 Pakistani troops. Long years later, after my move to America, I became a co-examiner of Subhash Bhatia at the American Board. I often introduced him as my first examinee.

Organization of The Department

Chandigarh was envisaged by Jawaharlal Nehru, as the replacement for Lahore, the adored Paris of Asia. I am no expert on the history of Chandigarh. PGI was the brainchild of Sardar Partap Singh Kairon, to replace the famous medical college in Lahore, King Edward's. Much of the initial faculty came as transplants from Lahore through Amritsar. If one goes by the tales of all those who claim to have come to Chandigarh on the legendary taxi from Amritsar, it must have been an airbus!

To start with, Psychiatry was a part of Medicine, a Division in the Department of Medicine. I recall attending the administrative meetings of the Department of Medicine. One of my initial

suggestions for medicine was that the M.D degree should be with specialization in subjects such as cardiology, neurology, gastroenterology, a suggestion which was summarily rejected by the hierarchy.

Harish Verma was the first graduate with M.D. (Medicine) with special subject in Psychiatry. He was followed by Dinesh Shah, Roshan Lal Narang, and then, by Bahadur Chand Khanna and Bharat Raj S. Nakra.

Professor Wig has already mentioned about the initial history of the Department. Of much relevance is the fact that, on the 1st April of 1967, PGI was designated as institute of national importance, one of only two institutions thus designated, the other being AIIMS, New Delhi. It bestows upon it a truly all-India character.

DEVELOPMENT OF THE DEPARTMENT OF PSYCHIATRY

Training Programme

To start with, the training programme in Psychiatry, geared for M.D. (Psychiatry) was largely tuned to clinical psychiatry. It was totally appropriate to impart training in mental illness and its treatment. The formal teaching consisted of a weekly lecture in general psychiatry. In addition, a weekly case conference was in practice from the very beginning, as was a weekly seminar on salient topics in psychiatry.

On joining the Department, I was assigned by Professor Wig to coordinate the residency training in psychiatry for M.D.(Psychiatry). A tradition developed designating No. 2 as the residency director that has continued. With the guidance from Professor Wig, we expanded the training programme to include courses in psychodynamics and psychotherapy. The University of Michigan model, under which I had trained, came as being very helpful in this. At the same time, training in psychotherapy was instituted, with residents being required to carry out individual psychotherapy, with individual supervision and case conference.

With the close association with the Department of Medicine, psychosomatic rounds were a part of the training from the very beginning. This included round involving general medicine, neurology, and later other departments, such as surgery.

Another area to be added to the training programme was Psychology – general, clinical and social. With Dr. Santosh Verma and Dwarka Pershad achieving their own Ph.D, and assuming faculty positions, formal training was instituted in lectures and practical aspects of these.

Social Sciences and Research Methodology

When I underwent residency training in psychiatry in the United States, I also enrolled myself for a graduate programme in Psychiatry at the University of Michigan, leading to the degree of Master of Science (Psychiatry). It was hard work, lectures on top of the clinical workload of the residency. One-half of the course load was in Psychiatry, but the other half could be taken in related subjects, what was called 'cognate'. I took my cognate in subjects such as neurology, neurosurgery, EEG, as also biostatistics as well as sociology. This exposed me to social sciences and research methodology, including biostatistics. At Michigan, I was also exposed to a brilliant biological scientist, Dr. Anatol Rapoport, who conducted research seminars.

With the geographic proximity to Panjab University, it being literally across the street, across Madhya Marg, I developed close relationship to it and to its faculty. Many of its faculty became my personal and family friends and continue to be lifelong.

We developed teaching in sociology and social psychology as part of our M.D. (Psychiatry) curriculum. Professor Wig was most supportive in this. Cultural anthropology was also added later. To start with, these formed parts of 'informal teaching'. (Apparently, these were

later assimilated in the formal training programme and Social Psychology and Sociology are listed as such in the 2003 Manual.)

Informal training programme:

M.D. (Psychiatry) training includes seminars/journal club and case conferences. These were already in force before I joined and have continued. A fortnightly research forum was added.

Psychosomatic Rounds:

The Department of Psychiatry has enjoyed very close relationship with many other departments of PGI. Being a part of the Department of Medicine, it was always close to it and to its other Divisions, particularly cardiology and neurology. Professor Wig was closely related to obstetrics and gynaecology through collaborative research. It was already in place when I joined and has continued, and expanded to include other departments.

M.D. (Psychiatry) Examinations:

The format of the M.D. examinations developed early and has continued largely unchanged. The examinations consist of four written papers, practical and vivavoce examinations. The four papers are the following:

- Basic Sciences as related to Psychiatry,
- Clinical Psychiatry,
- Psychiatric Theory and Psychiatric Specialties, and
- Neurology and General Medicine as related to Psychiatry.

The practical examinations consist of a long case and a few short cases.

It is interesting to note that the format of the PGI MD examinations has been largely copied, with minor modifications at many other training institutions in India and continues to be followed.

The Residency Programme in Psychiatry

The primary medical degree in India is not M.D.; it is M.B.B.S., after the British model. M.D. is the higher specialist postgraduate degree, comparable to the British MRCP or the American Boards. The postgraduate trainees are called Junior Residents.

When I joined the PGI in 1969, admission to Junior Residency required M.B.,B.S., plus internship and six months of experience. The Junior Residency was of a duration of three years and involved a thesis. In early 1970s, there was a strike over the amount of the stipend. As a compromise resolution, the Government increased the stipend, but reduced the duration from 3 years to 2 years.

The very first Resident to be trained under myself was Bharat Raj Swaroop Nakra (serial number 4). The last one was Gagandeep Singh (serial number 103, interestingly adding to exact 100). In addition, I guided five for Ph.D. (Dr. Savita Malhotra is the only one who belonged to both groups.)

Our initial Junior Residents joined the three-year programme, with thesis. This included Harish Verma, Dinesh Shah, Roshan Lal Narang, Bharat R.S. Nakra and Bahadur Chand Khanna, as also two earliest batches, of Bhatia, and colleagues. and Suri and colleagues. Because of the change in the programme, there were no theses between mid-1970s and mid-1980s.

The first full batch, of 5 Junior Residents, consisted of Subhash C. Bhatia, Salman Akhtar, Param Kulhara, Harish Malhotra and Sarbjit Singh. The first two successfully appeared at the M.D. examinations in December 1971, at the height of the Indo-Pak war of 1971, and the other three in May 1972. The second full batch consisted of Anil Suri, Anindya Ghosh, Anirudh Kala and Virander Mohan, in early 1970s. There was a two-some of Srinivasa Murthy and Kasturi Lal Garg. Then there was a batch of three ladies, Savita Malhotra, Usha Rao and Sudha Jain. It was followed by another batch of four, Sudhir Khandelwal and others. The 1980s saw a number of other Residents, 1-2 at a time,

but culminating in another full batch. My last full batch was a group of five completing in 1990. Pushpa Sharma and A.G. Asad were the only foreigners.

Many of the Residents have subsequently distinguished themselves in academic psychiatry. A note-worthy name is that of Srinivasa Murthy who occupied very important positions at the WHO and at the NIMHANS, Bangalore. Both Subhash Bhatia and Salman Akhtar went on to full professorship in the U.S.A. Rakesh Chadda is now a full professor at the AIIMS. Param Kulhara and Savita Malhotra succeeded me as the Professor and HOD, PGI. Anirudh Kala became a full professor in Ludhiana and later started a very prestigious psychiatric centre there. Virander Mohan and Sarbjit went on to very successful private practice. Sudhir Khandelwal went on to be the HOD at AIIMS. Vimal Sharma made a name for himself in geriatric psychiatry, along with Professor Copeland of Liverpool. Of our M.D.s, to my best knowledge, full professors and above, in addition to those already mentioned, include Usha Rao (now Naik), (Late) S.S. Raju, Prakash Behere, Hemen Phookun, Pramod Singh, Ajit Avasthi, Ram Jiloha, Rajeev Gupta, Rajiv Gupta, Santosh Chaturvedi, Murli Sharma, Roy Abraham, G. Prasad Rao, Ravi Sharma, Surendra Mattoo, Bir Singh Chavan, Swaran Preet Singh, Dinesh Arya, Debasish Basu, Subho Chakrabarti, etc.

The group of 1980s also produced many noteworthy psychiatrists. Ajit Avasthi still continues in the Department. He followed me as the President of the IPS. Roy Abraham also became the IPS President and now occupies the most prestigious position of the President-elect of the World Association for Social Psychiatry.

At the World Congress of Psychiatry, held in Cairo in 2005, I hosted a dinner replete with belly dancing, for my ex-students, colleagues and friends, kindly organized by Srinivasa Murthy who was then working at the W.H.O. there. There were my students, my grand-students and great-grand students. By reciprocity, I became their *Guru, Dada Guru, Pardada,* on to – and this one added by me - *Lakkad Dada.* We all had a good laugh.

PROFESSIONAL ORGANIZATIONAL ACTIVITIES

From the very beginning, the Department was actively associated with professional organizations in India.

Indian Psychiatric Society:

When I joined, Professor Wig was the General Secretary of the Indian Psychiatric Society. He quickly inducted me as the Assistant General Secretary. Hyderabad conference of January 1970 was my first annual conference. Dr. Wig introduced me to his colleagues as "Dr. Varma." Almost everybody immediately jumped to the conclusion "oh, Varma's son?" referring to my illustrious namesake, Dr. L.P. Varma (actually no relation).

The next conference was memorable as I travelled to it in Madurai in the company of three of my Residents. Although their teacher, I was more of a friend. We played card throughout on the train.

A memorable event was the annual conference of December 1972 held in Chandigarh, hosted by Professor Wig as the Chair and myself as the Associate Organizing Secretary. It was on this occasion that elections were held for officials of Indian Psychiatric Society. I contested for General Secretary against Dr. Anil Shah of Ahmedabad, whom I narrowly defeated. It was not a fair fight; being the conference host, I had an advantage. I have always regretted it. However, Anil Shah and myself became close friends. He preceded me for the President of IPS by almost a decade. In 1980, Anil served as the local guardian of my daughter, Rina, for her internship in architecture in Ahmedabad. As it happened, my darling daughter-in-law, Anjul, is from Ahmedabad, and whenever I visit her parents there, one evening is reserved to be spent with Anil and Sudevi Shah.

However, the next year I ran into a controversy with colleagues from Bangalore. In the summer of 1973, Professor Wig wrote to me: "South is in open revolt."

At the next annual general body meeting of the Society, I went into a spirited defense of my position:

The time has come the walrus said,
To talk of many things,
Of shoes, of ships, of sealing wax,
Of cabbages, of kings.
And why Bangalore is boiling mad?
And whether pigs have wings?

Of course, and as was advised by Professor Wig, as a corollary, such a defense had to follow by a resignation which I offered, but which was not accepted.

The Department continued to remain closely affiliated with the IPS. We have won all of the awards of the Society, many more than once. On the organizational side, we have served in many capacities; as Council members and finally as the President. I was elected as the President-elect at the IPS conference in Varanasi in 1988. The election was bedeviled by some procedural problem because of which most of the postal ballots were rejected. My election officer, Param Kulhara had quietly told me, "Sir, most of the ballots are actually in your favour." When the votes were being counted, Jagdish Desai, the Assistant General Secretary was calling out the ballots. Later on, I remarked to him that had he said "Jai Shri Krishna" in place of "Vijoy Varma" for each of my ballots, he would have surely been secured a place in heaven!

I served as the President in 1989-90, terminating at the IPS conference hosted by us in Chandigarh in January 1990. Subsequent to my departure from PGI, Dr. Ajit Avasthi and, then Dr. Roy Abraham, also were elected as IPS Presidents. The Department also hosted the 2005 annual conference of the IPS. As the IPS President, I had taken upon myself three special tasks: upgrading teaching in psychiatry in the M.B.,B.S. curriculum, a national headquarter building for the IPS, and bringing a World Congress to India. Although we made efforts, we were not fully successful. Our student, Roy Abraham, has now got the building.

Indian Association for Social Psychiatry

The idea that later blossomed into the formation of the Indian Association for Social Psychiatry was mooted at the Transcultural Psychiatric Meet held in Madurai, Tamil Nadu, on 23-25 August 1981. It was felt that it may be desirable to have a separate professional organization at the national level in India for social and/or transcultural psychiatry.

Subsequent to the Transcultural Psychiatric Meet in Madurai, I consulted with the likely interested professional colleagues through a circular. In view of an overwhelmingly positive response to the formation of such an organization, a meeting of interested persons was convened to coincide with the annual conference of the Indian Psychiatric Society held in Madras (now Chennai) in January 1982. At this meeting, an *ad hoc* committee was formed with Col. Kirpal Singh as the Chairman and myself as the Convener. At this meeting, it was decided to name the organization as "the Indian Association for Social Psychiatry." There was considerable debate between 'social' and 'transcultural' in the name and scope of the organization, but eventually, 'social' prevailed.

The subsequent formation and development of the organization took place both nationally and internationally. In addition, we engaged in close collaboration with the World Association for Social Psychiatry and derived support, encouragement and guidance from it. The WASP leadership was very supportive and kind, including its stalwarts such as Joshua Bierer, Jules Masserman, Jack Carleton, A. Guilherme Ferreira, Jorge A. Costa e Silva, Alfred Freedman, Stanley Lesse, Alexander Gralnick and others. At its 10th World Congress held in Osaka, Japan in 1983, which I attended, the

WASP Executive encouraged in the formation of the IASP, and pledged its full support in every way possible. At the last meeting of the *ad hoc* committee held in Ranchi on 14 January 1984, the constitution was adopted, office bearer and council members were elected the Society was fully launched.

The IASP started with Professor A. Venkoba Rao as the President and myself as the Secretary-General –cum- Treasurer. The first annual conference was hosted by Professor Venkoba Rao in Kodaikanal, T.N., in 1985 and the second conference by us in Chandigarh in March 1986. I served as the President-elect (1991-92) and President (1992-94), of the Indian Association for Social Psychiatry. One of the earliest organizational activities of the IASP was the Regional Symposium of the WASP held in New Delhi in February 1989 with myself as the Organizing Chairman.

The 13th World Congress of Social Psychiatry organized by us held in New Delhi in November 1992 was a resounding success. It was the first occasion that a world congress in any area of psychiatry or mental health was held in India. It was remarkable that as many as three Union Ministers joined in its inauguration and the valedictory was chaired by the Speaker of the Parliament.

World Health Organization

The WHO Collaborating Centre for Training and Research in Mental Health was inaugurated in March 1976 by the WHO Regional Director for South-East Asia.

I served on the WHO Panel on Alcohol and Drug Problems, 1980-96. In the very beginning, I was asked to serve as a WHO Short-term Consultant (STC) to serve in Sri Lanka in December 1975 to March 1976. This time was used mostly to teach psychiatry and psychodynamics at the Peradeniya campus. I further served as a STC in Sri Lanka in 1983 and in Afghanistan in 1991, both at the height of their internal insurgency.

International Professional Organizations

Over the years, the Department has been keenly involved with professional organizational activities at the global level. This included participation in the scientific Congresses of the respective organizations. The faculty of the Department often organized scientific presentations involving professional colleagues from other centres in the country. For example, during my time at PGI, my colleagues and I presented programmes at the World Congresses of Psychiatry (1983, 89, 93), the World Congresses of Social Psychiatry (1983, 86, 90, 92, 94), the World Congresses of Psychotherapy (1985, 88, 91), the World Congresses of the WFMH (1991, 99), and the World Congress of Psychosocial Rehabilitation (1991). We hosted the WPA International Symposium on Cultural Psychiatry in March 1995. A notable association was with the World Association of Dynamic Psychiatry, basically based in Germany, that we participated in 1992 and 99.

Medical Council of India

I was inducted as an Inspector of the Medical Council of India in 1985 and made many inspections of medical institutions in the country for approval of their training programmes. It provided to me a welcome opportunity to compare our programme at PGI with what was followed nationally. The PGI model was increasingly implemented at the national level. I was fortunate to have been a much favoured student of Dr. A.K.N. Sinha who served as the President of the Indian Medical Association, the Commonwealth Medical Association, and the World Medical Association, before he became the President of the Medical Council of India. During my Presidency of the IPS, 1989-90, I tried to upgrade psychiatric training in the M.B.B.S. curriculum, but was not fully successful. It is a matter of pleasure that my student, Dr. Roy Abraham Kallivayalil has been able to make further inroads in it during his Presidency of the IPS.

THE SOCIAL LIFE OF THE DEPARTMENT

From the very beginning, the Department developed an active social and extra-curricular programme. The faculty interacted closely as almost one family and close family relationships developed. The Residents looked up to the Faculty almost as family elders. Dr. Veena Wig was greatly regarded as the First Lady and the matriarch. This mantle was later variously passed, on to my wife and, then, to Mrs. Madhu Kulhara.

Of the various social programmes of the Department, the most notable were the annual picnic and the annual dinner. All staff participated in these, along with their family. They join along with the Faculty and the Residents. With its proximity to the Himalayas, its foothills formed attractive sites. With its altitude, it also provided a welcome respite from the summer heat, for the day. A location just across the State line in Himachal Pradesh became our first locale. Dhrampur, H.P. was also a very popular site. One of our Residents, Dr. Virander Mohan, established his private practice there by mid-1970s, and he provided help in organizing the picnics. Another location and one of the earliest was Ropar in Punjab. Our site was by the road bridge on Satluj.

The annual dinner was also very much looked forward to. The venue was mostly our own PGI club in Chandigarh, just across the street from Professor Wig's and my residence. A lot of debate often went on regarding the logistics of the dinner and the picnic – the menu, transport, cost, etc. The dinner also provided an opportunity for the Residents and other staff to delve in singing, jokes and other artistic endeavours.

On the more informal side, Residents were welcomed and inducted into the Department. Residents generally joined the Department in January and in July. Shortly thereafter, they were invited to the house of the HOD for a 'tea party'. Often, to break the ice, they were encouraged to present some aspect of their talents. It also gave them an opportunity to get to know each other and the families.

Various festivals are also celebrated. There are at least four festivals which were celebrated with the participation of patients. The lighting of lamps at Diwali is done on the rooftop adjoining the ward. On the Republic Day and the Independence Day, the HOD addresses the patients.

Personal

On a personal note, my time at the PGI was momentous to me and to my family. Our son was born here, our daughter got married and gave us two adorable grandchildren. Both our children had their school and college education in Chandigarh. The Department and the PGI was like a family, supporting in every way possible. When Rinku developed neo-natal jaundice, Mrs. Wig spent nights supporting my wife. When Rinku had a roadside accident in May 1993 from which he barely survived, the entire Department was there as one person.

On his recovery, in my thanksgiving card to the Department, I cited the Lord's prayer of St. Francis of Assisi:

"Lord, make me an instrument of Thy peace;
where there is hatred, let me sow love;
where there is injury, pardon;
where there is doubt, faith;
where there is despair, hope;
where there is darkness, light;
and where there is sadness, joy.
O Divine Master,
grant that I may not so much seek to be consoled as to console;
to be understood, as to understand;
to be loved, as to love;

for it is in giving that we receive,
it is in pardoning that we are pardoned,
and it is in dying that we are born to eternal life.
Amen."

I concluded: "and such marvelous instruments of His Eternal Peace you have all been!"

SERVICE

The Department started, as usual, with inpatient and outpatient services. During my tenure, the ward consisted of 24 beds. In late 1980s, a 20-bedded de-addiction ward was also added. It was located in the area of the erstwhile Army Command Hospital. Both the inpatient and the outpatient services were co-ordinated by the respective Senior Residents. One noteworthy aspect of the OPD has been a walk-in clinic where patients can be seen on intake, without an appointment. (Professor Wig often remarked that a patient is an *atithi, a-tithi,* i.e., dateless.)

In the OPD, each patient on appointment, is seen in detail by a Resident, who then discusses the case with a Faculty member or with the Senior Resident to arrive at the diagnosis and plan of treatment. It is noteworthy that the Department has had ECT services from the very beginning.

On admission to the ward, the patient is allotted to a Junior Resident (postgraduate trainee) who then works up the case and discusses it with the Senior Resident and the Faculty/Consultant in the ward rounds. One significant feature is that the Junior Resident is given the overall responsibility for the patient care, although under the supervision of the Senior Resident and the Faculty/Consultant.

Patient records are rigorously maintained. The OPD completed 25,000 cases by February 1982. Another noteworthy feature has been an annual statistical exercise at which the patient statistics are presented; breakdown of data is done by the diagnosis and by socio-demographic variables. Such an exercise has often resulted in unanticipated insights.

There was a considerable expansion in the services by the institution with the rural clinic at Raipur Rani in the late 1970s. This also afforded a research base for research into the outcome of major mental illness and its treatment.

Child Psychiatry Services

A child guidance clinic was started as early as 1967. It was constrained by the lack of availability of trained manpower. More specifically, there was no properly trained child psychiatrist. Some of us plugged in. To start with, Dr. J.S. Teja conducted the child guidance clinic around 1969-71. When he left, I looked after it for 2-3 years, till Dr. Savita Malhotra joined and gradually took over. She was increasingly involved in it. She also enrolled in a Ph.D. programme in child psychiatry (with myself as the guide, I am flattered), and got the first Ph. D. in psychiatry in 1985. Under her leadership, child psychiatry has prospered. Five beds for child and adolescent psychiatry were started in April 2013 and, in July 2013, a D.M. in child and adolescent psychiatry was approved.

Drug De-addiction Services

In the early 1980s, the Government of India (GOI) developed interest in developing drug de-addiction services at the national level, to address the problems of alcohol and drug dependence in the country. Alcohol use had been sky-rocketing, along with alcohol-related health and legal problems.

As such, the GOI formed a committee in 1986 to develop drug de-addiction services in the country, with myself as the Convenor. The Committee consisted of several representatives from different psychiatric centres in India. The committee held several meetings at the Ministry of Health and Family Welfare. The then

leadership of the Ministry was keenly interested in this endeavour. It recommended about a dozen centres to treat alcohol and drug dependence. It so happened that at the concluding meeting, I was away to a visiting professorship; as such, Dr. D. Mohan of the AIIMS chaired the finalization of the report, and got credited with it.

At the PGI, the alcohol and drug dependence services started functioning with an outpatients' clinic in March 1978. It was named Alcohol and Drug Dependence Clinic (ADDC). We had already been keenly involved in alcohol and drug research. ADDC functioned as a part of the outpatients' clinic of the Department, held one full afternoon a week. However, it gradually developed an identity of its own. The research staff at the time assisted in the clinic. However, there were no inpatients.

The in-patients' services started with a 6-bedded unit in the psychiatry ward on 1 September1988. On 15 April 1989, the bed strength went up to 8. It occupied the space of the psychiatry ward in Cobalt block. Patients were evaluated by Junior Residents and rounds were regularly made by Senior Residents, the Faculty and myself.

On 28 May 1992, the ward was relocated in the area vacated by the erstwhile command hospital of the Indian Army. The new campus was inaugurated by the Chief Minister of Punjab. The outlay and the structure of Army Hospital was quite different from what was required. A considerable amount of input was made to modify the building, but it was not quite satisfactory. The PGI hierarchy, particularly professor Walia, the Director was very helpful. We were also able to receive some support from the Government of India, through the intervention of Dr.Walia.

The treatment programme at the DDTC consisted of the usual assessment of patients at ward rounds in which Junior Residents presented cases to the Consultant. To start with, most cases were those of alcohol or opium dependence. In early 1990s, we developed opium detoxification by use of buprenorphine, way ahead of it elsewhere.

Subsequent to my departure from the PGI, DDTC continued to progress. Noteworthy was extension of services in outlying areas. A new building was inaugurated on 7 March 2006. The DDTC has progressed and excelled in providing an exemplary treatment, research and training at the national level.

RESEARCH (This Section is limited to my own research.)

The earliest research of the Department were carried out in conjunction with the Department of Obstetrics and Gynecology relating to family planning. My first project was supported by the ICMR, along with Dr. Amma of Biochemistry. Both, Professor Wig and myself were very interested in drug abuse. India being the home of cannabis, we jointly carried out research on the effects of long-term cannabis use. This was funded by the WHO. The WHO also supported our studies in drug use in students and non-student youth. Related studies in drug abuse included a survey of alcohol abuse in Chandigarh, 1977-79. Professor P.N. Chhuttani, the then PGI Director was a great encouragement in it.

The Department was closely linked with the WHO in its research activities. These included studies of acute psychosis and schizophrenia. The acute psychosis project was started with Professor Wig. Dr. Savita Malhotra joined it 1981-84.

One of the most notable research activities of the Department involved that on schizophrenia. These included the projects, Determinants of Outcome of Severe Mental Disorder (DOSMeD) and Long-Term Study of Schizophrenia (LCOS). It was supported by the WHO, 1980-83, and later by the ICMR, 1985-87 as also by PGI, 1990-92. It was initially started by Professor Wig. On the departure of Professor Wig in June 1980, I took over, although Professor Wig

continued to provide welcome guidance for another couple of years. Later on Dr. Savita Malhotra joined the LCOS.

Another milestone study, supported by the WHO, was Strategies for Extending Mental Health Care. A brainchild of Professor Wig, it was also richly contributed to by Professor Srinivasa Murthy. Both the DOSMeD and the Strategies project put PGI solidly on the world map.

Another important WHO study was in mental health legislation, conducted by Professor Santosh Verma and myself in early 1980s. There was an ICMR project on home care for mentally retarded children with Santosh Verma. There was a series of ICMR projects on pain. Towards the end of my tenure, I developed interest in yoga and we carried out an ICMR project on yoga in hypertension.

World Health Organization

I served on the WHO Panel on Alcohol and Drug Problems, from 1980-96. In the very beginning, I was asked to serve as a WHO Short-term Consultant (STC) to serve in Sri Lanka in December 1975 to March 1976. This time was used mostly to teach psychiatry and psychodynamics at the Peradeniya campus. I further served as a STC in Sri Lanka in 1983 and in Afghanistan in 1991, both at the height of their internal insurgency.

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Medical Council of India

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EPILOGUE

From a one-man beginning, the Department has greatly progressed to its current size and stature. Of most recent developments, during the tenure of Professor Savita Malhotra, are the opening of five beds for child and adolescent psychiatry in April 2013, and the approval of D.M. in Child Psychiatry and in Addiction Psychiatry, and M. Phil in Clinical Psychology, all in July 2013.

There are no prizes for correctly guessing the happiest man among us today. It is Professor

N.N. Wig. His brainchild has prospered so much. It is hard to think of the development encompassing so many diverse areas; training, service, research, professional organizational activities. Let me conclude on a personal note, by acknowledging his contribution not only to the Department, but also to me personally in my role in it, by guiding me; truly being my "Mentor-in-Chief."

Research Awards of Prof V K Varma While in the Department

Research Awards

1. Marfatia Award for best article at IPS Conference (Drs. S.C. Bhatia, V.K. Varma, M.K.P. Amma, 1974).

2. Bhagwat Award for best paper by young scientist at IPS Conference (Drs. A. Ghosh, V.K. Varma, M.K.P. Amma, 1978).

3. Dr.B.C. Roy award for outstanding teacher in Medicine (Dr. V.K. Varma, 1984).

4. Marfatia Award for best paper in IPS Conference (Drs. V.K. Varma, K. Das, R.C. Jiloha, 1985).

5. Dr. D.L.N. Murti Rao Oration Award (Dr. V.K. Varma, 1986).

6. Bhagwat Award for best paper by young scientist at IPS Conference (Drs. S. Malhotra, V.K. Varma, S.K. Verma, 1986).

7. Poona Psychiatrists Association Award II for best-published paper (Drs. S. K. Khandelwal, V.K. Varma, R.S. Murthy, 1986).

8. Dr Vidyasagar Award of ICMR (Dr. V.K. Varma, 1987).

9. Poona Psychiatrists Association Award I of IPS for best –published paper (Drs. V.K. Varma, A.K. Malhotra, S.K. Chaturvadi, 1988).

10. Best paper at 15th Annual Conference of IPS. North Zone (Drs. S.P. Singh, V.K. Varma, A. Avasthi, 1990).

11. Dr. G.C. Boral Award II of IASP (Drs. D. Basu, V.K. Varma, S. Malhotra, 1992).

12. Masserman Award for World Accords and Human Welfare (Dr. V.K. Varma, 1992).

13. Best Paper Award at 18th Annual Conference of IPS-North Zone (Drs. A. Avasthi, V.K. Varma, D.K. Arya, A. Mathur, 1993).

14. Best paper award at Silver Jubilee Conference of Indian Association of Clinical Psychologist (Drs. S. Vankatesh, M. Pal, V.K. Varma, S.K Verma, 1993).

15. Best paper award at the 18th Annual Conference of IPS-North Zone (Drs. A. Avasthi, V.K. Varma, D.K. Arya, A. Mathur 1993).

Honours/Honorary Appointments of Prof V K Varma While in the Department

Honours/Honorary Appointments

1. General Secretary of Indian Association of Social Psychiatry, 1985-1986
2. General Secretary of Indian Association of Social Psychiatry, 1987-1988
3. General Secretary of Indian Association of Social Psychiatry, 1989-1990
4. President of Indian Psychiatric Society, 1989
5. President of Indian Association of Social Psychiatry, 1992

Publication List of Prof V K Varma While in the Department

Publication List

Psychosis

1. Varma VK. Effect of Chronic Administration of Chlorpromazine on Stage 1 Sleep of Hebephrenic Schizophrenics. Indian J Psychiatry 1971; 13: 261-265.
2. Varma VK, Suri AK, Kaushal P. Abstract Thinking in Schizophrenia. Indian J Psychiatry 1973; 15: 123-130.
3. Akhtar S, Wig NN, Varma VK. Obsessional Potential Schizophrenics. Indian J Psychiatry 1975; 17: 22-25.
4. Arora M, Murthy RS, Varma VK. Operant Conditioning are Symbiotic in Infantile psychosis. Indian J Clin Psychol 1975; 2: 105-112.
5. Wig NN, Varma VK, Dash RJ. Effect of Chlorpromazine on Human Growth Hormone. American J Psychiatry. 1979; 136: 914-917.
6. Varma VK, Wig NN, Murthy RS, Misra AK. Sociodemographic Correlates of Schizophrenia Affective Psychoses and Neurosis in a Clinic in India. Acta Psychiatr Scand 1980; 61: 404-412.
7. Ghosh A, Varma VK, Amma MKP. Correlation Between Psychopathology and Urinary Steroid and Biogenic Amine Metabolites in Male Schizophrenics. Indian J Psychiatry 1981; 23:298-303.
8. Varma VK. Linguistic Competence and Psychopathology: A Cross-Cultural Model. Indian J Psychiatry 1982;24: 107-114.
9. Kulhara P, Varma V.K. Treatment of Schizophrenia. Drugs Bulletin, 1985, 8:31- 51.
10. Kulhara, P, Varma, V.K. Phenomenology of schizophrenia and affective disorders in India: a review. Indian J Soc Psychiatry.1985; 1:148-167.
11. Varma V.K., Agarwal R.K, Das K, JilohaR.C. Linguistic competence and Psychopathology: Construction of Test of Linguistic Competence. Indian J Psychiatry 1985;27: 183-191.
12. Varma V.K, Das K, Jiloha R.C. Correlation of Linguistic Competence with Psycho- pathology. Indian J Psychiatry 1985;27: 193- 199.
13. Varma VK. Concept and Psychogenesis of Schizophrenia. CME Programme 1989; 8: 13-31.
14. Chandiramani K, Varma V.K. Imagery in Schizophrenic Patients Compared to Normal Controls. British J Med Psychol 1987;60: 335-341.
15. Varma VK, Kulhara P. Open Drug Trial with Haloperidol Decanoate Injections in Schizophrenia. Indian J Psychiatry 1989; 31:144-150.
16. Giridhar C., Kulhara P., Varma V.K. Linguistic Competence in Positive and Negative Subjects of Schizophrenia. Indian J Psychiatry 1992; 34(4): 311-320.
17. Malhotra, S., Varma, V.K., Malhotra, A. (1992) Acute Nonorganic Psychotic States in India: Classification International. Journal of Mental Health 1992;16(4): 33.
18. Mala C, Kulhara P, Avasthi A. Postpsychotic 647. Basu D, Varma VK, Malhotra S, Malhotra A. Sensation seeking scale - Indian adaptation. Depression in Schizophrenia. Eur Arch Psychiatry Clin Neurosci 1993: 243, 103-108.

19. Wig NN, Varma VK, Mattoo SK, Bhere PB, Phookan HR, Misra AK, Murthy RS, Tripathy BM, Menon DK, Khandelwal SK, Bedi H. An Incidence Study of Schizophrenia in India. Indian J Psychiatry 1993: 35, 11-17.
20. Deka K, Varma VK, Malhotra S. Assessment of coping behaviour in schizophrenia and affective disorder. Indian J Social Psychiatry 1995; 11: 54-63.
21. Varma VK, Wig NN, Phookan HR, Misra AK, Khare CB, Tripathi BM, Behere PB, Yoo ES, Susser ES. First Onset Schizophrenia in the Community: Relationship of Urbanization With Onset. Early Manifestation & Typology. Acta Psychiatr Scand 1997, 96, 431-438.
22. Basu D, Malhotra A, Bhagat A, Varma VK. Cannabis Psychosis and Acute Schizophrenia – A Case-Control Study from India. Eur Addict Res 1999: 5, 71-73.
23. Mojtabai R, Varma VK, Malhotra S, Mattoo SK, Misra AK, Wig NN, Susser E. Mortality and long-term course in schizophrenia with a poor 2-year course: a study in a developing country. British J Psychiatry 2001;178: 71-75.
24. Varma V.K., Avasthi A., Matthoo S.K., Jain A.K. Diagnostic and Socio-Demographic Data of Psychiatric patients at the National Level. Indian J Social Psychiatry 1992; 8: 22-34.
25. Varma V.K., Malhtora S, Jiloha R.C. Acute Non-Organic Psychotic States in India: Symptomatology. Indian J Psychiatry 1992; 34:89-101.
26. Susser E., Varma V.K., Malhotra S., Conover S., Amador X.F. Delineation of Acute and Transient Psychotic Disorders in a Developing country Setting. British J Psychiatry, 1995: 167, 216-219.
27. Collins PY, Wig NN, Day R, Varma VK, Malhotra S, Misra AK, Schanzer B, Susser E. Psychosocial and Biological Aspects of Acute Brief Psychosis in Three Developing Country Sites. Psychiaric Quarterly 1996: 67, 177-193.
28. Varma VK, Malhotra S, Yoo ES, Jiloha RC, Finnerty MT, Susser E. Course and Outcome of Acute Non-organic Psychotic States in India. Psychiatric Quarterly 1996; 67: 195-207.
29. Varma VK, Brown AS, Wig NN, Tripathi BM, Misra AK, Khar CB, Phookan HR, Menon DK, Susser ES. Effects of Level of Socio-Economic Development on Course on Non-Affective Psychosis. British J Psychiatry, 1997: 171, 256-259.
30. Susser E, Varma VK, Mattoo SK, Finnerty M, Mojatabai R, Tripathi BM, Misra AK, Wig NN. Long-term Course of Acute Brief Psychosis in a Developing Country Setting. British J Psychiatry 1998; 173: 226- 230.
31. Harrison G, Hopper K, Craig T, Laska E, Seigel C, Wanderling J, Bube KC, Ganev K, Giel R, Ander Heiden W, Holmberg SK, Janca A, Lee PWH, Leon CA, Malhotra S, Marsella AJ, Nakane Y, Sartorius N, Shen Y, Skoda C, Thara R, Tsirkin SJ, Varma VK, Walsh D, Wiersma D. Recovery from psychotic -illness: 15-and 25-year international follow-up study. British J Psychiatry 2001; 178: 506-517.

Neurosis

32. Varma VK. Classification of Psychiatric Disorders for Use in India (Neurosis), Indian J Psychiatry 1971; 13: 1-6.
33. Akhtar S, Wig NN, Varma VK, Pershad D, Verma SK. A Phenomenological Analysis of Symptoms in Obsessive Compulsive Neurosis. British J Psychiatry. 1975; 127: 342-348.
34. Akhtar S, Wig NN, Varma VK, Pershad D. and Verma S.K. Sociocultural and Clinical Determination of Symptomatology in Obsessional Neurosis. International J Social Psychiatry. 1978; 24: 157-162.
35. Grover P, Varma VK, Pershad D, Verma S.K. Role of Yoga in the Treatment of Psychoneurosis. PGI Bulletin 1988; 22: 68-77.
36. Grover P, Varma VK, Verma SK, Pershad D. Factors Influencing. Treatment Acceptance in Neurotic Patients Referred for Yoga Therapy-AnExploratory Study. Indian J Psychiatry 1989; 31: 250-257.
37. Grover P, Varma VK, Pershad D, Verma SK. Role of Yoga in the Treatment of Neurotic Disorders: Current Status and Future Directions. Indian J Psychiatry 1994: 36, 153-162.

Psychodynamic/Psychotherapy

38. Varma VK. New Crutches for Old: Changing Pattern of Social Support and Cultural Defences in Rural India. Patna J Medicine 1971; 45: 269-273.
39. Varma VK, Kulhara P. Phallic Symbols in Acute Functional Psychoses. Indian J Psychiatry 1972; 14: 153-161.
40. Varma VK, Ghosh A. Psychotherapy as Practiced by the Indian Psychiatrists. Indian J Psychiatry 1976; 18: 177-186.
41. Varma VK. Nurturing Guru-Chela Relationship in Places other than Ashrams. Indian J Medical Education 1977; 16: 166 -169.
42. Varma VK. Present State of Psycho-Therapy in India. Indian J Psychiatry 1982;24: 209- 226.
43. Varma VK. Psychotherapy in India. Indian J Psychiatry 1983;25(1):4-5.
44. Varma VK. The Indian Mind and Psychopathology. Integrative Psychiatry 1985;3:290-296.
45. Varma V.K. Cultural Psychodynamics in Health and Illness. Indian J Psychiatry 1986;28:13-34.

Consultation-Liaison Psychiatry

46. Varma VK, Nakra BRS. and Singh S. Post- Febrile Organic Psychosis. Patna J Medicine 1972; 46: 153-158
47. Varma VK, Akhtar S, Kaushal P, Vasudev P, and Kulhara P. Measurement of Authoritarian Traits in India. Indian J Psychiatry 1973; 15: 156-165.
48. Mohan V, Varma VK, Sawhney BB, Menon DK. Cognitive Functions in Epileptics. Indian J Clin Psychol 1976; 3: 85-86.
49. Mohan V, Varma VK, Sawhney BB, Menon DK. Relationship of Cognitive Functions of Epileptics with Clinical Variables. Neurology India. 1976; 24: 134-140.
50. Khandelwal SK, Varma VK, Gupta R. Auto-castration: Review with A Case

Report. Indian J Psychological Medicine 1981;4: 119-121.
51. Mattoo SK, Varma VK, Bose SM. Psychosocial Adjustment to Treat Cancer: Preoperative Assessment-Preliminary report. PGI Bulletin.1983; 17: 121-125.
52. Varma VK, Chaturvedi SK, Malhotra A, Chari P. Psychiatric Aspects of Chronic Intractable Pain. Indian J Psychiatry 1983; 25:173-179.
53. Varma VK, Malhotra AK. Role of Psychosocial Variables in the Acceptance of Family Planning. Indian J. Medical Education 1983;22: 85-91.
54. Chaturvedi SK, Malhotra A, Varma VK, Michal A. Alexithymia: Brief Review and a Study in Chronic Pain Patients. Indian J Psychological Medicine 1984;7: 21-25.
55. Chaturvedi SK, Varma V.K, Malhotra A. Depression in Patients with Non-organic Chronic Intractable Pain. NIMHANS Jounral.1985;3:121-128.
56. Chaturvedi SK, Varma VK, Malhotra A. Non- organic Intractable Pain. A Comparative Study. Pain 1985;9: 87-94.
57. Khandelwal SK, Murthy RS, Varma VK. Neuro-psychiatric Complications of Anti- Rabies Vaccines: Review with Case Reports. Indian J Psychiatry 1985;27:163-166.
58. Mattoo S.K, Varma V.K, Bose S.M. Psychosocial Adjustments to Breast Cancer. Postoperative Assessment. PGI Bulletin 1985;19: 19-24.
59. Pant VLN, Chaturvedi S.K, Varma V.K. Long-Term Life Adjustment in Kidney Transplant Recipients. Indian J Psychological Medicine 1985;8: 10-14.
60. Varma V.K., Chaturvedi S.K., Malhotra A., Chari P. Psychiatric Symptoms in Patients with Non-organic Chronic intractable Pain. Indian J Medical Research 1991; 94: 60-63.
61. Varma V.K, Malhotra A, Chaturvedi S.K, Chari P. Socio- Demographic Study of Patients with Chronic Pain. Indian J Psychiatry 1986;28:119-125.
62. Varma V.K., Yadav R.V.S., Sharma K., Sarup S. Psychological Assessment of Blood Related Renal Donors. Indian J Medical Research 1992; 96: 182-185.
63. Varma VK, Sapru RP, Verma SK, Grover P, Riar M. Effect of Yoga on Psychological Variables in Mild Hypertensives. Recent Research in Education and Psychology, 1997: 2, 91-97.
64. Avasthi A, Sharan P, Kulhara P, Malhotra S, Varma VK. Psychiatric profiles in medical-surgical populations: need for a focused approach to consultation-liaison psychiatry in developing countries. Indian J Psychiatry 1998; 40 (3): 224-230.

Child Psychiatry

65. Akhtar S. and Varma V.K. Guidelines for the Parents of Mentally Retarded Children. Indian J. Mental Retardation 1972; 5: 75-88.
66. Pershad D, Kaushal P, Verma VK. Neuroticism Scores of Mothers of Mentally Retarded and of Neurotic Children. Indian J. Mental Retardation 1973; 6: 24-27.

67. Murthy RS, Ghosh A, Varma VK. Behaviour Disorder of Children and Adolescence. Indian J Psychiatry 1974; 16: 229-237.
68. Varma VK, Mangahwedhe KP, Misra A.K. Comparison of Socio-Demographic, Treatment and Follow-up Variables of Mentally Retarded and Emotionally Disturbed Children. Child Psychiatry Quarterly. 1976; 9: 1 -10.
69. Seshadri M, Varma VK, Verma SK, Pershad D. Impact of a Mentally Handicapped Child on the Family. Indian J Clin Psychol 1983;10: 473-478.
70. Malhotra S, Varma V.K, Verma S.K. Temparament as Determinant of Childhood Psychiatric Disorders. Indian J Psychiatry 1986;28: 263-276.
71. Varma V.K, Seshadri M. Intervention Programmes for Parents of the Mentally Retarded Children. Indian J Social Psychiatry 1987:328-242.
72. Varma V.K., S.K., Kapoor P. Evaluation of Home Care Programme for the Mentally Retarded Children Through Training of the Mother. Indian J Medical Research 1992; 96: 29-36.

Community Psychiatry

73. Varma VK. Distribution of Demographic Variables in a Clinical Catchment Area. Indian J Psychiatry 1975; 17: 295-296.
74. Varma VK, Khanna BC, Inam Shastri AS, Kaul R, Wig NN. The Catchment Area of General psychiatric Clinic. PGI and its Socio- Demographic Profile. PGI. Bulletin 1976; 10: 198-205.
75. Varma VK, Khanna BC, Inam S, Verma SK. Distribution of Demographic Variables in A Clinic Catchment Area. Indian J Clin Psychiatry 1976; 3: 51-57.
76. Varma V.K., Tripathi B.M. and Kulhara P. Psychiatric Clinic in a Rural Primary health Center. Indian J Social Psychiatry 1985;1: 121- 132.
77. Kulhara P, Chandiramani K, Mattoo S.K. and Varma V.K. Pattern of Follow-up visit in a Rural Psychiatric Clinic. Indian J Psychiatry 1987;29: 189-195.

Psychiatry Training

78. Wig NN, Varma VK, Murthy RS, Rao U, Gupta S. Training in Psychiatry for general physicians: An experience. PGI. Bulletin 1977; 11: 2124.
79. Varma VK, Kala R, Deodhar S.D. Role of Health Professionals as Perceived by patients in India. Indian J Clin Psychol 1981;23:343-350.

Affective Disorder

80. Bhatia SC, Varma VK, Amma MPK. A Study of the Relationship Between Urinary 5-Hydroxyindoles and Depressive States. Indian J Psychiatry 1978, 20: 6-14.
81. Gupta R, Khandelwal SK, Varma VK, Wig NN, Rao V, Tripathi BM. Depressive Symptoms – A Inter Centre Comparison. Indian J Psychiatry 1982;24(4):380-382
82. Khandelwal SK, Varma VK. Treatment of Mania. Drugs Bulletin.1982;5: 41-47.
83. Gupta R, Wig NN, Chawla H, Khandelwal S, Varma VK. A Comparison of Neurotic and Psychotic Depression Using a

Standardized Schedule. Indian J Psychiatry 1985;27: 145- 148.
84. Upadhyay A.K., Varma V.K, Sankaranarayanan and Goel A. Lithium in Prophylactic Therapy of Manic-Depressive Illness: Biological Correlates of Response. Bio Psychiatry 1985; 20:202-205.
85. Gupta R, Wig N.N, Rao U, Chawla H, Khandelwal S, Varma V.K. Symptom Comparison of Neurotic and Psychotic Depression Using SADD Schedule. Indian J Psychological Medicine 1986;9: 22-25.
86. Avasthi A, Sharma A, Gupta N, Kulhara P, Varma VK. Seasonality and unipolar mania: preliminary findings from a retrospective study. Indian J Psychiatry 1996; 38: 236-239.
87. Brown A, Varma VK, Malhotra S, Jiloha RC, Conover SA, Susser ES. Course of Acute Affective Disorder in a developing country setting. J Nervous and Mental Disease 1998; 186 (4): 207-213.
88. Avasthi A, Sharma A, Gupta N, Kulhara P, Varma VK, Malhotra S, Mattoo SK. Seasonality and Affective Disorders: A Report from North India. J Affective Disord 2001; 64: 145-154.

Social Psychiatry

89. Varma VK. Editorial. Social psychiatry: The Indian Perspective IJSP, 1969; 5: 1-3.
90. Varma V.K. The Behaviour Scientist and Social Issues. Indian J Soc Psychiatry 1986;2: 139-147.
91. Varma V.K. World Peace and Social Psychiatry: Perspective of the Developing Countries. Indian J Soc Psychiatry 1987;3:317-27.
92. Varma V.K. Some Implications of Cold War Psychology for us. Indian J Soc Psychiatry 1986;2: 301-310.
93. Varma VK. The Psychiatrist and Social Commitment. Andhra Pradesh Psychiatry 1988; 1:6-16.
94. Varma VK, Chandiramani K, Rao GP, Bhave S, Kaur S. Assassination of Indira Gandhi: Impact on Psychiatric Patients. American Psychotherapy 1989; 43: 77-86.
95. Avasthi A, Gupta S, Sharma A, Kulhara P, Varma VK. Lotteries and shares- an emerging psychosocial stressor: study of 9 cases from north India. Indian Journal of Behavioural Sciences 1997; 7: 31-34.
96. Varma VK. Culture, Personality and Psychotherapy. International J Soc Psychiatry 1988; 34: 142-149.
97. Varma VK. Epistemology of Mental Phenomena. Indian J Psychiatry 1989; 31: 3-21.
98. Varma V.K. Social Disadvantage, Mental Health and Social Justice. Indian J Soc Psychiatry 1992; 195-197.
99. Varma V.K. The Third World and International Accords. Social Psychiatry and World Accords. 1992; 8: 12-15.
100. Varma V.K. Transcultural Psychiatry. Postgraduate Psychiatry 1992; 45: 611-614.
101. Varma VK, Sikdar S. The Relationship Between Dynamic and Social Psychiatry in India. Dynamic Psychiatry. 1994: 144-145. 67-83.

Psychometry

102. Arora M, Varma VK. A Psychoticism Scale in Hindi: I Construction and Initial Tryouts Standardization. Indian J Psychiatry 1980;22: 225-229.
103. Arora M, Varma VK. A Psychoticism Scale in Hindi: II Standardization. Indian J Psychiatry 1980;22: 230-234.
104. Randhawa A, Pershad D, Varma SK. Digit Span Test: A Comparison of Scoring Methods. Indian J Applied Psychol. 1981;18:27-30.
105. Grover P, Varma VK, Pershad D, Verma SK. Construction of A Scale for the Measurement of Attitude to Yoga (A Preliminary) Report. Indian J Clin Psychol. 1983;10: 373-378.
106. Varma V.K, Malhotra A.K. and Chaturvedi S.K. Illness Behaviour Questionnaire (I.B.Q): Translation and Adaptation in India. Indian J Psychiatry 1986;28:41-46.
107. Malhotra S, Varma V.K., Verma S.K., Malhotra A. Childhood Psychopathology measurement Schedule: Development and Standardization. Indian J Psychiatry 1988; 30:325-331.
108. Avasthi A., Varma V.K., Nehra R., Das K. Construction and Standardization of a Sex Knowledge and Attitude Questionnaire (SKAQ) in Simple Hindi for North Indian Population. Indian J Psychiatry 1992: 34: 24-27.
109. Varma VK, Sapru RP, Verma SK, Madanpal, Venkatesh S, Negi BS. Standardization of Medication Attitude Scale. Indian J Clin Psychol 1995: 22, 37-40.
110. Varma VK, Sapru RP, Verma SK, Pal M, Venkatesh S, Negi BS. Construction of Medication Attitude Scale: A Preliminary Report. Indian J Clin Psychol 1994; 21: 51-56.

Substance Use Disorders

111. Varma VK, Dang R. Non- Medical Use of drugs among school and college students. Indian J Psychiatry 1979;21: 228-234.
112. Varma VK, Singh A. and Malhotra A. Extent and Pattern of Alcohol Use and Alcohol Related Problems in North India. Indian J Psychiatry 1980;22: 331-337.
113. Varma VK, Dang R. Non-Medical Drug Use Amongst Non-Student Youth in India. Drug and Alcohol Dependence.1980;5: 457- 465.
114. Agarwal RK, Varma VK, Dang R. Inter-relationship between drug use, anomie, alienation and authoritarianism amongst university students. Indian J Psychiatry 1980 Jan;22(1):103-7.
115. Uppal R, Garg SK, Sharma PK, Varma VK, Chaudhury RR. Antipyrine Kinetics in Cannabis Smokers. British J Clinical Pharmacy. 1981; 11:522-523.
116. Varma VK, Singh A, Malhotra AK. Das K, Singh S. Popular Attitude Towards Alcohol Use and Alcoholism. Indian J Psychiatry 1981;23:343-350.
117. Malhotra AK, Varma VK. Drug Treatment of Alcoholism. Drug Bulletin.1983;6: 15-25.
118. Malhotra AK, Varma VK. Extent of Alcohol and Drug Use in India. Indian J Chemical Psychology.1983;10: 183-194.
119. Varma V.K, Malhotra A. Dependency and Psychotherapy of

Drug Addiction. Indian J Social Psychiatry 1985;1:244-250.
120. Varma V.K, Malhotra A. Dand R. An Alcohol and Drug Dependence Clinic in North India: Initial Five Years Experience. Indian J Clin Psychol 1985;11:51-61.
121. Varma V.K, Malhotra A.K. Dependency and Psychotherapy of Drug Dependence. Alcoholism. 1986;22: 93-98.
122. Varma V.K., Nehra R, Malhotra A.K. and Dand R. Psychosocial Adjustment of Cannabis Users. Indian J Social Psychiatry 1987:170-85.
123. Mendiratta S, Varma VK, Dang R, Malhotra AK, Das K, Nehra R. Cannabis and Cognitive Functions: A Re-Evaluation Study. British J Addiction. 1988; 83: 749-753.
124. Varma V.K, Malhotra AK, Dang R, Das K, and Nehra R. Cannabis and Cognitive Functions: A Prospective Study. Drug Alcohol and Dependence 1988; 21; 147-152.
125. Varma VK, Malhotra AK. The Management of Alcohol Related Problems in General Practice in North India. Indian J Psychiatry 1988; 30: 211-219.
126. Varma VK, Malhotra AK. Treatment of Neurotics Addiction. Drugs Bulletin. 1988: 11: 37-55.
127. Basu D., Varma V.K., Malhotra S. Alienation and Psychoactive Substance Use. Indian J Social Psychiatry. 1992; 8(1-2): 24-36.
128. Singh R.A., Mattoo S.K., Malhtora A., Varma V.K. Cases of Buprenorphine Abuse in India. Acta Psychiatr Scand, 1992; 86: 46-48.
129. Basu D, Raj L, Mattoo SK, Malhotra A, Varma VK. The agoraphobic alcoholic: Report of two cases. Indian J Psychiatry 1993; 35: 185-186.
130. Malhotra A, Balaji M, Basu D, Mattoo SK, Varma VK, Sehgal S. HIV Screening and Risk Behaviour in Psychoactive Substance Users. Indian J Medical Research, 1993:97, 231-233.
131. Basu D, Malhotra A, Varma VK. Cannabis Related Psychiatric Syndromes: A Selective Review. Indian J Psychiatry 1994: 36, 121-128.
132. Varma VK, Basu D, Malhotra A, Sharma A, Mattoo S.K. Correlates of Early and Late Onset Alcohol Dependence. Addictive Behaviour 1994 19, 609-619.
133. Varma VK. Type 1/Type 2 Dichotomy in Alcoholism: The Controversy Continues. Addiction, 1994; 89, 1064-1066.
134. Basu D, Malhotra A, Varma VK, Malhotra R. Development of a scale to assess attitudes toward drinking and alcoholism. Indian J Psychiatry 1998; 40: 158-164.
135. Mattoo SK, Varma VK, Singh RA, Kurana H, Kaur R, Sharma SK. Alienation, Sensation Seeking ad Multiphasic Personality Questionnaire Profile in men being Treated for Alcohol and/or Opioid Dependence. Indian J Psychiatry 2001; 43: 317-326.
136. Basu D, Aggarwal M, Das PP, Mattoo SK, Kulhara P, Varma VK. Changing pattern of substance abuse in patients attending a de- addiction centre in north India. Indian J Medical Research 2012 Jun; 135(6): 830-836.

137. Basu D, Varma VK, Malhotra AK. Buprenorphine dependence: A new addiction in India. Disabilities and Impairments 1990; 3(2): 142-146.
138. Grover P, Verma SK, Varma VK. Yoga and Drug Addiction. Disabilities and Impairments 1990; 3: 89-97.
139. Sikdar S, Basu D, Malhtora AK, Varma VK, Mattoo S.K. Carisoprodolol Abuse: A Report from India. Acta Psychiatr Scand 1993: 88, 302-303.
140. Basu D, Mattoo SK, Arora A, Malhotra A, Varma VK. Pseudoaneurysm in Injecting Drug Abusers: Cases from India. Addiction, 1994: 89. 1697-1699.
141. Basu D, Varma VK, Malhotra S, Malhotra A. The Sensation-seeker who is also Alienated: Towards a New Hypothesis for Genesis of Opiate Addiction. Indian J Psychiatry 1994: 37, 17-22.
142. Basu D, Malhotra A, Varma VK, Malhotra R. Attitudes toward drug taking behavior: a factor- analytic study. J Indian Acad Applied Psychology 1997; 23: 23-29.
143. Malhotra A, Basu D, Chintalpuri M, Mattoo SK, Varma V.K. Clonidine versus Withdrawal Using an Opioid in Inpatient Opioid Detoxification: A Preliminary Report From India. Europe Addiction Research 1997: 3, 146-149.

General Hospital Psychiatry

144. Malhotra S, Murthy RS, Varma VK, Ghosh A, Wig NN. Readmission in a General Hospital Psychiatric Unit: Socioeconomic and Clinical Correlates. Indian J Psychiatry 1982;24: 37-41.
145. Malhotra S, Murthy RS, Varma VK, Ghosh A, Wig NN. A General Hospital Psychiatric Unit Inpatient Facility. Social Psychiatry.1982;17: 155-159.
146. Chaturvedi SK, Varma VK, Malhotra S, Kumar P. Hospital Stay of In-Patients in a General Hospital Psychiatric Unit. Indian J Psychiatry 1983; 25: 293-297.
147. Chaturvedi SK, Pardeep Kumar, Malhotra, S., Varma, V.K. Discharge Outcome in General Hospital Psychiatry Unit. Indian J Psychological Medicine 1983; 6:36 -43.

Miscellaneous

148. Varma VK. The Quest for Reliable Truths in Behavioural Sciences. Patna J Medicine 1969; 43: 536-542.
149. Akhtar S, Varma VK. Changing Corpro-Symbois in a Developing Country. Samiksha. 1973; 27: 47-55.
150. Deodhar SD, Qamra SR, Varma VK. Indigenous Medicine. PGI Bulletin.1980;14: 30-37.
151. Varma VK, Bouri M, Wig NN. Multiple Personality in India: Comparison with Historical Possession State. American J Psychotherapy.1981;35: 113-120.
152. Varma V.K, Malhotra S. Diagnosis and Classification of Acute Psychiatric Disorders in the Developing World. Indian J Social Psychiatry 1985;1: 11-21.
153. Grover P, Varma V.K, Verma S.K. and Pershad D. Relationship Between the Patient's Attitude towards Yoga and the Treatment Outcome. Indian J Psychiatry 1987;29: 253- 258

154. Chavan BS, Kulhara P., Varma V.K., Malhotra A. A Clinical and Treatment Outcome Study of Writers Cramp. Indian J Psychiatry 1991; 33:39-43.
155. Grover P., Varma V.K., Pershad D, Verma S.K. Further Data on The PGI Yoga Attitude Scale. J. Prs. Clini. Stud., 1991; 7: 219-226.
156. Varma VK. Editorial. Indian J Psychiatry 1995: 11, 1-11.
157. Varma VK, Das MK Mental Illness in India: Epidemiological Manifestation and Outcome. Indian Journal of Social Psychiatry 1995: 11, 16-25.

Book Chapters

1. Varma VK, Kulhara P, Dasserman CM, Malhotra A, Malik SC. Social Psychiatry: A Global Perspective, New Delhi, MacMillan India Ltd, 1998.
2. Kulhara P, Varma VK. Treatment of Schizophrenia. Drugs Bulletin, 1985, 8: 31-51.
3. Varma VK, Singh A, Malhotra S, Malhotra A. Extent and Pattern of Alcohol Use and Alcohol-Related Problems in North India. In: Current research in Drug Abuse in India. D. Mohan, H.S. Sethi, and E. Tongue (eds.) Second National Research Conf. On Drug Abuse. New Delhi 1980, Chap 21, 185-197.
4. Varma VK. Towards A Theory of Cultural Defenses. In Readings in Transcultural Psychiatry (Eds. A Kiev and A.V. Rao) Higgin Bothams Ltd. London 1982, pp. 31-46.
5. Varma VK. The Management of Alcohol Related Problems in General Practice in India (Chandigarh). In Management of Alcohol Related Problems in General Practice. 1984, WHO, Geneva. Pp 79-85.
6. Varma V.K. Psychosocial and Cultural Variables Relevant to Psychotherapy in the Developing Countries. In: Pichot P., Berner P., Wolf R. and Thau K. Psychiatry: The State of the Art. Vol. 4, Psychotherapy, 1986, pp
7. Varma VK. The Psychiatric and Social issues in the Third World. In. C.N. Stefanis et al (Eds.) Psychiatry: A World Perspective 1990, 54-60.
8. Varma VK, Avasthi A. Sexual Myths and Attitudes in India. In Stefanis C.N. et al (Eds.): Psychiatry: A World Perspective 1990, 227-233.
9. Varma VK. Transcultural Psychiatry. Postgraduate Psychiatry 1992, Chap. 45,611-635.
10. Varma VK. Child Psychiatry as an Academic Super-specialty in India. Relevance and Feasibility. In Child Mental Health in India (Eds. Malhtora S., Malhotra A and Varma V.K.) Delhi, Macmillan India Ltd. 1992, 15- 26.
11. Varma VK. Psychotherapy, Yoga and Medication. In: Decade of the Brain: India/USA Research in Mental Health and Neurosciences. (eds. Stephen H. Koslow R, Srinivasa Murthy, George V Coelho). National Institute of Mental Health, Rockville, MD, 1995, pp. 213-218.
12. Varma VK. Third World Perspectives on Social Psychiatry. In: Past, Present and Future of Psychiatry, World Congress of Psychiatry. (eds. A. Beigel, J.J. Lopez Ibor, Jr., and JA Costa a Silva). World Scientific Publishing Company, Singapore, 1994, pp. 1375-1382.

13. Varma VK, Chakraborty S. Social Correlates and Cultural Dynamics of Mental Illness in Traditional Society: India. In: Handbook of Culture and Mental Illness: An International perspective. (Ed. I Al Issa) International Universities Press, Madison, CT, pp. 115- 127. 14).
14. Varma VK, Malhotra A, Basu D, Sethi S. Alcohol Abuse in the Community: Screening by CAGE and MAST. In Social Psychiatry: A Global Perspective (eds. V.K. Vema, P. Kulhara, C McGuire Masserman, A. Malhotra,S.C. Malik), New Delhi, MacMillan India Ltd, 1998, pp 94-102.
15. Varma VK, Malhotra S. Determinants of Outcome of Severe Mental Disorders (DOSMeD): Chandigarh, India. In: Recovery from Schizophrenia: An International Perspective. A Report from the WHO Collaborative Project. The International Study of Schizophrenia. Hopper K, Harrison G, Janca A, Sartorius N (eds), Oxford University Press, 2007; 113-128.

Books/Manuals

16. Seshadri M, Varma VK, Verma SK. Kya aur Kaise Sikhanyen (in Hindi). Dept. of Psychiatry, PGI, Chandigarh, 1985.
17. Child Mental Health in India (Eds. Malhotra S., Malhotra.A. and Varma V.K.), Delhi, Macmillan India Ltd. 1992, 189-201.
18. Social Psychiatry: A Global Perspective (eds. V.K. Vema, P. Kulhara, C McGuire Masserman, A. Malhotra,S.C. Malik), New Delhi, MacMillan India Ltd, 1998, pp 94-102.
19. Culture, Personality and Mental Illness: A Perspective Of Traditional Societies", Eds: VK Varma, AK Kala, Nitin Gupta. Pub: Jaypee Brothers, 2009.

Selected Published Papers

Presidential Address, Indian Psychiatric Society, 1989

Indian J. Psychiat. (1989), **31**(1), 3-21

Presidential Address

THE EPISTEMOLOGY OF "MENTAL" PHENOMENA

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I consider it a great privilege and pleasure to address you this morning as the next President of the Indian Psychiatric Society. I am most grateful to the membership of the Society for having elected me to this highest position in the profession at the national level, and for having bestowed this high honour upon me. I feel humble when I think of all the great stalwarts who have earlier served as Presidents of the Society. Amongst this galaxy of luminaries are my senior colleagues, mentors and friends. Since 1969, when I joined the Indian Psychiatric Society, I have been considerably involved with the organization of the Society and have had occasions to know and work with many of its Presidents. We are all aware of the enormous tasks before us in the Society, from improvement of mental health services to better training programmes and research into the various aspects of psychiatry and mental health. I look forward to your help and cooperation in trying to advance in these areas in the year of my Presidency.

Many of you may have heard me in informal situations making a reference to professional brotherhood. The professional fraternity, of which I am a member, the fraternity of scientists and mental health professionals, is very important to me. The respect that you acquire from the professional brotherhood, "the Jury of the Peers" (and it includes Lady Peers also) is the ultimate arbitor of our professional standing and of our very worth. Respect for the Jury of the Peers is of utmost importance to us.

INTRODUCTION

More than other medical scientists, a psychiatrist must have a holistic vision, must see the human being as a whole. Most often, the psychiatrist has to be a generalist as regards the human situation. It is accordingly only appropriate for the psychiatrist to understand the process by which we assume and acquire knowledge about the external reality and as regards the human body and mind.

Most scientists, including natural scientists, do not possess enough orientation to epistemology, as to how the knowledge that they deal with everyday is derived. Biological scientists possess even less information as biological sciences are considered to be less exact than physical and chemical sciences. In this regard, I may add that I have been fortunate in having the benefit of attending a series of thoroughly stimulating seminars on the philosophy of science at the University of Michigan over two decades ago presided over by Dr. Anatol Rapoport, a brilliant biological mathematician, whom I consi der as one of my intelligent Gurus. It was on this occasion that I had the privilege of reading Hans Reichenbach's highly insightful book, "The Rise of Scientific Philosophy", along with a number of other books on concepts that materially

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altered my earlier naive understanding of the scientific process. A few years ago I had the privilege of reading Robert Pirsig's "Zen and the Art of Motor Cycle Maintenance" which gave many insights and upset many existing notions, but more on this later.

Epistemology is defined as the philosophy of knowledge as to how knowledge is acquired by studying the objective world around us. As an interested layman, I possess a copy of Will Durant's classic "The Story of Philosophy". The very preface (to the second edition) of Durant's book deterred me as far as the whole area of epistemology is concerned. Calling it "that dismal science" Durant refuses to offer any apology for the neglect of epistemology in his volume and further adds : "Doubtless now that epistemology is dying in Germany, it will be exported to America, as a fit return for the gift of democracy" (Durant, 1952, pp. xii-xiii). In the same vein he adds: "Now began the great game of epistemology, which in Liebnitz, Locke, Berkeley, Hume and Kant waxed into a Three Hundred Years' War that at once stimulated and devastated modern philosophy" (p. 151).

It may be worthwhile here to examine the common sense approach to the perception of the scientific process. As a budding scientist I used to think that the famous laws of physics and chemistry like the laws of gravity and motion, Charles's Law and Boyle's Laws were absolute and that the question of their fallibility did not arise, as though they were made in heaven. it was subsequently and mostly as a result of the influence of Reichenbach's book that I came to understand that it was not so that these so-called laws have been derived through a long process and have a certain (but not absolute) probability of being true. Alongside, I came to appreciate the limitations of the scientific approach and the empirical process.

There is no a-priori reason why we human beings should be aware of the nature of the external reality and of causality. In the universe it is only human beings who possess some such knowledge and are able to, albeit to a limited degree, understand the nature of the universe around them, including its objects and phenomena, and are able to predict certain phenomena and develop a theory about it. There is no a-priori reason for acquisition of this knowledge, and as Bertrand Russel points our "cosmically and causally, knowledge is an unimportant feature of the universe" (Russel, 1948 p. 9) and asks "....how comes it that human beings, whose contacts with the world are brief and personal and limited, are nevertheless able to know as much as they do know" (p. 5).

To start with let us give a brief definition for science and an outline of the scientific process. All of us have faced the problem of how to define science, ever since we started studying science. Many people define science as any systematic and methodical study and something that unravels the mysteries of nature. Science is an attempt to study natural phenomena, their nature and course, to classify them, to generalize about them, to predict about them, and thus to come up with a theory.

"Science represents man's most persistent effort to understand and organize knowledge by reasoned efforts that ultimately depend on evidence that can be consensually validated" (Odeggard, 1986). Einstein once characterised science as "nothing more than a refinement of everyday thinking" (Einstein, 1950, p. 59).

The concept of reality

Before we come to the scientific process, a few words about the concept of

external reality and the concept and causality are important. There have been two major approaches to the external reality. The Cartesian view originated from the famous philosopher Decartes, who said that the external reality exists only insofar as it is in the mind of the observer (the famous **cognito ergo sum** dictum of Descartes). As opposed to the Cartesian view has been the solikpsistic view which, in essence, says that there is an external reality out there, of which I may or may not be aware. Although my awareness may be limited, the external reality exists all the same. Empiricism sees the role of observations as important in understanding the external reality. Rationalism perceives reason itself as the source of knowledge.

The concept of causality

The concept of causality has been one of the key concepts in the philosophy of science. Are natural phenomena random happenings in the universe or do they follow certain laws ? Is there order in nature ? Immanuel Kant, the famous German philosopher, posited causality as one of the axioms, one of the synthetic a-prioris alongwith the other two of time and space. The concept of causality and of determinism simply says that there is order in the universe and events occurring therein follow certain laws and are predetermined according to those. Aristotle classified four types of causes, namely material, efficient, formal and final. More recent, and what may be more applicable to the mental phenomena, is the distinction between causes and reasons, the former being mechanistic and the latter teleological and anthropormorphic.

THE SCIENTIFIC PROCESS

With this background, let us look at the classical method and process of science. As we have seen, science is related to the study of nature and properties of objects and phenomena. What we call scientific has a certain general property. We know of the external world by the impact it makes on our sensory system. The object or the phenomenon either registers on our sensory systems or produces certain other things or phenomena which register on our senses. Thus, although we do not see the force of gravity or an atom or even the molecular structure of a chemical or a substance, we do see changes or things attributable to these. How we know about gravity is well known. Molecular structure of chemicals is known through colour reactions or through X-ray crystallography. It is assumed that the impact on the sensory system would be pretty consistent and universal and would apply alike to all humans, thus giving rise to its consistency over time and replicability.

The classical scientific approach is called an inductivodeductive approach. We make certain observations in the universe, develop a hypothesis on the basis of that, make certain more observations to confirm or refute the hypothesis, reason out about the observations and draw certain deductions from it. Insofar as the deductions drawn can never be final, it raises futher questions which require further induction to confirm or refute them. From hypotheses we move to theories and to laws of nature, each one increasingly more complex and at the same time more general and encompassing.

The English school which has been mostly responsible for delineating the above process is called the Empiricist school, and the underlying philosophy is called Empiricism. A number of major philosophers of science : Francis Bacon, John Locke and David Hume are foremost amongst its proponents. The scientific process, as we generaly understand it, is empirical. The observations should be

reliable across time, the place and observations thus should be objective. There may be other approaches to the discovery of the universe around us but that is not called scientific if we apply the narrow definition of science as here. The empirical scientific approach is characterised by the reliance on the sensory modalities for understanding the object and phenomena around us.

Criticism of Inductivism

There have been three major criticisms of the inductive, empirical approach as outlined above.

Fistly, our sensory organs of perception are both limited and fallible. The sensory organs are very much limited as far as the phenomena in the universe are concerned. Our eyes see and ears hear only a very limited range of waves of electromagnetic frequencies. We do not hear anything if the wave frequency runs below or above a relatively narrow range (for example, we do not hear the dog whistle). At the same time, our sensory organs suffer from sensory illusions. It is clear that our perceptions are very much coloured not only by the field in which the sensory stimulants operate but also by our mental set or attitude. As Ackerman (1965) has summarised "the existence of illusion or conflicting reports from the senses, proves ..that the senses cannot be trusted to provide knowledge in their sense" (p.16).

The second set of criticism to inductivism is that induction is not possible without hypotheses and axioms, assumptions and schemata. Russel (1948) also alluded to it in the following summation "Knowledge, in my opinion, is a much less precise concept than is generally thought, and has its roots more deeply *embedded in unverbalized animal behaviour* than most philosophers have been willing to admit" (p.13, italics added).

"Empiricism pre-supposes that one can apprehend the real world independently of hypotheses and axioms" (Wallace, 1988a). Chalmers has pointed out, "..the inductivist is wrong on two counts .. theory of some kind precedes all observation statements, and observation statements do not constitute a firm basis .. because they are fallible" (Chalmers, 1976, p.30).

The next criticism of inductivism is on account of limitations in drawing inferences out of a limited number of observations. The scientist studies a particular sample and on the basis of his observations, he draws inferences about the total population. It is sobering to note that even David Hume, one of the founders of empiricism, contended that "even after the observation of the frequent or constant conjunction of objects. We have no reason to draw any inference concerning any object beyond those of which we have had an experience" (Hume, 1939, p.165). Karl Popper, perhaps the greatest philosopher of science, pointed out that no matter how large the number of hitherto supporting observations, this amount, when compared with the infinity of conceivable, future situations, approaches zero probability (Popper, 1965). "The history of science furnishes one refutation after another of supposedly iron-clad inductively derived truths" (Wallace, 1988a). As Chalmers (1976, p.33) has summarised : "The main reason why I think inductivism should be abandoned is that, compared with rival and more modern approaches it has increasingly failed to throw new and interesting light on the nature science". In the same way, Chalmers has reasoned : "the probability of the universal generalization being true is thus finite number divided by an infinite number, which remains zero however much the finite number of observation statements constituting the ev ide

is increased" (Chalmers, 1976, p.17).

So, where we do go from here ? Does it mean that induction has no relevance ? In view of the limitations of the inductive approach, the concept of positivity came about. A posit is a statement with a defined, but not absolute, probability of being true. To give an example, let us look at the statement, "Man is mortal". It has been estimated that since the beginning of evolution about sixty five billion human beings have been born on this earth. Out of them, five billion are still living and the remaining sixty billion have died. Man is mortal cannot be definitely said regarding the five billion were still living and hence, "man is mortal" has a 12/13 chances of being true.

The other Approaches to Epistemology

We can perhaps briefly address to the other approaches that have been brought forward in view of the limitations of the inductive approach.

Falsificationism : This approach, which is generally associated with the name of Popper briefly states that the job of the scientist is to refute theories and that science advances by replacement of falsified theories by yet to be falsified ones (Popper, 1968 ; Wallace, 1988a). According to Popper, it is the job of a scientist to attack and to falsify a theory and that science advances only in this manner. The merit of a scientific theory is not in what it predicts will happen but what it predicts will not happen, how it limits certain things from happening. The more falsifiable a theory is and the more it constrains the phenomena, the better it is. The hypotheses which are not falsifiable are just not within the realm of scientific pursuits. The aim of science is to falsify theoires and to replace them by better theories.

The objection to and limitation of falsificanism is roughly the same as in case of inductivism. One needs to proceed along the same empiricist and inductive approach to falsify a theory as much as to prove it and it accordingly suffers from the same limitations of empiricism that we have earlier discussed. Popper even considers somebody's approach to disprove a theory as a contribution to the development of that theory. One major problem in falsificanism is that, like inductivism, a part of the complex test situation involved in observation can be wrong and can result in erroneous prediction (Chalmers, 1976, p.61). "An embarrassing historical fact for falsificationists is that if their methodology had been strictly adhered to by scientists then those theories generally regarded as being among the best examples of scientific theories would never have been developed because they would have been rejected in their infancy" (Chalmers, 1976, p.63).

The paradigm approach: The paradigm approach is related to the name of Thomas S. Kuhn. Kuhn openly admits that no unbiased observation is possible and that observation depends on a paradigm. Kuhn (1970) came to realize that traditional accounts of science, whether inductivist or falsificationist, do not bear self-comparison with historical evidence. According to him, a mature science is governed by a single paradigm. A paradigm is a must for a science and it is this characteristic that distinguishes science from non-science. In the course of the development of a particular science, a time comes when the paradigm hitherto adhered to does not serve the purpose any more and it has to be discarded for a totally new way of looking at—a new paradigm. According to Kuhn (1970, 1977) science advances through the revolutionary overthrow of one scientific paradigm by another, and "... the communities' rejection of one-

time-honoured scientific theory in favour of another incompatible with it" (Kuhn, 1970, p.6). Paradigm is a sign of maturity in the development of any given scientific field.

Kuhn argues that no natural history can be interpreted in the absence of at least some implicit body of inter-twined theoretical and methodical belief. If that belief is not already implicit, it must be externally supplied by a current metaphysic, by another science, or by personal or historical accident (Kuhn, 1970, pp. 16-17).

In the course of development out of the various paradigms one emerges as clearly better than its competitors. It is that paradigm which is to be accepted. Kuhn quotes Francis Bacon (1969, p. 210) as having said "truth emerges more readily from error than from confusion".

Relativism-Subjectivism: In view of the problems in inductive approach, relativism-subjectivism accents the role of the investigator's preconceptions and subjectivity. The relativist-subjectivist makes no assumption of pure objectivity and asserts that one cannot comprehend the real world independently of hypotheses and axioms and a subjective bias may always be present. Popper (1979) spoke of evolutionarily determined "anticipatory theories" that are "genetically incorporated" into the sensory organs of all members of the animal kingdom. Psychologically and anthropologically, we know that even stark perceptions or sensations are governed by assumptions and schemata (Wallace, 1988a). Thus a subjective bias is present in all observations.

Anarchist Theory : This theory, which goes by the name of P. Feyerabend (1975) denies that there is something intrinsically special about science and that there is an objective scientific method. He considers the high status attributed to science in a modern society to be unjustified. To him, a scientific theory is like an ideology or religious belief system : like works of art and aesthetic judgement or a matter of taste. Just like you cannot say that a particular painting is more true than the other or a particular religious system is closer to the ultimate reality or truth, the same way a scientific theory is not superior to any other. He even argues that the scientific theory enters "a complex discussion involving conflicting preferences and propaganda" (p.366) and that "what remains are aesthetic judgements, judgements of taste, metaphysical prejudices, religious desires, in short, what remains are our *subjective wishes*" (p. 285, Feyerabend's italics). He concludes that there is not a shade of argument that modern science is superior to magic or to Aristotelian science.

Intersectionalism : More recently, Edwin R. Wallace, IV, has brought forward an intersectional approach to science. According to him human behaviour is determined through an intersection between the antecedent state including the constitutionally and historically determined conscious and unconscious desires, fears, inhibitions, and mode of interpreting the world and the immediately precedent situation, that is the current environment (Wallace, 1986). The resulting behaviour may vary according to the modifications in each of the above. Even given the fixity of the antecedent state, the resulting behaviour may differ according to alterations in the immediately precedent situation. "In sofar as our behaviour is not externally compelled or constrained it is free ; as a function of our history and personality structure, it is determined" (Wallace, 1986). The human behaviour is determined by the "the sort of person I was and the sort of situation I faced". He makes a point that although human behaviour is determined, it is not predetermined and it does not carry fatalistic implications "nor does

determinism negate the importance of *conscious* efforts, attitudes, deliberations, and volition" (Wallace, 1986; Wallace's italics). He believes that autonomy, internal locus of control and capacity for self-transcendence are fully permissible in a deterministic universe and he sees the reduction of determinism as originating from its violation of "man's narcisistic presumption to rise above the causal nexus" (Wallace, 1986).

He further perceives the cause-effect relationship as a continuous process in time. "That reality is a *continuum* which cause and effect explanations arbitrarily segment into a series of temporally and specially frozen events" (Wallace, 1988b). As early as 1896, Freud invoked an intersectional concept of causality (Freud, 1896, p.217). In a way, it contrasts with one usual concept of causality as given by Mandelbaum's (1977, pp. 47-77) as "the end point of a process, of which the effect is viewed as its end point or result: the cause of this result is the process itself".

As Wallace (1987) summed up: "Psychoanalysis, like evolution and other grand theories of science, is assessed by data derived from various sources. it is the convergence or divergence of multiple lines of evidence that gives the verdict. We do not require certainty".

The Theories of Truth

One way of looking at science is that it is an approach to arrive at the true picture of nature. Science, thus, is an unending search for the truth. The truth or otherwise of any scientific theory or proposed law has to be established. There are four basic ways of looking at the concept of truth in the context of scientific pursuit.

1. **Correspondence Theory :** This theory is based on empirical criteria. Observations are used to establish whether a particular theory is true or not and the usual inductivo-deductive process is used to arrive at the truth of the theory. In brief, it can be said that "true propositions faithfully represent the structure of the reality to which they refer: "a statement is true if it corresponds to the facts', as Popper (1962, p.376) tersely put it" (Wallace, 1988a). A statement is true if it corresponds to the facts. It is nearer to the truth (i.e. has more "truth content") than another statement if it corresponds to the facts more closely than the other statement (Popper, 1962, p. 376).

2. **Coherence Theory:** This is based on the logical criteria. A theory is true if the elements of it are related to each other by ties of logical implications.

3. **Truth as Aesthetic and Pragmatic:** This theory acknowledges that there is no absolute route to truth in scientific investigations. However, whether a theory is accepted or not depends upon the possible gains from it. Based to a certain degree on the Feyerabandian anarchist theory, a theory is true "as long as it is pretty and helps somebody" (Wallace, 1988).

4. **Truth as the absolute, ultimate, undeniable reality :** We do not have to prove the existence or otherwise of truth. Is there any ultimate nature and structure of the universe in which we live, and is there any theory and spirit guiding this reality ? As children when we started studying science, we learnt that we must pursue and establish the truth as if truth depends upon our providing it. The Hindu concept is very clear in this matter that there is an absolute and undeniable truth and reality, whether we can see it or not.

EPISTEMOLOGY OF MENTAL PHENOMENA

When we try to look at the process of knowledge as far as the behavioura sciences are concerned, we immediately come face to face with the problem of the concept of mind. We can surmise of mind only through the behavioural activities

that we ascribe to the minds. For most of human history, it has been the heart and not the brain that has been considered to be the seat of the mind. We know of mind only through its behavioural correlates. "We know the mind, said Hume, only as we know matter : by perception, though it be in this case internal. Never do we perceive any such entity as the "mind" : we perceive merely separate ideas, memories, feelings, etc .." (Durant, 1952, p.257).

Classically, in the modern times, cognition, conation and affect have been considered as the major constituents of the functions of mind. The term mental includes all of these and also a number of other functions, phenomena and manifestations which seem related to the mind but which do not easily seem implied in the above three-way classification. This may include such things as dreams, autochthonous thoughts, after images, revelations, faith, etc.

Mind-Matter & Mind-Body Problems

Any discussion of the epistemology of behavioural and mental phenomena immediately runs into the concept and definition of mind. The Western philosophy has been plagued for over 2,000 years with the dualistic theory of mind vs. matter. Is mind a part of matter or is it something separate ? "What we term 'mind' is an abstraction that refers to the organization of those properties which emerge from the interaction between two species of *matter*—the human body and its environment" (Wallace, 1985, p. 165).

The Indian philosophy has, by and large stayed out of the mind-matter controversy. Matter is only a product of our ignorance ; our inability to see Brahman. Matter has a certain quality and disposition (*Upadhi*) whereas the mind is *Upadhi*-less.

Truth is not debatable in the Indian thought and it is only a construct based on our culture's construct. Truth, in the Indian belief, is transcendant and non-human.

The Indian philosophy has been basically monistic as far as the mind-matter relationship and the mind-body problem is concerned. It does not say that mind and matter are the same, but it does not appreciate the nature of the problem either and discards it as irrelevant.

One Indian approach has been the approach of the Sankhya philosophy which makes a distinction between *prakriti* and *purasha*. *Purasha* is the pure consciousness and reflects *buddhi* whereas *prakriti* is absolute, capable of cognition and not simply a product of *purasha*.

The Indian philosophy very well appreciates the qualities and properties of objects. In this way, it is antethetical to the Western characteristation of an object which is basically analytical and chemical. Indian philosophy recognises seven qualities of an object, namely, *Dravya*, *Guna*, *Karma*, *Samanya*, *Vishesh*, *Prabhav* and *Samvaya*.

Causality and Determinism in Psychology

"Medicine has long possessed a primitive concept of psychic causality—of the influence of ideas and emotions on health and disease" (Wallace, 1985, p. 132). Schopenhauer espoused a determinism in the psychological sphere identical to that in the physical (Wallace, 1985, p. 138). John Stuart Mill, who wrote extensively on many subjects and who is supposed to have been one of the most intelligent men who ever lived, attributed to the concept of determinism , "the existence of universal laws for the Formation of Character" (Mill, 1969, p.14). Tylor (1874, vol, I, p.2) who has been called the father of cultural anthropology maintains that "human thoughts, will, and actions accord

with laws as definite as those which govern the motion of waves, the combination of acids and bases and growth of plants and animals".

Although Freuds' concept of determinism had its predecessors, "the explanation of Schopenhauer and Herbart, none of his precursors had a developed conception of unconscious motives" (Wallace, 1985, p. 141) and causal concepts were too mechanistic.

Freud has been criticised for his concept of psychic determinism. As we well know, psychic determinism and unconscious were the two basic concepts on which the entire theory of psycho-analysis was based. We now know that Freud did not discover either of these and that the concept of unconscious enjoyed considerable currency in Freud's days. With regard to determinism, what Freud did was to extrapolate the concept of determinism from the physical, natural sciences to the science of mind. In other words, if we accept that the physical events are not random happenings in the universe, but are caused by certain other events, there is no reason why mental phenomena are also not random happenings but are caused accidentally. Accordingly, Freud only extended the concept of determinism to the mental phenomena.

If we look at the concept of determinism even in the physical world, the concept of causality, and determinism was, to start with, taken from the mental world. The concept of causality was, to a considerable degree, an anthropomorphic concept. It was as if the metals and elements had a mind of their own and that their behaviour was purposive and teleological. The stone fell because it wanted to unite with the centre of the earth, plants grow upward to reach the source of light, elements attract each other or repel each other, etc. Such a "primitive notion of psychic causality was the *first* conception of causality" (Wallace, 1985, p.117). The actions of one element upon others have been referred to as injustices.

Strong (1978, p.115) defines causation in psychology in the following terms : "A cause is an event that precedes the event of interest and that can be shown to have an invariant relationship to the event".

The concept of causality has given rise to so many problems that Bertrand Russel (1929) advocated its "complete extrusion from the philosophical vocabulary", Wittgenstein (1967) considered causation as superstitious and Reiner (1932, pp. 709-710) charged that causation is an anthropomorphic concept which "ceases to exist in physics".

Role of Introspection and Intuition

Introspection and intuition have always been considered as legitimate methods of knowing about the mind. In a way, we can say that from the sample of one (ourselves), we can generalize about the entire population of mankind. We may say that the sample of one is totally inadequate for the entire human race. Such a small sample would not be acceptable to a scientist. However, there is one aspect of this issue that is worth keeping in mind. In considering some other natural phenomenon, the phenomenon to be observed lies outside us. We do not have any direct method of learning about it and, hence, a large sample is required to rectify the error of observation. There is no fool-proof method by which we can learn about the event. However, in trying to understand the working of our own mind, this aspect of the error of observation is removed. As we are the observers and the observed at the same time, we can be sure that we know what is actually going on as far as the phenomenon to be observed is concerned.

Accordingly, introspection and intui-

tion have been well recognised as methods in human psychology. It was Fechner, during the second half of the 19th century, who, for the first time, suggested that there was no reason why psychological events also did not follow the laws of physics and chemistry. This was a major turning point in the history of psychology. Subsequently, although Freud added impetus to this scientific approach of the study of mind, in fact, he depended greatly on intuitive and introspective processes in developing a theory of psyche and personality. His study was also allegorical which is consistent with the accepted pattern then prevalent. In evaluating the contributions of Freud, we must keep in mind that in his time intuitive and introspective approaches were well acceptable as scientific methods in psychology and that although he elaborated greatly on the concepts of unconscious and psychic determinism (causality) ; he was by no means its founder. Russell (1948) calls absurd the view maintained by "a certain school of psychologists, who maintain that 'introspection' is not a valid scientific method" (p. 59) and he maintains that "Introspection is valid as a source of data, and is to a considerable extent amenable to scientific controls" (p.65). As Ackerman (1965) has pointed out, "just as there are objects which the senses experience, so there are objects which the mind experiences" (p.18).

The role of intuition in science has been far greater than is commonly believed. It is singularly important in developing hypotheses. "The formation of hypotheses is the most mysterious of all the categories of scientific method" (Pirsig, 1974. p. 106). Even Einstein has said : "Man tries to make for himself, in the fashion that suits him best, a simplified and intelligible picture of the world. . . . in order to find in this way the peace and serenity .. The surpreme task .. is to arrive at those universal elementary laws from which the cosmos can be built up by pure deduction" (cited in Pirsig, 1974, p. 106). Is it that the scientific laws are more convenient than true ? Regarding the role of intuition in the formulation of these laws, Einstein adds, "There is no logical path to these laws : only intuition, resting on sympathetic understanding of experience, can reach them .. (cited in Pirsig, 1974, pp. 106-107).

We have to depend upon introspection for a number of psychological phenomena. The classical example given in this regard is that of after-image. If you look at a bright object for some time and then suddenly close your eyes, you "see" an outline of the object in complementary colour. There is no way how this experience can be objectively and empirically validated. The empirical approach requires that the phenomenon should be similarly perceived by outside, independent raters, thus giving it replicability and consistency. Similarly, phenomena like hallucinations (i.e. sensations in the absence of an external stimulus) and even pain can be perceived only at the individual, intuitive level. Does it make it any less real ?

Another important problem in the study of the mental phenomena is that the very process of observation may influence the event. A simple example could be that if the people are aware that they are being observed, this knowledge itself may affect their behaviour. This problem has been encountered in many experiments in social psychology and the question is how to make the observation unobtrusively. A related and more serious problem is where the process of drawing one's observation towards it may result in the cessation of the phenomenon to be observed.

The classical example given here is the debate regarding the wave theory vs the corpuscular theory of light. The pro-

cess of observation is such that it will disturb the phenomenon so that an answer to this question cannot be found. It is one of the 'indeterminate' questions. Coming to the psychic events, a very ready example is that of dreams. If one were to focus conscious attention on dreams, the focus would bring about a cessation of the dream activity itself. There is reason to believe that the mental activities that occur in the process of falling asleep and the process of waking up from sleep may throw important light on the mental operations. Many people commonly experience fragmented or what has been called autochthonous thoughts or perceptions during the half-awake-half-asleep state. However, again, focussing attention to it will bring about a cessation of these phenomena. So, how must one study it ?

For mental operations to be empirically studied, it would require that the phenomenon is perceived and reported by the person. However, although a person may introspectively experience something, he may not always be able to experience it in words which would be essential for others to comprehend the phenomenon. Unless the above occurs, the empirical validity cannot be reached. What happens if the person is unable to express the experience in words ? There may be a number of mystical experiences which cannot be translated into words. Although the experiences which are common may have a vocabulary for their expression, the same cannot be said about unusual or idiosyncratic experiences. A colleague of mine is very fond of giving the following analogy : "How would a dumb person relate his experience on eating sweet ?" (Wig, personal communication).

INDIAN APPROACHES TO THE EPISTEMOLOGY OF MENTAL PHENOMENA

Although it is not the purpose of this discourse to talk in detail about the Indian approaches to epistemology and this talk cannot do justice to the richness of Indian philosophical approaches to the above, perhaps certain points of departure from the Western approach can be taken note of. The following points may be considered in this respect :

(1) Mind-Matter duality

As opposed to much of the Western thought the mind-matter duality, which has plagued the Western thought for over 2000 years, does not exist in Indian philosophy. In a way, mind is also a part of matter and there is a continuous ongoing intercourse between the two. The observer is not separate from the observed. The two are engaged in continuous interaction. Since the Western thought maintains a duality between the observer and the observed, objectivity assumes great importance. In Indian philosophy, it is accepted that an observation cannot be fool proof. The purpose of the conjunction of the seer with the seen is for unfolding inherent powers of nature and spirit so that the seer discovers his own true nature.

As we have seen earlier, the Indian approach is monistic, *advaita*. It is true that the *samkhya* philosophy maintains a distinction between the *prakriti* and *purasha* and is a philosophy of pluralistic dualism; by and large, Indian philosophy remains monistic.

(2) Synthetic, holistic

In contrast to the Western analytical approach to recognition and theorizing, the Indian approach is synthetic and holistic. In the Western approach, if you are trying to understand something you must break it in two parts. Your break something into two ; if you still do not understand, break it into halves again and keep on breaking it till you understand it.

This has resulted in the Western approach to identify the key attributes and active ingredients of substances and phenomena.

In Western science, the active ingredient in most situations has been identified in chemical rather than physical terms and thus does not pay adequate attention to the "state" of the thing. For example, iron is iron irrespective of its shape. H_2O represents water whether it is in the shape of water or ice or steam and whether water is stagnant in a pond or running water in a river. Alcohol is C_2H_5OH irrespective of the type of alcoholic beverage. Now a person who is savouring a rather rare scotch will be aghast if you say that he is drinking C_2H_5OH and thus something similar to the cheapest gin or arrack. The Indian concept of external reality has always been holistic and it is well documented in the ancient scriptures like Gita and Patanjali Yoga Sutra in which the shape and the state of the object have all been taken into account. The Western approach to identifying the essential ingredients also serves some purpose as it describes the object substantially but certainly not totally.

The Indian approach to science has also seen causality in the holistic fashion. As regards time, it is somewhat akin to Wallace's concept in that there is a continuous change of cause and effect. It also sees causality in a multifactorial way in which the entire system is interacting with each other to produce the effects.

(3) Illusionary nature of perception

The Indian philosophy also is cognisant of the limitations of perceptions and the inferences to be drawn from it. The Srimad Bhagwat Gita attests to the illusionary character of human perceptions, as does Patanjali Sutra. There is no fool-proof method of seeing the external reality. Identifying the seer with the instrument of seeing, namely, the senses of perception and organs of action intelligence and ego is considered as *asmita* or egoism, and hence should be avoided.

(4) Non-normative approach to human behaviour

One of the definitions of health and illness is a statistical one, a normative approach. If you are like everybody else, you are all right. The usual is normal and healthy. Any deviation from the statistical approach is viewed with suspicion and is a *prima facie* evidence of abnormality.

However, the Indian approach to mind is aware of the differences across individuals and across time. It attests to a number of reasons for such variability, evoking concepts like *sanskara* and fatalism which may limit and prescribe what a particular individual may perceive.

However, it is clear that perceptions may vary not only across individuals but in the same individual from time to time. Many of the things that occur to us cannot be called usual by any means. Let us look at the creative process. We all know that scientists have flashes of creative insight. This does not occur everyday ; in fact, it will not occur more than a few times in one's lifetime. This can, in no way, be called abnormal or pathological. Similarly, there are such things as religious revelations or *itham*. So are other para-normal perceptions that can occur to some but not to all.

The Indian philosophy attests to the variability across individuals and the idiosyncratic nature of many mental phenomena. There is a greater awareness of such possibilities and of its awareness.

(5) From causes to consequences

Like me, others who began their careers in psychiatry in the environment of

the University of Michigan in the early 1960s were familiar with the famous aphorism of Ralph Gerard who directed the Schizophrenia Project in the 1950s : "Not a crooked thought without a crooked neuron." The converse of it, its corollary, is however not so well appreciated:

"Not a crooked neurone without a crooked thought". It is inconceivable that if you believe in the former, you can reject the latter. So, what do we have here ? We are actually moving from theory of causality to that of consequences. Every event in the universe, howsoever trivial, will have its consequences. It also applies to our thoughts, emotions, words and deeds over which we seem to have some control. If we engage in wrong-doing, we will have to face its consequences.

If we extend this concept, we will no doubt realize that we are talking about a *karma* theory. People generally think that many acts are finite and delimited as long as no one knows about it. You can cheat or steal or engage in a sexual escapade as long as no one knows about it. How would anyone know about it, after all ? We know, as a theoretical possibility, what Julius Caesar said 2000 years ago can be retrieved even now. The energy change has taken place ; it is up to us to retrieve this information. A simple analogy comes to mind. In India, even now when one makes a subscriber trunk dialing (STD) telephone call, it is counted as so many local calls, and there is no record who was the party called, what time the call was made and its duration. But, the telephone company can easily eavesdrop on it by hooking your telephone to a computer and come up with all the data ; something that is routinely done in many advanced countries. The point I am trying to make is that, it is theoretically possible to record every event in the universe. Simply because a thing is not recorded does not make it a non-event and does not subtract from its causal properties.

The above may be theoretically applicable also to events that are not possible to record or measure at present. What about the consequences of dallying in the titillating enjoyment of a pornographic book, or of having uttered an obscenity ! If we believe in causality and consequences, these will also have their impacts.

In a way, the *Karma* theory is related also to the *sanskara* theory and the free-will-determinism issues. Your *sanskara* is determined by your good deeds and mis-deeds in the previous births and are passed on to you with re-birth. If the body is burnt, how can these be transmitted ? Again, we are running into the fallacy that we have been trying to avoid, namely that everything is important, whether you can measure it, record it or not. If you have committed mis-deeds earlier, you are born with tainted wisdom which will impair your ability to do good deeds. But it is a must to try your best to do good deeds, otherwise, you cannot rise from the morass.

The above is also related to the free will vs. determinism issue. We have seen how complicated the issue of determinism is, especially pertaining to mental acts. The Indian ethos, like virtually all religious belief systems in the world, is ambivalent on the issue. Determinism is related to fatalism, but you have freedom of choice as well. If you are born with bad *sanskara* and wisdom, your capacity for good deeds is limited, but still you must try your best to elevate your position through good deeds.

One important point regarding Indian, especially Hindu philosophy. We have seen the difference between the mechanistic, pushing causes and technological, anthropomorphic, pulling rea-

sons. Indian philosophy accepts the above, the purposefulness of the reasons. However, there is also the concept of *kaaran*. It will again have to be translated as "reason", but it is not the reason as we have discussed above. *Kaaran* is a cosmic causality how the event fits in God's scheme of things, God who is perceived as the cause of it all : *Sakal Jagat ke kaaramam*.

(6) Contemplative, participant approach

Finally, the Indian approach to science is basically contemplative, as opposed to the aggressive, manipulative Western approach. We try to understand nature, for its own sake and to adapt ourselves to it, rather than to meddle with it. We are not masters of the universe, but only participants. The aggressive, manipulative, exploitative approach to nature is already having a large number of repercussions. Furthermore, unfortunately, we do not know all the possible repercussions of our meddling with nature.

LIMITATIONS OF THE SCIENTIFIC APPROACH

As we have seen, each one of the various scientific approaches has its limitations. Popper admits the limitations and falliability of the scientific approach and emphasizes it with a striking metaphor :

> "The empirical basis of objective science has thus nothing "absolute" about it. Science does not rest upon solid bedrock. The bold structure of its theories rises, as it were, above a swamp. It is like a building erected on piles. The piles are driven down from above into the swamp, but not down to any natural or "given" base ; and if we stop driving the piles deeper, it is not because we have reached firm ground. We simply stop when we are satisfied that the piles are firm enough to carry the structure, at least for the time being (Popper, 1968, p. 111).

Popper further writes ". . if we expect truth we must search for it by persistently searching for our errors : by indefatigable rational criticism, and self-criticism" (Popper, 1968, p. 3) and further adds ". . my answer to the question, "How do you know ? What is the source or the basis of your assertion ? What observations have led you to it ?" would be : "I do not know : my assertion was merely a guess. Never mind the source, or the sources, from which it may spring—there are many possible sources, and I may not be aware of half of them; and the origins or pedigrees have in any case little bearing on truth. But if you are interested in the problem which I tried to solve by my tentative assertion, you may help me by criticising it as severely as you can; and if you can design some experimental test which you think might refute my assertion, I shall gladly, and to the best of my powers, help you to refute it" (Popper, 1968, p. 27).

The modern approach to science depends greatly on measurement. Sampooran Singh (The Sunday Tribune, September 18, 1988) quotes R. D. Laing, a renowned psychiatrist, as lamenting the obsession of the scientist with "measurement and quantification" and physical science being concerned with a world of shadows and falling into the error of identifying appearance with reality. Sampooran Singh maintains that the concepts are not features of reality but constructs of the mind; part of the map, not of territory. Science seems to miss many important things, for example, the language of love and friendship and mutual understanding.

Einstein, Schrodenger and others have

referred to **another mode of knowing** that does not update by separating the subject and the object (Sampooran Singh, 1938). Such a mode of knowing is of course well appreciated in the Indian scientific tradition.

Chalmers (1976, p.xiv) quotes an inscription of the social science research building at the University of Chicago as reading "If you cannot measure, your knowledge is meagre and unsatisfactory". Toulmin (1976) points out that Heraclitus argued that sensory observation always hold good for particular, specific times and places. All our resulting knowledge must, as a result, be correspondingly "contingent"—that is local, transcendatory and conditional in its scope and validity. Heraclitus accordingly formulated his much quoted epigram "everything is in flux" (p. 73).

In a way our difficulty can be summed up as per the following scheme :

"All of our knowledge of the world comes by way of the five senses.
So, all of our knowledge of the world is contingent;
So, we can make no necessary or permanent assertions about anything in the world—even about words and their meanings; So, language is "in flux"—from place to place and moment to moment—like everything else;
So, we cannot use language intelligibly.',

But the fact is :

"We do use language intelligibly;
So, language cannot be entirely "in flux". So, we can make some necessary or permanent assertions about the meanings of words;
So, not all of our knowledge of the world is contingent;
So, not all of our knowledge of the world comes by
way of the five senses alone." (Toulmin, 1976, pp. 75-76).

In science, our insurmountable problem is really that of the need for certainty. We like to understand and predict about the universe around us as it gives a certain sense of security and control. But is there really an actual certainty? "Is This City of Truth a Reality, or is it a mirage"? (Toulmin, 1976, p. 48). As Wallace has rather pungentally put it, "there is a bitch goddess or dog god against which we should declare. And her or his name is Certainty" (Wallace, 1988a).

Pirsig in his eminently readable and influential book, "Zen and the Art of Motor Cycle Maintenance", mounts a concerted attack on the entire area of scientific truth. He discovers, for example, that "the time spans of scientific truths are an inverse function of the intensity of scientific effort" (Pirsig, 1974, p. 108) and : "What shortens the life span of the existing truth is the volume of hypotheses offered to replace it;... as you try to move toward unchanging truth through the applications of scientific method, you actually do not move toward it at all. You move *away* from it ! ... it is science itself that is leaving mankind from single absolute truths to multiple, indeterminate, relative ones" (p. 109, italics in the original). It appears, thus that the scientific theories are not necessarily true, but are only convenint schemes of understanding the universe and its phenomena and thus reduce uncertainties, and the question of arriving at final and lasting truths does not even arise.

It is being recognized increasingly that although the inductive, empirical approach has well served acquisition of knowledge, it has important inherent limitations and is not the only approach possible to science.

"If all our knowledge comes from sensory data, what exactly is this substance which is supposed to give off the

sensory data itself ?... If one accepts the premise that all our knowledge comes to us through our senses, Hume says, then one must logically conclude that both 'Nature' and 'Nature's Laws' are creations of our own imagination" (Pirsig, 1974, pp. 124-125). "It seems to me that the law of gravity has passed every test of non-existence there is. ... law of gravity exists **nowhere** except in people's heads! It's a ghost!" (Pirsig, 1974, p. 33, italics in the original). He further adds : "It is not uncommon, ... for Indian villagers to see ghosts. But they have a terrible time seeing the law of gravity." (p. 244).

However, undeniably science does something useful. The scientific theories, surely have resulted in our ability to predict about and manipulate nature to our benefit. There is no doubt that there is such a thing as electricity which has been harvested and which I am using just now in addressing you. In addition, as has been pointed by Chalmers, (1976, p. 108); "Scientific theories have an objective structure outside of the minds of individual scientists."

"Science exists in a particular society because it serves a specific function in that society" (Chalmers, 1976, p. 143). However, "The task for the 'science of mind' is not to **discredit** our experience of aesthetics, sensory, perception and the rest, rather, it is to bring to light the learning sequences and neural mechanism **called into play** in those activities" (Toulmin 1976, p. 277).

CONCLUSION

We have seen that much of our knowledge of the world around us, the external reality and nature comes through our sense organs. This ability to perceive the external reality is the basis of the empirical, inductivist approach. Induction is also involved in the other scientific approaches, directly or indirectly, i.e., in falsificationism, paradigm approach and in intersectionalism. All these approaches have problems. "Can we avoid the scylla of simplistic dogmatism and the charybdis of epistemological anarchy?" (Wallace, 1988a).

However, we have seen that our sensory apparatus is both limited and fallible. We can perceive only certain things and phenomena and not others.

Pirsig (1974) raises a number of issues pertaining to the validity of the entire scientific process and scientific theories and truths.

Science faces, furthermore, the problem that it is totally incapable of studying certain important mental phenomena, at least "objectively", at the present time. How do you study or measure things such as the sense of joy that you experience at the mountain top or seashore? How do you study beauty, love and hatred, reverence and decision, faith and cynicism, patriotism, friendship, quality, excellence and dharma? The fact that we can not study them through the "scientific" method does not make these any the less important. As a matter of fact, we can even say the **things that most importantly concern us**, do not lend themselves to the scientific approach, science simply scratches the surface of the totality of the human situation. Science has been, and is useful, but it would be fatal to think that it has answers to all or even the most important issues, at least at present.

By the above, I am not trying to run science down. Science has been useful in many ways and we are reaping the convenience and comfort resulting from it. However, its impact so far has been only on the physical environment. It has made little impact on our mental state and almost none on the spiritual. It would be wise to maintain the right

perspective about the role of science in our everyday life.

There is no a-priori reason for us to have absolute knowledge of the universe in which we live. In the universe, only humans have some knowledge of it. Scientific theories subserve useful functions to reduce uncertainties and fear and to help desirable action. However, it would be wrong to think that we know, or will know everything regarding the operations of nature. It is possible for us to draw only some conclusions about the external reality—and most conclusions must remain tentative forever.

The scientific theories have ranged from subjectivism to empiricism, and from rationalism to anarchy to nihilism. The Indian thought is more cognisant of the limitations of knowledge. Indian philosophy is holistic, causality is not temporally linear, cause following effect. Furthermore, I would like to suggest that causality is multifactorial and interactive, based on the ongoing interaction between the various factors.

So, where do we go? It is not suggested by any means that we abandon science. Science is after all, in more general terms, our pursuit for knowledge. However, we need to assume a middle epistemological position. Induction is there, but we need take it with some reservations. We need to develop and maintain tolerance for ambiguities, uncertainties; even contradicitions and opposites. We Indians, as it is, are less upset by these than the Western man with his analytical approach. The only possible position is for us to acknowledge our limitations. If that borders on intellectual nihilism, let it be so, for such are the ways of God.

ACKNOWLEDGEMENTS

I have already made a reference to the earlier influences on me which have contributed to this work. Two more recent happenings need to be mentioned.

After I had selected the topic of the Presidential address early last year, I came across, in May 1988, the article of Dr Edwin R. Wallace IV, M. D. entitled, "What is truth? Some Philosophical Contributions to Psychiatric Issues" published in the February 1988 issue of the American Journal of Psychiatry. This led to my corresponding with him which blossomed into a full collaboration and friendship in which we exchanged views and Dr. Wallace made available to me several of his and other's publications, including the gift of a number of books. This has been most helpful in the preparation of this essay.

The other person whom I would like to recognize at this time is Professor Dharmendra Goel of the Department of Philosophy, Panjab University. On his invitation, I presented a paper, "Epistemology of behavioral sciences" at the National Seminar, "Is Epistemology Sociology of Knowledge ?" held in Chandigarh, March 1-4, 1985. We have maintained our liaison and he was most helpful in discussing with and offering helpful comments and suggestions in the preparation of this paper.

Dr. Swaran Preet Singh, my Junior Resident, helped in editing the paper and Mr. K. Aravindakshan provided excellent secretarial help.

BIBLIOGRAPHY

Ackerman, R. (1965) : Theories of knowledge : A Critical Introduction. Tata McGraw Hill Publishing Co. Bombay, New Delhi.

Bacon, F. (1869) · Nervum Organum Vol VIII. In ; Spedding J. Ellis RL and Health DD : The Works of Francis Bacon, New York.

Chalmers, A. F. (1976) : What is This Thing Called Science ? University of Queensland Press, Queensland.

Delbruck, M. (1986) : Mind from Matter ? An Essay on Evolutionary Epistemology. Black Well Scientific Publication, Palo Alto.

Durant, W. (1952) : The Story of Philosophy. Washington Square Press, New York.

Einstein, A. (1950) : Out of My Later Years Philosophical Library, New York.

Engel, G. L. (1988) : How much longer must medicine's Science be bound by a 17th century world view? In: White KL (Ed) : The Task of Medicine : Dialogue in Wickenburg (In press). The Henry J Kaiser Family Foundation, California.

Engelhardt, H. T. and Pellegrino, E. (1986) : Philosophy and medicine : A decade later. Journal of Medical Philosophy, 11, 1-117.

Feyerabend, P. (1975) : Against Method: Outline of an Anarchist Theory of Knowledge. New Left Books, London.

Freud, S. (1896) : Heredity and the Aetiology of the Neuroses. Standard Edition, Vol. 3, Hogarth Press, London, 1962.

Hume, D. (1939) : Treatise on Human Nature, Dent, London.

Kuhn, T. (1970) : The Structure of Scientific Revolutions, revised ed. University of Chicago Press, Chicago.

Kuhn, T. (1977) : The Essential Tension : Selected Studies on Scientific Tradition and Change. University of Chicago Press, Chicago.

Mandelbaum, M. (1977) : The Anatomy of Historical Knowledge. John Hopkins University Press, Baltimore.

Mill, J. S. (1969) : Ethology—the Science of the formation of character. In: Nash, R. (Ed.) : Ideas in History, vol. 2. E.P. Dutton, New York.

Odegaard, C.E. (1986) : Dear Doctor. A. Personal Letter to a Physician. Henry J Kaiser Family Foundation, California.

Pellegrino, E. D. and Thomasma, D.C. (1981) : A Philosophical Basis for Medical Practice. Oxford University Press, New York.

Pirsig, R. M. (1974) : Zen and the Art of Motorcycle Maintenance. Corgi Books, London.

Popper, K. (1962) : The Open Society and Its Enemies. Vol. 2. Princeton University Press, Princeton.

Popper, K. (1965) : The logic of Scientific Discovery. Harper and Row, New York.

Popper, K. (1968) : Conjectures and Refutations : The Growth of Scientific Knowledge. Harper and Row, New York.

Popper, K. (1979) : Objective Knowledge : An Evolutionary Approach. Revised Ed. Clarendon Press, Oxford.

Popper, K. and Eccles, J. (1981) : The Self and Its Brain. Springer International, New York.

Reiner, M. (1932) : Causality and psychoanalysis. Psychoanalytic Quarterly, 1, 701-704.

Russell, B. C, (1929) : Mysticism and Logic. Norton, New York.

Russell, B. C. (1948) : Human Knowledge. George Allen and Unwin.

Ryle, G. (1949) : The Concept of Mind. Barnes and Noble, New York.

Singh, S. (1988) : Survival Crisis : Cause and Cure. The Sunday Tribune. Chandigarh, Sept. 18, 1988.

Spillane R. (1987) : Rhetoric as remedy : Some philosophical antecedents of psychotherapeutic ethics. British Journal of Medical Psychology, 60, 217-224.

Strong, S. (1978) : Social Psychological approaches to psychotherapy research. In: Garfield, S. and Bergin, A. (Eds) Handbook of Psychotherapy and Behaviour Change. 2nd Ed. Wiley, New York.

Toulmin, S. (1976) : Knowing and Acting : An Invitation to Philosopy. Macmillan Publishing Co, New York.

Tylor, E (1874): Primitive Culture. 2 volumes, New York.

Varma, V. K. (1985) : Epistemology of behavioural sciences. Paper presented at the national seminar on "Is Epistemology Sociology of Knowledge ?" Chandigarh, March 1-4, 1985.

Varma, V. K. (1988): The philosophy of Science : The Indian Perspective. Oration of the ICMR Dr Vidya Sagar Award, delivered at Srinagar, J & K, Sept. 30, 1988.

Wallace, E. R. (1985) : Historiography and Causation in Psychoanalysis. The Analytic Press, USA.

Wallace, E. R. (1986) : Determinism, possibility and ethics. Journal of American Psychoanalytic Association, 34, 933-974.

Wallace, E. R. (1987) : Pitfalls of a one-sided vision of science : Adolf Grunbaum's foundation of psychoanalysis. In press, Journal of American Analytic Association.

Wallace, E. R. (1988a) : What is "truth"? Some philosophical contributions to psychiatric issue. American Journal of Psychiatry, 145, 137-147.

Wallace, E. R. (1988b): Psychoanalytic causation revisited. The Psychiatric Forum, 14, 1-21.

Wallace E. R. (1988c) : Mind-Body : Monistic dual aspect interactionism. Journal of Nervous and Mental Diseases, 176, 1-20.

Wallace, E. R.: Philosophy of Psychiatry .. General Issues. In press for Current Opinion in Psychiatry.

Wallace. E. R. : Psychiatry : the healing amphibian. Second opinion. (in press).

Wittgenstein, L. (1967) : Lectures and Conversations on Aesthetics, Psychology and Religious Belief' University of California Press, Berkley.

D.L.N. Murti Rao Oration, Indian Psychiatric Society, 1986

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DR D.L.N. MURTI RAO ORATION

CULTURAL PSYCHODYNAMICS IN HEALTH AND ILLNESS

VIJOY K. VARMA*

All the Dr D. L. N. Murti Rao Orators so far have been persons who knew Dr D.L.N. Murti Rao personally. Some like Professor N.N. Wig, Professor A. Venkoba Rao and Professor A. Verghese had been his students. Others like Professor K.C. Dube and Col. Kirpal Singh knew him in course of their professional interactions. I am possibly the first Dr D.L.N. Murti Rao Orator who was not fortunate enough to have known the great man in the flesh. I have, however, been greatly impressed and touched by the high regard bordering on reverence with which he has been held by his students. Many of them, my senior colleagues, like Professor N.N. Wig, Professor A. Venkoba Rao and others I have, in turn, greatly respected and admired and derived guidance and inspiration from.

The picture of Dr Murti Rao that emerges before me is that of an astute and committed clinician, a very popular teacher with deep concern for the professional development of his students – a true guru, a professional possessing a sharp, analytical mind, and a man in the highest reaches of humanism. His honesty of purpose, humility and humanism have been highly lauded. I understand that, not surprisingly, he was very interested in unravelling the jigsaw puzzle of schizophrenia as also of other mental illnesses.

It is as a tribute to the great man that I dedicate my oration which, I hope, will take us a few tiny steps further in the direction shown by Dr Murti Rao.

Man lives in an intimate relationship with the society. The important relationship between man and society has been extensively studied and variously interpreted. In the context of mental health and illness, just like those are dependent upon individual psychological variables, they are also dependent upon socio-cultural factors. The culture may exercise powerful pathogenic and pathoplastic, as well as health-sustaining influences. In this paper, we shall examine such socio-cultural factors and its relevance to psychiatry.

Since the turn of the present century, the Western man has been increasingly aware of and interested in other cultures. To start with, this was possibly mainly an idle curiosity in cultures grossly different from the Western culture. Anthropologists and other social scientists from North America and Western Eurupe undertook studies of the non-Western cultures, primarily the primitive, pre-literate, "exotic" societies. Some of the greatest figures in cultural anthropology who stood out as giants in the entire area of human thought, such as Radcliffe-Brown, Franz Boas, Sir J.G. Frazier, R. Linton, W.H.R. Rivers, Bronislaw Malinowski, Ruth Benedict and Margaret Mead participated in this exploration. To start with, it was discrete quests into other cultures, the empahsis being on them being alien, different, peculiar, "quaint", "exotic". Thus we have a Samoa here, a Trobriand there, Alor, Kwakiutl,

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Hopi, Zuni, Arapesh and others in different parts of the world. The emphasis all through was on them being "Oh, so different". It was only later that anthropologists started looking at these different cultural forms as comprehensive, viable solutions to the problem of human existence. As Ruth Benedict exclaimed, is it not wonderful that there can be so many different solutions to the problem of human existence and isn't it great that they all seem to work. Benedict developed the theory of functionalism, namely that each cultural form, norms and institutions, roles and expectations that hold a culture together fit with each other to produce the cultural whole just like pieces of jigsaw puzzle without necessitating readjustment and realignment of the other pieces. These insights paved way to the theories of cultural relatively and functional integration.

There was a parallel, though later, development in the field of transcultural psychiatry. To start, with contact with non-Western societies, Western psychiatrists became aware of the apparently unusual and peculiar presentations of psychopathology in the non-Western societies. A number of so-called culture-bound syndromes were identified and described and specific names were applied to them. Thus, there was an *amok* and a *latah* here, a *koro* there, a *piblokto* in the third place. One side aspect of recognition of these was a pejorative connotation assigned to these – these illnesses were the preserve of the "primitive" and did not affect the civilized Western man. It has been only much later that an appreciation is dawning upon the scientific community that the so-called culture-bound syndromes do not represent specific entities, but illustrate the influence of cultural factors in modifying the manifestations of psychological upheaval – the pathoplastic influences of the culture and that there is nothing about them qualifying them as specific, clearly different clinical entities. Pfeiffer (in Al-Issa) has considered this issue in detail. Additional credence to the scope and extent of the degree to which cultures can mould presentation and natural history of the "universal" illnesses, e.g. schizophrenia, depression, etc. came from internationally monitored studies, e.g. the U.K., U.S.A. study and studies on schizophrenia, depression carried out under the aegis of the international organizations, e.g. the World Health Organization which, using standardized instruments and uniform methodologies, brought to light important trans-cultural differences.

Transcultural psychiatry need not only be of esoteric importance, only an academic exercise, but may be of relevance and importance to all mental health professionals. As the phenomenology, course and outcome of mental disorders may be dependent to a great extent on socio-cultural factors, analysis of the transcultural differences in these may be helpful in separating out the culturally-generated features from others. Whereas the differences across cultures may be related to the interaction of the illness with the socio-cultural variables, the similarities, "the universals" of the illness may reflect the "core" and basic nature of the illness. In this fashion, transcultural psychiatry may be helpful in facilitating greater insight into the basic nature and concept of a mental illness, and the socio-cultural factors which must be taken into account not only in understanding the illness, but also in planning its treatment.

Transcultural psychiatry has, thus, come to be recognized as a speciality within psychiatry. However, although there have been a few exceptions, the model remains basically descriptive and phenomenological. There is every need to correlate the transcultural differences in phenomenology, course, outcome and treatment of mental illness with the cultural variables, so as to

arrive at a dynamic model of transcultural psychitry. The need is to switch from "what" to "how" of the issue. The role of socio-cultural variables in the transcultural differences must be understood and correlated with each other. However, the relationship between the two must be visualized not as a static but as an on-going dynamic interchange. In this fashion, a dynamic synthesis may be effected in transcultural psychiatry.

The Dynamics of Culture and Mental Health

A number of workers, anthropologists and psychoanalysts, have tried psychodynamic interpretations of cultures. "Benedict showed that the first-order facts of a culture,...could be transcended by finding abstract qualities linking domains of life like war, menstruation, death, puberty and others....This method gave anthropology a new maturity and opened the way for other bases of interpretation using, for example, psycho-analytic theory to find new meaning in familiar cultural forms" (Honigman 1972).

Although culture evolves as a group solution to the problems of human existence and should thus be something positive and beneficial to mankind, it has often been viewed as constraining and limiting human beings; as having a generally undesirable and deletorious effect. In a way, this view can be linked to the increasing complexity of life, especially since the industrial revolution, thus leading to viewing "cultivation" as bad and holding a fond wish for the return of the primitive. Even Freud was not immune to this bias and "when he turned his attention to social phenomena it seems to have been with the intention of indicting society for its deleterious influences on personality" (Hall and Lindzey 1968). The negative approach also manifests itself in blaming "culture" for mental illness, in religious renunciation and in glorifying the primitive.

The Theory of Cultural Defences

However, not every one has taken a negative view of culture. Civilization can be viewed as reducing source of acute fear, disgust and anger; reducing variability in the environment and making it more predictable and manageable (Lindgren 1969). Fromm (1959) viewed this issue in a larger perspective: "It is the belief of the progressive forces in society that such a realisation is possible, that the interest of society and of the individual need not be antagonistic for ever. Psychoanalysis, if it does not lose sight of the human problem, has an important contribution to make in this direction. This contribution, by which it transcends the field of medical speciality, was part of the vision Freud had".

Conflict is an integral part of human existence. Conflict can be said to exist intrapsychically when a particular wish or impulse cannot be readily realized in an harmonious relationship with one's super-ego and the external reality, including the people in it. When faced with such a conflict, the individual brings into play certain mental defense mechanisms, genetically determined and unconsciously operating to reduce the anxiety and the guilt, and permit partial gratification of the wish.

I have proposed the thesis (Varma 1982a) that similar to individual defenses, there exist a number of "cultural defenses" which are the culturally determined mechanisms of allaying anxiety. These are available in a readymade form for all members of the society to utilize them in appropriate situations. Cultural defense has been defined as: 'Psychological defense mechanism, genetically determined and unconsciously operative, which allays anxiety and enables partial gratification and where the mechanism is provided in the form of institutions, customs, traditions, rituals, sanctions, prohibitions, folkways and symbo-

lisms; and is available for use of all members of the society in appropriate situations".

Cultural defenses are similar to the individual defense mechanisms in that these are brought into play to alleviate anxiety and permit gratification. However, rather than the individual using his ingenuity to fabricate, as it were, a defense mechanism, he utilizes one, readymade, provided by the society for use of its members in similar situations.

Culturally determined filters – perpetual as well as cognitive-serve such defensive functions. The child is taught early in life that it is wrong to see, think, or know about certain things. In this way, the individual is spared the anxiety which can be invoked by such conflictual areas. We live through our lives utilizing similar blinders. Also, social institutions, for example marriage, family, school, church, caste and class systems reduce uncertainties and channellize gratifications in an acceptable form, and hence can be considered to be subserving defensive functions.

A study of the customs and rituals is a rich source of understanding defenses. Although some customs and rituals are understandable as serving realistic, useful functions, many other rituals and customs do not appear meaningful and useful. The question arises as to why are they practised. The thesis is put forward that in addition to serving realistic functions, they also operate at a symbolic level to serve as defense mechanisms. In so far as these are available to be shared by all members of the society, these can be called cultural defenses.

A simple example of defensive functions of the customs is illustrated by the ritualised group-mourning process associated with the death of a family member. Elaborate customs prevail in practically all cultures to permit this communal mourning. In our own set-up in India, the process in Hindus usually lasts for thirteen days with specific rituals and activities to be performed on the various days. This permits members of the family to come together, to talk about the deceased to re-live their life with the deceased and thus to relinquish him. This is precisely what is recommended in the treatment of grief reaction and the death ritual permits this treatment at a group level to permit an optimal resolution of the bereavement.

The customs and rituals associated specially with the important life events provide a rich source of material for the study of cultural defenses. Drawing from anthropological data I have focussed attention to a number of customs and rituals practised in different societies and to their defense functions. The following is a brief account of such customs:

At puberty, initiation ceremonies are very common in many cultures. Amongst boys, this often involves torture and fear inflicted upon him, haircut or shaving the head or requiring him to give an evidence of his strength and fearlessness. It has been suggested that torture or haircut, as symbolic castration, reduces anxiety aroused by sexuality by undoing or expiating for the guilt of sexual desire. Similarly displays of strength may be analogous to the sadist's display of strength before he is able to enjoy sexuality – "I do not have to fear castration, I can, myself, castrate".

There is widespread belief in the uncleanliness of the menstruating women. Accordingly, isolation of girls and women at menarche and menstruation is commonly resorted to as they are considered as source of pollution. This apparently meaningless custom can only be understood as a perceptual filter to keep out of awareness an embarrassing matter, namely that women have been mutilated (castrated). With regard to sex and marriage the custom of incest taboo

has been shown to be universal. Elaborate rules exist in different cultures in this matter and with regard to the interaction between the two sexes. "A great many cultures with pre-adolescent sexual license require marital fidelity and a great many which value premarital virginity in either male or female arranging their marital life with great license" (Benedict 1959). This as well as the institution of marriage regulates the gratification of the sexual need and removes uncertainties about the process. In many cultures, including our own, self-sacrifice and privation are associated with the rituals of marriage. Among the Hindus, the bride and the bridegroom fast for varying number of days before the wedding. In some societies, voluntary abstinence is practised for a number of days after marriage. Such privation could, like the initiation ceremonies, serve to reduce the guilt associated with sexual act.

The naming of an infant is an important activity. Many cultures practise *"teknonymy"* namely calling someone not by his given name but as so-and-so's father, mother, son, daughter, etc. It has been suggested by me that *teknonymy* can foster identification between members of a family and can facilitate identification of a parent with his or her child.

The reaction to illness illustrates defensive functions of the customs. Ascribing illness to external malevolent influences or projection is very common in many cultures including our own country. It often leads to the aggression towards an animal or a human resulting from the projection. Introjection, i.e., blaming oneself for the illness and deliberate acts to deflect illness are also common.

It is in the rituals related to death that the cultural defenses are brought to full force. The defensive functions of the rituals can be considered under two major headings: (a) denial and (b) introjection and projection. The denial consists of such things as refusing to utter the name of the deceased, dressing up the corpse and providing it with food and other articles of everyday life. It is also manifested by the belief in after-life. Such denial may take the shape of belief in transmigration of souls like amongst Hindus or in a final resting place of the soul – Valhalla of the early Nordics and heaven and hell of Christianity and Islam. How can something as important as human life just simply disappear? It is frustrating that mankind, having developed so far intellectually, aesthetically, morally and religiously, should end entirely with death. "For, we are not born or created idly or fortuitously; but doubtless there is some power which takes thought for the race of men and which was not likely to create and foster what, – when it had accomplished all its toils – would sink into everlasting misery in death" (Cicero, cited in Encyclopaedia Britannica, 1964 ed., University of Chicago, Vol. 12, p. 109).

Introjection and projection following death are manifested by such things as shaving or hair-cut and other forms of self-inflicted injuries, including the *Suttee* system. In many societies, the family members gash themselves, chop off a finger joint, tear bits of flesh from their body, cut or shave their head and carry out other acts of actual or symbolic torture. Why do they do it? How do we make sense out of this apparently meaningless activity? This is precisely where the concept of cultural defenses comes useful. Although not subserving a real function, these activities of symbolic castration can be viewed as acts of expiation or undoing for one's assumed responsibility in the death.

Following death, projection is manifested by such things as the fear of the ghosts, blaming others for the death, and taking steps to expiate the passage of the spirit. As Ruth Benedict comments, in many cultures, burial is an orgy of terror. In Austral-

ian tribes, the nearest of the kin fall upon the skull and pound it to bits, so that it may not subsequently trouble them (Benedict 1935). To reduce the danger of the ghosts, steps include carrying out one's duties during the process of the mourning. Also attempts are made to appease and expedite the passage of the spirit. Amongst the Hindus, there is a belief that the spirit is in the *Pret yoni* * for 13 days, after which it is reborn and hence no longer dangerous. Fasting and offerings are made to expedite the passsage through the *Pret yoni*.

A most striking and intriguing aspect of the rituals associated with the death is the institution of death feasts. This practice appears to be widespread. It is almost incongruous that a period of mourning after death should be marked with feasting that generally goes with joyous occasions. I have suggested that we can make sense out of it by proposing that the death feast may serve the purpose of incorporation of the person, a symbolic cannibalism, so to say.

Thus, in the examples given above we see how culturally determined rituals and customs serve defensive functions. The defense mechanisms illustrated include denial (e.g. of death or castration), repression and sublimation (e.g. of sexual drive), projection (as exemplified by blaming others for illness or death), incorporation (e.g. death feasts), introjection (e.g. self-punitive behaviour following death), identification (e.g. teknonymy), and undoing (personal suffering and privation associated with sex and marriage).

It may have struck the reader that most of the examples given pertain to the less developed societies. By comparison, it can be said that the developed societies make lesser use of rituals. Some rituals may have fallen victim to scientific advancement making them no longer tenable. But, what about their defensive role? Would giving up one set of rituals give rise to another set, better camouflaged and appearing rational?

Wittkower and Dubreuil (1971) have expressed concern that "inhibition of these cultural strategies for the sake of the highly valued social conformity, especially in North America, may have reduced the beneficial effects of these institutionalised emotional outlets". By denuding societies of the protection of cultural defenses, are we not exposing them to the possibility of cataclysmic and irrational outbursts of human drives – sexual, aggressive and others? The answer to this question may have very important and far-reaching consequences for human society and implications for those interested in futuristic social engineering and control.

Transcultural Differences in Psychopathology

With increasing awareness of other cultures, differences across cultures became noticed. As mentioned earlier, to start with, attention was mostly directed towards the so-called culture-bound syndromes which were considered to be culture-specific manifestations of mental illness. Gradually, the attention shifted to the "universal" illnesses, e.g. schizophrenia, depresssion and neuroses. The trans-cultural differences can be considered with regard to incidence, types, manifestations, natural history, course, outcome and treatment of mental illness.

Schizophrenia

Earlier, there has been a notion that mental illnesses, in general, and schizophrenia, in particular, are functions of increasing complexities of life. The value judgement is evidenced by such a statement as calling African schizophrenia as a

* Spirit phase, an intervening period between death and rebirth.

"poor imitation of the European forms" (Gordon 1934). Gradually, it has come to be known that schizophrenia is universal and about equally prevalent in all societies. Certain studies, including the International Pilot Study of Schizophrenia (IPSS) (WHO 1973, 1979) have, however, pointed out cross-cultural differences in it. Observers from both Africa and India agree that paranoid formations in schizophrenic patients under their care are less systematized than in Euro-Americans (Hoch 1959, 1961). Wittkower and Dubreuil (1971) comment on the paucity of delusional content in these patients. "While chronic schizophrenic catatonic states have become rare in Europe and America, they are common in India and other Asiatic countries" (Wittkower and Dubreuil 1971). The philosophical tenets of Hinduism and Buddihism which consider emotional withdrawal as an acceptable mode of reacting to difficulties have also been implicated by Wittkower and Dubreuil. The current transcultural literature has been recently summarized by Murphy (Al-Issa 1982). According to him, "that Christians should have more delusions of destruction ... is most probably because of wrathful character of Old Trestament Scriptures ...".

Those psychiatrists who have had clinical experience in both the West and the East can attest to other differences. The intense emotional anxiety of the West is seldom seen in the East where confusion and preplexity predominate in early schizophrenics. The highly systematized, bizarre and idiosyncratic (i.e. culture discordant) delusions of the West are also less well seen in the East. The on-going WHO study "Determinants of Outcome of Severe Mental Disorder" has brought to light an interesting finding. Whereas there are differences across centres in the one-year incidence of first-incidence functional psychoses diagnosed clinically, translating the data to computerized CATEGO diagnosis gave incidence figure fairly comparable across the twelve centres in nine countries. The incidence rate on the basis of clinical diagnosis was one of the highest in Chandigarh which fell to about one-third when CATEGO criteria were applied, thus indicating that in Chandigarh (as also in some other centres), there is a sizeable incidence of non-schizophrenic psychotic breakdowns. Furthermore, the IPSS has documented a more favourable course and outcome of schizophrenia in the developing countries. It may be that, in the developed countries, the illness has a greater tendency to get more deeply entrenched and, hence, less amenable to therapeutic change.

Depression

The literature pertaining to depression is highly complicated. Till only decades ago, it was widely believed that depression did not occur in the non-Western, developing world (Carothers 1948). Ideas of sin and unworthiness were thought to be almost non-existent. Opler (1956) has tried to explain it on the basis of the individual's tendency to minimise free will, and to shift responsibility to groups or to shift grief to group rituals.

However, more recent research using more reliable tools and diagnostic criteria with cross-cultural validity has pretty much demolished the earlier notion regarding the incidence of depression in non-Western cultures. Not only depression occurs everywhere, the incidence of at least the endogenous forms is comparable. Relating it to less of guilt in developing countries is also being questioned. Ideas of sin or guilt are not uncommon in the East, although often these may be assigned to *karma* or to the deeds of a previous birth in groups subscribing to such beliefs. The tendency to somatize seems to be more common in the East. This may be related to the tendency to convert the anxiety from the psychic to the somatic. The current status of trans-cultural literature on depression has been summed

up by Engelsmann (Al-Issa 1982). He makes an interesting comment "...the non-Western cultures differ not in frequency, but in content of guilt feeling. Criteria for separating guilt from shame are difficult to establish...".

Mania

The classical effusiveness and frank grandiosity seen in the West is seldom encountered in India. What is usually seen is some sort of dysphoria, irritability, impatience and hostility.

Neuroses

There are considerable difficulties in defining neuroses to permit cross-cultural comparisons. The definition and diagnosis of neurosis is influenced to a considerable degree by the subject's perception of illness which may vary to a sizeable extent across socio-cultural groups. To illustrate, if a person comes complaining of a subjective sense of anxiety or sadness which he considers out of proportion to the external situation and which he views as an illness, to a very large extent, we also shall diagnose him to be suffering from the respective neurosis. Most of the cross-cultural differences in the incidence of mental illness, therefore, no wonder, pertain to the area of neuroses.

Certain types of neuroses require special mention though. It is a common knowledge that hysteria, especially in the form of convulsive "grand hysteria" has virtually disappeared from the West. In the West, in the last 80 years, there has been a steady influx of psychoanalytical material influencing all aspects of life : popular literature, art form, etc. The average man is inundated by the onslaught from such psychological material. It has been said that the reduction in hysteria has been related to the increase in psychological sophistication that has resulted from that. After all, hysterical conversion or dissociation represents relatively "naive" solutions to the problem of emotional conflict. You can almost see through the symptom; the camouflage is unsuccessful.

At the same time, virtually all cases of multiple personality have been reported from the West. In a paper (Varma, Bouri and Wig 1981), we have tried to speculate on the reasons for it. Multiple personality must be distinguished from possessional syndrome. In possession syndrome the personality establishes identity with a known person, his spirit or with a deity, whereas multiple personality represents expression of certain personality propensities not based on a specific, real person. It has been suggested that whereas polytheism may be related to possession syndrome, multiple personality represents the culturally sanctioned mechanism of role playing in the West.

Acute/reactive psychosis

Briefer, psychotic illness, often precipitated and supported by external events, have been reported from all cultures. There is reason to believe that it is more common in the non-Western countries. It is possible that the incidence of such psychotic illnesses represents a greater vulnerability of the basic personality to break down and to use psychotic rather than neurotic or normal defense mechanisms in the face of stress. Why do certain individuals or people in certain cultures use more of psychotic rather than neurotic or normal defense mechanisms? We shall speculate upon the reasons for it in a subsequent section. The WHO "Outcome" study has given some credence that such psychotic conditions represent non-schizophrenic, functional psychoses in certain cultures. It is possible that, partly, as these illnesses run a more benign and circumscribed course, the course and outcome of "schizophrenia" from the cultures rich in reactive psychoses has been reported to be more favourable.

Personality disorders and sexual deviation

These conditions are reported much less

frequently from the developing countries. It is not clear, if the true incidence of these is lower in the general population in these countries. However, possibly these are not perceived as illness, and, hence, not brought to the attention of the mental professional. These, as also drug dependence, may be viewed more as "habit" or "nature" rather than illness.

Dynamic and Formal Explanations to the Transcultural Differences

As I mentioned earlier, so far the model of transcultural psychiatry has remained at a phenomenological, descriptive model – in terms of describing either the so-called culture-bound syndromes, or to the transcultural differences in the manifestations, course and outcome of the different illness. The need now is to go from the descriptive to explanatory. More specifically, it needs to be seen how the transcultural differences in the personality configurations and psychological operations can be correlated with the cross-cultural differences in psychopathology to arrive at an understanding of these.

To start with, a number of explanations are needed. Individuals vary both within and across cultures in personality structure and psychological mechanisms. However, in comparing individuals, where inter-cultural differences appear greater than intra-cultural variations, the role of culture can be said to be significant. It is not said, by any means, that all individuals in a particular culture are alike, or that individuals in diverse cultures lack any commonality. However, commonalities in certain traits and variables bind individual members of a society with each other and differences, in general, on these as compared to other societies separate the members of the different societies from one another. Although there may well be a considerable overlap across cultures there is such a thing as a particular national personality or character.

Just like we are able to surmise the general differences in psychopathology across cultures, transcultural differences in the personality dimensions can also be concluded and the two correlated with each other. I have tried to offer formal and dynamic explanations for the transcultural differences in psychopathology on the basis of the differences in terms of the following variables.

National Character/Modal Personality

Cora Dubois, in her study of the people of Alor, gave the concept of modal personality, as the personality that is modal among the adult members of a particular culture. This concept, although apparently useful, has been widely criticized. Those critical of this concept point out that it obscures intra-societal differences and gives rise to stereotypies, often with pejorative and prejudicial connotations. The fact, however, remains that there is such a thing as a German personality, an Italian personality, a Japanese personality. To an outsider passing through the above three countries, the people in general will appear different across the countries. This is not meant to obscure individual differences within a culture, but to highlight how the cultures generally seem to differ from each other. The German is seen as perfectionistic and exact, Italian as gregarious and emotional, and so forth. Not all Germans or Italians will fit the above. However, the idea and purpose of developing such stereotypes is primarily as an aid in cognition. You cannot separately analyze and remember each individual, but can do so by lumping them into groups. The events, the observations, the objects have to be categorized as aids to cognitition It does not and should not imply, by any means, that all observations of objects in a particular category are exactly alike. Furthermore, such cate-

gorization should not give rise to value judgements or discrimination.

At a later stage, Inkeles and Levinson (1954) gave a definition of national character as follows :-

"National character refers to relatively enduring personality characteristics and pattern that are modal among the adult members of a society".

The task of describing each one of the societies in terms of its modal personality would be very difficult, if not well nigh impossible. Hsu (1972b) and his collaborators have tried to discuss a number of representative personalities. The emphasis has lately shifted from the simple, primitive societies that cultural anthropologists studied in the beginning of this century to the more complex national societies today. A number of major ethnic groups have been identified around the world, e. g. Western Euro-American, Japanese, Indian, Chinese, Sub-Saharan Africa, etc.

As an illustration to the interaction between culture, personality and mental illness, I propose to compare the "East" and the "West", with India and Euro-America, respectively, representing as the prototypes of the two. It is not assumed, by any means, that these two represent all the personality configurations in the different societies around the world. The two, however, stand in contrast in a number of ways, contrasting the developing, traditional with the developed, industrialized and urbanized. In this way, the two may represent extremes on a particular continuum. Also, the two represent large societies with long histories. Furthermore, India is clearly more relevant to us for obvious reasons, and America may represent the resultant of future changes that may be facing us, with its own problems and results not all of which may be desirable. Also, it is clearly conceded that it would be a folly to lump together all developing, pre-industrial societies in one basket and ignore the considerable differences across them. Many such societies may represent what I have labelled "island cultures" with lesser tradition rootedness and being more easily swayed by all external influences. Also, Western Europe and North America have been rapidly changing societies with new challenges being experienced and handled with each passing decade. It is with all these qualifications that the following contrast is offered.

(1) Dependence vrs. autonomy : "Dependence is an integral part of human existence. It has been pointed out that on account of the disparity between the dimension of the birth canal and the projected head size, the human infant must be born incomplete, partly 'baked' so to say, and much of development must be completed after birth, thus giving rise to a protracted period of dependence. The early dependence thus created influences all inter-personal relationships throught life." (Varma and Malhotra 1975).

Dependency as a key attribute of th Indian mind and culture has been earlier commented upon (Neki, 1975, 1976a, 1976b; Varma, 1982c, 1985b). It has been pointed out that the Indian person is more dependent upon each other than is the case, for example, in the Western setting. As children, we depend upon our parents. As we grow older, there is dependence upon peer group and spouse. When we grow old, the tables are turned, we come full circle, and we start depending upon our children. In this you have a beautiful system of inter-dependence with everybody leaning on everybody else. Many manifestations of this inter-dependence in social intercourse, and colloquial language and idioms and folklore have been pointed out by Varma (1985b). Most of the folklores as also popular literature and art-forms are centred around giving and receiving, a sense of piety, sacrifice,

submission and gratitude, and idioms give references to oral activities (e.g. he ate up the money, he digested the money, etc.)

A related attribute of the dependent personality is the strong sense of identity with the primary, filial group. Much of the life seems to revolve around the family groups and one's responsiblities and obligations towards it. Accordingly, there are different codes of conduct for those within and those outside the primary group. To illustrate, although Indian hospitality has been highly praised, it applies only to the members of the primary group, or to those who can be brought into the primary circle (hence need to draw outsiders into filial relationships). The Indian person can be quite rude and callous to a stranger and the Western egalitarian value of according respect and consideration to someone simply because he is a human animal appears to be relatively lacking.

Another related attribute is that pertaining to the concept of "fairness". Such a concept, in the Western sense, does not seem to exist. All actions of others are interpreted in personal terms, i. e. whether it is favourable or unfavourable to oneself. You are either a member of the in-group, in which case you are expected to do everything in the interest of the person; or else, you are an outsider.

The "Western" personality, on the other hand, is characterized by a sense of autonomy. The control over one's sphincters becomes the prototype of autonomy. This is my body, and I have complete control over and the responsibility for everything that it does - over my thoughts, emotions, actions and behaviour. This later gets generalized into greater self-reliance and a more acute awarenes of one's responsibilities, duties, rights and prerogatives on an individual basis. He should be able to look after his needs and aspirations and to resolve his problems. As he is self-reliant, he expects others also to be so, to look after themselves.

Associated traits of autonomy include competetiveness, acquisitiveness and orderliness. These indicate the adequacy of fulfilment of his roles vis-a-vis those of the others. There are limitations not only in expending, but in some ways, accepting help. In the Western literature and idiom, one finds copious references to "anal" activities, like messing up, dirtying, and abhorrence of loss of control over oneself.

A related concept, most developed by Marriott (1976, 1977, 1979) is that of ego-boundaries. A sense of personal identity requires that the person is able to distinguish between himself and others - "me" vrs. "not me". This is my corpus and everything that lies outside is not-me. As Marriott has pointed out, in contrast to the generally closed, homogeneous and enduring mental integrations attributable to the adult persons in the West, the Hindu adults are posited as persons "who are open, composed of exogenous elements, substantially fluid... and thus necessarily changing and intechanging in their nature.... Given the vulnerability of open Hindu persons to a cosmos of interpersonal flow, persons as wholes cannot be thought of enduring or bounded 'egos' in any Western sense".

Thus, the Indian person functions in an on-going close relationship with the society. Rather than perceiving himself as an individual in his own right, he mostly looks upon himself as an integral part and parcel of the social systems; the boundaries between "me" and "not-me" get blurred. The individual needs and aspirations, values and conflicts become indistinguishable from those of the society.

The dependent individual accordingly develops certain other characteristics attributable to dependence. For example, being simply a part of the society, he is most

"open" and lacks the sense of confidentiality as compared to the autonomous individual. That a person can have secrets in relation to the society at large is not acceptable as a social value. The rules and dictates are not clearly seen as emanating from without but something in which the person has direct role to play. Accordingly, the blind obedience to external authority may be lacking and morals may be more flexible and, at times, may appear more corruptible.

The autonomous individual on the other hand makes sharp distinctions between him and others. He likes to look after his own needs and not to have to depend on others for its. He is more aware of his individual rights and prerogatives. He also likes to maintain complete control over his body; over his actions, thoughts and emotions. As the individuals are viewed as relatively separate from each other, it leads to a greater amount of competitiveness and acquisitiveness. Greater adherence to orderliness, cleanliness and punctuality are also necessary.

However, it is obvious that neither total dependence nor total autonomy are possible in any society. Dependence and autonomy are always relative. A total dependence which results in total submission and reduces a person to almost non-existence will not be tolerated. At the same time, complete autonomy is not possible. The concept of complete autonomy actually negates that man has social needs. No man can be an island into himself. As Hsu (1972 a) has beautifully pointed out: "But American self-reliance is a militant ideal which parents inculcate in their children. This is the self-reliance about which Ralph Waldo Emerson wrote so eloquently and convincingly in some immortal pieces.... However, it is obvious that no individual can be self-reliant. In fact, the very foundation of the human way of life is man's dependence upon his fellow human beings...."

(2) Social ethos and communal responsibility: In certain ways, there seems to be a selfish outlook as far as the Indian Person is concerned. To illustrate, although personal cleanliness is highly valued, e.g. taking bath once or several times a day, washing, etc., one does not bother much as to where the polluted water goes and how it may affect others adversely. Such selfishness is also manifested in one's relationship with God. For the holy dip in Ganga at the time of *Kumbh Mela** one does not mind even if he has to trample over ten women and twenty children, as long as he succeeds in attaining the holy dip. In a way, "everyone is responsible for his own salvation".

In a larger sense, the rules of social interaction in the Indian context are defined largely in an ego-centric and intuitive way. According to a Sanskrit saying, the code can be simply summed up in three things: considering all women as mother, considering things of others as valueless and considering all human beings as oneself. Do unto others as you would want them to do to you. This simplicity contrasts greatly with the elaborate social codes developed in certain religions. One is reminded of the Jewish Rabbis sitting over two centuries in Tiberias developing, in minutest details, the moral and social codes.

(3) Omnipotence and narcissism: A sense of narcissism prevails to different degrees in all cultures and can be said to have psychological survival value. After all, man cannot reconcile himself to the fact that he is just one out of 4.8 billion men on the earth, which itself is a mere speck in the universe. Denial of this fact results in emergence of man's narcissism and omnipotence. As Popper has pointed out, the clear

* An important religious fair held every 12 years in which devotees take a dip in the holy Ganga.

sky above (which reminds him of the universe) and his own intellect (which helps him comprehend and transcend the universe) are the two most important aspects of human existence. The same sense of omnipotence militates against the idea that human life itself is finite in time (Varma 1985a). In the Indian setting, such omnipotence betrays itself in epics and folklore. When Arjuna shoots one arrow, it can kill a thousand foot-soldiers, but when a thousand arrows hit Arjuna, it injures his chest only slightly.

(4) Obsessionality : One thing that strikes the Westerner in India is the lack of compulsivity in performing a job. The predominant approach towards work seems to be to do it as casually as you can get by with. There seems to be a lack of pride in doing a job well. *"Chalta hai"* (will do) seems to be the prototype of one's responsibilities. The Western work ethic and compulsivity, meticulousness and thoroughness are generally at a low premium. One is reminded of the saying of Lord Chesterton : "If anything is worth doing at all, it is worth doing it well".

It is not easy to explain the East-West differences in the above. It can be speculated that like all obsessional traits, the Western obsessionality also has a magical quality. As long as you do everything perfectly, all will be well and dangers will be avoided. On the other hand, it can be said that with our long history and tradition, we have gradually become somewhat more cognizant of the futility of obsessive adherence to details. Perhaps, at some time in our historic past, we have tried these and found them to be inadequate to answer the basic issues of human existence.

(5) Duality in value systems : In-built contradictions in moral and social values abound in virtually all cultures. The contradiction between free-will vrs. determinism prevails, more or less, in all cultures. Your fate is pre-ordained, but you must do things to improve it, though even your wisdom is pre-determined. In the Western context, as Hsu (1972a) has pointed out, the following illustrate some of the contradictions in social values :

"1. Christian love with religious bigotry.

2. Emphasis on science, progress and humanitarianism with parochialism, group-superiority themes and racism.

3. Puritan ethic with increasing laxity in sex mores.

4. Democratic ideals of equality and freedom with totalitarian tendencies".

(6) Preoccupation with peace and fear of aggression : In the Indian society, one is struck by a great deal of preoccupation with peace. The religious functions begin and end with incantations for peace. Such an over-preoccupation with peace may indicate a decadent rather than a developing society.

What is, after all, peace. Peace can be said to be the opposite of violent activity, maybe all activities which upset things, maybe a reversal to the primoridal state, like the Nirvana. Such a peace is also exemplified by the Islamic greeting "Assalam Aalekum" – peace be with you.

(7) Tradition – orientation : In view of its long, unbroken history, it is not surprising that the Indian mind is highly tradition-oriented. Nehru in his "Discovery of India" spoke of our tradition-rootedness as an impediment to change and development. In a way, such traditionalism makes for a certain stability in the social structure. Progress, in the present sense of technological progress, must not be viewed simply as a matter of moving forwards or upwards. There are many forces which restrict, retard or undo such "progress". In this matter, we Indians can be said to differ from several small na-

tions with traditions not going so far back in history and which are more easily swayed by every passing external influence (the so-called island cultures).

To contrast, the predominant North American, Western personality traits can be summarized as consisting of the following (Coleman 1940, Cuber and Harper 1948).

1. Concern with lack of control over oneself

2. Righteous indignation, punitive super-ego

3. Compulsivity, pride in doing a job well, Activity and work highly valued.

4. Reference in colloquial language about messing, dirtying

5. High guilt-proneness

6. Acquisitiveness

7. Insecurity, lack of permanency, competitiveness

8. Abhorrence of dependence

9. Contradictions in social values

10. Belief in equality of all, Humanitarian and egalitarian mores.

11. Belief in individual freedom

It is understandable that an autonomous individual will be concerned with lack of control over oneself. As he is supposed to have total control over oneself, he alone has to accept responsibility for any lapse and he cannot share it with others. At the same time, he expects others to be self-reliant and in control of themselves, thus giving rise to righteous indignation. Compulsivity, competitiveness and acquisitiveness may be viewed as attributes of the autonomous personality. With weakening of social bonds and increasingly ephemeral relationships, he feels insecure.

The Indian mind, thus, lacks certain attributes of the Western personality. The concern with lack of control over oneself is not so great or so anxiety-or guilt-provoking. The responsibilities are shared. The punitive super-ego and righteous indignation of the Western, Puritanical, Calvinist society are difficult for an average Indian to understand. Finally, as opposed to the Westerner, the Indian is better able to extend support to and accept it from his fellow human beings.

In the larger sense, the transcultural differences in personality configurations can be understood in terms of the basic human needs. These can be conceptualized as follows:

(1) Biological needs: We are all born with certain undeniable biological needs. These include nutritional, eliminative and sexual needs. Societies differ in the manner in which such needs are handled. Denial, projection or reaction formation may characterize our attitudes towards these basic, biological needs. On the other hand, there may be more ready acceptance or sublimation of these. Denial seems to characterize how the Indian mind reacts to these requirements. Denial of nutritional needs are characterized by observing fasts and food fads. Eliminative and sexual needs are shrouded in mystery. As a matter of fact, the so-called "modesty" is mostly related to the denial of the eliminative and sexual needs.

In a way, it can be said that the Western man is similar to the Indian in the basic attitude towards biological needs. This is not surprising considering the commonalities in our history. It must be understood that the present, apparent permissiveness in the West in matters of sexuality does not represent a basic change in their values. They do it, often with a vengeance, but at a tremendous emotional cost in terms of guilt and anxiety. On the other hand, the Orientals, e.g. the Chinese and the Japanese, seem to have a more open and accepting attitude

towards biological, especially eliminative, needs.

(2) Social relationships and needs : Man is a social animal. His altriciality, his ability to communicate with other humans and his capacity for empathy underline his relationship with the society. This relationship has been most conveniently understood on a dependence-autonomy continuum. Personal vrs. group identity and delimitation of ego-boundaries may also be related to it.

As the super-ego represents internalization of the social and moral values, one other aspect of the social relationship is the nature and configuration of the super-ego. In different cultures, the super-ego may be more or less assimilated in the psyche, thus giving rise to guilt-or shame-orientation. In secondary-group dominated societies, where independence is emphasized, super-ego is more deeply internalized giving rise to guilt-orientation (Varma 1985c). On the other hand, where interdependence weaves the social pattern, and control of behaviour continues in the form of interpersonal surveillance, the society develops shame-orientation (Neki 1976a).

(3) Cosmic, existential and religious needs : Societies can differ from each other in terms of cosmology and existential-religious belief systems. Some concept of cosmology has been reported from all societies and it is truly one of the "universals" of human societies. The cosmos can be viewed as finite or limitless, within or outside one's control. Also, some speculation of the nature and meaning of one's existence permeates most societies. Man likes to know where he came from, where he will go, what was here before he came and what will it be like after he is gone and what happens to him after his death. He tries to transcend his own existence, admittedly though with limited success. Narcissism will not let him accept that he is simply like other matter and that life is finite. The concept of the continuity of life finds expression either in the belief of re-incarnation or of a final resting place after death.

The concept of God evolves as one of the most important belief systems of man. To start with, God was conceptualized to explain the unexplainable, especially natural events, particularly the cataclysmic and catastrophic ones. In the beginning, most societies were accordingly nature-worshipers. God represents an abstraction of the forces and laws of nature. However, the amount of concreteness vrs. abstractness in the concept of God varies from society to society. The various gods worshipped by Hindus also represent varying levels of abstraction.

Ages of Mankind

As the society is a conglomerate of individuals, it can be argued that the needs of the society should be comparable to the needs of the persons. Dynamically speaking, the problems of human existence can be understood in terms of man's coming to terms with, adequately mastering, as it were, his drives in harmonious relationship with his environment, including the people in it. Just as the individual personality develops in an attempt to master and fulfil the basic human needs in an optimal manner, the society also develops by its attempt to enable fulfilment of the same biological and psychological needs of man, as well as additional socially generated needs.

Depending upon the major biological concerns, societies can manifest variable degrees of "oral", "anal" and "general" traits which may find reflection in the individual personality. It can be said that, so far, the different cultures have been primarily battling with the fulfilment of basic biological needs, especially nutritional eliminative. It is hoped that, in the centuries to come, we shall advance not only to the "ge-

nital" level based on full acceptance of sexual needs, but would go further to what Erikson has so well described as creative, generative and integrative personalities.

Linguistic competence

Language is a species-specific attribute of Homo sapiens. "Every human society has a language and no animal society has one" (Brown 1965). However, the various communities of man differ from one another in type and organization of languages used. Languages differ from one another in such basic things as classification of words and rules of syntax. The Indo-European classification of words into nouns, verbs, adjectives, etc. is not universal, and word order is not very important in some languages.

We owe to Benjamin Whorf (1950) the Sapir-Whorf hypothesis that language and thought go together and that language limits (and facilitates) particular concepts. When linguists became able to examine widely different languages, they noted that language "is itself the shaper of ideas, the programmer and guide for the individual mental activity, for his analysis of impressions, for his synthesis of his mental stock in trade" (Whorf 1961). "Language is a determinant of the conception of reality, a model shaping the mind as well as a code connecting minds" (Brown 1965, P. 314). It is reasonable to conclude that "the language and thought of a people develop together" (Brown and Lennenberg 1954).

The differences in the world view between languages may be in such simple things like the number of colours names to more complex differences in temporal and spatial relationships. Time can be taken as a flowing system or as a static material. "... as U.N. translators observe, different languages seem to imply different attitudes – the English pattern is said to be pragmatic and inductive, the French generalizing and deductive, the Russian intuitional and particular" (Lotz 1961). Languages promote greater precision in expression of those things that matter most in a particular society. Thus, you have 92 varieties of rice in Hanunoo in the Phillippines as opposed to 92 varieties of engineering at the H.I.T. There are approximately half-a-dozen equivalents of 'uncle' in Hindi. There is no clear Hindi equivalent of "how often".

On the basis of the considerable transcultural differences in the phenomenology and outcome of mental illness on the one hand and languages on the other, I have put forward the hypothesis (Varma 1982b) that the two can be inter-related. More specifically, it has been proposed that the linguistic competence (i.e. the intrinsic ability) importantly determines the phenomenology of schizophrenia.

In the context of schizophrenia, Arieti (1955) has outlined an innovative, longitudinal view of the mental operations. The first stage starts from a period of intense anxiety, panic, confusion and perplexity and culminates in achievement of psychotic insight: "Aha! I am not afraid for no reason, but because people in general and so-and-so in particular are conspiring to harm me". However, this regression into a psychotic insight does not fully resolve the anxiety. As Arieti (1955) has pointed out, the anxiety leads to regression to but not an integration at a lower level of functioning, thus leading to furher regression.

Whether schizophrenia is based on an intense anxiety psychogenetically determined or on an organic "defect", I have proposed that language may take over from the intense anxiety or organic defect, and set into motion a reverberating cycle, with increasing elaboration of delusions. As the delusions do not fully bind the anxiety, a vicious cycle results causing the delusion to become more and more systematized and elaborated and also entrenched, thus mak-

ing them less amenable to therapeutic change. It has been proposed that a high linguistic competence may lead to the above, whereas, in case of low linguistic competence, the anxiety may remain unbound, or give rise to catatonic and somatic symptoms. The same high linguistic competence which is an advantage in logical and analytical thinking, becomes a bane when trying to resolve the psychotic anxiety or "defect". It is possible that linguistic competence can thus determine the sub-type of schizophrenia manifested, and possibly also of psychosis, neurosis, or mental illness in general.

In order to test out the above hypothesis, we have constructed a test of linguistic competence applicable to North India (Varma et al 1985) consisting of eight sub-tests. The linguistic competence thus measured is relatively independent of intelligence. It also does not differ between normals and schizophrenics which is consistent with the available literature that linguistic competence is not impaired in schizophrenia (Koplin 1968). The test of linquistic competence, thus constructed, was administered to 15 patients each of acute, paranoid and chronic schizophrenia; manic depressive psychosis; and anxiety, hysterical and obsessive-compulsive neurosis. In general, paranoid schizophrenics and obsessional and anxiety neurotics scored highest and chronic schizophrenics and manic depressives lowest on the test (Varma, Das and Jiloha 1985). The study thus suggests that the above illnesses may be phenomenological correlates of high and low linguistic competence, respectively, and thus extends support to our theory that linguistic competence may importantly determine manifestation of psychopathology. A study of the relationship of linguistic competence with the course and outcome of illnesses currently underway. It is also important to study if differences in linguistic competence can help explain the transcultural differences in phenomenology and course of mental illness, for which a cross-culturally valid tool of linguistic competence needs to be developed.

Cognitive Styles

Cognitive styles represent the ways in which the mind perceives the environment, interprets it and draws conclusions about it. That inividuals and cultures differ from each other in cognitive styles appears to be a reasonable assumption. The cognitive style can be characterized as "analytical" at one extreme and "synthetic-gestalt" at the other. The analytical mind tries to understand a thing or a phenomenon by breaking it into parts. If you cannot understand something, break it into halves; if you still cannot understand it, break each half into two again, and so forth. The synthetic mind, on the other hand, tries to see things or phenomena in the totality and see the relationships between them. This perception is field dependent. The difference between the two styles, to a certain extent, can be viewed as between seeing things and seeing relationships. In this continuum, the Western mind has been classically analytical. The analytical reasoning that we owe to Aristotle, has served science and technology well. However, lately its limitations are becoming more apparent and it is being attacked, for example, by the general systems theorists who point out that human behaviour cannot be simply understood in parts. The Indian mind, on the other hand, is synthetic in its cognitive style. Relationships between things are more important than the things themselves. The synthetic style is helpful in quickly deriving conclusions from observations. It is also more conducive to the development of a unitary, holistic concept, e.g. of cosmology. The synthetic style is also evident by such things as attending to several things simultaneously. The Western approach, on the other hand, has been to attend to things seriatum one

thing at a time. Faced with more than one thing requiring his attention simultaneously quickly confuses the Westerner. The Indian, on the other hand, thrives on attending to several things at a time, interdigitating them with each other.

It is possible that the cognitive styles may be related to the dependency-autonomy continuum. The synthetic style may be more consistent with the useful in case of dependence and loose ego-boundaries in the relationship of individual with society. On the other hand, an autonomous individual may prefer analytical approach in his relationship with the environment.

Social Support System

With increasing transcultural research, the differences across cultures in the social support system have been correlated with course and outcome of mental illness. The same traditional, developing societies which are richer in social support network have also been shown to have a better prognosis of severe mental illnesses (WHO 1973, 1979). One aspect of this research, intra-culturally, has been the elucidation of the relationship of joint vrs. nuclear families with outcome. In the Indian context, such research have been reviewed by Sethi and Sharma (1982). The conclusion seems to be somewhat ambiguous. It may also be kept in mind that if you have many members in the family who can extend support to a mentally ill member, at the same time, you have so many more members who can perceive and be influenced by abnormality and tolerance for deviance may, accordingly, decrease.

A very fruitful area of research in the field of social network has been that of "expressed emotions". Relatives' expressed emotions, especially critical comments and hostility, have been correlated with adverse prognosis. As much has already been written about it, we need not discuss it here further.

Material Culture

Culture has been defined as those aspects of the environment that are man-made, including subjective environment, which consists of the beliefs, values, norms and myths and the physical environment which is comprised of artifacts like roads, bridges, buildings, etc. (Al-Issa, 1982).

It is understandable that the nature of material culture may influence the psychopathology. The same malevolent force may be perceived as a spirit of a ghost in a developing society and as X-rays and radiowaves in a technologically advanced society. It seems that now we are moving even further into implicating extra-terrestrial forces (Martiana, UFO's, Pulsars, etc.) into our delusional systems.

Psychological Sophistication

Although hard to define exactly, phychological sophistication can be perceived as the ability to see conflicts in intrapsychic terms. In other words, the conflict is perceived as within the mind, or more specifically, between the components of the psychic structure. By corollary, the conflict is not simply lying in or due to external situtions, environment or persons. Even though it emanates from without, it is due to the inability of the psyche to optimally handle it. In this way, the conflict cannot be ascribed directly, for example, to social prohibitions, external authority or malevolent spirits.

Psychological sophistication may be related to coping mechanisms and certain types of neuroses, especially hysteria as discussed earlier. It may also give rise to high introspecton as a mental attribute to understand and resolve conflicts.

Personality, Coping Mechanisms and Illness

In the context of schizophrenic psychoses, Manfred Bleuler (1979) comments :

"...unhappiness can reach a threshold...when the patient autistically withdraws from reality under overwhelming stress, when he thinks, acts feels as if he is not in the real world but in a world...adapted to...the dysharmony between his needs and reality." However, referring to his illustrious father, he comments that "he did not answer the question of why the schizophrenic individual tries to defend his ego in the Schizophrenic way and not in the way of a neurotic or healthy person".

It is possible that the culturally-detemined personality attributes may important ly influence coping mechanisms and mental illness. When faced with emotional conflict, a passive-dependent person may be likely to more easily "give up", throw in the towel, so to say. He may, thus, be more prone to break with reality, develop psychotic coping behaviour. On account of close ties with the society, he can more easily turn to them to be taken care of. He may also develop hysterical and somato-form disorders, so as to involve other members of the society in its resolution. On the other hand, an autonomous individual, on account of his abhorrence of loss of control and rejection of his dependency needs, may try to resolve his conflicts himself - at the intrapsychic level. He may keep on battling with the anxiety, unbound, or may convert them into development of neurotic-type distress.

There are clear limitations in the ways in which a person can react when faced with an emotional conflict. The total repertoire of human behaviour, normal as well as abnormal, clearly do not exhaust all that can be theoretically possible. The person can continue to battle with the conflict and the resultant anxiety. Alternatively : (a) the anxiety can be channelized into neurotic symptoms which magically or expediently control it, e.g. phobia, obsession, somatization or depression ; (b) the anxiety can lead to avoidance of really or potentially anxiety-provoking situations, e.g. constraints in interaction as exemplified by personality disorders, or (c) it can be resolved by renunciation of reality. It is possible that the personality configuration, either individually or culturally shaped may influence the choice made. The subsequent elaboration and proliferation of the symptomatology may depend, to a certain degree, upon the various socio-cultural factors as earlier discussed.

Culture and Psychotherapy

"As psychotherapy is predicted upon a linguistic system of communication of thoughts and emotions, it is inevitable that cross cultural differences in these would be relevant to psychotherapy and must be taken into account in ascertaining suitability of and in adopting psychotherapy for a particular culture" (Varma 1985a). Wittkower and Warnes (1974) have emphasized that, to be popular, psychotherapy should be consistent with the socio-philosophical background of the people. The Western model of psychoanalysis which involves as interaction, a contract indeed, between two autonomous and individually responsible adults as a relatively equal level 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 being consistent with the respective social values (Varma 1982c).

It is important to analyse the cultural relativity of the values and premises on which the Western psychotherapy is based, so as to adapt it to suit the needs of a particular culture. As I have already dealt with these in my other publications (Varma 1982c, 1985a, 1985c), I shall refrain from going into details regarding these. As I have point-

ed out, the cross-cultural differences in the following personality variables and social values need to be taken into account.

(1) Dependence vrs. autonomy : In view of the high tacit dependence of Western psychotherapy on autonomy and personal responsibility, variation in it needs to be taken into account for the local setting.

(2) Psychological Sophistication, introspective and verbal ability : As psychotherapy requires the ability to see conflicts in interpsychic terms, to introspect and to translate one's emotions into words, the cross-cultural differences in these need to be taken into account in psychotherapy.

(3) Need for confidentiality and nature of dyadic relationship : In view of the considerable differences across cultures in the need for and right to confidentiality and to withhold information, the strictly one-to-one relationship which is the hallmark of the conventional psychotherapy needs to be examined.

(4) Personal responsibility for decision-making : Although offered as suggestions and explanations, the final responsibility for accepting interpretations and acting on it rests with the patient. In some cultures, patients may expect a more assertive and definitive attitude of the therapist.

(5) Nature of guilt vrs. shame : Operating intra-psychically, psychotherapy is more suited for guilt-prone societies, as shame prone societies require presence of others to operate. "It is possible that whereas the societies following the Judeo-Christian religions are guilt-prone on subscribing to the view that man was created in sin, and hence attempts to absolve him from such sin (Christ died for our sins, saving one's soul, concept of damnation, etc.), the Eastern religions do not subscribe to guilt as a prerequisite to human existence" (Varma 1985a).

(6) Religious and social belief-systems : These belief systems, especially those related to cosmology, free will vrs. determinism, fatalism, re-incarnation/after life and one's responsibility in context of the above can importantly influence the conduct of psychotherapy.

(7) Patient's expectation : The expectation with which the patient approaches the exalted position of the therapist (what Torrey, 1972, calles the 'edifice complex') can importantly determine the conduct and outcome of psychotherapy, and there may be considerable cross-cultural differences in the expectation, trust and faith reposed in the therapist.

(8) Social distance between the patient and the therapist : The equilitarian model on which the Western psychotherapy is predicated may not be suited to traditional societies with large social differences between doctors and patients and a tendency on the part of the patient to substitute a filial in place of a purely professional relationship.

To sum up, the conventional psychotherapy is coming under increasing attack, partly on account of its lack of flexibility. The very basic premises of psychotherapy are being questioned. It must reconcile itself to the socio-cultural realities, so as to evolve a transculturally valid definition and methodology adaptable to changing circumstances.

Conclusion

The individual operates in a dynamic relationship with the culture of which he is a member. The culture exerts powerful pathoplastic and pathogenic influences, in addition to health-sustaining effects. The human personality, in health and illness, must be understood in the context of cultural and social factors, in addition to individual variables. The transcultural differences in phenomenology, course, outcome and treatment of mental illness must be synthesized with the dynamic interaction with the cultural factors.

Just like the individual personality develops in an attempt to resolve the basic needs, the society develops in trying to find a common solution to individual needs – biological, social, cosmic, religious and others. The health sustaining aspects of culture are illustrated by customs and rituals, as well as sanctions and institutions. In so far as these subserve defensive functions, these can be called cultural defenses".

The transcultural differences in psychopathology can be understood by correlating these with socio-cultural factors. Important among these are : (1) national/modal personality configuration especially in terms of ego-boundaries, dependence vrs. autonomy and social ethos as underlying the relationship of individuals with each other, and in approach towards fulfilment of basic biological, social, cosmological, existential and religious needs, (2) linguistic competence, i.e. the intrinsic language ability ; (3) cognitive styles; (4) social support system; (5) material culture ; and (6) psychological sophistication. The socio-cultural factors also need to be considered and taken into account in adapting psychological treatment to suit the needs of a particular society and culture. In this fashion, a dynamic model of transcultural psychiatry would emerge.

Bibliography

AL-ISSA, I. (1982) Culture and Psychopathology. Uiversity Park Press, Baltimore.

ARIETI, S. (1955) Interpretation of Schizophrenia. Robert Brunner, New York.

BENEDICT, R. (1935) Patterns of Culture, Routledge and Kegan Paul, London.

BENEDICT, R. (1959) Continuities and discontinuities in cultural conditioning, in Personality in Nature, Society and Culture, 2nd edn., C. Kluckhohn and H. A. Murray (eds.), Alfred A. Knopf, New York.

BLEULER, M., (1979) On schizophrenic psychoses. *American Journal of Psychiatry,* 136 : 1403-1409.

BROWN, R. and LENNEBERG, E. H. (1954) A study in language and cognition. *Journal of Abnormal and Social Psychology,* 49 : 454.

CAROTHERS, J. C. (1948) A study of mental derangement in Africans and an attempt to explain its peculiarities more especially in relation to African attitude to life. *Psychiatry,* 11 : 47-85.

COLEMAN, L. (1941) What is America : A study of alleged American traits. *Social Forces,* Vol. xix, No. 4.

CUBER, J. F. and HARPER, R. A. (1948) Problems of American Society : Values in Conflict, Henry Holt & Co., New York.

FROMM, E. (1959) Individual and social origins of neurosis. in *Personality in Nature, Society and Culture,* 2nd edn., C. Kluckhohn and H. A. MURRAY (eds.), Alfred A. Knopf, New York.

GORDON, H. L. (1934) Psychiatry in Kenya colony. *Journal of Mental Sciences,* 80 : 167.

HALL, C. S. and LINDZEY, G. (1968) The relevance of Freudian psychology and related viewpoints for the social sciences, in, *The Handbook of Social Psychology,* Addison-Wesley Pblishing Co., vol. I, pp. 245-319.

HOCH, E. M. (1959) Psychiatrische Beobachtungen and Erfahrungen an Indischen Patienten, *Praxis (Berne),* 48 : 1051.

HOCH, E. M. (1961) Letter. in : *Transcultural Psychiatric Research Review,* No. 11, 65.

HSU, F. L. K. (1972a) American core value and national character, in Hsu, F. L. K. (ed.) *Psychological Anthropology,* New ed., Schenkman Publishing Co., Cambridge, Mass., 1972.

HSU, F. L. K. ed. (1972b) Psychological Anthropology, New ed., Schenkman Publishing Co., Cambridge, Mass., 1972.

HONIGMAN, J. J. (1972) North America. in *Psychological Anthropology,* New ed., F. L. K. Hsu (ed.) Schenkman Publishing Co., Cambridge, Mass.

KOPLIN, J. H., (1968) Applied Psycholinguistics : Aim and current status. in Developments in *Applied Psycholinguistics Research.* S. Rosenberg and J. H. Koplin (edn.). Macmillan, New York.

LINDGREN, H. C. (1969) An Introduction to Social Psychology. John Wiley and Sons, Inc., New York.

LOTZ, J. (1961) Linguistics : Symbols make man. in *Psycholinguistics : A Book of Rea-*

dings, S. Saporta (ed.), Holt, Rinehart and Winston, New York.

MARRIOTT, M. (1976) Interpreting Indian Society: A monistic alternative to Dumont's dualism. *Journal of Asian Studies*, 36(1): 189-195

MARRIOTT, M. (1979) The open Hindu person and humane sciences. Unpublished paper.

MARRIOTT, M. and INDEN, R.B. (1977) Toward an ethnosociology of South Asian caste system. *In the New Wind: Changing Identities in South Asia*. K. David (ed.), Mouton, The Hague.

NEKI, J.S. (1975) Psychotherapy in India: Past, Present and future. *American Journal of Psychotherapy*, 29: 92.

NEKI, J.S. (1976a) An examination of the cultural relativism of dependence as a dynamic of social and therapeutic relationship. I. Sociodevelopmental. *British Journal of Medical Psychology*, 49: 1-10.

NEKI, J.S. (1976b) An examination of the cultural relativism of dependence as a dynamic of social and therapeutic relationships. II. Therapeutic. British Journal of Medical Psychology, 49: 11-22.

OPLER, M.K. (1956) Culture, Psychiatry and Human Values, Charles C. Thomas, Springfield.

SETHI, B.B., and SHARMA, M. (1982) Family factors in psychiatric illness. *In Readings in Transcultural Psychiatry*, Ari Kiev and A. Venkoba Rao (eds.), Higginbothams Ltd., Madras.

TOOTH, G. (1950) Studies in mental illness in the Gold Coast. London: Her Majesty's Stationery Office. *Colonial Research Publication*, 6.

TORREY, E.F. (1972) The Mind Game: Witchdoctors and Psychiatrists. Emerson Hall, New York.

VARMA, V.K., (1982a) Toward a theory of cultural defenses. *In Readings in Transcultural Psychiatry*, Ari Kiev and A. Venkoba Rao (eds.), Higginbothams Ltd., Madras.

VARMA, V.K. (1982b) Linguistic competence and psychopathology: A cross-cultural model. *Indian Journal of Psychiatry*, 24: 107-114.

VARMA, V.K. (1982c) Present state of psychotherapy in India. *Indian Journal of Psychiatry*, 24: 209-226.

VARMA, V.K. (1985a) Psychosocial and cultural variables relevant to psychotherapy in the developing countries. In *Psychiatry: The State of the Art*. vol. 4: Psychotherapy, Psychosomatic Medicine. Plenum Press, pp. 159-165.

VARMA, V.K. (1985b) The Indian mind and psychopathology. *Integrative Psychiatry*, 3: 290-296.

VARMA, V.K. (1985c) Culture, personality and psychotherapy. Paper presented at the XIII International Congress of Psychotherapy, Opatija, Yugoslavia, October, 1985.

VARMA, V.K., AGARWAL, R.K., DAS, K. and JILOHA, R.C. (1985) Linguistic competence and psychopathology: Construction of a test of linguistic competence. *Indian Journal of Psychiatry*, 27: 183-191.

VARMA, V.K., BOURI, M. and WIG, N.N. (1981) Multiple personality in India: Comparison with hysterical possession state. *American Journal of Psychotherapy*, 35: 113-120.

VARMA, V.K., DAS, K. and JILOHA, R.C. (1985) Correlation of linguistic competence with psychopathology, *Indian Journal of Psychiatry*, 27: 193-199.

VARMA, V.K. and MALHOTRA, A.K. (1985) Dependency and psychotherapy of drug addiction. Paper presented at the XIII International Congress of Psychotherapy, Opatija, Yugoslavia, October, 1985.

WHO (1973) International Pilot Study of Schizophrenia, World Health Organization, Geneva.

WHO (1979) Schizophrenia: An International Follow-up Study, John Wiley, Toronto.

WHORF, B.L. (1950) Four Articles on Metalinguistics, Foreign Service Institute, Washington.

WHORF, B.L. (1961) Science and linguistics. In S. Saporta (ed.) *Psycholinguistics: A book of Readings*, Holt, Rinehart and Winston, New York.

WITTKOWER, E.D. and DUBREUIL (1971) Reflectons in the interface between psychiatry and anthropology. in Interface between Psychiatry and Anthropology. Iago Galdston (ed.), Brunner Mazel, New York.

WITTKOWER, E.D. and WARNES, H. (1974) Cultural aspects of psychotherapy. *American Jornal of Psychotherapy*, 28: 566.

A note on Silver Jubilee Conference of IASP held at PGIMS, Rohtak, 2018

An Ode to the Silver Jubilee Conference of Indian Association for Social Psychiatry: Too Long a Time to Reach Here? Or too Short Perhaps?

Abstract

Standing on the vantage point of the Silver Jubilee National Conference of the Indian Association for Social Psychiatry, what have we learned, achieved, accomplished? We held a large number of conferences, have made a number of collaborations. However, most importantly, we have survived! This is, to my mind, no mean task, given the unrelenting ascendancy of biological psychiatry. Social psychiatry must be seen in a global context and in the backdrop of major threats to our civilization. Any discerning person, who himself has survived five decades of psychiatry, would vouch for the bare fact that "no psychiatry is complete without social psychiatry." Indeed, I would even go as far as to assert that "social psychiatry is core psychiatry." The few issues that I have highlighted in this perspective – and I am sure there are many more – simply go to show that, in this era of living in a global village, social psychiatry will continue to live forever!

Keywords: *Global, Indian, psychiatry, social*

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Winston Churchill, who wrote the multi-volume history of the Second World War, as also the History of the English speaking People, is said to have remarked: "History will be kind to me, as I intend to write a large part of it myself."

Introduction

Silver Jubilee of any event is a favorite time to look back, look around, and look forth. It is a time when the event (birth, marriage, and conference!) has reached a reasonable maturity to pause, reflect, count the blessings (and the barriers), and to look forward to a more meaningful and satisfying future. I am glad that the present editor of the Indian Journal of Social Psychiatry has invited me to do these things, standing from the vantage point of the 25th National Conference of the Indian Association for Social Psychiatry (IASP), of which I happen to be one of the founding members, its first Secretary-General, later its President, and now its Patron.

The idea that later blossomed into the formation of the IASP was mooted at the Transcultural Psychiatric Meet held in Madurai, Tamil Nadu, on 23–25 August 1981. It was felt that it may be desirable to have a separate professional organization at the national level in India for social and/or transcultural psychiatry. In addition to examining the social and cultural correlates of psychiatric disorders in its totality – the phenomenology, classification, course, and outcome as also its treatment – such an organization can examine the interface culture and personality and mental illness and engage in a scientific study of social issues relevant to the society and the nation.

Subsequent to the Transcultural Psychiatric Meet in Madurai, I consulted with the likely interested professional colleagues through a circular. In view of an overwhelmingly positive response to the formation of such an organization, a meeting of interested persons was convened to coincide with the annual conference of the Indian Psychiatric Society held in Madras (now Chennai) in January 1982. At this meeting, an *ad hoc* committee was formed with Col. Kirpal Singh as the Chairman and me as the Convener. At this meeting, it was decided to name the organization as the "Indian Association for Social Psychiatry." There was a considerable debate between "social" and "transcultural" in the name and scope of the organization, but eventually, "social" prevailed.

The subsequent formation and development of the organization took place both

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nationally and internationally. The *ad hoc committee* met on a number of occasions, often taking advantage of annual conferences and council meetings of the Indian Psychiatric Society to conserve time and costs. In addition, we engaged in close collaboration with the World Association for Social Psychiatry (WASP) and derived support, encouragement, and guidance from it. The WASP leadership was very supportive and kind including its stalwarts such as Joshua Bierer, Jules Masserman, Jack Carleton, A. Guilherme Ferreira, Jorge A. Costa e Silva, Alfred Freedman, Stanley Lesse, Alexander Gralnick, and others. At its 10th World Congress held in Osaka, Japan, in 1983, which I attended, the WASP Executive encouraged in the formation of the IASP and pledged its full support in every way possible. At the last meeting of the *ad hoc* committee held in Ranchi on January 14, 1984, the constitution was adopted; office bearer and council members were elected. IASP was fully launched!

The first conference of the Association was held at Kodaikanal on February 24th–25th, 1985 under the chairmanship of Professor A Venkoba Rao. The first issue of the Indian Journal of Social Psychiatry was published in 1985 under the editorship of Professor B. B. Sethi. The Association had as its office bearers leading mental health professionals of the country, who are acclaimed internationally for their professional achievements. Some of them included Professor A Venkoba Rao, Professor S. M. Channabasavanna, Professor B. B Sethi, Professor S. D. Sharma, Professor L. P. Shah, Professor Anil Shah, Professor N. Chakraborty, Professor P Kulhara, Professor S. C. Malik, Professor R. S. Bhatti, Professor J. K. Trivedi, Professor Savita Malhotra, and Professor Anil Malhotra. Some of these eminent persons are no longer with us; however, they all left their indelible impression and contribution to the cause of social psychiatry in India. Professor Roy Abraham Kallivayalil, one of the past presidents of IASP, has risen to the coveted position of the President of the World Association of Social Psychiatry, the world body which IASP is associated as a member society.

Objectives of Indian Association for Social Psychiatry

The purposes and objectives of the association as outlined in its constitution are as follows:

A. To study the nature of man and his cultures and the prevention and treatment of his vicissitudes and behavior disorders
B. To promote national and international collaboration among professionals and societies in fields related to social psychiatry
C. To make the knowledge and practice of social psychiatry available to professionals in social psychiatry and other sciences and to the public by such methods as scientific meetings and publications
D. To advance the physical, social, psychological, and philosophic well-being of mankind by such methods as the promotion of research and deliberations into it
E. To extend consultations and carry out charitable and voluntary work for the furtherance of the objectives mentioned above
F. To do all such things and matters that are incidental or conducive to the attainment of the above objectives.

If we look to see to what has been achieved so far, we can see there is definitely some satisfaction. Important national conferences have been held all over India year after year. There was a decision for some years that the national conference would be held once in 2 years. Further, internal problems and resource crunch at times stood in the way of holding annual conferences. Hence, the 25th year of IASP saw its conference held in Lucknow, in 2009, though chronologically that was the seventeenth national conference. Thus, technically that was the conference held at the silver jubilee *year* of the IASP. The current conference is truly its 25th national conference.

The World Social Psychiatry Conference was first held in India in November 1992 in India. It was a great success by all means. The world acknowledged India, and India acknowledged the world! A large number of people attended the conference from worldwide. The next big global event took place in 2016 when another world conference on social psychiatry took place in Delhi. The congress was attended by 1074 delegates from 49 countries, across all the five continents of the world!

In the following sections, I outline some of the major recurrent global themes relevant to social psychiatry. I have been talking and writing about them for the past three decades, and have summarized them in my article published in the first issue of the Indian Journal of Social Psychiatry under the editorship of Professor Debasish Basu.[1] Many, if not most, of these themes are still very relevant today; hence, I have liberally borrowed from that article. In this era of the global village powered by digital technology, it is time for Indian social psychiatry to go global too!

Putting Social Psychiatry in the Global Context

Much of the professional output of psychiatrists, psychologists, and other mental health professionals in India can be subsumed under the rubric of social psychiatry. Modern psychiatry developed in a particular time period and a part of the world. The timing was the Victorian era of the 19th century and the locale European. It was only subsequently that it was extrapolated to other parts of the world and applied to other populations.

Till about 40 years ago, most of the Indian psychiatrists cut their psychiatric teeth either in West or on the Western model. On return to the home country, they often encountered significant difficulties in applying the Western model to the ground realities in India. "One major

concern of the Indian psychiatrists has been to translate modern psychiatry as it has evolved in the West to the Indian setting.… This exercise has covered topics such as the epidemiology, types, manifestations, course, and outcome of mental illness. Comparing the Indian situation to the Western textbooks has been a prime concern, particularly of the Indian psychiatrists trained in the West, and to a lesser extent all psychiatrists, as the Western frame of reference continues in their training and education."[2]

Psychiatrists and Social Issues

Social psychiatrists globally have assigned to themselves the role of examining social issues and offering solutions to these. It is a moot point if they possess any expertise in these and are qualified to pontificate on such issues. I have repeatedly argued that, as concerned and knowledgeable citizens, they certainly have a responsibility in it.[2-4]

Hubert H. Humphrey, former Vice President of the United States and one-time Presidential nominee, emphatically expressed an important role for the behavioral scientist in the most crucial problem of human survival. "The behavioral scientist can help us resolve the awesome dilemmas we face. It is not only the physicist but also the chemist, the biologist who can find new answers to the prevention of World War III; it is the psychiatrist, the psychologist, and allied professionals. From all these, we need not only facts but also questions, innovative concepts, challenges to cherished dogmas, and imagination."[5]

In my write-ups to the souvenirs of the first (1985), the second (1986), and the fifth (1989) annual conferences of the IASP, summarized and updated in my later article,[1] I have drawn attention to the social issues and problems of particular relevance to our country. The great diversity of the Indian culture both in temporal and spatial contexts has been pointed out particularly in view of the problem of national integration. In the national context, problems of poverty and economic deprivation, technological backwardness, social and economic inequalities, urbanization, industrialization and social change, population control, cultural diversity and national integration and intrasocietal conflict, and violence have been particularly identified as social problems. Increasingly, attention has also been drawn to crimes against women including dowry death and rape and to the legal situation regarding attempted suicide and drug abuse.

Social Control of Human Drives

"The proverbial (American) freedom of life, liberty, and pursuit of happiness has unfortunately degenerated, in the modern world, to mean freedom to *plunder,* to *waste,* and to *pollute.* The limited resources of the planet earth are being exploited, plundered literally, without much concern for the future. The right to spend a particular commodity or to use a particular facility is perceived as limited, by and large, only by one's capacity to pay for it.… Ecological pollution has reached such proportions that the delicate physical and chemical equilibrium which was responsible for initiating life on this planet in the first place and which has been sustaining it so far is threatened, thus jeopardizing all life."[4] As Capra wrote, "… rape has become a central metaphor of our culture– rape of women, of minority groups, and of the earth itself."[6]

Further, Capra pointed out, "… to keep up a pattern of competitive consumption, many of the goods thus consumed are unnecessary, wasteful, and often downright harmful. The price we pay … is the continual degradation of the real qualities of life – the air we breathe, the food we eat, the environment we live in, and the social relations that constitute the basic fabric of our lives." He further lamented that "human technology is severely disrupting and upsetting the ecological processes that sustain our natural environment and are the very basis of our existence.… Entire fabrics of life that took 1000 of years to evolve are rapidly disappearing."[6]

The free enterprise system implies that if you desire a particular commodity or service you can have it if you can pay for it. The larger implications on the ecosystem are often overlooked. Living most of my life in a developing country brought many thoughts to my mind. In our country, most things and services were also in short supply. We all remember how we struggled for things such as telephone, radio, scooter, car, etc. The moment a product or service became available, the demand always outstripped availability. Hence, no matter how much we progressed, we never felt fulfilled. In India, as in many other developing countries, the population growth also militated against anything ever becoming enough. I remember that we thought that with the computerization of train reservation system, the old long and tedious lines to make a train reservation would be a thing of the past. Unfortunately, that did not happen, as the demand grew more than the supply. If you can pay for it, you can travel wherever you want to, without any consideration of need. Should there be a quota, should the state regulate or control utilization of services and commodities? This may smack of a totalitarian control over free will.

However, the last 2–3 decades have witnessed increasing awareness of the need for such a control. We are becoming more and more aware that all human activities have implications for the planet Earth. All activities produce carbon dioxide which is toxic for the planet, and can be measured in carbon print. I pointed out three decades ago the impact of the industrial revolution on the ecology.[4] Now, we have been able to measure the consequences of global warming. We talk regarding carbon print of all our activities; to illustrate, air travel. We realize that we are simply tenants of the planet and we must not destroy the ecosystem; we can do so only

at our peril. Furthermore, most energy sources are finite in quantity and nonrenewable. I also pointed out that "all the consequences of tampering with the environment cannot be fully anticipated and the repercussions may act in strange and hitherto unforeseen ways."[4] Pollution to threaten ecological balance and viability may result from chemical waste, deforestation, accident involving chemical and biological toxin, nuclear testing, and accidents, and finally, full-scale nuclear warfare. Think of Bhopal gas tragedy, Three-Mile Island, Chernobyl, the impact of the tsunami of 2011 on the Japanese nuclear plant. I have pointed out that although "we may not rank as one of the most industrialized nations in the world, we in India have the dubious distinction of having been at the receiving end of the worst chemical disaster in human history, namely the Bhopal Gas Tragedy of December 1984."[4] Furthermore, we are becoming increasingly aware of global warming resulting from human activities and its implications for all of us. Considerations, which were mere speculations, now occupy center-stage in global planning, as evidenced by large-scale debate about global warming and Nobel Peace Prize to the former US Vice-President, Al Gore, and to the Intergovernmental Panel on Climate Change in 2007.

The Nuclear Threat: Perspective of Developing Countries

"With the powerful nuclear weapons being available and the potential of any international conflict escalating into nuclear warfare being present, disarmament and abolition of warfare are considered not only desirable but also a must for human survival; the question often being posed being whether it will come before or after a nuclear holocaust."[7] As one of the latest nuclear states, we in India have been increasingly cognizant of what an all-out nuclear warfare can do. Although it has mostly concerned Western nations, which maintained a long-term *détente,* I have argued that "it would be patently wrong for the developing, third world countries, to assume a position of complacency about it."[4]

Although the Second World War represented a major defining epoch in world history, violence has continued since then. Furthermore, there has been a lot of warfare since then, and more and more of violence has affected developing world. I have pointed out a number of factors in the developing world which may actually facilitate international conflicts. These include parochialism, pursuit of nationalism, distrust of the erstwhile imperial powers, lack of national identity, internal insurgency, lack of stable political traditions and conventions, totalitarianism, oligarchy and anarchy, vulnerability to be caught in cross fire, and war as an outlet for the insoluble socioeconomic problems. Although many of these concerns may have sounded far-fetched till a few decades ago, recent history has brought out its relevance.

The nuclear club is fast proliferating. India joined it in 1974, to be followed by Pakistan thereafter. Several countries are producing plutonium and may soon join the nuclear club. We are currently at the throes of the process and implications of the nuclear capability of North Korea and Iran. These are not only idle debates but also actual matters of human survival.

As long ago as 1987, I underscored as follows: "The present-day nuclear stalemate rests on a balance of terror and on the premise that it is a no-win situation. This situation can continue indefinitely, as such, provided we assume that the powers that be will continue to act in a fully analytical, rational fashion keeping the global perspective in mind. This probably is too much to hope for. Nations are governed by individuals with their own frailties… (with) chances of irrationality … creeping into the destruction of mankind. There is, accordingly, need for greater concern and consideration to the possible role of the developing countries in a nuclear holocaust which, hopefully, can be avoided."[7]

Epilogue

Standing on the vantage point of the Silver Jubilee Conference of IASP, what have we learned, achieved, accomplished? We held a large number of conferences, have made a number of collaborations. However, most importantly, we have *survived!!!* This is, to my mind, no mean task, given the unrelenting ascendancy of biological psychiatry. Any discerning person, who himself has survived five decades of psychiatry, would vouch for the bare fact that "no psychiatry is complete without social psychiatry." Indeed, I would even go as far as to assert that "social psychiatry is core psychiatry." The few issues that I have highlighted above – and I am sure there are many more – simply goes to show that, in this era of living in a global village, social psychiatry will continue to live forever!

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References

1. Varma VK. Whither social psychiatry? Indian J Soc Psychiatry 2012;28:4-7.
2. Varma VK. Social psychiatry: The Indian perspective. Indian J Soc Psychiatry 1989;5:1-3.
3. Varma VK. The behavioral scientist and social issues. Indian J Soc Psychiatry 1986;2:139-147.
4. Varma VK. The psychiatrist and social commitment. Andhra Pradesh J Psychiatry 1988;1:6-16.
5. Humphrey HH. The behavioral sciences and survival. Am Psychol 1963;18:290-4.
6. Varma VK. The psychiatrist and social issues in the third world. In: Stefanis CN, Soldatos CR, Rabavilas AD. editors. Psychiatry: A World Perspective. Vol. 4. New Delhi: Elsevier Science Publishers; 1990.
7. Varma VK. World peace and social psychiatry: Perspective of developing countries. Indian J Soc Psychiatry 1987;3:317-27.

A Treasure on Psychotherapy

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PSYCHOTHERAPY AS PRACTISED BY THE INDIAN PSYCHIATRISTS

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Inspite of the various comments and reservations often expressed, mostly informally by the Indian psychiatrists and other mental health professionals regarding the place, the relevance, of psychotherapy for India, factual data, unfortunately, regarding the nature and extent of psychotherapy practised in the country are almost non-existent. Reservations are often voiced if psychotherapy, or at least its classical Western model, is suitable for India considering the significant differences in socio-cultural beliefs and practices; specially in terms of apparent lower psychological sophistication of our patients; greater dependency needs of the Indian population; their inability to enter into a professional as opposed to a filial relationship, the impediment created by a greater social distance perceived between the doctor and the patient; the possible implications of the Hindu philosophical beliefs of transmigration of soul, re-birth, and fatalism; the different nature and quantum of guilt-feeling in our culture, and the differences in the need for confidentiality and inactivity exercised by the therapist especially with regard to decision-making for the patient and environmental manipulation.

It was felt that a study of the collective experience of the Indian psychotherapists as regards the extent and nature of psychotherapy practised by them, and the model and devices adopted by them to tackle the problems peculiar to this country, if any, may throw some light on the possible relevance of the socio-cultural factors enumerated above. For a beginning, the present study was undertaken to ascertain the nature and extent of psychotherapy practised by the Indian Psychiatrists.

Material and methods

The study was conducted on the Fellows of the Indian Psychiatric Society practising in India. Out of a total number of 222 Fellows listed in the Membership Directory, 1973, 34 were listed as resident abroad and 2 were deceased. A request was addressed to the remaining 186 soliciting their concurrence to complete a questionnaire on the extent and nature of psychotherapy in their practice. It was subsequently found out that 4 more were available for the present study.

80 psychiatrists expressed their willingness to complete the questionnaire, to whom it

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was sent. (15 others expressed their inability to contribute towards this survey for a variety of reasons, and there was no response from the remainder). In the letter accompanying the questionnaire, psychotherapy was defined for the purpose of this study, as follows :

"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 of removing, modifying or retarding existing symptoms, of mediating disturbed patterns of behaviour, and of promoting positive personality growth and development" (Wolberg, 1967). Furthermore, it was clearly specified that to qualify for psychotherapy for the purpose of this survey, all of the following criteria must be fulfilled:

(i) There was a deliberate contract between the therapist and the patient.

(ii) The therapeutic sessions were scheduled for particular days of the week and times, and

(iii) The patient was seen at least once a week, each session was of a minimum duration of 20 minutes, and the total time devoted to the patient was at least 30 minutes per week.

The psychiatrists were asked to indicate the total number of patients *currently* receiving psychotherapy from them, and to provide the following information on each patient (by tick-marking appropriate response categories provided) : age, sex, education, occupation, income, diagnosis, duration of psychotherapy, frequency of visits, fee charged, seating arranged, role of patient and therapist and type of psychotherapy, form of recording, if other treatments were given simultaneously, and if psychotherapy was the primary or ancillary treatment. It was felt that by soliciting information only on patients receiving psychotherapy at this point of time, impressionistic information, which may be inaccurate may be avoided they were also requested to elaborate on their attitude towards psychotherapy in general, whether they consdiered it useful or not, whether they looked upon it as a primary or an ancillary mode of treatment, and whether and what modifications from the Western model did they recommend. They were also encouraged to add general comments.

Completed questionnaires were received from 32 psychiatrists. 16 others replied that, at that time, they did not have any patients who qualified under our criteria for psychotherapy. The 32 psychiatrists who returned the completed questionnaire were seeing a total of 180 patients at the time of the study. However, they provided complete information only on 153 of their patients.

Out of these, 21 patients did not fulfil the criteria set out, in the study, for psychotherapy, hence they were not studied. Of the remaining 132, 77 (58.3%) were males and 55 (41.7%) females.

Although the psychiatrists were not asked to disclose their identity, many of them, nevertheless clearly indicated it. On this basis and on the basis of the signature, it was possible to clearly identify 23 of them. An analysis of their training and background will be separetely reported.

Results

As noted above, 48 psychiatrists (including 16 who did not have any patients in psychotherapy at the time of the study) participated in the study. This represented 26.4% of the total of 182 psychiatrists available for this study. (If we exclude the 15 psychiatrists who explicitly stated their inability to participate in this study, the 48 responding psychiatrists represent 28.7% of the 167 psychiatrists really available for the study.)

Tables 1 to 17 give the breakdown of the 132 patients on whom information was provided on the various demographic, socio-economic and therapeutic variables studies.

TABLE 1

Age - wise distribution of sexes

Age Range	Male	Female
5-15 yrs	2	0
16-30 yrs	46	38
31-45 yrs	23	17
46-65 yrs	6	0
Total	77	55

TABLE 2

Occupation (N=132)

Occupation	Male N=77	Female N=55	Total Number	%
Unemployed	8	3	11	8.3
Students	14	8	22	16.7
Unskilled Workers	1	0	1	0.8
Skilled Workers	15	6	21	15.9
Housewives	0	23	23	17.4
Defence	6	0	6	4.5
Teachers	3	6	9	6.8
Priests	2	0	2	1.5
Businessmen	13	1	14	10.6
Professionals	15	5	20	15.2
Information not available	0	3	3	2.3

TABLE 3

Education (N=132)

Education levels	Total	Percentage
Illiterates	3	2.3
Primary	11	8.3
Middle	6	4.5
Matric, Hr. Sec., I. Sc. & Sr. Cambrg.	41	31.1
Graduates	42	31.8
Post-graduates	29	22.0

TABLE 4

Income (N=132)

Income Ranges (Rs. p. m.)	Number	Percentage
0-100	21	15.9
101-300	16	12.1
301-500	19	14.4
501-1000	21	15.9
1001 and above	27	20.5
Information not available	28	21.2

TABLE 5

Diagnostic breakdown (N=132)

Diagnosis		Number	Percentage
Psychosis		24	18.2
M. D. P.	3		
Schizophrenia	21		
Neuroses		86	65.2
Personality Disorders		9	6.8
Addictions		9	6.8
Others		4	3.0

TABLE 6

Total duration of psychotherapy (N=132)

Duration	Number	Percentage
One week to one month	42	31.8
1 month to 3 months	44	33.3
3 months to 6 months	24	18.2
6 months to 1 year	8	6.1
1 year to 2 years	2	1.5
More than 2 years	12	9.1

TABLE 7
Frequency of visits for psychotherapy (N = 132)

Frequency	Number	Percentage
Once a week	75	56.8
Twice a week	37	28.0
More than twice a week	20	15.2

TABLE 8
Fee charged per session (N = 132)

Amount	Number	Percentage
Nil	41	31.1
Rs. 5-10	19	14.4
Rs. 11-20	29	22-0
Rs. 21-40	30	22. 7
Rs. 41-and above	6	4.5
Information not available	7	5.3

TABLE 9
Seating arrangement (N = 132)

Method employed	Number	Percentage
Face to face	106	80.3
Patient on the side	10	7.6
Couch	14	10 6
Play therapy	2	1.5

TABLE 10
How psychotherapy arranged ? (N = 132)

How arranged	Number	Percentage
Patient asked for it	31	23.5
Patient accepted suggestion readily	45	34.1
Relatives suggested and arranged	16	12.1
Referred by a Doctor	31	23.5
Patient persuaded to accept	9	6.8

TABLE 11
Therapist's role in psychotherapy (N = 132)*

Role of Therapist	Number	Percentage
Passive	12	9.1
Giving suggestions	85	64 4
Teaching'Didactic	48	36.4
Sympathising	45	32.6
Environmental manipulation	43	32.6
Reassuring	49	37.1
Authoritative	21	15:9

* Some patients classed under more than one categogry.

TABLE 12
Form of recording (N = 132)

Mode of Recording	Number	Percentage
Verbatim	31	23.5
Writing a summary after each session	48	36.4
Writing summary of few sessions together	28	2
Tape recording	0	0. (
No recording	25	18.9

TABLE 13
Type of psychotherapy (N = 132)

Types	Number	Percentage
Supportive	54	40.9
Reeducative	54	40.9
Reconstructive	51	38.6
Counselling	27	20.4
Behaviour Therapy	2	1.5
Religious	13	9.8
Others*	23	17 4

* Psychodrama (9) Playtherapy (2) Milieu Therapy (2) Pavlovian Therapy (5) Hypnosis (3) and Yoga Therapy (2)

TABLE 14
Associated treatments (N = 132)

Treatment modalities	Number	Percentage
Drugs	85	64.4
E. C. T.	10	7.6
Psychotherapy alone	37	28.0

TABLE 15
Role of patient in psychotherapy (N = 132)*

Role	Number	Percentage
Passive	39	29.5
Dependent	26	19.7
Active	60	45.5
Learning	49	37.1

TABLE 16
Place of psychotherapy in the total treatment (N = 132)

Place of psychotherapy	Number	Percentag :
Primary	80	60. 6
Ancillary	52	39.4

* Some patients classed under more than one category.

TABLE 17
Total number of sessions held (N = 132)

No. of sessions	Number	Percentage
1 to 10	57	43.2
11 to 30	52	39.4
31 to 50	8	6.1
51 to 100	6	4.5
More than 100	9	6.8

The following findings are specially noteworthy :

(i) Although the percentage of females in the age-group (16-30 years) was little higher than that of males in same age bracket, this difference was not significant. The findings do not support the notion of a young (and? attractive) female as the prototype of psychotherapy patients (Table 1).

ii) As expected, 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 and28.0% had a monthly income not exceeding Rs. 300/-per month. (Table 2, 3 & 4)

iii) As expected, the majority of patients were suffering from psychoneuroses (65 2%). However, 18.2% were suffering from functional psychoses, most of them from schizophrenia.

iv) In most cases, psychotherapy was not too long-term and not intensive. However, 15.2% of patients had been receiving psychotherapy oftener than twice a week, 9.1% had been in psychotherapy for over two years, and 6.8% had over 100 sessions each (Tables 6, 7 and 17).

v) As regards the seating arrangements, the patient sat facing the therapist in a vast majority of cases (80.3%). Unexpectedly, couch was used in case of 10.6% of patients (Table 9).

vi) Some form of record was maintained in 81.1% of cases; surprisingly, verbatim records in 23.5% (Table 12).

vii) The therapist played a relatively more active role than that in the Western model, suggesting, sympathising, manipulating the environment, teaching and reassuring. Psychotherapy was generally, thus, of more of a supportive nature. However, in full 38.6% of cases it was considered to be of reconstructive variety. A small number of patients were also reported to be undergoing psychodrama, play therapy, milieu therapy, Pavlovian therapy, hypnosis and Yoga therapy. (Table 11 & 13)

viii) 28.0% of patients were receiving psychotherapy as the sole treatment The rest were also receiving drugs or E. C. T. Psychotherapy was considered to be the primary treatment in 60.6% of patients and ancillary in the rest (Table 14 & 16).

The attitude of the participating psychiatrists who completed the questionnaire (N = 32) towards psychotherapy are summarized in Table 18 & 19.

TABLE 18
Attitude of participating psychiatrists regarding psychotherapy (N = 132)

	Number	Percentage
Useful	32	100
Not useful	0	0
Primary	5	15.6
Ancillary	8	25 0
Both	18	56.2
Information not available	1	3.1
Should be modified	24	75.0
Need not be modified	7	21.9
Information not available	1	3.1

TABLE 19
Modifications suggested (N = 32)

	Number	Percentage
Should be short term, crisis oriented and supportive	8	25.0
More flexibility in the rules suggested	1	3.1
Eclectic approach recommended	5	15.6
Role of psychotherapist should be more active	1	3.1
Should be tuned to the cultural and social conditions	6	18.7
Religious blending - Guru-Chela Relationship	4	12.5
More use of suggestion, reassurance and less use of dynamic interpretation	2	6.2

* Some psychiatrists gave more than one suggestion

All participating psychiatrists felt that psychotherapy was a useful mode of treatment. A large majority, however, felt that it should be modified from the Western model. The various modifications suggested were that it should be of shorter-term, crisis-oriented, supportive, flexible, eclectic and tuned to the 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.

The participating psychiatrists were also encouraged to make general comments. Some of the comments were the following:

"I feel that the traditional 'insight' pattern of the modern western hospital is of limited value in many Indian patients. They are not used to speaking freely before a person whom they consider so much 'superior' to them ..... It is very difficult indeed for the average Indian patient to express strongly negative feelings towards a doctor".

"No Western model has suited me in all cases ... My main aim is to encourage the patient to gain insight by gradually confronting his/her subconscious processes to his or her conscious stream of thought and re-educating and reconstructing his personality by all available means at our disposal".

"Simplification of psychoanalytic terms in day to day language, incorporation of religious principles are usually helpful...Aggressive, rather then sexual instinct seems to be more easy to handle in psychotherapy in Indian patients"

"Though a useful adjunct to various other treatments like psychopharmaco-therapy, and E.C.T..... I have found that patients do not like to take psychotherapy as the only mode of treatment."

And a laconic comment, "Better results are achieved if the psychotherapist is of the opposite sex".

Discussion

The most important limitation of the work is indicated in the title itself, namely that it pertains to psychotherapy as practised only by the Indian psychiatrists. Thus, the survey does not include psychotherapy undertaken by non-medical professionals (e.g., psychologists and social workers) nor the various types of treatment that seem to operate by psychological means administered by a whole variety of persons who are ordinarily labelled as faith healers.

It is not to say that none of the people not covered by this study practise what may be termed as psychotherapy. Also, al-

though a lot has been written about diffrence between psychotherapy and religious healing, it cannot be said that there are no similarities between them or between the ways in which these help (Torrey, 1972)

For the purpose of this paper, Fellows of the Indian Psychiatric Society were taken to be psychiatrists. To qualify for Fellowship of the Society, the person must have a basic medical qualification in what may be termed Modern or Allopathic medicine (Schedule I or II, or Part II of Schedule III of the Indian Medical Council Act 1956), and possess qualification and experience in psychiatry, either a postgraduate qualification (e. g. M. D. or D. P. M,) in psychiatry with two additional years of experience, or five years of full-time experience in psychiatry. (Indian Psychiatric Society, 1973b). Hence, practitioners of Indigenous system of medicine (homeopaths, Vaids, and Hakims) do not qualify for Fellowship and thus were excluded from the study. Also, perhaps there are a few Ordinary Members of the Society who would qualify for Fellowship, but who had not taken the necessary steps for it, and certain other psychiatrists in the country (possibly very few) who have not associated themselves with the Society at all. They were, again, not covered by the study.

Another important fact having a bearing on the scope of the study and the conclusion drawn is the definition of psychotherapy adopted. The definition adopted is definitely weighed in favour of a structured and deliberate, rather than occasional and chance psychological interactions between the therapist and the patient. Thus "helping situations" and other unstructured interactions were excluded from the scope of the study. In addition to the general definition of psychotherapy; concrete, operational criteria were also specified which have, perhaps, ensured greater precision in the data reported.

32 psychiatrists reported that they were doing psychotheapy at the time of the study. This represents 66.7% of the 48 psychiatrists who participated in the study. Thus, it can be said that psythotherapy is practised to a significant, but a somewhat limited degree by the Indian psychiatrists. It might also be speculated that an additional unknown number of psychiatrists were participating in "helping situations" and other therapeutic interventions of psychological nature, which could not qualify to be called psychotherapy according to the criteria adopted.

As expected, the higher socio-economic brackets were over-represented in the patient sample (compared to the general population). However, relatively lower social classes were also represented to an unexpectedly high degree. This may perhaps have something to do with our systems of close kinship relationships and social interdependence which may materially augment the person's individual resources and experiences It also may suggest that the social distance between the therapist and the patient does not necessarily preclude their receiving psychotherapy.

Although most of the patients, expectedly were suffering from neurotic disturbances, a sizeable proportion of them were suffering from schizophrenia and other psychotic disorders. It is quite likely however, that

psychotherapy with schizophrenics mostly represented supportive, nurturing relationships rather than exploratory exercises.

Considering the great paucity of analytically trained or even dynamically oriented psychiatrists in the country, and considering the various traits like lack of psychological sophistication, overdependence and inability to enter into a professional rather than a filial relationship that we often attribute to our patient population, it was anticipated that most of the therapies reported would be of supportive and relatively less intensive sort. Hence the findings that 43.2% of patients were receiving psychotherapy two or more times a week, and 38.6% were categorized to be in reconstructive therapy came as surprise. As regards the proportion of patients in reconstructive therapy, it may be clarified that although "reconstructive" was mentioned as one of the response categories under "type of psychotherapy", the term was not explained, thus leaving scope for the responding psychiatrists to interpret it according to their own criteria.

Each one of the 32, psychiatrisis who completed the questionnaire felt that psychotherapy is useful. In addition to testifying the utility of psychotherapy, this probably also indicates that all of them were highly committed to this treatment modality. It can be speculated that those who did not participate in the study differed from those who did in that the former had lower motivation towards psychotherapy, and this may indeed have been the reason why they did not participate. Hence, it may be that the data presented reflect psychotherapy practised by those greatly interested in it, and psychotherapies of various sorts practised by those not so committed may not have been represented in the study. This may, again, be construed to be one of the limitations of the study. The pain taken by the participating psychiatrists to maintain adequate (in may cases, verbatim) records of psychotherapy again attests to their commitment.

Although certain differences in techniques from the Western model were practised by the psychiatrists studied, it must be said however, that looking upon the results on the whole, the model of psychotherapy practised by the Indian psychiatrists did not differ very much from the classical model. It is apparent, nevertheless, from the attitude expressed that most of the psychiatrists are not fully satisfied with the Western model. Although many of them have suggested certain departures from the Western model in various techniques and facets of psychotherapy, no one presented a fully crystallized and comprehensive model suited to this country. To be fair to the responding psychiatrists, however, it must be added that a completely new school of psychotherapy is not easy to evolve, and even the various 'schools' of psychotherapy that are supposed to be totally different to one another are actually not so different, but they share with one another, a great many theoretical bases and the general techniques.

How do the findings of this study compare with the situation in the West. Wing and Wing (1970) reported on the characteristics of patients seen 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 difference in the demographic and clinical characteristics of the two groups. Older age-groups (35% Vs 5% above 45 years), and females were clearly over-represented in the supportive psychotherapy group, and single patients (26% Vs. 57%) and social classes 1 & 2 (4% Vs. 41%) under-represented. As regards the diagnostic labels, personality disorders (25% Vs. 6%) and sexual disorders (17% Vs 2%) were over represented in the specialised psychotherapy group, and psychoses (3% Vs. 32%) under-represented. In the present study, by comparison, 4.5% of patients were above 45 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 specialised psychotherapy patients.

In another study, Mowbray and Timbury (1966) collected the opinion of Scottish psychiatrists 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 the present study.)

Summary

In response to a questionnaire sent to all Fellows of the Indian Psychiatrie Society practising in India, 32 out of a total of 182 furnished data on 132 out of a total of 180 patients being treated by psychotherapy by them at the time of the study. (16 others who responded were not treating any patients in psychotherapy at the time of the study) It was noted that out of this 132 patients, males out-numbered females (58:42). As expected, socio-economically, the patients fell in the higher brackets than the general population However a significant proportion were unemployed, students, house wives and those with less than a monthly income of Rs. 300/- 65.2% of the patients were suffering from neurosis. However, 15.9% were schizophrenics. In most cases, psychotherapy was not long-term and not intensive. However, 15.2% of patients had been receiving psychotherapy oftener than twice a week, 9.1% had been in psychotherapy for over 2 years and 6.8% had over one hundred sessions each. Face-to-face seating arrangement was employed in most cases, however, couch was used in case of 16.6% of patients. Some form of record was maintained in 81.1% of cases, verbatim record in 23.5%. The therapists played a more active role than in the Western model, suggesting, sympathising, manipulating the environment, teaching and reassuring. Psychotherapy was of a supporting nature in most cases; however, in 38.6% of cases it was considered to be of the reconstructive variety. A few patients were also reported to be undergoing psychodrama, play therapy, milieu therapy, Pavlovian therapy, hyponsis and yoga therapy, 28.0% were receiving psychotherapy alone; 64.4% and 7 6% were also receiving drugs and E. C. T. respectively. Psychotherapy was considered to be the primary treatment in 60.6% of patients and ancillary in the rest.

All responding psychiatrists felt that psychotherapy is a useful mode of treatment. A large majority (75%), however,

felt that it should be modified from the Western model. The various modifications suggested were that it should be of shorter term, crisis-oriented, supportive, flexible, eclectic and tuned to the cultural and social conditions. Greater activity on the part of 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.

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REFERENCES

Indian Psychiatric Society, Membership Directory, 1973a.

Indian Psychiatric Society, Memorandum of Association and Rules & Regulations including Bye-laws, 1973b, Page 2.

Torrey, E. F., (1972) : The Mind Game. New York : Bantam Books.

Wolberg, L. R. (1967) : The Technique of Psychotherapy. New York : Grune and Stratton, Page 3.

Mowbray, R. M. and Timbury, G. C. (1966) : Opinions on Psychotherapy : An enquiry. *Brit. J. Psychiat. 112*, 351.

Wing, J. K. and Wing, Lorna. (1970) : Psychotherapy and the National Health Service : An operational study. *Brit. J. Psychiat, 116*, 51.

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PRESENT STATE OF PSYCHOTHERAPY IN INDIA

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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

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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 hased 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).

REFERENCES

ABROMS, G. M. Persuasion in Psychotherapy. (1968) Am. J. Psychiat. 124, 1212.

BERNE, E. (1960) The cultural problem: Psychotherapy in Tahiti. Am. J. Psychiat. 116, 1076.

BOLMAN, W. M. Cross-cultural psychotherapy. Am. J. Psychiat. 124 : 1237-44, 1968.

BRENNEIS, C. B. & LAUB, D. (1973) Current strains for mental health trainees. Am. J. Psychiat. 130, 41.

CHESSICK, R. D. (1969) How Psychotherapy Heals : The Process of Intensive Psychotherapy. New York: Science House, P. 107-22, 193, 199.

DHAIRYAM, D. Presidential address to the V All-India Convention of Clinical Psychologists. (1975) Indian J. Clini Psychol. 2, 1.

DICKS, H. V. (1969) The state of psychotherapy in British psychiatry. Am. J. Psychiat. 125, 1232.

FRANK, J. D. (1961) Persuasion and Healing : A Comparative Study of Psychotherapy. Baltimore: Johns Hopkins, p. 114.

FRANK, J. D. (1968) Recent American research in psychotherapy. Brit. J. Med. Psychol., 41, 5.

GOLDSTEIN, ARNOLD, P. (1962) Therapist-Patient Expectations in Psychotherapy. Oxford, Lond., New York, Paris : Pergamon Press, pp. 111-121.

KOLB, L. C. (1968) Noyes' Modern Clinical Psychiatry. Philadelphia : Saunders, (Indian edition by Oxford and IBH, 1970, p. 546).

KUBIE, L. (1971) The retreat from patients : an unanticipated penalty of the full-time system. Arch. Gen. Psychiat., 24, 98.

MAJUMDAR, S. K. (1975a) A case study on pedagophobia psychotherapeutic approach to behaviour modification. Indian J. Clin. Psychol., 2, 91.

MAJUMDAR, S. K. (1975b) Psychotherapy of pedagophobia by reciprocal inhibition—a mechanical technique. Indian J. Clin. Psychol., 2, 191.

MARKS, I. (1971) The future of the psychotherapies. Br. J. Psychiat., 118, 69.

MARMOR, J. (1973) The future of psychoanalytic therapy. Am. J. Psychiat., 130, 1197.

MOWBRAY, R. M. AND TIMBURY, G. C. (1966) Opinions on psychotherapy : An enquiry. Brit. J. Psychiat., 112, 351.

NAUG, R. N. (1975) Yoga therapy in neurotic disorders. Indian J. Clin. Psychol. 2, 87.

NEKI, J. S.)1974) A reappraisal of the Guru-Chela relationship as a therapeutic paradigm. Int. Ment. Health Res. Newsletter, 16, 2.

NEKI, J. S. (1975) Psychotherapy in India ; Past, present and future. Amer. J. Psychother., 29, 92.

PETTISON, E. M. (1973) Social system psychotherapy. Am. J. Psychother, 27, 396.

PRIEST, P. N. (1972) The destiny of psychological therapies : Convergence or divergence. Br. J. Med. Psychol., 45, 209.

ROMANO, John. (1947) Psychotherapy *in* Witmer, H. L. (ed.) Teaching Psychotherapeutic Medicine. New York ; The Commonwealth Fund and Cambridge, Massachusettes, Harvard Univ., p. 122.

SEN, N. N. (1974) Behaviour therapy in depression I. An experimental analysis. Indian J. Clini. Psychol., 1, 53.

SEN, N. N., (1975a) Behaviour therapy in depression II. Plan and procedure of case analysis and treatment. Indian J. Clini. Psychol., 2, 77.

SEN, N. N., (1975b) Clinical Psychology of eighties : Editorial. Indian J. Clin. Psychol., 2, i-iv.

SHARMA, V. P., (1970) Psychodiagnostic tests and psychotherapy. Brit. J. Proj. Psychol. & Pers. Stud., 15, 13.

SHARMA, V. P., OJHA, K. N. AND VAGRECHA, Y. S. (1975) Clinical psychologists in India II. Indian J. Clini. Psychol., 2, 73.

SINHA, T. C., (1956) Development of psychoanalysis in India. Indian J. Psychoanal., 47, 427.

SNYDER, W. U. (1963) Dependency in Psychotherapy : A Casebook. New York : Macmillan, p. 3 & 6.

SURYA, N. C. AND JAYARAM, S. S. (1964) Some basic

considerations in the practice of psychotherapy in the Indian setting. Indian. J. Psychiat., 6, 153.

TEJA, J. S., NARANG, R. L. AND AGARWAL, A. K. (1971) Depression across cultures. British J. Psychiat., 119, 253.

TORREY, E. F. (1972a) What Western psychotherapists can learn from witchdoctors. Am. J. Orthopsychiat., 42, 69.

TORREY, E. F. (1972b) The Mind Game: Witchdoctors and Psychiatrists. New York : Emerson Hall.

VAHIA, N. S., VINEKAR, S. L. AND DOONGAJI, D. R. (1966) Some ancient Indian concepts in the treatment of psychiatric disorders. Brit. J. Psychiat., 112, 1089.

VAHIA, N. S. (1969) A therapy based upon some concepts prevalent in India. Indian J. Psychiat., 11, 7.

VAHIA, N. S. *et al.* (1972) A deconditioning therapy based upon concepts of Patanjali. Int. J. Soc. Psychiat., 18, 61.

VAHIA, N. S., DOONGAJI, D. R., JESTE, D. V., KAPOOR, S. N., ARDHAPURKAR, I. AND NATH, S. R. (1973) Further experience in the therapy based upon the concepts of Patanjali in the treatment of psychiatric disorders. Indian J. Psychiat. 15, 32.

VARMA, V. K. AND GHOSH, A. (1975) Psychotherapy as practised by the Indian psychiatrists. Paper presented at the 27th annual conference of the Indian Psychiatric Society.

VENKOBA RAO, A. (1973) Depressive illness and guilt in Indian culture. Indian J. Psychiat., 15, 231.

WING, J. K. AND WING, LORNA. (1970) Psychotherapy and the National Health Service : an operational study. Brit. J. Psychiat., 116, 51.

WITTKOWER, E. D. AND WARNES, H. (1974) Cultural aspects of psychotherapy. Am. J. Psychother., 28, 566.

WOLBERG, L. R. (1967) The Technique of Psychotherapy. New York : Grune & Stratton, p. 3.

A note on Social Psychiatry

The First Editorial: Commentary and Reflections

WHITHER SOCIAL PSYCHIATRY?

Vijoy K. Varma

It is a matter of great pleasure to write this commentary on the very first *EDITORIAL* of the Indian Journal of Social Psychiatry, written by my esteemed senior colleague, late lamented Dr. B.B. Sethi who unfortunately left us quite prematurely. Our present editor, Dr. Debasish Basu, has caught on a really great idea of inviting commentaries on the Editorial. I am grateful to him for having invited me to write such a commentary.

The idea that later blossomed into the formation of the Indian Association for Social Psychiatry was mooted at the Transcultural Psychiatric Meet held in Madurai, Tamil Nadu, on 23-25 August 1981. It was felt that it may be desirable to have a separate professional organization at the national level in India for social and/or transcultural psychiatry. In addition to examining the social and cultural correlates of psychiatric disorders in its totality – the phenomenology, classification, course and outcome; as also its treatment – such an organization can examine the interface culture and personality and mental illness and engage in a scientific study of social issues relevant to the society and the nation.

Subsequent to the Transcultural Psychiatric Meet in Madurai, I consulted with the likely interested professional colleagues through a circular. In view of an overwhelmingly positive response to the formation of such an organization, a meeting of interested persons was convened to coincide with the annual conference of the Indian Psychiatric Society held in Madras (now Chennai) in January 1982. At this meeting, an *ad hoc* committee was formed with Col. Kirpal Singh as the Chairman and myself as the Convener. At this meeting, it was decided to name the organization as "the Indian Association for Social Psychiatry." There was considerable debate between 'social' and 'transcultural' in the name and scope of the organization, but eventually, 'social' prevailed.

The subsequent formation and development of the organization took place both nationally and internationally. The *ad hoc* met on a number of occasions, often taking advantage of annual conferences and council meetings of the Indian Psychiatry Society to conserve time and costs. In addition, we engaged in close collaboration with the World Association for Social Psychiatry and derived support, encouragement and guidance from it. The WASP leadership was very supportive and kind, including its stalwarts such as Joshua Bierer, Jules Masserman, Jack Carleton, A. Guilherme Ferreira, Jorge A. Costa e Silva, Alfred Freedman, Stanley Lesse, Alexander Gralnick and others. At its 10th World Congress held in Osaka, Japan in 1983, which I attended, the WASP Executive encouraged in the formation of the IASP, and pledged its full support in every way possible. At the last meeting of the *ad hoc* committee held in Ranchi on 14 January 1984, the constitution was adopted, office bearer and council members were elected the Society was fully launched.

Much of professional output of psychiatrists, psychologists and other mental health professionals in India can be subsumed under the rubric of social psychiatry. Modern psychiatry developed in a particular time period and a part of the world. The timing was the Victorian era of the 19th century and the locale European. It was only subsequently that it was extrapolated to other parts of the world and applied to other populations.

Till about 40 years ago, most of Indian psychiatrists cut their psychiatric teeth either in West or on the Western model. On return to the home country, they often encountered significant difficulties in applying the Western model to the ground realities in India. "One major concern of the Indian psychiatrists has been to translate modern psychiatry as it has evolved in the West to the Indian setting. ... This exercise has covered topics such as the epidemiology, types, manifestations, course and outcome of mental illness. Comparing the Indian situation to the Western textbooks has been a prime concern, particularly of the Indian psychiatrists trained in the West, and to a lesser extent all psychiatrists, as the Western frame of reference continues in their training and education (Varma, 1989)."

PSYCHIATRISTS AND SOCIAL ISSUES

Social psychiatrists globally have assigned to

themselves the role of examining social issues and offering solutions to these. It is a moot point if they possess any expertise in these and are qualified to pontificate on such issues. I have argued that, as concerned and knowledgeable citizens, they certainly have a responsibility in it. I have summarized my thoughts on this issue as follows (Varma, 1986, 1988, 1989):

"Lately there has been a lot of debate if and to what extent do we, behavioral and social scientists, have role to play in social issues. ... The usual debate in this controversy runs something like the following. The camp that denies any such special role to the scientist argues that these problems and issues are for everybody ... and this should not remain the exclusive domain of ... social scientists. *Secondly,* ... although the scientist has a better general orientation and a more rigorous training, he does not necessarily know more than the layman about the specific problem at hand – i.e., he does not have any special expertise in it." Choice of a solution may depend on personal choice and social and moral considerations, implications and the eventual objective desired. "*Finally,* it is said that with increasing complexity of society, the problems and issues become so complicated that an interdisciplinary approach to their solution is needed which the individual scientist is unable to provide."

The opposite camp sees important roles for behavioural scientists in advising in a resolution of social problems and issues. Proclaiming "I shall assert quite boldly that there are useful roles for psychologists in the present scene and in the development of future policy and practices," Russell (1961) outlined at least four roles for psychologists in the formation and evaluation of policy. These include (1) examination of policy issues for their psychological component, (2) summarizing and integrating current information, (3) research and (4) application of current knowledge and skills. It may be pointed out that the scientist is also a member of the larger community and has responsibilities as such. Also, the scientist is not only a citizen, but in many ways a more knowledgeable one.

Hubert H. Humphrey, the ex-Vice President of the United States and one-time Presidential nominee, emphatically expressed an important role for the behavioural scientist in the most crucial problem of human survival. "The behavioral scientist can help us resolve the awesome dilemmas we face. It is not just the physicist, the chemist, the biologist who can find new answers to the prevention of World War III; it is the psychiatrist the psychologist, and allied professionals. From all these we need not only facts, we need questions. We need innovative concepts. We need challenges to cherished dogmas. We need imagination" (Humphrey, 1963).

In my write-ups to the souvenirs of the first (1985), the second (1986) and the fifth (1989) annual conferences of the IASP, I have drawn attention to the social issues and problems of particular relevance to our country. 'The great diversity of the Indian culture both in temporal and spatial contexts' has been pointed out, particularly in view of the problem of national integration. In the national context "problems of poverty and economic deprivation, technological backwardness, social and economic inequalities, urbanization, industrialization and social change, population control, cultural diversity and national integration and intrasocietal conflict and violence have been particularly identified as social problems. Increasingly, attention has also been drawn to crimes against women, including dowry death and rape and to the legal situation regarding attempted suicide and drug abuse."

SOCIAL CONTROL OF HUMAN DRIVES

"The proverbial (American) freedom of life, liberty and pursuit of happiness, has unfortunately degenerated, in the modern world, to mean freedom to *plunder,* to *waste* and to *pollute.* The limited resources of the planet earth are being exploited, plundered literally, without much concern for the future. The right to spend a particular commodity or to use a particular facility is perceived as limited, by and large, only by one's capacity to pay for it. ... Ecological pollution has reached such proportions that the delicate physical and chemical equilibrium which was responsible for initiating life on this planet in the first place and which has been sustaining it so far is threatened, thus jeopardizing all life (Varma, 1988)." Per Capra (1982, p. 28), "... rape has become a central metaphor of our culture – rape of women, of minority groups, and of the earth itself."

Further, Capra (1982, p. 226) has pointed out, "... to keep up a pattern of competitive consumption, many of the goods thus consumed are unnecessary, wasteful, and often downright harmful. The price we pay ... is the continual degradation of the real qualities of life – the air we breathe, the food we eat, the environment we live in, and the social relations that constitute the basic fabric of our lives." He further lamented that "Human

technology is severely disrupting and upsetting the ecological processes that sustain our natural environment and are the very basis of our existence. "... entire fabrics of life that took thousands of years to evolve are rapidly disappearing" (Capra, 1982, p. 252).

The free enterprise system implies that if you desire a particular commodity or service you can have it if you can pay for it. The larger implications on the eco-system are often overlooked. Living most of my life in a developing country brought many thoughts to my mind. In our country, most things and services were also in short supply. We all remember how we struggled for things like telephone, radio, scooter, car, etc. The moment a product or service became available, the demand always outstripped availability. So, no matter how much we progressed, we never felt fulfilled. In India, as in many other developing countries, the population growth also militated against anything ever becoming enough. I remember that we thought that with the computerization of train reservation system, the old long and tedious lines to make a train reservation would be a thing of the past. Unfortunately, that did not happen, as the demand grew more than the supply. If you can pay for it, you can travel wherever you want to, without any consideration of need. Should there be a quota, should the state regulate or control utilization of services and commodities? This may smack of a totalitarian control over free will.

However, the last 2-3 decades have witnessed increasing awareness of the need for such a control. We are becoming more and more aware that all human activities have implications for the planet Earth. All activities produce carbon dioxide which is toxic for the planet, and can be measured in carbon print. I pointed out over two decades ago the impact of the industrial revolution on the ecology (Varma, 1988). Now, we have been able to measure the consequences in global warming. We talk in terms of carbon print of all our activities; to illustrate, air travel. We realize that we are simply tenants of the planet and we must not destroy the eco system; we can do so only at our peril. Also, most energy sources are finite in quantity and non-renewable. I also pointed out that "all the consequences of tampering with the environment cannot be fully anticipated and the repercussions may act in strange and hitherto unforeseen ways (Varma, 1988)." Pollution to threaten ecological balance and viability may result from chemical waste, deforestation, accident involving chemical and biological toxin, nuclear testing and accidents and, finally, full-scale nuclear warfare. Think of Bhopal gas tragedy, Three-mile, Chernobyl, the impact of tsunami of 2011 on the Japanese nuclear plant. I have pointed out that although "we may not rank as one of the most industrialized nations in the world, we in India have the dubious distinction of having been at the receiving end of the worst chemical disaster in human history, namely the Bhopal Gas Tragedy of December 1984 (Varma, 1988)." Also, we are becoming increasingly aware of global warming resulting from human activities and its implications for all of us. Considerations which were mere speculations, now occupy centre-stage in global planning, as evidenced by large-scale debate about global warming and Nobel Peace Prize to the former U.S. Vice-President, Al Gore, and to the Intergovernmental Panel on Climate Change in 2007.

THE NUCLEAR THREAT: PERSPECTIVE OF DEVELOPING COUNTRIES

"With the powerful nuclear weapons being available and the potential of any international conflict escalating into nuclear warfare being present, disarmament and abolition of warfare is considered not only desirable, but a must for human survival; the question often being posed being whether it will come before or after a nuclear holocaust (Varma, 1986, 1990)." As one of the latest nuclear states, we in India have been increasingly cognizant of what an all-out nuclear warfare cab do. Although it has mostly concerned Western nations, which maintained a long-term *détente,* I have argued that "it would be patently wrong for the developing, third world countries, to assume a position of complacence about it (Varma, 1988)."

Although the Second World War represented a major defining epoch in world history, violence has continued since then. Also, there has been a lot of warfare since then, and more and more of violence has affected developing world. I have pointed out a number of factors in developing world which may actually facilitate international conflicts. These include: parochialism, pursuit of nationalism, distrust of the erstwhile imperial powers, lack of national identity, internal insurgency, lack of stable political traditions and conventions, totalitarianism, oligarchy and anarchy, vulnerability to be caught in cross-fire, and war as an outlet for the insoluble socio-economic problems (Varma, 1988). Although many of these concerns may have sounded far-fetched till a few decades ago, recent history has brought out its relevance.

The nuclear club is fast proliferating. India joined it in 1974, to be followed by Pakistan thereafter. Several countries are producing plutonium and may soon join the nuclear club. We are currently at the throes of the process and implications of the nuclear capability of North Korea and Iran. These are not idle debates, but actual matters of human survival.

As long ago as 1988 (Varma), I underscored as follows: "The present-day nuclear stalemate rests on a balance of terror and on the premise that it is a no-win situation. This situation can continue indefinitely, as such, provided we assume that the powers that be will continue to act in a fully analytical, rational fashion keeping the global perspective in mind. This probably is too much to hope for. Nations are governed by individuals with their own frailties... [with] chances of irrationality ... creeping in to the destruction of mankind. There is, accordingly, need for greater concern and consideration to the possible role of the developing countries in a nuclear holocaust which, hopefully, can be avoided."

EPILOGUE

Our founding Editor rightly outlined the scope and dimension of social psychiatry. In this, he took into account the particular socio-cultural variables relevant to our country, India. This includes social and cultural correlates of mental illness and its treatment. He also pointed out the technological changes underway in the country at the founding of the journal and its impact on family and mental illness. The subsequent development of social psychiatry in the country, as evidenced by deliberations of its annual conferences as also publications in the IJSP, have borne out the pathway so well identified by Professor Sethi.

REFERENCES

Capra F (1982) The Turning Point: Society and the Rising Culture. Simon and Schuster

Humphrey HH (1963) The behavioral sciences and survival. American Psychologist: 18:290-94

Russell RW (1961) Roles of psychologists in the formulation and evaluation of policy. Journal of Social Issues: 17(3):79-84

Varma VK (1985) Indian Association for Social Psychiatry. Souvenir of the first annual conference of the IASP

Varma VK (1986) The behavioral scientist and social issues. Indian Journal of Social Psychiatry; 2(3): 139-147

Varma VK (1986) Indian Association for Social Psychiatry. Souvenir of the second annual conference of the IASP

Varma VK (1987) World peace and social psychiatry: Perspective of developing countries. Indian Journal of Social Psychiatry; 3: 317-327

Varma VK (1988) The psychiatrist and social commitment. Andhra Pradesh Journal of Psychiatry: 1(1), 6-16

Varma VK (1989) Social psychiatry: The Indian perspective. Indian Journal of Social Psychiatry; 5:1-3

Varma VK (1989) Indian Association for Social Psychiatry. Souvenir of the fifth annual conference of the IASP.

Varma VK (1990) The psychiatrist and social issues in the third world. *In,* Psychiatry: A World Perspective, vol 4. Elsevier Science Publishers B.V., C.N. Stefanis et al., editors.

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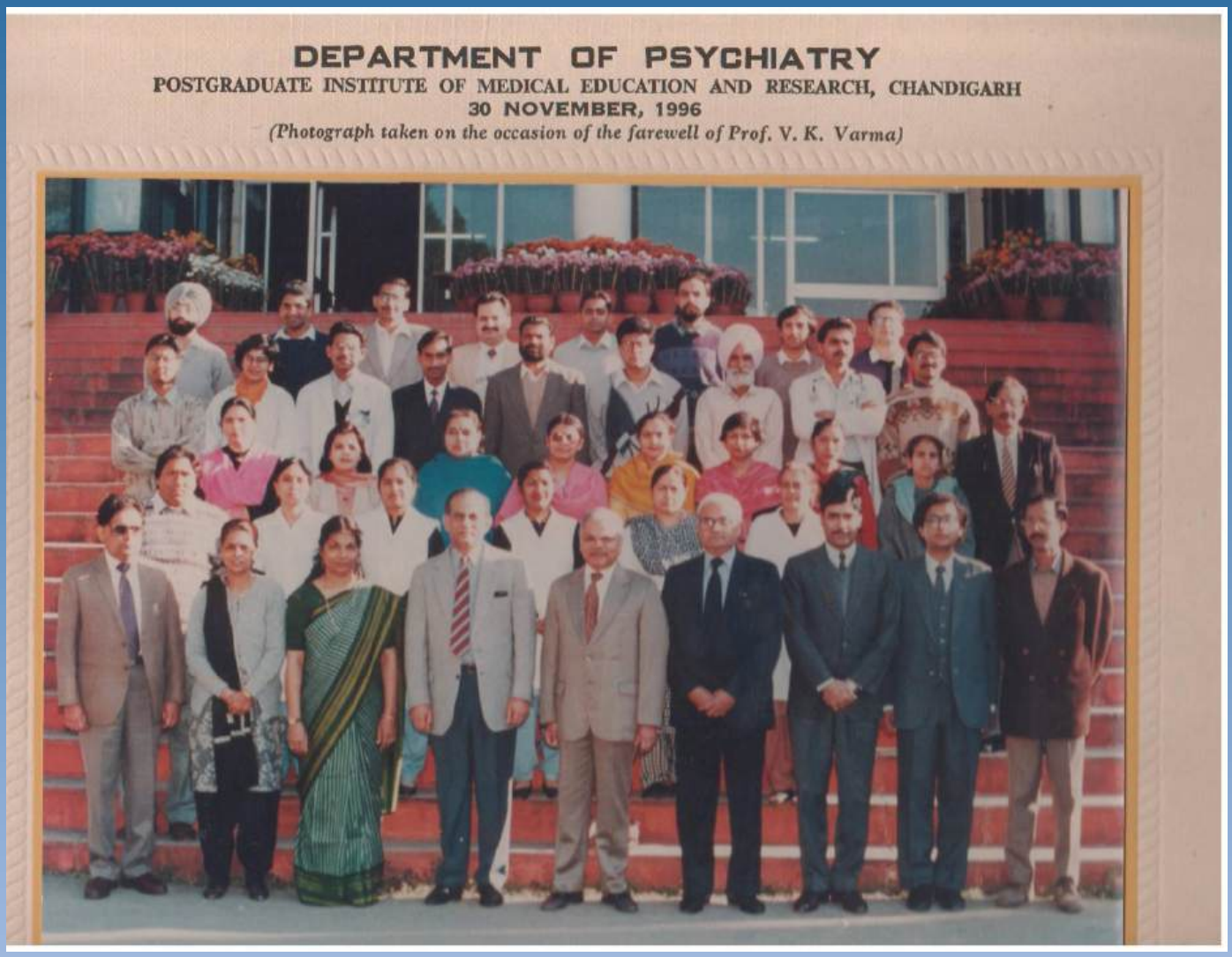

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