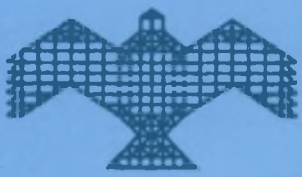

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What is Psychotherapy?

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NATIONAL INSTITUTE OF ADVANCED STUDIES

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NIAS LECTURE L2 - 2003

NATIONAL INSTITUTE OF ADVANCED STUDIES
Indian Institute of Science Campus, Bangalore 560 012, India

Published by
National Institute of Advanced Studies
Indian Institute of Science Campus
Bangalore 560 012

Price : Rs. 35/-

Copies of this paper can be ordered from:

The Controller
National Institute of Advanced Studies
Indian Institute of Science Campus
Bangalore 560 012
Phone : 080-360 4351
Email : mgp@nias.iisc.ernet.in

ISBN 81-87663-48-0

Typeset & Printed by
Focus Communications
139, Cozy Apts., 8th Main, 12th Cross
Malleswaram, Bangalore 560 003
Tel.: 334 6692

What is psychotherapy?

This question has been asked of me several times during the forty years I have practiced as a psychiatrist – sometimes with genuine curiosity but often with derision and cynicism. Some make a joke; "You mean, you treat patients just by talking to them? That is a good way to make money" they say. "You get to hear interesting stories and then you get paid for hearing them".

In fact, it is not an easy question to answer. Words and phrases, which require a rational structure, are often unable to convey the meaning of an enterprise, which operates largely through emotions. Still, in this paper, I intend to try and explain the aims, process and the philosophy of psychotherapy. One might well ask if, what I intend to say, comes from some standard literature on the subject or from my experience as a psychiatrist

working in the context of Indian culture. The answer to that would be that it comes from many sources. It comes from the writings of stalwarts like Freud and Jung as well as many who followed them. It comes from the apprenticeship I have had under my teachers. It comes from the values embedded in the culture I have grown up in and it comes from the interaction I have had with my patients who have taught me and continue to teach me even to this day. There is always something new to be learnt from these interactions; each patient is in many ways unique. Like all clichés this also contains a fair amount of truth and wisdom.

Let us, first of all, put psychotherapy in its proper context by saying that it is *one* of the tools mental health professionals employ to do their job. And what is this job? It is to relieve the distress either of the patient who cannot cope with his or her morbid emotions or that of the family who cannot cope with the inappropriate and destructive behaviour of the patient. This has been the job of priests, shamans and wise men ever since civilisation began but as our understanding of the brain functions has increased, newer techniques of doing this task have emerged which require a great amount of sophistication, scholarship and technical expertise on the part of the healer. The task has now become the prerogative of the professional psychiatrists and psychologists who have to understand life at many different levels, each with its own laws, which cannot be

fully derived from laws which operate at another level. The human mind, and as a corollary, its pathology can be understood at the atomic, molecular, cellular, organic, psychological, social, spiritual and many other levels above and below this hierarchy; levels which have not yet even been conceived. There is a tendency on part of some fellow professionals to believe that as we understand more of the neuro-chemistry and neuro-physiology, we shall not need to bother about the laws which determine interaction between people or questions regarding social justice or purpose of life. I am afraid this optimism is grossly exaggerated. The understanding of neurochemistry, neuro-physiology and neuro-anatomy has given us wonderful new methods to heal mental distress but to imagine that one day we shall discover one precise chemical to counteract a precise morbid emotion is wrong (Kapur 1987) Even with the limited knowledge we possess about these chemicals, we know that many different neurotransmitters are involved in the experience of, for example, the emotion of anxiety. Some of these chemicals can combine with some others to produce a feeling of depression or suspicion and so on, but *only under certain circumstances*. If the environmental situation is different, the same chemicals produce a different experience. The truth hit me hard when we were very young, when my wife and I experimented with LSD. Our experience, our perceptions and our emotions were totally different. She had a lark of a time and I had the most frightful

hallucinations, this difference being determined not just by our current preoccupations but also by our respective life histories.

Psychotherapy operates at the psychological level. What do I mean by psychological level? This is the level at which *meanings* emerge from a complex interaction between our brain processes and the life around. By entering into a relationship with the patient a mental health professional encourages the emergence of new meanings which replace the negative preoccupations by a sense of hope and enthusiasm – enough to goad the individual towards newer ways of living.

And what does the therapist do in this whole process? First, he *listens*. He allows the patient to tell her story and express her distress. It is sad that so many persons in the world have no one who would listen to them. The telling of the story has a very important function. Very often the distress is caused by a confused understanding of what actually happened. One often builds up resentments, suspicions, anguish and depression because the person does not have a clear sense of the sequence of events, which led to pain and an understanding of his own and other people's precise role in this chronology. Very often we find a person seething with anger because of some insult caused by others, forgetting that he himself provoked that insult. Not only does the therapist listen – intently with patience and sincerity – but also, through a disciplined process of history taking, he systematically

uncovers the life events, *in their precise order,* on the mental screen of the patient so that the latter gets to have more accurate understanding of what happened. One has known of patients feeling better just after one session of therapy not because the therapist did anything miraculous but only because the former saw things more clearly.

The therapist often encourages the expression of distress through a process which is called *catharsis*. Technically the term means the "reliving of those experience which originally caused the emotional build up". The loss of a loved one or of a relationship or even of material possessions is often so painful that the patient blocks the experience. The classic case is of a young adolescent unable to cry after the death of a parent. By encouraging the patient to relate the event in detail, often repeatedly – from different angles – a therapist opens the floodgates, which allow the person to cry. Mourning and crying after a loss are healthy behaviours, which are unfortunately getting unfashionable in the modern society.

A very important function of psychotherapy is the offering of *support and reassurance*. A distressed person is often a lost person, feeling very alone and with very low self esteem. A good therapist assures the patient that in spite of his problems he is still a worthy person, deserving love and respect.

Once, the patient has expressed his distress and has received reassurance, the stage is set for the process of education. Very often the distress is caused by patient's own mistakes, difficulties in forming relationships, excitable temperament or irritating behaviour traits. Once, snug in the warmth of the therapist's acceptance, the patient is more willing to face his errors rather than going on the defensive.

The errors and mistakes are in most cases based on personality traits which got formed early in childhood and which get exhibited repeatedly either because the patient is not conscious of their origin or because he is helpless in preventing their expression. The most ambitious form of psychotherapy aims at discovering these sources and in the light of this discovery, help the patient in altering his or her personality structure. Freudian psychoanalysis is one such form of *depth psychotherapy*, but there are many others, following different theoretical frameworks and practical strategies.

One particular phenomenon, which always occurs in course of psychotherapy, is that of transference/counter transference. In transference, the patient projects on to the therapist such emotions, which she had for her father, brother or a lover. In counter-transference, the therapist responds to these emotions or projects his own. This is not necessarily bad because such unconscious mental expectations provide the fuel for the progress of the therapist-patient relationship. However, if the game were

allowed to proceed on its own momentum, there would be only a replay of the past and no growth. A good therapist anticipates this drama, uses it judiciously and interprets it to the patient at an appropriate time so that the latter learns to examine the old relationships in a new light.

In the preceding paragraphs, I have very briefly examined various stages of psychotherapy as well as the techniques and strategies used but let me say forcefully that the techniques and strategies are only a small part of the whole process. The most important instrument used in psychotherapy is the therapist himself and it is this instrument I shall now examine. What kind of a person must a psychotherapist be, to be competent in his vocation? I shall endeavour to answer this question with illustrations from my own growth as a psychotherapist.

Before I go any further, let me make a formal statement about psychotherapy. Following Jung I do believe that psychotherapy is a *dialectical* process in which the doctor participates as much as the patient. (Jung 1954). In this interaction, if the therapist wishes to induce a change in the patient he must be ready to undergo change himself. Any attempt at keeping himself aloof, enclosed – as if it were – in the armour of his own professional mystique, is going to make him ineffective as a therapist. Certainly there are the phenomena of transference and counter-transference, both of which have to be interpreted and used at appropriate junctures but there is also the *real relationship* in which the doctor must

respond to the patient as one human being responds to another.

This brings me to the discussion of a quality which I think is of paramount importance for a therapist. A therapist must be able to love. Put like this, it sounds rather trite but I do not mean 'love' in the romantic or sentimental sense. People often assume that if one loves, it necessarily results in greater pleasure. I do not see it that way. As Angyal (1964) says, loving makes one's life larger, not necessarily more pleasant. In the context of this discussion, this ability to love implies ability to suffer along with the other; for the other. This suffering often goes beyond the one hour you assign to your patient. You may well ask whether this kind of suffering would not affect the therapist's day-to-day functioning. It certainly could do so. It used to keep me awake. I still occasionally stay awake thinking of my patients and I am very sure that many other therapists also do the same. The pain is most shattering when a patient you have been treating, commits suicide. While a surgeon can remain largely unaffected if his patient dies on the table, a therapist can hardly do so because of the emotional involvement, which exists in spite of several theoretical injunctions against this possibility. However, as one grows as a therapist, one understands that this ache for the other, gives meaning to one's own existence and a wise therapist passes on this insight to his patients.

Let me illustrate what I have said above by telling the parable of the Zen master (Smith, 1983) who was considered by all to be a wise man. One evening, when he was taking a walk he heard wailing sounds in a house he was passing by. On entering quietly, he found that the householder had died and his family members were crying. Immediately, he sat down and tears started flowing down his eyes. A gentleman who was shaken by the display of such emotion in the famous master remarked, "I would have thought that you at least, were beyond such things." "But it is *this* which puts me beyond it", the master replied, through his sobs. What did the master mean? The master was talking of a particular kind of peace which comes when there is no way to relieve the pain of life and the only way to combat it is by giving in to it. A therapist learns about this kind of peace slowly; as he grows to surrender to the pain of his own living as well as the pain of – at times – not being able to relieve some one else's pain. It is my belief that a lot of patients (and therapists!) suffer because of their inability to accept that suffering is a natural part of existence. "why me?" is a common complaint in my clinic. "Why can I not do anything about my patient's suffering?" is a thought which often agitates the therapist.

Let me talk of a patient of mine; a 50 year old woman. A lively and fun loving person when young, she lost her husband when she was only 28. She had two young children at that time. As the time passed her in-

laws robbed her of much of her husband's wealth. She had a very difficult time bringing up the two children by herself, both of whom required psychiatric help at one time or another. Being beautiful, affectionate and naive she entered many relationships, only to be rudely abandoned time and again. Finally she got married to a widower. This man discovered that while she had told him of all her previous unfortunate relationships she had hidden one, of which she was particularly ashamed. He came to know of it from some one else. Confronting her with this deception he said he would never be able to trust her and sought divorce. She became very depressed and after unsuccessful treatment with antidepressants, she came to me. After listening to her, my eyes filled with tears and I said spontaneously, "you have suffered a lot, haven't you?" This response did not require any strategy; one only needed to be alive to one's own humanity. It was an acceptance by me of the fact that I could not get her back her marital bliss. She too cried and after that we sat together for a long time watching the stars which one could seen shining in the sky, through the window. Following this reverie we started talking again and this time the talk automatically turned to plans she would have to make for starting a single person's existence once again: issues like renting a flat, taking a job, claiming for alimony, developing a social circle and so on. I learnt later that the previous therapy was unsuccessful because she constantly kept saying "why me" and the therapist

responding with putting her into a diagnostic category instead of responding as one human being to another with genuine pain.

People say love is blind. Real love is not blind; it is visionary. It sees beyond what others see. Many therapists know how to find unhealthy patterns and to analyse where and when the patient went wrong but loving means an ability to see the real self behind and within the neurotic behaviour of the patient. The task of the psychotherapist is not just to break down defenses and make the patient see himself in all his nakedness; it is also to reconstruct him towards his true self. How do you reconstruct without love? To be sure, faults have to be pointed at, unhealthy behaviour patterns have to be recognised but at the same time the therapist must see beyond the patients' faults, just as a loving wife sees her alcoholic husband or a mother sees her errant child. Reconstruction starts with forgiveness for the past. If the therapist is able to forgive, he facilitates self- forgiving in his patient, releasing funds of energy, which were tied up with guilt, funds which can now be used for patient's own attempts at reconstruction. One can pretend to be indifferent but real forgiving occurs only in the context of loving.

Let me add a cautionary note to what I have been saying. There are the very real phenomena of transference and counter transference, which occur during psychotherapy. I would like to make it clear that the therapists' need for dependency, approval, exploitation

and control must not be equated with love. It is very easy to make the patient infatuated with you. There are several women who come to me with the anguish that their husbands or lovers do not respect them. This is the first time they encounter a man who is listening to them sympathetically. The signals of gratitude sent by these extremely vulnerable women are powerful enough to fuel one's own egotistical needs. This is anything but love and can lead both the patient and the therapist into trouble.

Can one *learn* to love in this fashion? I do not really know. I do believe that seeds of loving are present in all of us. In all of us there is a need to become larger than what we are – through meaning something to someone else. But I also believe that the process of acculturation in a civilisation built on greed destroys these seeds in many people. *Let me be bold enough to say that not every one is fit to be a therapist*!

How would one prepare for becoming this kind of loving person? Hoch (1979) says something very important in this context. She says that one would need to inculcate two rather contradictory qualities, which are not usually found in the same person. On one hand, there is the need for developing interest, openness, permeability and receptivity. But this alone is not enough. This may make the person fragile, incapable of standing up against the hard realities of life. This sensitivity must be accompanied by an exceptional strength and ability to transform the forces which enter through this permeable

exterior and which can then be communicated in an effective and at the same time, harmless dose to the person one is attempting to change. The achievement of the ideal balance between the two is the key to the love I am talking about. Needless to say; to bring about this change in his own self, the therapist would require tremendous self-discipline, effort and passion.

Let me tell you how the growing affection and respect for others has catalysed a change in my preoccupations as a therapist. There was a time when it was very important for me to discover the 'truth' behind the patients' problems. Their blocks and resistances used to annoy me and impatient as I was, I would probe furiously, sometimes using techniques like hypnotism, abreaction, truth serum, etc., to reach the heart of the matter. Now, I find it much more prudent to let the patient divulge himself, at his own pace or not divulge himself if he is inclined that way at a particular juncture. **The essence of psychotherapy is an affectionate and respectful relationship, not excavation**. Incidentally, the reduction in my own anxiety to know makes it easier for the patient to reveal. All in all, the therapeutic process is faster now than it used to be, when I had a crusading spirit and employed weapons of the kind I mentioned earlier.

A corollary of this attitude is that I am no more obsessed with removal of symptoms, for example, in patients suffering from hysteria. Of course symptom removal has a calming influence on the relatives but to

tell the truth, it is not necessarily a priority in the psychotherapeutic relationship. Most certainly I find the process of using 'tricks' to remove symptoms quite demeaning both to the patient as well as to myself. That these strategies can be demeaning, came home to me with force, when I used a simple trick to make a young person with hysterical aphonia utter some words. I succeeded and he talked but then said to me in a choking voice, "I shall never forgive you for this". I discovered that he was privy to such secrets of his mother and father, any revelation of which would have destroyed the family. His only recourse was to keep quiet and quiet he had become. As I have grown in my profession I have learnt to ignore the symptoms and deal directly with the conflicts. Conflicts in hysterical patients, as we all know, lie quite at the surface. So what, if the housewife who is pressured by her mother-in-law takes to bed for a few days by developing hysterical fits? So what, if a student who is ill prepared for the examination develops a paralysis of the right hand? Heavens won't fall if the mother-in-law cooks for a few days or the student appears for the examination six months later. And if my benign negligence raises the anxieties of the family – so much the better – let *them* be a little anxious for a change, and reduce pressure on the patient!

Let me describe a recent case:

This is a young woman, the only child of working parents, brought up with a great degree of affection. She

was married three years ago to a doctor who works long hours such that she is alone most of the day. When she became pregnant a year ago, the husband really did not have time to take her to the antenatal clinic regularly. When the time for delivery arrived, she found the labour to be an extremely painful and frightening event. She begged for delivery through caesarian section. The obstetrician insisted on natural birth and she delivered after eight hours of a very painful and shattering experience in her life.

After the delivery, she developed pain in the lower back and weakness in the lower limbs, which the orthopedic surgeon ruled out as being due to organic factors. When I saw her, she was walking with a great difficulty, holding my hands, but when I asked her to go and sit down on the chair after the walk (a common enough diagnostic strategy) she had no problem doing so without any help. Obviously, I was dealing with a conversion reaction. However, when I got some more details, I discovered that she was too frightened to take the responsibility of looking after the child by herself. Her 'illness' forced her working mother to take one month's leave and be with her. I could have, of course, confronted the patient with the 'truth' and perhaps even persuaded her to give up the 'symptoms', but I chose not to do so. I only reassured her every time we met that she was indeed recovering very fast and while I was playing out my role, the mother was able to teach her skills of how to look

after babies. The patient is quite well now and on top of the situation. If I had broken the 'symptoms' in the beginning, I would probably have made her very anxious about her deficiencies, and also made her busy mother, hostile at being 'fooled' in this manner. In any case, it would not have taken her less than a month to develop the skills which she learnt any way. After she 'recovered' I was able to sit her down with and explain how psychological factors could cause physical symptoms. In her new confident state of mind, she was able to accept this quite easily.

Let me now take up another issue, which is particularly related to psychotherapy in the Indian setting. It has often been said that in India, since the relationships are hierarchical, similar relationship strategies should be used in psychotherapy. My co-therapists talk of a *Guru-Chela* relationship, in which the therapist teaches and the patient learns. I am afraid I do not accept Guru-Chela relationship as an appropriate model for psychotherapy with Indian patients. The'Guru-Chela relationship' has been misunderstood by those, who recommend it for psychotherapy. Just to talk about it very briefly, a Guru is as if everything for the disciple – "which means father, mother, friend, even a child but eventually his protector, his world, his deity..."(Hoch 1985). Guru is not worried about transferences but allows himself to be used by the disciple according to the latter's needs. This is hardly what the therapists are capable of even if they

were willing to act as Gurus. What the proponents of the Guru-Chela paradigm seem to be aiming for is a power relationship in which the patient occupies the position of a supplicant. I do not accept this hierarchical model. It is true that our patients fall in line with hierarchical demands both in their real life as well in therapy but it does not mean they like it. Every human being wishes to express his or her individuality. Every human being would like to be treated with dignity. I am particularly thinking of women. They are the victims of hierarchy, all over the world but specially so in the Indian culture. Many psychiatric problems for which they come to the therapist are in fact, due to hierarchical demands on part of their spouses and in-laws. I aim for equity and mutuality in my relationship with my patients and try to bring it about in their families.

A few years ago I saw a woman showing psychotic symptoms. In her life she was tied to the kitchen the whole day. The mother-in-law, who *could not work* because of her chronic back pain, dominated her. Her husband, who did not want to hear her complaints, because he worked so hard every day, neglected her. Her husband's younger brother, who was studying to be a doctor and hence could not be expected to do household errands, bullied her. One day she screamed and was diagnosed as suffering from psychosis. I screamed louder than her and successfully frightened these tyrants. I told them that unless they changed their ways, this woman will live in

the mental hospital forever and if that happened, "who would run their happy family?" Things are much better now. The mother-in-law cuts the vegetables and dusts the house. Husband is willing to listen to his wife. The brother-in-law does the outside errands. The woman has attained a great deal of dignity in the house.

Let me move to a new theme.

Another essential personal quality of a therapist is the ability to walk on the razor's edge between different polarities, which are not reconcilable. Life is nothing if not a bundle of contradictions and a therapist must realise that there are never going to be final answers to some questions. For example, how much should the therapist involve himself with the patient? If you do not involve yourself you are often not effective; if you over-involve yourself, you get transference problems. A therapist must walk on the razor's edge between these polarities. Does one help the patient to gain autonomy or does one help her adjust to the society. Both are important. A therapist walks on the razor's edge between these polarities. A couple comes for therapy. You hear the wife's story and she excites a sympathetic cord in your heart. You hear the husband's story and he seems to be right also. They build two different stories from the same set of facts. Whose story is true? The therapist has often no choice but to walk on the razor's edge between these polarities. I am reminded of the set of novels called the "Alexandria Quartet" written by Lawrence Durell – four

different characters, four different stories but built from the same facts. Which one is true? A therapist slowly learns that 'truth' is relatively unimportant in psychotherapy; what is important is the relationship. Sometimes I feel that the whole process of psychotherapy is, in fact, a process of conjuring up a story jointly by the therapist and the patient so that the relationship goes on. Healing occurs through relationship.

Let me go on to another personal quality, which a therapist must have. He must have a personal philosophy - a set of values around which he builds his own life. One does not expect the patient to accept his values. But a patient in his confusion needs an edge to push against. In the safety of a therapeutic relationship, he needs a strong pillar, which he holds on to for pulling himself out of the mire and stand on his own ground. Patients often ask me, "What will you do in my position?" I might delay my answer till the patient has shown signs of thinking for himself but if this a genuine query and not an attempt to see the therapist as a father figure, I never hesitate to tell them. If I do not know, I say that also.

I am strongly against the therapists hiding behind their professional masks and saying, "my life should be of no concern to you". This, of course, does not mean that the therapists should have their hearts on their palms or try to solve patients' problems by giving examples from their own lives.

And finally, to the last point I wish to make. Just like a surgeon needs clean hands, a therapist needs a clean mind. If it is not clean, one at least expects sustained attempts to remove the dirty spots and if one cannot do it alone, one should do it with the help of fellow therapists. A *Satsang* with fellow therapists in which the problems, both of the patients and one's own life, could be talked about is extremely helpful. One is not asking for perfection but only for *'Abhyasa'* – only for the attitude of a devoted experimenter. As my teacher used to say, to be a mountain guide, you need not have climbed the Everest but you must be actively climbing mountains (Surya 1979).

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He has been interested in issues connecting spirituality and psychology for many years. In 1981, he spent a year as an apprentice sadhaka with a Guru, undergoing training in yoga. Since then he has been going to the Himalayas every year, interviewing sanyasis regarding their life trajectories. He aims at picking up from the Indian scriptures as well as from the sanyasis he interviews, principles which could be useful for psychotherapy.

ISBN 81-87663-48-0