VIEWPOINT

Cross-Cultural Views of Self in the Treatment of Mental Illness: Disentangling the Curative Aspects of Myth from the Mythic Aspects of Cure

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THIS paper compares Eastern and Western concepts of self within the context of the healing process. I draw upon the work of Sudhir Kakar and Heinz Kohut to illustrate differences in how mental illness is expressed and treated in India and the United States. I propose that cultural variances in the way that illness is expressed and treated relate to differences in culturally determined "myths" of the self. In India, where Kakar lives and works, the self is conceived as fluid and interdependent; in the West, the self is conceived as more solid and autonomous. The therapeutic methods employed by the Western-trained psychoanalyst and psychotherapist make use of the Western myth of self. Likewise, in India the shaman heals in accordance with the myths available to him. No matter what our cultural background, such myths lend coherence to our experience and influence the way in which we solve our problems, including the problem of "mental illness." Finally, I suggest that these "myths" of self are not static and point out ways in which the Western myth of self is evolving. As these myths change, so do our methods of treating mental illness.

Much has been written on the distinction between the Western and Eastern views of self (Marsella et al. 1985; Shweder and LeVine 1984). Broadly speaking, the Western self has been described as more autonomous and differentiated, while the Eastern self is more relational and interdependent. McKim Marriott (Kakar 1982) has suggested that in the West the person is conceived of as an *individual* (indivisible): a discrete entity which is "enduring, closed, and has an internally homogenous structure" (p. 274). In India the person is regarded as a *dividual* (divisible): a fluctuating composite of his/her relationships, contextually defined, and open to outside influences. Kakar warns against making too much of the distinction between *individual* and *dividual*. He suggests that Westerners are less individuated and Easterners are less interdependent than most cross-cultural psychologists and anthropologists would lead us to believe.

In this paper I hope to articulate something about why differences in the definition of self are important, particularly from the perspective of a clinician, and

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something about how too much emphasis on such differences can lead us to become theoretically entangled in the mythological aspects of illness. The clinician is almost always caught between using some aspects of his culture to help heal his patient and protecting his patient from those aspects of his culture that are contributing to the illness. I am interested in the relationship between definitions of self, illness, and the healing process. In this paper I will discuss shamanism and psychoanalysis with an eye toward clarifying the nature of this relationship.

One of the benefits of examining therapeutic methods cross-culturally is that it helps us to become aware of our own myths. While we cannot escape these myths, because they are ingrained in who we are, such an examination permits us to see their limitations. Recognizing our own culturally determined limitations is helpful in understanding both how these limitations impact upon our patients and the mythic nature of our cures.

Mental health implies some degree of balance in one's sense of continuity and discontinuity between self and environment. This balance requires that the "normal" lines of communication between individual and culture be relatively free of obstructions. The individual's subjective experience of self must be somewhat contiguous with how that individual is objectively perceived. How he chooses to express himself must make sense within the context of his culture. For an individual to be "healthy," there must be some overlap between personal meaning and shared meaning. The degree to which a person feels connected with or separate from his world depends upon how well he is perceptually and affectively attuned to his environment.

The basis upon which this sense of continuity/discontinuity is established depends on how we define ourselves in relation to our environment. For example, I define my sense of continuity in terms of the degree to which I am able to express myself freely and act as an independent agent, unfettered by the demands of others. In other words, I am more assimilative than accommodative, and if something needs to bend, I more or less expect my environment to do the bending. In fact, I spend a great deal of my time trying to get the world to conform to my way of seeing things. For me, the balance is heavily weighted in favor of individual freedom and the open expression of feelings. Ironically, I was raised to think and behave as such, so to a large extent my penchant for rugged individualism is culturally determined. If I were suddenly transported to a different culture, where the balance is weighted toward community concerns, I would be under some pressure to redefine my sense of self. It is likely that my sense of continuity would shift and I would become more accommodating.

In the West, children are raised to stand on their own. In the field of psychology, the internalization of object representations and the achievement of "object permanence"—which enable the child to become increasingly self-reliant—are considered the most significant developmental milestones. Once the development of the psychic structure is complete, the individual is no longer quite so open to environmental influences, or so helpless and dependent on others. In the West, "normal" development is a process leading from a state of being psychologically merged with mother to states of greater and greater degrees of autonomy. The importance of the individual's capacity to maintain a proper distance from his environment is underscored by Freud's comment that "*Protection against* stimuli is an almost more important function for the living organism than *reception* of stimuli" (Freud 1920, p. 27). True to the Western myth of self, the psychoanalytic literature (Landis 1970) tends to define ego boundaries as barriers or ditches protecting the psychic structure. Solid ego boundaries are considered "healthy," while loose and permeable ego boundaries are considered pathological (Polster 1983).

In India and China, where there is less emphasis on the autonomy of the individ-

ual, there is more fluidity between self and other. Psychoanalytically speaking, the internalized object representations are less static (and less stable?). The Indian's psychic structure remains plastic and more open to external influence. Cross-cultural differences in "body imagery" help to clarify the distinctions that exist between the Eastern and Western views of self. Kakar writes:

> The Indian body image stresses an unremitting interchange taking place with the environment, simultaneously accompanied by ceaseless change within the body. As Frank Zimmermann writes, "There is no map nor topography of the body but only an *economy*, that is to say fluids going in or coming out, residing in some *asrya* (recipient) or flowing through some *srotas* (channels)." It is the imagery from the vegetable kingdom, such as the plant's drawing of nourishment through the roots, the rising of the sap, and the milky exudation of the resinous trees, that provides models for the image in Ayurveda. Indeed, as Wendy O'Flaherty has shown in her discussion of some Vedic and post-Vedic myths, fluidity and the transactions of fluids – between humans, between gods and between humans and gods – are central Hindu preoccupations. [p. 234]

The differences in how the self is defined are reflected in the variety of treatment modalities that exist across cultures. How people become ill, and what they do to get well, is determined at least in part by their cultural belief systems. The nature of illness is defined in terms of how the patient feels, how the patient expresses his affective experience, and how the healer enacts a cure. In different therapeutic modalities, affect is expressed and handled in radically different ways. The goal of all therapy is to facilitate healing; however, the terms by which health and illness are defined vary from culture to culture, from system to system. For example, in the United States, a person who is confronted with tremendous stress and significant loss may be likely to become "depressed" and complain about disturbed sleep patterns, loss of appetite, feelings of hopelessness, emptiness and despair. In China, under similar circumstances, a person is more likely to develop somatic complaints and be diagnosed with neurasthenia. Kleinman (1980, 1986) explains this discrepancy in how "depression" is experienced and expressed in China and in the West in terms of fundamental cultural differences. In China, where psychological illness is highly stigmatized and a source of tremendous pain and shame to one's family, the expression of depressive affect poses a greater threat to one's intimate relations. Neurasthenia is a more acceptable "explanatory model" because its implications are less insidious than those of depression, which is experienced deep within the self and threatens to cut the patient off from his surroundings. Within the context of Chinese culture, it "makes sense" to somaticize one's emotional distress.

The goal of treatment in India is to reestablish harmony within the family, while in the West the goal of treatment is greater autonomy and freedom for the individual (Kakar). Although this distinction in therapeutic goals is not absolute, it is helpful in understanding differences in how the sense of balance between self and other is achieved in different contexts. In a society that is relationally oriented, reestablishing continuity between patient and environment requires that the illness be made understandable and acceptable to the patient's family. The expression of illness and the explanation of its cause must fit within the cultural context. In traditional cultures such as those of India, China and Japan – where the individual is more firmly embedded in the social environment – the direct expression of negative social affect is experienced as a threat to the social fabric. However, as I shall describe in the following case study, in India there are culturally prescribed ways of safely expressing unacceptable emotions.

The Temple of Balaji

In *Shamans, Mystics and Doctors*, Kakar describes the temple of the god Balaji, a shrine of healing well known for its effec-

tiveness in treating cases of spirit possession. A decision to go to Balaji is a big step, an open admission by the patient and his family that something is seriously wrong; such a decision indicates a strong emotional investment in finding a solution. The journey itself is a way of psychologically preparing the patient and family for what is to come. Once the family arrives, they are absorbed into the temple community, which helps to raise hopes and expectations. The community is made up of other patients and their families, plus ex-patients and supplicants to the deity. Many ex-patients return to the temple on a regular basis to pay homage to the healing god and fortify themselves against a relapse. Before the treatment begins, the patient is required to purify herself/himself by abstaining from any impure activities and refraining from eating impure foods.

In essence, the healing process involves a direct attack on the possessing spirit. First, the patient is given food, which has been empowered by the spirit of Balaji. This food (*laddoos*) is meant to force the spirit to make an appearance. When the spirit "appears," the patient goes into a trancelike state of semi-consciousness, typified by rhythmic swaying motions of his upper body, shaking of his head, and beating of the floor with his hands. What usually follows is a struggle between the spirit and the temple deities, played out as a struggle between patient and shaman. This struggle often includes the people in the temple, most notably the patient's family, who shout slogans in support of the deity, and who are often the victims of the possessing spirit's vicious verbal attacks. This outpouring of intense emotion is in essence a cathartic experience. Kakar writes:

> The torrent of aggressive abuse, especially when it is issuing out of the otherwise demure mouths of frail young girls and women, leaves little doubt that we are witnessing a convulsive release of pent-up aggression and a rare rebellion against the inhibiting norms and mores of a conservative Hindu society of which its gods are the more obvious representatives. [p. 67]

The shaman, who is the flesh-and-blood representative of the temple deity, symbolically beats the spirit into submission; in the end the spirit begs for forgiveness, promises to leave the patient alone, and throws itself at the mercy of the god (Kakar, p. 68).

Asha is a 26-year-old woman who came to the temple of Balaji with her mother and uncle. Her symptoms were mostly somatic: severe headaches, violent stomach aches, and periodic episodes in which she had the sensation of ants crawling over her body. She also experienced "bouts of gluttony and fits of rage in which she would break objects and physically lash out at anyone who happened to be near her" (Kakar, p. 71). Previously, Asha had sought medical treatment and consulted with an exorcist, all to no avail.

Throughout her childhood, Asha had been her father's favorite. When she was 15, she fell in love with a college student who had been employed as her tutor. Her father strongly disapproved and sent Asha to live with her aunt in another part of the country to put an end to the romance. After about a year her father became ill and sent for Asha, as he wanted her to be his nurse. She cared for him, and his health improved, but the subject of the tutor was never discussed. Three years later, Asha's brother, with whom she was close, married a woman with whom Asha didn't get along. Asha felt that since the marriage, her brother had become indifferent to her. At around the same time, a man in the neighborhood developed an interest in Asha and openly declared his love for her. Her father became furious and went to speak to the man's family. However, the man's mother convinced Asha's father that Asha should marry the man's younger brother, and an engagement was agreed upon. Asha was not at all pleased with this arrangement, but her father became ill again, and she felt that she could not give voice to her displeasure. She again nursed her father

back to health, which required that she bathe him, including "holding and cleaning the organ which a girl never holds in her hand" (Kakar, p. 73). Meanwhile, Asha's fiancé's older brother continued to make sexual advances. It was in this context that Asha's array of symptoms developed.

Shortly after coming to the temple and being fed *laddoos*, Asha went into a trance, fell to the floor, and revealed that she was possessed by two spirits. The first spirit, who was responsible for Asha's stomach aches, claimed to be sent by Asha's sister-in-law. This particular ghost was identified as the type that usually inhabits cemeteries and whose "specialty" is eating unborn babies in the womb. The second spirit, who claimed responsibility for the sensation of crawling ants and Asha's fits of rage, revealed that it had been sent by the elder brother of Asha's fiancé. After the two spirits appeared and identified themselves, no more was heard from them, and Asha took little interest in punishing her spirits. However, Asha continued to experience these trance-like states on a regular basis. She would emerge from these states with a "feeling of heightened well being." In fact, it seemed that she was beginning to rely on these trances, and if several days went by without one occurring, she would experience intense discomfort.

Interpersonal/intrapsychic conflicts that might be experienced and understood as "neurosis" in the West are often treated as "spirit possession" in India (Kakar). From a psychoanalytic perspective, the spirits are symbolic representatives of Asha's unresolved conflicts. Kakar suggests that "Asha was attempting to exchange her possession symptom, a pathological reaction to an individual conflict, for the ritual trance. . . . a socially sanctioned psychological defense" (p. 72).

However, the shaman treats the spirits not as symbols but as the actual cause of Asha's problems. Kakar points out that the shaman approaches the problem from an entirely different angle than the analyst. While the analyst allows himself to be drawn into the patient's *text* and concerns himself with decoding the symbolic significance of the symptoms, the shaman is more concerned with the *context* of the patient's illness and directs his healing efforts toward reconnecting the patient with "the sources of psychological strength available to his or her life situation" (Kakar, p. 82).

In addition, the shaman helps first to purge and then to repress feelings of despair, shame, guilt, confusion, and isolation that interfere with the patient's relatedness. The emphasis is on resolving the patient's feelings of alienation from the social order, specifically his or her family. The rules of the temple are set up so that the healing process includes the patient's caretakers, usually his or her family members. Many of the rituals involve the active participation of the patient's family. It is not uncommon for the possessing spirit to be temporarily transported into the body of a close relative, which underscores the tacit understanding that the patient's illness is a collective problem. As the family members are integrated into the healing process, the distinction between who is sick and who is normal begins to fade. In some respects, like a structural family therapist, the shaman tends to treat the patient's illness as a symptom of a larger systemic problem.

In shamanism, the affective experience of the individual is depersonalized. Both the patient's outward behavior and his subjective experience are explained in terms of invading spirits. The patient is thought to be a vessel in which homeless spirits take up temporary residence. The shaman's powers are derived from his close affiliation to a god or saint, and he is believed to be a receptacle through which the god speaks and acts. Just as the patient is not directly responsible for his illness, so the shaman is not directly responsible for the cure. Both patient and shaman are merely vessels—all significant events are attributed to either the possessing demon or the god.

This form of therapy helps the person to distance himself from his illness. In traditional India, the "unconscious" resides in the public domain. The "spirit world" ex-

ists as an external entity that can either interfere with one's sense of continuity, or help to cushion and protect one's relationships. Externalizing the cause of illness is not simply a means of disclaiming responsibility: it also helps the individual to feel less isolated from his environment. He searches for an explanation to which others can readily relate. Having one's difficulties explained in terms of cultural motifs helps to bond the experience of self with the experience of others.

Both the shaman and psychoanalyst attempt to give structure to the patient's experience. However, in the West the therapist enters the mythic world of the patient, while in India the patient enters the mythic world of the shaman. Cure is the process of turning a meaningless, painful experience into a meaningful experience. In classical psychoanalysis, the therapist works with the patient to bring unconscious feelings into conscious awareness, the assumption being that what lies beyond our conscious awareness is beyond our control. Similarly, as we saw in the case of Asha, the shaman uses his power to force the patient's spirits to make an "appearance." In psychoanalysis, knowledge of self leads to greater control and ultimately more freedom: where once there was id, now there is ego (Freud 1923).

In the following sections I discuss the shift in psychoanalytic technique from Freud's asocial, intrapsychically oriented approach to a more interpersonal, contextually oriented understanding of psychopathology. It is my hope that this discussion will shed some light on how the current "myth" of self in Western culture is undergoing a transformation, away from an exclusively individualistic orientation.

Freud and Classical Psychoanalysis

As Kakar points out, if one looks closely enough, many of the patients at Balaji bear a remarkable resemblance to the hysterics Freud treated in Vienna at the turn of the century. Despite these similarities, Freud had a radically different understanding of the cause of his patients' illnesses and took a somewhat different approach to their treatment.

Freud began his inquiry into the psyche under the assumption that many of his patients' troubles were due to a strangulation of the emotions. Together with Breuer, Freud found that when in a hypnotic state, patients would relive past traumatic experiences that had been "forgotten." The cathartic effect of remembering put an end to – and confirmed in Freud's mind – the emotional root of mental disorder. The success Freud had with hypnosis gave him a window through which he could peer into the vast pools of unconscious feelings and forgotten events that seemed to be the cause of his patients' suffering.

Freud eventually replaced hypnosis with the techniques of free association, dream interpretation and eventually the analysis of transference. As Freud became more interested in why the mind blocks out and distorts certain feelings and memories, he realized that by using hypnosis, he was sidestepping the patient's psychic conflict. He wanted to know why the mind was keeping so much of itself behind locked doors, and he became interested in the mechanism of "resistance." Freud suggests that the reflective/critical aspect of human consciousness is somewhat like a doorman at an exclusive club. It allows only a few selective thoughts to pass into awareness, allows even fewer to be expressed, and turns the rest away to seek entertainment elsewhere. It may be that our ability to think selectively is important to the maintenance of the civilized world, but Freud discovered that an overly critical mind could create a pathological rift within the self. With free association and dream interpretation, Freud hoped that he not only could reveal the buried secrets of the unconscious but also could examine the process through which his patients distorted and suppressed their unwelcome thoughts. Breaking down the patient's resistances and discovering their meaning

seems to be curative because it is cathartic and helps to diffuse the internal conflict. Through analysis these hidden feelings are expressed and reintegrated into the psyche.

The idea of the transference became central to the psychoanalytic treatment of mental illness. Briefly stated, transference is the process emanating from a basic human tendency to transfer or displace unconscious feelings about significant persons in one's past onto one's current relationships, particularly one's therapeutic relationship. Understanding the transference is essential to the therapy because the patient's fantasies about his/her analyst provide access to the patient's unconscious conflicts. The relationship that develops between patient and therapist will in part be a repetition of the patient's past relationships and thus may reveal the cause of the disturbance.

Freud believed that the therapist would be most effective if he maintained a thoroughly "objective" position with regard to his patients. The analyst was to serve as a "blank screen" onto which the patient's unconscious conflicts were to be "projected." Likening the work of the analyst to that of the surgeon, Freud argued that if the transference cure was to be effective, the therapist must maintain his emotional distance from his patients. Any hint of a "countertransference" reaction on the part of the therapist would threaten to contaminate the transference neurosis and undermine the therapeutic process. The attempt to cast psychoanalysis in an objective, scientific mold led Freud and many of his followers to underemphasize the interpersonal component of the treatment process.

Freud described his model of the mind in terms of drives and structural components. In mental illness, he held, a conflict occurs between two or more components of the self, blocking the normal discharge of psychic energy and preventing the intrapsychic mechanism from functioning properly. In this model of the mind, the individual is seen as a discrete entity. The individual's attachment to other persons ("objects") is understood within the context of drive satisfaction. In psychopathology, an internal conflict prevents drive satisfaction from occurring, damming the flow of psychic energy. While the individual variants of unconscious conflict are innumerable, what remains fairly constant is the structure of the psychic mechanism. The analyst is able to use his understanding of the psychic structure to "make sense" of the patient's symptoms. The analyst spells out the historical basis of the patient's conflict, bringing the conflict into consciousness. He anticipates that once the mythologic/pathologic component of the patient's past is laid bare, there will be a release of the patient's pent-up emotions. Like Asha's spirits, the unveiled unconscious is forced to submit itself to the ego. The analyst's interpretation is often enough to set things right. The work of the patient and analyst is oriented toward resolving such an internal conflict; once this has been achieved, it is hoped that one's "object relations" will become more satisfying.

Within the field of psychoanalytic psychotherapy, there has been increasing emphasis on the "interpersonal" realm of the therapeutic experience (Greenberg and Mitchell 1983; Mitchell 1988). The "Interpersonalists" (Sullivan, Fromm-Reichmann), the "Object Relationists" (Winnicott) and the "Self Psychologists" (Kohut) began to move away from the drive-oriented, intrapsychic structural approach and focused more on the role of "the other" in the development of the self. This shift in emphasis was to some extent based on the recognition that the therapist's capacity to cure depends not simply on his knowledge of psychic structures and unconscious processes but also on his ability to *relate* to his patients. In contrast to classical psychoanalysts, Kohut (1984) argues that while bringing unconscious motives into conscious awareness is often a byproduct of analysis, it is not a necessary ingredient. For Kohut, the success of the healing process rests upon the therapist's capacity to become and remain empathically involved with the patient. Empathy

is defined as "the capacity to think and feel oneself into the inner life of another person" (Kohut 1984, p. 82). It is a "fundamental mode of human relatedness. . . . the recognition of the self in the other. . . . the accepting, confirming, and understanding human echo" (Kohut 1978, pp. 704–05). If the cure is to take root, the therapist must adjust (and readjust) himself—both affectively and cognitively—to the private world of the patient.

KOHUT AND THE EMPATHIC APPROACH

In *How Does Analysis Cure?*, Kohut describes the case of a middle-aged man with a severe narcissistic personality disorder, who enters into treatment with the complaint that he experiences chronic painful feelings of being unreal. Prior to entering treatment with Kohut, this man had begun treatment with several other therapists. According to the patient's report, past treatment had not been successful because his former therapist had failed to understand him. He made an appointment to see Kohut after hearing him speak at a local university. (Kohut's stature at that time, as Chicago's senior analyst, makes a comparison with the shaman at Balaji all the more compelling.)

The treatment began in "an atmosphere of friendly cooperation," which eventually—with the development of the transference—gave way to a "searing blaze of attacks" on Kohut, "mainly, but not exclusively, in the form of verbal reproaches" (Kohut 1984, p. 179). In the course of treatment, the patient developed severe headaches, which were most prominent before and during his sessions. As these headaches worsened, the patient would fill the therapy hours with descriptions of the excruciating pain he was experiencing. Kohut attempted to interpret the patient's deteriorating condition in terms of feelings of abandonment and deprivation, as Kohut had recently returned from a lengthy vacation. This interpretation failed to help and led to further remonstrations. He then suggested that "the worsening of the patient's condition was part and parcel of his improvement, that he had opened himself more to emotional interactions with the world. . . . and as a consequence of his increased courage and enterprise, he now faced a variety of tasks that exposed him to anxieties and tensions from which he had formerly protected himself" (p. 181). This interpretation elicited an initially favorable response, which inspired Kohut to pursue it further. However, his further attempts to explore the underlying dynamic led nowhere. The success of the intervention was short-lived; the headaches and the complaints intensified. In time a crucial shift took place, not in the patient's attitude toward therapy but rather in Kohut's approach to the patient:

> The patient, as I finally grasped, insisted—and had a right to insist—that I learn to see things exclusively in *his* way and not at all in *my* way. And as we finally came to see—or rather I finally came to see, since the patient had seen it all along—the content of *all* my various interpretations had been cognitively correct but incomplete in a decisive direction. The patient had indeed reacted to my having been away; he had indeed felt overwhelmed by the traumatizations to which he was now exposed by virtue of his expanding activities, and he continued to react with prolonged, intense suffering as a result of remaining broadly engaged with the world. What I had not seen, however, was that the patient had felt additionally traumatized by feeling that all these explanations on my part came only from the outside: that I did not fully feel what he felt, that I gave him words but not real understanding, and that I thereby repeated the essential trauma of his early life. [p. 182]

In the above example, Kohut's attempts to make sense of the patient's difficulties are unsuccessful because they lack empathy. What Kohut learned from this patient is that before a change can take place in the patient, a change must occur in the therapist. Specifically, he must remove the "inner barriers that stand in his way of his empathic grasp of the patient" (Kohut 1984, p. 182). Once the patient feels "empathically grasped," there is some

forward movement from the understanding phase of therapy to the explaining phase, in which the patient is able to take a more objective approach to his feelings, thoughts, and behavior. Developmentally, this marks a step in the direction of greater cohesion and an increased sense of autonomy. This is accomplished primarily because the therapist, as an empathic selfobject representation, has become internalized.

Here, the success of the curative process depends on the patient's capacity to experience emotional attunement and optimal frustration within the therapeutic setting. First, the therapist must be receptive to the patient's mode of expression. By understanding and empathizing with the patient's affective experience, he helps to create a situation in which the patient feels continuous with his environment. Eventually, an empathic failure will occur, and the patient will be forced to come to terms with his separateness from the therapist. From a self-psychology perspective the sense of continuity between therapist and patient is established through the use of empathy, while the sense of discontinuity (separateness) is established through the inevitable failures of empathy that occur in therapy. To prevent this sense of separateness from traumatizing the patient and destroying the therapeutic relationship, the therapist must be aware of and attempt to empathize with the patient's feelings of disappointment and narcissistic rage at not being perfectly understood. Kohut explains how the combination of empathy and frustration leads to the internalization of a more adaptive psychic structure:

> The psychoanalytic situation sets in motion a process which, via the optimal frustrations to which the analyst exposes the patient through more or less accurate and timely interpretations, leads to the transmuting internalization of the selfobject analyst and his functions and thus to the acquisition of a psychic structure. [1984, p. 172]

Kohut's use of empathy as a method of cure fits with the Western myth of the individual, because the analyst's role is to totally accommodate himself to the patient. The patient's experience is seen as unique; understanding it requires that the therapist become totally absorbed in the patient's way of seeing things. At the same time, however, Kohut's emphasis on the importance of empathy is a departure from classical psychoanalysis. His use of empathy as "cure" is a step away from the myth of the individual because the method is essentially "relational." It requires that the analyst temporarily extend himself beyond his own boundaries. If we recognize empathy as an important human function, then we are forced to reassess the psychoanalytic view that a healthy individual has solid, nonpermeable ego boundaries. If the capacity to experience empathy is an important part of being human, then we are more relationally oriented than classical psychoanalytic theory had supposed.

Recognizing the importance of empathy, both in the therapeutic context (Kohut 1984) and in the normal developmental context (Hoffman 1978), requires not only that we redefine our understanding of ego boundaries (Jordan 1984) but also that we reappraise our idealization of the autonomous self. In the ecosystemic model advocated by Wilden (1972) and Bateson (1972), boundary is conceptualized as the area of communication and exchange between self and environment, belonging to neither one nor the other. Ego boundary is defined both as a barrier to and the facilitator of communication between self and other. The boundary becomes more or less permeable depending on the contextual conditions (Polster 1983). Boundaries between humans, as among nations, are constantly being renegotiated. The problem with conceptualizing the mind as a structure and individuals as closed systems is that in doing so we fail to address the relational-interpersonal quality of human experience. Sarah Polster writes,

> Such emphasis on entities, whether they be structures or pools of energy, renders discussion of relationships (which is what "bounda-

ry" describes) secondary. Relationships are seen as functions of the ego. Boundaries in this model become derivatives of entities. They become things between things, and their constitutive, assimilative and adaptive roles cannot be described in such terms.

Such "entity" language facilitates description of the barrier aspect of the ego boundary—an important aspect, certainly, but one that is incomplete and ultimately of limited usefulness in describing the subtleties of a person's discourse with self and world. Such language does not facilitate description of communication or exchange. While quite appropriate for the discussion of entities and structure, it is not appropriate for discussion of system and context. [1983, p. 249]

Recent research into empathy suggests there are two lines of development (Jordan 1984): the development of the autonomous self and the development of the relational self. From this perspective, the self is capable of being simultaneously distinct from and merged with the other. In empathy, the relational self-representation and autonomous self-representation co-exist harmoniously. Judith Jordan explains:

> In order to empathize, one must have a well-differentiated sense of self, in addition to an appreciation for the differentness and sameness of the other. Empathy always involves surrender to feelings and active cognitive structuring; in order for empathy to occur, self-boundaries must be flexible. Experientially, empathy begins with some general motivation for interpersonal relatedness which allows for the perception of the other's affective cues (both verbal and nonverbal) followed by surrender to affective arousal in oneself. This involves temporary identification with the other's state during which one is aware that the source of affect is in the other. In the final resolution period the affect subsides and one's self feels more separate; therapeutically, the final step involves making use of this experience to help the patient understand his/her inner world better. [1984, p. 3]

The recent emphasis on contextual/interpersonal factors in understanding normal development and in the treatment of the mentally ill marks a shift away from the myth of the individuated, autonomous self. Perhaps in this shift psychoanalysis is moving closer to an understanding of the universal substratum that lies below its culturally determined structuralist orientation.

Lévi-Strauss (1963) suggests that while the content of myth varies from culture to culture, the laws that govern the structure of myth are essentially the same. All myth, whether it be the product of the individual's unconscious or a product of his culture, is constructed according to a set of universal rules. This is important because it helps to explain why—despite the vast differences between shamanism and psychoanalysis—there seem to be so many important underlying similarities in their respective methods. The power of myth lies in its capacity to give some structure to the patient's chaotic experience. The rules that govern the shaman's rituals and that guide the therapist as he listens to and interprets his patient's thoughts provide the patient with a sense of continuity and order.

In all healing systems it is necessary for the afflicted individual to attach a culturally meaningful label to his personal problems, to "undertake a culturally sanctioned repatterning of the unconscious materials" (Davidson and Day 1976, p. 232). In traditional Indian society, the experience of self is made meaningful by placing it within a cultural/interpersonal context. The shaman's cure is effective because it provides an avenue for the expression of an affective experience that would otherwise be unexpressible (Davidson and Day 1976; Lévi-Strauss 1963). In shamanism, the patient is provided with a culturally constructed myth.

The psychoanalyst, in contrast, helps the patient to construct an individual myth based on the events of his past. The psychoanalyst is the receptive agent, creating a situation in which the patient is encouraged to project his "self" and "object" representations onto the therapist. The relative anonymity of the therapist allows the patient to express himself more freely and prevents the personality of the

therapist from being superimposed upon the patient. In stark contrast to shamanism, psychoanalysis treats disturbances in the unconscious processes as private affairs, unique to the individual. The goal of therapy is not primarily to help reestablish the individual's relationships with others but rather to mend the conflict within himself and make him whole again. This individualistic approach to treatment is true to the Western myth of self, and in this sense it is as much a product of the Western culture as the Temple of Balaji is a product of Indian culture. Lévi-Strauss writes: "In the case of psychoanalysis, the myth that is recovered is an individual possession, whereas in the case of shamanism, the myth is received from a collective tradition" (1963, p. 202). It matters very little, he continues, whether one attacks the patient's illness at the individual or cultural level: "Whether the myth is re-created by the individual or borrowed from tradition, it derives from its sources – individual or collective – only the stock of representations with which it operates. But the structure remains the same, and through it the symbolic function is fulfilled" (p. 203). Shamanism and psychoanalysis do the same thing, in essence; their difference lies in the culturally determined myths they employ.

Cross-cultural differences in how the self is defined have become bigger than life and have taken on a mythic quality of their own. It seems to me that the tendency to mythologize the self is particularly evident in the psychoanalytic literature, where it is written that "normal" development leads to greater autonomy, and that a healthy person is someone whose "self and object representations" are securely embedded in a stable psychic structure, protected by a sturdy set of ego boundaries. We make use of such myths in everyday life, as well as in the treatment of mental illness. For example, the myth of internalization frees us from being dependent on others. We carry our self and object representations with us, while Indians and Chinese, whose psychic structure is less well packaged, remain embedded in and dependent on their family structure and social milieu. The psychoanalyst's tendency to explain spiritual possession in terms of "unconscious conflicts" reflects a wish to view the individual as self-contained. As David Orlinsky once commented, "The unconscious is the supernatural moved indoors" (personal communication). Perhaps the idea of "the unconscious" became such a persuasive force in Western forms of treatment because of our desire to explain everything in terms of a closed system – the individual – rather than in terms of an open system – the cosmos.

REFERENCES

BATESON, G. *Steps to an Ecology of Mind*. Ballantine, 1972.

DAVIDSON, R., and DAY, R. Magic and healing: An ethnopsychoanalytic examination. In W. Muensterberger, A. Esman and L. B. Boyer, eds., *The Psychoanalytic Study of Society*, vol. 7. Yale University Press, 1976.

FREUD, S. *Standard Edition of the Complete Psychological Works*. Hogarth, 1953–74.
Beyond the Pleasure Principle (1920), vol. 18.
The Ego and the Id (1923), vol. 19.

GREENBERG, J., and MITCHELL, S. *Object Relations in Psychoanalytic Theory*. Harvard University Press, 1983.

HOFFMAN, M. Toward a theory of empathic arousal and development: In M. Lewis and L. Rosenbaum, eds., *The Development of Affect*. Plenum Press, 1978.

JORDAN, J. Empathy and self boundaries. Presented at Cambridgeport Problem Center Conference, The Development of Empathy and Its Role in Psychology, 1984.

KAKAR, S. *Shamans, Mystics, and Doctors*. Beacon Press, 1982.

KLEINMAN, A. *Patients and Healers in the Context of Culture*. University of California Press, 1980.

KLEINMAN, A. *Social Origins of Distress and Disease*. Yale University Press, 1986.

KOHUT, H. The psychoanalyst in the community of scholars. In P. Ornstein, ed., *The Search for the Self: Selected Writings of Heinz Kohut*, vol. 2. International Universities Press, 1978.

KOHUT, H. *How Does Analysis Cure?* University of Chicago Press, 1978.

LANDIS, B. *Ego Boundaries. Psychological Issues* (1970) 6 (4) monograph 24:1–177.

LÉVI-STRAUSS, C. *Structural Anthropology.* Basic Books, 1963.

MARSELLA, A., DE VOS, G., and HSU, F., eds. *Culture and Self: Asian and Western Perspectives.* Tavistock Publications, 1985.

MITCHELL, S. *Relational Concepts in Psychoanalysis.* Harvard University Press, 1988.

POLSTER, S. Ego boundary as process: A systemic-contextual approach. *Psychiatry* (1983) 46:247–58.

SHWEDER, R., and LE VINE, R., eds. *Culture Theory: Essays on Mind, Self, and Emotion.* Cambridge University Press, 1984.

WILDEN, A. *System and Structure.* Tavistock Publications, 1972.