Culture, Empathy, and the Therapeutic Alliance

Helen E. Ullrich

Abstract: When the therapist and patient are from different cultures, there may be impediments to the development of empathy and a therapeutic alliance. South India culture provides an example of contrasting values and customs about which patients may be reluctant to discuss. The initial case history is of a South Indian who sought treatment in the United States. The remaining cases, drawn from a village in South India with which the author has had a 55-year history of research, illustrate cultural factors potentially inhibiting or facilitating the development of empathy and a therapeutic alliance.

Keywords: empathy, cultural assumptions, rapport, depression, life events, therapeutic alliance, transference

Culture, which molds an individual's expectations, is significant for the therapist-patient relationship. Case studies of South Indians illustrate the thesis of this article, namely the importance of interpreting cultural issues when they have an impact on the therapeutic alliance. Etiquette and the classification of individuals including transference based on cultural assumptions may result in misunderstandings and prevent the development of a therapeutic relationship. Cultural sensitivity, essential for the development of rapport, can transcend cultural backgrounds in the development of empathy and a therapeutic alliance. Moreover, an empathic therapist can provide a patient with the perspective to evaluate cultural assumptions.

A KARNATAKA, SOUTH INDIA PERSPECTIVE

With the exception of the first case study, the cases in this article have been drawn from a northern Karnataka, South India, village located in the Western Ghats approximately 200 miles from Bangalore. The village of

---

Helen E. Ullrich, M.D., Ph.D., Clinical Assistant Professor of Psychiatry and Behavioral Sciences, Tulane University Medical School. Retired from private practice.

An earlier version of this article was presented at the 63rd annual meeting of the American Academy of Dynamic Psychiatry and Psychoanalysis, San Francisco, California, May 16–18, 2019.

I gratefully acknowledge the following support for research in India: The American Institute of Indian Studies (1964–1966; 1974–1975; 1987; 1994; 1995) and The American Philosophical Society (1985). The National Endowment for the Humanities provided additional support for the 1994 and 1995 trips.

This article was originally published in *Psychodynamic Psychiatry, 47*(4), 425–440 (2019).

Totagadde (a pseudonym referring to the major crops of the village: *to:Ta*[1] "areca nut or betel nut plantation" and *gadde* "rice paddy") has a population of approximately 800 residents. Each of the nine castes has its own hamlet and its place in a strict hierarchy. In the 1960s, higher caste members referred to members of lower castes as "boy" or "girl" regardless of the age of the people involved. A primary school girl referred to her household indentured servant, an elderly woman, as *nam mane huDugi* "my house girl." These forms of address and reference showing the caste stratification (Ullrich 1975a, 2017) were no longer in use by 2010. Caste stratification, while still in existence, is no longer overt.

During my first research trip to Totagadde (1964–1966), I focused on an analysis of the Havik Brahmin dialect of Kannada, the subject of my linguistics PhD dissertation (Ullrich, 1980). Since only Havik Brahmins speak Havyaka Kannada, the dialect known also as *haLe KannaDa* "Old Kannada" has preserved features of the proto-Dravidian era. An example of this is the classification of women and things in one grammatical class and men and gods in an honorific grammatical class (Ullrich, 1971). Generally, the dialect of the elite becomes the established language of the general populace. As a social dialect, *haLe KannaDa* is an exception to this pattern.

My residing with a Havik Brahmin family without an interpreter provided the opportunity for Havik Brahmins to teach me their dialect and culture. Two individuals came daily to my room to respond to my queries about the language. The rest of the Brahmin population also participated in my queries about the language and taught me about their culture. My linguistic focus included phonemics, morphology, syntax, and language accommodation among different castes. During my initial trip, the competition for innovations and the desire for education among Brahmins, who regarded themselves as educationally backward, was obvious (Ullrich, 1975b). Education would continue to be a theme relevant to cultural change in Totagadde (Ullrich, 1969, 1994, 2017, 2019), with older Brahmin women regarding their lack of education as an emblem of their inferiority.

The goal for my second research trip (1975–1976) was the analysis of the non-Brahmin and Dalit (formerly known as untouchable) caste dialects and the accommodations individuals made when speaking with members of other castes (Ullrich, 1982, 2017). Totagadde residents gave me access to all of their households. I was free to wander throughout the village unaccompanied. During these first two trips, I developed rapport, cultural knowledge, and linguistic skills. Each Brahmin household expected a daily visit, but with three Brahmin hamlets and a total of 33 houses, daily visits would have been impossible. The remaining 19 trips involved a study of the village mental health, primarily depression, as well as cultural change. After I entered private practice in 1997, I self-funded annual six-week to two-month research trips. My last trip was in 2017.

In the 1960s when some women reported depression at their prepubertal marriages, I became interested in the relationship of marriage

1. The transliteration of Kannada words is as follows: a capital letter indicates a retroflex phoneme; a colon, vowel length; and *sh*, a palatal sibilant.

to depression, learned helplessness, and assertiveness. While the Havik Brahmins were the most highly educated, Havik Brahmin women generally experienced learned helplessness. Some, however, used passivity and religious practices as a means of control (Ullrich, 1977). This contrasted sharply with the Divaru, a low-ranking caste, in which the women controlled the money, were illiterate, but were shrewd businesswomen. My hypothesis was that appropriate assertiveness provided protection against major depressive disorders while learned helplessness created vulnerability for depression (Ullrich 1977, 1987, 1988, 1993, 2011). I have integrated linguistics, anthropology, cultural change, and psychiatry to develop an understanding behind the dynamics of psychopathology.

In preparation for my initial studies of depression among Totagadde women in 1984 and 1985, I used a formal questionnaire combining the Schedule for Affective Disorders and Schizophrenia (SADS; Spitzer & Endicott, 1978), the Indian Psychiatric Survey, and the Social Functioning Questionnaire (Carstairs & Kapur, 1976; Ullrich, 1987, 1988). A Havik Brahmin in Bangalore, the state capital, translated the questionnaires into Havik Kannada. To randomize the order for administering the questionnaires, I drew the women's names out of a hat. The Totagadde women were cooperative with the interview, which lasted approximately three hours. The Brahmin women typically answered all my questions while the Divaru women frequently commented that I already knew the answers to the questions.

While responding to the questionnaires, the women often free associated with additional information. Moreover, I encouraged in-depth interviews to obtain their accounts of personal experiences. I often went early in the morning to interview the women while they were engaged in housework and cooking and the men were in the fields. One husband went to town so that his wife would have privacy for her interview. In the years following, I have continued to use the questionnaires as a basis for research. Individuals urged me to visit daily for an hour or so.

The only woman to refuse permission to be taped felt that her speech marked her as uneducated. This may have been a generational factor, as most women in her age cohort were more highly educated and some even had college degrees. When she was depressed at the birth of her second daughter, however, she welcomed my presence. After the resolution of her depression, she bonded with her younger daughter. To my knowledge, only one woman failed to bond with her younger daughter.

In the 1960s, for the annual religious observations of one's parents after their death (*tithi*), families wanted two sons. Occasionally, after many daughters and one son, the husband obtained a vasectomy. While first-born children, regardless of sex, have always been welcome, parents were often disappointed at the birth of a second daughter. By the 1980s, two children had become the ideal family size. The desire for a child of each sex determined whether parents chose to have a second child. By 2010, families in urban areas were beginning to limit their family size to one child regardless of sex. The reason most frequently provided was the cost of private school education and college. However, in my field notes are cases of women with high-risk pregnancies who wanted to limit their family size to one child, rather than risk their lives. Those with many miscarriages may have settled

for one child regardless of sex. The value of this child-centric culture was to cherish each child—whether one had one child or a dozen.

My most important papers with a focus on cross-cultural psychiatry dealt with depression and cultural change (Ullrich, 1987), depression as an appropriate response to widowhood (1988, 2011), the cultural shaping of depression (Ullrich, 1993), and the impact of beauty as a protective factor against depression (Ullrich, 2010). Marriage, menses, and widowhood are the major times in a Havik woman's life when a woman's inferior status was especially poignant. Each event lowered a woman's position in society. A woman's highest ritual status was pre-pubertal and post-menopausal—unless she was a widow. Within a family, a woman gained status with the birth of a child and even more status with the birth of a son. When she became the wife of the household head, *yejma:nru*, she was at the pinnacle of her power. As women became educated and married after a college education, they had an opportunity to develop their own views. They ceased to believe that menses marked a woman as untouchable. No longer did they regard a widow as responsible for her husband's death. Consequently, women's emotional status improved.

In my article on the widow (Ullrich, 1988), I argue that widows were culturally destined for depression, psychotic depression, and suicide. A woman who died within 10 days of her husband was not regarded as a widow, but as fortunate and auspicious. Her death was proof of her wifely devotion. Widows with their shaved heads and a maroon or white sari were a target for discrimination. The belief that a wife's devotion would prevent her husband from dying was the basis for discrimination against widows. In the proper order, wives should die before their husbands. Widows were limited to one rice meal a day and a regimen of meditation to expiate their failure to keep their husbands alive. An ill omen, they were excluded from all joyful events, such as weddings.

In the 1960s, sons commented to me that widows received prejudicial treatment and that they hoped to protect their mothers against such discrimination. At that time, some women volunteered that they planned to commit suicide should their husbands die. Not until the 1970s did these same women comment that the marriage of a young girl to an old man guaranteed her future as a widow. Once the culture changed to allow widows to keep their hair and to wear clothing of their own choice, they ceased to be a symbol of bad luck. They experienced bereavement, but to my knowledge there has been only one widow who, in spite of psychiatric treatment including anxiolytic and antidepressant medication, was noncompliant, became psychotic, and committed suicide. Since the 1980s, there have been no other instances of psychosis, major depression, or suicide among widows. Other articles show that socialization regarding a child's attractiveness has an impact on self-image and vulnerability to depression, as do cultural features such as menstrual taboos denigrating women. Endorsed assertiveness decreased vulnerability to depression in contrast to learned helplessness.

In 1964, each household made its own rules as to whether I should stay on the outside porch, be invited inside, or be invited into the most sacred room of the house, the kitchen, with its household shrine for the gods.

Only Brahmins entered Brahmin households. Non-Brahmins were limited to sitting on the porch. Dalits, formerly known as untouchables, sat on the perimeter around the porch. Since non-Brahmins and Dalits did not enter Brahmin houses, the Brahmins did their own housekeeping and cooking. Between 1964 and 1976 some elders decided that welcoming their children's non-Brahmin friends into their home was preferable to alienating their children.

The importance of education as an agent of change and modernization was the theme of my first edited book (Ullrich, 1975b), an article (Ullrich, 1994), and my two recent books (Ullrich, 2017, 2019). Education for both men and women has led to marked changes in marital choice, career opportunities, and mobility. These changes evolved with the support of the elders so that there was little intergenerational conflict. The youth were more united in support of women's education and women's choice of marital partner than the occasional elder who objected to women's having a say or even their own daughters' insisting on the final approval of their spouse. These changes occurred household by household.

The use of kinship terms for physicians provides an example of respect and intimacy in Karnataka culture. In Karnataka, the kinship system divides everyone of the same caste into two categories—blood relatives and potential relatives by marriage. Depending on the presence of others and the closeness of the relationship, patients in Totagadde address their therapists by title and last name or by the appropriate kinship term of respect. In group settings, patients use title and last name, while in private settings a Havik patient and doctor might use the Havik dialect of Kannada with the patient using a kinship term of respect. Listening to the patient's rationale would allow the therapist to learn the reasons for the kinship terms as well as an opportunity to negotiate the therapist's preference. Alan Roland (1988, 1996) reported this as an issue in his treating patients of India. His consideration of terms of address contributed to an alliance with patients in and from India.

In my experience, Indian patients in the United States use the professional designation. In Totagadde where Brahmins are accustomed to using my first name, they would continue using my first name—even when other Brahmins instructed them to show me deference. A feature of Havyaka Kannada is to use the singular form of address, unlike standard Kannada which has a plural of respect. Lower caste individuals of Totagadde called me either by my first name, my first name plus *amma* "mother" as a term of respect, or just plain *amma*.

The advantage of a therapeutic relationship that begins with establishing the terms of address acceptable to both patient and therapist is that it provides a positive initiation to therapy. The consideration of cultural difference allows tolerance of both positive and negative transference on the part of the patient and positive and negative countertransference on the part of the therapist. Working through the transference maintains the therapeutic alliance and an empathic relationship.

Children develop their cultural roles from an early age. To my surprise, when on a visit to descendants of Totagadde living in Maryland, the five-year-old great-granddaughter of the village remained silent on the way from the airport. After she arrived home, she asked her mother, "How can

she be a grandmother? She does not wear a sari. She has no braid. Moreover, she doesn't wear glasses." Her expectation was for her American grandmother to look like her grandmothers in India. She became content after I put on my glasses in the evening and let her choose the sari I would wear to meet her school bus the next day. That way she could point out her "American grandmother." In spite of seeing her classmates' grandmothers and desperately wanting an American grandmother, she thought her American grandmother would look like her Indian grandmothers. By expressing her views, I was able to adjust to her needs. With adjustments on both of our parts, I modified her view of the grandmother role to include me as her American grandmother.

Culture in this article includes the customs, values, etiquette, behavior, ritual, beliefs, language, social structure, expectations of relationships, and symbols passed on to succeeding generations. These have both conscious and unconscious dimensions. During the 55 years of my association with Totagadde, ritual rules have been modified. For example, few Havik Brahmins still believe in and observe the menstrual taboos, while women of lower castes still believe in and observe the taboos. Women attending school and college, as well as those employed and those living in urban areas, no longer follow them. When those living in town visit Totagadde, they come at a time when there will be no obligation to observe the taboos.

Caste hierarchy has become less important with younger people. Some no longer believe in the ritual purity demarcating the various castes. Orthopraxy refers to the practice of ritual without reference to a belief system. Orthodoxy refers to the belief system underlying the ritual rules or etiquette. In general, the person who follows the strictest ritual determines the ritual observed. After three months in Totagadde I noted a collective sigh of relief signifying that they considered that I knew the rules and could explain them to any American visitors. No longer did I present a risk for ritually polluting the populace of Totagadde. No one inquired about my belief system, but appropriate behavior, orthopraxy, was essential to my residing in Totagadde.

CASE STUDIES

The case studies[2] fall into two groups of South Indians. The first case study focuses on a patient whose ritual observances developed into an obsessive-compulsive disorder as a response to anxiety when he came to the United States for graduate work (Ullrich, 1997). The remaining cases are residents of Totagadde who experienced depression. Four cases reflect a major depressive episode at the time of marriage—initially on the part of the bride and later on the part of the bride's mother. In the concluding case,

2. To protect privacy, each individual, as well as the village, has a pseudonym. Patients provided permission for the use of pseudonyms. The modification of details further protects privacy.

the woman attributed her depression to her polluting the god at a religious ceremony. These cases illustrate the impact of culture on the precipitation and presentation of depression and obsessive-compulsive disorder.

Case 1: Obsessive-Compulsive Disorder: Ritual Reassurance

When Gopal, a 26-year-old Hindu graduate student, came for treatment in 1990, he reported a history of obsessive thoughts and compulsive disorder dating from the time he was sent to boarding school in India. However, only after coming to the United States for graduate work did his obsessions and compulsions disrupt his life. Upon arriving in the United States, a relative noted Gopal's obsessive ritual observations and suggested he seek psychiatric treatment. After he started fluoxetine, he was able to participate fully in psychotherapy and in his graduate studies. Treated with fluoxetine and weekly psychodynamic psychotherapy for a period of six years, the obsessive thoughts and compulsions remitted.

Aware that some Hindus are reluctant to discuss religious practices, I informed Gopal that I had followed Hindu rituals when doing research in a South India village. The concept of saliva pollution (*yenjalu*) might seem bizarre, but it occurs whenever one puts anything in one's mouth, drinks from a vessel, or eats a meal. An individual dining at a table in 1964 would pollute the entire table with saliva pollution if he/ she put the cup he/she had been drinking from on the table. If the cup was placed on the floor instead, the floor did not transmit pollution; however, wood and metal would. In the 1960s, each person would sit at a different table in a restaurant to avoid *yenjalu*. Observing has since changed, so that in 1974 when a woman told me she observed *yenjalu*, she meant that she wouldn't take or give food from her plate once she had started eating. Before one starts eating, there is no *yenjalu*. However, by 2017, with the exception of religious ceremonies or in the presence of extremely orthoprax individuals when the plates are served on the floor, people eat at tables. Saliva pollution is removed with washing one's mouth, hands, utensils, and plate with water. Gopal's compulsion to swallow his saliva, however, reflected insecurity in dealing with people from other castes or countries.

After informing Gopal about my knowledge of Hindu ritual, I noted that he felt free to discuss his specific religious ritual compulsions and explore their origin, which he related to his mother's death in a car accident when he was 7 and his subsequent residence with his grandparents rather than his father and stepmother. At the termination of psychotherapy with me, completion of his graduate work, and obtaining employment in a distant city, Gopal celebrated by taking me to a restaurant for dinner. This demonstration of his freedom from obsession around eating seemed a fitting termination of therapy with a patient whose pathology had centered on food. Upon moving, he planned to continue psychotherapy and fluoxetine with another therapist.

Change in Manifestation of Major Depressive Disorder (Cases 2–4)

Three generations in one family experienced a presumed major depressive disorder at the time of marriage (Ullrich, 1993; 2017).

Case 2. Sharda (a pseudonym) at age 12 married a man 18 years her senior. Before marriage and before puberty, girls received parental attention, were allowed to play, but received no instruction on household or marital matters. At marriage, the bride had the lowest rank in the household.

Sharda's depression took the form of spirit possession, a *pishaci*. This possession gave her the freedom to disobey ritual rules, to cry, and to express feelings of depression because cultural beliefs regarded a new bride as helpless when a *pishaci* possessed her. A scarf covering Sharda's head indicated the spirit's presence. If she had acknowledged her feelings and her anger, her guilt in refusing to assist the other women with household chores and meal preparation would have been overwhelming. Brides in their first years of marriage were vulnerable to spirit possession. The *pishaci* possession was a culturally acceptable manifestation of depression.

Sharda's treatment involved travel with her husband to religious healers. She improved when she left Totagadde. The *pishaci* climbed a tree when she left and possessed her upon her return to Totagadde. This lasted for four years. When I was in the village in 1964–1966, her husband told me about the spirit possession. When I asked her about it, her response was, "How did you know?"

Satisfied that I had her husband's confidence, she was able to discuss the spirit possession with me. Her husband was the one who put an end to her helplessness and worthlessness by teaching her a sacred verse, *mantra*, which she used for meditation for the remainder of her life. Although the culture regarded women between menarche and before menopause as too impure to meditate or recite mantras, her extremely orthoprax (ritual-observant) husband successfully treated his wife. I believe his orthodoxy (deep religious convictions) was behind the flexibility in his belief system to allow changes to his orthopraxy (ritual practices) for the benefit of his family. His flexibility surprised others, but enhanced his reputation as a compassionate person. Whereas healers had been unsuccessful for four years, her husband's teaching her a *mantra* plus meditation provided her with solace and kept the spirit away.

My schedule for visits with Sharda was three times a week, although she wanted daily visits. My focus on depression from 1984 allowed her to acknowledge or reinterpret the spirit possession as depression. When I asked her about depression after discussing her spirit possession, she shocked me with the response, "Of course I was depressed." Sharda's case illustrates how an underlying depression may be culturally acceptable as spirit possession.

Sharda had observed her cousins' culturally acceptable possession at the time of their marriages. The sickness may have been depression, but the illness was spirit possession at a time when women had no right to express negative emotions. She reported a depressed mood, anger, hopelessness,

worthlessness, a lack of interest, weight loss, irritability, psychomotor retardation, recurrent thoughts of death, at times no appetite, at other times gorging, and fatigue. This suggests that her marriage at age 12 was a traumatic life event. The empathy her husband displayed allowed her to resolve the trauma and to develop a close marital relationship.

Her husband's confidence in me was the defining factor in her developing a therapeutic relationship with me. My listening to her provided her with an opportunity to relate the difficulties she had experienced upon her marriage. This illustrates both a traumatic life event (her marriage) and an empathic husband with whom she developed a close relationship of mutual respect.

Case 3. Sharda's oldest daughter developed somatization upon her marriage. She was 19 when she married. I was present when the suitor came to view her. After he left, I tried to elicit her opinion, which she refused to give in case it differed from her father's. Her mother vociferously expressed her negative opinion about the groom, which her husband ignored. When he realized how unhappy she was after her marriage, he refused to arrange any of his younger children's marriages. After the marriage, she lost weight, developed ulcers, had many gastrointestinal complaints, experienced a loss of interest, apathy, fatigue, and constantly worried about her children. Unlike other newly married daughters who visit their parents for every festival, her husband refused to send her to her parents during her first year of marriage. Her parents visited her instead. Although she rarely visited her maternal home, her children lived with their grandparents to attend school in Totagadde. She saved face by reporting that she had to care for her sick mother-in-law.

After her marriage, I saw her on her rare visits to Totagadde. She sought medical assistance through her internist who provided her with appropriate medications, but no antidepressants. Her parents and siblings spoke of her depression and interpreted her depression as the basis of her physical complaints.

Case 4. Sharda's youngest daughter chose as her husband a man she had met in college. Employed before her marriage at age 26, she had waited until she was able to get a transfer to Bangalore where her husband lived and worked. Upon the transfer to Bangalore, she became depressed. She believed that if she sought psychiatric help, not only would her parents become concerned, but her family would also develop a reputation for women who became depressed at marriage. Grateful that her parents supported her choice, she had no one in whom to confide her depressed feelings. Ironically, she was the one with the greatest insight about her depression and the fewest resources, as spirit possession and somatization had brought her mother and oldest sister in touch with healers. Whenever I visited Bangalore, she came to see me. She was grateful for the four sessions we had, but never took medication. Just as with her oldest sister, her parents and siblings provided a great deal of emotional support. After she recovered from her depression, she became the Bangalore hostess for family members and provided a place for their children to stay while attending college. She continued her job until retirement in 2017.

The point of this family portrayal of depression is the change in generations. By the time of the younger generations (1980s), psychiatrists were accessible to treat depression. Family members of those claiming spirit possession reinterpreted this as a manifestation of psychiatric illness—depression or malingering—and took them for a psychiatric consultation. The change from spirit possession to somatization to recognition of major depressive episodes reflects a difference in social structure. Individuals became responsible for their own mental health. Whereas Sharda was illiterate upon her marriage, her youngest daughter graduated from college with honors. She acknowledged her depression, but regarded her family history of women who became depressed at the time of their marriages as stigmatizing. She rejected the idea of consulting a psychiatrist, but regarded me as a family member in whom she could confide her symptoms. The changes are congruent with increased personal and economic responsibility. The flexibility of the therapist in noting the underlying depression of these three women at marriage allowed for a therapeutic relationship in which each responded to empathic listening. None received antidepressants for their depression, as they were unwilling to consider medication. I saw Sharda and her daughters several times a week when I was in Totagadde. I saw the younger daughter during my visits to Bangalore.

DEPRESSION ASSOCIATED WITH MARRIAGE

When fathers arranged pre-puberty marriages for their daughters, it was often the first time the fathers disregarded their opinion. I know of only one girl, a ten-year-old, whose father and uncle consulted her about her marriage. She gave her consent, although in 2017 at the age of 79, she said, "What did I know as a 10-year-old?" However, her father and uncle respected her opinion. When a father ignored a daughter's objections to his marriage arrangement, it was often the first time he neglected her wishes. Even if the marriage proved to be a happy one, some daughters never forgave their fathers for this betrayal.

Case 5: Lili (Ullrich, 2017) is an example of a daughter who protested her father's choice. She tried unsuccessfully to drown herself before her marriage, but reported no attempts after her marriage. Confiding in me, she reported that her mother, in a physically abusive marriage, had attempted suicide. Her father was furious and made her mother promise never to try again. Her mother obeyed her husband.

At age 12, Lili married a man more than twice her age with no idea of what being a wife entailed. As was customary, Lili cried profusely at leaving her parents. Some men regard the frequent visiting of brides with their parents as helpful for the marital adjustment. Lili's feelings of hopelessness and helplessness at the time of her marriage predisposed her to future depressions.

Lili's adopting passivity may have been culturally appropriate behavior at the time of her marriage in the 1940s, as independent actions brought on beatings. One beating in the 1970s occurred because she had gone to a

temple festival in her parents' town without her husband's permission. He had already left for market day when a neighbor asked her to accompany her. What harm could there be in going to worship at a temple and having a brief visit with her parents? Her husband arrived home before she did. He greeted her arrival home with a beating. Independently during my 1976 research trip, both Lili and her husband separately described the incident. During the following years, Lili had an "anniversary" reaction on the day the beating had occcurred; and her husband expressed remorse at his loss of temper. If divorce had been an option in the 1960s and 1970s and if Lili had been able to earn her own living, she would have obtained a divorce. When divorce became a possibility and women achieved self-sufficiency, divorce became an accepted option. At that time, physical and verbal abuse, as well as incompatibility, became grounds for divorce, with both husband and wife retaining their self-respect. As a result, physical and/or verbal abuse rarely occurs.

With the increase in marriage age and with female education, girls began to have a say in their marriages. Some women eloped, some families yielded to their daughter's marital choice, and some arranged marriages met the approval of the bride. The priest's daughter eagerly looked forward to the marriage her father had arranged. There was one problem. The bride was so pleased with her groom that when the time came to go to his home, she forgot to cry. The father became so upset that he displaced his anger onto his wife. His yelling and beating her made the neighbors aware of his distress. The Brahmin men of Totagadde gathered to soothe him and to emphasize the importance of retaining a good relationship with his daughter, her husband, and her in-laws. Although his daughter had married a man who lived 1½ miles away, he felt she had betrayed him. No longer are girls typically depressed at their marriage. However, their parents may be sad and upset, and some may become depressed when a daughter marries. Many feel as if they have lost their best friend. The following case is of a woman who suffered a major depressive episode upon her daughter's marriage.

Case 6. When Lili's daughter married at age 18, Lili was so depressed that she lost interest in everything, went to her daughter's room every afternoon to sob, lost weight, had no appetite, and spoke only of her depression. Lili denied that she was suicidal. Nevertheless, relatives came to stay with her because they felt she was suicidal. Neighbors asked Lili why she allowed her daughter to marry someone who would be transferred to a different place every three years. But the decision to marry was the daughter's—not Lili's or Lili's husband. Indeed, the daughter had a fight with her father when he wanted her to marry an eligible bachelor who lived nearby. The daughter wanted travel and to see different areas of India. Lili put her daughter's interests ahead of her own. When I suggested Lili consult a psychiatrist, she responded that it involved too much stigma. I had the rapport, empathy, and a therapeutic alliance. Since I was the American family member, my treating her would have been inappropriate. This is one example of boundaries, which prevented my formal treatment. However, Lili spoke with me daily. I noticed that other household members gave us privacy during our talks. She refused medication.

RITUAL POLLUTION: A CAUSATIVE AGENT IN DEPRESSION

Case 7. One low caste woman was instrumental in a special religious ceremony. When she realized that her menses had begun during the ceremony, the guilt she assumed for polluting the god during a religious ceremony was so severe she consulted a psychiatrist. However, this psychiatrist had radio broadcasts in which he labeled menstrual taboos as superstitious nonsense—not an ideal match for a patient who worried about her menses ruining an expensive ceremony. Moreover, he prescribed anti-anxiety medication, antidepressants, and antipsychotics. Knowing that I had observed the menstrual taboos and that I am a psychiatrist, she sought a consultation with me. Since she found me walking on a public street, I suggested we sit on a bridge so I could listen to her and then made an appointment to see her in her home the next day. Even though I am a foreigner and am primarily associated with a high caste, she decided my knowledge and respect of her culture were more appropriate than a male Indian psychiatrist.[3] Her positive transference and belief in my empathy led her to seek me for a consultation. I saw her twice a week for a month and limited her medication to fluoxetine. She had no need for antipsychotic or anxiolytic medication. Upon my return visits to Totagadde, she has remained stable, without any of the symptoms of depression.

CONCLUSION

While culture defines the ways individuals relate to each other, the empathic therapist facilitates the development of a therapeutic alliance. Familiarity with a patient's cultural background, either from personal experience or a patient's presentation, contributes to empathy. The first case study illustrates the escalation of culturally appropriate ritual into an obsessive-compulsive disorder when in emotionally threatening situations such as graduate school in the United States. Knowledge of the patient's culture made possible a therapeutic alliance. In contrast, the last case illustrates how a psychiatrist's denigration of a patient's beliefs in menstrual pollution as causative of a major depressive episode prevented a therapeutic alliance. Instead, the patient consulted a psychiatrist she believed had observed the ritual that she regarded as the basis for her major depressive episode. This argues for the neutrality of the therapist, as the patient had no direct experience with either therapist before the consultation.

The focus on depression at the girls' marriages illustrates changes in the presentation from spirit possession to somatization to acknowledged depression. With the availability of physicians and psychiatrists, the

3. Horowitz (2014, p. 672) cites Vervaeke and colleagues in reporting that "disparities in patient and therapist values have been found to be associated with premature termination by the patient" (Vervaeke, Vertommen, & Storms, 1997).

recognition of psychiatric illness increased. At the same time as girls began to receive an education and even embark on careers before marriage, they had greater awareness of their psychiatric status. The stigma associated with psychiatric treatment is more closely associated with the higher castes than the lower castes. With daughters choosing to marry men who worked at a distance, mothers became more vulnerable to depression at a daughter's marriage. These case histories illustrate the variability in response to a life event, such as graduate school in the United States, marriage, and an auspicious religious ceremony.

The hypothesis of this article is that no matter how bizarre a situation appears, the route to understanding an individual's culture leads to empathy and a therapeutic alliance. When the patient believed her psychiatrist failed to respect her belief system, she became more rigid in her view of ritual transgression as a causative factor in her depression. When the same patient believed her psychiatrist respected her belief system, she was able to consider interpretations alleviating her guilt and removing personal responsibility for her depression. Flexibility and accessibility to learning about the cultural background of patients allows the therapeutic relationship. At that point, the psychiatrist and patient are able to work through their challenges to a patient's belief system and to endure both positive and negative transference.

REFERENCES

Carstairs, C.M., & Kapur, R. I. (1976). *The great universe of Kota*. Toronto, ONT: Clarke, Irwin & Company.

Horowitz, M. J. (2014). Clarifying values in psychotherapy. *Psychodynamic Psychiatry, 42*(4), 671–679.

Roland A. (1988). *In search of self in India and Japan: Toward a cross-cultural psychology*. Princeton, NJ: Princeton University Press.

Roland, A. (1996). *Cultural pluralism and psychoanalysis: The Asian and North American experience*. New York: Routledge.

Spitzer, R. I., & Endicott, J. (1978). *Schedule for affective disorders and schizophrenia* (*SADS*). New York: New York State Psychiatric Institute, Biometric Research.

Ullrich, H. E. (1969). A note on rural attitudes towards Hindi: A Mysore village study. *Anthropological Linguistics, 11*(2), 58–61.

Ullrich, H. E. (1971) Linguistic aspects of antiquity: A dialect study. A*nthropological Linguistics, 13*(3), 106–113.

Ullrich, H. E. (1975a). Etiquette among women in rural Karnataka: Forms of address in the village and the family. *Social Action, 25*, 1–14 (reprinted 1975. In A. de Souza (Ed.), *Women in contemporary India and South Asia* (pp. 54–75). New Delhi, India: Manohar; reissued and updated 1980. In A. deSouza (Ed.), *Women in contemporary India and South Asia* (pp. 241–262). New Delhi, India: Manohar.

Ullrich, H. E. (1975b). Competition and modernization in a South Indian village. In H. E. Ullrich (Ed.), *Competition and modernization in South Asia* (pp. 9–25). New Delhi, India: Abhinav.

Ullrich, H. E. (1977). Caste differences and female roles in a South Indian village. In A. Schlegel (Ed.), *Sexual stratification: A cross-cultural view* (pp. 94–108). New York: Columbia University Press.

Ullrich, H. E. (1980). *Clause structure of Northern Havyaka Kannada* (*Dravidian*)*: A Tagmemic analysis*. Vanchiyoor, Trivandrum: Dravidian Linguistics Association.

Ullrich, H. E. (1982). Rural and urban multilingualism: A South India case. International *Journal of the Sociology of Language, 34*, 25–50.

Ullrich, H. E. (1987). A study of change and depression among Havik Brahmin women in a South India village. *Culture, Medicine, and Psychiatry, 11*, 261–287.

Ullrich, H. E. (1988). Widows in a South India society: Depression as an appropriate response to cultural factors. *Sex Roles, 19*, 169–188.

Ullrich, H. E. (1993). Cultural shaping of illness: A longitudinal perspective on apparent depression. *Journal of Nervous and Mental Disease, 181*(10), 647–659.

Ullrich, H. E. (1994). Asset and liability: The role of female education in changing marriage patterns among Havik Brahmins. In S. Seymour & C. Mukhopadhyay (Eds.), *Women, education, and family structure in India* (pp. 187–212). Boulder, CO: Westview.

Ullrich, H. E. (1997). Remembrance of incarnations past: A Hindu case study. *Journal of the American Academy of Psychoanalysis, 25*(3), 493–505.

Ullrich, H. E. (2010). Is beauty skin deep? The impact of "beautiful attributes" on life opportunities and interpersonal relationships: A tale of two sisters in South India. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 38*(2), 243–254.

Ullrich, H. E. (2011). The impact of cultural factors on the ego ideal, depression, psychosis, and suicide: A South India community study of the widow. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 39*(3), 453–470.

Ullrich, H. E. (2017). *The women of Totagadde: Broken silence*. New York: Palgrave Macmillan.

Ullrich, H. E. (Ed.) (2019). *The impact of education on South Asia: Perspectives from Sri Lanka to Nepal*. New York: Palgrave Macmillan.

Vervaeke, G. A. C., Vertommen, H., & Storms, G. (1997). Client and therapist values in relation to drop-out. *Clinical Psychology and Psychotherapy, 4*(1), 1–6.