Indian J. Psychiat. (1982), **24**(2), 101—106

GUILT IN INDIA (SOCIAL, CULTURAL AND PSYCHOLOGICAL PERSPECTIVES)

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Guilt according to the psychodynamic model occupies a pivotal spot in the understanding of depression. In fact, depressions with and depressions without guilt are often considered totally different entities according to some. It is extremely interesting to observe that the occurrence of guilt across different cultural groups varies and that this phenomenon is essentially related to the cultural traditions and social influences of that particular culture.

Socio-cultural Correlates in Indian Culture

According to the Hindu philosophy, the 'Law of Karma' has been the pivot around which revolve the major traditions of philosophy and culture. It implies that there is a cause-effect relationship to every event in one's life and upholds the doctrine of previous and future lives. In other words, the deeds of the past life determine the quality of the present life which in turn fashion that of the next. According to this viewpoint, each individual carries with him three types of 'Karmas'. The 'Prarabdha Karma' is the carry over from previous existence and is unalterable and therefore the individual has to suffer both its good and bad consequences. 'Samchita Karma' is exercised in the present life by the individual independently and out of his own will. Lastly, the 'Agami-Karmas' denote the potential for good or evil within the individual which produce consequences in the future life. The 'Prarabdha Karma' may be considered to some extent analogous to the genetic component of the individual while the other two denote environmental influences. Thus, although the current life situation with accompanying guilt may somewhat depend upon the deeds of the previous existence, the individual still retains the free will to mould his present life and determine the fate of his succeeding life. Guilt originating from 'Karmic' deeds may therefore be handled by socio-cultural patterns, e.g. religious rituals, strict moral principles such as ascetism, nonviolence, dietetic restrictions and other means for the appeasement of the Gods. In keeping with this viewpoint were the observations of Venkoba Rao (1973) who reported that only 2 of the 20 endogenous depressives with a belief in the 'Law of Karma' had guilt over 'Karmic' deeds. However, social factors were more contributory to the development of mild guilt and these included lapses in care of children, parents, spouses and work etc. (Non-Karmic guilt). The author concluded that guilt feelings were not integral to depressive illness but are likely to be its consequences. Hoch (1961) a Swiss who has worked in India for over 2 decades suggests that in the Hindu view of life, one shapes one's fate himself but his deeds would not be afflicted by a painful depression, unless by wrong doing one had deserved it. Blaming something outside one's self may help a person forget this painful event. Guilt and suicide represent the most internalized depressive ideas, and guilt in Indian patients is more governed by concepts of custom and tradition than by the real inward call of conscience. She further points out that a relative poverty of guilt even in the western depressive patient would much rather mean that man inflated

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with his importance and power over material forces is increasingly hiding and escaping from his true responsibility. Existential guilt is therefore more likely to be felt as a spiritual crisis than as an illness.

Sociocultural factors too play an important role in the genesis of guilt. Child rearing practices seem an important consideration in this regard. It is of common knowledge that in India, upbringing of a female child is more strict, rigorous and harsh while the male child is offered all the privileges and fewer restrictions. Hence, development of a harsh and more punitive super-ego in female might explain the more frequent occurrence of a mild or severe guilt in a particular setting as compared to Indian males. This however, would also be determined by the opportunity available to restore a lowered self esteem. On the other hand, pathoplastic influences are also available to lighten the feelings of guilt and prolonged mourning rituals particularly amongst Hindu women are possibly conducive to a diminished overt manifestation of guilt amongst Hindus in South India (Venkoba Rao, 1968).

Comparing with western patients, qualitative differences are apparent in the guilt content of Indian depressives. Guilt feelings in Indian patients are of an impersonal character as a consequence to the 'Karmas'. Individualized guilt is less often experienced and when present, only by the more literate group. Due to conformity with the social system, individuation and assumption of self responsibility for one's acts is less well developed in Indian patients and the superego dictates continue to be dependant upon external sources to a fairly large extent. These are often ascribed as feelings of shame, while guilt represents the dictates of intrapsychic superego. Indian culture is predominantly religion dominated and therefore, even illness is considered as God's will. It appears that the tendency to attribute the present plight to events in the previous life rarely generates guilt but instead serves to relieve it and is akin to rationalization and projection. In India expression of guilt amounts to personal humiliation and loss of face while 'denial' serves as a socially protective device. Hence, even when depression is clinically obvious, feelings of guilt are expressed only in an intense psychotherapeutic dialogue.

Though guilt may be an important factor in the psychogenesis of depressive illness, 'manifest-guilt' may not be the typical presentation of Indian depressives.

Review of work in India

A sprinkling of studies in India relating to guilt are subject to the bias of being impressionistic in nature. It is only of late that research workers have begun to employ more objective criteria and rigorous statistical measures to formulate the symptomatological patterns of psychiatric disorders. The role of guilt related to early oedepal strivings was observed in an anecdotal case report by Bhaskaran in 1959. Far from being uncommon in Indian patients, Hoch (1961) found guilt in 68.7% of all depressives examined. Das (1967) illustrated the psychogenesis of conversion in 2 cases of conversion reaction and attributed guilt against oedepal strivings as the 'root cause'. The role of guilt in self mutilatory behaviour such as pulling hair, skin and wrist slashing was discussed by Gupta and Thacore (1972). Such behaviours are considered a form of self punishment to lighten the feelings of guilt (Sethi *et al.*, 1969). Teja *et al.* (1971) found guilt in 48% of the 100 depressives studied. Comparing with the studies of Venkoba Rao (1966) and of Kiloh and Garside (1963) significant differences were seen in the prevalence of guilt. Comparing Rao's figures of guilt (in 27 out of 30 depressives) with those of Carney (Carney

et al., 1965) guilt was observed more often in the latter group (59 out of 116 depressives). A comparison of North Indian Vs. South Indian depressives (Teja *et al.* Vs. Rao's group) revealed no significant differences on the guilt scores. When both these Indian studies were combined and compared to the combined guilt scores of the 2 western studies, frequencies of this symptom were 43% and 44% respectively and were not significantly different. The authors suggested that whereas there were no significant differences in the incidence of guilt in Indian and British depressives, a qualitative difference possibly exists. They subscribed to the view that guilt feelings amongst Indians are of an impersonal character as a consequence of one's 'Karmas' while individualized guilt is less frequently experienced. In an analysis of the dream contents of psychiatric patients, feelings of guilt were seen in only 1.3% patients (Nathawat and Sethi, 1973). A low incidence of guilt feelings among Indian patients have been reported by several workers i.e. Murphy *et al.* (1967); Bhattacharya and Vyas (1969), Bagadia *et al.* (1973), Sethi *et al.* (1973) and Bagadia *et al.* (1976). In Bagadia's sample of 1973 which included 233 depressives, guilt feelings were seen in only 5.3% patients. Australian patients had much higher guilt scores as compared to Indian patients (Bhattacharya and Vyas, 1969) and the religion dominated Hindu culture was hypothesized as a factor minimising guilt feelings. No evidence however, in favour of this hypothesis has been established.

It has also been argued (Sethi *et al.*, 1973) whether the low frequency of 'manifest guilt' in Indian culture could be attributed to imprecise tools employed to elicit this symptom. Questionnaires and other such investigatory tools are usually not enough to establish the affect of guilt. In a study conducted to determine the relationship between suicidal attempt and employment status, more of those who were unemployed exhibited regret at failure of the suicidal attempt while guilt and shame were infrequent (Bagadia *et al.*, 1976).

Very few studies have employed the use of dynamic tools in eliciting guilt in psychiatric patients. Guilt over hostility and guilt over dependency strivings feature prominently in the aetiology of psychosomatic conditions. Using the H.D.H.Q. and Thematic Apperception Test, no significant differences were observed between guilt and hostility scores of psychosomatic patients and normal controls. In a psychodynamic investigation involving 35 primary depressives, Sethi *et al.* (1980) did not find any significant difference between the guilt scores of moderate and severe depressives. Females, however had higher guilt scores than males ($p<0.05$). In another recent report (Trivedi *et al.*, 1981), highly significant ($p<0.001$) differences were observed amongst the guilt scores of depressives when compared to normal controls. In this study the selection criteria of patients were stringent, and the patients were administered five cards of the T.A.T. (Uma Chowdhury, 1977 adaptation). Guilt was rated according to the method of Saltz and Epstein (1963). The results of this study highlight a significant finding that guilt as well as hostility scores of depressives were significantly higher than those of normal controls when projective techniques were used. It may be that social and cultural restrictions mask the typical clinical evidence of manifest guilt, yet the symptom may be present in an intense form. Therefore, projective techniques may be more conclusive in identifying guilt as the core psycho-pathology. However, reports to the contrary are also available (Indra and Murthy, 1979; Manchanda *et al.*, 1979). The latter workers found no significant difference between the guilt scores of

patients of obsessive compulsive disorder and neurotic depression using the TAT.

Cross Cultural Aspects

The differences in the occurrence of guilt amongst Indian patients is not a unique phenomenon. Relationship of guilt to the cultural traditions of that particular ethnic group are well documented. Guilt feelings amongst European depressives are considered an expression of the Judeo Christian emphasis a sin and guilt and also to the internalized ideals of behaviour (Murphy *et al.*, 1967). Guilt feelings among the Netherlanders are attributed to their inward directedness and the Calvinism (Saenger, 1968). In an early report, Kraeplin, in 1921 pointed out that while excitement and confusion was clinically prominent in Javanese depressives, ideas of sin and suicide were usually absent. Carothers (1958) was unable to elicit feelings of guilt and self abasement in Kenyan depressives. Lambo (1956) in Nigeria has also reported a poverty of guilt in African depressives. Contrari-wise, a higher frequency was observed amongst the Hutterites (Eaton and Weil, 1956). Reports of paucity of guilt in non occidental cultures have been reported from time to time, i.e. Japan and Philippines (Murphy *et al.*, 1967) ; Iraq (Bazzoui, 1970) ; Africa (Asuni, 1962 ; Amara, 1967) ; China (Yap, 1965) and Bangla Desh (Rahman, 1970). It appears that acculturation, industrialization and major social changes may yield to guilt over social factors as observed in the more developed countries.

Pathoplastic Effects of Culture :

Having familiarized one's self with Hindu thought and the frequency of guilt in Indian patients, one is prompted to draw several conclusions. It appears from a large number of studies that guilt in its 'manifest' form does not constitute a typical clinical presentation of the depressive symptomatology in Indian patients. In keeping with religious and socio-cultural traditions, acceptance of guilt or even depresison for that matter, entails a loss of face and self esteem. Hence, externalization, projection and denial of guilt minimise its presence and it is therefore manifested in an impersonal manner such as blame or God's will. Cultural practices such as ceremonial dips in sacred rivers and prolonged mourning rituals which have a wide social acceptance do much to "wash" away feelings of sin, self rapproachment and guilt. So much ingrained are these religious beliefs that even 'Karmic' guilt may be taken care of in such a manner. Guilt feelings amongst Hindus are inextricably linked to religion and therefore excessive religiosity, participation in rituals, charms, penance, etc. serve as defenses to ward off painful and traumatic affects such as depression and accompanying guilt. To date, only very few workers have cited guilt feelings as being no different in Indian patients than those of the West (Trivedi *et al.*, 1981) and this opens new frontiers in the exploration of 'covert' guilt in the true psychodynamic sense. This observation however, requires to be substantiated on a larger group of diverse populations. Child rearing practices and sexual discrimination fosters development of a more punitive superego which may in turn affect the intensity of guilt feelings in different ethnic groups. Opportunities made available to the individual to regain his self esteem also work to modify ideas of guilt in a particular setting. Interestingly, majority of reports that indicate a low prevalence of guilt among sub groups of populations are from the less developed or developing countries where illiteracy, magico-religious beliefs and superstitions are widely rampant. Major social changes in the rapidly developing countries may soon change the spectrum of depressive illness and guilt may then be

manifest as a more integral symptom of illness.

CONCLUSION

A review of Indian literature on the prevalence of guilt amongst our patients reveals a diverse status regarding its prevalence in psychiatric patients. In keeping with reports from Africa and South East Asia there is no doubt that classic psychotic depression with manifest delusional guilt is rare amongst Indian patients. Nevertheless it may be that socio-cultural factors would affect the expression of guilt. Excessive religious beliefs, cultural practices, personality styles and belief in the Hindu philosophy of 'Karma' may be acting as pathoplastic forces and minimize the degree of guilt amongst the Hindus. These patients are more apt to use the psychodynamic defences of denial, externalisation and rationalization to handle guilt and self recrimination—while introjection is used only by a minority of the population particularly those belonging to the highly literate groups. Lately, it has also been speculated that the earlier reports related to the poverty of guilt in Indian culture may be an expression of poor evaluational instruments to pick up ideas of guilt than due to an actual low incidence. It has also been felt that there may be a qualitative than quantitative difference in the expression of this symptom. Hence, the importance of investigating overt versus covert guilt can not be overemphasized (Trivedi, *et al.*, 1981). It is unfortunate that a majority of the earlier reports are to an extent impressionistic, thereby minimising the prevalence of observed guilt. Questionnairs and direct clinical interviews too, do not appear to be the ideal research techniques that should be employed in dynamic studies relating to guilt. Till as much time that more precise evaluational instruments are available at our disposal use of projective techniques appears most promising.

Cross-cultural differences in the presentation of psychiatric syndromes have a tremendous impact not only in their identification but also the prognosis and treatment. Changing values and traditions cosequent to rapid industrialization may weaken the patho plasic effects of culture in developing countries. Hence, new trends and symptom clusters may emerge which may in turn modify the current prevailing views on this issue.

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