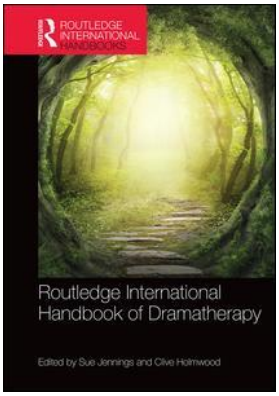

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Sue Jennings, Clive Holmwood

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Aanand Chabukswar, Zubin Balsara
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Converging lineages

Arts-based therapy in contemporary India

Aanand Chabukswar with Zubin Balsara

Arts-based therapy (ABT) is the name of a practice that has evolved in contemporary India from the need to reach out to those who can directly benefit from art forms in a healing context. The study and practice of ABT is based on the 'view' of systems and practices in health, psyche and the arts from an Indian perspective. It is shaped dynamically by realities of space and time, poignant details of specific contexts and some aspects that are greater and subtler than descriptions. To narrate this formation is no more than an attempt to write on the surface of a lake.

Traditionally, in India, all art forms, including drama, are strongly 'integrated'. This integration at one level is the coming together of all arts in performance. *Natyashastra* presents theatre as inclusive of sound, song, gesture, movement, plot and story to represent the sentiments or emotions on stage (Gupta 2010). Most folk forms that have emerged over millennia, many of them still extant, do not distinguish between dance, music, drama and visual arts as separate. They are multisensory extravaganzas that create an aesthetic and entertaining joy. Integration also indicates another level of synthesis – that of everyday life and rites, rituals, performances. Significant artistic and aesthetic experiences cannot be separated from events or occurrences of social, personal and psychospiritual or sacred significance. In fact, Indian theatre is 'not confined to neat, narrow categories' (Richmond et al. 1990, p. 3). All the arts – from crafts to painting to dance to storytelling and more – formed the dimension of the 'extra-daily' (*natyadharmi*) marked by rituals, ceremonies, festivals and such, within the workings of the daily (*lokadharmi*) life of the community. Entire villages, castes, functions – from farming to manufacturing, marriages to meditation and renunciation – were governed by a pantheon of customs, worship, offerings, recitations, performance routines and divergent sets of multidimensional belief systems with philosophical bases. In this sense, what mattered most in the Indian life of antiquity was the exploration, depiction and bridging between the subtle, unknown, unexpressed and the lived, daily, expressed. The strands of the material and non-material were cognized as a continuum of existence, touched and transcended by the occasions and performances, designated now as ritual, theatre/drama and the arts.

The ancient and customary life in India was also oriented towards a very refined human aspiration to reach 'wisdom' about existence. Complex and dynamic systems of thought and practices flourished. From monotheism to pluralism, cosmologism, sensualism, annihilism, eternalism and materialism, among many others, all were being vigorously debated and practised

more than 2,500 years ago, in the pre-Buddhist period (Sharma 1987). Jain thought, Buddhist schools, Vednata and branches of theistic and non-theistic Hindu paths, Sikhism, Sufi practices – all these and many more hold within their folds a wide variety of dynamic schools of metaphysics, which in their own way define and deal with human existence, suffering (*dukkha*) and the liberation from it. The quest for freedom from suffering was a pervading theme. In addition to the obvious grief and misery, pleasure too is characterised as a part of suffering (Palsane and Lam 2011). There are extremely sophisticated methods or paths that practically guide one to the end of this suffering. There are many unbroken lineages and whole range of *siddhas* (accomplished beings), *fakirs*, saints, yogis and gurus who have lived and liberated, who have demonstrated and taught, right until the present day and age. The world-view is so grand and yet so specific that each activity, each task, from eating food to commerce, from the gaze of the eyes in different activities to complex hand gestures (*mudras*) in ritual practices, is codified and infused with meanings to remind about 'paying attention to your existence' (Trungpa 2005, p. 161). Life itself is an integrated system of seeing, accessing, creating and participating in reality.

Health and well-being were integrated with the dynamic world-view and practices, like everything else. For example, we find Ayurveda prescribing remedies for depression that include, not only dietary and herbal treatments, but also meditation, massage and music (Simoes 2002)! Medical as well as non-medical treatments focused on the person, not the disease alone. Traditional folk healing practices, although taking several forms and methods, had elements of chanting, rhythm, aroma, music, (re)telling of narratives and stories, invocation of 'other' dimensions, participation of family and community. They were not only remedial, but also served as preventive social medicine. In some cases, they became elaborate rituals involving whole villages, with masks, or trance states and story enactments. The process is holistic and does not cut the physical off from the mental, elemental, social and spiritual. The person is seen as a composite of body, mind and consciousness. The larger context is freedom from suffering and the state of moksha or nirvana as the ultimate state. 'No matter what are the perceived causes of the problem, be it organic, emotional or social, the suffering is viewed as a state of mind, a subjective experience' (Dalal 2011, p. 27) and, as such, it is dealt with by solutions 'deeply entrenched in folk wisdom and sound theories of mind' (p. 22). Deconstruction of ego is a necessary prerequisite for this undertaking. We come from a tradition that doesn't uncover or strengthen the ego; we train to be free of its grasp on us. It is a persistent theme of millennia of saints, philosophers and teachers to study the roots of the ego construct – to study the mind and the consciousness. It is undoubtedly a thoroughly subjective, inner, contextual study, and no one method binds it. The actual action or forms of practice are easily made and unmade. That explains, in part, the manifestation of uncountable methods to suit equally diverse, subjective, context-bound human tendencies and traits. Even theatre was one more method, 'one of the disciplines of contemplation by which peace was established in the soul' (Wells 1963, in Tarlekar 1975/1991, p. 53). The use of art forms for healing was entrenched in the view of the aesthetic as the vehicle for the psychospiritual. In fact, the capacity of art forms to engage and energise made them central in all endeavours; they are inseparable from the cultural design of Indian life. Their transformational potential was recognized and played out, like folk stories changing meanings and values, depending on the 'context-sensitive designs that embed a seeming variety of modes and materials' (Ramanujan 1999, p. 42). The subjective, the individual, is at the centre of this process, woven within an overarching theme of journey to the other shore of existence.

Much of this altered in form and function by the twentieth century. Degeneration of the classical and folk philosophies and paths into items of blind faith, rituals beaten senseless by habit, colonial rule, changes in speeds and scale and many such factors corroded the world-view

and practices based on wisdom. These changes were consolidated by systems that adopted a model of development that is not indigenous. A case in point is the establishment of psychology as a discipline in modern India. The first Department of Psychology was established at the University of Calcutta in 1916. The start came from colonial, circumstantial factors, but it continued expanding in the same vein, while ignoring 'a hoary Indian tradition of a long line of philosophers and medical researchers' (Rao 2008, p. 4), and it cannot be denied that we were enamoured by Western presentation of ideas and practices, appealing for their 'deceptive simplicity and apparent objectivity' (Rao 2008, p. 5). The colonial shadow left its mark in 'western methods of analysing the problem and treating it' (Kumar 2004, p. 179), and what this import did was eventually displace people from the centre of their suffering, and it objectified them into progressively longer lists of illnesses considered 'treatable' with medicine and therapeutics acting within an extraneous, clinical paradigm. It is almost forgotten, though not entirely, that the construct of illness is only a part of a more 'correlative and integrated system', the person (Salema 2002, p. 7). The official discourse on health and medicine in modern India did not cipher between the corrupted versions and meaningful origins of traditional modes, methods and materials. A materialist, positivist, biomedical view became prevalent, as it is worldwide. Today, in India, we have psychiatrists trained only in Western categories and medicine who prescribe drugs for ADHD to very small children, while a whole range of methods on mindfulness and attention designed and practised for millennia by several Buddhist schools lie fallow, without the effort to research, revive or explore through experimentation for the particular purpose. The paradox is that Western civilizations, in turn, have turned substantial attention towards the study of classical Indian languages, wisdom traditions and practices, using them as antidotes for human suffering not sorted by material advancement.

Abandoning native systems of knowledge and practices created a deficit in the increasingly demanding scenario of mental health and disability needs. In the pre-independence period, apart from the building of 'asylums', there was no clear strategy for the care of the mentally ill. In the post-independence period, the need for a different approach was recognized: 'first, trained mental health professionals alone would be inadequate . . . second, the need to develop services beyond mental health institutions' (Kumar 2004, p. 174). However, these insights have not been followed up by systematic action, and the situation has not improved. The paradigm of categorizing and treating is itself problematic: 'the legal definitions view dis-ability strictly from the medical and/or psychometric perspective. This ends up reinforcing a medical model of intervention' (Bhagat 2008, p. 41). There are only forty-three state mental health care institutions, unevenly dispersed across this vast country. The human resources are woefully inadequate to cater for a rising need; for example, as of 2013, there were only 898 clinical psychologists, against the need for 17,250 (Press Information Bureau 2013; Seervai 2013). In such a scenario, the private sector vies to take over health and medical facilities, with unfavourable consequences for the majority of relief seekers (DNA 2014). Despite the statistics, however, in what is termed the 'outcomes paradox', markedly better outcomes for schizophrenia patients in India have been reported in WHO's long-term studies (Jablensky and Sartorius 2008, Padma 2014). The better results are attributed to sociocultural factors, such as family, community and local conditions. The erosion of local and community care on one hand and institutionalisation of disability and mental health in the national health policy and programmes on the other shouldn't have been inevitable.

Those of us who had the intent to use the arts for healing systematically had to forge ahead in the face of these complex realities. One of the encouraging facts was the manifestation of dramatherapy, music therapy and art therapy in their modern avatar in the West. They have carved out existence through astute diligence in research and practice. In dramatherapy, pioneers

have made it their lifelong mission to demonstrate the healing power of drama as valuable (Jennings et al. 1994; Lindkvist 1997). Music therapy evolved with models of treatment including neurological models and several applications (Riley 2012, Thaut 2005, MacTavish and Balsara 2012). Being equipped with Western training did not, however, ensure any actual practice in India. Even basics such as information on the client's exact diagnosis, space for sessions and support staff were, and still often are, a far cry. Add to that the huge number of clients an institution or therapist is expected to cater for. The issues were compounded by wrong views on the illness or disability and lack of resources, leading to rigid notions, low capacity and even neglect. But, despite all limitations, there are several institutions and people with an exceptional devotion to care, hope, persistence, hard work and compassion. As we had a commitment to consistently take the arts to institutions and did not expect to get paid for it, we were welcomed! Following the norm, we did initially try categorising the work as dramatherapy, improvisational music therapy, counselling and such, but soon came face to face with what was really taking shape.

A variety of artistic tools and techniques were required to cater for the heterogeneous backgrounds and tastes of clients. For one group, *bhajans* (devotional songs) worked far better than romantic numbers, whereas, for others, Hindi film songs from a specific period did it! The same with stories, games and improvisational materials. Different groups of clients related to different arts in a variety of ways. In palliative care, story circles fitted better, whereas drumming and rhythms were far more useful for those going through withdrawal symptoms in de-addiction. Groups exposed to a variety of artistic forms simultaneously benefited from them (WCCL Foundation 2004). With the focus firmly on the particular needs of clients that are to be addressed, in practice, we crossed the so-called boundaries between art forms very easily. Art forms merged and emerged from each other, complementing the steps in a therapeutic alliance. Why, then, was a particular identity – say a dramatherapy practitioner – needed, when it was not so in fact? The critical enquiry of our practice showed us that breaking down barriers between art forms and our individual identities to form a continuum of possibilities, which could be offered according to the needs of the clients, was far more important than going by the training or need for identity of the therapist. A generic vocabulary of stories, songs, roles, rhythms, colours and images is accessible and replicable. It speaks simply and directly to the client, spontaneously bounding across artificial barriers, outer and inner. It also frees the therapist, who is not trained intensively in any single art form, but is an artist in the therapeutic space, to explore, play freely with a richer variety of resources, more methods, media and magic.

More fundamental was the investigation of the paradigm of therapy. We were faced with the question of congruence between what was 'theoretically' available and the actuality of our Indian lives. In the adventurous mix of our contemporary life we are taught Western sciences as objective, accurate, but, at the most critical points in life, we seem to rely on a different set of guidance, often coming from the wisdom lineage of masters, values, views and practices embedded in culture. Which one to follow – the external, learned, or the internalized, intuitively more accurate? A structure or practice useful elsewhere was questioned in our own context. It was essential to investigate, reinvent and reintegrate what was seemingly objectified and separated. The Indian inheritance beckoned.

We had to look back at the astute studies of the mind by yogis. These are accessible through multiple pathways, through analysis, devotion, practices, and all paths together. Their findings and assertions, millennia old, are so important that scientists are inviting practitioners to laboratories to study and understand them (Mingyur Rinpoche and Swanson 2007). The sophistication of these scientists of the mind is astounding. It inspired us to study and practise 'Buddhist mind-training' and ethics as the foundation for the ABT practice and practitioner

alike (Pillai-Balsara 2013a, 2013b). With this 'view', it was essential to work through questions of the values of the practitioner/healer – first and foremost, in simple but most pragmatic terms. Concerns about funding (or the lack of it), maintaining integrity in actions and the actual, keeping awareness for a sober, non-self-centred outlook, these were the real challenges, rather than the outer, more visible matters. In an already hostile environment, the standing of the arts and healing was null, and dramatherapy and music therapy sounded like nice new words needing their own separate niche. Artists found the idea of arts in therapy interesting, but the rigour and lack of attention in the social sector scary. We found that the glamour and attraction of artistic success cast shadows on therapeutic work. Even within the therapy framework, traps abounded – fame, gain, praise. There's a belief that not having some of these alluring things would mean forsaking pleasure in life itself! As these concerns dominated the unschooled mind, we were fortunate to be guided in a fierce community by an authentic leader. It was a rare conjunction that constantly reminded us of our own mind. The hard work over years meant being vigilant about what one was seeking to create. Being responsible for co-creating with others is what kept individual desires in check, often through the fear of breaking the inconceivable bond of kindness nurtured between us. ABT constantly evolved because a choice was made between following one's own lead and the path that needed paring of individualistic ambition. It was bright as daylight, which is the Indian way! Examining and refining the mind, keeping awareness and acting out of concern for all, for one's own freedom and others', these are the essentials for claiming the Indian legacy, in practicum. Luminous examples of these principles in action in other spheres of life abound within our reach and knowing (Mackenzie 1998), not myths or legends, but living proof that these approaches are critically important. The traditional healing practices emphasise the intention or resolve and deep aspiration to help and heal (Paranjape 2014) as fundamental. Without the constant clarity of mind to recollect the intent, no amount of putting together of technologies or methodologies would be effective as a meaningful healing practice. The shifting points of identity were turmoil. But, it simply made sense.

In ABT, the person and their well-being are reinstated at the centre, with the art forms coming together in coherence with a healing intention. ABT maintains a non-religious but decidedly spiritual framework. The subjective is balanced with the objective – established modes are used in diagnosis, in research and assessment, and sought to promote authenticity and veracity of the discipline. ABT relies on evidence-based use of art forms. A recent study of ABT in de-addiction, for example, showed that experimental and control groups were significantly different for measures of advance warning of relapse (AWARE; $t = 1.84$, $p < 0.03$), purpose of life ($t = 4.92$, $p < 0.001$), group therapy record ($t = 5.27$, $p < 0.01$), and on all domains of the rating scale ($t = 7.29$, $p < 0.01$) showing improvement in relapse patients undergoing ABT sessions over relapse patients undergoing only group therapy and art activities (Daniel et al. 2013). The balance in this amalgamation is emerging as community-centred care, and healing is slowly taking steps to reclaim its place. It's not a nostalgic revivalism, but dynamic reintegration for sake of the present. The success of projects such as Medicine–Prayer (*Dawa-Dua*), where psychiatrists work in tandem with traditional faith healers (*mujawars*) – 'a project to link spirituality with medicine to cure people of behavioural disorders' (Vijay Kumar 2013) – shows that this could be one of the ways to bridge the gaps in health care in India (Smitha 2012).

Social workers, psychologists, psychiatrists and special educators have turned to the ABT training course to bridge the gap and to reach out to their clients in a friendly, balanced and accessible way. The ABT training course has been studied as an innovation that can benefit future education infrastructure ideas in India (Machado et al. 2009). ABT meets the needs of local practitioners, handholding and sustaining practice over a period of time. It is important to note that short workshops to train people in India have been tried, but, without a long-term

commitment to developing human resources, these are not useful. A shift in hypothesis is advocated for anyone coming from a so-called 'developed' country; check ground realities, cross-cultural competency and soundness of the philosophical foundation applicable here before imparting your knowledge. When we set out to reinstall the art forms as therapy systematically, it was a dream. It took nearly 15 years of action and research to make a place for ABT. Today, there is a bustling community of ABT practitioners spread across the length and breadth of the country, reaching out to thousands in a year, and the mainstay of their practice is consistent service (WCCL Foundation 2010; Sapatnekar 2012). None of us could have come close to this outcome without the helping hands of numerous philanthropists, foremost among them the Sir Dorabji Tata Trust and Allied Trusts. They supported the vision, mission and its manifestation in the field.

ABT has now taken root in India. This has been made possible, to the small extent that it has succeeded, by the principles being distilled into refined action. It has the potential here to allow non-medical, safe interventions supported by and within the community. ABT stands on the ground consecrated by many lineages that dynamically converge to make it a traditional, yet contemporary, practice for human welfare.

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