CHAPTER - II

HISTORY OF MENTAL ILLNESS: AN OVERVIEW

1.1 Introduction

The biomedical model of disease interprets it as the outcome of specific malfunction of the human body; it is believed that disease is an organic condition that can be cured by medical intervention. In the biomedical method, disease is experienced by the sick person, who becomes the object of treatment by scientific and logical reasoning. Objectivism, mind/body dualism, impersonalism and value neutrality are characteristics of Western medical culture that have staked claims to be of universal use. Biomedicine is scientific in the everyday logic of the term as it works on the methods and assumption of positivist natural science. A patient would be treated using highly sophisticated technology and medicine but this comes at a price.

Understanding of a disease and its medical care is related to the structure of society. Society influences the shaping of diseases and illnesses as well as medical care system to a significant degree (Conrad 2005, 1). Social scientists are interested to study the social interaction of health, cultural variation and it’s affect on health and how society constructs ‘reality’ of disease and illness. In sociological account, the structure of society usually decides ‘who will get sick’, ‘how they will be detected and treated’, and ‘how they will be cured’ (Curtis 2000). If we look at the history of disease in Western society from seventeenth century to the beginning of nineteenth century, life threatening epidemics were common and mortality rates were very high. Disease was thought to ‘just happen to someone’ who could not be cured without medical care and death occurred if it was ‘acute’. Pneumonia, influenza, tuberculosis, typhoid, various forms of dysentery took the lives of many people. People’s perception was that such diseases were rooted in evil forces or divine interference.

In the fourth century B.C Hippocrates explained that diseases are caused by four humors in the body (blood, black bile, yellow bile and phlegm) and any imbalance between these humors might be reflected in bodily symptoms. For a long time in human history, the belief in the concept of humours continued. Many believe that
it continued for around two thousand years. However, the concept did undergo some change in the Middle Ages. Demonology and mysticism played a dominant role and the evil spirit was thought to be main cause of disease during the Middle Ages. Treatment was given by inflicting torture upon the body in various ways in order to liberate the evil spirit from the body (Curtis 2000, 2-4). In the more recent past, these diseases were conquered but they came to be replaced by a new category of diseases that were labelled as ‘chronic’ or as ‘diseases of living’; in addition, diseases such as heart ailments, cancer, stroke, HIV/AIDS etc have changed the concept of death (Curtis 2000, 2). Scientific discoveries and medical interventions were responsible for reducing death of infectious diseases (Conrad 2005, 5-6). Society has thus become completely dependent on the new model of health.

Though medical interventions of disease play a dominant role, the social construction of disease cannot be ignored. Illness is the term which can be used to refer to the interaction between disease and the sick individual in society. It focuses on the subjective world of meaning and experiences. Joseph R Gusfield says “Illness is a social designation, by no means given in the nature of medical fact” (Gusfield 1974, 177). Hence, the focus on social and cultural values in shaping perception of disease and in examining social meaning of illness. Illness may reflect cultural supposition and biases of particular groups of people which make identification of another group as ‘ill’. Sociologists on the basis of empirical research demonstrate how illness is a social production and how it could be understood, treated and conferred with different social meanings (White 2002). Knowledge of disease is shaped by the history of the particular society. Caste, class, gender, ethnic groups are important variables that shape the identity of illness. In the conceptual framework of medicine, diseases are framed as completely natural object and medicine is completely distinct from social boundary. Thus disease is rather socially constructed and to understand the actual meaning of a particular disease is problematic in the social context.

1.2 Disease as ‘Abnormality’

The meaning of ‘normal’ and ‘abnormal’ has been interpreted from various conceptual standpoints –constructionist, anthropological, materialist, feminist and
utilitarian. Disease, along with mental illness and its social understanding, has been discussed below.

Conrad and Schneider describe that the compass reading of deviance focuses on the morality of society. Morality is the tool of certain people who try to impose certain rules, views and values in the world for their own particular interest (Conrad and Schneider 1992, 2). Morality of the society, what is ‘right’ or ‘wrong’, is interconnected and socially constructed. The more powerful ones in the society can endorse and enforce certain rules over the less powerful ones. For interactionists the human behavior that is called deviance is intentional and of free will that is employed in the life of the people (Conrad and Schneider 1992, 2-4).

‘Deviants’ are seen as people who have failed in the process of socialization. According to the social-labeling theorist Becker,

Social groups create deviance by making the rules whose infraction constitutes deviance and by, applying their rules to particular people and labelling them as outsiders (Becker 1963, 9).

Generally the people who are thought to be deviants are those who practice alternative lifestyles, thereby breaking the rules of a particular society. Scheff (1966) used the labeling theory in defining the mentally ill as people who have ruptured the rules and regulation of a particular society. Psychiatrists play a dominant role in authenticating the label of mental illness in the society (Bowers 1998).

As history has unfolded, mental illness has become one of the most stigmatized diseases; the person suffering from mental illness is regarded as the “most deviant” and are regarded as threatening and dangerous.

Heretics whose ideas challenge our most basic values and ideas, freaks whose hair style, grooming, and manner of dress challenge conventional conceptions of propriety and respectability, and people with deformed bodies are all harmless, yet all bear the deviant label. When someone is labeled deviant, he or she may be relegated to a marginal status in the group or community (Back 1977, 209)
Thomas Scheff, formulated the idea of residual deviance, where most of the social conventions are violated and society decides to label as such. A mentally ill person is being confused and frightened by his/her own behavior during the time of stress or by other people’s behavior towards them and it is difficult for them to return to their ‘normal’ role once acquired.

The usual reaction to residual rule breaking (that is, bizarre behavior), is denial, and in those cases most rule breaking is transitory ……..The societal reaction of rule breaking is to seek out signs of abnormality in the deviant’s history to show that he was essentially a deviant (Scheff 1966, 81-82)

The understanding of what constitutes ‘abnormality’ may be different from one society to another; in other words, what is abnormal for one society or culture may be normal for another. Social anthropologist Ruth Benedict has described ‘normality’ as culturally defined within a social structure. “The most spectacular illustrations of the extent to which normality may be culturally defined are those cultures where an abnormality of our culture is cornerstone of their social structure” (Benedict 2007, 113). She studied culture pattern of different societies and said that abnormality is that which comes under the traditional norms of a particular society, being performed in an alternative way. “Normality … is culturally defined. It is primarily a term for the socially elaborated segment of human behavior in any culture; and abnormality, a term for the segment that particular civilization does not use. The very eyes with which we see the problem are conditioned by long traditional habits of our society” (Benedict 2007, 115-116). Durkheim defines abnormality or deviance as universal occurrence (Durkheim 1938). All societies have explanation of some conduct and behavior as abnormal or morally blameworthy so it is contextual. According to Durkheim deviance is related to construction of power and the collective sentiments that are the basis of a normative social structure:

Crime, [or deviance] properly so called, will there be unknown but faults which appear venial to the lay men [sic] will create there the same scandal that the ordinary offence does in ordinary consciousness. If, then, this
society has the power to judge and punish. It will define this acts as criminal [or deviant] and will treat them as such (Durkheim, 1938 68-69)

The power in the society to construct reality is connected with social structure, mainly the agencies of social control. Religion and state were the most dominant agencies of social control in the past. In modern societies, medical science with state legitimation has acquired the supreme position that possessed all the power and authority to identify as well as declare the normal or abnormal in terms of disease. Michel Foucault, a French philosopher, social scientist, and critic, has examined the construction of health and illness along with the concept of power and control and dominant medical discourses within medico-political structure. In his book *The Birth of the Clinic* (1973) he coined the term ‘medical gaze’ to express the dehumanizing medical separation of the patient’s body from the patient’s personal identity by gazing at the body through the medical power and knowledge. Foucault (1973) argues that it is through medical gaze that the patient’s body is constructed as an archetype of particular illness. The medical gaze is a product of a dominant discourse in scientific medicine that champions the importance of expert medical practitioners using visual care to assess and monitor patient’s bodies (Lupton 2000, 55). Michel Foucault argues that “under the scrutiny of the gaze […] under observation of the ‘eye’ that knows and decides, ‘the eye that governs’ and the ‘eye’ that ‘dissects, isolates and classifies’, the patient becomes the passive and silent object of knowledge” (Foucault 1973, 89). Michel Foucault is concerned with the process whereby the human is turned into the subject of scientific investigation and control (Foucault 1984).

Talcott Parson emphasized the social importance of the role of the sick from his utilitarian stand (Parson 1951). The people who are ‘sick’ and need treatment have the tendency to withdraw from normal patterns of social behaviour. The ‘sick’ persons are managed and controlled by the social system. Medicine can control and regulate those who have fallen sick as medicine has complete power to control ‘deviance’ in modern societies. Medicine is not only a minor institution based on scientific care; it can verify the ‘deviant’ tendencies of a person who may try to escape from the ‘sick’ role. Parson believes that the medical profession acts to control provoked ‘deviance’ and provides an account of illness as a response to social burden. Parson’s concept of ‘sick’ role is very important in
problematizing the idea of disease as natural and biological (White 2002, 8-9). Parson said that illness and crime are both designated as ‘deviant’ behaviour (Parson 1951, 428-479). For a person both illness and crime are threat for social stability through its impact on role performance violating social or medical norms. So both are defined as ‘deviance’ where illness is controlled by physician or medicine. The dominant designation of deviance of what badness [sinful or criminal] is now has changed to sickness (Conrad 2005, 104).

Marxist theory emphasizes the role of economic interest in producing diseases and shaping the way in which it is dealt. According to Marxist theory medicine is a major social organization in capitalist societies and it is shaped by capitalist interest. Medicine has become a specialized market commodity. Thus, ‘disease is treated … as an aspect of capitalist society’ (White 2002, 8). The medical profession has the power over the society and working class which individualizes and depoliticizes diseases and provides certificate of sickness.

Feminists are concerned with patriarchal domination in society and its effect on women’s health. They have analyzed how patriarchal medical construction of woman makes her health status inferior to man, subordinating her through different medical technology. Patriarchal technology enforces their sexist and patriarchal attitude in the form of medical authority over powerless patients (Seaman, 1987). In feminist analyses women is defined by their biology; menses, pregnancy and menopause (Barker-Penfield 1979) and medicine plays a dominant role. Woman is traditionally seen as an object of medical investigation mainly due to their reproductive health. The image of woman as perennially sick and requiring constant and greater medical care than man has been generated by a society which has confined her to the roles and responsibilities relating to others; in other words, very often woman’s health is highlighted only for the sake of her reproductive role. Foucauldian feminists have made important contribution to issues relating to the construction of body and analyzing the forms of surveillance and medicalization of women (White 2002). Thus there are many examples of the in which social structures create and catagorise illness as ‘deviant’.

The metaphorical representation of diseases in popular media may create a derogatory image of diseases in people’s mind.
1.3 Representation of disease in popular culture

According to the Chambers Twentieth-Century dictionary representation is the act, state or fact of representing or being represented: that which represents: an image; picture: dramatic performance: a mental image: a presentation of a view of facts or arguments: a petition, remonstrance, expostulation, assumption of succession by an heir; a body of representatives (Cavallaro 2001, 38). Barker defines representation as the media through which signifying practices appear to stand for or depict another object or practice in the ‘real’ world. According to him representations are constitutive of culture, meaning and knowledge (Barker 2006, 448). Mitchell argues that representation differs in ways like ‘object’ ‘manner’ and ‘means’; ‘object’ which is represented, ‘manner’ the way of representation; ‘means’ (called ‘codes’ by Mitchell), the material which is represented as language, musical forms, paints etc. The ‘means’ may be the same in representation but the ways of employment of codes may be different as the employment of means in literary representations may be ‘dramatic’, ‘narration’, ‘description’, to achieve effects of pity, admiration, laughter, scorn etc.. Mitchell says that some codes become institutionalized as style or genres so these are social agreements (Mitchell 1995, 13). Mitchell says that representation cannot be extracted from political and ideological enquiry; “if the literature is a ‘representation of life’, then the representation is the exactly the place where life, in all its social and subjective complexity, gets into to the literary world” (Mitchell 1995, 15).

Cavallaro says that representation has been traditionally associated with concepts of similarity and replication. Objects are supposed to have two images: their actual images and then mental images fashioned by a variety of individuals (Cavallaro 2001, 44). So to study a culture the study of its signifying practices is very important to discover the textual creation of meaning that are entrenched in sounds, inscriptions, objects, images, magazines, books, televisions and how these are fashioned, ratified, used and comprehended in a particular social context (Barker 2006).

Social scientists are interested to study the narrative accounts of disease and illness in popular texts and works of literature. Writers who suffer from serious
illness often add their painful experiences in their work using dramatic imaginary ways in both fictions and autobiographies. The representation of disease in elite and popular culture in Western societies can be useful to understand the conceptualization of disease and illness in these societies in their changing socio-cultural and political environments. Western novels gave special attention to diseases like leprosy, tuberculosis, cancer, syphilis and mental illness as a disease of physical decay, pain and suffering and terror. Renowned literary figures like Keats, Rabelais, Chekov, and William Carols were engaged in such types of writings. The sick body was also represented in the literary works of the nineteenth century. During this period disease was used in literature as motif of chronic illness affected by stubborn and mysterious forces beyond human control and conception. Traditionally in the novels the diseases are described as foreign and incomprehensible forces that destroy and bring distress to human life. In seventeenth century England religion, health and illness were closely related (Lupton 2003). Lupton describes, “the Gothic novel emerging in the Romantic era…. depicting diseases and bodily symptoms of illness or physical decay as evil demons and monsters to evoke horror and to symbolize the internal sufferings or evil of characters” (Lupton 2003, 55). Literature of the Victorian period represented disease as preoccupation with death and the supernatural. Mary Shelley described in her literature that god is the creator of the human body and he possessed the whole responsibility of disease (Lupton 2003). Later on, horror stories representing disease became the central theme in popular culture of the West and it continues to be popular till date. During the Romantic period tuberculosis was a common disease and cause of death of many of the prominent literary figures such as Keats, Percy Shelly, and Byron. It inspired the writers for creative compulsion of romanticism and tragic expression of disease. Thus the Romantic period encouraged certain stereotypical images of the diseased as lonely and forlorn. With the advent of scientific medicine in the twentieth century, disease and illness came to be represented as metaphysical, hopelessness, loneliness and separation and self hesitation (Lupton 2003, 54-56).

Susan Sontag was one of the first writer, literary critic, and body theorist to write extensively on diseases. She published Illness as Metaphor in which she considers the contemporary usage of illness and disease as metaphor to construct moral
judgment regarding the ‘ill’ (Sontag 1987). She describes in her essay how myth and metaphor surrounding disease like tuberculosis and cancer add greater suffering of the patients and often hold back them from seeking proper treatment. She commented that “It is hardly possible to take up one’s residence in the kingdom of the ill unprejudiced by the lurid metaphor with which it has been landscaped” (Sontag 1987, 3-4). Sontag was one of the first modern critics to argue that metaphor made illness meaningful. Sontag wrote how tuberculosis, cancer and later on HIV/AIDS got extraordinary cultural significance in Western societies over the past two centuries. According to Sontag metaphor is a vital epistemological device to understand the world (Lupton 2003, 61). Sontag has analyzed the stigmatized and discriminatory affect of metaphorical discourses of diseases. She describes the metaphorical image of tuberculosis as a disease of mystery, a disease of ‘romance’, sign of inward burning, hyperactivity, disease of liquid, possessing transparency, leading to a noble, poetic, death (Sontag 1987, 11). On the other hand cancer was imagined as ‘protuberance’ with abnormal growth and the disease of evil. Both the diseases were thought to be contagious and felt to have magic power (Sontag 1987, 6). Cancer was projected as more fearful than T.B and people were often demoralized knowing the suffering associated with the disease so they are not informed about it. T.B was considered to be shameful and cancer was considered more grueling. Patient’s families hid the disease because it could threaten their love life, job etc (Sontag 1987, 6-8). Death for such patients was thought to be better than life: mostly sudden and immediate death, liberating the patient from deep pain was welcome. Death and disease was treated at par. Cancer was felt to be ‘ill-omened’, ‘abominable’, ‘repugnant’ to the senses (Sontag1987, 9). T.B was thought to produce spells of euphoria or increased appetite and sexual desire. On the other hand, cancer is considered to be a desexualizing disease (Sontag 1987, 13). T.B was considered as a disease of poverty: of ‘thin garments, thin bodies, poor hygiene, inadequate food’; on the other hand, cancer was considered as a disease of ‘middle class’ life with excesses. T.B was considered as wet disease and doctors usually advised patients to move to dry places. So death by T.B in popular literature has been portrayed as beautiful and emotional and death by cancer has been projected as being ‘humiliated by fear and agony’ (Sontag1987, 17). Traditional mythology has portrayed T.B as a disease of the lung (which is in upper part and so
spiritualized) and cancer is disease of colon, rectum, bladder, breast, cervix, prostate, testicles that are awkward to admit and so shameful in nature (Sontag 1987, 17). Sontag describes the understanding of disease as a supernatural punishment, demonic possession and a result of natural causes which is revealed in the *Iliad* and the *Odyssey*. For the Greeks disease was a sign of personal fault, a collective misdemeanor or crime of one’s ancestor. Christians used to moralize the notion of disease as it was the punishment for sins. In the nineteenth century the notion was replaced by the expression of character which is the product of will. According to Sontag physician like Bichat used health as ‘silence of organ’ and disease as their ‘revolt’ as disease was the expression of dramatization of mental form speaking through body. Disease was considered as excess expression of feelings and patient and disease became the subject of interpretation (Sontag 1987, 43-45). Sontag thus analyzed how different metaphors of disease were represented in Western societies through literary wrings and it became deeply rooted in people’s mind. The hierarchical and stigmatized notion of disease as cancer is more violent and evil had created problem in treatment procedures also. By demystifying fantasies surrounding cancer Sontag shows how cancer is not a nuisance, not a punishment, but a highly curable disease. Almost a decade later Sontag published another book on the metaphor of HIV/AIDS (1989), where she portrayed the same metaphorical impression of HIV/AIDS in the society. Here the incursion was by an outsider in the form of a virus. Whereas in cancer cells propagate, in HIV/AIDS cells die (Sontag 1989, 107). So HIV/AIDS and cancer are represented as punishment for living unhealthy lives, for taking health risks, for excesses of diet and lifestyles, weaknesses of will, self indulgence and addiction (Sontag 1989, 113). Sontag described in her book how the metaphorical representation of HIV/AIDS have created stigmatized and discriminatory attitude towards people affected by HIV/AIDS.

Popular media has become dominant in the twentieth century. Patient, doctor and other health professionals have become a common sight in popular fiction and film, television dramas and soap operas since the 1950s. Injury and death in accident, violent events, suicide, and mental illness are common themes in soap operas. Doctors are represented as a supreme authority and symbol of power. With their white coat and stethoscope, they possess the ability of successfully treating
patients, using latest technology and fast acting drugs, always doing the right things, and curing all maladies. On the other hand patients are represented in a helpless condition because of their inability to understand bodily functions. So they are in absolute subordination to the doctor. Seventeenth century writers used the religious metaphor of body in comparison with the workmanship of God, and the sinner as ill man. Later medical metaphoric expression also used ‘healing’ as ‘salvation’ with the same meaning (Lupton 2003, 57).

Social meaning can shape the response to illness. Leprosy, epilepsy, AIDS, mental illnesses have acquired moral meaning of illness and this has affected the perception of these illnesses. These illnesses can be categorized as some of the most ‘stigmatized diseases’ of the present century. Traditional beliefs, folklore, myth, metaphor, and social stereotyping play a dominant role in constructing notions related to diseases like syphilis, HIV/AIDS, mental illness almost in all societies.

In traditional belief systems illness is construed as a form of supernatural possession and evil spirit. Sometimes sinful acts amounting to violation of God’s decree are considered to be the cause of diseases like mental illness or sexually transmitted diseases. In the eighteen century, Cotton Mather, New England Puritan minister declared syphilis as punishment and judgment of god. The negative image of venereal diseases affected the treatment procedure and government funds were also allocated in a restricted amount dealing with these diseases (Conrad 2005, 105).

“Stereotypes are beliefs and characteristics of groups of individual (for instance, that women are emotional or that college professors are absent minded), and stereotyping is the application of these stereotypes when we interact with people from a given social group” (Stangor 2000, 1). Stereotypes attribute negative characteristics to the persons who are mentally ill or those who carry some contagious disease, thereby separating ‘them’ from ‘us’. Stereotypical notions make categorization and help in creation of this marginalized group in society. Thus, myths and stereotypical notions add to the stigma associated with mental illness and other diseases.
Stigma is a serious obstruction for the wellbeing of the person who faces such an experience. Goffman illustrated that the ancient Greeks came up with the term stigma to refer to bodily signs designed to expose something unusual and bad about the moral status of the signifier (Goffman 1963, 4). Stigma is a form of deviance that leads others to judge an individual as ineligible to participate in social interaction (Goffman 1963). This is because of the perception of lack of proficiency to interact with society which is influenced by the person’s dangerousness and unpredictability. Stigma is a “collection of negative attitudes, beliefs, thoughts, and behaviors that influence the individual, or the general public, to fear, reject, avoid, be prejudiced and discriminate people” (Gary 2005a, 980).

Stigma is a social construct and it seriously impacts patients and families alike. Stigmatized persons are regarded as people who have lost social value and are “spoiled” forever. It could be described as a construct which changes depending on time and society. Stigma is a serious problem and a barrier for achieving life-goals for those with mental illness or sexually transmitted disease. Stigma is a phenomenon associated with many chronic health conditions, including leprosy, HIV/AIDS/STD, mental illness, epilepsy, disability and tuberculosis.

1.4.1 History of Mental Illness: Treatment in the West

Mental illness has been variously treated in different parts of the world at different times. It would not be an exaggeration to say that a lot of experimentation was carried out in the treatment of the mentally ill. The attitude and behavior of different societies towards mental illness as reflected in their treatment procedures as has been analyzed in this chapter.

**Primitive treatment:**

The history of treatment of the mentally ill can be traced back to the prehistoric past. In fact, it is as old as mankind. There is little evidence to know how the mentally ill were treated in the prehistoric times. Some human skulls unearthed by anthropologists from South America and Europe dating back to 10,000 B.C. possessed small holes. These evidences show that prehistoric people developed a crude form of surgery by drilling the skull of a mentally ill person to release the
evil spirit from the body. This method has been termed as trepanning (Thompson 2007, 5). Kent also describes (from reconstruction of evidences of human skulls with tiny holes received in earth’s crust) that people of the Neolithic period used to drill heads with small sharp holes to release demons that were believed to cause mental illness and it shows similarities with modern medical technique called trepanning that is used to relieve pressure on the brain (Kent 2003, 16).

Mental illness has been feared, misunderstood and treated with contempt throughout human history. Different ancient civilizations and ethnic groups had their own ways of treating mental illness. It is a very common belief all over the world that demonology and spirit possession can cause mental illness and shamanistic practices play a dominant role in the beliefs and practiced related to treatment of mental illness. During the thirteenth century B.C the magico-religious concept of mental illness was developed in ancient Egypt, where the evidence of first mental health care was found. They used temples as mental hospitals to treat the mentally ill. Egyptian priests treated the mentally ill by using different rites, rituals and prayers of specific gods and also by the interpretation of dreams. They used opium and similar drugs to give relief from the trouble. Opium and similar drugs were used to induce “incubation sleep”. Scholars discovered about the Babylonian belief and healing practices from a form of writings known as ‘cuneiform’. Babylonians believed that mental illness was caused by demons and the madness caused by demon was called as Idta. In these tablets the treatment of mental illness is inscribed: the solution was to sprinkle the affected man by the water collected from the mouth of the river. They believed that the magic power of the water will help to exorcise the demon from the body of the mentally ill (Kent 2003, 18-19).

Porter suggested that the Babylonians and Mesopotamians held that mental illnesses were caused by spirit incursion, sorcery, demonic malevolence, the evil eye, or breaking of taboos of tribal societies (2002,12). The treatment of the mentally ill in ancient Greece can be gathered from myths and epics where it was mentioned that the only way out of mental illness was by overcoming the demon or spirit which grasped the body and soul. They were treated in the temples dedicated to the Greek god Asklepios (Asclepius) by the priests. This was an elaborate process involving procedures like cleansing, bathing in the sacred
spring, massage. They were later treated by inducing incubation sleep. Asclepius was the most famous Greek god of healing and medicine. It is believed that the practice of incubation sleep came to Greece from Egypt (Kent 2003, 19). Greek priests mainly used shock therapy: snakes would be used to shock people out of the stage of delirium. The ancient plays of Aeschylus, Sophocles, and Euripides represented madness as accompanied by grief, shame and guilt. Very often the Greek methods were a strange admixture of modern and traditional casts of mind. “A more modern mental landscape was emerging, however, by the time of Athen’s golden age” (Porter 2002, 12).

The concept of mental illness underwent a bit of change after the advent of Greek philosophers and physicians like Homer, Aeschylus, Socrates, Plato etc. The superstitious notion of mental illness being cured by the divine power of priests gradually made way for scientific approaches that attempted to unravel the mysteries of the human psyche. Homer (c 1200 BC) believed that the mind of mentally ill persons had been taken away by God. Aeschylus (525-456 B.C) believed that the cause of mental illness was demonic possession and the treatment of this was exorcism (Thompson 2007, 6). Socrates (469-399 B.C) described mental illness as a gift of God. Socrates’ most famous pupil, Plato (428-348BC) related mental health to the soul. He divided the soul into the rational and the irrational parts (Plato 1977). According to him the rational soul existed in its purest form in human nature while the irrational soul was made up of jealousy, fear and anger. In his work Timaeus, he wrote that mental illness and abnormal behavior could be attributed to bodily imbalance (Plato 1977). He said that along with balanced mind and body education is also responsible for good mental health. Plato made a distinction between mind and body which showed the superiority of mind over matter. He thought that the problems of mind originated from the diseases of the body along with lack of balance of emotions and interventions of god. He thought that these could be cured by talking to the patient, showing fear by threatening him with confinement or showing good behavior to restore the balance of emotions (Plato 1977). His theory introduced the psychological perspective later proposed in the twentieth century by the psychoanalyst Sigmund Freud who tried to represent the relation between id, ego and super ego. Plato believed that the peace of the community can be also
threatened by the unpredictable, bizarre behavior of the mentally ill persons. So Plato suggested a law to protect the people of Athens from the mentally ill people living among them. “If a man is mad he shall not be at large in the city, but his family shall keep him at home in a way which they can, or if not, let them pay a penalty” (Peterson 1982, 342).

Greek Physician Hippocrates (c 460 to 377 B.C) made the greatest contribution to the field of medicine. He suggested that the cause of mental illness was the imbalance of the bodily fluids and humors. He believed that black bile caused sadness (melancholia). Melancholia is now known as depression. Hippocrates proposed various treatments like different therapies to establish a balance between the humors. He suggested different exercises and the use of medicines made of certain plants and roots. He advised vegetarian diet during illness. Though Hippocratic treatment did not have any scientific accuracy, his theory of the biological origin of mental illness had laid the path for modern medical model of mental illness (Thompson 2007, 8).

Aristotle (384-322 B.C) believed that the human soul was guided by rationality and reason along with wisdom and knowledge while on the other hand, the irrational soul was marked by morality, dispassion, and courage (Thompson 2007). He believed that mental illness had organic etiologies. Physical illness might lead to mental aberrations. According to him reason lives independent of mortal beings and while it is creative, it can also have insulated effects of mental illness. Sometimes mental illness can have a creative value. He argued that mental illness enhanced creativity as was proved in the case of many eminent writers, politicians, philosophers and artists who tended to suffer from melancholia. The Greek physician Claudius Galen (A.D 129 – 216) accepted Hippocrates’ theory of humor. However, when dissection of human anatomy led to the discovery of nerves and their actions, he completely denied divine intervention in mental illness. Thus, the theory of the duality of body and mind leading to the onset of mental illness was proposed by the Greek philosophers (Kent 2003, 25). The philosophy of Plato, Pythagoras, and Aristotle showed that reason lived in the soul and fought against the dangers of irrationality. Thus, by making man the measure of all things, the Greek philosophers humanized madness by explaining it as a disease of the mind.
The ideas of the philosophers and physicians could not reach the masses of Greece because there were very few literates in those days. Thus, belief in demonic possession, witchcraft and anger of gods as causing mental illness remained with people. The mentally ill were therefore insulted, chained up, beaten, stoned, and also driven out of the villages. Rationality was the defining characteristic of the human mind for philosophers like Aristotle and Plato. For Pythagoras man was the measure of all objects in the world. The fourth and fifth century philosophers thought that only reason could rescue human beings from disaster. Women and other marginalized groups were treated as irrational.

The attitude towards mental illness during the dawn of the Christian era on the fringes of Roman Empire can be perceived in the New Testament Book of Mark. Here mental illness is believed to be caused by the possession of evil spirits and is cured by Jesus (Kent 2003). In the first few hundred years of the Christian era, the Church came to be the supreme authority in matters relating to the treatment and categorization of mental illness and the theories and ideas of Greek philosophers and scientists were cast aside.

Unlike Greek philosophy, Christianity denied that reason was the essence of man: what counted were sin, divine will, and love, and a believer’s faith……. human race was outnumbered by otherworldly spiritual beings…………and semi sanctioned by Church’s supernaturalism… In Christian divinity, the Holy Ghost and the Devil battled for possession of individual soul. The marks of such ‘psychomachy’ might include despair, anguish, and other symptoms of disturbance of mind (Porter 2002, 17).

Madness during that period was the “madness of the Cross” treated as “good madness”: holy, innocent, prophets, ascetics and visionaries were the “good mad” suffering from fear of bewitchment and religious desire. The insane possessed by unclean spirit was treated by reading out from the Bible, prayer, counsel or by using the miraculous healing powers of saints in the religious houses. During this period, a religious concept of mental health was dominant. Madness, which was the loss of reason, was the acute phase caused by violating god’s order. In Europe, Catholic Church divided itself well from evil, by its own law. The mentally ill often found themselves under the control of religious and political forces.
A History of Madness during the Middle Ages, the Renaissance, and the Post-Renaissance periods:

In Western Europe, even after the fall of the Roman Empire, the Roman Catholic Church began to dominate politically and socially. The Church remained the constant authority even though rulers kept on changing. Villagers abided by the rules of the priests. They were assured by the church that they would be rewarded in heaven if they were obedient and faithful towards the system and would suffer the agonies of hellfire if they disobeyed the warnings of the priests (Porter 2002). The concept of good and evil was very prominent and mental illness was perceived as a religious disturbance. In medieval Europe demonic possession was thought to be the cause of mental illness and priests usually treated them through application of holy relics. Exorcism was also used for healing purposes by shamans during this period. The Catholic Church had totally banned the ‘freedom of speech’ and ‘freedom of religion’ in medieval Europe. The rule breaker of the church was vigorously punished (Porter 2002). Gradually witchcraft gained currency and became to be the biggest menace for good Christians.

Witches, who used their demonic powers to do the devil’s work on earth, were enemies of church, heretics in the highest degree. In 1484 Pope Innocent VIII issued a decree, or Papal Bull, calling upon the church to seek out and eradicate witches throughout Christendom (Kent 2003, 39).

Witches were thought to be possessed by their own will and they were burned, hanged and drowned. Women behaving in a strange and unusual way were suspected to be witches. Suspected women were prosecuted, and once forced confessions were extracted from them, they were punished. In the seventeenth century, King James I made an attempt to “identify” witches through witch finding technique. “The suspect was bound hand and foot and tossed into the water. If she floated, her guilt was certain. If the waters embraced her and she sank to the bottom, her innocence was revealed” (Kent 42). Later European colonists carried their belief of witchcraft to North America and many women became the victims of witch hunting. More than 200,000 people, especially women, were executed during ‘witch craze’ (Porter 2002, 25).
During this period the physicians of the Middle East took the path of the Greek philosophers in treating mental illness. In 9\textsuperscript{th} century A.D a Persian physician named Unhammad had described different types of mental illness as ‘kutrib’ (being prosecuted by other) and ‘murrae sauda’ (groundless worries) which resembled modern biomedical terms like paranoia and obsessive compulsive disorder (Kent 2003).

Abu Al-Husain Ibn Sina (980-1037), the famous physician of Persia, was known as 	extit{Avicenna} in Europe. He was the follower of Hippocrates who believed that mental illness was caused by the imbalance of body humor which affected the mind. Another famous physician, who practiced in the royal court of Cairo and Egypt, was Moses Ben Maimon or Maimonides (1135-1204); he believed that mental illness was a disease of the soul and it could be treated by treating the mind. Thus, paradoxically, Europe and other parts of the world passed through different notions of mental illness and treatment procedures (Kent 2003).

During the middle ages (5\textsuperscript{th} century to 15\textsuperscript{th} century) in Europe, the mentally ill were clubbed as the undesirable elements of society along with beggars and lepers. The towns and cities were surrounded by walls for protection against enemies and these undesirables were thrown out of the cities by the watchmen. Mental illness was thought to be the result of demonic possession and to be strange and bizarre. People were scared of the mentally ill. The French philosopher Michel Foucault in 	extit{Madness and Civilization: Insanity in the Age of Reason} describes that after the disappearance of leprosy in Europe during the Middle Ages, mental illness came to occupy its place. Similar to leprosy in the age before, mental illness evoked reactions of purification, exclusion and isolation (Foucault 1965, 6). Lepers were treated as a symbol of sin, a result of disobedience to god, and they were excluded from society as the bearers of divine retribution. Gradually criminals and the mentally ill occupied the place of lepers.

Leprosy disappeared, the leper vanished, or almost, from memory; these structures remained. Often, in these same places the formulas of exclusion would be repeated, strangely similar two or three centuries later. Poor vagabonds, criminals and ‘deranged minds’ would take the part played by leper… (Foucault 1965, 7)
The 15th century was the age of Renaissance in Western Europe. This was indeed a period of awakening and new beginnings – the Roman Catholic Church was challenged by the Protestant Reformation. According to Foucault, interpretation of madness also changed during the Renaissance. Foucault explores the understanding of mental illness during the Renaissance (15th to 17th) in his writings. Here the imaginary landscape of mental illness of this period is captured through Bosch’s painting, Narnrenschiff, the literary composition in ‘Sultifera Navis’ or ‘Ship of the fools’. Ship of the fools has been for long a metaphor in western literature and art. The allegory depicts a vessel populated by human inhabitants who are deranged, frolicsome or passengers aboard a ship without a pilot. Foucault saw in the ship of the fools a symbol of consciousness of sin and evil alive in the mediavel mindset and imaginative landscape of Renaissance. In Bosch’s painting madness was shown as a dark, dream-like, tragic threat and in literature it was represented as a kind of ironic juxtaposition for reason. The mentally ill were allowed to wander freely in the countryside when they were expelled from the city. The responsibility of these people was offered to a group of merchants and pilgrims who kept them at a safe distance from their neighborhoods. This was done for “social security”. The mad priests were of course beyond such laws (Foucault 1965, 10-12). The fool was popularly denoted as blind and as being far removed from truth and the madman was represented as a fool in the tales and satires of Europe in the Middle Ages. Reason as the opposite of madness was a strong and recurring theme in the comedies of this period (Foucault 1965, 22).

Representation of madness has always been a vexed problem, offering no easy solutions. Sometimes, it was possible that a poor man pretended to be mad for a piece of bread. In all ages, madness stood in opposition to what man thought was his essence, his quintessential characteristic. Thus, during the Renaissance a dialogue developed between madness and reason. During this period madness and reason entered into a reversible relation, mutually exclusive qualities that were mutually dependent to impart meaning to each other. In fact, madness became an integral part of reason. But madness was regarded as unavailability of reason, not access to inner human truth. So Foucault said that during Renaissance, madness was not treated violently or treated to systematic confinement. Foucault argues
that madness mediates between life and death. During Renaissance madness was compared to death which may strike any one at anytime. For Foucault, madness during the Renaissance was an expression of void and sometimes it appeared as folly (Foucault 1965, 66).

In the beginning of the thirteenth century institutions for the mentally ill were opened in Florence, Spain, Belgium, and England. St. Mary of Bethlehem, popularly known and listed as ‘Bedlam’, the word that ‘endures in English language to this day, connoting unbridled noise and disorder’ (Kent 2003, 47) was established in 1247 and it provided services till fourteenth century England. During 1403 ‘mad houses’ were opened all over London to give shelter to the insane. By the middle of the seventeenth century public hospitals were opened in major cities of Europe to treat the insane people by locking them, hiding them from the sight of the people demanding the welfare of the patients as well as communities. Hôpital Général was the one of the famous institution founded in Paris in 1665 by King Louise XIII and this institution confined one percent population of Paris and one tenth of this population was listed as ‘insane’. The poor people were considered as shameful for the society; the disabled, sick and other marginal groups of people were admitted in the Hôpital Général and provided food and lodging at the cost of great suffering and disgrace. In Salpêtrière, one of the branches of Hôpital Général, the women and children’s condition was pathetic and measurable as they had to suffer from different ailments. The European madhouses reflected the pictures of Hospital General where women were chained, kept in pigsty binding their hands and feet; half naked men were locked in cages with iron rods. They were treated more like animals. People came there to watch these ‘lunatics’ and offered money to them (in one year four hundred pennies were collected from 96,000 visitors in Bedlam) (Kent 2003, 51).

Foucault, says that madness in the classical period (1665-1800) was seen as a total threat to reason, and was therefore, justifiably, subject to moral exclusion (1965, 73). Houses for confinement such as prison work houses, hospitals, and similar institutions were built all over Europe during the 17th century but they had no connection whatsoever with medicine and science. The Hôpital Général appointed a director and gave him all powers of authority, jurisdiction, and punishment. The
expression of the intention behind the confinement was not only the punishment of the mad but also the epistemic attempt to drive away unreason from the discourse of classical reason (Foucault 1965, 116).

Foucault here used another term ‘unreason’ which was not synonymous with classical madness. Through unreason, madness of the classical age was expressed in a third category which had nothing positive to say about itself that could be expressed through reason. Unreason was thought as moral failing to be manifested by the idleness and failure to work. This was punished by confinement. Madness was considered to be another group representing unreason, degrading all forms of humanity which was confined, punished as well as controlled. During the classical period the mad were related to animals and thus they could be caged, chained and served food like animals. Foucault suggested that the mad were displayed as alien wild animals and were presented as spectacle to be watched and thus animality of madness was glorified in confinement (Foucault 1965, 78).

**The Eighteenth Century: The Great Confinement and the Reform**

In the late 17th century doctors tried a different way to treat the mentally ill people. They made an effort to run the hospitals where the mad people could be treated and cured and they could be sent back to society. The madhouses were being changed to asylums. In 1793 Philip Pinel, was made director of the madhouse of the Paris, *Bicêtre*. This period of a series of cataclysmic events has come to be known as the French Revolution. The revolution was the dawn of a new era that championed the cause of equality, freedom, brotherhood. The royal families were thrown out. Pinal saw the disgusting situation of the madhouse and the patients chained in locked cells. He was eager to put the principles of the revolution in practice and unchain the patients. Many Parisians were motivated by the plan of Pinal. One local Philanthropist invited Pinel to make a tour of the institution where he had witnessed the plight of the patients who were very often subjected to cruel and abusive words. Pinel unchained the patients of *Bicêtre* and came to be regarded as the father of modern psychiatry. The works of Pinal helped to change the attitude towards mental illness in 18th century Europe to some extent. In 1774 British parliament passed a law that medical certificate was required to lock a mad
as many people pretended to be mad for other benefits, including, at times, attempts to escape the law (Kent 2003).

In 1970, William Tuke, spiritual Quaker, made an investigation of English mad houses and noticed the terrible condition there. In 1796 he opened a new institution, the York Retreat, with a vision to treat the patients with kindness. With Tuke’s institution a new history of treating mental illness was started. Psychiatry developed accordingly in the asylum to manage its prisoners. The prevalent assumption was that the mad were wild animals requiring cruel education and treatment with shock therapies, drugs, bloodletting, and vomiting. After Tuke, the mentally ill were kept under examination of the physicians and psychiatry became better designed and well managed with slogans of innovation and experience. William Battie, physician of new St. Luke Asylum of London, accepted that madness is controllable like other diseases. In England the faith in sheltered asylum grew with the supervision of doctors like Thomas Arnold, Joseph Mason Cox and Francis Willis followed by Bettie with the notion that “moral management” was the most important medicine. Moral treatment was in progress in the York asylum of Tuke. His retreat was idealized in bourgeois circles as patient and staff lived as well as worked together in a homely environment. They were punished or rewarded depending on their recovery, where the aim was to return their self control. Samuel Tuke, the grandson of William Tuke, who later became the Superintendent of the York retreat appealed that the medical means of treatment was discarded by moral treatment to regain the powers of reason and humanity (Porter 2002).

In the first half of the nineteenth century moral treatment of mental illness developed all over Europe. Moral treatment was a fundamental departure from the medical model which believed that biological disease had partial effect on mental illness where the mind played a vital role which could be cured in lunatic asylum. Asylum was the place of safety, isolated from family stress treated by wise doctors and attendants. The patients were being bound to maintain a disciplined life in the asylum, employing them in different activities under observation of attendants. Work therapy became a major tool of moral management under surveillance of keepers.
But moral treatment became less benevolent as patients were afraid of being chained up if they broke the rules of the asylum. The attendants and patients often underwent guilt feelings of wrong doing. Moral treatment replaced physical treatment by emphasizing the sense of fear and shame of guilt feelings and patients became objects of surveillance by the other.

…[B]y this guilt the madman became the object of punishment always vulnerable to himself and to the Other; and from the acknowledgement of his status as object, from the awareness of his guilt, the madman was to return to his awareness of himself as a free and responsible subject, and consequently to reason. This movement by which, by objectifying himself for the Order, the madman thus returned to his liberty was to be found as much in Work as in Observation (Foucault 1965, 247)

Thus, madness gradually became a matter of judgment and surveillance under scientific investigation. Doctors played a major role in nineteenth century asylums. They took advantage of their power to conceptualize mental illness:

The physician could exercise his absolute authority in the world of asylum only insofar as, from the beginning he was Father and Judge, Family and Law.-- his medical practice being for a long time no more than a complement to the old rights of Order, Authority, and Punishment (Foucault 1965, 272)

The liberation of the mentally ill turned out to be illusory as they were converted to moral prisoners in the hand of scientific knowledge, thereby giving birth to the power of asylum and psychiatry.

Enlightenment:

The enlightenment was a philosophical movement of the 18th century, characterised by belief in the power of human reason and by innovations in political, religious and educational doctrine. As regards Immanuel Kant, in his 1784 essay “Beantwortung der Frage: Was ist Aufklärung” (“Answer in the question: What is Enlightenment?”), he defined the enlightenment as mankind’s final coming of age, as the emancipation of the human consciousness from an immature state of ignorance (Foucault 1984). In social history the vision of
enlightenment was the freedom from superstition, freedom from random authority of church, where the middle class controlled the state, and where knowledge acquired ultimate power. America underwent a process of enlightenment during the 18th century. Enlightenment thought is signified with its principle that Reason can throw light on and enlighten the world removing myth and superstition through human creativity, rationality and scientific exploration following modernity which was based on the French Revolutionary slogan ‘Equality, Liberty, Fraternity’. During enlightenment men participated collectively and acted singularly as an element which was dominated by the world of reason through different types of knowledge system (Foucault 1984).

Kant said that the impact of the enlightenment was felt all over the world in social as well as political sphere. Here he made distinction on the use of reason during enlightenment one was public use of reason and another was private use of reason. But the use of reason would be free and public when one was reasoning as a reasonable human race not as a part of machine. “Enlightenment is thus not merely the process by which individuals would see their own personal freedom of thought guaranteed. There is Enlightenment when the universal, the free, and the public uses of reason are superimposed on one another” (Foucault 1984, 37).

Modernity is often said to be the forerunner of the enlightenment. Foucault however believed that modernity was an attitude rather than an era. By attitude he meant the people’s way of thinking and feeling compared with the way of acting and behaving and their relation with the reality of present situation.

According to Foucault, the truth of modernity was concerned with the relation of power/knowledge where knowledge as a form of power was applied to produce subjectivity just as prisons, schools and hospitals were used to operate power through different types of knowledge systems.

Criticism is no longer going to be practiced in the search for formal structures with universal value, but rather as a historical investigation into the events that have led us to constitute ourselves and to recognize ourselves as subjects of what we are doing, thinking, saying………..from the contingency that has made us what we are, the possibility of no longer being, doing, or thinking what we are, do, or think (Foucault 1984b, 45-6)
According to Foucault, Freud’s concept of neuroses lessened the gap between reason and madness (Foucault 1965). For Foucault in a true sense psychoanalysis could not liberate the insane because it rests on the hands of power of analysts.

Freud demystified all the other asylum structures: he abolished silence and observation……..he regrouped its power, extended them to the maximum by uniting them to the doctor’s hands; he created the psychoanalytic situation where, by an inspired short circuit, alienation become desalination because, in the doctor, it becomes a subject ……..Psychoanalysis can unravel some of the forms of madness; it remains a stranger to the sovereign enterprise of unreason (Foucault 1984, 277-278)

The modern treatment of mental illness produced alienated relationship of doctors with patients. So called scientific definition of mental illness of psychiatry or psycho analysis was derived from the disciplinary moral practices which is termed by Nigel Dodd as completely post hoc (Dodd 1999).

**Treatment of mental illness in the 20th century**

In the late nineteenth century psychiatrists established their discipline through ‘hard’ biomedical science, with neurology and pathology. Psychiatrists tried various treatment procedures for the treatment of the mentally ill. Psychiatrists declared that psychoanalytic treatment did not have a scientific basis. Julius Wagner –Jauregg, the first Nobel Prize winning psychiatrist, introduced insulin shock therapy for treatment of severe mental illness in 1934. The Budapest psychiatrist Ladislas Josheph von Meduna developed another shock treatment in which camphor like drugs were used. In 1938, Ugo Cerletti began to use electric shocks (Electroconvulsive therapy) to recover the patients from severe depression. Psychosurgery emerged as a craze after the 1930s. In 1935 Egas Moinz developed the surgical treatment to calm highly disturbed patients. Later Walter Freeman developed prefrontal lobotomy. Some surgeons used to search the brain by drilling holes on the skull; others entered sharp and slender instruments through eye sockets. Psychosurgery turned out to be a misadventure. The negative effects of it were seen as hostility after treatment or loss of the ability to speak. It was practiced until the 1950’s. In the 1930’s Adolf Hitler authorized the programme
T-4, where some groups of people were transferred to some designated hospitals for evaluation and then killed by poison gas. The groups of people include mentally ill patients, Jews, Gypsies, unproductive men and women and ‘other undesirables’. After World War II, American public woke up and writers began to write on horrors of mental hospitals and their treatment through ETC and lobotomy (Kent 2003).

In the 1940s penicillin was introduced and psychopharmacology came into the field with great expectation. In 1949 mood influencing drugs were introduced to manage manic depression. In Tunisia, Laborit developed a medication and called it 4560 R.P (Kent 2003). The name of the drug was later changed to chlorpromazine. It quickly spread globally. Another drug launched in French named as Thorazine in 1954 was tried on the patients affected by mental illness. These showed lots of side effects in their body after prolonged use – dry mouth, drowsiness, sensitivity of sunlight, develop tumors and uncontrollable facial twitches which lead to the patients’ suffering from social and physical discomfort. For these physical discomforts people had to suffer from social stigma and their treatment remained incomplete (Kent 2003, 108). After the 1950s a sample of antipsychotic drugs were introduced which are used on the basis of experimentation by doctors on the patients. In 1952 lithium was introduced as the treatment for bipolar disorder but many American doctors declared use of lithium as dangerous where high doses might cause heart trouble. In 1970 the Food and Drug Administration (FDA) approved the use of lithium for people with bipolar disorder. In 1960-70 medications through tricyclic anti-depressant was widely used by psychiatrists of United States. From 1950 doctors used to prescribe Librium, Miltown and another anti-anxiety drug for patients with excessive nervousness, fearfulness, and panic attacks. Tranquilizers (diazepam) became popular as ‘mother’s little helper’ which was used by women mostly to reduce anxiety till 1960. In the last half of twentieth century anti psychotic, anti manic and anti depressant drugs were popularly used. In 1975 FDA enforced prohibition on prescription of Valium and similar drugs because of their side effects. Meanwhile, the treatment of mental illness through drug treatment, ETC, or lobotomy all failed. Many drugs came to the market with different compositions. The result of the treatments was not satisfactory as it did not express
straightforward results as seen in the case of physical illness. In 1952 a group of psychiatrists accumulated a small volume called *Diagnostic and Statistical Manual* (DSM) of mental disorders containing short descriptions and classifications of a variety of mental illnesses. In 1980 American Psychiatric Association published a revised version of DSM-III documenting a broad categories of mental disorder as ‘disorder of childhood or infancy’ (hyperactivity, anorexia, retardation, autism); known organic cause (disease of old age, drug-induced); disorders of schizophrenia (disorganized, catatonia, paranoid, undifferentiated); paranoid disorders (without schizophrenic signs); affective disorders (bipolar and major depressive); anxiety disorders (phobias, obsessive compulsive); somatoform (convention disorder, hypochondriasis); dissociative (fugue states, amnesia, multiple personality); and personality disorders”(Porter 2002, 213).

American Psychiatric Association defined mental illness according to the DSM-III. According to this, all problematic internal states are not disorders. In medical sense dysfunctional mechanisms must be cognitive, behavioral, emotional or psychological. DSM-III mentioned about two kinds of dysfunctions – one is distress and the other is disability. Disorder is applied in both ‘harmful’ mental and physical dysfunction (Wakefield 1999, 39). In 1994 psychiatrics came up with DSM-IV with more specialized form of diagnostic symptoms of mental illness and it was reviewed year after year. This version of diagnostic manual included more mental health problems with various symptoms. Few of them are Major Depressive Disorder, Separation Anxiety Disorder, Substance Abuse, Disorder of Written Expression, Anti-social Personality Disorder etc. A set of questions are arranged on behalf of every category and when patients’ symptoms resemble the disease, it is diagnosed as that particular illness (Wakefield 1999, 43-57).

Most of the critics inform that the disease syndromes of these manuals are shaped by politico-cultural, racial, and gender prejudices. The increasing number of pages of DSM manuals from 100 pages (DSM-I) to 134 pages (DSM-II) to 500 pages (DSM-III) and then to 2000 (DSM-IV-TR) poses serious questions to think if we are really progressing towards diagnosis of more psychiatric disorders or if we are merely increasing the number of categories (Porter 2002, 214).
In the beginning of the twenty first century, neurophysiologic and neurochemical understanding of brain impacted medication for mental health. Psychiatrists used to treat patients with acute symptoms with psycho-pharmaceutical drugs. Of all the recent innovation of drug therapy, the anti-depressant especially Prozac, has been most commonly used on people with mental illness. Mild chemotherapy is also used in the treatment. Most frequently prescribed drugs are mild tranquillizers such as Valium and Xanax (Kornblum and Julian 1998, 80). New profession of mental health to treat mentally ill has emerged with psychiatrists as clinical psychologists, clinical social workers and marriage and family counsellor. As psychiatrists depend on psychotropic drugs they are legally permitted to prescribe drugs, where other professions cannot prescribe drugs.

Religious fanaticism that very often borders on belief in supernaturalism turned into psychopathology during the modern age. The focus on reason that the Enlightenment encouraged continues to be dominant in the modern era. Enlightenment rationality constructed by exclusion of otherness became a universal idea that remains powerful till the twenty first century. With the advent of modern psychiatry and with the patholization of the patient’s body, they became the silent and passive objects of scientific observation.

The medical model that was started in Tuke and Pinel’s asylum did not actually start off as ‘true’ science but borrowed a ‘personality’ that is a psychiatrist, who had the power of camouflage of science; on the basis of his mastery, he objectified mental illness due to its marginalized status. The true nature of psychiatric treatment was power and ascendancy over the mentally ill. Psychiatrists applying their master rule and power alienated the patient from the society.

…Tuke and Pinal opened the asylum to medical knowledge. They did not introduce science, but a personality, whose powers borrowed from science only their disguise, or at most their justification. These powers, by their nature were of a moral and social order; they took root in the madmen’s minority status, in the insanity of his person, not of his mind. If the medical personage could isolate madness, it was not because he knew it, but because he mastered it; and what for positivism would be an image of
objectivity was only the other side of its domination (Foucault 1965, 271-272)

Foucault suggested in his later writings that the individual is controlled in the system of power and knowledge through the regulation of ‘discipline’ in a sovereign society through the systems of prison, school, asylums etc (Foucault 1977). Through disciplinary power the individual in the society is in ‘disguise’ or in ‘repression’, thereby ‘confined’, ‘mastered’, ‘silenced’ and ‘suppressed’. Disciplinary power produces truth, the truth of domination and suppression.

We must cease once and for all to describe the effects of power in negative terms: it ‘excludes’, it ‘represses’, it ‘censors’, it ‘abstracts’, it ‘masks’, it ‘conceals’. In fact power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production (Foucault 1977, 194)

In the modern medical model, patients remained separated from doctors as a marginal body, an ‘other’, a silenced object of medical intervention. “Thus while the victim of mental illness is entirely alienated in the person of his doctor, the doctor dissipates the reality of the mental illness in the critical concept of madness” (Foucault 1965, 277).

Many psychiatrists were themselves critical of the work of fellow-psychiatrists on mental illness from the mid of twentieth century. ‘Anti-psychiatry movement’ started with the work of Thomas Szasz, a psychoanalyst of Hungary, who published a book called *Myth of Mental illness* in 1960 where he argued that psychiatric illnesses does not really exist. Here he said that the notion of mental illness is constructed by society in order to label and separate ‘troublesome’ individuals who refuse to obey the traditional rules (Szasz 1961). In 1970, Szasz in *Manufacture of Madness*, made a criticism of modern psychiatric practices in mediaeval Europe. The method of the psychiatrist is comparable to that of inquisitors who sought to disclose hidden thoughts of the accused. The psychiatrist’s search for symptoms and treatment of mentally ill patients was profitable for them just as the inquisitor’s search for witch’s sign and tribunals of witches was profitable for the church authorities. A person is automatically
branded as mentally ill if he/she goes for psychiatric treatment; inquisitors tried to prove that the person who was accused of witchcraft was guilty. Szasz wrote,

In more than twenty years of psychiatric work, I have never known a clinical psychologist to report, on the basis of projective test, that the subject is a normal, mentally healthy person ……There is no behavior or person that a modern psychiatrist cannot plausibly diagnose as abnormal or ill (Szasz 1970, 35)

British psychiatrist Ronald David Laing argued that the mad might be the most sensitive member of a disturbed family who was forced to give ground for destructive behavior that surrounds them. He mainly worked on schizophrenia and claimed that they had special guts (Laing 1967).

Other than anti psychiatrists, social scientists come up with the notion that like other diseases mental illness is constructed and controlled by society. Foucault discussed the discourse of psychiatry and medicine and its dominance on the individual (Foucault 1965). He always wrote on power/knowledge and its role on social control. He suggested that power does not only relate to economic relation it is also related with documented knowledge of universities. The new academic ‘disciplines’ like psychology, psychiatry and medicine is the result of the development of sophisticated forms of power/knowledge of social control. According to him the new ‘disciplines’ established the ‘scientific’ criteria to create docile bodies and through which we differentiated the groups of people as sane/insane, able/disable, normal/deviant etc (Foucault 1977).

1.4.2 History of Treatment of Mental Illness: India in Perspective

There is very little information available regarding the treatment of the mentally ill in prehistoric India. The Hindu religion has a long historical development in India (Kinzie 2005). During the pre-Vedic period mental illness was thought to be the result of possession by demons or divine agents. Sometimes it was thought to be the result of revenge taken by the spirit of the dead. Trusted remedies included magico-religious notions such as prayers to God, incantations, amulets, mascots etc (Nizamie and Goyal 2010).
During the Vedic period (1500 to 500 B.C) Hinduism entered Indian society with a new philosophy through the four Vedas (Rig, Yajur, Sama and Atharva). Three Vedas – Rig, Yajur and Sama – presumed that mental illness was caused by possession of demons and ghosts and it could be treated by magic or witchcraft. It is mentioned in Atharva Veda that mental illness is caused by supernatural agents which could be treated by mesmerism and by dietary practices. In fact, some remedial drugs were mentioned in the Vedic texts (Kinzie 2005). Ayurvedic manuscripts of the post-Vedic Period, Charaka Samhita by Charaka and Sushruta Shamhita by Sushruta, written in 1st century B.C. give some idea about the ancient medical practices of India. The great physician Charaka, describing madness in some of his writings, classified it in two ways. Firstly, mental illness could be caused by divine punishment or sin or failure to perform the duties of previous birth. Secondly, mental illness could be caused by imbalance in bodily and mental fluids – humors (Kinzie 2005).

In the Ayurvedic texts of the post-Vedic period, Bhuta Vidya (demonology) or Graha Vidya is mentioned as providing the key to the treatment. But cikitsas or treatises of traditional medical system to treatment of mental illness were – Apasmara cikitsa and Unmada cikitsa. Apasmara has been translated by Western Indologists as epilepsy caused by excitation of dosha which in turn affects the mind. Unmada is generally described as caused by psychological disturbances with symptoms of delirium, uneasiness, irrelevant speech (Obeyesekere 1970, 293). The treatment of unmada, ‘madness’ and apasmara were treated in a naturalistic manner with the use of herbal ointments and decoctions along with some psychological advice (Obeyesekere 293). Sushutra mentioned another types of ‘madness’ caused by demonic (Bhuta) possession leading to psychic excitement. He has devoted separate chapters to demonic madness (amanusha pratishecha). Mental illness was depicted in the Atharva Veda as a divine curse. The description of schizophrenia is also found in these scriptures (Nizamie and Goyal 2010).

In Tamil Nadu, a different type of healing practice to cure mental illness was in vogue that was called “Siddha” which meant ‘achievement’. Siddhas were men who had achieved mastery over medicine, yoga and meditation. The founder was Agastya, who is considered to be one of the eighteen Siddhas (Rao 1975).
During the reign of Emperor Ashoka many asylums were constructed for mentally ill patients. Separate enclosures were made for various practices that prevailed during those times. Some inscriptions depicted on the walls of Lord Venkateswara temple at Tirumukkudal, Tamil Nadu, exhibited that during the Chola period, the mentally ill patients were alienated in Shahdaula’s Shauhas in Gujarat and Punjab. During the reign of Mughal emperor Mohammad Khilji (1436-1469), evidences of some asylums were found (Nizamie and Goyal 2010).

In the 17th century the first modern hospitals were introduced in Portuguese Goa. The British East India Company set up the first mental asylums only to treat European patients in the Indian subcontinent on the model of the hospitals of England and Europe of those days. Like the classical madness of Europe, the objective of these asylums was to protect the community from the insane and thus they were constructed far away from the cities. The concept of segregation of the lunatics in mental asylums and their supervision was entirely of British origin (Weiss 1983). In 1754 and 1784, the first asylum was constructed in Bombay and Calcutta respectively. During 1774 to 1821 many asylums were opened, but they did not run at all. In 1817 Bredsmore, a surgeon opened a private hospital in Calcutta; the patients were treated with opium, morphia, and blood sucking by leech etc during this period. In 1821 another asylum was constructed by British rulers in Bihar known as “Pahgak Ghar building”. In 1874 many asylums were constructed in Eastern India – Bhawanipur in Calcutta, Patna, Dacca (now in Bangladesh), Berhampur, Dulana in Calcutta, and at Cuttak. In 1876, the only lunatic asylum of North East India was constructed in Tezpur during the British rule. Music therapy was used to normalize the excited patients during this period. In 1906 larger hospitals were established in Lahore, Ranchi and Poona under the charge of the inspector General of prison and under the influence of Lord Morley. During this period the traditional mode of treatment was thought to be out of date. Instead of traditional notion of treatment of mental illness doctors used to treat in a different way which was influenced by Western notion of mental health. Doctors used methods such as mesmerism, homeopathy, cannabis or hemp therapy and morphia. West-influenced moral treatment and electric therapy was also practiced in the asylums of India. In the last quarter of 19th century, Dr Payne frequently used electric shock in native asylum at Dullunda, the then Superintendent of that
asylum (Weiss 1983). Patients were kept under observation in a homely atmosphere. They were motivated to work, sing and allowed some amount of freedom under the observation of keepers and doctors. They were given indulgence to smoke tobacco, chew betel nut and leaf and play cards. The authorities did understand the value of entertainment and harmless habits in the life of the patients (Weiss 1983). Lobotomy, leucotomy, hot bath, whipping, starvation, blistering and use of leech to suck blood was used along with convulsive therapy as methods of treatment during this period. Doctors knew that blisters had no genuine relation with mental illness. Blisters actually diverted the patient’s attention to physical symptoms and thereby helped in the reduction of mental torment. In 1912 the Indian Lunacy Act was introduced. In 1918, the Central Institute of Psychiatry was established at Ranchi and Col. Berkeley Hill was appointed as a Superintendent there who later in 1920 decided to change the lunatic asylum to a mental hospital (Weiss 1983).

Dr. Girindrasekhar Bose was the pioneer of psychoanalytic study in India. In 1921 he founded Psychoanalytical Society in India with the continuous effort of S.C. Mitra, T.C. Sinha, S.K. Mitra, and D.N. Nandi etc. The Indian Psychological Association was founded in 1925 with the advent of modern psychotherapeutical treatment. In 1933 Dr. G.S. Bose and Dr. K.R. Masani opened more psychiatric departments in different hospitals of India (Nizamie and Goyal 2010).

The colonization in India started right from 1757, with the loss in the battle of Plassey. The effect of colonization and European modernity was faced by the traditional, non-modern societies. Asish Nandy analyzed the psychology of colonialism in India. He made a critique of nineteenth century colonised India; he presented a terrible spectacle of the country under the impact of modernity: this encouraged binary division among civilized/uncivilized, normal/abnormal, secular/non secular, scientific/superstitious etc. The ‘modernity’ which colonialism brought to India, encouraged the concepts of domination of science and technology over traditionality, masculinity over femininity etc.

The awareness has come at a time when the attack on the non-modern cultures has become a threat to their survival. As this century [the twentieth century] with its bloodstained record draws to a close, the
nineteenth century dream of one world has re-emerged, this time as a nightmare. It haunts us with the prospect of a fully homogenized, technologically controlled, absolutely hierarchized world, defined by polarities like the modern and the primitive, the secular and the non secular, the scientific and the unscientific, the expert and the layman, the normal and the abnormal, the developed and the underdeveloped, the vanguard and the led, the liberated and the savable (Nandy 1983, 10).

The effect of colonization impacted both the physical and psychological configuration of the Indian people. In *The Intimate Enemy, Loss and Recovery of Self Under Colonialism*, Nandy analyzed the story of White Sahib, the modern master as a rational, reserved colonialist on high point of reason and on the other hand the non-modern slave who accepts the master as a human being. The slave was identified as a ‘thing’ for the sahib. According to him this modern oppression was to humanize the self and to objectify the other. The technologically advanced, modern bureaucrats and pseudo rulers anticipated the poor slave as a ‘subject’ (Nandy 1983, 16).

Dipesh Chakrabarty, influenced by Michel Foucault, critiqued historicism and the Enlightenment reason based on old passion of ‘struggles of enlightenment against superstition’ and how India as a scientific, secular, democratic nation had to triumph over all ‘irrational’ and ‘superstitious’ citizen (Chakrabarty 2001). J.H. Mills made a critical analysis on the uses of colonial power. He described how colonial power postulated the insanity of nineteenth century asylum of India through the use of cannabis. During the nineteenth century the British set up a network of lunatic asylums in colonial India where Indian soldiers and mentally ill were kept under observation. Hospital authorities usually reported to their higher authority that the main cause of mental disorder of these patients was the use of cannabis. Cannabis users were designated as cause of social problem during that period. Medical officers of the asylums used to believe that cannabis was linked to insanity in India and they used asylum as a site where they could observe cannabis users and could identify them as a distinct human being to watch out for their dangerousness (Mills 2005). In another study A.R Basu focused on the questionnaire used by Indian Humped Drug Commission and analyzed, how history constructed the cannabis psychosis (Basu 2005).
Gyan Prakash said that in the nineteenth century India saw the growth of modern institutional infrastructure apart from growth of knowledge and practices under the project of colonial development when British used empirical scientific knowledge which was thought to be free from any form of prejudices and superstition to rationalize the society for the sake of their benefit. Gyan Prakash has made an analysis of colonialism and modernity which opened us up to how scientific reason assumed a position of privilege. He said, “Compelled to use universal reason as particular means of rule, the British positioned modernity in colonial India as an uncanny double, not a copy of the original - It was almost the same but not quite. In the colonial context universal claims of science always had to be represented, imposed and translated into other terms. It was not just that Western culture was different; it was decontextualized and imposed on a subject people” (Prakash 1999, 5). According to Prakash science influenced modernity which infiltrated the foundations of Indian social life.

Girindra Sekhar Bose was the first psychoanalyst who worked independently of Freud by recalling memories and encouraging associations. Bose, though influenced by Freudian theory, created a distinct theoretical notion keeping in mind the Indian cultural milieu. He integrated Indian traditional philosophy with Freud’s notion of unconscious. The British army officers, Berkeley Hill and Claude Danger Daly were the original members of Indian Psychoanalytic Society of India. But tragically both of them used psychoanalysis as vehicle of cultural prejudice and oppression in their studies of Hindu personality (Hartnack 1987). Their interest was not placed on the experiment and proper treatment of the patients; rather they sought to oppress the patients by colonial power. Thus psychoanalytical treatment in India was in a very terrible condition where the whole power was in the hands of the colonial authorities (Akhter 2005).

The whole concept of mental illness and its treatment lies in the hands of the powerful –priests, shamans, churches, psychiatrists, psychoanalysts both in the context of West as well as in India. Madness was identified as loss of reason and their rationality was often compared with the irrationality of animals. The perception of rationality created by the Enlightenment under the roof of absolute truth of science and technology remained static throughout the ages. This Enlightenment based rationality entered India with colonialism. Colonial power
and the power of rationality doubly marginalized mentally ill Indians. After independence in the era of scientific domination, treatment of the mentally ill in India officially continued to follow the Western model. But this does not mean that Indian traditional healing practices disappeared or ceased to be practised.

1.5 Alternative Healing Practices in India

Cultural concept of illness is closely related to healing practices which differ from society to society. And these practices became a part of the folkways of people who associated mental illness with notions of the uncanny and the mysterious (Klein 1956, 54). In the recent decades traditional healing or folk healing practices have grown in popularity in the United States followed by holistic health movement initiated in the 1970s. This was followed by the New Age movement as well as the rise of complementary and alternative medicine. Traditional healers are largely multidisciplinary practitioners who combine various religious healing practices rooted in traditional–belief systems. They provide a physical and social space to support informal faith healing on the basis of religious belonging within culturally meaningful explanatory model of disease and healing. Most of the healers use natural and supernatural remedies which are very cost effective to treat the mentally ill.

Wen-Shing Tseng, in *Handbook of Cultural Psychiatry* has described different traditional healing practices of different places with some common features. He has defined folk healing practices as based on informal cultural tradition outside of official health care practices mainly observed in ‘pre-industrial’ societies. Indigenous healing practices are termed differently as religious healing practices, shamanism, astrology or physiognomy. These healing practices are invented and utilized by indigenous people for treatment of illness; quite often these are rooted in traditional belief and folk interpretation of problems (Tseng 2001, 515-516). Anthropologists, social scientists even psychiatrists have studied different treatment procedures practiced in different societies as supernatural orientation (shamanism, religious healing, divination), nature orientation (fortune telling, astrology, meditation), medical physiological orientation (Mesmerism, acupuncture, and herb medicine) and socio-psychological orientation (Zen training, Alcoholic anonyms and most modern psychotherapy) (Tseng 2001, 517).
Healers claim to experience altered and heightened states of consciousness during ‘possession’. In shamanism the healer is thought to have control over a supernatural being and the supernatural power is represented as the main strength of the therapeutic mechanism. Sometimes therapeutic mechanisms differ according to the nature of trance or possession. Shamanism is practiced in South–East Asia, America and in Eurasia. In some religious ceremonies shaman can go to the trance state through rhythmic singing, dancing, and through mild meditation. They thus claim to make connection between the ‘God’ and ‘supernatural’. The goal of such trance is to establish a balance between a client’s mental and physical status through supernatural power. In religious healing ceremonies priests or monks use different chanting techniques to release the patient from the clutches of the evil spirit. Divination is another therapeutic mechanism controlled by supernatural power, where ‘divine’ instructions are followed by patients as psychological remedy of any problems. It is widely popular in Japan, China, Africa and India. Fortune telling is a shift from supernatural to natural form of orientation on any treatment. In fortune telling people are advised to follow certain rules of universe where it is told that disharmony between nature and person may bring some problems in human life. In astrology which is one subdivision of astrology there is a belief that human life is regulated by certain movements of stars and astrologers of different parts several remedies differs from place to place (Tsang 524-530).

As we go through the history of treating the mentally ill in India, we find that superstition played a major role in its interpretation here as elsewhere. Brij Mohan describes about three types of practitioners dealing with treatment of mentally ill with the help of indigenous methods in India. These are Sadhus and Faquirs who read certain religious scripts and prescribe ‘therapeutic’ measures. Another type is the Siyane, famous in the ‘Braj’ region and popular by different names as Yogi, Bhagat, Babaji, etc. They are thought to possess supernatural power to control the agents which damage the individuals’ mental health. Vaidyas and Hakims are the experts of old Indian or Unani medicines without formal orientation and they prescribe some short of somatogenic medicines. Sometimes elderly persons of the village also try to treat mentally ill (Mohan 1973, 91-92). He did a study in a place named Mahuwa in Jaipur on the Agra National Highway. A Balaji temple is
located there where mentally ill patients are treated and they are thought to be the possession of ghosts and evil spirits. According to the folklore of the place, the people suffering from mild or severe mental illness have to be present in front of the king of spirits (Prait Raj) in his court in the temple dedicated to god ‘Hanuman’ and different treatments including physical torture, scolding and other forms of exorcisms are practiced. Exorcists are Syana, Fakir or Sadhu. According to Brij Mohan no one is found to be relieved by these treatments. Many of the healers prescribe tabeez and tona that are also used to get rid of supernatural influence from the patient’s body. Tabeez is a kind of token that is worn in the neck or the arms or the waist, possessing different divine or evil mantras and tona is kind of black magic that is performed in different places in different ways. In India neem or peepal trees are supposed to be the residents of ghosts and supernatural spirits. People worship these trees during any problem in their life (Mohan 1973, 92-93).

Vieda Skultans studied the Mahanubhav temple of Phaltan, Maharashtra where mental illness is treated in a traditional way. The founder of the Mahanubhav sect is Chakradhar. Among the three Mahanubhav temples in Phaltan one Abbasai temple accommodates the mentally ill with their families and the families can live with their patients until they are cured. In case of men the caregivers are mostly their mothers and wives; in case of women the caregivers are mothers and daughters. Patients usually do not receive any special attention during the residential period in the temple as they are kept aside and not allowed to participate in any of the ritual activities or intense communal life of the temple. Only the caregivers take part in worship or ritual activities with the patients seated at the back. Violent and disobedient behavior of the patients draw special attention of the temple authorities and then they take help from police or psychiatrists (Skultans 1987, 667). The temple has its own standing that it possesses healing power along with trance-inducing properties which have therapeutic value. Trance is practiced on the people who are threatened by malicious spiritual attack. Skultans says that according to the priests trance is indisputably a female affliction as women are naturally weaker than men and they became more vulnerable during menstruation. Possessed patients are treated in calls meted out to spirits. During the healing period the possessed try different
means of humiliating themselves by punishing themselves, drinking polluted water and causing embarrassment for the spirits to convince them to leave the site of unrelenting pain. Priests denied the idea of divine possession as they believe that mental illness is the result of the affliction of bhut or evil spirit (Skultans 1987, 669-672). According to Skultans, the symptoms of mental illness are incoherent and inappropriate talk, fighting without reason, dirtiness, inability to work and execute orders, aloofness and having no structured lifestyle (Skultans 1987, 667). It is believed that the whole family is under the shadow of the evil spirit, not the patient alone. Mental illness is considered to be the manifestation of misfortune or bad luck for the whole family. The history of illness does not disappear in the family with complete healing of the patient (Skultans 1987, 670). Skultans found gender discrimination and bias in the treatment procedure as well as in the whole society of Maharashtra. The traditional attitude towards women’s health was seen in the treatment of the mentally ill in the temple. The influence of cultural stereotypes which are depicted through the lives of Sita, Gandhari in religious texts in women’s life is exposed in the study of the Mahanubhav temple (Skultans 1987, 668).

Sudhir Kakar studied the traditional healing practices among the mentally ill patients in different temples (Balaji at Mehndipur) caused by malignant spirit (Bhuta, preta, chureil, ‘atripta atma’ or ‘ghost with unsatisfied desire’) by traditional shamanic healers. He also analysed the cases of spirit possession in different places of India in his essay ‘Lord of the Spirit World’ (Kakar 2011, 35). He mentions that the Indian concept of masculinity is shaped by the myths of the powerful gods like Balaji and Ganesha:

… the worship of Balaji as a god of power and fearlessness alone makes him much too masculine and distant to fulfil ideally the role of divine healer (Kakar 2011, 8)

He said that in the Indian context ‘sickness’ and ‘health’ became very permeable and the vague impression of the distinction between ‘normal’ and ‘possessed’ lies in the fact that it helps the patient to overcome his feelings of isolation and valuelessness. Feeling of isolation attributed to possession leads to social stigma. The traditional healing practices reflects the concept of mental illness as “an
experience of alienation from bodily order, illness as an alienation from the self, and illness as alienation from social order” (Kakar 2011, 32).

The underlying values of traditional temple healing is the faith of surrender to the power beyond the individual human strength; it also lies in harmonious integration with one’s community, individual’s assertion of community values and his compliance to community’s God (Kakar 2011, 34). Kakar in his article ‘The Indian mind’ describes about the Indian ‘world view’ specially connected to Hinduism which is relevant for religious and intellectual elite’s beliefs and attitudes. Indian world view is reflected in their lives, their songs and stories scattered through myths, legends, proverbs, and metaphor, represented in Bollywood films, conveyed through tales to children, enforced in religious practices and it is absorbed early in life (Kakar and Kakar 2007, 181).

In another article, ‘Empathy in Psychoanalysis and Spiritual Healing’ Kakar discusses the spiritual healing practices which are slightly different from the religious healing practices of mental illness. Spiritual healing relies more on therapeutic measures such as meditation and yoga. In these practices the mind was treated to be the absolute cause in processing disturbed thought and feeling that leads to mental health problems. “Thus in Hinduism, it is the working of the five passions, sexual desire, rage, greed, infatuation and egotism which are held responsible for mental illness….Similarly Buddhism…Eastern spiritual traditions, thus, converge with …psychodynamic therapies in the shared conviction that life does not happen to us through us, and that it is false to believe that someone outside us is responsible for our distress” (Kakar 2011, 37). The understanding of ‘true’ nature of the self by purification of mind, removal of its distortions and illusions is the aim of meditative and yogic disciplines in eastern spiritual healing system. Spiritual gurus suggest immediate healing of mental agony through purification of mind and ultimate purification through meditation.

[T]he complete devotion and unquestioning faith expected of the seeker by the Hindu guru … is identical with the expectations entertained by the Tibetan Buddhist master, in spite of the differences in their respective yogic and tantric meditation practices. In other words the teacher, more than the meditative discipline itself,
incorporates a therapeutic potential which draws to him the many seeking relief from emotional distress or physical suffering (Kakar 2011, 39).

Kakar said that spiritual healing is also completely based on mysticism where gurus, through the teaching of self object, and guru-disciple interaction loosen the patient’s boundary of the self. Kakar believes that spirituality is the centre of Indian worldview. Occult practitioners fascinated average Indians to a high degree because they possess unshakable belief in a higher ‘reality’. Astrologers, fakirs, soothsayers, and other shamanic practitioners are part and parcel of Indian society who get high regard and conviction as they are thought to be connected with this higher ‘reality’. Scientists and other scholars get secondary status. Most Indian children are incorporated spiritual gurus as ‘good men’ in their childhood longing for omniscience and perfection in parental figures. “Their presumed contact with another reality is supposed to confer on them supernatural powers, superhuman status, and moral excellence that is beyond the ordinary lot” (Kakar and Kakar 2007, 184).

In another article, ‘Health and Healing: Dying and Death’ Kakar describes about the Indian notion of body that is completely different from that of that of the West. “The involvement of all orders of being in health and illness also means that an Indian is generally inclined to seek more than one cause for illness in especially intractable cases” (Kakar and Kakar 2007, 110). Kakar has described his experience with a patient named Ramnath who has undergone multiple traditional treatments of diseases. He says that Ayurvedic theory provides the governing paradigm for the explanation of psychological processes in traditional ways. In the case of Ramanth the cause of Arthritic pain was disequilibrium of *dosha* by Ayurvedic interpretation and can be cured by maintaining balance through diet, drugs and external applications. Disequilibrium occurred due to negative thoughts and habits that changed the level of the self. Disease may also be linked astrologically to ‘bad times,’ requiring ‘analgesic’ cure such as *puja*. The astrological cause can be traced as the result of bad deeds of the past. Thus Ayurveda encompasses the Indian notions of elements of the person and nature of the body’s connection with the psyche, the natural environment, the polis and the
cosmos, so Ayurveda is more than traditional medicine in the Indian context (Kakar and Kakar 2007, 110-111).

Ayurveda was the major therapeutic treatment which shaped Indian cultural belief systems and consciousness till the nineteenth century. It was challenged by Western medicine and had to fight with notions of ‘scientific’ evidence for healing value. To cope with Western allopathic medicine and new forms of commercializing and standardizing, Ayurvedic therapy emerged as pleasurable, pain relieving herbal massage oil, dietary advice for urban middle classes and international clients. Ayurvedic medicine including both prescribed by trained and untrained professionals are mostly used among the rural poor (Kakar and Kakar 2007, 112-126).

1.6 Mental Health Movements around the World

It has been mentioned above that the welfare activities for mentally ill were started with the work of psychiatrist Phillip Pinel, who freed the patients from chains and tried to relieve them from the cruelty and pain suffered by the patients in the hospital in the first half of the nineteenth century. Clifford W. Beers, following Pinel worked for the mentally ill and started the ‘Mental Hygiene Movement’ in the first half of the twentieth century. Beers was not a skilful technician of mental health; he was a patient of mental illness and was admitted in various private and government mental hospitals for several days and had undergone various experiences related to the treatment of the mentally ill in the institutions. He noticed that not at all the patients are violent and noisy to be treated in such a cruel and violent way. After being released from hospital in 1900 Beers wrote his autobiography named A Mind That Found Itself, depicting the life in the mental health institutes and the pain and sorrow of the patients there. He told that the ‘sane’ or ‘insane’ patients were treated in a very insane way by the physicians. Thus he became the chief motivator of the mental hygiene movement in twentieth century and the main objective of the movement was about ‘reforms in hospital management’ by exposing existing abuses. Like Pinal, Beers was famous as the ‘Liberator of the Insane’ in the modern world. Other two eminent persons Adolf Meyer, the psychiatrist and William James, the psychologist have contributed greatly to the mental hygiene movement. Adolph Mayer was the first
to suggest the phrase ‘mental hygiene’. By this word hygiene Meyer used to suggest a new group’s title to teach the public how to protect against mental illness just as other groups had succeeded in reducing tuberculosis by campaigns of public enlightenment. With the encouragement and support of Mayer, James and many others, the official mental hygiene movement was started on 6th May 1908 with fourteen public-spirited citizens in the New Haven home of Rev. Anson Phleps Stokes and they founded ‘The Connecticut Society for Mental Hygiene’ (Klein 1956, 25-36). The resolution by the society was that “… this Society shall have to work for the conservation of mental health; to help prevent nervous and mental disorders and mental defects; to help raise the standards of care for those suffering from any of these disorders or defects; to secure and disseminate reliable information on these subjects; to cooperate with federal state and local agencies or officials and with public and private agencies whose work is in any way related to that of a society of mental hygiene” (Klein 1956, 37). The society’s aim was both ‘prevention’ and conservation of mental health’. In 1909 the ‘National Committee of Mental Hygiene’ was formed by Beers and it took care of full surveys of existing facilities of the mentally ill and stressed for the improvement of these facilities. Within ten years the committee published a journal ‘Mental Hygiene’ and the mental hygiene movement spread out all over the world. The International Committee for Mental Hygiene was organized in 1930 when the first international congress was held in Washington D.C where fifty three countries represented. The establishment of United Nations World Federation for Mental Health and representation in third International Congress met in London in 1948 became evident for new worldwide cooperation in the field of mental health. The first and foremost task of these movements was to change the complete architecture of mental health institutions through changing the atmosphere of prisons and making a homely atmosphere in the hospital setting. The Mental Hygiene movement made efforts to maintain family hygiene through proper measures by parents to facilitate socialization and children’s personality development; there was special emphasis of the mental hygiene of the different racial groups. After a struggle of fifty years, the movement initiated steps for care of the hospitalized mentally ill patients (Klein 1956, 49).
Human rights include the basic right and freedom which all human beings are granted. “The simplest way of defining human rights is that they are about balancing the inalienable rights of all of us as human beings within the community regardless of differences in birth, social origin, gender, physical differences, faith and belief, ideology, nationality and so on” (Mishra 2008, 16). According to Article 1, Universal Declaration of Human Rights, “All human beings are born free and are equal in dignity and rights” (Mishra 2008, 16).

The legal standard of International Human rights has been made public since 1948 in the UN Universal declaration of Human Rights, codified in 1966 in the International Covenant on Civil and Political Rights and International Covenant on Economic, Social and Cultural rights. In 1971 the United Nations made the Declaration on the Rights of Mentally Retarded Persons; in 1975 the United Nations made the Declaration on the rights of disabled persons; in 1984 on discrimination against women; in 1984 the UN organized the Convention against torture and other cruel, inhuman or degrading treatment or punishment. In 1991 the United Nation made principles for the protection of persons with mental illness and improvement of mental health care. In 1996, the World Health Organization developed the ‘Mental Health Care Law: Ten Basic Principles and Guidelines for Promotion of Human Rights of Persons with Mental Disorders’. The Ten Basic principles were promotion of mental health and prevention of mental disorders, access to basic mental health care, mental health assessments in accordance with internationally accepted principles, provision of the least restrictive type of mental health care, self–determination, right to be assisted in the exercise of self–determination, availability of review procedure, automatic periodic review mechanism, qualified decision–maker (acting in official capacity or surrogate), respect of the rule of law (Mishra 2008). The principles with respect to the treatment of persons with mental illness are

The aim of psychiatry is to treat mental illness and promote health to the best of his or her (psychiatrists) ability; consistent with accepted scientific knowledge and ethical principles…..The psychiatrists should inform the patient of the nature of the condition…..Of the possible outcomes…..Members of the medical profession are often amongst first to become aware of violations of human rights, Medical association have
an essential role to play in calling attention to such violations in their countries (Mishra 2008, 19-20)

The UN Convention on the Right of the Persons with disabilities in 2006, marks a shift in attitudes and approaches to the person with disabilities and proposed a comprehensive definition of person with disabilities as “All those who have long – term physical, mental, intellectual and sensory impairments” (Article -1). The convention calls upon nations to take specific action to protect rights and offer special attention and care for mentally ill persons both at home and in hospitals. All these rights are connected with home, as “treated the mentally ill persons with dignity, decency, kindness and compassion……taking the person for follow-up as advised……Extending cooperation to the psychiatric social worker during follow-up home visits…..” (Mishra 2008, 21).

In India, if we go through history some initiatives were taken in favour of the mentally ill in 1818 with the Bengal Enquiry where inquiries in various asylums were conducted regarding the overall condition of asylums, food supplies, staff handling of the mentally ill patients etc. It was reported that the condition of asylums of Murshidabad, Calcutta (Rasapagla asylum) was the worst, and those in Bareily and Banaras were overcrowded. In 1940, investigation on the State Native Lunatics in Bengal was made for evaluation pertaining to mental health care issues. The report stated that there was an increase in death rates of mentally ill in the asylums due to the influence of individual style of functioning, management and patient care of European Superintendents (Venkatasubramanian 2008, 39-40). In 1912 the Indian Lunacy Act was implemented and Berkeley Hill, the Superintendent of the Central European Hospital at Ranchi, made a great contribution in changing the attitude towards the institutions, which subsequently changed the names of lunatic asylums to mental hospitals. He involved social scientists, trained psychiatrists and psychiatric nurses in treating the mentally ill. In 1930 the manual for the superintendents of mental hospitals was formulated which describes procedures of patient care, administration, treatment, roles of different staffs. In 1938 Mapother’s report suggested that the Indian asylums are overcrowded and so death rate occurred in great mass. According to him most of the mental hospitals were based on the conception that the insane are unresponsive to viciousness and are harmful. He advocated a comprehensive program and
reorganized mental health services in India. In 1946, Col Moore, Superintendent of the European Mental hospital at Ranchi and member of Health Survey and Bhore Committee made a report on observing 19 mental hospitals that most of the mental hospitals were out dated, disgraceful and cause for major public outrage and recommended for further development of hospital conditions (Venkatasubramanium 2008, 42-44). The National Mental Health Program was initiated in 1982 and reorganized in 1996 and different mental health care programs were initiated in different districts in different phase.

Just as any other citizen of the country, the persons suffering from both major and minor mental illness have an equal right to a life of dignity. Indian constitution and Supreme Court have also laid down certain laws for maintenance and improvement of public health. Mental health legislation of India has certain acts such as Narcotic Drugs and Psychotropic Substances Act, 1985; Mental Health Act, 1987; Rehabilitation Council of India Act, 1992; Persons with Disabilities (Equal Opportunities, Protection of Rights) Act,1995; Juvenile Justice (Care and protection of children) Act, 2000; National Trust for welfare of persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999; Protection of Women and Domestic Violation Act, 2005. All the acts possess common objectives to provide a noble life, protecting human rights and to address preventive and curative aspects of mental health (Math and Nagaraja 2008, 51-52). Mental health Act and persons with Disability Act, 1995 is to specifically protect the rights of mentally ill persons. On 12th October 1993, the National Human Rights Commission was established in India under the legislative mandate of protection of Human Rights Act, to protect human rights in the country. The commission covers areas of civil, political, economic social rights, custodial death, rape, torture, reform of the police, prisons and other institutions such as juvenile homes, mental hospitals and shelters for women. Other areas of interest for the commission are basic needs such as drinking water, maternal and child welfare, equity and justice for Schedule Castes and Schedule Tribes, rights of the disabled, access to public services for displaced people, rights of child, rights of women, sexual harassment and discrimination etc (Sekar 2008, 250).

Though there are certain acts that are enacted and human right activities are pursuing the welfare of mental health in India, there are daily incidents of human
rights violation by hospitals where services are not provided, treatments are given
in a very inhuman way and patients are abused. Sometimes the patients are found
to be naked, with dirty clothes; women patients are found only in or without

Article 66(1) of the Indian constitution regarding Persons with Disability Act
states, “The appropriate Governments and local authorities shall within the limits
of their economic capacity and development undertake or cause to be undertake
rehabilitation of all persons with disabilities” (The Person with Disability Act
1995). Though persons with mental illness come under disability according to
section 2 of PWD Act, 1995, they do not enjoy any facilities such as concession,
scholarship for education etc compared to other disabled categories
(Kalyanasundaram 2008, 228). In India there is no insurance for the mentally ill.
Private insurance companies also exclude mentally ill from their insurance
policies. Even people with incidence of mental illness in their family history are
refused by life insurance, health insurance and travel insurance companies
(Kalyanasundaram 2008, 228-229). It is seen that treatment of mental illness was
conducted in many mental homes and asylum run by religious institutions and
traditional healing practices. On 6 August 2001, Moideen Bahdhusa Mental home
at Erawadi, a fishing village 27 km south of Ramanathapuram town in southern
Tamil Nadu was engulfed by fire and more than twenty seven mentally ill persons
were burnt alive as they were in chain. Patients were treated in a very inhuman
way (Kumari 2008). Thus violation of Human Rights by hospitals came to public
notice and mental health care was acknowledged as part of public health agenda.

The situation of mental health is worse in the case of women (Kumari 2008). All
over the world more women than men, suffer from common mental disorder and
several mental health issues. These arise from social, psychological and
physiological differences on account of gender and specific attention is needed.
Gender based violence is very important in mental health and stigma surrounding
mental illness increase suffering in humans mainly in women (Kumari 2008, 233).
Though Human Rights for women and mentally ill prevail and have improved
over decades, the actual practice of Human Rights worldwide as well as in India is
still under criticism (Sekar 2008, 250).