Chapter 3

The Psychiatrists: Guarded Epistemology

This chapter will examine the practice of psychiatry as an instance of a modern, formalised, institutionalised biomedical system. It will examine how psychiatrists view mental disorder and how they interface with other practices or practitioners, and what aids or hinders this process. Some of the questions that this chapter will attempt to answer include whether psychiatry is practised as it was taught canonically or not; if the practise differs from teaching, are shifts temporary or do they inform psychiatric theory? The larger question is: do psychiatrists believe in interfacing with other systems? Who initiates such interface and what motivates psychiatrists to engage across their disciplinary boundary? Is the interface by default or design? Do practitioners recognise it as a need at all? Finally, what are the implications of such interface for psychiatry as a larger discipline?

Before going into the data, it must be reiterated that the modern system of medicine, including psychiatry, has a definite history. The previous chapters have shown how medicine and psychiatry are connected to the period of the Enlightenment in European history and how they were influenced by the latter (Chakravarty 2010). Enlightenment represented a genesis in the way human beings viewed themselves, the pursuit of knowledge and the universe. The Enlightenment marked an epistemological transformation advocating the use of reason and rationality to attain an objective truth about the universe (Hooker 2001). This rationalist worldview soon became pervasive and powerful, adopted and epitomised by the discipline of medicine and eventually led to the ‘biomedical model’ of the human being in the field of medicine, health and healing and subsumed the field of psychiatry.

Numerous studies have examined the influence that western medicine had in the ‘imperial project of the British in India’ (Fabrega 2009: 551; see also Jeffrey 1988; Arnold 1993). The health and wellbeing of the British East India Company personnel including civil servants and military that were stationed in India was of major concern.

---

1 The historicity of knowledge and its creation is a fluid process and subject to change. Elements of power are inherent in this process (Foucault 1977) and the knowledge that assumes centre stage is also reflective of the power of its creators. ‘Western thought, since inception of philosophical questioning in ancient Athens, is driven towards a knowledge that would be a timeless unconditioned truth about the universe and human life, a knowledge based... on human reason alone’ (Clark 2002: 10). This attitude was the cornerstone of the intellectual movement called the Enlightenment that was to herald the western world into a progressive, secular and essentially modern era.
Management of colonial administrative policies called for the control of infectious diseases and general improvement of public health. Disease outbreaks like that of cholera, smallpox, and plague along with diarrhoeal diseases, tuberculosis and malaria posed significant obstacles to effective administration. Hence maintaining their health was of particular importance. An immediate outcome of this was the development and growth of tropical medicine as a distinct discipline (Fabrega 2009). Given the wider health threats in the form of different diseases, mental illness among the British subjects took on a tertiary significance; mental illness amongst the local populace was not of concern. In the colonial context, ‘incidence and prevalence of mental illness and psychiatric disability was not taken into consideration’ (ibid.: 551), because among other things, psychiatry during the 18th century simply lacked a definitive framework. More importantly, mental illness was hugely ‘overshadowed’ (ibid.) by public health and especially infectious disease. Also, significant developments in psychiatry were more a 20th century phenomena and social and political problems posed by the mentally ill were more a subject of concern in Western Europe rather than viewing it as a medical problem per se (ibid., see also Chakravarty 2010). It was only sometime during the 19th century that psychiatric conditions emerged as a ‘naturalistic identity, as phenomena in themselves’ (ibid.: 552).

The inception of psychiatry in India took place at a time when the country was under colonial rule (Keller 2001; Addlakha 2010). Psychiatry came into India under the guise of the larger colonial project and all that it implied in terms of attitude, policy and practice towards the local population. Psychiatry in India is deemed to be one more instance of a set of larger asymmetries that the western world and worldview brought forth. It was a part of the modern, secular-science-based practice that epitomised the western world and claimed to stand in contrast to the non-western world with its ‘superstition’ and ‘religious outlook’.

By and large, colonial psychiatry was an addendum to colonial medicine and did not see significant attention until the late 19th century and early 20th century when modern psychiatry took its roots in India. Even as modern psychiatry came to be established, the country’s indigenous practices dealing with mental illness continued to flourish. At one level, the history of Indian psychiatry reflects a unique blend of the country’s indigenous traditions of mental health as well as western ideas that were infused.

---

2 More details of this history have been provided in Chapter 4.
Externally, psychiatry in India had to sync itself with colonialism, the latter marked by a distinctly discriminatory attitude towards everything Indian. At the same time, psychiatry was waging its own internal battle, one that grappled with the juxtaposition of biology and culture. The history of psychiatry, for instance will reveal a period when medical personnel attributed mental illness to supernatural causes; this gave way to the biomedical paradigm that, in time, marked off the socio cultural factors as peripheral and shifted focus more on to an organic understanding of mental disorder and became the dominant paradigm (Chakravarty 2010). It purported to espouse a modern, progressive, rational and secular view. While being powerful and pervasive, this existed in concatenation with the non-psychiatric view, that is more traditional, often religious, ‘irrational’ and involved elements of the supernatural and evoked a more cosmological worldview to explain and understand mental illness and related therapeutics. This biology-culture binary vis-à-vis mental illness is deep rooted because of its historical origins3 that can be traced to the advent of science and scientific methodology. The boundaries between these binaries are fluid and permeable. This is because the epistemology concerning mental illness is constantly shifting (ibid.). This has important implications for the interface under reference.

Generally, the physicians trained in the allopathic tradition, being primarily oriented towards organic or biological psychiatry, ignore the traditional medical concepts and treatment practices and oppose them on grounds of ‘epistemological validity and therapeutic efficacy’ (Addlakha 2010 : 64). Since the inception of psychiatry, with a view to further professionalise the discipline, its principles have been sought to be consolidated and made universal. With the establishment of an organisation like the American Psychiatric Association (APA), mental illness has even been neatly classified; the fifth revised version of the Diagnostic and Statistical Manual (DSM) has recently been published by the APA. Biological psychiatry has undergone exponential growth over the past few decades (Addlakha 2010).

---

3 The period referred to as the Age of Enlightenment primarily advocated ‘reason’ as a means to establishing an authoritative system of ethics, of logic, government and authority. It enabled the attainment of objective truth about the universe through its emphasis on reason, on science and rationality (Rosen 1968). This movement is significant as it gave birth to a series of binaries that defined the world and everything therein, including that between subjective and objective, realism and idealism, tradition and modernity, fact and value, science and culture (including religion) and so on. It not only brought forth these binaries, it actively promoted them, such that they became the basis of inequality and asymmetries, further perpetuated by a series of related events, including that of colonialism and subsequently modernity.
Psychiatry as a discipline and practice in India has remained entrenched in this organic/biological space, despite the vernacular socio-cultural influences. What has helped psychiatry to maintain its predominant position as a health system is the deep ontological security that its practitioners enjoy. Laws and policies concerning mental illness reflect a similar trend, advocating biological psychiatry and ignoring cultural factors. Nonetheless, spaces for expansion and change in the boundaries of the discipline are emerging too, as will be seen. As studies have shown interface between systems can take on varied forms and be to different effects (Naraindas 2012, Quack 2012).

Two aspects need to be flagged here. One is the interface that takes place between two or more practices based on distinct epistemologies and what happens therein. The other concerns the implications of a particular practitioner trained in a predominant system of ontological/epistemological practice adopting another system with different ontological/epistemological assumptions. The adoption of multiple epistemological positions is significant, as it raises the question: does the object deemed as psychiatry resist a single unitary explanation or not? (Daston 2000).

The history of psychiatry is deemed to have witnessed three major revolutions. The first occurred when it was believed that the supernatural was responsible for mental illness and the mentally ill were chained and often kept confined to asylums and even incarcerated. The second major breakthrough was the advent of psychoanalysis and its rendition of the aetiology of psychiatric disorders. The third was the development of community psychiatry that resulted in the integration of mental health care in the larger community (Parker et al. 2001).

Depending on which position one occupies epistemologically, the course of treatment and attitude towards mental illness will be determined. Following a medical model will bring into operation an organic approach to mental illness, like it is for psychiatry. The picture, however, is not so clearly demarcated because mental illness has not exclusively occupied this biological position. This is because for the practitioners, among other things, the concern has also been not so much mental illness, as it has been mental health. The fact of the matter is that people suffering from mental health often experience it as extremely debilitating, often being unable to lead a regular life and undertake simple quotidian activities. The predominant question that practitioners then face is how to provide effective relief to those afflicted (Chakravarty 2010).

Accordingly, psychiatry, while taking recourse to medicines and surgery and other organic routes has, as reflected in its history, attempted to provide due credence to socio-
cultural factors in the aetiology of mental illness. This view has paved the way for the practice of social psychiatry, for instance, within the discipline. This changing model of aetiology holds that a multiplicity of causal factors produces diseases. A multidisciplinary approach, studying patterns of physiological and chemical reactions as well as psychological responses to stress situations embodies modern research of mental illness.

Psychiatrists have actively worked to expand the boundaries of their discipline, moving beyond the organic framework. Outside of India, Dr Arthur Kleinman’s work epitomises the efforts at bridging the epistemological gaps between medicine and non-medicine. Kleinman is a psychiatrist and anthropologist who has done extensive work with healers and looked at cultural factors in health, illness, including mental disorder and healing especially in Southeast Asia. His explorations of the importance of illness narratives and experiences have helped reshape the conception of illness and disease, in anthropology and psychiatry.

Since 1969, Kleinman has studied mental illnesses such as depression, schizophrenia and suicide in Taiwan, China and Hong Kong. He has examined the intersections of culture, social construction of illness and biomedicine and expanded the concepts of interpretive medical anthropology by viewing illness experience and the biomedical doctor-patient exchanges as symbolic realities. Doctors and patients often navigate different meanings of symptoms and semantic networks, which can result in misunderstandings and poor quality of medical care.

In his work, *The Illness Narratives: Suffering, Healing, and the Human Condition* (1989), Kleinman explored the tension and gap between advances in medical technology and the quality of care and illness as experienced by patients. To counter this, he recommended the use of an ‘explanatory model’, a method devised to improve doctor-patient exchanges by helping doctors understand their patient’s experience of illness through narratives.

In other less clinical realms, Kleinman explored subjectivity and suffering in *Social Suffering* (1997), a volume that examined consequences of human-made and natural disasters and human responses therein. The focus on subjectivity continued in *Violence and Subjectivity* (2000), the anthology that he co-edited focusing on how violence shapes subjectivity. The contributors to this volume analysed how people live with more subtle and structural forms of violence (http 9).

Many countries across the world have seen the concatenated efforts of practitioners belonging to different systems to address mental illness. Africa has provided an important
space for interface. Examples include parts of Sudan, where the works of two psychiatrists stand out as setting new patterns of treatment. Dr Tigani El Mahi was a London-trained specialist as well as an Arabic scholar, who actively enlisted the help and co-operation of Mollahs (Muslim priests) to whom most community members would turn to for help, especially in cases of mental disorder. Dr El Mahi fostered a connection with these healers by acknowledging and respecting the latter’s knowledge of the Quran and spiritual authority and encouraged them to reach out to his system by acknowledging his skills. Dr El Mahi and his successor Dr Taha Baasher established working relations with numerous Mollahs, and taught them to recognise cases of schizophrenia and epilepsy. Dr El Mahi believed that these could not be dealt with by spiritual means alone; he asked these cases be referred to the psychiatrist’s clinic as well. Many psychiatrists have realised that ‘shared religious belief, and participation in sacred rituals, could be of great value to sufferers...following their discharge from hospital or outpatient clinic treatment’ (Carstairs et al. 1976: 137).

Dr T.A. Lambo, from Nigeria is yet another pioneer psychiatrist who initiated what is termed the Aro Village Scheme, where rural patients lived in familiar surroundings and consulted traditional medicine-men, while receiving medication under the active supervision of nurses from a modern psychiatric hospital (ibid.).

In any discussion on the role of approaches to psychiatry other than that of modern medicine, India with its ‘truly remarkable ability to tolerate contradictions’ (ibid.: 138) is a good case in point. India represents the understanding that seemingly incompatible systems of belief, for instance modern medicine and religion can co-exist because they represent ‘one of innumerable aspects of reality’ (ibid.). India is a repository of a large amount of medical knowledge formed by codified and folk therapies including Ayurveda, Unani and Siddha apart from local folk practices (Sebastia 2009a). Some of the key studies undertaken in the Indian context with regard to treatment of mental illness that lie outside of the western medical approach include studies on folk therapies, examining the phenomenon of possession often seen as hysterical pathology, diagnostic and therapeutic techniques of healers, religious therapy used in temples and shrines and so on (ibid.). The shifting epistemology has opened out new spaces for exploration and development apart from providing alternatives.

Given this vast repository of practice including therapeutics, it is not surprising that psychiatrists in India have worked outside of the boundaries of their discipline and attempted to engage with other systems, often incorporating them into their practice. One
of the earliest Indian psychiatrists to explain the importance of health was Dr M.V. Govindaswamy in 1948. He provided three important objectives of mental health: (i) regaining of the health of a mentally ill person, (ii) prevention of mental illness in a vulnerable individual and (iii) protection and development at all levels of human society of secure, affectionate and satisfying human relationships and the reduction of hostile tensions in persons and groups. He posited selfishness as a psychological trait and starvation as a physical condition as being responsible for the disorganisation of the individual and society. He also stressed upon culture to understand personality. Similarly, relations between social stress, modernisation and occurrence of mental disorder have been studied by psychiatrist. Traditional concepts of therapy and the importance of family on therapy have also been studied (Parkar et al. 2001).

The late Dr R.L. Kapur, a former head of the Department of Psychiatry at the National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru is another exemplar of interfacing between systems. He spent four years in rural Karnataka, studying patterns of mental disorder and the wide array of practitioners and local healers that people access, to treat mental disorder. His findings were published in a book, *The Great Universe of Kota* (1976). In his other seminal book, *Another Way to Live* (2009), he explores whether mental illness can be managed with the help of spirituality and explores a possible connect between psychology and asceticism. Intrigued by people who visit ascetics to treat psychiatric problems like schizophrenia Dr Kapur learnt yoga and maintained a detailed account of the effects of the yoga *asanas* (yogic positions). He was the first and possibly the only psychiatrist in India to have studied the subjective experiences of yogic practices, having done so under the aegis of the Indian Council of Medical Research (ICMR). Dr Kapur balanced his keen interest in psychosocial aspects of psychiatry with biological psychiatry. He was, in fact, instrumental in setting up the Department of Psychopharmacology at NIMHANS. He adopted a multidisciplinary approach, and listed psychiatric epidemiology, cross-cultural psychiatry, psychotherapy and yoga as his main areas of interest. For over a decade he pursued his interest in studying spirituality, and researched the lives of *rishis* and *sadhus* in the Himalayas, expanding on the mental health implications of his findings (http 10). However, ‘his interest in spirituality never distanced him from his abiding faith in rationality.’ (ibid.).

Dr J.S. Neki is another prominent psychiatrist who studied various aspects of socio-cultural practice to understand how it informs mental health. He examined the *guru-chela*

Similarly, the community mental health movement in India is said to have started in the 1950s and involved the efforts of Dr Vidya Sagar who at the time linked the treatment of mentally ill patients in the Amritsar Mental Hospital with programmes that included their families. Case conferences were conducted wherein patients and their families were made familiar with mental illness and methods of treatment. In these sessions, Dr Sagar drew upon his knowledge of classical Hindu texts. His efforts helped to initiate a major attempt to involve family members in the treatment of the mentally ill. He greatly revitalised the community mental health centre of the hundred-year-old hospital that he was in charge of. He enlisted thousands of relatives as village-level helpers, ‘better informed and better equipped ... to take care of mentally disturbed members of their family or their village’ (Carstairs et al. 1976: 139). The need to bridge modern and indigenous psychiatry was deemed to be deeply salient (Carstairs et al. 1976; Fabrega 2009).

Dr N.C. Surya is another psychiatrist who expanded the boundaries of psychiatry and incorporated elements from a different system of health and healing into his own modern western system. Dr Surya was an army doctor and spent several years in Europe, where he studied psychiatry as well as German and Russian, to understand the latter’s contribution to psychiatry. In his role as Director of the All-India Institute of Mental Health (later to become NIMHANS) in Bengaluru, he believed that social, political and economic changes were as important as treatment services for optimal mental health, especially amongst peasants and labourers. Despite his western training, he sought to return to the practices of meditation, to the study of the Bhagavad Gita, the Vedas and the Puranas - all classic Hindu texts in which he found ‘profound observation on normal and abnormal human psychology’ (Carstairs et al. 1976: 140). Dr Surya eventually relinquished his position of a Director and joined an ashram (monastic community), and practised psychiatry here as well as in the nearby charitable village dispensaries.

Psychiatrists despite their strict biomedical training have time and again moved outside the boundaries of their discipline in a bid to not just provide better care for their patients, but in the process acknowledge and actively incorporate aspects of other practices and systems. Such attempts have expanded the boundaries of their own discipline while building significant epistemological bridges between disparate systems.
The confidence born out of being trained in a system with a well-defined ontological foundation was evident in the course of the twenty interviews that I conducted with psychiatrists in Mumbai between June 2011 and March 2012, as well as the three conducted at NIMHANS, Bengaluru in March 2012. Although the purpose of the interviews was to explore the interface between psychiatry and other systems of medicine, it was important to understand what the psychiatrists thought of their own discipline. The interviews covered factors that were deemed to be related to the practitioners’ ideas about interface, including views on mental illness, process of diagnosis, perceptions of gaps or drawbacks in their systems and how they overcame such drawbacks. In the context of the latter, did they think interfacing with other systems and practitioners was a possible way out.4

The interviews began with questions about the educational background of the psychiatrists interviewed and why they chose psychiatry as a specialisation of study. This was an easy question to pose and helped break the ice as well as allow the participants to get into a mode of introspection; most had completed their studies decades ago and had been practising for years. The interview begun with why psychiatry and moved on to asking how psychiatry defined mental illness. Did they think the definition sufficed to deal with the disorders they encountered in the course of their practice on a daily basis or did they perceive any gap. In other words, did the problems they saw always fit into the categories provided by DSM and also the International Classification of Disease (ICD)? If they thought there was a limitation in the way mental illness was defined by the discipline, how did they address it, especially in the course of their practise? In other words, how did they think the gap/s could be overcome? Did one of the ways include interfacing with another system? What did they think about other systems and practitioners like Ayurveda or traditional healers addressing mental illness? What did they think about the idea of interfacing: does it/will it work? Finally, how did they envision the future of psychiatry in India?

4 For a list of complete questions see Appendix I.
Why Psychiatry?

A wide range of answers were given by the participants to this question. Dr Jignesh Mehta said it was an option ‘available’ to him, as he had gotten admission into the specialisation. Same was the case with Dr Dinesh Kejriwal, who said he did not get admission into his first choice of specialisation, so he opted for the one he got admission into. For a few, it was an ‘automatic choice’, as they had always been interested in the ‘mind’ and ‘problems of the mind’ and ‘why people behaved in a certain manner’. Furthermore, they all claimed to be good with ‘listening to people’s problems’; they stated that they were good with people and that people liked to ‘speak with them’. As Dr Sheriar Furniturewala, a prominent paediatric psychiatrist, put it, ‘people came to me with their problems’, and he had a ‘sympathetic demeanour’, and people responded well to him; so he ‘just decided to continue’, and turn it into a profession. Similarly, Dr Dipanita Deodhar liked ‘simply listening to people’. Dr Himanee Gaokar, who had a walking disability, due to polio in childhood, said that because of her own disability, she was more empathetic and had chosen psychiatry. For Dr Hetav Mehta, an early interest in hypnosis fuelled interest in the field of mental health and eventually led to psychiatry. Dr Amit Namdeo who heads an organisation that works with people and caregivers of people living with mental disorder, expressed a more deeper interest with the mind; fuelled by an added ‘interest in dramatics and being drawn towards characters and their psychology’, and with the active support and advice from his teachers while pursuing his Bachelor’s degree in medicine, he finally chose psychiatry.

Eight female psychiatrists were interviewed, not so much by design as default. A few among them stated that it was a relatively ‘easy’ subject of specialisation for a female doctor as compared to something strenuous and time consuming like surgery. As Dr Ekta Mirchandani said, ‘I did not want a very busy field, but...I wanted a clinical line’. Another determining factor was the presence of a family member in the same or related profession like psychology. Dr Jignesh Mehta’s father and uncle are both psychiatrists. Dr Nehang Dahiya’s father was a renowned psychiatrist who had taught for years in government colleges in Mumbai. He was, in fact, the inspiration for Dr Laxmi Niar to take up psychiatry as a specialisation, having taught her when she was pursuing her Bachelor’s degree. Dr Meena Gore grew up near a mental hospital, where her father worked as a

---

5 All responses of the interviewees, produced verbatim have been italicised.
well-known psychiatrist and superintendent for years. Dr Parani Tonk’s mother is a psychologist.

A range of factors thus determined why psychiatry was chosen by the participants. One set of factors are external. For instance, simply having the choice made for them to some extent: getting admission into psychiatry and deciding to take it up. Having had a family member in the same or related profession was also identified as a factor that influenced their choice. Gender was another determining factor, for the female respondents especially; how they perceived the discipline of psychiatry, as easier compared to other busier, time consuming and stressful specialisation like surgery.

Another set of factors were internal; the fact that the respondents perceived themselves to be good with people and were able to listen well. Thus, being able to maintain good human relations and their perceived propensity for it was also a factor. The psychiatrists believed that they had a particular predisposition that made psychiatry a natural outcome of that predisposition. Within this, apart from being able to connect with people, an interest in the ‘mind’, vis-à-vis the body was the most prevalent and important consideration.

The participants all believed that psychiatry deals with problems of the mind and since they had shown some skill and inclination towards dealing with problems, they naturally gravitated towards psychiatry, which they all saw as being concerned with just that- problems of the mind. This is what the next set of questions were aimed at: understanding how the respondents thought psychiatry defined mental illness, or rather how did they define psychiatry as a field of study; did they see it differently from mental illness as a larger concept or the former subsuming the latter.

**Psychiatry and Mental Disorder**

Was a textual definition sufficient to deal with the mental disorders the psychiatrists dealt with in the course of their practice or did they need to go beyond? If the latter, did they think there were then gaps in psychiatric theory that needed to be filled? The definitions provided were cut and dried and some more clinical than experiential.

Dr. Jignesh Mehta stated, ‘Basically we equate psychiatry with doctors or with the speciality which takes care of mental disorders. By and large the clinical approach is used to define mental disorder.’ Dr Gore went beyond the clinical definition when she stated, ‘Psychiatry is basically a nice amalgamation of science and art. It is very much a
medical speciality on the one hand...and on the other hand it is linked to the behavioural sciences, psychosocial sciences’.

Dr Girish Mishra had a different take on the subject. Psychiatry, according to him, does not ‘really cover the Indian psyche’. He, therefore, had to, ‘do his own homework and work outside the boundaries of psychiatry’ to truly address the problems he was looking at. He stated emphatically: ‘Our requirements are different. Our cultures are different.’ He further stated that one cannot follow diagnostic manuals to a T. He put it succinctly: ‘Suppose the patient says he is suffering for a few days, and it is lesser than DSM IV and ICD X, are you not going to treat him?’ He answered his question by stating, ‘It is your clinical acumen that saves you’. Practice and experience in the field Dr Mishra meant is what teaches and counts eventually, moving much beyond the text books, and teaches the most effectively too. Dr Namdeo agreed:

*Psychiatric education in our country only takes care of what is called as clinical psychiatry...it only takes care of disorder in a rigid pharmacological sense. In broader terms it only takes care of a layer of mental health that is called disorder. So psychiatry only trains you in clinical psychiatry. It does not train you in mental health at all. Or even cover what the psychiatrists are seeing in their practice. Mental illness is a much wider concept.*

Dr Tonk defined psychiatry by elaborating upon its drawbacks:

*Psychiatry looks into the core mental illnesses. There are a lot of sub-liminal mental illnesses going around like just adjustment problems, behaviour problems, emotional problems, personality problems. Psychiatry doesn’t address it till it reaches a deterioration point for the individual.*

Dr Dahiya, practising in a south Mumbai hospital with a steady stream of patients, and whose father was in the same profession stated rather irritably, ‘That is a very philosophical question. I practice medical model psychiatry.’ This position, however, was a one off. Most agreed that there are gaps. Another government hospital doctor, Dr Neelima Kadam, clearly over worked and caught with the sheer volume of people that she had to see, said without ceremony that psychiatry takes care of all mental illness. Expressing a similar outlook, another government hospital doctor, Dr Shobha Jadhav stated ‘Psychiatry deals with everything else also. It is much larger compared to what only mental illness is.’

Dr Hetav Mehta put forth a more sceptical position:

*There is a huge difference between theory and practice. There are various angles, dimensions to it. It is sometimes complicated or sometime very simple as
in the text book...text books gives us a framework. But not all cases are text book cases and also not necessary that a situation in that individual’s life is leading to psychopathology’.

Dr Hetav Mehta added another dimension to the debate: ‘The individual’s attitude also is very essential; the one who finally suffers from it. That itself decides his outcome or failure.’ What follows is ‘giving a customised treatment plan for individual patients’, which he said is ‘very essential for us.’

Dr Dindayal Chugani expressed doubts too: ‘We were very good in our theory papers; in the psychotherapeutic part, not so. Biologically we are trained much better than we are psychotherapeutically.’ He further stated, ‘Psychiatry now has become mainly bio-medical. There is hardly any rehab or recovery’. However, Dr Gaokar said, ‘Mental illness is psycho-social and cultural. All three aspects are included when we treat the psychiatric patient.’

Dr Deodhar reiterated: ‘The basic model in psychiatry is biological, psychological, socio [sic] and environmental. It is always going to be an interaction between genetics and environment.’ But she added that research is a must and needs to move beyond ‘just discovering drugs or getting medications’, to identify the aetiology behind it. Dr. Namit Bheda summarised: ‘Mental illness is big. Psychiatry addresses some part of it’.

None but one of the participants defined psychiatry in purely biomedical terms or claimed that psychiatry met all the challenges faced in the field during practice. They all distinguished between clinical/biomedical psychiatry and mental health as a wider concept. Psychotherapy was identified as another area that psychiatry did not effectively address. Though they did not critique psychiatry decisively, they pointed out what they believed were shortfalls in the discipline. They expressed it variedly by invoking culture, experience and sub-liminal illnesses or by saying they lack in psychotherapeutic skills. Nobody expressed any extreme positions and appeared to be satisfied with their practise. Some who had identified limitations were pursuing their own private practice and had found ways of working around them. Those working in government hospitals were more formidable about their positions.

By and large, however, all the psychiatrists interviewed displayed confidence in their training and knowledge. All defined mental illness in accordance with their education and professional training, and most deemed it sufficient to deal with the mental illness cases they treated on a day-to-day basis. On the question about whether psychiatry as a field of study subsumes mental illness as a concept, degrees of affirmation were expressed. Dr
Dahiya, a psychiatrist with about three decades of experience, was categorical and responded in a terse, staccato, almost arrogant and impatient fashion to almost all questions posed. He dismissed the idea of alternatives to psychiatry or the bio-medical approach. He stated at the very outset of the interview, ‘I practise medical model psychiatry. I am a medical doctor and I practise psychiatry within the framework of medicine’.

Dr Jadhav, working with a government hospital overrun with waiting patients all jostling for the doctor’s attention, expressed confidence in the discipline of psychiatry and said ‘Mental illness can be just one part of psychiatry. Psychiatry deals with everything else. It is much larger compared to what only mental illness is.’ Psychiatry is also about prevention and not just cure, is what she meant. She made a distinction between what she termed ‘soft psychiatry’ and ‘hard-core psychiatry’, the former referring to neurotic disorders and the latter to the psychotic disorders. According to her, only psychiatry had the knowledge and tools to deal with psychotic disorders. She exuded confidence in psychiatry and its ability to address mental health and illness effectively.

Dr Mirchandani, a psychiatrist who works primarily with children, reinforced a similar sense of security gained through her training when she stated ‘I look at how the patient is clinically and then decide the treatment.’ Dr Gaokar, who is the head of department in a government hospital stated that psychiatry has become more organically oriented over the years and even more so now with the availability of diagnostic tools like MRI (Magnetic Resonance Imagery) and CT (Computerised Tomography) scan as well as better and a wider variety of drugs.

Dr Gore defined psychiatry to be an amalgamation of science and art. But, again, she expressed hope in the form of new generation drugs with lesser side-effects. Dr Kejriwal, President of the Mumbai Psychiatric Society said that psychiatry has an important role to play across an entire gamut of disease and disorders, ‘all related to the psyche’. He stated that ‘Everything has a neuro-chemical basis, a biological, structural, bio-chemical basis. There has been a shift from psychodynamic theories to biological theories, to neuro transmitters. Now it is structural....psychiatry is neuro-based.’

The psychiatrists, while responding to the question of defining mental illness and whether psychiatry subsumed everything they saw in their practice, made a clear distinction between mental health and mental illness. Most responses implied that mental illness was well taken care of by psychiatry, but it fell short of inculcating preventive medicine. It did not say enough about how to establish and maintain good mental health.
Psychiatry was seen as a medical speciality that adopts a clinical framework and also follows a pharmacological approach. Mental illness is covered by psychiatry, but mental health is a much wider concept. However, there were various degrees of acceptance here too. While Dr Gore saw psychiatry both as a science and an art, Dr Mishra contextualised it by saying it does not address the Indian psyche.

Dr Mishra distinguished between the eastern and western cultures and said that their requirements are different and psychiatry does not recognise this. That is, psychiatry as an objective universal science does not help. Dr Hetav Mehta mirrored this opinion by invoking a difference between theory and practice and added another dimension, that of individual attitude and its impact on the treatment outcome. Dr Tonk said, psychiatry does not take care of what she termed sub-liminal mental illnesses, or what was referred to as ‘soft psychiatry’ by another psychiatrist, Dr Jadhav. For Dr Dahiya, who clearly worked with the biomedical model there was no conflict and he deemed the medical model to work. Others believed that psychiatry did take care of ‘everything’, and had both preventive and curative aspects. Some made a difference between biology and psychotherapy and the latter was thought to be the Achilles heel in psychiatry. Mental illness is thus a much wider concept than what psychiatry covered was the prevailing opinion.

**Gaps in Psychiatry**

The question about whether psychiatry subsumes all mental illness led to a discussion about gaps or weaknesses in psychiatry, whether gaps or weaknesses were at all identified and acknowledged in psychiatry and how did they address it, if at all. Dr Tonk, practising in a private hospital, in response to the question said, ‘Earlier it was considered just psycho-social. But now, being biological, treatment looks more specific.’ She also stated, ‘I think if there is true biological illness, it works better; the treatment is faster.’ She sees the future of psychiatry to be more advancement in its organic aspect: ‘I think what will happen is psychiatry is going to become very biological; even behaviour is going to become very genetic.’

There were exceptions to the position that biological psychiatry is able to address all problems. Dr Bheda, who interfaces with a maulana said ‘Psychiatry addresses some part of it [mental illness]. It is still not able to address as much as it should actually and ideally address.’ He clarified, ‘You do not expect one philosophy to address all the mental ailments.’ Elsewhere in the interview he said, ‘I learnt my own psychiatry. I was taught
how to look at mental illness in a linear fashion. The reductionist model of American psychiatry...so I learnt my own psychiatry.' ‘Functioning’ and ‘balance’ are what he said he aims for in his practise. Dr Bheda has worked outside of the clinic as well. He has taught psychiatry in a medical college and in a social work course and works with various NGOs. He works with addicts and has initiated support groups amongst families of people living with mental illness and done research on yoga. He termed all of this effort ‘self-explorations’. Still loyal to psychiatry, despite all of these initiatives, he stated ‘I did not substitute what I learnt. I added to it.’

Others simply stated that there are no significant gaps between theory and practice. Dr Kadam, working in a government teaching-hospital, in answer to a question about gaps in psychiatry and whether while teaching she talks to her students about other practices said, ‘No. Everything we generally try to fit into psychiatry...we consider everything biological. When the neuro-transmitters increase or decrease, patients have all these symptoms. Cultural aspect is there definitely. But that is not the only important factor. The medical model is also a very important factor.’ Dr Hetav Mehta acknowledged that there is a gap and said clinical experience/expertise can counter it. Failure to focus on counselling and psychotherapy more effectively was identified as major drawbacks in psychiatry, as mentioned earlier, by at least four psychiatrists (including Dr Niar, Dr Furniturewala, Dr Chugani and Dr Gokhale).

Dr Namdeo who has worked extensively outside the clinical space and now runs an organisation that trains young psychiatrists and conducts regular support groups adopted a more critical stance vis-à-vis psychiatry and articulated his displeasure with the discipline as such:

‘We [teach] topics such as mental health professional as a team, community mental health, psychiatrists as a counsellor. These are...never taken in their curriculum. Working with teens and adolescents, parents, people with personality disorders and caregivers is not taught. Absolutely nothing is taught. These are the kinds of things that we take. So all that has started happening.’

Dr Mishra identified the drawbacks in psychiatry not as a gap but as a ‘valley’. After working and teaching in a government hospital for many years, he started his own private practice and works with different groups across the city. He writes extensively, including in English and local vernacular newspapers, in an attempt to generate awareness about mental health issues. He said, there is a gap between theory and practice and the latter did not always adhere to the former.
On being asked to describe the process of diagnosis, all the psychiatrists interviewed said they used either DSM or ICD for diagnosis. They were aware that the DSM undergoes periodic revisions and each time new disease states are added and old disease states renamed, or even re-configured, wherein new symptoms are added or deleted. But this had no implications for daily practice. There is a category in DSM termed NOS (Not Otherwise Specified). If any form of mental disorder does not fit into an already given category in DSM, the NOS category is the residual basket into which it was deposited. Most culture-related syndromes find place in the NOU basket. Most often, the question about how diagnosis is made was answered technically, referring to DSM and ICD. Interestingly, one of the psychiatrists said that ‘overt’ mental illnesses like schizophrenia and bi-polar disorder definitely come under the purview of psychiatry, but psychologists can handle, what she termed, ‘sub-liminal mental illnesses’ like adjustment problems, behaviour problems, emotional problems and personality problems. Psychotic disorders are what psychiatrists are equipped to handle and handle well, since they include almost immediate and long-term medication, while neurotic disorders can be handled by a range of other practitioners, is what was repeatedly implied.

Most of the psychiatrists interviewed stated that there are gaps or weaknesses in the discipline of psychiatry; one of them being that not enough research has been done to localise the biological/organic origins of mental illness as a disease state. Any disease state, according to Dr Sumit Dhanagre, working as an associate professor at NIMHANS, has four major elements, namely ‘signs, syndrome, pathology and aetiology’. Dr Dhanagre stated, ‘Psychiatry is still struggling with signs and syndromes and not enough is known about pathology and aetiology and that was a major drawback.’ Medically, signs are objective evidence of a disease as perceptible to the examining physician. Syndromes are a set of symptoms and signs occurring together. Pathology is a branch of medicine that deals with the essential nature of diseases, especially changes in the body tissues and organs that causes or are caused by disease. The term pathology refers to the structural and functional manifestation of disease. Aetiology refers to the cause and origins of a disease state. Dr Gopalakrishnan, another psychiatrist from NIMHANS like his colleague Dr Dhanagre, was categorical that what is required is more scientific research on the biology of mental illness, to localise the disease and seek evidence for it.

In answer to a question about whether psychiatry cures or heals, the responses were varied. Five doctors stated that psychiatry attempts to cure but only manages the disease; Dr Chugani stated that ‘nature cures and psychiatric medicines help with the suffering’. 
The term one psychiatrist used was that psychiatry helps to ‘function’. Dr Hetav Mehta said psychiatry does not heal as much as cure. It is meant to heal but because ‘the psychopathology may remain’, one cannot say for sure. Dr Bheda described both healing and curing as metaphysical concepts and thereby irrelevant. He said, ‘Who is interested in healing or curing…the person [needs to] come back to a balance within himself...’ Dr Gaokar said psychiatry just keeps the disease under control mirroring the management-of-disease position held by her colleagues.

According to Dr Kejriwal, there was no difference between the two terms and it was simply rhetorical; he said that psychiatry cures as much as it heals. Dr Hetav Mehta saw the distinction itself as arbitrary and cited the example of malaria to say that, even if the person is cured at a point in time, he/she might still contract the disease again making this distinction irrelevant. Dr More said that with the advent of new drugs healing has become a possibility now. Dr Niar differed and said it is meant to heal, but it does not. Absence of follow-up was the cause cited by Dr Mishra. Dr Gokhale added another dimension by saying ‘Psychiatric medicines will… not ever cure completely unless the person wants to...improve himself.’ I was aiming to understand if they saw a conceptual difference between ‘curing’ and ‘healing’. In other words, would they connect it to their own practice or even to their clients’ perceptions about their illness?

Dr Kadam stated ‘Curing is...symptomatically curing. But healing is from all aspects, everything from the psychiatric point of view and from the psychological point of view...The whole holistic approach is also very important. That will be healing according to me.’ Dr Jejebhoy who manages a large mental hospital, asserted, ‘I prefer to use the term heals rather than cures. Curing...[is] controlling the symptoms. Healing, you are changing the life of the person.’ He added, psychiatry can be a ‘nice healing process’ if you have the right people with you, implying a larger team effort. Dr Jejebhoy teaches and he said that he focuses on the syllabus and talks about cure inside the classroom; he said he cannot deviate ‘too much’ from the text books. But, in his own practice, he is aware of the absence of healing for his clients. He thus brings to the fore the gap between theory and practice rather effectively. To enhance the discipline and ‘improve the quality of life, healing is important’, he concluded.

The psychiatrists interviewed thus gave a gamut of answers in response to the question about psychiatry’s objective: healing or curing? Very few connected healing to the wider purpose of treatment; they simply looked at psychiatry as managing mental illness. Others said that healing requires a multidisciplinary effort and is beyond the scope
of psychiatry. Healing also implies being able to take on the perspective of the patient and their families; this was seldom done. The psychiatrists did not view taking on a patient’s perspective as a part of their role responsibility. Some were able to effectively articulate a distinction between curing and healing, but did not see their role encompassing both. Healing required a larger team effort, much beyond the scope of psychiatry.

Interface

Ideas about interface were an important part of the interview. The preceding questions and discussions set the stage for what they thought about other systems and practitioners. In response to a question about whether clients they see approached any other practitioner to address mental health, all responded in the affirmative. Most, however, did not have too many details about it. Some said that their patients approached another system while they consulted with them. The psychiatrists knew about it as much as it was needed as a part of the history-taking and not more. Most were ambivalent about it.

However, the psychiatrists, no matter how open or closed to the idea of other practice, believed that patients should not take medicines other than what they prescribe. They were uncomfortable that their patients ingested medications not prescribed by them as they did not ‘know’ the medicines from other systems. What they are in effect saying is that anything that alters the organic/chemical composition of the body is unacceptable to psychiatry, given the understanding of mental illness within the discipline and the significant role that biology and the organic play within it. They were more accepting of the idea of patients accessing other systems without mixing medication. This also reflects upon the psychiatrists assuming a Cartesian dualism between mind and body, claiming the body as belonging to the discipline of psychiatry. Ironically, they do so despite their understanding that psychiatry deals with the mind primarily.

Dr Kejriwal stated, ‘There is a revolving door because we know that it is a chronic illness...they go to someone, it’s no harm. As long as they go to someone.’ Dr Dahiya was more cautious and stated, ‘They can do what they want. I can only give them advice. I cannot dictate terms.’ Dr Gokhale, a young psychiatrist with about five years of practice behind him, was far more sceptical about interfacing with other systems and practitioners. ‘I don’t trust in all these things. I give medicines and I think you should give it a reasonable time to work.’
Dr Ekta Mirchandani was more in favour of educating her patients about her own system and expressed faith in its ability to show results and she took a neutral stand towards her patient’s choices. She said,

*I educate them about the illness. Why is there an illness, what is the reason behind symptoms and how they will benefit from the medications. Once they see the results they are convinced. Then they decide. My role is to educate them. My role is to tell them if you go to faith healers, you may benefit, you may not benefit, but my medication you cannot stop. Because I know my medications help. Frankly about Ayurveda, Homeopathy...I am not against them. It is not in my power to discourage people from believing in them. But I have no knowledge. So I cannot encourage nor can I discourage. I take a neutral stand. It’s their opinion, their decision. I educate them. I educate them about how psychiatric illnesses are.*

Dr Chugani had a more specific opinion. He stated, ‘*Homeopathy I believe is harmless.*’ He asks his patients to make a choice between psychiatry and Ayurveda because ‘there is interaction between the medicine’. Taking a rather sympathetic stance towards non-psychiatric practices, Dr Deodhar said, people from smaller cities where ‘culture bound syndromes’ are more prevalent like ‘hysterical states, possessions states, trance states’, they will ‘go to their traditional healers... It is always going to be.’ She further stated that traditional healers are also aware and that: ‘*They know that when it is minor things they can manage, but if it is psychosis then they themselves say that we won’t be able to manage so please take him to a hospital. That has also happened*’

Dr Jadhav stated,

*If you want to continue your faith healing and all that we have no problems with that. But you continue to take our medicines. We are not interfering with your faith. You continue to do that but more importantly the patient also needs medicine so simultaneously continue both. Then the patient benefits and we don’t lose the patient. That is our main aim.*

Dr. Gaokar expressed a similar opinion: ‘*It is everybody’s choice, what they want to do.*’ She further spoke about two studies that were done in two major government hospitals in Mumbai on faith healers – how many psychiatric patients coming to the OPD also go to faith healers. The studies found was that more than sixty per cent patients go to faith healers first and then come to psychiatry. The studies also found that ‘faith healers after one or two sessions, when they realises that they cannot do this, says that abhi bhoot nikal liya, abhi doctor ke paas jao [the ghost has been exorcised, now go to a doctor]. So ...rather than criticising them [the faith healers], we should take them into confidence and educate them about when to refer the case to us.’
When posed with the question of working with alternative practitioners, Dr Vahiya stated emphatically ‘I will not work with any faith healers. I am not into that segment of psychiatry. I am a clinical psychiatrist. I am not into policy making and a general do-gooder. That’s not me. I am just a clinical psychiatrist and I do my work’.

According to the psychiatrists then, the organic, physical body belongs to the discipline of psychiatry. What they do outside of taking/ingesting medicines is completely unto the patients and their families. These could include any number of therapies, like flower therapy or crystal healing or going to a jhar phoonk baba (one who blows holy ash to ward off evil) or a temple to do puja (worship), or even yoga, which most psychiatrists actively encouraged. The psychiatrists made a few distinctions: the medical and the non-medical practices, the somatic and the psychological, the institutionalised and the non-institutionalised, etc. They did not express any overt displeasure to their patients so long as they stayed with the medicines.

The space of practise was found to be complex and nuanced. Given its complex history, it is not surprising that psychiatry as practice would present an equally complex picture. Psychiatry has been on the focus for different reasons at different times. During the colonial period, among other things, psychiatry was a means to social and political control and maintaining law and order (Addlakha 2010). However, to see psychiatry only as a tool of social control and coercion is to however deny what Parthasarthy Mondal terms ‘adequate agency and capacity for creative resistance to the social order’ (2009: 231). The discourse on colonialism and psychiatry is the ideology of freedom as much as the one that talks about coercion and control; British and European reformers believed that the humanism of asylums would emancipate the mentally distressed. This ‘moral treatment’ also stems from the ‘rationalistic and enlightened tradition of science and medicine’ (ibid.: 239). The mental asylum was thus positioned in an interstitial space between freedom and bondage. After independence, the local context became a focus of research, cognisance taken of cultural factors and the role they play in defining and treating mental illness. The psychiatrist’s socio-cultural context was seen to influence the therapeutics employed and accordingly studied.

While the biomedical model is a powerful aspect of psychiatry theoretically, there is more to it, especially in the realm of practise that resists being bound in a uni-dimensional frame. The question of efficacy becomes centre-stage here. Does the biomedical model of psychiatry work? According to the psychiatrists interviewed, it does and it does not. Some stated having to move beyond text books to truly engage with and address the range of
mental illness that they see. And while doing so, psychiatrists, as seen, have drawn from various sources, to enhance their own practice.

For instance, in the past, psychiatrists in India have used the Hindu scriptures and indigenous medical systems ‘as filters’ to question western psychiatric concepts (Addlakha 2010: 55). Ayurveda has also been studied and parallels sought in treating disorders like schizophrenia. The Bhagavad Gita has been used to redefine doctor-patient relationship and yoga has been used extensively as a part of the treatment regime. Psychiatrists like Dr Kapur, Dr Neki, Dr Sagar and Dr Surya have attempted to redefine health outside of the biological-organic construct of psychiatry in general to look at a more holistic and cosmological understanding of health involving aspects of the spiritual as well. According to Horacio Fabrega, ‘India’s contemporary psychiatric establishment is embedded in an alive, vibrant history and culture whose accomplishments in medical and mental health related knowledge, scholarship and practice exemplify an ancestry of millennia.’ (2009: xi). India presents an opportunity to study what he calls the ‘cultural evolution of psychiatry’ (ibid.). An examination of the discourse on mental illness in India will necessarily need to engage with a ‘mixture of intellectual and practical traditions and resources involving sickness and healing, the ancient and the modern, pulsating realities in the contemporary social, medical scene’ (ibid.).

My interviews with psychiatrists brought forth similar views. Most psychiatrists interviewed expressed fortitude in biological psychiatry and the medical model and the fact that medication is the core strength of their practice. Understandably, they looked upon faith healers and alternative practitioners with varying degrees of scepticism. Most psychiatrists were unsure about the specific role that the latter can play. Paradoxically, however, none, but one psychiatrist interviewed, explicitly dismissed them; most assumed an ambivalent position. Their professional training in the medical model makes this the dominant approach for most of the psychiatrists interviewed. Yet they did not dismiss the other practitioners altogether, but expressed varying degrees of acceptance/rejection.

The interviews yielded the following observations: that interface is not a distinct event or phase, but a process marked by complexity and confusion. It also changes perspective in accordance with different practitioners. Psychiatry has at its core a defining principle that sets it apart from other approaches. The principle is its inherent ability to prescribe medication and thus work within the biological and organic framework in a distinct and emphatic manner. It is its one indelible defining quality and constitutes its ontological and epistemological core that has more or less remained unchanged. Any
excursion is always an addendum to the basic principle and serves to fortify it further. The closer the aetiology of a mental illness to this biological/organic core, the greater the reluctance to allow other systems to intervene.

Having said that, I also noticed something more complex than merely a complete dismissal of other systems of healing, including the non-medical systems. To begin with, I refer to the psychiatrist, Dr Bheda who has been working with a maulana for the last fifteen years and the fact that both refer patients back and forth. The psychiatrist realised early on in his practice that clients are much more comfortable seeking help from a traditional healer and that they actively do so even while they are consulting an allopathic doctor. Also, the kind of problems that the clients brought to his clinic did not necessarily fit into a definite diagnostic category; there was some disconnect in understanding the condition when viewed through the lens of western modern medicine.

One prime example is spirit possession, which is termed ‘conversion disorder’ in modern psychiatric parlance. Rather than convincing the client and her/his family about this illness category and disease state, Dr Bheda recommended that they might like to meet the maulana, who by virtue of his qualifications would be able to address the problem more effectively, thereby exorcising the spirit and helping the client move into the path of healing. Once the family was/is convinced that the spirit has left the person or has been exorcised, it is recommended that they go back to the psychiatrist, so he can take care of any other remaining problems.

Dr Bheda claimed that this strategy works. When asked specifically if his clients approached other practitioners, he said, ‘Absolutely. I think they have every right to do that. So many of them access god, Homeopathy, counsellors, psychologists, healers, witchcraft.’ When asked what his take was on these multiple approaches, he said, ‘I ally with them. I form an alliance. I don’t reject them.’ He also said, ‘I don’t encourage them.’ Later in the interview, he said, ‘I don’t think any illness has any single model approach. When it comes to illness with multiple causes, multiple dimensions, you have to accept that you don’t know everything and others can add value. The basic tenet of practice is that the client should get well.’ He admitted that working with alternative practitioners was also a ‘strategy’ to help clients; he discussed cases with the maulana and decided a course of action accordingly.

Dr Chugani had learnt Narrative Therapy and Solution Focused Therapy apart from hypnosis, and admitted ‘I do both’, referring to medication and therapy, including hypnosis. He stated that his clients feel better after most sessions. He also said often his
clients did not want therapy. ‘They just want medication.’ He further said, ‘There is no one unitary form of psychiatry.’ According to him, more work is required to strengthen the psychotherapeutic arm of psychiatry, and that the medical aspect is ‘clouded by drug company propaganda’. He adopted a more cautious approach to other practices, saying ‘Homeopathy is harmless’, but ‘I have never seen Ayurvedic medicines helping anyone’. He said, for minor problems, it helps to approach multiple practitioners and systems, but for major psychosis, it does not.

An ascetic who is a teacher of the Vedanta system works in close association with a psychiatrist, even though they belong to two different systems. Dr Gore, who has clients referred to her by Swami Satchitananda,6 while expressing confidence about the virtues of new generation of drugs mentioned improvement in psycho-social methods, and admitted that other practitioners were ‘...part of our culture, so let’s not say don’t go to them. It is not going to work. So we might as well in a sense include them in the system.’ She is a member of the Chinmaya Mission and goes for lessons in Vedanta philosophy regularly and said, in that context, ‘I get a lot of references from Chinmaya Mission. Mostly distressed persons firstly go to religious persons and he has the awareness to know what he can handle and what he should refer to me. That helps a lot.’ There are two parts to this she said. One part is the cultural part, which is very important, and faith in religion is equally important, and has to be ‘taken into account’. On the other hand, everything is also ‘getting more and more medicalised, because of neurotransmitters, receptors, neurological orientations and biological research’, and this too has to be acknowledged. Dr Gore observed how both work in tandem: ‘However much you deal at the chemical level, you cannot deal with the person just in isolation. You have to retain that humanism.’

A major part of my interviews involved questions about interface with other practitioners and systems: what they thought about it, would they be willing to work with other practitioners and so on. Most psychiatrists interviewed recognised the role that healers and other practitioners can play, however uneasy they were with it. Dr. Kejriwal, for instance, said there should definitely be interface. Dr Namdeo, a prominent psychiatrist who has done some pioneering work outside of the medical model, including initiating active family support groups and working with a team of multidisciplinary professionals, stated he wanted,

6 Swami Satchitananda is a teacher of Vedanta philosophy in Mumbai.
compliance of [the] patient. Let them take medication. Let god also take credit. In ninety out of hundred times, they [relatives] come to know that dawa [medicine] has worked; also dua [prayer] might have helped. They are not very irrational people. I have observed that it is better to be with them during this stage and not confront at that time and not antagonise them. They are more amiable and more likely to come to your side.

Dr Namdeo was clear that systems should interface: ‘Both the processes will go on simultaneously.’ When asked what his colleagues in the field thought about his foray into non-medical psychiatry, he said, ‘They are the victims of their own framework’, and unable to look outside of it.

Dr Jejebhoy, heading the Psychiatry Department of an old Mumbai hospital, said, so long as it does not interfere with the medication regimes prescribed, it is okay to explore interface. ‘It is a part of our culture’; he reiterated: ‘I have respect for them and I recognise them.’ He, like another colleague said, ‘I may not encourage them. I will not tread.’ He used a multidisciplinary approach and has a social worker, a counsellor and a psychologist among his staff in the hospital. He belongs to the Bohra Muslim community, which has a spiritual head, who, he says, has influenced him and his work. The latter is often consulted by community members to seek solutions to various problems, including medical problems and even deciding on the use of MRI and CT scans.

Dr Gaokar who spoke about advanced diagnostic tools and medicines also said, ‘Cultural factors are important, in diagnosing and in treating also. Because when I get very old patients, I advise them to go to temples, attend bhajans [devotional songs], do japa [chanting] because it really helps’.

Dr Mirchandani stated, ‘Because I know my medications help, I take a neutral stand. It is not in my power to discourage people from believing in them. I cannot break their trust and their beliefs.’ Dr Mirchandani works with a multidisciplinary team in her clinic that includes a psychologist, a remedial therapist, yoga instructor, speech therapist and a nutrition expert, to deal with the excess weight-gain problem that people on long-term psychiatric medicines often face as a side effect. Medication intake as the primary concern was also expressed by other psychiatrists. But they were not averse to other practitioners addressing mental illness.

Dr Jadhav, working in a government hospital, stated they tell the clients,

If you want to continue your faith healing, we have no problem with that. But you continue to take our medicines. We are not interfering with your faith. The patient also needs medicine, so simultaneously do both. Then the patient benefits and we don’t lose the patient. That is our main aim.
Dr Tonk, practising in a private nursing home, with years of teaching experience, said that a lot of faith healers refer patients to her; so, she believes that ‘Times have changed. It is a land of faith healers so you can’t let them go. Take your medications and go. So you do both.’

Subtle spaces for interface have opened. Mental health is addressed in multiple spaces, literally and figuratively. Psychiatrists have moved beyond the boundaries of their profession to not just seek a greater understanding of cultural factors in determining mental illness, but also to draw from other systems of health and healing to address the problems of mental illness. Psychiatry includes pharmacology at its core, but it also has a therapeutic arm. While this non-medical aspect does not inform the medical aspect, it is open to additions and at its core lies the therapeutic relationship between the doctor and the patient; this is essentially fluid and permeable. Herein lies the potential for building the epistemological bridges that provides for interface of psychiatry with other systems. Thus, we have a psychiatrist who has learnt hypnosis, Solution Focused Therapy and Narrative Therapy in an effort to enhance the psychotherapeutic relationship between him and his patients/clients.

How essential do psychiatrists deem this space to be in the larger psychiatric approach to the treatment of mental disorder and illness? The answer to this question influences their motivation to allow or explore other approaches. The answers to this question can be placed on a continuum. At one end lies the position that the medical model alone defines psychiatry and that is the sole objective of it. Any therapeutic relationship is a mere by-product of this and nothing more. At the other end is the position that there is a dearth in psychiatry, an absence, that prevents it from reaching out to people with mental illness; and that this lack can only be addressed by building and strengthening the therapeutic arm of psychiatry. What this also implies is a multi-disciplinary approach to mental illness, and this yields the best results.

There two positions have been assumed by the psychiatrists interviewed: either they have interfaced with a different system by learning and incorporating it into their own system, like learning Narrative Therapy, Solution Focused Therapy, hypnosis, and drawing from Indian sacred texts and so on, or they have interfaced with another system by working with practitioners therein. Dr Bheda working with a maulana would be an example. For a list of consolidated responses to the issues that the psychiatrists discussed, see Table 3.1.
Two other important insights have been gained about this interface. One is that the kind of mental disorder is an essential point in determining interface. The disease conditions deemed to be totally organic in nature like the psychotic illnesses are thought of as requiring only medication and medical intervention to show amelioration or even management. Neurotic disorders, including adjustment disorders as disease states appear to be more permeable and open to interface and inputs from other practitioners, on the other hand.

Another important point is what is termed the ‘natural history of the illness’. This is the history of the disorder that is inherent to the disorder itself. Thus, patterns will be seen in the growth and development of the disease state, including periods of remission. An example is epilepsy. The observation that was made is that, during periods of remission, when the particular disease state is in remission, like it can be for mood disorders or epilepsy, the space for interface heightens. If people seek interface with other practices at this time, the tendency is to attribute the absence of illness to the practitioners. This encourages further interface. It may be argued that getting better then cannot be attributed to an alternative practitioner, because the person has not improved due to the alternative healing method, but actually due to the natural history of the illness which involves a period of remission. Whether or not actual healing and ‘getting better’ has taken place is a moot point. The fact is that this period of remission in the natural history of the disorder probably provides another important space for interface with other systems.

Both positions underlie an understanding of the aetiology of mental illness. If the approach adopted is biological and medical alone, then the treatment falls within and is confined to this design. If the aetiology is deemed to lie outside of the organic, then there is scope to widen the treatment approaches. As far as the psychiatric approach goes, no matter where it lies in the continuum, its ontological core, that which defines it, stays. So even if a psychiatrist is open to other possibilities or other treatment approaches that her/his clients have adopted, s/he will not diverge from this essential biological/organic core. Other approaches are then seen as adjuncts, or as assuming a peripheral position. It is also noted that psychiatrists do not stop their clients from approaching other treatment modalities, so long as this does not contradict or conflict with their own approach. If it does, clients are often asked to make a choice. None of the psychiatrists that I spoke to expressed any sense of insecurity, however.

---

7 A well-known neurosurgeon, whom I interviewed in Bengaluru, brought this point to my attention.
Dr Furniturewala was clear that he would not recommend his patients to any alternative systems, even though he knows a few faith healers and says, ‘I have a lot of rapport with various faith healers.’ And ‘a lot of faith healers refer patients to me’. He distinguishes between good and bad faith healers; good faith healers know their limitations and know when to refer a case to a psychiatrist. He further stated that ‘I have indirectly trained a lot of faith healers...there are a lot of doctors who speak against the faith healers. I don’t do that. I respect them.’ Nonetheless, he was not open to working with them, thereby reflecting an ambivalent attitude. He was weary about healers asking for medicines to be stopped. Dr Furniturewala said he acknowledges the presence of multiple systems in ‘our culture’, and said ‘they are right in their own place’. Though he has a multidisciplinary team in his hospital, he is wary of incorporating a ‘baba’ (traditional healer) within it. He is more comfortable interfacing with allied disciplines like psychology and social work and for another psychiatrist, even a nutrition expert, but not a baba.

The psychiatrists interviewed also took a non-antagonistic attitude towards other systems because they want patient compliance. So, not criticising a healer or practitioner was a strategic decision to ensure that patients come back and do not stop medication. All agreed that they would not force the clients to choose, but would tell them that stopping medications is counter-productive. Interface is conditional for all the psychiatrists interviewed; medications cannot be stopped, proper training needs to be given to healers and other practitioners to enable them to recognise psychiatric illnesses and so on.

Some of the practitioners that the psychiatrists said their patients consulted include Ayurvedic doctors, Homeopaths and faith healers. People also took recourse to being part of various religious groups and yoga was thought to be very popular as well. While some psychiatrists mentioned that the practitioners of other systems referred patients to them - Dr Sheriar mentioned an acupressurist and a Catholic priest who refer patients to him; Dr Furniturewala, faith healers; Dr Gore, an ascetic who teaches Vedanta philosophy – none of the psychiatrists referred their patients to any other system. They all said that psychiatry as a system was the constant in the lives of the patient and the other systems were the variables. So, while patients moved in and out of different systems, they ‘always come back to psychiatry.’ Dr Bheda, who works with a maulana and is open to interfacing with other practitioners, explained his motivation thus: ‘The basic tenet of practice is that the client should get well.’
Conclusion
The above raises a larger question: is mental illness like any other illness? There are three possible answers to this: (i) yes, it is, (ii) no, it is not, and (iii) yes, it is and it is a bit more. Psychiatrists assume the latter two positions and this determines their treatment modalities as well.

Medical practitioners, including psychiatrists, have often stepped out of their comfort zones and sought interface with other ostensibly disparate systems that do not easily gel with each other. An example is the work done by Dr Abhay Bang in the Ghadchiroli district of Maharashtra, wherein he and his wife, both allopathic doctors, have explored local epistemologies of health and illness, especially with regard to women in the community, and integrated them into community health initiatives. Community health in India otherwise falls within the purview of public health, steeped in the principles of modern biomedicine. Here, health and illness, or disease and treatment, are located within ‘Local theories of health and healing. Pathology articulated within a rich tapestry of traditional codes and beliefs’ (Dighe 2011: 237). This ‘dialogue between the bio-medical and the local systems of medicine’ also ‘articulate the relations between pathology and anthropology’ (ibid.).

Dr Malavika Kapur, former head of the Department of Clinical Psychology at NIMHANS a practising clinical psychologist based in Bengaluru, interviewed as a part of the study, stated that lay people have and continue to exhibit, what she terms, ‘great sophistication’ while making choices regarding practitioners for health and healing. Dr Bang’s work in Ghadchiroli shows the same. Women in the district access doctors as well as a vaidu (witchdoctor) simultaneously for all health related problems; both credited with expertise on different aspects of the same problem. This is akin to mental illness, where spiritual as well as medical help is sought. Women in the Ghadchiroli district attribute natural and supernatural causes for illness, both in aetiology and treatment. They are not seen as disparate irreconcilable categories; rather they are what Dighe terms ‘two aspects of one universal theory causing or curing the illness’ (2011:243).

Psychiatry is a complex field that sees the simultaneous interplay of different processes; an intangible weave of modern and traditional, medical/universal and cultural/local context that comprises the reality of mental illness. There is, however, an asymmetrical relationship between psychiatry and other systems. Johannes Quack, addresses the asymmetrical relationship between ‘modern scientific medicine’ and ‘traditional, religious healing practices’ (2012:17) and states that a structurally blind
position is often adopted by the former vis-à-vis the latter. According to Quack, this can manifest at various levels such that ‘global health statistics’ become blind to issues of ‘mental health’, or ‘mental health statistics’ can become blind to issues of ‘non-biomedical therapies’, or ‘psychiatrists’ being blind to ‘folk therapies’ in the context of India (ibid.).

The psychiatrists interviewed did not all assume a structurally blind position. Ambiguity and ambivalence is more the stance adopted with regards to other systems. Thus, a psychiatrist interviewed is ‘objective’, ‘modern’ and ‘progressive’; will use the DSM and ICD to diagnose and treat; is sceptical of traditional healers, yet wary of dismissing their role outright, assuming an ambivalent position instead.

Michel Foucault’s work on ‘episteme’, which he later replaced with ‘discursive formations’, provides some insights as well. Psychiatrist and healers both play upon a particular discourse of mental illness; and, in doing so, bring about a certain ‘discursive unity’ (Foucault 1989) that will account for disparate, incommensurate systems existing on a same plane. There is, no doubt, a certain ‘regime of truth’ vis-à-vis mental illness that is reproduced and consolidated by the psychiatrist, that s/he draws from psychiatry as a larger field and knowledge base. But what is also being produced is a particular dispositif of health and healing, a thoroughly heterogeneous ensemble (Foucault 1977).

Here there is a multiplicity of forces (systems and practitioners) in movement, and these in contestation and power makes for a ‘fractured field’ in which the ‘different lines of forces are sometimes reinforcing, sometimes undermining and contradicting one another’ (Bussolini 2010: 90). The diagnostic procedure, the technology, the space, the practitioner all come together to fulfil an important function of managing people with mental disorder. The particular ‘regime’, however, does not appear to be fixed; there is a juxtaposition, however precarious or uneasy, of two or more systems of knowledge. While referral work between psychiatrists and healers does try, to some extent, to fit and categorise symptoms enabling it to fall into either/or categories, there is also a certain degree of intersection of multiple temporalities, rational/modern and cultural/local, operating at multiple sites including the body, procedure and technology. An element of the modern and hence rational is inherent to all three; but, at the same time, it is mediated by cultural factors.

Dr Gaokar spoke about the need for and a possibility of a separate classificatory system of mental illness for India. She thinks classifications like DSM are very
‘American’, and do not apply in the socio-cultural context of India. This is yet another take on the culture-specific-medicine debate.

The psychiatrists interviewed were sceptical of the non-medical approach to mental illness, and this can be attributed to their training that inculcates the medical model quite thoroughly and exclusively. But, once they begin practice, they realise that they have to deal with the non-organic in more ways than one. The clients they see necessarily bring with them their affiliations with other practitioners and systems of health and healing; this continues despite the former taking psychiatric treatment. For clients, the contestations between practitioners are not so stark as to compel them to make a categorical choice in favour of one or the other. The psychiatrists, it appears, despite their qualms and reservations about other practitioners, occupy a vacillating position; they acknowledge the latter, at least, if not ally with them. The psychiatrists believed that other systems and practitioners have a role to play, however indeterminate, in the larger canvas of mental disorder.

Often a psychiatrist herself or himself is affiliated with a particular spiritual practice or space. And this influences their professional work as well, both by providing a spiritual angle to their work and in encouraging reposition of greater faith from their clients. Dr Namita Melwani is an active member of a local church that holds regular sessions conducted by a resident healer, whom I also interviewed. The clients who come to Dr Melwani, who are also members of the church, and regularly consult the healer, experience no contradiction. And neither does the psychiatrist, who otherwise was as ‘biological’ in her basic orientation as any other. She said she connects her work as well as her clients getting better to her larger spiritual quest and goals. The medical thus appears to subsume the spiritual smoothly.

This is a significant phenomenon sociologically. The inter-personal interaction at a non-professional level, through social networks or common group membership actually facilitates interface between systems. This is located at a micro level entirely and is at an informal level, but significant enough to impact a practitioner’s orientation and attitude to interfacing with a practitioner of another system.

The medical and non-medical aspects work in tandem here. The important question is, how distinct are the boundaries, are they permeable and, if so, to what extent? The field reality seems to suggest that the boundaries are permeable. Is psychiatry in India unique because we see a juxtaposition and interweaving of both the medical and non-medical, that neither modernity nor colonialism could completely separate? Is the
psychiatrist in India then able to comfortably negotiate disparate systems and rather paradoxically be modern without dismissing the traditional?

Perhaps the way forward is to examine this outside of the boundaries of the categories we use to explore this in the first place: like modern and traditional, or subjective and objective, or even rational and irrational. The focus then should be on how to lessen the suffering of the people and not merely to seek validity in the adherence to principles of scientific rationality (Scheper-Hughes and Lock 1987). Spaces for interface between ostensibly disparate systems need to be examined separately. This space of interface is convoluted to say the least. One example of this is the ‘modern doctor of traditional medicine’ (Naraindas 2012) that is, doctors of indigenous systems of medicine like Ayurveda, Unani and Siddha are privy to allopathy. Harish Naraindas looks at the interface between Ayurveda and allopathy and observes that ‘the result of this mangling may be best described as a form of creolization, which is premised on a structural asymmetry between allopathy and Ayurveda’ (ibid.: 1), referring to a mix of new and old, of traditional and modern. This has important implications for mental health and illness too. Given the premises of modern psychiatry, will working with other systems produce a creolised version of psychiatry? The other related question is: how effective will this version of psychiatry be in addressing mental disorder?

The challenge is to examine the ‘object’ deemed psychiatry more closely. It is somewhat opaque and obdurate, but can it necessarily be reduced to one set of elements that define it completely? Or can its nature be gleamed by examining its relation (Latour et al. 2011) to practitioners, to technology, to other systems of healing and to the people who receive treatment and their families? Is psychiatry a sum of its relations or something outside of it, or both, is an important question that requires further attention.

In conclusion, psychiatrists do interface with other systems, though they are not so open to interfacing with other practitioners. They occupy an ambivalent position with regard to interfacing with other systems nonetheless. They constantly negotiate what they have learnt as theory and add to it. They admit that not all of what they see in their practice they have been taught to address. The shifts into other systems - be it working with traditional healers or hypnotherapy - are not ephemeral. They do not do so for a few cases and revert to biomedical psychiatry. They are altering the boundaries of their discipline and recognise the importance of interfacing with other systems. They are motivated to ameliorate the suffering of their clients and this opens avenues for interface as well.
To summarise and answer the questions posed at the beginning of the Chapter, psychiatry is taught and practised the way it was learnt by the psychiatrists but with more and more clinical experience and acumen as well as exposure to the field, they do add to the corpus of knowledge. And in the process draw from other systems as well. They do not however let go of the biological ontological core. The shifts into other systems are not in the form of temporary in-roads into other systems. The fact that the psychiatrists explore other approaches at all is reflective of the fact that they do perceive gaps in their own system; hence reach out to another. These elements are then incorporated into their practice and are long-lasting. These shifts are then not temporary but inform their theoretical understanding of mental disorder. For example, Dr Chugani actively incorporates hypnosis into his practice of psychiatry and stated that it helps to enable his patients to articulate emotionally traumatic events; here medicine alone would not have helped.

The psychiatrists interviewed then do believe in interfacing with other systems, but as seen, with certain conditions and under certain situations. Systems are more acceptable than practitioners of systems. Therapeutic systems are more readily interfaced with and not those that include medicines like Ayurveda. Interface with systems are often initiated by psychiatrists but the decision to do so is not always a professional one, taken within the boundaries of their profession. In other words, two factors are relevant here. One, that patients and caregivers often already make in-roads into other systems when they come to a psychiatrist, or even while they consult a psychiatrist and hence access more than one system simultaneously. Leaving the psychiatrist with little option but to try and understand what these systems are because it impacts their treatment sometimes. Secondly, psychiatrists themselves are part of social networks and groups at a personal level that include practitioners from other systems. These common affiliations and interpersonal interactions also facilitate interface.

Psychiatrists are motivated by different factors to interface. One of the most important ones identified is a need to see amelioration in the suffering of their patients. The psychiatrists also want what they term ‘patient compliance’; to ease this process they interface with other systems and also practitioners. Thus a psychiatrist will interface with a maulana and address mental disorder in tandem. Interface then is both by default and design and it is recognised and acknowledged as a need by the psychiatrists interviewed.

The implications for psychiatry as a larger discipline are varied. One the study clearly shows that the core principles of psychiatry are guarded by its practitioners.
Pharmacotherapy is intrinsic to this understanding and that stays. But the psychiatrists realise that this is not always enough. While they see the future of psychiatry in the direction of more research and development in the biology of mental disorder, in identifying more specific physiological locations to explain mental disorder; they are keenly aware of the socio-cultural impact upon the treatment and aetiology of mental disorder as well.

While the psychiatrists interviewed expressed various opinions and attitudes towards other systems of health and medicine, it is important to establish what other systems think of psychiatry, because practitioner/system interface is a two-way street. To understand whether psychiatry can and does interface with other systems, it is necessary to understand what these other systems think of interfacing with psychiatry. The next chapter will attempt to do this by examining another system of health and healing, namely Ayurveda.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>Personal disability</td>
<td>Organic, psychosocial/cultural</td>
<td>–</td>
<td>Sometimes</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>Interested in the mind</td>
<td>Smaller area within psychiatry</td>
<td>Stigma</td>
<td>Yes with medication</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>Interested in clinical line; not hectic</td>
<td>Contextual; moves outside textbooks</td>
<td>DSM does not cover everything</td>
<td>Yes with medication</td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>Predisposition</td>
<td>Social and occupational dysfunction</td>
<td>Insufficient counselling inputs</td>
<td>Medication; interface for minor problems</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>Predisposition</td>
<td>Specialised medical discipline that is psycho-social, cultural/holistic</td>
<td>No gaps</td>
<td>Works with education about psychiatry</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>Interested</td>
<td>Clinical model; psychiatry takes care of all mental illness</td>
<td>No gaps as such</td>
<td>Good idea only if other systems deal with biology of mental illness</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>Interested; mother psychologist; easier for women</td>
<td>Clinical model</td>
<td>Only addresses core mental illness</td>
<td>Conditional, homeopathy better for children</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>Interested; father psychiatrist</td>
<td>Medical speciality; psychiatry an amalgamation of science and art</td>
<td>Requires team effort</td>
<td>Conditional, should not hamper treatment</td>
</tr>
<tr>
<td>9</td>
<td>M</td>
<td>Interested</td>
<td>Psychiatry takes care of mental disorder</td>
<td>Not enough psychotherapy</td>
<td>Conditional; no medicines</td>
</tr>
<tr>
<td>10</td>
<td>M</td>
<td>Interested</td>
<td>Mental illness wider than what psychiatry covers</td>
<td>Not like physical problems</td>
<td>Do not trust</td>
</tr>
<tr>
<td>11</td>
<td>M</td>
<td>Predisposition</td>
<td>Limited concept; psychiatry covers more</td>
<td>Not trained in psychotherapeutics</td>
<td>Not a good idea</td>
</tr>
<tr>
<td>12</td>
<td>M</td>
<td>Interested in mind</td>
<td>Bio-medical</td>
<td>No rehabilitation/recovery</td>
<td>Open to some systems, with reservations</td>
</tr>
<tr>
<td>13</td>
<td>M</td>
<td>Interested; father a psychiatrist</td>
<td>Medical model</td>
<td>No gaps</td>
<td>Will not work with faith healers</td>
</tr>
<tr>
<td>14</td>
<td>M</td>
<td>Interested</td>
<td>Mental illness bigger than what psychiatry covers</td>
<td>Poor detection; one philosophy cannot answer all questions</td>
<td>Interfaces with a Maulana, seeks treatment compliance, strategic alliance</td>
</tr>
<tr>
<td>15</td>
<td>M</td>
<td>Interested; father and uncle psychiatrists</td>
<td>Clinical model</td>
<td>No gaps; developing</td>
<td>Complimentary</td>
</tr>
<tr>
<td>16</td>
<td>M</td>
<td>Interested</td>
<td>Neuro chemical model. Mental illness wider than what psychiatry deals with</td>
<td>Counselling</td>
<td>No harm</td>
</tr>
</tbody>
</table>

*Continued on the next page*
<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>Interested</th>
<th>Multidimensional</th>
<th>Gap between theory and practise</th>
<th>Don’t mind, do not interfere with treatment plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Male</td>
<td>Interested</td>
<td>Multidimensional</td>
<td>Gap between theory and practise</td>
<td>Don’t mind, do not interfere with treatment plan</td>
</tr>
<tr>
<td>18</td>
<td>Male</td>
<td>Interested</td>
<td>Clinical model</td>
<td>Needs multidisciplinary effort</td>
<td>Don’t mind, do not interfere with treatment plan, do not encourage</td>
</tr>
<tr>
<td>19</td>
<td>Male</td>
<td>Interested</td>
<td>Multidimensional</td>
<td>Need multidisciplinary effort</td>
<td>Don’t mind, do not interfere with treatment plan, do not encourage</td>
</tr>
<tr>
<td>20</td>
<td>Male</td>
<td>Interested</td>
<td>Multidimensional</td>
<td>Lack of awareness, cannot adhere to texts</td>
<td>Open to the idea</td>
</tr>
<tr>
<td>21</td>
<td>Male</td>
<td>Interested</td>
<td>Clinical model</td>
<td>Not enough known about aetiology</td>
<td>Sceptical</td>
</tr>
<tr>
<td>22</td>
<td>Male</td>
<td>Interested</td>
<td>Clinical model</td>
<td>-</td>
<td>Sceptical</td>
</tr>
<tr>
<td>23</td>
<td>Male</td>
<td>Interested</td>
<td>Clinical model</td>
<td>-</td>
<td>Sceptical</td>
</tr>
</tbody>
</table>

Note:  F = Female, M = Male