Chapter 4
The Ayurveda Practitioners:
Integrated/Disintegrated Epistemologies

The previous chapter focused on psychiatrists in India and examined how open or closed they are to interfacing with other systems. It also examined how they view mental disorder and how this impacts their attitude to and perception of other systems. This chapter will examine another important health care system; one that owes its inception to completely local/indigenous conditions and that has, despite the overarching influence of modern biomedicine, stood the test of time. It was assimilated from several sources at its onset, grew slowly and steadily; a part of it became professionalised and institutionalised and re-structured itself to adjust to modern conditions. That system is Ayurveda. This chapter will examine this system of health care in the context of its practitioners and with reference to mental disorder.

The biomedical model of health and illness is powerful and thriving across the world. In India, state-sponsored health care is based on biomedicine (Sujatha et al. 2012), and reflects its long term ideological supremacy (Frakenberg 1981). The biomedical ontology is based on such concepts as observation, hypothesis, experimentation, and is evidence-based (Lake 2007; Salud 2010), making it scientific and rational. Biomedicine is certainly the cornerstone of modern health care and, in India, it goes back two hundred years, whence it came from Europe (Sujatha et al. 2012). Despite all of this, more than 70 per cent of India’s 1.1 billion population uses non-allopathic systems of medicine (Kushagra et al. 2011). For India is home to other medical systems as well, laying credence to an almost unparalleled plurality in health care and culture anywhere in the world.

Some of the varied systems of medicine, apart from bio-medicine, are Ayurveda, Siddha, Unani, Homeopathy, Naturopathy, yoga and a whole host of folk and traditional practices (Sebastia 2009a; Sujatha et al. 2012) including those associated with religious spaces. Ayurveda is an ancient codified system of medicine that originated in India with a mythic story dating back to gods and goddesses. ¹It not only refers to a system of treatment of diseases, but also addresses ways of healthy living (Dahanukar et al. 1989). More about this system, which is the crux of this chapter follows, after a cursory look at the systems other than Ayurveda that dot the plural health systems landscape of India,

¹ A combination of two words ayu (life) and Veda (knowledge), Ayurveda is believed to have been taught by the creator Brahma.
beginning with Siddha. This is to provide an understanding of the truly wide array of therapeutic options available, other than psychiatry in the Indian context.

According to O. Somasundaram, ‘The origin of Siddha is shrouded in mythology, tradition, and religion’ (2009: 28). The Siddha system is mostly found in southern India and its texts are largely in Tamil and Telugu languages. The Siddhars were a group of heretics who belonged to the non-Brahmin communities and critiqued Brahmanical Hinduism and religious orthodoxy. They promoted the use of herbal and mineral substances that aid yogic attainments (Sujatha 2012) and in ‘rejuvenation and longevity’ (Somasundaram 2009: 28). This system is based on the concept of the *panchabhuta* (five elements) and *tridosa* (three humours) theory. Harmonious function of both ensures positive health, and alteration affects physical and mental health. The Siddha system classifies mental illness on the basis of symptomatology. Among the treatises on this system, Akattiyar manitakkirukkanul-64 and Yuki cintamani-800 are ‘noteworthy’ (ibid.: 32). The former work by Akattiyar mentions eighteen types of psychoses. Mental illness has also been classified based on aetiology, and there is mention of bilious insanity, phlegmatic insanity and possessed insanity. Accordingly, this work describes eighteen varieties of medicine for the types of psychoses mentioned as well as general medicine.

The origins of the Unani system of medicine can be traced back to the doctrines of ancient Greek physicians Hippocrates and Galen. The development of Unani as a healing system is also credited to a Muslim scholar Avicenna who wrote a medical encyclopaedia, *The Cannon of Medicine*. While Avicenna was influenced by Greek and Islamic medicine, he also drew from the works of Sushruta and Charaka. Unani first arrived in India during the 12th and 13th centuries with the establishment of the Delhi Sultanate and Islamic rule over north India (Javed et al. 2009; Singh 2012).

Management of disease within the Unani system is based on diagnosis dependent on signs, symptoms as well as *mizaj* (temperament). Abnormal humours lead to pathological changes. Post diagnosis, *Usoole Ilaaj* (principle of management) is determined by three steps, namely, elimination of causes, normalisation of humours and normalisation of tissues and organs. There are different kinds of therapies involved including aromatherapy, regimental therapy, cupping, pharmacotherapy and surgery. In Unani, healing is based on the principles of ‘harmony and balance, uniting the physical, mental and spiritual realms’ (http:11).

The concept of *Amraz-e-nafsaniya* (psychiatric disorders) is mentioned by many scholars and Unani physicians including Soranus of Ephesus (98–138 CE), Areataeus
(150–200 CE), Galen (131–210 CE), Rhazes (850–925 CE), Al-Majusi (930–994 CE), Abu Sahal Masihi (1010 CE), and also Avicenna (980–1037 CE) (Javed et al. 2009). They mention several psychiatric disorders including delirium, melancholia, hysteria and insomnia. A separate mention of what is termed Quwwat-e-nafsaniya (the psychic faculty) has been made while describing the faculties of the human body. Avicenna’s The Cannon of Medicine mentions five faculties of the interior senses. Similarly Ibn-e-Nafees (1210–1288 CE), in his book, Kulliyat-e-Nafeesi (Book on Fundamentals), has examined the effect of psychological signs and symptoms on the body. These works describe mental and psychiatric disorders and examine causative factors, clinical features and also differential diagnosis of psychiatric disorders along with their management (ibid.).

Homeopathy in India can be traced to the early 19th century (see Ghosh 2010) when Johann Martin Honiberger of Romania treated Maharaja Ranjit Singh in Lahore in 1839 (http 12). The first homeopathic college was established in 1881 and, in 1973, the Government recognised it as a national system of medicine (Ghosh 2010). Modern practice of Naturopathy has its roots in Europe and the term was coined by John Scheel in 1895 and popularised by Benedict Lust in the United States. This science of healing is also traced to Vedic times and purports ways of healthy living and addresses disease by seeking to restore displaced harmony in the body. It is a holistic method of healing that looks at stress reduction, healthy diet and lifestyle changes.

Yoga is, of course, intrinsic to India, and is traced to Patanjali who was a philosopher, grammarian and a physician. Yoga like the previously mentioned systems seeks to unite mind, body and soul, and the body must be accordingly strengthened through the practice of various aasanas or yogic postures. It also involves breathing exercises to calm the mind, among other things.

There are also many folk and traditional practices that are neither organised nor institutionalised, but are as popular. There are healers in various traditions including those associated with religious spaces like churches, temples and mosques. These healers reach out to a large number of people and are deeply embedded in particular communities and groups.

Indigenous systems of medicine like the above play an important role in meeting the health needs of people and have become popular in the past few decades because of a host of reasons including ‘efficacy’ of the practitioners themselves, their ‘social and political power’, and their ‘growing market share’ (Sujatha et al. 2012: 2). These systems of medicine, especially Ayurveda, have also been associated with strong nationalist
sentiments and are often positioned as such against western biomedicine. Ayurveda has been generally invoked to exemplify a uniquely Indian cultural practice as well (ibid., Langford 2004).

In response to the popularity and outreach of these non-western systems of medicine, the Ministry of Health and Family Welfare, Government of India established the Department of Indian Systems of Medicine and Homeopathy (ISM&H) in 1995, and it was later renamed the Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH) in 2003 ‘with a view to providing focused attention to development of Education & Research in Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy systems’ (http 13). The Department looks at issues like educational standards, quality control and standardisation of drugs, research and development, increasing awareness about the efficacy of such systems both at the national and international standards, etc. (ibid.).

Ayurveda: A Brief History

The exact origins of Ayurveda are difficult to pinpoint (Varier 2002; Fabrega 2009; Jayasundar 2012). Codified Ayurveda has been traced to at least 1,500 years prior to Hippocrates (Jayasundar 2012). It has been described as ‘A way of life, a philosophy and a science of healing and health care’ (Varier 2002: 1). The fundamental basis of Ayurveda are the darsanas, which are texts dealing with the perception of the world and universe in ancient India (Jayasundar 2012). Some scholars have attributed its inception to divine sources as well (see Jaggi 1976), in accordance to the traditional origins of the vedas. Sushruta, one of the two persons indelibly associated with Ayurveda, termed Ayurveda an upanga (intrinsic) of the Atharva Veda (Kutumbiah 1962; Thakar 2010). The

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2 Darsana can be compared to the concept of theory. As in the latter case darsanas are associated with the names of their formulators, Kanada’s Vaisesika, Gautama’s Nyaya, Jaimini’s Purva Mimamsa, Kapila’s Samkhya and Patanjali’s Yoga and Vyasa’s Vedanta. Vaisisika are concerned with the organic structure of the universe, and is a materialist school whose logical teachings have been used to understand the human body and diseases and treatment as well. Samkhya and Vedanta are more metaphysical and concerned with creation and relationships and their philosophical implications (Jayasundar 2012).

3 One version states that god Indra learnt it from the Ashwin twins who were physicians to gods, who had learnt it from Daksha Prajapati who, in turn, learnt it from Brahma, the Supreme Creator. Sage Bharadvaja learnt it from Indra and taught it to sage Attreyya who taught it to six students including Agnivesha, Bhela, Jatukarna, Parasara, Harita and Ksirapani. The version that Agnivesha wrote was revised by Charaka and eventually termed Charaka Samhita. Similarly Dhvanvantari, the King of Benaras revealed it to Sushruta (Kutumbiah 1962; Jaggi 1976).

4 The Vedas are the earliest known sacred books of India. There are four Vedas, namely Rigveda, Samaveda, Yajurveda and Atharva-Veda (Kutumbiah 1962).
predominant mythic story relating to Ayurveda is that of its divine primordial origins and its ineffaceable connection with the sacred texts, the *Vedas*.

**Role of Ancient Text**

The pre-Vedic period was epitomised by the belief in the external causes of diseases. Treatment of disease was based on cauterisation by fire, bathing, use of herbs, diet, massage, use of purgatives and diuretics accompanied by rituals, spells, incantations, ritual sacrifices and prayers.

Many ancient works formulated during the pre-Vedic and Vedic age provides the precursors to Ayurveda. One version mentions Ayurveda as intrinsic to the Atharva Veda (Kutumbiah 1962; Jaggi 1976; Thakar 2010). Another is that Vedic medicine is deemed to have ‘evolved into Ayurveda’ and, in doing so, crossing an epistemological divide from metaphysical/magical/religious to physical/somatic/organic phenomena (Fabrega 2009: 194, 195). The emphasis of the pre-Vedic age to explain sickness and health involved metaphysical and religious ideas, including sickness caused by gods, demons and spirits and treatment involved incantations, hymns, wearing of amulets and other procedures to placate the gods. Disease was a magical or magico-religious phenomenon (Kutumbiah 1962). The larger cosmos was connected to health and illness, to pain and suffering and this idea can be traced to ancient Indo-Aryan and pre-Indo-European people (Fabrega 2009). The Vedic age saw a shift to a more naturalistic emphasis looking at physiological, anatomical and organic causes. Treatment included herbal preparations, emesis, purgation and the like (ibid.). There was no distinction between mental health and physical health and all treatment was aimed at an amalgam of both. This non-dualistic understanding of health is particularly significant, especially in the light of a clear separation between mind and body in western biomedicine. Here too religion and magic continued to play a role, such that treatment was a combination of religion, magic and empirical and rational elements (ibid.; see also Kutumbiah 1962). Diseases were caused by possession of evil spirits, wraths of the gods, evil deeds and sorcery as well. Incantations, charms, rites and rituals, offerings, penance were all a part of the treatment regime. Magic was an important element (Kutumbiah 1962).

Mention of disease and treatment appear in the early portions of the Rig Veda, but a more advanced knowledge of the same is found in the Atharva Veda, which also mentions

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5 The Rig Veda mentions diseases like *jvara* (fever), *kushtha* (leprosy), *rajayakshma* (tuberculosis), blindness, deafness, sterility and baldness. Hymns in the Rig Veda also mention treatment for fatal wounds (Verier 2002).
specific medicines. Detailed description of parts of the human body also reflects advanced knowledge about human anatomy as well as health and healing along scientific lines. The Atharva Veda also contains information about mental and physical disorders ‘caused by curses and wraths of the gods’. It combined two epistemologies thus ‘blending the science of health with a supernatural element’ (Varier 2002: 4). The Atharva Veda mentions charms and drugs, but the latter occupied a subordinate position (Kutumbiah 1962). Both the Rig Veda and Atharva Veda are seen to have contributed to Ayurveda.

Post-Vedic medicine can be divided into two parts: one, extending from the completion of the Vedic hymns to the rise of medical schools, and the second that extended from the rise of the medical schools to the end of classical Indian medicine (ibid.). Two centuries between the completion of the Vedic hymns and the rise of medical schools saw the influence of works like the Brahmanas and the Upanishads. Though there are no records of medical practices during this period, non-medical sources indicate that, in the period following the Atharva Veda, studies were confined to bhuta-vidya (demons), sarpa-vidya (poison), pitiya-vaiddya (spirit of ancestors), rasayana (chemistry) and vajikarana (aphrodisiac therapy) though it was still dominated by demonology (ibid.).

The term ‘Ayurveda’ was not used in either text and appears for the first time only in the samhita traditions, though Atharva Veda is deemed to be closer to Ayurveda (Varier 2002). The samhitas mention the principle of the tridosas for the first time. They constitute the earliest literature on medicine and were seen as an attempt to systematise existing medical knowledge. Three important samhitas are those of Charaka, Sushruta and Bhela. The samhitas of Charaka and Sushruta form the classics of ancient Indian medicine. The medical schools of Charaka and Bhela conform to the tradition of an astanga Ayurveda, or an Ayurveda with eight divisions (Kutumbiah 1962). Four divisions were common to Ayurveda and Atharva Veda, including bhuta-vidya (demons), sarpa-vidya (poison) rasayana (chemistry) and vajikarana (aphrodisiac therapy), and this might also explain the earlier mentioned connection between the two; but Ayurveda additionally had four other divisions, that gave it a decided empirico-rational bent, as opposed to the Atharva Veda where ‘magic eclipses everything’ (Kumtumbiah 1962: xi). By and large, ‘Vedic medicine did not make a marked difference between disease and demons’ (ibid. xii). But even at the time of the Atharva Veda there were physicians treating diseases with

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6 The samhitas are a corpus of technical work that focused on scientific reasoning and marked a shift from divinity and magical spells.
drugs made of herbs, which were also used in amulets for protection against disease as well as witchcraft (ibid.). Elements of the rational and metaphysical were thus bound together.

The Ayurvedic knowledge system matured considerably by the middle of the first millennium BCE including treatment for ‘well-being, longevity and rejuvenation’ (Varier 2002: 9). By and large, the samhitas of Charaka and Sushruta and the Ashtangasamgraha of Vagbhata together are seen to constitute the corpus of Ayurveda (Abraham 2009).

A dominant influence on Ayurveda was also from the Samkhya and Vaisesika traditions of philosophy, although Vedanta and Nyaya also contributed (Gupta 1977, Fabrega 2009). The Mauryan king Ashoka played an instrumental role in the unification and standardisation of the knowledge and practice of the system (Fabrega 2009). The period between the 7th and 8th centuries CE saw the formation of regional cultures, including religious groups, followed by incorporation of local variations and innovations in Ayurveda. A new development was the adoption of Ayurveda by affluent urban centres. The formation of local regional groups saw the adoption of separate traditional practices for each group including medicine. Ayurveda percolated to various communities; regions now had their own gurukulam (learning centres) practices to impart Ayurvedic knowledge.

Linguistic groups too adopted and developed their own versions of the Ayurvedic system incorporating local wisdom. Ayurveda received patronage from kings and lay people alike. Places like Kasi (Varanasi), Taxila, Nalanda and Pataliputra (Patna) were reputed seats of Ayurvedic learning. The other ancient classics that Ayurveda is seen to draw from apart from Ashtangasamgraha include Ashtanghridya Samhita, Bhela Samhita, Nava Nitaka or the Bower manuscript, Madhava Nidana and Bhavaprakasha (Jaggi 1976).

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7 Vagbhata was a disciple of Charaka and wrote two important works, Ashtangasamgraha and Ashtanga Hridayam Samhita.

8 For instance the co-presence of purusa and prakriti, that is consciousness and materiality, nature of the material subtle body and its components, what the gross body is composed of are all Samkhayan ideas (Fabrega 2009).

9 A parallel development was that of quackery; they ‘meddled with the accuracy and efficacy of the system’ (Varier 2002: 11).

10 An example is that of the ashtavaidyans of Kerala (Varier 2002; Abraham 2009).

11 Kerala is a good example of this process. The practice of ayurveda in Kerala has its own distinct local flavour, including the ‘use of basic granthas, yoga and combinations of medicines’. Kerala had a well-developed medical tradition prior to arrival of the Sanskrit, textual tradition of Ayurveda. The preferred text is the Ashtangasamgraha of Vagbhata and not the Samhitas of Sushruta and Charaka (Abraham 2009: 12).
The key point is that India developed a naturalistic approach to medicine and disease and not just metaphysical and religious. Further the two epistemologies or biology and culture were fused in laying down a holistic cosmological understanding of health and illness. With regard to Ayurveda, the understanding is that, while the origins of it remain obfuscated, Ayurveda has drawn considerably from several ancient texts, especially the Atharva Veda. Disease during the pre-Vedic period was seen as the result of malevolent forces and had a strong element of magic associated with it where disease was caused by supernatural forces and treated with magic, incantations and other rituals (ibid.). But there was also a simultaneous focus on empirico-rational elements including elaborate pharmacopoeia. In fact, both epistemologies were combined effectively such that amulets contained medicines made of herbs that were supposed to work in a supernatural way; medicines were internal amulets. Accordingly, the ‘functions of the priest and physician were combined in one and the same person’ (Kutumbiah 1962: xiv).

Medicine was largely drawn from the Rig Veda and the Atharva Veda but was also influenced by popular and folk cultures (Fabrega 2009). Priests were highly sought and they often taught healers ritual performances. There were also wandering medical healers who amalgamated their practices with mendicant Buddhist medical practitioners. It would appear that, at the time of the Atharva Veda, there were physicians treating diseases with drugs. Two systems existed, one that saw the prescription of charms by priest-physician and the other that saw the prescription of drugs by ordinary medical practitioners. The use of herbs as medicines used in a rational way actually marked the beginning of the separation of the empirico-rational medicine from the magico-religious medicine (Kutumbiah 1962).

Medicine in India thus moved from a mythical, semi-mythical to a historical beginning (ibid.). It is believed that, Attreya, a noted pioneer of Ayurveda was taught medicine by god Indra and surgery was similarly taught to Dhanvantari. Both, in turn, taught their respective subjects to six students each, who in turn wrote several treatises on medicine and surgery. Sushruta was one of these students.

Knowledge about management of illness and health has been drawn from other sources like the Bhagavad Gita and the Dharmasastra as well. This was a holistic and cosmological understanding of health as noted earlier, that involved not just the organic elements but the metaphysical as well. All of these have been seen to add to to the corpus of Ayurvedic knowledge. The Astangasamgraha by Vagbhata along with the compilations of Sushruta and Charaka is considered as one of the canonical works of Ayurveda (Varier
However, Charaka, at the very beginning of his *samhita*, defines the meaning and scope of Ayurveda and deems it ‘the science of life...the union of body, senses, mind and soul’ (Kutumbiah 1962: xix).

The doctrine of the human body, therapy, disease, diagnosis and health in classical medicine is based on what is termed *bhutas* or the five elements or elementary substances, namely, water, fire, air, earth and ether, and *dhatu*, which are modifications of these five elements. Equilibrium is what maintains health and disequilibrium causes disease (ibid.).

According to Kutumbiah,

‘The sole aim of Ayurveda is to prescribe diet, medicines and a regimen of life such as, if properly followed, will enable a normally healthy man to maintain the equilibrium of his *dhatu* [italics mine] and one who has lost his equilibrium to regain it, i.e., to advise man how to preserve or secure health’ (1962: xx).

**Ayurveda in the Post-Vedic Age**

After the 16th century no major work of Ayurveda was published (Jaggi 1976), but it did see various additions. Sexually transmitted diseases were included for the first time in 1600 and the first Ayurvedic dictionary was published between 1800 and 1830, drugs started to be manufactured between 1860 and 1870. Between 1870 and 1900, efforts were made to disseminate Ayurveda in the regional languages; an Ayurvedic magazine was published in Bengali and the Charaka Samhita was translated into Marathi and Gujarati as well. Ayurvedic societies were started along with colleges. A large number of scholars were also doing research on Ayurveda12 (Dahanukar et al. 1989).

Despite such attempts, Ayurveda did suffer too, especially with the advent of colonialism, modernity and western medicine. The year 1836 marked the end of the period of British patronage of Ayurveda, whence it was studied alongside European medical science at the Native Medical Institution during the previous decade. Thomas Babington Macauley overturned the dual educational programme in 1835 when he declared that all Indian higher education will be conducted in English and modelled on the British system, emphatically marking the superiority of European knowledge. The period of intermingling of modern medicine with classical Indian medicine was rather

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brief and Indian knowledge system was decisively differentiated. The attempt was also to produce ‘the Indian practitioner of European medicine’ (Langford 2004: 6).

By the end of the 19th century, Ayurvedic practitioners began to realise that, to counter the growing hegemony of European medicine, they had to learn from the latter; professional associations, colleges and pharmaceutical firms were established (ibid.). Ironically, it was also seen to be out of step with modernity and reflected in the ambivalent position that the elite designing the nation took. For instance, most members of the Indian National Congress preferred European medicine over Ayurveda, but passed a resolution in support of Ayurvedic medicine in the 1920s. For the practitioners, this was an opportunity to establish Ayurveda in contrast to modern medicine. ‘...Ayurveda gradually transformed from an eclectic set of healing practices to a quintessentially Indian medicine’ (ibid.: 7). Further, in order to qualify as a medical system, practitioners recognised that ‘Ayurveda had to be arranged into college courses, institutionalized in hospital procedures, scientifically proven in clinical research, and ordered into new taxonomies of drugs and diseases’ (ibid.: 7). The tussle between becoming modern yet authentic and all the complexities that this process brings on had begun for Ayurveda and continues.

Without going into further details, suffice it to say that the practice of Ayurveda diachronically follows both traditional and modern modes. One is traditional Ayurveda, practised by vaidś (physician) who have learnt it from a guru (teacher) and who, in turn, teach apprentices. The other option was to go study in a gurukul (centre of learning) like Nalanda or Taxila (Jaggi 1976). This has transformed into the modern institutionalised version of Ayurveda taught in private or government colleges across the country, governed by rules and regulations, monitored by a government body. This is to actively promote the practice in response to a global need to promote, preserve and develop indigenous forms of medicine. The former is pre-modern, pre-colonial, pre-institutionalised Ayurveda and the latter is a modernised, formalised and institutionalised Ayurveda. Both exist simultaneously.

There is then no one practice of Ayurveda. As Jean M. Langford states, ‘The name Ayurveda has a powerful polyvalence ...’ (2004: 9). The earlier orientalist rendition

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13 The term vaid is seen to derive from the word vidya, or knowledge. But it could also refer to a learned person of any description. But by the time of Charaka the term attained a specific meaning; the vaid or vaidyas were a ‘recognised craft group...following the profession of their fathers and forefathers.’ Vagbhata for instance mentioned that his father and grandfather were both physicians (Basham 1976: 23)
attempted to locate it in ancient texts alone rather than in the field of practice. In fact, the latter was seen to reflect the decline of Ayurveda, despite cosmopolitan practitioners attempting to systematise and standardise it. Ayurveda in the 20th century has been reinvented as a medical system to compete with European medicine and also ‘offer a corrective for it’ (ibid.: 11). But Ayurveda has assumed the role of a cultural and political entity and project too at certain times, when it has become synonymous with being a Hindu practice, for instance. It has oscillated between being a medicinal practice and a cultural one; medicine constitutes only a part of Ayurveda and not the whole of it (Abraham 2009). Recent trends in the path of modernising Ayurveda include the mass production and manufacture of proprietary drugs made for a global market reflecting the commodification of Ayurveda in a neo-liberal market (Abraham 2009; Banerjee 2009).

**Ayurvedic Conception of Health and Disease**

In Ayurveda the person is viewed as a system of relationships and health is a combination and balance of different elements. This view is at once both individual and cosmological; it is also non-dualistic. In this view, everything in the world is ultimately composed of pancha bhutas (five elements), prithvi (earth), apa (water), teja (fire), vayu (air) and akash (ether). These five elements combine in pairs to constitute what is termed tridosas, or the three dosas: vata (ether and air), pitta (water and fire), and kapha (water and earth). While the dosas can refer to several things like movement, transformation, or to physiological parameters, literally the term means ‘that which can become impaired and also has the potential to impair other tissues’ (Jayasundar 2012: 43).

It is difficult to get an exact translation of the term dosas; the closest would be biological type or physical constitution. But in Sanskrit, it also refers to that which contaminates. So dosas could be pathogenic factors or disease-causing agents in the body. Imbalance of the tridosas, namely vata, pitta and kapha cause disease in the body (http 14). The dynamic balance of tridosas creates health. The tridosas represents a set of functions as well as certain parameters that are physico-chemical and physiological in nature. For instance, vata represents dryness, lightness, coldness, roughness and movement; pitta refers to parameters like heat, fluidity and causing movement; kapha indicates unctuousness, coldness, heaviness, sluggishness, smoothness and firmness (ibid.).

The tridosas cover both physiological and psychological functions. These three primary forces, that is vata or motion, pitta or energy and kapha or inertia control all
functions of the human body and are produced and regulated endogenously. These dosas, in turn, influence the dhatus (tissues) (Dahanukar et al. 1989). Dhatus have also been described as different entities and are seven in number: ahara rasa (food juice), rakta (blood), mamsa (flesh), medas (fat), asthi (bones), majja (bone marrow) and sukra (semen) (Jaggi 1976). Digestion and assimilation produce two products, prasadas which maintain and sustain the body and malas that which pollute the body and needs to be expelled. Malas includes urine, faeces and sweat and are waste products (Jaggi 1976).

According to Charaka, disease can be caused by three sets of factors, namely nija (internal), agantu (external) and manasa (psychological). All three are related and affect one another. The dosas need to be in harmony and increase or decrease in one will influence the other and result in impaired functions (Jayasundar 2012). This model is a holistic and non-linear model. The constitution of a person is important in determining balance and equilibrium in the dosas. Diagnosis is not simply naming the disease, but would involve an elaborate process that includes identifying the predisposing causes, symptoms and full extent of the disease. Increase and decrease of the dosas has to be assessed. Treatment would include correcting the imbalance of the dosas through diet and drugs (Jaggi 1976).

The Ayurvedic compendium comprises eight branches including internal medicine, surgery, ophthalmology and ENT (eyes, nose, and throat), paediatrics-obstetrics-gynaecology, toxicology, geriatric and nutrition, sexology and psychiatry and demonology (bhuta vidya). The letter has been described by Frederick Smith as the ‘science of existent beings.....believed to cause various diseases, including certain forms of mental illness’ (2006: 472). There are other more intricate and detailed concepts involved in Ayurveda that contribute to the understanding of health and disease; their discussion, however, is outside the scope of this research.

**Ayurveda and Mental Disorder**

Indian classical medicine, as seen above, contained both metaphysical and rational elements. In general, Vedic medicine adopted a holistic approach wherein all types of medical, psychological and spiritual problems were addressed. Specifically, two kinds of insanities are represented in Vedic medicine: one is caused by the violation of divine mores and taboos (unmadita) and the other, by the possession of demons
Propitiatory offerings were made to the gods for *unmadita* and medicines were prepared to calm the patient and drive away the evil forces for *unmatta*.14

The Atharva Veda describes at least twenty types of mental illness and community rites to address them. Some of this includes *upasana* (devotional worship), *namaskara* (bowing in reverence), *vandana* (acknowledging the greatness of god) *seva* (social service) and so on (Fabrega 2009). Specifically, the Atharva-Vedic medicine is an amalgam of religion, magic and empirico-rational elements. Therapy included healing rites, mantras, amulets, talismans and charms mostly to expel demons (Kutumbiah 1962; Fabrega 2009). The parameters of psychiatric condition involve disorganised, disruptive behaviour, loss of emotional control or an altered state of consciousness. During the Vedic times, psychiatric conditions were mostly attributed to benevolent and malevolent deities.

Ayurveda incorporated ideas and beliefs from ancient Indian philosophical works like the Vedas. This also influenced its approach to and treatment of psychiatric disorders. The Charaka Samhita mentions three kinds of therapy: spiritual, rational and psychological (Smith 2006). It also mentions different kinds of fevers and fever due to excited or faulted humours manifesting in accidental insanity. In Ayurveda, five types of human constitutions are mentioned depending upon the balance of the three humours, that is, *vata*, *pitta* and *kapha*. These constitutions are at times viewed as personalities that ‘protect, facilitate, and modify disease, including insanity’ (Fabrega 2009: 273). Insanity also involves spiritual attack or possession where certain personality types and temperament are linked to types of offending spirits and behavioural manifestations. There are generally five varieties of psychiatric conditions, four endogenous or humour based and one exogenous or caused by outside forces including eating impure or improper food, attacks by deities and mental shock caused by fear and joy (Fabrega 2009).

The Sushruta Samhita, which constitutes an early foundational text of Ayurveda, also mentions psychiatric disorders. While it is seen as making a significant contribution to surgery, a part of the text, a supplementary section termed Uttaratantra mentions additional disease that can be equated with psychiatric conditions (ibid.). This also mentions fevers and a class of fever is ascribed to malignant spirits and is to be dealt with by incantations, bindings and beatings. But it also deals with *unmada* or disease of the mind. This involves a derangement of the bodily *dosas* making it an organic condition.

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14 Even without the advent of any system of medicine, communities had developed concepts about mental illness and its management (Fabrega 2009).
and includes six kinds; three stem from each of the three *dosas* that have become deranged and aggravated, one from their combination, one due to grief and one due to the effects of poison. The last two are additions that do not appear in the Charaka Samhita. One is termed *sokaja* and refers to grief and the mental distraction that it causes and the other is termed *visaja* or insanity caused by poison. The symptoms would differ, the latter showing more organic symptoms like redness of eyes and a dull complexion (ibid.). Treatment involves a series of herbal and physical procedures including fumigation, the use of powders, herbs, emetics and purgatives.

The Susruta Samhita’s Uttaratantra also mentions metaphysical insanities termed *bhutas* (same as exogenous by Charaka Samhita), where the cause is supernatural including ghosts, deities, demons and even serpent deities. These elements are deemed to roam the world in search of victims; those of impure mind, body and action qualify as victims. Symptoms are different for possession by each agent; those attacked by deities behave in a godly, spiritual way; those attacked by a demon would speak ill of the gods (ibid.). Treatment for this kind of insanity would include taking religious measures like chanting, offerings to gods and practice of rituals. The term *bhutavidya* first appears in Chandogya Upanishad, indicating animate and inanimate beings (Smith 2006). Various categories of *unmada* and exogenous disease causing spirits and categories of *bhutavidya* in Ayurvedic texts have also been studied (ibid.).

Vagbhata’s Ashtangasamgraha also mentions certain psychiatric conditions caused by aggravated *dosas* of mind and body and vivid descriptions are provided. Insanity due to *vata* produces senseless and irrational behaviour, *pitta* causes high energy, loss of control and coordination; and *kapha* causes quietude and isolation (ibid.). Similarly the Bela Samhita mentions characteristics of insanity, but also mentions insanity resulting from unforeseen circumstances.

Ayurveda thus contains very detailed accounts of various kinds of mental disorder. It involved a partly rational/naturalistic epistemology, but also had strong elements of the metaphysical. Both were integrated in a holistic manner and treatment practices drew from both and often combined them. With the advent of historical exigencies, there was a certain amount of disintegration between the two epistemologies; given the popularity of western biomedicine with its evidence-based focus, the focus shifted to the rational side. This was more so for the modern institutionalised, formalised, version of Ayurveda.

The question is: given its historical roots and orientation, how does Ayurveda, which was drawn from several sources and at one point combined epistemologies to address
health and healing, respond to other systems of health in the present time? The primary reference point here is biomedicine and psychiatry, given the preponderance of the latter in addressing mental disorders.

**Ayurveda and Interface**

The concept of interface is significant in the context of Ayurveda. Historically, it has drawn from local and folk cultures. It has an eclectic beginning whence it was drawn from sacred texts with differing emphasis. Today, Ayurveda is often juxtaposed to the modern biomedical system. At one level, it is seen as distinct from modern medicine in a number of ways, especially in the way it conceptualises health and illness. For one, the psychic and somatic components are integrated in Ayurveda unlike in modern medicine. It postulates a non-dualistic understanding of health and disease. Scholars like Gananath Obeyesekere (1976) and Sudhir Kakar (1982) note that, in biomedicine, the body is fixed and bounded. But, in Ayurveda, it is ‘fluid and penetrable’ (Langford 2004: 11), constantly engaged in a dialectical relationship with the social and natural environment around it. Disease is a disequilibrium; a person, body, illness and disease are all processes and involve patterns of relationships (ibid.).

At another level, because its precedents involve an eclectic mix of epistemologies, it also contains strong somatic/organic elements. The institutionalised version of Ayurveda contains rudiments of biomedicine that have also been absorbed without damaging its own fundamental principles; there has been a smooth intermingling of rational and the religio-socio-cultural paradigms. In fact, this distinction, while it existed even in pre-Vedic times, did not become a predominant lens whereby one gained superiority over the other till the advent of modern medicine and the rise of the scientific-rational paradigm. Ancient scholars did recognise both as distinct but did not judge one over the other; they simply acknowledged both as essential to maintaining health and healing.

Ayurveda has, however undergone several courses of change. Modernisation is one. Three important trends that need to be mentioned in this context are: (i) the growth and expansion of colleges teaching Ayurveda, (ii) the use of apparatus and techniques of modern medicine to assess severity of the disease or confirm diagnosis, and (iii) research on modern lines of Ayurvedic drugs and their marketing and sale (Banerjee 2009, Jaggi 1976). Inadvertently though, modernisation has thus also meant interface.

As foundational courses, many programmes in Ayurvedic education teach fundamentals of basic science such as physics, biology, chemistry and zoology, and
anatomy and dissection as well. Ayurvedic physicians use clinical pathology laboratories to ascertain various parameters, like haemoglobin levels or blood sugar level. Modern methods of clinical research are also being used to test efficacy of drugs, by finding out its active chemical component.

Ayurveda has thus undergone phases of integration-disintegration-integration. It was based on an integrated ontology and epistemology initially; in modern times there has been an epistemic break whereby the focus was shifted onto the organic/biological, and the metaphysical relegated to the background. This arm of Ayurveda received further fillip with the process of its modernisation and institutionalisation. This process of accretion and synthesis thus led to the development and growth of a modern rendition of Ayurveda. It was thus reintegrated into a system that drew from modern medicine and assimilated these elements into its own and in the process expanding in scope and reach.

The historical and contemporary backdrop to Ayurveda is important because its interface with the modern system of medicine, in this case with psychiatry, is influenced by it. From the kind of Ayurveda that is practised, to the training received and the understanding of mental illness involved, all influences interface.

Ayurveda now has a pronounced biomedical and organic element woven into its teaching and practice. The modern pharmaceutical rendition of Ayurveda emulates biomedicine in areas like marketing strategy and product research (Banerjee 2009; Bode 2012). Traditional practitioners of Ayurveda use biomedicine in their treatment process too. For instance, Bode (2012) mentions an Ayurvedic practitioner in his study who uses modern medicine to monitor the outcome of Ayurvedic diagnosis and treatment of heart disease. Yet, another Ayurvedic physician in the same study disagrees, because the disease categories are so different between both the systems and have no commonality. A patient’s experience of the illness is more important in Ayurveda than indicators of biomedical tests. Ayurveda unlike biomedicine links multiple dimensions of mind, body and ecology to produce balance and health. Biomedicine looks at a disease class using objective diagnostic tools that explain disease with deeper levels of materiality, such as organs, cells and gene (Bode 2012). Ayurveda engages with the individual experience of illness as much as the organic disease condition if not more.

But, while there are vast differences in terms of ontology and epistemology between Ayurveda and biomedicine, patients have known to approach both for various illnesses including mental illness. But what form does interface take in terms of practice and what
The Interviews

I interviewed eight Ayurvedic doctors; none of them were traditional Ayurvedic practitioners and none had learnt under a traditional guru. All of them had gone to Ayurvedic medical colleges and attained formal degrees and started practice. Initially I began by identifying and interviewing two Ayurvedic physicians in Mumbai. Both were teachers with over two decades of experience working in government teaching hospitals. They had also passed out from government Ayurvedic colleges. While they spoke extensively about Ayurveda and their individual experience, they admitted that they were not really addressing psychiatric illness in any specific way, unless it came as an adjunct to another illness, like diabetes, hypertension or epilepsy. They also said that, in Mumbai, psychiatric illness was not treated with Ayurveda and most cases were referred to modern medicine. They told me about Arya Vaidya Sala, a century-old institution that was established in Kottakkal, Kerala in 1902 for the practice and propagation of Ayurveda, and recommended that I go there. According to its website Arya Vaidya Sala offers ‘classical Ayurvedic medicines and authentic Ayurvedic treatments and therapies to patients from all over India and abroad’ (http 15). Since it is the only institution in the country with an Ayurvedic mental hospital, they thought, I stand to gain by talking to the doctors there.

After Mumbai and before heading to Kottakkal I was in Bengaluru to interview psychiatric doctors from the National Institute of Mental Health and Neuro Sciences (NIMHANS). Besides psychiatry, NIMHANS is also host to the Advanced Centre for Ayurveda in Mental Health and Neurosciences, under the auspices of the Ministry of Health and Family Welfare, Government of India. This Centre is engaged in the study of the effects of Ayurvedic medicine in the treatment of psychiatric and neurological disorders, and in propagating interface between Ayurveda and other systems of medicine.

There has been interface between psychiatry and Ayurveda at NIMHANS with regard to drugs for instance. An Indian Express newspaper report dated 19th November 2009 stated that mentally ill patients at the NIMHANS would avail of Ayurvedic medicine, other than the psychotic drugs that are administered to alleviate their conditions. The Ayurveda centre located at NIMHANS has come up with an Ayurvedic medicine called
‘Ayush Manas’ to help people with mild to moderate mental illness and it was to be tested on patients at NIMHANS.

The medicine, in the form of a tablet, is prepared from four natural herbs and is expected to work as nutrition for the neural cells. It serves as a memory booster and improves the brain’s capacity. ‘Three years of research study, and we have come up with a new formulation called Ayush Manas, which will help improve and restore intellectual functioning of mentally retarded patients’, said Dr B. Chandrashekar Rao, Assistant Director, Advanced Centre for Ayurveda, NIMHANS, quoted in the above mentioned article.

Further citing the advantages of Ayurveda over modern methods of medication, Rao, in the article said, ‘Unlike the MRI scanning which mentally ill people undergo, this natural medicine, in the form of Rasayana (a kind of rejuvenating medicine), stimulates the surviving capacity without any side effects, and even if it is given in higher doses it will not create much of a problem.’ Further Ayush Manas can be taken by healthy people as well. According to Dr Rao, ‘While it helps in restoring the health of the mentally retarded, it also helps in maintaining the health of otherwise healthy people.’ The study, funded by the Central Council for Research in Ayurveda and Siddha, New Delhi, under the Department of AYUSH, Ministry of Health and Family Welfare, was conducted in collaboration with NIMHANS and Ram Manohar Lohia Hospital, New Delhi.

I conducted an additional three interviews here; two with Ayurvedic doctors and one with a mantarwadi/naturopathist/traditional Ayurvedic practitioner at the Centre. I also interviewed the head of a private Ayurvedic institute located on the outskirts of Bengaluru. He had over four decades of teaching experience, apart from practice. I then went to Kottakkal and interviewed three Ayurvedic doctors at the Government Ayurveda Mental Hospital established in 1974. Fully owned by the Government of Kerala, this institution has the distinction of being the only institution with expert Ayurvedic in-patient and out-patient treatment facility solely following an Ayurvedic management of mental illness.

The focus of the interviews was to understand the orientation of Ayurveda to mental disorder and to examine Ayurveda’s interface with regards to other systems and how its practitioners approached interface. The data has been presented in terms of the following themes.


Education

I asked about the education of the Ayurvedic physicians in general and specifically about Ayurveda to see if they had studied Ayurveda in an institution and if they had also studied with a guru and why they chose the particular system to graduate in. All except one had studied in government Ayurvedic colleges in Karnataka, Kerala or Maharashtra or in smaller cities like Nanded in Maharashtra, Trivandrum or Kottayam in Kerala. Kerala has a long-standing tradition of Ayurvedic physicians trained through the gurukul system as well. The interviewees from Kerala said they chose to go to a formal institution to study the subject to have better professional qualifications. Their reasons for studying Ayurveda were varied. Dr Rathnam’s father and uncle are both Ayurvedic doctors - he described his family as ‘hereditary physicians’. Since he grew up with Ayurveda all around him, he obviously chose to study it himself. Two of the interviewees had applied to Ayurvedic colleges, not knowing where else to go since they did not qualify to study modern medicine. Dr Kamat was advised by a neighbour to apply for Ayurveda since he had good marks in the science subjects. He applied not knowing what Ayurveda was exactly. He was told it was a ‘good choice’ to make however. It is important to note that none of them expressed avid interest as a motivating factor to study Ayurveda. Lack of any other choice was a more prominent reason. Five of the doctors interviewed stated that the length of the course, which is over seven years for a basic degree, was exhausting. They were not taught the Ayurvedic subject till the fourth year. In the first three years, they had to learn Sanskrit and study some of the original texts from which Ayurveda is drawn.

The Central Council of Indian Medicine (CCIM) formulates the curriculum for all Ayurvedic courses across the country, both at the Bachelor’s and the Master’s degrees. The BAMS (Bachelor of Ayurvedic Medicine and Surgery) degree includes a two-hundred-mark paper on the philosophy and history of Ayurveda, a hundred-mark Sanskrit paper, a two-hundred-mark paper on physiology that includes both Ayurvedic and modern physiology. The latter includes topics like the blood system, the cardio-vascular system, the reproductive system and the endocrine system. The course also includes ‘practicals’ that involve exposure to modern laboratory equipment and procedures like examination of blood and urine, cardio vascular system, respiratory system and the nervous system. They also have another two-hundred-mark paper on anatomy. Here too there are two theory papers, one Ayurvedic and the other modern where all the systems are studied. Lastly, they have a paper on Ashtanga Hridaya which is for one-hundred marks. This comprises the first year syllabus.
The post graduate course has *Mansik Roga* (mental illness) as a specialisation in which, apart from the Ayurvedic concepts, students are also taught parts of modern psychiatry including the Diagnostic and Statistical Manual (DSM) and the International Classification of Disease (ICD), both of which are used by psychiatrists for diagnosis. They also learn about various diagnostic applications like ECG (Electro Cardiogram), EEG (Electro Encephelogram), USG (Ultra Sonography), MRI (Magnetic Resonance Imaging), CT (Computed Tomography) scan and PET (Positron Emission Tomography) scan used in psychosomatic, psychiatric and neuro-psychiatric practices.

Thus, Ayurvedic graduates are conversant with the modern system of medicine. In fact, as some of the doctors interviewed said, because they have studied science subjects like Physics, Chemistry and Biology in their X and XII standard, it was not difficult to grasp the modern physiology and anatomy subjects that they had to learn. The Ayurvedic concepts, which have no parallel in the school education system, are more complex and take longer for students to grasp and become familiar with. Only one doctor, Dr Kamat, practising in Kottakkal, had done a post-graduate specialisation in *Mano Vigyan Avam Manas Roga* (Psychiatry). Dr Kamat described the course as ‘too lengthy’, and not having to study any ‘medicine for the first three years’ makes it tedious. Anatomy and physiology are studied only in the fourth year.

None of the doctors interviewed stated on record that they had any aspiration to become Ayurvedic doctors, unlike in modern medicine. We may recall, most psychiatric doctors interviewed stated that they were interested in medicine and hence chose to pursue it before doing a specialisation in psychiatry because they were interested in the mind and saw themselves as empathetic and as good listeners (see Chapter 3). The only Ayurvedic doctor interviewed who had a degree in *Manasa Roga* said he was interested in mental health and hence pursued it. Perceptions of both systems are vastly different. Dr Kamat with over two decades of teaching experience admitted that he was not aware that Ayurveda was a medical science before his neighbour asked him to apply for the course.

Dr Rathnam, heading an Ayurvedic college in the outskirts of Bengaluru when the interview was conducted, has been practising Ayurveda for over forty years. He has been involved closely - as a Professor and as Head of the Department - in the workings of five Ayurveda colleges in his career. He has also held various administrative posts during his tenure. He expressed outrage about the lack of awareness regarding Ayurveda, including the kind of expectations that people have from it. But he admitted it has gotten better now,
judging by the number of students who apply. He had two family members (his father and uncle) practising Ayurveda. His choice was ‘easier to make’, he said.

Only one practitioner did not go to a formal Ayurvedic college. He was employed at the Ayurvedic Centre at NIMHANS but not as a physician, but a clerk, a post he has held for years. He had extensive knowledge about Ayurveda and connected it to naturopathy about which he knew quite a lot as well. He said he was also a mantarwadi and had learnt it from his father. He has been advising people about health issues using all three systems for years now. But he said his work with the Centre does not leave him time to practice as a mantarwadi, but when he is in his village he does.

**Mental Disorder**

All the formally trained Ayurvedic doctors interviewed had gone through training in Ayurveda from an educational institution. They had, in other words, all studied the CCIM formulated standard curriculum; none had apprenticed with an older vaid/guru. When asked about Ayurveda and mental illness, all of them described it according to the texts they had been taught. Ayurveda talks about psychiatric disorders at great length. But, in general, it talks about not just disease, but prevention too. In fact, as Dr Kamath stated, ‘Eighty per cent is about prevention’. Ayurvedic texts, they all agreed, had immense details about why people fall ill, physically and mentally. The concept of imbalance plays an important role in determining health and illness. Dr Kamath invoked the concepts of ‘dhee, dhriti and smruti’, to explain it. Dhee is self-realisation and knowledge; to know whether something is good or bad, to be able to discern, the power of reasoning. Dhriti is one’s will power; the capacity to stay away from that which one knows has a negative influence on one’s health. And smruti is the ability to remember and recollect. A derangement in any of these three lead to what is termed pradnyaparadha and is the cause of many diseases.

Dr Devi, heading a hospital that uses Ayurveda to treat psychiatric illness, spoke about two kinds of mental illness, one that is purely psychological and the other caused by an imbalance in the tridosas. She stated that, according to Ayurveda, people are also born with certain vulnerabilities including sins from a previous life or entering a temple without undergoing the prescribed ritual like washing of hands and feet. All of this can become precursors to the onset of psychiatric disease in the future. The other kind that Dr Devi spoke about was bhuta unmada and grahas (planets) that only affect children. Neither has to do with balance and refer to unseen forces that cause a radical change in
personality. There is also dosa unmada, which can be classified into six types: vataja, pittaja and kaphaja and its combinations apart from vishaja and sukhaja. The trigunas, namely, sattva, rajas and tamas are also invoked to explain mental illness. The closest English equivalent to this is quality; it refers to certain qualities of the mind: sattva would refer to knowledge and purity, rajas to action and passion and tamas to inertia and ignorance. Ayurveda provides a distinct description of people based on their manasa or psychology and their prakriti or constitution. Psychological characteristics are dependent on the relative dominance of the gunas. Every individual will have a mix of the three gunas, but one predominant guna will determine his or her manasa prakriti. The three gunas preserve the mind keeping it in a healthy state. Specifically, sattva is pure and cannot be disturbed in any way. But rajas and tamas can be affected by such factors as kama (lust), krodha (anger), lobha (greed), chinta (anxiety), bhaya (fear), moha (delusion and hallucination) and irshya (malice).

Dr Devi pointed out that the understanding of mental health and illness in Ayurveda is theoretically very broad and holistic. Training is what narrows it down sometimes. She also stated that though most people tend to think of Ayurveda only in the context of the psychological or use terms like bhuta unmada, the fact is that, in Ayurveda, the focus has been on putting forth the human body in material terms as well. Charaka too put forth the view that the biological approach or the pharmacological approach is superior to the other approaches. Dr Devi pointed out that just like modern medicine, in Ayurveda, especially in the context of mental illness, drug therapy is given due diligence. She further pointed to the fact that both metaphysical and biological/physiological factors have been covered to explain mental illness in Ayurveda. References to invisible supranatural forces made in the ancient texts have found their way into the modern curriculum as well. What Dr Devi points to is the asymmetry between modern medicine and Ayurveda by stating that psychiatrists are not aware of or seldom use the metaphysical paradigm to explain mental illness. It is entirely excluded in the training and study of modern medicine and psychiatry.

Dr Karandikar and Dr Kamat, both practising and teaching in government colleges in Mumbai, agreed that not too many people come to them with psychiatric problems alone. Behaviour was an important determining factor for mental illness; they also recommended MRI and CT scans to know what they were dealing with. They mentioned that, as compared to Ayurveda, allopathy worked faster.
Nonetheless, on asking how Ayurveda explains mental illness, all the doctors interviewed stated both paradigms. By using the concept of dosas and trigunas they reiterated the idea of balance and equilibrium in maintaining health and disequilibrium causing disease including psychiatric illness. They, however, also mentioned the non-physiological factors. The basics of Ayurveda include both these epistemologies, and are a part of training and study. They did not hesitate to mention factors like bhuta unmada or past-life causes, unlike psychiatrists. Ayurveda smoothly incorporates both without conflict.

Treatment was another important category that the Ayurvedic doctors were asked about. Diagnosis was determined by multiple factors. Treatment followed several different lines. Dr Kamat pointed out that the physical health is an important criterion in determining improvement. Even if the presenting problem is psychological, the physical health of the person has to be addressed. The first priority must be to improve the physical health of the person by focusing on factors like food and nutrition. This is completely in keeping with Ayurvedic principles of balance based on a holistic conception of health. Bringing the person to normal levels of health is a complex process. This would mean balancing the dosas, dhatus and mala among other things.

Spiritual strength is as important a criterion. ‘Atman’, Dr Kamat posited, is very important to health and healing; an element that does not exist in western medicine at all. ‘Looking at the social is the concession that is made.’ Ayurveda has procedures like the panchakarma used to normalise the dhatus and dosas. When to rest, what to do, when to drink water, what to eat, when to sleep, what to say all become important and related factors in determining and maintaining health. The doctors admitted that one cannot normalise a patient completely, but the fact that they were working with a set of principles and instructions developed over five thousand years added immense credibility to that attempt.

Dr Rajesh put it succinctly by saying that treatment involves the physical, the mental and the spiritual all working in cohesion and in tandem to lead a person from disease to healing to good health. In Ayurveda, the spiritual is not an added marginal factor, often referred to as cultural or social, but is intrinsic to aetiology and therapeutics. Technically, the treatment procedures are often mixed because it is difficult to determine with exactitude whether the problem is purely a dosa unmada or a graha unmada or something else. Most modern institutions of Ayurveda look at dosa involvement nonetheless and follow a treatment regimen accordingly. But religious therapies like chanting, rites and
rituals are also mentioned in the ancient texts and can be followed or recommended. However, given the modern rational bent that most institutionally trained Ayurvedic doctors follow, the stress is on factors like physical health, food consumption and role of the family.

Another important factor in determining the kind of treatment followed is the treatment already undergone by the patient prior to coming to an Ayurvedic doctor. All the doctors interviewed admitted that they do not stop the modern medicine suddenly, but taper it off gradually over time. Their training has already exposed them to the drugs and diagnostic categories used by psychiatry and modern medicine like anti-psychotics and anti-depressants. Hence, they are able to work with both systems in a synchronised manner that enables them to wean a patient off from one system and gradually introduce them to the other without conflict, or endangering the health of the patient.

One important aspect of Ayurvedic treatment procedure and therapeutics is purification. The attempt is to make the body undergo a series of purificatory procedures with the understanding that this will have a beneficial effect upon the mind as well. Dr Devi explained that the *panchkarma* – the elimination of *dosas* from the body – procedures are aimed at this. Since disease is caused by imbalance, and this means an increase in the *dosas*, the best way to address it is by expelling the excess *dosas* to regain balance. These are five procedures that can be undergone by a healthy person too to maintain good health. Each procedure is divided into three parts that include a pre-, main procedure and a post-procedure. The two pre-procedures are *snehana* or lubrication of the body using clarified butter or ghee and *svedana*, which is a steam bath to induce sweating. Then begins the *panchakarma* procedures, which includes five procedures and each will have a pre-, main and post-operative procedure: (i) *vamana*, a process of emesis or vomiting; (ii) *virechana*, or inducing loose motions; (iii) *basti*, where enema with herbal decoction with oil, honey and salt is given; (v) *nasya*, which is the installation of medicines into the nostrils; and (v) *raktamokshana*, where blood with the *dosas* flow out of the body (leeches can also be used for the same purpose). The patient has to be prepared to receive the *panchakarma* treatment procedure and this happens gradually over time; ideally, it takes thirty days to complete the *panchakarma* procedure. This is interspersed with pacificatory procedures too, like covering the head with a medicated paste, termed *talapodichil* (see Halliburton 2009).

Treatment, as can be seen, is not about simply ingesting medicines. It is a complex time-consuming process. Length of treatment depends upon the problem. For mental
illness, apart from physical procedures and medication, counselling and involvement of the family becomes imperative. Medicines to increase strength and vitality are often given. The primary drawback in Ayurveda is that all the participants spoke about was the lack of response to emergency situations - be it a heart attack, high blood pressure or violent behaviour. Withdrawal symptoms pose another problem. And modern medicine was the way out, all admitted.

The family is an important element in the treatment procedure. Related to this is the kind of response they have to Ayurveda. The Ayurvedic physicians stated that the modern system was tried and did not work for most of the patients who come to them for help. This is for a myriad of health problems including mental disorder. All the doctors were of the opinion that Ayurveda is not the first choice for most illnesses; very often it is the last choice. Religious therapies are also chosen over Ayurveda. But, by and large, the doctors all recognised that the pathology often begins with the family. The family’s co-operation is important to the treatment and healing. Most families are ready to work with the doctors. Change is slow and usually takes time. But, once they see the change, it becomes easier for the doctors to continue.

Gaps or drawbacks in Ayurvedic treatment were not easily identified. As Dr Kamat put it, ‘Everything is already stated in the texts’, including which conditions cannot be cured completely. The texts also state that the patient and their family must be told very clearly about the problem, the treatment procedures to be followed as well as the chances of improvement and recovery.

Lack of emergency care is the biggest drawback of the Ayurvedic system. Dr Devi stated that getting patients to co-operate was another issue, especially people with psychiatric disorders. ‘Panchakarma works but we need willing patients’, said Dr Devi with a laugh. The procedures are difficult and cumbersome and more than 50 per cent of the patients are not willing. Dr Devi heads the only Ayurvedic hospital in the country that solely addresses psychiatric disorders.

Mental Disorders: Ayurveda and Bio-Medicine
The participants stated that non-essential modern medicines are stopped once patients come into the Ayurvedic fold of treatment. The doctors can do this smoothly without harming the patient because they are aware of allopathic medicines and their side effects. Some medicines are reduced gradually while constantly monitoring the patient.
Dr Rajesh emphatically said that there is a difference in the basic principles of the two systems. Among other things, modern medicine very simply works with symptoms and on symptoms. The main aim is to reduce those. ‘Drugs have very specific action. But drugs cannot change aetiology. They can only suppress the symptoms.’ Ayurvedic therapy, unlike modern medicine, has a dual aim: maintaining and establishing the balance of the life energies or tridosas within an individual rather than focusing on symptoms alone. It further recognises unique constitutional differences among individuals and recommends different treatment regimen accordingly, because the combination of the dosas in each individual is different. Two kinds of treatment approaches are present. One is samana chikitsa where medicines are given and it is curative in nature. The medicines are to balance the dosas and are for people who cannot undergo the panchakarma treatment procedure. The other approach is shodhana chikitsa, or purificatory therapy. This involves the panchakarma procedures including vamana, virechana, vasti, nasyam and rakta. There are other kinds of treatment procedures too like rasayana (for rejuvenation) and vijikarana (for fertility treatment).

‘Ayurveda involves much more than what modern medicine looks at’, says Dr Rajesh. Drugs are given for symptomatic relief, but the main focus remains addressing imbalance in the dosas. The fact remains that there is no equivalent for the tridosas in modern medicine. The understanding of health is more nuanced in Ayurveda. Unmada is an umbrella term for psychiatric illness that includes further subdivisions. The Diagnostic and Statistical Manual (DSM) mentions positive and negative symptoms. Ayurveda too mentions similar symptoms like social withdrawal and decreased psycho-motor activity, but terms it kaphaja unmada. Such parallels can be found but treatment styles differ widely because the approach to health is different. Dr Karandikar said that philosophically all sciences have gaps between theory and practice. But the task in front of most Ayurvedic doctors, as it is with biomedical doctors, is to ‘Follow the book as much as possible. Changes will take place with time, but the basic principles will stay as it has clearly been with Ayurveda.’

I conducted three interviews with Ayurvedic doctors at the Advanced Centre for Ayurveda in Mental Health and Neuro Sciences located within the NIMHANS campus at Bengaluru. This centre started in 1959 and in 1971 the Government of India took it over. The Director stated that the Centre undertakes a lot of research on Ayurveda including on Ayurvedic drugs. He said that allopathic doctors from NIMHANS often recommended patients come to the Centre. He did not, however, comment about the presence of a
psychiatrist in the Centre; exactly how that worked in the day-to-day functioning of the Centre, what the role of the psychiatrist was, how did he/she contribute to the Ayurvedic Centre. Neither did the next doctor I interviewed, who went into great detail about how Ayurveda works with psychiatric illnesses.

The person who spoke about the presence of the psychiatrist was a clerk in the office. As mentioned earlier, he was a mantarwadi with a great deal of knowledge about Ayurveda as well, and had been in the Centre for over three decades. His grandfather was a physician. He had studied Siddha and Naturopathy, and he said he has also translated several palm leaf works. He went into an elaborate explanation about the causes of mental illness and covered a wide gamut of factors including dhatu, dosa and tattva. He said the role of the psychiatrist at the Centre was ‘very confusing’. While the medicines are all Ayurvedic, the psychiatrist is required to sit at the Out Patient Department (OPD), and suggest treatment lines occasionally.

On the other hand, the fact remains that Ayurvedic doctors actively use the tools and techniques of modern medicine to enhance their own practice. ‘Interface happens. It should definitely happen’, said Dr Kamat in response to the question about whether interface takes place between Ayurveda and modern medicine. The most explicit indication of this is the fact that an integrated course is taught to the students of Ayurveda. Dr Kamat was frank when he said, ‘Ayurveda mixes well with allopathy. Allopathy does not mix well with Ayurveda. They need to know. Every individual is different and treated differently. Individual constitution determines everything. It is not like modern medicine.’

Despite this, Dr Kamat stressed that interface is necessary. Unfortunately, the government has not been very helpful despite the World Health Organisation stating otherwise. According to Dr Kamath, the government prefers allopathy and provide more resources, including money, to that system. Ayurveda is just an ‘alternative method’ now, he lamented. But the fact is that, ‘Ayurvedic processes are complicated. Modern medicine has just a pill. Allopathy is evidence based and Ayurveda is observation based, observation made over hundreds of years’, ironically pointing to the inherent strength of Ayurveda as a deeper system, one that is not just a medicinal system, but a system that also espouses an entire life philosophy. The government hospital in which Dr Kamath practices and teaches holds orientation programmes often for Ayurvedic doctors who come from across the country. They have trained over five hundred doctors in the previous year alone. Allopathic doctors are also invited for these orientations. Lectures are held and speakers include both Ayurvedic and allopathic doctors.
This is one level of interface certainly. Another kind of interface takes place at a more micro-level, as put forth by Dr Devi and her colleagues Dr Sushma and Dr Rajesh. This kind of interface happens when psychiatrists refer patients to them sometimes. And, at other times, patients and their families themselves come to seek Ayurvedic treatment despite consulting a psychiatrist at the same time. They simultaneously see both and may or may not confess the fact to the psychiatrist, but feel comfortable speaking about it to the Ayurvedic doctor. Most times, the Ayurvedic doctors do not discuss cases with the psychiatrist involved. But Dr Sushma did admit to the occasional telephonic conversation to discuss a particular case. But they all said that the relationship with psychiatrists in the smaller city that they were practising in, renowned for its Ayurvedic institutions were amicable and there has never been a situation of confrontation. This might also have to do with the larger social networks and relationships that they have in common. As mentioned in the Chapter on psychiatrists, this inter-personal networking is a significant factor in determining interface here as well.

By and large, they all said that they did not impose any system upon the patient. Dr Sushma pointed to the new health policies that the government has adopted of late, saying they underlined and encouraged interaction. She, however, stated that psychiatrists may not feel the same. It was mostly an individual choice, to discuss a case with an Ayurvedic doctor. The term she used to describe this interaction was ‘very sporadic’.

Dr Rajesh seemed more hopeful when he stated that, ‘Clients connect the both of us. It starts from the patients.’ He gave an example saying, a month after a by-pass surgery, patients come to see an Ayurvedic doctor, but the surgeon is not aware of it. Within psychiatry, the doctors interviewed admitted that about 85 per cent of the patients they had were seeing or are seeking help from modern medicine as well. Some psychiatrists know and some do not because patients simply choose not to tell. He said, epitomising the state of interface, that one ‘...cannot say what works better. Depends on patients. We need to know. More research is required.’ At some level ‘managing lives’ as Dr Rajesh put it, is a much more important factor than making informed choices about different systems.

Different scenarios can be played out in this respect. Some would be taking modern medicine for over two decades and then move to Ayurveda and find beneficial results. By and large, most patients, observed all the doctors interviewed, do not come to Ayurveda as a first choice, especially with psychiatric disorders. Some who do approach after having seen a modern doctor or even a psychiatrist may not get results even with Ayurveda. Yet
others have gained short-term benefits. The nature of treatment in Ayurveda makes it difficult to gauge success and failure. But, as Dr Sushma put it, ‘we need to know’, indicating a range of information that will help her, including which kind of practitioner a patient has already been to, what is the nature of the presenting problem, its severity, side effects of the medicines taken and so on. She admitted that ‘a small portion require modern medicine’.

Dr Rajesh expressed a similar outlook when he said that patients are already using allopathic medicines when they come to him. Ayurvedic doctors study allopathic pharmacology as a part of their course. It does not feel alien to them, unlike modern medicine and their perspective on Ayurveda. Any decision they make about medicine is thus an informed decision, wherein drugs are tapered off gradually in a manner that is in the best interest of the patient. Sometimes patients are referred to the same modern doctor or psychiatrist they had been to. If patients or their families express a desire to change systems, it is done in consultation with both sets of doctors so that the patient benefits. Often patients have other kinds of constraints than the dilemma about picking the appropriate system and the right practitioner. These include economic and monetary constraints. Dr Rajesh, Dr Sushma both stated that some psychiatrists co-operate and some do not, but patients appear to always tell them.

Individual differences also determine systemic choices. Some respond better to Ayurvedic medicine and procedures and some to psychiatric medicines. Individual constitution is an important determining factor in treatment and recovery. Severe mental disorders that are more intense and are termed psychosis respond better to modern medicine. Psychosis consists of the presence of hallucinations and/or delusions, marked impairment that grossly interferes with social, occupational, academic or basic day-to-day functioning, and poor reality orientation. While neurotic disorders - like anxiety and depression - respond better to Ayurvedic medicine. Sometimes, Dr Rajesh said, it does not really matter. If a patient shows increased symptoms or is in an aggravated condition, the only way to subdue the patient is with modern medicine, mirroring what his colleagues across the country had stated earlier about the greatest disadvantage of Ayurveda being its lack of preparedness to emergency treatment.

Like his colleagues, Dr Rajesh too stated that, by and large, allopathy is the first choice. Traditional healers are also another popular option as are religious healers. But this is not seen as out of sync with the Ayurvedic treatment process since the texts mention this paradigm quite clearly.
The nature of the disease is a very important determining factor for interface. Modern medicine often just manages psychiatric disorder. But the side effects of powerful medicines take their toll on the patients. Ayurveda can play an important role here. ‘Yes they can work together’, stated Dr Rajesh. ‘The benefits outweigh the costs’ is how he described it. Vis-à-vis traditional healers he stated, adding another layer to the interface debate, that ‘They go everywhere, but what medicines can do, only medicines can do.’

Dr Rathnam gave concrete examples by pointing to institutions like NIMHANS and the work they were doing in attempting to integrate psychiatry with Ayurveda. His personal stance was more uncompromising when he stated that remedies are there in both systems. The ‘quarrel’, as he put it, is only in the minds of the patients and their families. Medicines will act upon the body irrespective of what system they originate from. Interface, however, he said was good. The only problem is that ‘many a time it is not required’. For the same problem two systems are not required is how he saw it, adding another dimension to it. He further stated that, unlike modern medicine, they were also dealing with plenty of misconceptions about Ayurveda. Dr Rathnam was a purist when it came to the practice of Ayurveda and stated that it was an ancient system and had a bright future judging by the number of students who applied each year, but Ayurveda needs doctors who dedicate their lives to it and ‘render service with devotion’. ‘Allopathic doctors are not the hindrance. They do not prevent Ayurveda from developing.’ His stance was in keeping with viewing Ayurveda as a cultural and nationalist project. He appeared indignant that renewed interest in Ayurveda was due to its propagation as an indigenous system alone.

Dr Karandikar expressed more practical problems in interfacing with modern medicine. Recognising that medicines are different, he expected conflict is also a possibility. Moreover, Ayurvedic dimensions of health and healing are much more than what modern medicine, including psychiatry offers.

Conclusion
Ayurveda as a system theoretically has mythic roots, and its beginnings are hard to pinpoint. The basic understanding is that it has drawn from several ancient texts that examined health and healing among other things. Its understanding of health is holistic and involves a wide gamut of factors that included and connected the individual along with his/her body constitution and physiology to larger factors like planetary positions and also metaphysical elements. It purports a non-dualistic understanding of health in
other words. Ghosts, spirits and black magic were a part of this discourse. Ayurveda then
has elements of both and a large part of this continues to the present times, whence
modern Ayurveda as taught in institutions include elements from both epistemologies.

Having said that, the modern institutionalised rendition of Ayurveda has been one
that focuses more on the physiology and biology rather than ghosts and spirits; because
they exist in the same space as the biomedical system and has been influenced by it. The
fact that an Ayurvedic curriculum at a degree level includes subjects and topics that are
covered in biomedicine is proof of the interface that they are already doing. Ayurvedic
doctors are trained in the basics of the biomedical system and use this knowledge while
they work with their patients who also avail of both systems. Biomedicine is the system
that receives backing from the government as well. All efforts to then modernise
Ayurveda hold biomedicine as the model to emulate. Incorporating elements from the
latter in a bid to modernise Ayurveda is thus not surprising at all.

Interface is a complex phenomenon and takes on many shades; the Ayurvedic
practitioners expressed different degrees of acceptance and laid down conditions that mar
the process as well. But, by and large, the system and its practitioners are open to the idea
of interface and they actively interface with the biomedical system at a macro level and in
small doses at a micro level. However, the contact with practitioners of the biomedical
system is not obvious or official.

Apart from biomedicine, the Ayurvedic practitioners stated that their patients seek
help from folk and traditional healers. Ayurveda as a system historically drew from these
systems as well and incorporated them into its corpus. The practitioners did not state that
they have interfaced with healers; Mani Shankar, the clerk at the office was the exception
because he epitomised interface by studying and working with many systems including
Ayurveda, Siddha, Naturopathy and was also a mantarwadi. There are similarities in the
fundamental principles of these systems that facilitate interface. The next chapter will
examine one such system, that of traditional healers.

To conclude, interface is a more amenable and acceptable option for Ayurvedic
practitioners because of the nature of the health system itself. And the ontological core
that it holds. Here elements of both biology and culture exist in tandem and have done so
historically. Disintegration took place with the advent of the modernisation of Ayurveda.
But, because the system is drawn from a series of canonical texts that referred to both
epistemologies, the disintegration between them is not complete and absolute. Even if the
institutionalised version of Ayurveda highlights the rational, organic aspects, there
remains the traditional version of the system that is practiced and taught outside of a formalised institution. Interface then is facilitated not just by individual practitioners of Ayurveda but by historical conditions and conditioning as well.

Interface between systems however is not a benign process; among other things it is also a struggle for power and space. Recent events in Kerala reflect this sufficiently. Conceding to the demands made by the Kerala chapter of the Indian Medical Association (IMA), the Kerala government rolled back on its earlier decision to co-locate Ayush hospitals with primary health centres (PHCs) for facilitating patients to choose a system of treatment on their own choice; thus integration and co-location is not a government policy now.

The integration of Ayush and allopathic facilities was a national level proposal submitted to the Union health ministry by the steering committee on Ayush for the 12\textsuperscript{th} Five-Year Plan and it is under the consideration of the government. From 2005 onwards, the government of India launched the project of co-locating Ayush facilities with primary health centres under national rural health mission (NRHM) scheme. The finance minister of Kerala had made an announcement in his budget speech that the state government wanted to integrate allopathy and Ayush in the primary levels in order to convert the PHCs into holistic clinics for the benefit of the patients in the village areas. He was referring to the integrated health facilities working in various states under the NRHM scheme. A report of the Union health ministry reveals that Ayush facilities have been co-located with 416 district hospitals, 2942 community health centres and 9559 primary health centres till 2011. There is an integration of Ayush and modern medical systems in the district hospitals of Goa, Haryana, Jharkhand, Maharashtra, Mizoram, Sikkim, Tamil Nadu, Tripura, Lakshadweep and Pondicherry. The report also says that the states with more than 50 per cent of the district hospitals co-located with Ayush facilities are Chhattisgarh, Punjab, Madhya Pradesh and Uttarakhand (http 16).

According to a *Deccan Herald* newspaper report dated June 19\textsuperscript{th} 2013, The Union Health and Family Welfare Ministry’s proposal to allow doctors under the Indian system of medicine to practice modern medicine ‘has come under attack from the allopathic doctors who termed the decision as illegal and illogical’. The Joint Secretary in the Union Ministry of Health and Family Welfare had notified that all the state health departments should amend the laws prevailing in their states to register ISM professionals in state medical registers. The Joint Secretary had cited the shortage of allopathic doctors in primary healthcare centres (PHC) while making the recommendation. And had further
stated that the department of AYUSH- that deals with the ISM (Indigenous System of Medicine) - had taken an in-principal approval to empower ISM qualified doctors to practice allopathy in a limited way and constituted a committee to examine the issue. This decision was criticised by the Indian Medical Association (IMA) that stated that ‘this decision will amount to playing with the lives of people ... This will only encourage quackery.’ (http 17).

Hence while at a micro level interface does happen, and Ayurveda and bio-medicine have interfaced as well, a larger policy level decision to promote interface is seen to be threatening and is ridden with contention. Much of the latter stems from a deep distrust of modern medicine towards Ayurveda, a distrust rooted in the epistemology of the practice of Ayurveda. Such a vehement protest is also reflective of the power and authority that biomedicine claims, that has been accumulated and consolidated over a period of time, whereby power is constituted through accepted forms of knowledge, scientific understanding and truth.