Chapter 7

Conclusion:
The Intricacies of Interface

This study conceived as an exercise in Psychiatric Sociology, examined (a) the interface between three different systems of health and healing addressing mental disorder in India, namely, psychiatry (biomedicine), Ayurveda (an indigenous institutionalised system) and traditional (mainly religion-based) healing, and (b) the role played by caregivers in facilitating this interface between systems based on different ontological and epistemological principles. This chapter brings together the findings of the study focusing on both the inter-systemic interface and the practitioner-system interfaces.

Different models and approaches to mental disorder are embedded in diverse socio-cultural spaces like hospitals, clinics, ritual healing sites, sacred spaces like temples, mosques and churches, non-profit organisations and so on. The study looked at three systems which are based on dissimilar ontologies and epistemologies. The argument is that, despite being based on differing ontological and epistemological principles, these systems addressing mental disorder interface perforce. Why does this interface take place, how does it play out, who initiates it and why, is it sustainable and what are the implications for the treatment and approach to mental disorder in India are some of the questions that have been addressed. The two vantage points from which these questions are sought to be answered are (i) that of a system of health and medicine and (ii) that of its practitioners. Caregivers constitute the third dimension of this interface triangle.

The three systems that this study examined are (i) psychiatry, as an instance of a modern, scientific, rational, organised, formalised/institutionalised system, (ii) Ayurveda, as an instance of an indigenous, organised, institutionalised (as different from a more local guru-shishya tradition) and (iii) traditional healing, as an instance of an unorganised, folk practice. The study also examined caregivers of people living with mental disorder and the role they play in the interface between systems.

At the outset, some general comments can be made about interface between systems of health/medicine. The term interface, as defined in the Oxford dictionary means a point where two or more systems, subjects or organisations meet and interact. Interface in the context of this study is both a process and an event. In other words, interface is episodic and long-term, both. A psychiatrist conferring with a maulana on a case or an ascetic
conferring with a psychiatrist are both events or episodes wherein two practitioners belonging to two different systems interface and actively interact to deal with mental disorder; or when a psychiatrist belonging to a religious group attends meetings and interacts with the healer who conducts the group and they discuss a client who seeks help from both practitioner and is also a member of the same religious group; whereas a psychiatrist learning hypnosis or narrative therapy and incorporating them into her/his own practice involves a longer process. The former is an instance of a practitioner from one system interfacing with her/his counterpart from another system. The latter is an instance of a practitioner of one system interfacing with another system.

Interface, as a process, differs in degrees across systems; some systems are more open than others to interfacing with other systems. Also, certain elements of a system are interfaced with and not necessarily the whole system. Thus, for example, institutionalised Ayurveda incorporates tools and techniques of modern medicine.

Interface may or may not be voluntarily initiated by a practitioner. In other words, interface may be inadvertent in the context of treatment and approach to mental disorder. This is especially in the context of caregivers who easily move between systems in their quest to ameliorate the conditions of their wards, unrestricted by systemic concerns. For these reasons, each system will be examined in the context of interface and conclusions drawn.

The Background

Before examining the context of India, some observations need to be highlighted about the historical conditions that have influenced interface between systems, either facilitating or hindering the process. It is important to take cognisance of this history because of the role it played in shaping modern medicine, including the practice of psychiatry and the increasing role of medicalisation within it; and the quest for organic aetiology in psychiatry and that of the increasing space of pharmacology within this paradigm. This organic/pharmacological orientation of psychiatry continues to the present times and can be seen across cultural contexts. While this organic orientation is predominant and has significantly shaped the discourse of mental disorder, the role of socio-cultural factors have also played a significant role in this discourse and cannot be discounted (Chakravarty 2010).
Historically, medicine started acquiring the status of a profession sometime in the Middle Ages, ‘when it became a fundamentally intellectual discipline that did not fully develop in therapeutics and counselling functions till the 19th century’ (Kottow 1992: 18). The two distinct epistemologies of the organic and metaphysical were merged; priests were physicians and religion played an important role in determining health and healing (Alexander and Selesnick 1967; Rosen 1968; Porter et al. 1988). Religion monopolised medicine and many other social functions, and medicine has had to compete with the traditional healing functions of religious institutions. Gradually, medicine became a ‘rational enterprise built on a scientific tradition’, operating within ‘logical arguments, laws of causality and the epistemic strategies of observation and experimentation’ (Kottow 1992: 19). The conceptual mainstreaming of one of the epistemologies took place at a particular point in history facilitated by distinct historical conditions, including the Enlightenment, the unprecedented growth of science and the rationality principle, of the scientific methodology (Chakravarty 2010).

Consequently, medicalisation was a powerful process that created a rift between the two ontological and epistemological positions and tipped the scales in favour of the biomedical model. The social and intellectual context shaped the emergence and development of the medical model. ‘Attributing mental disorder to principally organic and physiological causes brings into fore a different set of ontological and epistemological principles, than attributing it to supernatural or socio-cultural causes’ (ibid.: ii). In other words, the phenomenon of mental illness has thus been articulated differently during different times. For instance, in the context of Europe, during the period of the Renaissance, madness was depicted through literature and art; during the Enlightenment, the predominant feature was ‘confinement and seclusion’, marking a transition from the public space to a private space (ibid.: iii). Before this division took place, ‘classical medicine … co-existed with alternative therapies, both paradigms sharing the social functions of palliating suffering, healing and controlling biological disorder’ (Kottow 1992: 18). Madness has been structured in accordance with historical conditions, and these different contexts have brought forth an entire range of approaches to mental disorder (Chakravarty 2010).

Despite these two distinct streams of thought/ideas regarding mental disorder, there are similarities in their orientation, too. For instance, studies have posited that the basic convictions of folk cultures are consistent with principles ascribed by modern health professionals (Wing 1998), and there are several instances where modern medicine has
interfaced with traditional systems (Hiegel 1983; Rekdal 1999), and people use both systems simultaneously (Stoner 1986; Saethre 2007). Medical pluralism is a common phenomenon in several societies and is the co-existence and use of various forms of modern and traditional medical systems (Leslie 1986; Stoner 1986; Phillips et al. 1992; Han 2002), and is the outcome of a dialectical relationship between modern biomedicine and traditional forms of healing. It underlies the fact that, despite the powerful influence of modern biomedicine, older forms of healing are not just extant, but flourishing.

India is home to a whole repertoire of health systems that address health and healing and disease and illness. Some of these systems are home-grown, like Ayurveda and Siddha, while others, like Homeopathy, Unani and western biomedicine, including psychiatry, are implants from other countries. The historical trajectory of these systems can be traced and drawn out and points of inception marked as well as subsequent development and assimilation in the context of India mapped out; all of which contributes to India becoming a syncretic space for facilitating the growth and development of a plurality of health systems and for medical pluralism.

India is a melting pot for a whole host of practices and systems of every hue that actively address health and healing, including mental health, and make for a variegated therapeutic landscape. The understanding of health differs in various systems, from being the mere absence of disease to a more cosmological and holistic understanding of health that encompasses a wide range of factors to define health, which is then not just an absence of disease but involves a more integrated understanding that connects health and illness with larger cosmological forces including natural elements like water, air and earth. Given the existence of multiple practices, interface appears to be inevitable. Practitioners of one system while interfacing with another system might very well be straddling two ‘cognitive, epistemic and ontological universes’ (Naraindas 2012: 6).

Central to an understanding of health and illness/disease and well-being in the western context is the idea of duality between the mind and the body (Kottow 1992). Western intellectual tradition has treated these separately for centuries and because modern western medicine is a product of this very tradition, it is primarily body-centred and all notions of health and illness, including mental health, have developed accordingly within a biological orientation and its focus is more on understanding pathogenesis than anything else. This has had a profound effect on the western conception of disease and health, traced to the period of the Enlightenment wherein the major ontological assumptions were dualism and materialism. Associated principles include atomism,
methodological monism, objectivity, nominalism and a focus upon empirical knowledge.
The corresponding practice vis-à-vis mental disorder was the medicalisation of mental disorder and the application of the medical model and an increased application of the organic and physiological explanation to describe mental disorder (Chakravarty 2010). Psychiatry epitomises the latter in more ways than one.

However, the debate about the true nature of mental disorder has always been polarised between those arguing for a social aetiology and those arguing for a physiological aetiology (ibid.). Within psychiatry too, despite its medicalised orientation, there is an understanding of health that is wider than mere physiology, encompassing and giving due credence to socio-cultural factors. The first two chapters elaborated upon the above formulations at length.

Analytically, two distinct lines of understanding can then be traced. One is biological and the other is socio-cultural. Madness has always occupied a liminal space between the two. Within the socio-cultural understanding, religion is an important motif. What is relevant here is that these two epistemological positions cannot be seen as distinct and separate; historically, they were fused such that a magico-religious and organic explanation existed in tandem. The advent of science separated them and rendered them distinct; but, in the case of India, this separation has not been complete and absolute. Rather, they exist in a continuum and different perspectives assume allegiance to differing positions within it. The medical model of mental illness predominates, but with more and more people arguing for a much wider aetiology.

Just as there are multiple perceptions of mental illness, there have always been multiple agencies that have dealt with mental disorder. These are traditional/folk practitioners who, through a whole host of therapeutic practices, including rituals, chanting, using charms and amulets, following planetary positions and even medication using natural substances, have been treating mental disorder for ages. The effectiveness of their treatment procedure is a moot point. What is significant and relevant is that they exist in concatenation with medical professionals in the community and, as this study shows, people access these systems without conflict or contradiction.

Historically then there was a mix of epistemologies which facilitated interface of different systems. This refers to two different epistemological positions deemed to contribute to aetiology of mental disorder, namely, organicity and socio-cultural factors including magico-religious, supernatural factors as well. Each system historically has at some point dealt with both these sets of aetiological factors: be it psychiatry and western
biomedicine or Ayurveda, as also traditional healing. The difference is that at some point one set of factors gained precedence over the other. Hence, while magic and religion were important motifs in the treatment of mental disorder in the West, the advent of science and scientific rationality ensured that organicity became the leitmotif post the 17th century. Similarly, in the context of Ayurveda, pre-Vedic medicine had magic and religion as important aspects of aetiology and treatment of disease, but this lost ground with post-Vedic medicine and natural explanations were sought and gained fillip. Both sets of histories show these two ontologies and epistemologies mixing and co-existing until a separation took place. This separation has, however, not been absolute; even more so in the context of India, because of its history. India has thus been a fertile ground for interface of systems.

Before examining the nature and extent of interface between the systems, we need to posit a framework that will enable comparisons to be made. Each system has one or more epistemic principles, which constitute its ontological core. The ingression into and excursions out are dependent on the strength of the central core principles and how tightly bound they are. Each of the systems also claims degrees of allegiance to either organicity or socio-cultural factors and this can be mapped along a continuum. Interface is determined by the overlay of both these sets of factors, namely, the core principle, how strongly or loosely defined that is, and accordingly movements in and out that take place. By and large, the stronger and more well-defined the core principles are, the less likely that system is to interface with other systems. Theoretically, well-defined systems then do not open themselves to expanding and diluting the core principles. This is not impossible, but, by and large, they resist this process. This is so because systems, as mentioned earlier, do not have agency. Practitioners do. Hence, while practitioners of certain systems guard the boundaries of their discipline, they also reach out to other systems and expand the boundaries of their discipline through a process of interface.

The Findings

Psychiatry
Psychiatry is an institutionalised and formalised system whose core principles are well-defined and integrated. This among other things means that the boundaries of the discipline are well protected and its practitioners as gatekeepers are wary of encroachment by other systems. Excursions are made by practitioners, no doubt, but the
The core medicalisation principle rules. The fact that medicalisation further fortifies this is reflected through such tools as the Diagnostic and Statistical Manual which is now out with its fifth revised version. For psychiatry, within its core principles there are elements of biology/organicity and also socio-cultural elements. However, its biological element is stronger than the socio-cultural/therapeutic element. This makes its interface with other systems difficult. Interface is more likely to take place within the space of the therapeutic element and not the biological one. Hence, in this study the psychiatrists were wary, if not outright rejecting, of mixing medicines from different systems. They were fine with different therapies mixing, but not the mixing of pharmacotherapy. Additions to theory or revisions thereof in psychiatry are mostly made from within the realm of biology.

All the psychiatrists interviewed in this study have been practising in India and were exposed to and aware of other practitioners and systems. Some of them had reached out to these systems and incorporated elements into their own practice. Interestingly enough, the psychiatrists affiliated with teaching hospitals said they did not talk about these excursions while teaching psychiatry as a subject to medical students. Hence, while Dr Jejebhoy said that he had worked with healers and was aware of their work and admitted that they are important resources to address mental disorder, he did not talk about them to his students in the classroom; rather, he said, he stayed with the syllabus. Similarly, another government teaching-hospital psychiatrist Dr Jadhav mentioned that she tries to keep everything within the gambit of psychiatry, even while she is aware of other systems and admitted that all her patients accessed more than one system at any point in time; psychiatrists acknowledge cultural factors and multiplicity of health systems that patients can choose from to a certain extent. There have also been instances where psychiatrists have moved outside the boundaries of their discipline and actively worked with other practitioners and build epistemological bridges in the process.

All the psychiatrists interviewed in Mumbai and in Bengaluru said that their patients or the family members approached other practitioners to seek treatment for mental disorder. The psychiatrists were not aware of the details. What concerned them foremost and what they did pay attention to was whether their patients were ingesting medicines from another system along with the medicines that they had prescribed.

Mixing therapeutics that was not drugs-based was, however, not a problem. The psychiatrists admitted that mental disorder is a complex problem and, if it is chronic, it is even more difficult to deal with for the patient and the family members. Given this, they were fine with patients and their families accessing other systems. Also, the psychiatrists
were aware that there were alternatives to choose from, all around them. So, it is only natural that patients and their families will reach out to other systems.

Psychiatrists expressed degrees of acceptance and rejection of other systems. Some were openly sceptical of other systems and dismissed them outright. Others were more tolerant; but said rather than look at other systems, the effort should be to educate people further about the virtues of psychiatry and wait for the medicines to work, because they do. Some took a neutral stand and left the choice to their patients.

A difference was also made between the kind of illness and help sought. So, for chronic and psychotic illnesses as well as for what is termed ‘culture-bound syndromes’, because of the sheer magnitude of the problem, the psychiatrists admitted that people seek help actively. Interestingly enough, they also said that, because psychotic mental disorder is so intense and the levels of suffering so high and persistent, often healers referred such cases to psychiatry, because medication is imperative; sometimes to just calm the person down. Ayurvedic doctors admitted that precisely this kind of lack of emergency care is a huge drawback of the Ayurvedic system; at such times, only modern allopathic medicines help. Often, faith healers refer patients to psychiatrists after they have exorcised a person of an errant spirit. A psychiatrist admitted that rather than antagonise and reject the faith healer, they should be educated and made aware of so they can refer cases that they cannot deal with to psychiatry. Sometimes it is just about understanding that, given the complexity of mental disorder, the best approach is to allow different systems to work in tandem and in a synchronised manner, like it is for the psychiatrist interviewed who works with a maulana.

At the heart of the debate is also the fundamental understanding about whether psychiatry works or not. Depending on the position a psychiatrist takes vis-à-vis this basic question, he or she will avoid, be averse to or align with other systems. The psychiatry that they study and train in is a system that works, for the psychiatrists. But, along with the system, they are also getting constant feedback from their patients and caregivers. This feedback also determines how much psychiatrists reach out to other systems. A psychiatrist realised the lack in psychiatry of counselling and therapy and the need to enable caregivers to interact and compare notes about caregiving as well as have a support system in place that will help them cope and strengthen their caregiving roles. Accordingly, the psychiatrist started a non-profit organisation that addressed all these aspects along with pharmacotherapy and brought in a multi-disciplinary team to work with. Some of these fields like nutrition, counselling and even yoga were thought to be
well aligned with psychiatry and did not contradict psychiatry’s core principles. Interface with them was actively sought and developed.

Religion is an important aspect of Indian culture. Psychiatrists actively engage with the secular space in the form of their own work as well as the sacred, in terms of their own religious orientations. Sometimes this also influences interface. Thus, a psychiatrist who was interviewed was a member of a religious group that had a spiritual head, whose views had a profound impact upon the psychiatrist’s work. Similarly, another psychiatrist interviewed was a part of a group that learnt about different aspects of the Bhagavad Gita, a sacred text of Hindus and part of an epic story, the Mahabharata. The Bhagavad Gita is also seen as an allegory for the ethical and moral struggles of daily life. Her guru similarly has had an impact upon her work, as well as what she has imbibed about the larger purpose of life and work through the classes, that she attends wherein the Bhagavad Gita is explicated. Interestingly, her guru/teacher, Swami Satchitanand, whom I interviewed as well, often refers people to her; these are people who come for his Gita classes and whom he interacts with actively. Similarly, another psychiatrist I interviewed was an active member of a church that has a healer. They too often work together to address problems of people belonging to their congregation. People, in turn, are more accepting and trusting of psychiatry because they are often referred to by the healer and know the psychiatrist as a part of their own religious group. These various forms of inter-group and intra-group alignments enable and greatly facilitate interface, and is significant sociologically.

Excursions and explorations into other systemic domains of health, from within the discipline are thus determined and conditioned by a whole host of factors. The core principle, however, remains and is strong and resistant to change. Psychiatrists who were interviewed, including one from NIMHANS, which has an Ayurvedic centre that encourages interface between psychiatry and Ayurveda, stated despite this exposure that developments in psychiatry should be along the lines of localising and locating more specific areas in the brain or body responsible for mental disorder, and that more research is required along these biological/organic lines

This position was mirrored by several psychiatrists. All admitted that the biology of mental disorder is powerful and here to stay. Ironically, psychiatry is not a home-grown system for India; it is a western import. But there has been a level of integration into the local conditions and this is so fine that there now exists a wider community of psychiatrists across the world who works along the same principles, irrespective of the
specific differences in practice due to the presence of cultural sub-groups within psychiatry.

Thus, there is a world-wide community of psychiatrists who actively engage with one another and work together to strengthen their discipline. A case in point is that of a news report that appeared in the Mumbai edition of The Times of India on 2 October 2013. It spoke about an Australian youth, Benjamin Walt, who travelled all the way to Mumbai to undergo a brain surgery to control depression. He had been diagnosed with what has been termed treatment-resistant depression, also known as drug-resistant depression. Deep brain stimulation surgery (DBS) has been recently approved to be used to treat psycho-neurological problems, such as obsessive-compulsive disorder and depression. The doctor who performed the surgery is an Indian, one of seventeen surgeons authorised by the International Society for Psychiatric Surgery to carry out DBS for depression. While Benjamin and his family believe he is better off with the surgery, members of the Indian psychiatric community in Mumbai express reservation; one said ‘There is a bouquet of treatments available for depression. Something that works for one patient may not for another.’ Another psychiatrist commented, ‘Depression is a bio-psycho-social problem. DBS may take care of the biological part of the problem, but what about the psychological and the social aspects?’ (The Times of India, Mumbai 2 October 2013).

While the fact that an Indian psychiatrist has conducted a complex surgery on an Australian patient reflects the universality of psychiatry and the pervasiveness and popularity of the biological model, the fact that members of the same fraternity are also expressing reservations show that not everyone is comfortable with the increasing medicalisation of mental disorder. Another instance of the reservation about this increased medicalisation can be garnered by examining responses of psychiatrists to the fifth revised edition of the Diagnostic and Statistical Manual (DSM).

According to a newspaper report in the Mumbai edition of The Times of India dated 24 March 2013, DSM-V will turn temper tantrums that children often throw into a mental disorder, grief will become a major depressive disorder and old-age forgetfulness can be diagnosed as a neuro-cognitive disorder among other things. While the aim of DSM is to ensure that diagnosis of a particular disorder is consistent across clinicians, psychiatrists in India as reported in the article, have expressed reservations about this new edition of DSM.

One psychiatrist, Dr Bhede, interviewed in Mumbai and quoted in the above mentioned newspaper article, critiqued the medical model as not being adequate to take
care of the needs of the patients said, with regard to DSM V, ‘Treatment modalities should focus on narratives of life and not on presentation of symptoms alone’. But the fact is also that the Indian Psychiatric Society (IPS) had set up a task force to discuss DSM-V and had send its recommendations, and a prominent psychiatrist from NIMHANS who was a part of the IPS task force said that diagnosis in India is mainly done on the basis of the World Health Organisation’s parallel scale called the International Classification of Diseases - X (ICD-X). But there is space for DSM-V too, and a need for it.

A counsellor quoted in the above mentioned article said that DSM is ‘… popular in India’s westernised metros because it aids fast diagnosis. People want a treatment plan as quickly as possible’. Nonetheless, there is no denying that the current trend of DSM is more and more medicalisation and subsequent need for drug therapy. Dr Bhede interviewed for this study, as quoted in the newspaper report, put it succinctly, ‘DSM-V is an aggressive campaign for space and more power for psychiatry in a world where physical illnesses are the emperors.’

DSM-V has identified new conditions that have been received with scepticism by practitioners. For instance, it has introduced a new condition termed ‘somatic symptom disorder’ that will need only one bodily symptom distressing or disrupting daily life for about six months and are not too supportive of this, according to The Times of India article cited above. As the Head of Department of Psychiatry of a large government hospital with years of experience stated, in the article, ‘One symptom cannot be used to diagnose a mental condition. In India we need to take into account the patient’s body language, our social milieu and families before making a diagnosis.’

Thus, while, on the one hand, there is an identifiable trend to increasingly medicalise and deem as mental disorder various conditions, there is, on the other, a contiguous scepticism of the same trend and not an unequivocal acceptance of it. While DSM is a part of the effort to universalise the practice of psychiatry across the world theoretically, in practice it is not always followed to a T. Indian psychiatrists have the option of using ICD-X, which, during the course of the interviews conducted, psychiatrists reported to be more ‘culture friendly’, and hence used more. They also have access to other systems and practitioners and, as this study shows, they do take recourse to these every now and then.

To conclude, psychiatrists do interface with other systems and practitioners, though more with systems than with practitioners. The sites of interface differ. With systems, because a psychiatrist learns a particular therapy, the site of interface becomes the clinic or the hospital where they practise. But it could also be other spaces like that of a church,
where a psychiatrist will actively work with a healer. At other times, there is no physical
site, but a constant interaction and interchange and dialogue that constitutes the space for
interface. For instance, the psychiatrist who works with a maulana and a swami both
actively interact with the latter and discuss cases and figure out the best course of action
that involves both the systems and is in the best interest of the patients and the caregivers.

Therefore, psychiatry is not always practised the way it is taught, that is, it is not
practised in its pure form. Changes are actively made and excursions ensure that the
boundaries of the discipline are expanded. To repeat, the core principle stays, but there is
a level of fluidity to the outer circles of the discipline; for instance, that outer circle
constituted by therapeutics, or family and caregiver involvement. Here the boundaries are
fluid and permeable and elements from other systems are more easily assimilated. Hence,
yoga can easily fit in here, as much as focus group discussions for caregivers. There are
then certain organising principles to psychiatry, like the principle of medicalisation, or
drug therapy, and these taken as they are will negate other systems. As Dr Dahiya had
stated, he practised medical model psychiatry and hence there was no need to interface or
interact with any other system or practitioner.

At an abstract level, psychiatry as a system can be seen in terms of concentric circles,
and each circle represents an ontological principle. The first few circles are dense and
closely drawn together. Here the boundaries are impermeable and placed closer to one
another. As the circles are drawn outwards, the space between circles is more and the
boundaries become more permeable. Here then, interface becomes possible and plausible.
This is the space where epistemological bridges can be built with other systems. The
shifts due to interface at the level of practice does not appear to be temporary. But they
appear to stop short of informing theory. These transitions are initiated by the
psychiatrists to some extent and the fact that they do reflects a felt need to do so and a
concurrent acknowledgement of deficiency in their own system.

**Ayurveda**

Ayurveda has been described more as a system encompassing the knowledge of life than a
medical system. It also focuses on preventive aspects and fosters health as a positive state.
While the bio-medical model of psychiatry pays more attention to theory and the
treatment of disease, Ayurveda shows more interest in the development and maintenance
of health. Ayurveda, like psychiatry, historically had two distinct sets of aetiological
factors, natural and supernatural. The separation between the two through the process of
institutionalisation and formalisation was, however, neither distinct nor absolute, and probably less than it was for psychiatry. Institutionally, in fact, elements of both have found space in formalised Ayurveda as taught in colleges across the country. The core principle of Ayurveda thus has elements of both natural and supernatural within it. Its core principles are wide and cosmological and are more concerned with health than disease. All of this makes for more openness of Ayurveda to interfacing with other systems.

Institutionalised Ayurveda, to begin with, actively draws from modern medicine as well by integrating allopathy into its syllabus. Since they study the rudiments of the allopathic system, Ayurvedic doctors can decide which non-essential medicines to stop or suspend when people suffering from mental disorder come to them for help. The core principle of Ayurveda has two strong elements. While modern medicine in keeping with its core medicalised principle works on and with symptoms, signs and syndromes, all related to organicity very strongly, Ayurveda has a dual aim. It addresses symptoms, but also focuses on maintaining and establishing balance of the life energies, dosas within an individual. It further recognises the unique constitutional differences between individuals because it posits that the combination of dosas is different for each individual. There are then two different kinds of treatment, namely samana chikitcha or curative therapy and shodhana chikitsha or purificatory therapy. Ayurveda actively uses the tools and techniques of modern medicine to enhance its core principles without conflict. This kind of interface decision is made more at a macro, policy level. There are instances of micro-level interface as well.

In Kottakkal, Kerala, where the interviews were conducted, Ayurvedic doctors at the Arya Vaidya Sala do interact with psychiatrists and discuss common cases occasionally. Their patients, just like those of the psychiatrists, actively access multiple systems of health and healing and the Ayurvedic doctors expressed an important need to ‘know’ what these systems and practitioners are, so that their treatments and therapeutics can be aligned with these. The level of openness is more than that of psychiatry because they also acknowledge that psychiatry as a system is more powerful and pervasive as well. And it has certain advantages that Ayurveda lacks. The most obvious and often quoted in the study is the lack of emergency care vis-à-vis Ayurveda. On the flip side, they also pointed out the excessive side effects of modern medicine and the potent drugs that psychiatry will prescribe. Compared to that, they believe, Ayurveda is gentler on the body and medicines are designed and prescribed in a more constitutionally specific manner than as generically applicable.
Ayurveda as a formalised indigenous system is more open and amenable to interface than psychiatry as a bio-medical system is. Historically, it has drawn from many sources including sacred texts and local folk cultures. It is also not a dualistic system, unlike modern medicine that sees a clear distinction between the mind and body. In Ayurveda, the psychic and the somatic are fused, and this view renders the body a fluid and permeable constitution constantly interacting with the physical and the socio-cultural environment around it. Balance and equilibrium are significant concepts in defining health in this system. All of this contributes to making its core principles unrestricted and open. It can then take on elements of other systems without radically altering its core.

Even the distinction between the rational and the religious or somatic and psychic only gained precedence and influenced the constitution and position of these elements within Ayurveda because of the significant position they assumed vis-à-vis psychiatry and how the latter positioned them. Because psychiatry is popular, powerful and pervasive, and in a way sets the standard, Ayurveda too began to examine and re-position these elements such that the focus for institutionalised Ayurveda is more on the naturalistic organic aspects and not so much the supernatural ones. This position was reiterated by the Ayurvedic doctors interviewed for the study; they stated that, while elements of bhuta vidya were studied and included in the Ayurvedic syllabus, in practice, they did not have a significant impact. Development and growth of pharmacotherapy within Ayurveda is reflecting the same influence.

Because the scope of Ayurveda is much more than modern medicine, the space for interface vis-à-vis modern medicine becomes restricted. It already interfaces actively with modern medicine by inculcating certain elements into it and does so to enhance Ayurveda and fill some of the gaps within it.

Ayurveda has been drawn from different sources and is an eclectic system. Health has been defined in a broad sense here and is constituted by a wider set of concepts like balance and equilibrium. Ayurvedic physicians interviewed for this study were hence open to interfacing with allopatherapy and allopathic doctors. At an informal level, they do interact with psychiatrists, as reported by the Ayurvedic doctors interviewed in Kottakkal.

Institutionalised form of Ayurveda has historically also drawn from local folk practices. The doctors interviewed, however, did make a distinction and said that while their patients access local healing and healers they were ambivalent about interfacing with them. Ironically, the psychiatrists too assumed a similar ambivalence vis-à-vis Ayurveda. Non-institutionalised form of Ayurveda was practised by the sole mantarwadi interviewed
in this study: Mani Shankar includes elements of folk medicine along with Ayurvedic practices to treat various ailments, not at the Ayurvedic Centre in NIMHANS, Bengaluru where he works, but in the village where he hails from.

Traditional Healers

Traditional healers are most open to interface and most tolerant of other systems. Among them, institutionalisation, formalisation and organisation are almost non-existent in India. The core principle moves between being loosely defined and undefined. Appeal to cosmological and supernatural forces constitutes its core principle, with elements of minimal use of medicinal substances periodically. Church healing is more defined than either mosque or temple healing, which is the most ritualistic. Because of the non-existence of drugs and the minimal use of mostly benign substances like water that has been purified through rituals or the use of substances like ash, this system does not pose a threat to other health systems but fits in and compliments any other system smoothly.

Prayer, which is the hallmark of traditional healing, fits well with any treatment process and is believed to enhance the success of treatment procedures, among other things. Prayer, in any form, within this system is seen to be imperative to the healing process. Because it does not involve any physical intrusion into the body in most cases, it is acceptable by all practitioners from different systems. Psychiatrists interviewed for this study validated the use of prayers and access to traditional healing and acknowledged it. Moreover, given the socio-cultural context of India they saw it as inevitable. An obvious advantage that traditional healers have is the fact that they are closely connected with the community and are privy to not just problems that community members face, but also inter-familial connections and kin relations, and, therefore, support systems available to them, resources they can access and so on.

Healers are aware of the entire ecological system of the community members and the changes wrought by a member afflicted with a disease state. They are then able to negotiate these relations and affect positive changes in treatment seeking decisions. The Christian congregation praying for an ill member mediated by the healer becomes a source of immense psychological support for the caregivers. Accessibility is another important advantage. Caregivers and patients can access a healer on a daily basis; can visit a temple, church or mosque every day. This is also the only system that easily assimilates patients, caregivers and practitioners, and addresses problems including health
and healing concerns of all three sets of people. In terms of economy too, they are the most affordable.

Thus, caregivers can be prayed over as much as a patient. An amulet given to both: one to deal with the stressors of caregiving role and the other to heal from a disease or illness state. This is also the only system that takes into account the illness condition; in other words, the perception of illness by caregivers, and accordingly address it.

The healers are open to interfacing with other systems and they do interface with other systems at various levels. But they have closed boundaries in terms of their own respective groups as associated with sacred spaces. The Christian healers were found to be the least accessible to interfacing with other healers. People from other religious communities did not actively access the Christian healers interviewed. The Muslim and Hindu healers reached out to all communities including Christians and Parsis. Healing shrines were the most secular spaces, like the Reay road shrine in Mumbai. Temple priests too were open to all communities and the ritualistic healing that they took recourse to was open and applicable to all, conditioned on assuming a sick role entirely and other associated roles like caregiving.

Thus, any individual, irrespective of identity and community background, could be evaluated in terms of her/his well-being and this connected to planetary positions or her/his karmic chart mapped out or malevolent influences of different forces garnered. Accordingly, a solution is put forth, which could involve anything from offering oblations to god, to making donations of food and money to the poor and offering prayers or chanting on behalf of the sick person. None of this conflicts with treatment approaches of any other system. Accordingly, all the healers interviewed stated that doctors are a must and medicines are imperative. Healing within their practice is a process of empowerment and providing psychological succour. It compliments and enhances any other system that it interfaces with.

The only space where the traditional healers believe that other systems cannot intervene and where they can help exclusively is with regard to the phenomenon of possession by a malevolent spirit. This is also their core strength and constitutes an important part of their core principle/episteme. Here too ingressions by other systems is allowed but it is not believed to alter the condition in any significant way. A spirit has to be exorcised for which no other approach will work and no medication will help. Post exorcism, other systems can come in and provide further treatment. Healers, apart from this one specialised task are otherwise generalists. Psychiatry is a super-specialisation
discipline within modern medicine. Ayurveda has a more over-arching epistemology and is wider than psychiatry. Healers are the generalists; they take care of all kinds of problems – physical, psychological, financial, emotional and even legal problems. The epistemological principles of traditional healing as a system are most fuzzy.

The traditional healers interviewed for this study were the most open to interfacing with other systems, biomedical or indigenous. They too like the other sets of practitioners admitted that the people who come to them for help actively access other systems and often come to them not as alternatives to this but to enhance the possibility of success of the treatment approaches that they already have adopted. A key factor here is also that of economy. Often it is just cheaper to seek help from a traditional healer than it is to go to a doctor.

The traditional healing system is then most open to interfacing with other systems of health and healing. This is so for a number of reasons as noted above; the most significant point that makes this system most amenable and amicable is the fact that the healers believed that any element of connecting a secular realm with that of the sacred does not have harmful effects at any level. The act of praying, the healers believed, can overarch any activity and infuse it with an element of the sacred thereby enhancing it in a positive way. A certain level of skill and training is required here too, but it is far from being an organised system, or even a formalised one. This also facilitates interface with other systems. Because its speciality is its ability to connect with the supernatural, at one level, this becomes a self-preservation technique; only healers can do this. It works on the fundamental assumption of trust, faith and belief, which are impervious to science and rationality. Incursions into this principle core will not unduly affect it or alter it. Thus, for people who believe, it cannot be proven false. Of course, the healers are all aware of charlatans; for them, these charlatans are merely frauds and impostors and not true healers at all.

Caregivers
Caregivers cannot really be compared to practitioners of different systems of health or healing. They belong to a different category by virtue of the fact that they, unlike the practitioners, are not the doers in a professional-skill sense, but are the receivers of the services rendered by the practitioners. Nonetheless, they play a vital role in the interface between systems (and their practitioners) because of the simple fact that it is they who connect the practitioners across disparate systems. They are motivated by a different set
of factors and operate out of a different life-world. Caregiving, especially in the context of people living with mental disorder, is a stressful and often long-term proposition that calls for the use of immense amounts of resources, not just human resource but also financial, emotional and mental resources.

Caregivers are most open to interfacing between systems. Thus, more than any other group use socio-cultural aspects to explain mental disorder. For them, doctors and medicine are central and significant, but are not adequate. Success of treatment is dependent on what else one is able to do, and this places it purely in the realm of other systems that are non-medical; it is this which invokes building bridges with traditional healing systems. A clear distinction is made between the secular and the sacred and both are deemed to be necessary conditions for healing and well-being. The cultural orientation is paramount in approaching mental disorder and determines treatment approaches as well. For caregivers, it is not just about looking after a close family member with mental disorder (and often also a host of other physical problems), it is also about looking after a larger family and themselves. Often this is very stressful and calls for extreme amounts of physical work, which is draining of energy and money. Given these circumstances, caregivers in the study stated that they need all the help they can get. One system is simply not able to meet a complex set of needs that caregiving brings into operation. They need elements of both secular and the sacred to sustain their caregiving roles: dawa and dua are both imperative stated almost all the caregivers who were interviewed. Interface is facilitated thus.

Severity and length of the illness are important factors as well. Chronic illnesses mean that caregiving is a long-term engagement. Short-term but severe illness also has a profound impact upon the family members. With mental disorder this is even more so, because the disorder is complex and manifests in behavioural changes so emphatically. A deeply aggressive or violent family member, or one who is always tense, fearful, full of anxiety and suspicion presents very difficult situation for the family members, especially if the sick person has previously assumed a caregiving role, like a parent, for instance. It affects all aspects of their lives including financial and interpersonal relations. With mental disorder it is even more difficult because of the stigma attached to it.

Given these conditions, it is only natural that caregivers reach out to multiple systems for help and support and in the process they build epistemological bridges. For them, aetiology of mental disorder has many dimensions: medical/biological/organic, as also socio-cultural and cosmological. Hence, their core principles are drawn not by systemic
needs and motivations, but by meeting the needs that ensures well-being of their family members and themselves. In other words, they are not bound by any systemic allegiance. They operate out of a much wider set of concerns and not just elimination of a disease state; their cognitive package includes both *dua* and *dawa*.

**Conclusion**

Instances across the world show that illness as a category cannot be clearly and strictly demarcated from the larger social, cultural and political context. Perhaps examining therapeutic alternatives rather than clear-cut systems will yield greater insights about how choices are made. In the words of B.P. Stoner (1986), a comprehensive study of health system in any culture ‘must give attention to the development of syncretic health care alternatives... where traditional, popular, folk, professional or modern medical treatments have co-existed, mingled and traded ideas and treatment modalities for long periods of time’ (1986: 47). This is hardly surprising in a post-colonial global era (Waldram 2000).

The use of dichotomies like traditional and modern, healing and curing or illness and disease are ambivalent at heart. While biomedicine appears to be more focused on curing and traditional practice on healing, the fact is that all medical systems are culturally constructed and include curing and healing both in lesser or greater magnitude and could be so due to differing epistemological emphasis (ibid.). This is more so because health not only refers to a biological condition, but reflects a broader frame which includes aspects such as freedom from incapacitation, vitality and feelings of well-being. Health care should then also be related to such a broader framework, encompassing traditional and contemporary systems of medicine, incorporate preventive aspects, treatment methods and include social issues as well.

The hegemony of rationality and science draws a deep divide between doctors/physicians and healers, and also practitioners of other systems of health and healing. Scholars like Foucault (1965), Kleinman (1980), Leslie (1982) and Good (1994) and so on have examined this position at length and have put forth the ‘medicine-as-culture’ view and have, as a part of this endeavour, examined the stringent power relation that exist between systems. The ‘medicine-as-culture’ view, by and large, posits that modern western medicine is as much a product of social, cultural, political and economic processes as is medical knowledge and practices of non-western cultures. It is what Deborah Lupton terms a ‘conglomeration of meanings, discourses, technologies and
practices that accumulate around medicine within western societies as well as outside them’ (2012: viii).

The larger framework within which various practices and practitioners can be located is in terms of the wider ontology and epistemology they espouse. This determines particular practices which, in turn, influence methods and modalities adopted as well as tools and techniques used. The latter also influences the former in a cyclical manner. Hence, biomedicine or modern medicine has a predominantly materialist or positivist ontology and advocates an epistemological position that is scientific, objective, empirical and atomistic (Chakravarty 2010).

Doctors are trained in the modern biomedical system and are conferred a formal degree at the end of a formal course and a series of examinations that all students of medicine need to pass. There is thus an organised and institutional set up that works to confer a body of knowledge about health and illness that is deemed to be universal, rational, factual and scientific. This is also termed western biomedicine, given its historical origins. This system of medicine is both powerful and pervasive and often sets the standards for a superior brand of health care across the world. This standard has ironically given rise to an entire lexicon of terms and practices, all defined in the primary context of what they are not, that is, biomedicine. These health care practices that exist in the wider constellation or universe of health seeking behaviour are consequently termed ‘alternative’, ‘complimentary’, ‘traditional’, ‘folk’, ‘local’, ‘indigenous’ and so on. These systems are further seen as ‘culturally constructed, subjective and primarily symbolic’ as opposed to a ‘universal, acultural’, ‘empirically biomedical’ and factual system (Waldram 2000: 604).

These healing practices have existed in particular societies since time immemorial. Modern medicine, in fact, was the alternative introduced – an intrusion into an already existing system. It was steeped in a larger world view that valued and actively promoted a set of principles, including the use of a methodical and scientific method, based on such concepts as hypothesis, observation and experimentation, that made a clear distinction between the mind and body (Wing 1998). What did not fit in was either rejected or deemed irrational, superstitious and non-progressive. Origins of illness in the traditional systems are related to a lack of harmony and balance like in the Southeast Asian systems or not following the laws of nature like in the Afro-Caribbean systems (ibid.). Another category of illness is the unnatural illness caused by a third party with the power to inflict evil. This is seen in many parts of Africa, Asia, Latin America, the Mediterranean and
amongst Native Americans too. An example is the ‘evil eye’ that brings misfortune, including ill health (ibid.).

A clear bifurcation or dichotomy exists between modern medicine and traditional/folk/indigenous/local medicine that have evolved within particular communities. In the context of India, we have Ayurveda, Unani and Siddha all of which can be contrasted from both modern medicine as well as each other. The term ‘traditional’ is not to be used homogeneously. In fact, it is found to be inadequate to truly understand the range of health care alternatives in a pluralistic society. This dichotomy of modern and traditional is as inadequate because it implies a clear line of delineation between systems that are modern and those that are deemed traditional. The fact is that health care professionals and practitioners actively incorporate elements of both and this syncretic approach confounds and confuses their clear identification as modern and traditional (Stoner 1986).

Traditional healers, contrary to what the term implies, are a dynamic set of people who have undergone considerable change in the last century and have actively incorporated elements of modern medicine, including technology and skills, into their practice. The case of the kampo clinic in modern urban Japan is one such example. Here biomedicine is integrated with traditional East Asian medical approaches for the diagnosis and treatment of health problems. Guatemala has another such example; here mention can be made of a mid-wife who incorporates and integrates both biomedical and traditional elements in her daily practice. After several years of being a traditional healer she underwent a training course at the Guatemalan Ministry of Health on biomedical approaches to the practice of birth. Thus, Maria would remove the ‘evil-eye’ from children in her role as a curandera or healer, is a zajorin or shaman and is also a midwife who helps in the birthing process using modern tools and techniques (ibid.). She then at one level falsifies the tradition-modern dichotomy. This dichotomisation is a part of a larger western-social-anthropological approach that assumes that there are clear cut demarcations between such domains as the political system and religious systems in societies other than their own. This has been termed a ‘Western essentialist view of the world’ (ibid: 46) or Eurocentric view and assumes that health care decisions are divorced and separated from other systems like religious beliefs or politics.

In other words, there has always been practices other than psychiatry that deals with mental disorder. Within these systems, unlike in psychiatry the role of culture has been paramount. The ontological and epistemological principles of these two approaches are
different as is their treatment processes and practise. However, two significant factors connect them together. One is that fact that these varied practices exist in the same bounded socio-cultural field of healing options. And two, the fact that patients and caregivers of people living with mental disorder do not make distinct separations between systems. The third significant factor is that the history of mental disorder and that of the systems that deal with it reveal that the two primary ontological and epistemological positions, that of biology and culture were not distinctly separated either. This separation came about with the advent of modernity and the growth and unprecedented rise of science and the scientific paradigm. Even then, the separation has not been absolute. Cultural nuances permeate the practise of psychiatry, obfuscating the boundaries between disciplines and systems. It is here that interface is located and heightened. Another significant point is that all systems are here to stay, be it western biomedicine or not.

Caregiving is another heterogeneous multi-dimensional concept. While caring is a fundamental issue in the rehabilitation of a person with mental illness, caregivers and caregiving have their own unique set of dynamics quite separate from that of practitioners and systems. Families view caregiving as their responsibility towards their offspring and their ill parents. In India, the majority of people with severe mental illness live with their families (Thara, Padmavathi, Kumar and Srinivasan 1998; Murthy, 2006); we do not have adequate government-run services either. The paucity of mental health care has resulted in families having to shoulder greater responsibilities of caring for their mentally ill family member; it is difficult to conclude whether this is by choice, cultural influence or lack of facilities, though there is some evidence to support the fact that family involvement in care was and continues to be a preference of families. (Thara et al. 2008). Accordingly, community mental health has been focused upon as well (Vashisht 2005).

Mental disorder is a complex phenomenon. In the context of this study it was seen that coping and dealing with mental disorder calls for the involvement of multiple systems to enable families and patients to cope. Practitioners deal with different aspects of the disorder. The line of cleavage in the healing professions and among different healers is not between simply being traditional and modern or between being western and Asian or indigenous. The real line of demarcation cutting across cultures and even historical eras is an allegiance to or a demarcation between two fundamental positions or, what Sudhir Kakar terms, ‘ideological orientations’: one, towards the biomedical paradigm of illness that strictly adheres to empiricism and rational therapeutics, and the other, an orientation where the paradigm of illness is ‘metaphysical, psychological or
social’ that ‘accords greater recognition to irrationality’ in the therapeutics’ (1982: 29). There has not been a clear-cut separation between these two epistemologies. Rather there has then been a dialectical interplay of society, culture, ecology, indigenous systems of meaning pertaining to mental health ideas and practices and institutions of India along with psychiatric phenomena (Fabrega 2009).

For instance, the current understanding of treating Obsessive Compulsive Disorder, a debilitating anxiety disorder characterised by obsessive thoughts and compulsive actions such as cleaning or counting repeatedly is neurosurgery. An article in the supplement to The Times of India, Mumbai 28 December 2013, talks about Rodney King from Australia who underwent a five-hour neurosurgery termed ‘psychiatric surgery’ for an OCD condition he has suffered for years. The treatment for the same condition included Electro Convulsive Therapy, Cognitive and Behaviour Therapy and also transcranial magnetic stimulation. The change in aetiology is clear here and a corresponding change in ontology and epistemology of treatment approaches. While India has drafted guidelines on psychiatric surgery, countries like Sweden and Japan have banned it fearing indiscriminate use. Within psychiatry, OCD is currently understood in terms of abnormalities in neurotransmitters and it is hypothesised that the serotonin receptors of OCD sufferers may be relatively under-stimulated. What is interesting is that psychiatrists say that OCD is triggered by traumatic life events: for Rodney King it was his brother’s death in a car accident when he was thirteen years. He is fifty-one now. Rodney has undergone an array of treatments for his problem, surgery being the latest; reflecting a concatenating mix of epistemologies.

To recapitulate, there have been several trends in research with regard to mental illness and mental disorder. A vast amount of this research has been directed to examining the history of psychiatry, and contiguously connect it with the history of medicine and specifically western biomedicine and its profound influence on the growth and development of biological psychiatry. Another trend has been the critical stance adopted in relation to biological psychiatry and this has been pitted at various levels, including its biomedical leanings, its views about patients and caregivers, cultural factors at work in the context of mental disorder and so on. A related trend connected to examining the cultural factors in psychiatry has been epitomised by the ‘medicine-as-culture’ view. Within this sub-discipline a lot of interest has been generated in non-western societies and their treatment and cultural orientations towards health and disease. The role of the individual and how s/he constructs health and illness are located here as much as such
concepts like pluralism in health care and interface between health systems. It is here that alternatives to biomedicine, in other words, have been explored and studied.

The comparative study of medical systems is a fast-growing space for socio-cultural research that has addressed several key issues like the idea of subjectivity (Biehl et al. 2007) and embodiment (Csordas 1994). Here the body is seen as a space where cultural values are actively inscribed into. These studies move beyond seeing the body as passively constructed to a position where embodiment is the existential condition of cultural life. It posits a phenomenological theory of culture and self (Turner 1992, Csordas 1994). The body has been the focus of prolific anthropological research in the past few decades (see Hughes and Lock 1987). While some of this research makes a distinction between the mind and the body, Murphy Halliburton (2002), while studying Ayurveda in India, argues that research on the body has created a false dichotomy between the mind and body. His research conducted among people living in Kerala suffering from psychopathology and possession shows that these people experience what he terms a ‘continuum of states of being that includes the body, mind, consciousness and self/soul’ (ibid.: 1123). The study also underlies the importance of studying local and cultural notions phenomenologically.

Studies undertaken by disciplines like anthropology and sociology regarding health and health care practices across the world have shown that the use of different health care practices within societies and communities across the world is often the rule and not an exception (Leslie 1980; Stoner 1986). Medical pluralism offers a variety of treatment choices. These are linked to individual systems of health each representing a distinct ideology and practice dynamic, with each having a distinct philosophical and historical lineage and basis and, in turn, providing a different theory for health, illness and disease states (ibid.).

In the context of interface, studies have looked at issues like community psychiatry and an interface between medical personnel and community level workers. This linkage with community services will go a long way to supplement and complement specialised mental health services (Cohen 1974).

Social psychiatry actively involves multi-professional teams to address mental health and not biomedicine. This means that different institutions with different overall notions and therapeutic principles provide services in the same region. Interface is the place on the borderline between two systems that mediate between them. Interaction with other
systems, exchange of information and the reality construction of the interacting systems all take place at the interface.

In the context of India, by and large, with regard to interface not many studies have been undertaken, in comparison to the examination and critical explorations of individual systems like psychiatry and traditional healing or even health systems clubbed together like Asian systems of health (Leslie 1992). A few have looked at interface between modern biomedicine and Ayurveda or biomedicine and traditional healing. Halliburton’s work Mudpacks and Prozac: Experiencing Ayurvedic, Biomedical and Religious Healing (2009), based in South India, is an exception.

A dialectical movement and negotiation between different systems was observed in the instant study. Each system has a predominant epistemic principle or principles that defines it; and a concomitant healing role reflecting an allegiance to biomedicine or metaphysical aspects. Having said this, it has to be underlined that because both ontologies and epistemologies are so intrinsic in defining mental disorder, no one system seeking affiliation to one ontology and epistemology can limit itself to that one position alone. Sooner or later, it necessarily seeks and in the process builds bridges with other systems, however tenuous or pervasive. The most important factor in this process, one that is intrinsic to the raison d’être of the systems of health and healing are the patients and caregivers of people living with mental illness. They are what in the final analysis drive the process of interface. They are the reason that practitioners reach out to other systems.

Mental disorder can be an extremely debilitating experience, for the afflicted and for the caregivers. No one system is able to truly encompass and effectively ameliorate the suffering involved, either for patients or caregivers. The latter necessarily reach out to multiple systems to cope with mental disorder, facilitating interface between systems in the process. Even within systems, despite ontological boundaries practitioners have the scope to reach out to other systems. There are different reasons for why they do so; the well-being of their patients and caregivers is one important motivating factor.

This study has shown that not only is interface between systems plausible, it is being done, in everyday practice. To truly make a difference it has to be taken on and modalities worked out at the systemic level as well. This is easier said than done. At a larger macro policy level, a different set of factors come into play that involve elements of power and politics. Thus, a decision to allow Ayush hospitals to exist alongside Primary Health Care centres in Kerala by the Government was struck down after protests by the Indian
Medical Association. Similarly, a *Hindustan Times* Mumbai 10 January 2014 report states that the allopathic association in Maharashtra has decided to move court against the state cabinet’s decision allowing homeopaths to practise allopathy after completing a one-year course in pharmacology.

Finally, to summarise and answer the research questions raised in this study, the discourse of mental disorder in India is truly a multivocal discourse/space. Given this plurality, interface is inevitable. Interface takes place because these varied approaches share a bounded space cohered together by patients and caregivers. The space for interface is accordingly determined. While it can be located in actual sites like a clinic or hospital, it is also located at an abstract level, like being determined through interpersonal communication between practitioners. Interface takes place at a level of theory (like it is for Ayurveda and biomedicine) and also practice. It is both by design and default. Practitioners do recognise the need for interface, but not uniformly either within systems or across systems. Caregivers and patients are the most important factor in determining interface between systems and, as this study shows, interfacing is identified as essential and beneficial.