Interface in Approaches to Mental Disorder in India: A Study in Psychiatric Sociology

(Abstract)

The main objective of this thesis is to explore the interface between approaches to mental disorder in India. It is a study in psychiatric sociology because the thesis attempts to examine not just the organic approach but also the socio-cultural approach to mental disorder, underlining its significance under the rubric of different systems including psychiatry.

Various systems of healing in India address mental disorder from different perspectives and with varied results. It is not sought here to establish the efficacy of one system of health and healing over the other; rather the focus is on exploring the possibilities of systems of health and healing interfacing, despite being based on disparate ontologies and epistemologies. How do systems addressing mental disorder interface and under what conditions? What allows for or inhibits interface and what role do practitioners play, are some of the questions that this study has attempted to answer.

Before examining the phenomenon of interface among these disparate systems, it is important to underline that two distinct conceptual/paradigmatic positions can be identified in drawing out the discourse of mental disorder in general; these have an important bearing on the systems of health as well. A distinct contiguous shift can also be traced in the attitude and treatment of those deemed to be mentally ill. This shift is not just conceptual but also ontological and epistemological. One looks at mental illness in terms of socio-cultural factors and the other locates its aetiology primarily in an organic or physiological base. They refer to the socio-cultural model and the organic model respectively.

These two clear epistemologies, while distinct, are neither absolute nor completely disconnected in the context of explaining mental disorder. A historical tracing of these two epistemological positions will reveal that, at a point in time, one paradigm assumed significance and received much attention and fillip; like the biomedical paradigm (that posits aetiology of mental disorder to biological/organic causes) for instance epitomised
by psychiatry. While this was so, the alternative socio-cultural framework (that posits mental disorder to supernatural/metaphysical causes including angry gods, ghosts, spirits, and possession and so on) did not become redundant; it continued to exist in the peripheries.

A closer examination of the various systems of health will reveal that they differ in their degrees of affiliation to either of these two ontological and epistemological positions, that is the rational, scientific, biomedical, organic position and the metaphysical, supernatural, ‘irrational’, socio-cultural position. Elements of both have been a part of the various systems of health and healing that address mental disorder in greater or lesser degrees. In the context of these systems of health and healing there was a shifting between epistemologies and this is particularly significant in examining the phenomenon of interface between these systems.

Besides modern psychiatry, three codified indigenous systems of medicine address mental disorder in India, namely, Ayurveda, Siddha and Unani, apart from traditional folk remedies mostly based on religious practices. The ontological and epistemological assumptions of these systems are markedly different from that of modern psychiatry. The repertoire of treatment approaches in India has always been wide and plural. Other systems like Homeopathy and Naturopathy are also a part of this amalgam, but outside the scope of this study.

This study attempted to examine the sites of interface between three systems of health and healing. Systems were chosen by way of their primary orientations. Psychiatry as an instance of a primarily western, biomedical, rational system finds a significant presence in the landscape of practices. An ostensibly disparate ontology and epistemology was provided by a codified, institutionalised, indigenous system, namely Ayurveda. Third, an instance of a non-codified, non-institutionalised, non-formalised, unorganised sector was that of the traditional healers. These systems exist within the same socio-cultural space in which mental disorder is addressed. A major objective of this research was to examine how the different epistemologies interface, and what the implications of this possible interface are for the treatment of mental disorder.

Each system of health and healing has a predominant episteme that forms its ontological core. For instance with psychiatry it is the predominantly biomedical bent
that constitutes its ontological core; for Ayurveda it is a mix of empirical and metaphysical elements and for traditional healers it is predominantly the engagement with the metaphysical that defines it. Given these varied epistemological leanings, interface takes on several shades of meaning, and can be pitched at multiple levels.

One could be in terms of a therapeutic overlap. This could be in the use of medication and drugs as a part of the treatment regime. Another strand of interface is through using elements of one system to understand notions of another health system. For example, the cultural re-interpretation of psychiatric notions through Indian religious texts, like the Bhagavad Gita. A third level of interface could be in terms of the underlying principles of the systems at the level of ontology and epistemology or theory. For instance, indigenous systems of medicine are based on the principle of confluence that sees the concatenation of the medicinal and the spiritual. Religion is an important motif that characterises the indigenous systems.

The fact that community members access these varied set of practitioners reveals yet another site of interface- at the community level referring to the interface resulting from the family members and caregivers accessing practitioners of more than one system simultaneously.

In other words, an important phenomenon, given the simultaneous existence of multiple systems is the interface of these varied systems. The question is how does interface work out and under what conditions; what restrains or inhibits the process of interface and what facilitates and promotes it; how do the different stakeholders view interface. Systems differ in terms of the degree of openness and closeness to forays from other systems, and this is determined by how closely the boundaries of the system are guarded by a practitioner and the ontological principles of a system and how closely a practitioner will adhere to these principles.

Caregivers in this respect are the least restrained by systemic and professional concerns. People who seek help, either for themselves or for their families often do not. They are merely concerned with what works, and this sometimes means oscillating between ostensibly irreconcilable systems.
There are two vantage points from which the interface between systems of medicine can be approached. One at the level of ontology and epistemology of a particular approach or system and the other is at the level of practice. The modality of interface needs to be determined. Is it at the level of ontology or practice that the space for interface is greater? Are possible shifts due to interface, if at all, at the level of practice temporary, or do they inform theory? The other key questions include when and how do these transitions take place, who initiates them and what are the motivating factors? Does this interface take place by design or by default? Do practitioners recognise interface as a need, if at all? Does it stem from a recognition of their respective strengths and weaknesses? Do they see other systems as complimentary to theirs, or is it a mere mining into other systems to enhance their respective systems? How are in essence then epistemological bridges built between differing systems?