Chapter 1

The Variegated Space of Mental Disorder in India

The main objective of this thesis is to explore the interface between approaches to mental disorder\(^1\) in India. 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 and caregivers play, are some of the questions that this thesis has attempted to answer.

Before examining these questions it is necessary to look at the phenomenon of mental disorder, since there are differing approaches to it. At the outset, two questions need to be flagged: (i) what is mental disorder from the perspective of different systems and practitioners, and (ii) what is mental illness from the perspective of patients and caregivers? The first question will be examined by eliciting the views of the practitioners of different systems and traditions that define and treat mental disorder. The second question will be examined by eliciting the views of caregivers.

The way mental disorder is defined in any system is intrinsically connected with the way it is treated and could also determine how open or close it is to interfacing with other systems. The most powerful and pervasive approach to mental disorder is the biomedical model. This chapter, therefore, begins with an outline of the history of mental disorder and the biomedical model. But there are and have always been cultures throughout history that have recorded instances of behaviour deemed to be outside of the ordinary or ‘normal’, and have used their own set of parameters for doing so (Chakravarty 2010, 2011). Accordingly, the chapter analyses the idea of multiplicity of approaches and subsequently that of the shifting between epistemologies vis-à-vis the approach to and treatment of mental disorders. Following this, the chapter looks at India in the context of

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\(^1\) The terms mental disorder, mental illness and even psychiatric illness/disorder are often used synonymously in literature. However, disorder implies a biomedical condition and is seen to be from the perspective of a biomedical practitioner, like a physician or a psychiatrist. The term ‘illness’ has been defined by scholars like Kleinman (1980) from the patient and caregiver’s perspective and has been used in a more phenomenological sense. For the purpose of this research, ‘mental disorder’ has been used as an undifferentiated term, unless otherwise specified as illness, as the term appears in literature.
multiple approaches. Finally, it presents the objectives of the study, discusses the methodological strategy followed in realising these objectives and concludes with a note on the organisation of the chapters. The chapter is divided into two parts: the first part deals with the history and background of mental disorder and illness, and the second part focuses specifically on the details of the study.

Before elaborating upon the study, an important theoretical perspective needs to be explicated upon; one that has an important bearing upon the multiplicity-of-approaches-framework that underlines this study, and subsequently on the concept of interface between approaches/systems of health and healing. This theoretical framework is that of medical pluralism which posits that complex societies usually have array of medical systems that provide varied health options. It has been argued that medical pluralism is not a recent phenomenon; early state societies exhibited the beginnings of the institutions or systems of medicine, that included not only an elaborate corpus of medical knowledge that is an amalgam of ‘aspects of cosmology, religion and morality’, but also contained the beginnings of medical pluralism manifested by the presence of a wide variety of healers including general practitioners, priests, diviners, herbalists, bone-setters and midwives (Baer 2004: 110). There are two identifiable levels of plural medical systems of early civilisations namely ‘an official, scholarly academic system oriented to the care of the elite’ and ‘a wide array of less prestigious physicians and folk healers who treat subordinate segments of society’ (ibid.) like artisans, craftspeople and peasants.

Without going into details, suffice to say that scholars have formulated different approaches to explain the phenomenon of multiplicity of approaches to health and healing, including one that delineates three types of medical systems namely local, regional and cosmopolitan. Local systems are folk or indigenous medical systems. Regional medical systems are systems spread over a relatively large area. Examples include Ayurveda, Unani and Chinese medicine. Cosmopolitan medicine is western medicine or biomedicine (ibid.).

Arthur Kleinman (1980) put forth three overlapping sectors in health care systems; namely, the popular sector that includes health care provided by lay people and basically includes patients and caregivers themselves. This refers to practices like diet, use of herbs as medicines, exercise, rest, therapeutic baths, massages, taking of non-prescriptive medication and so on. The next is the folk sector and includes healers like shamans, mediums, magicians, herbalists, bone setters and so on. The third sector is the professional sector and includes practitioners and associated institutions like clinics and
hospitals. This would include western biomedicine and indigenous systems like Ayurveda and Unani as well as Homeopathy, Naturopathy and so on. Medical pluralism posits and accordingly examines multiple systems of health and healing existing in the same society, and more importantly allows for the examination of interface between systems. The latter influenced by factors like the dominant medical system in place and what conditions facilitated its establishment as a dominant system as well as the presence of other systems of health and what sustains these myriad systems. The dominant system in the context of mental disorder is biomedical psychiatry by and large. There is a prolific amount of research done on medical pluralism in societies across the world, but it is relevant here as much as it contributes to the phenomenon of interface between systems, and focus on it per se is beyond the scope of this study.

This study is conceptualised as a contribution to psychiatric sociology. This is so because it examines social factors and processes that affect mental disorder including those affecting treatment and care of people living with mental disorder and have implications for the prevention of mental disorder as well. Psychiatric sociology locates studies to do with mental disorder within a sociological perspective. The study of mental illness, including psychiatric illnesses, can be traced to scholars like Leo Srole (1908–1993) who made significant contributions to psychiatric research including sociological study of psychiatry and mental disorder and Arnold Rose’s work *Mental Health and Mental Disorder: A Sociological Approach* (1955). According to Rose, cultural values and meanings are important elements in human interaction and are held to involve selected patterned ways of thinking, feeling and acting (Ball 1971).

I

History of Mental Disorder

Mental disorder as a phenomenon has been acknowledged in various forms since time immemorial. Passages in the Old Testament show that the ancient Hebrews recognised mental disorder (Rosen 1968). Illness in general, including mental disorder, was thought to be inflicted by supernatural powers; for example, an angry deity who punished the

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2 All diacritical marks have been removed from Sanskrit words, for felicity of presentation and due to inconsistency in their spelling, in literature.

3 While biomedicine and psychiatry is seen to be the dominant practice and system, practices like Ayurveda are sometimes seen as pre-dominant in certain places, like Kerala by virtue of its popularity and sustenance here.
perpetrator for sins committed. Another prevalent cause of mental disorder was thought to be possession by evil spirits and demons, as reflected in the New Testament (ibid.: 28, 33). The belief in such intrusions as a possible cause of mental disorder was prevalent throughout the western world including Europe since the earliest times (Rosen 1968). Examples also occur in literatures of Egypt, Babylonia and Assyria as well as the ancient Mediterranean-Near East\textsuperscript{4} area (Alexander and Selesnick 1967; Rosen 1968).

Historically, the treatment of mental disorders has been embedded in a variety of social and intellectual spaces. The parameters for distinguishing between normal and abnormal behaviour patterns have neither been clear-cut nor absolute (Chakravarty 2010). Treatment and attitude were connected to ideas within the larger social milieu.

Knowledge and knowledge generation, particularly in the field of mental health and illness, has been inexorably tied to the social, political, economic and religious conditions of particular historical periods. For instance, many societies distinguish between what they consider mentally deranged behaviour that is chronic, and behaviour that is similar to the latter condition but, by virtue of the fact that it is exhibited only during socially sanctioned situations, like a religious rite, becomes acceptable (Rosen 1968). While it is difficult to draw a neat line between what is ‘normal’ and what is not, some forms of behaviour have been labelled as disorders and as illness by almost all cultures throughout history (ibid.; Cockerham 2000).\textsuperscript{5} Whether or not a person is deemed to be mentally ill depended upon the degree to which any displayed behaviour was considered disturbed and the attitude of a larger social group towards this deviant behaviour (Rosen 1968).\textsuperscript{6} Mental disorder, as patterns of behaviour, appears to have occupied an interstitial space throughout history (Chakravarty 2010).

Modern concepts of mental illness can be traced to the Greeks and Romans. The Greeks have been attributed with the formulation of a rational approach towards understanding nature and society. They replaced the supernatural with an appeal to a

\textsuperscript{4} The Mediterranean-Near East belt includes the countries of Turkey, Lebanon, Israel, Iraq, Jordan, Saudi Arabia and other countries of the Arabian Peninsula. The Mediterranean region alone includes the countries of Morocco, Tunisia, Algeria, Syria and Egypt among others.

\textsuperscript{5} Beginning with Homer, Greek writers wrote about a wide range of human behaviour including those considered to be abnormal and requiring special explanation. What in particular appeared to preoccupy them is what causes this kind of behaviour. Two explanations of mental derangement were put forth: one attributing it to supernatural or divine cause and the other to natural causes. Both reflect the attitude prevalent largely during the Graeco-Roman times (Rosen 1968).

\textsuperscript{6} Among the ancient Greeks and Romans, the mentally disordered were defined in terms of their orientation to the accepted idea of reality in terms of the style and consistency of their behaviour and its consequences for themselves and those in contact with them (Rosen 1968).
natural cause-and-effect relationship. This involved the view that mental illness was no different from physical illness; the same factors that can cause physical ailments can also cause mental ailments. While the idea of mental illness being attributed to natural causes germinated during the Graeco-Roman era, this view existed in tandem with the more prevalent one that attributed mental illness to supernatural causes, including being caused by demons and angry wrathful gods (Rosen 1968).

The 17th century marked some degree of erosion of the belief in demonic manifestation in England. The 18th century marked the age of the Great Confinement. Hospitals were set up across Europe meant to house all those who in some form or other disrupted social order, including the insane (Foucault 1965; Rosen 1968; Cockerham 2000). What marked this attitude for the 17th and 18th centuries was the definition of insanity as an inability to use the faculty of reason. Eccentric or irrational behaviour, that which diverged from accepted norms, was reflective of a deranged will and, therefore, needed to be subjected to correction, ideally carried out within the sterile confines of an institution (Rosen 1968). Institutionalisation was completely in sync with the view that there is an organic base to mental illness, implying the need for specialised care. This position has been epitomised by the discipline of psychiatry.

Thus, ‘the history of mental disorder brings to the fore a variegated articulation.’ (Chakravarty 2010: 61). The aetiological history of mental illness is significant. When mental illness was seen to be the result of supernatural forces, various rituals were used by the community to ‘treat’ the illness with varying results. For instance, the use by traditional healers including shamans of white magic to alleviate the suffering caused by the use of black magic. Contrary to this view is what was propounded by the Greeks and the Romans. There was an emphatic shift from the supernatural to the natural causes. This was further marked by a shift in the thinking as to what causes madness.

Two distinct conceptual/paradigmatic positions can be identified in drawing out the discourse of mental disorder. 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 primarily locates its aetiology in an organic or physiological base.

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7 The purpose was to deal with immoral and antisocial behaviour. Thus, ‘deviants’ were segregated and alienated by internment (Rosen 1968).

8 The supernatural paradigm gets clubbed with the socio-cultural approach to mental disorder, one extension of which is the social constructivist approach epitomised at one point by the anti-psychiatric movement.
They refer to the socio-cultural model and the organic model respectively. The inception of the latter can be traced to the period of European history referred to as the Enlightenment, and the advent and unprecedented rise of science, concepts of rationality and objectivity. Prior to this period, mental disorder was not strictly seen as a disorder in the medical sense. It occupied a grey area, an interstitial space wherein certain behaviour patterns were deemed to be disorders while others were not. Social sanction was provided to certain figures like the shaman for displaying ostensibly disordered behaviour patterns under certain circumstances, like during a healing ritual.

Figures like prophets and shamans were thus allowed the exhibition of eccentric behaviour, without drawing undue attention of the larger community. In fact, often such phenomenon as ‘possession’ was deliberately invoked. Ideas of madness were hence inextricably tied with religion and carried inherent religious symbolism. With the coming of the Enlightenment in the course of European history, much of this idiom of expression was lost. Madness moved from a public realm into the private space of the institution, including the asylum; it became medicalised. Organic, physiological and neurological reasons were sought to explain mental disorder.

These two clear epistemologies, while distinct, were not absolute nor completely disconnected (Chakravarty 2011). In other words, while one paradigm assumed significance and did receive much attention and fillip, the earlier framework did not become redundant; it continued to exist in the peripheries. In the ancient and early medieval Europe, the supernatural explained and determined the discourse of mental disorder. With the advent and increasing popularity of the scientific paradigm in the 17\textsuperscript{th} century and early Renaissance period, scholars and physicians started to seek organic and natural explanations for mental disorder. Soon the brain became the centre of attention and pharmacology the most significant approach to treatment, and continues to be so (ibid.).

Since the mid-19\textsuperscript{th} century, the medical model became and has remained the most powerful mode of treating mental disorder. Despite severe criticism at a point in time, including an anti-psychiatric movement, it continues to be extant and flourishing. The medical model nonetheless has been called into question by those who argue that to treat mental illness like any other illness is to seriously undermine its social origins (see Bowers 1998). The social constructivist position calls for viewing mental disorder and other disease states as socially and not biologically defined and have been endorsed by historians of medicine and medical anthropology as well. Three important scholars (and
psychiatrists) who have contested the medical model of psychiatry included R.D. Laing (1964), David Cooper (1967) and Thomas Szasz (1972).

It was Cooper who coined the term anti-psychiatry in his work *Psychiatry and Anti-Psychiatry* (1967) ‘to express dissent towards the mainstream practice of psychiatry and believed that madness was a product of society’ (cited in Chakravarty 2010: 58). Laing explained mental disorder purely in terms of social-psychological processes. He, in fact, rejected the illness model of psychiatry and focused on the ‘intelligibility of the psychotic experience’ (Nasser 1995: 744). Szasz argued that the concept of illness can be understood in the context of ‘specified social setting’9 (1972: 208; see also Laing and Esterson 1964; Sedgwick 1972; Addlakha 2008).

Cooper, Laing and Szasz challenged mainstream psychiatry and were associated with the anti-psychiatry movement during the 1970s. It would be wrong to say that this movement has not had any impact upon the present day practice of psychiatry. Present changes in terminology reflecting upon what Mervat Nasser calls ‘growing understanding of the political power of the word’ (1995: 745) can be seen in the use of terms like ‘therapy’ instead of ‘treatment’ and ‘client’ instead of ‘patient’. The anti-psychiatric movement has also been responsible for the demand for laying down guidelines for the provision of psychiatric services. Advocacy groups upholding rights of the mentally ill have emerged as a result. Perhaps the greatest impact might be seen in the shift from the institution to the community with regard to the provision of care, reflecting a concomitant widening of the circle of caretakers to non-medical personnel like social workers (ibid.).

Nonetheless, the biomedical model and psychiatry continues to exert a powerful influence upon mental disorders. The fact that the Diagnostic and Statistical Manual (DSM), first published in 1952, has just come out with its fifth revised version in 2013, is testament to the pervasiveness of the medical model. A brief history of this model will shed some light on why it is so powerful.

**History of the Medical Model of Psychiatry**

Developments in the scientific knowledge of the universe and the human body during the period of the Renaissance had set the stage for unprecedented work in related fields. The late 1700s and the early 1800s witnessed tremendous advancements in medicine, medical

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9 For further details about the anti-psychiatry movement see Chapter 2.
knowledge and medical procedures and technology. Diseases were more precisely localised and diagnosis was more accurate. Systematisation and codification of symptoms was the order of the day, whereby generalisations were drawn, leading to the development of an elaborate system of classification and nosology. By the 1800s, a large number of clinicians had meticulously reported and classified their observations on mental symptoms that were described with more detail (Alexander and Selesnick 1967).

This period also saw the conceptualisation of the germ theory of disease, which is based on the premise that every disease had a specific pathogenic cause whose treatment could best be accomplished within a biomedical mode. It was inevitable, given the success of this model, that physician as psychiatrist would come to view mental disorder in a similar vein (Shorter 1997). Central to the scientific discourse was the belief that all essential phenomena of life can be understood in terms of physics and chemistry and this understanding soon came to dominate medicine as well (ibid.: 10).

By the end of the 17th century, mental illness had been ensconced within the field of medicine, bringing into force a specific set of organising principles. For instance, physicians started to look at the human anatomy for evidence that madness was caused by organic processes within the body. This view was also compounded with the powerful influence of psychiatrists who viewed mental disorders as primarily brought on by organic causes. Benjamin Rush (1745–1813), the founder of American psychiatry maintained, for example, that abnormal behaviour was derived from brain disease that had its locus in the brain’s blood vessels. He firmly believed that insanity is the result of disturbances within the individual and not due to unknown forces that enter the body (Alexander and Selesnick 1967; Cockerham 2000: 22). This view got a fillip in the 18th century by the further growth of the scientific framework and tremendous advancements in the field of medicine (Cockerham 2000).

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10 The kind of progress that the natural sciences witnessed during this period was staggering. Luigi Galvani (1737–1798), an Italian physiologist and Count Alessandro Volta (1745–1827), an Italian physicist pioneered in electricity. John Dalton (1766–1844), an English chemist did revolutionary work on atomic theory. Carbon dioxide was discovered by Henry Cavendish (1731–1810). Similarly, hydrogen, nitrogen and oxygen were discovered. This period also saw the incipient stages of understanding the digestive system due to the work of French naturalist, Rene de Reaumur (1683–1757) and an Italian abbe, Lazaro Spallanzani (1729–1799) (Alexander and Selesnick 1967).

11 The work of Giovanni Battista Morgagni (1682–1771) is important with regard to the development of organic psychiatry, as his anatomical findings affirmed the concept of localisation (ibid.: 107).

12 William Cullen’s classification of mental illness was the most comprehensive in the middle of the 18th century. He was the first to use the term ‘neurosis’ to mean diseases that are not accompanied by fever or localised pathology (ibid.: 110).
William Cullen (1710–1790), a Scottish physician and chemist and Rush’s teacher, spoke of a physiological basis of melancholia and his treatment included all the regular measures used to treat any other physiological disturbance, including bloodletting, cold dousing, induced vomiting, diet and physiotherapy among others. Giovanni Battista Morgagni attempted to relate the symptoms of the patient to post-mortem findings. John Haslam (1764–1844), who was the superintendent of the Bethlem Mental Asylum from 1795 to 1816, in his quest to locate a centre of mental illness, examined the brains of deceased insane (ibid.: 111). Phillippe Pinel (1745–1826) believed that the basis of mental derangement might be a lesion in the central nervous system and, therefore, maintained and reinforced traditional notions about the physical cause of mental disease. He also believed that the asylum and the experience of incarceration could be used in a healing manner (Shorter 1997). Alexander Haindorf (1782–1862) wrote a textbook of psychiatry on mental illness (1811) wherein physiological sources of psychological drives and their influence upon reasoning were discussed and he tried to locate this source in different parts of the brain (Cockerham 2000). The infamous mad house had been converted into a hospital. This transition was thought to be singularly important in the psychiatric treatment of the insane and the particular form that it took, that is, of a physiological and organic nature.

Thus, by the end of the 18th century, the predominant mainstream thinking about madness and insanity was mostly in terms of it being an illness, with a physiological basis. By the early decades of the 18th century, physicians were looking for destroyed matter in the brain to explain mental disease (Alexander and Selesnick 1967). This was just a reflection of the developments in the natural sciences and medicine wherein the effort was to localise and diagnose diseases with more precision (ibid.: 107).

Towards the middle of the 19th century, psychiatry, following medicine, tried to become modern and scientific by explaining disordered behaviour in terms of disrupted

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13 In 1810 John Haslam wrote a book *Illustrations of Madness* which details the case of James Tilly Matthews, who had been a patient in the Bethlem Hospital for about ten years. The book contains detailed accounts of Matthews’ delusions and hallucinatory experiences and is considered a classic in medical literature because it was the first book-length account of one single psychiatric case detailing the symptoms of paranoid schizophrenia. James Tilly Mathews however claimed that he was sane. This controversy eventually led to a court case, leading up to Haslam’s dismissal from the case (Porter and Dynum 1988).

14 Pinel further believed that mental illness was a natural phenomenon to be studied according to the principles of the natural sciences, namely, observation followed by a systematic presentation of data (Alexander and Selesnick 1967).

15 In the latter part of the 19th century medical science was devoted to an intensive study of pathological anatomy and biochemical investigations. In fact, by the end of the nineteenth century, it became clear that a nation’s economic and political future and progress depended upon a concomitant progress in science. Powerful nations like Great
nervous structure and function (ibid.). Clinical medicine had already made great strides in the first half of the 19th century.  

This period saw the juxtaposition of medicine and psychiatry like never before, such that each strengthened the other and saw the increasing confluence of organising principles. Neurologists were grouping neurological symptoms into syndromes and diseases. Neuropathologists were looking at lesions to explain these clinical phenomena and soon neuropsychiatrists followed suite by applying similar principles to behaviour. In the words of Franz G. Alexander and Sheldon T. Selesnick, ‘The symptoms of disordered behaviour and confused thinking could be labelled and eventually linked... to real medical knowledge of the pathways of the nervous system’ (1967: 161). Such developments encouraged students of behaviour of the 19th century to describe, systematise and classify mental diseases. The symptoms of disordered behaviour and confused thinking can be successfully linked to real medical knowledge, invoking concepts of neurological pathways, disease states of the brain and the spinal column instead of precarious philosophical and psychological vagaries.

Medicalisation, in effect, ordered the phenomenon of mental illness, that is, defined and classified it; it provided explanations for the development of mental illness and also indicated ways of treatment (Gove 1979). It completely altered the conceptualisation of mental illness, including social attitude and terminology. The language used to define the phenomenon of mental illness changed. Madness became a disease state invoking a specific epidemiological explanation and model that primarily held a mechanistic approach, where the method of intervention was mainly biological, and the nature of cure external to the person afflicted, and the attitude of the person afflicted, mostly passive (Dombeck 2000).

It is to be noted that biomedicine is variously termed western medicine, evidence-based medicine, contemporary medicine, modern medicine, cosmopolitan medicine and allopathy. Allopathy is a term coined in 1810 by the founder of Homeopathic medicine, Samuel Hahneman to refer to biomedicine and this term was seen as a derisive term and literally means ‘other than the disease’.

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Britain and France went all out subsequently to encourage scientific investigation (Alexander and Selesnick 1967).  

16 Thomas Adison (1793–1860) described a disease of the adrenal gland; Charles Bell (1789–1858), a form of paralysis of the face due to neuropathology; Richard Bright (1789–1858) a form of kidney disease; James Parkinson (1755–1824), a shaking palsy; and Thomas Hodgkin (1798–1866), a type of leukaemia that attacks the lymph glands (ibid.: 151).
Psychiatry in India

As can be seen, there is a particular history to the medicalisation of mental disorder and the growth of psychiatry in Europe, and it was this highly biomedicalised form of psychiatry with its focus on biology and organicity with a concatenating classificatory system and nosology, that was implanted in India by way of colonialism. Indeed, scholars examining the history of psychiatry in India (see Ernst 1997; Keller 2001; Mondal 2009; Sebastia 2009b; Addlakha 2010) have looked at a diverse set of issues including ‘linkages between the colonial state and psychiatry, indigenous medical systems, socio-economic change and cultural practices’ (Addlakha 2010: 47). The development of psychiatry in India has been described as ‘poor and inadequate’, and the whole area of mental disorder generally marred by ‘ignorance or persistent misconceptions’ (Sebastia 2009a: 3).

Psychiatry was not a specific and separate concern for the British authorities when they came to India. Rather it got clubbed with colonial medicine, much of which was concerned about public health in general and possible epidemics like the plague and cholera. It was only during the late 19th and early 20th century that psychiatry took roots in India (Fabrega 2009). It should be understood that during this time the indigenous systems continued to flourish. This context highlights the presence of alternatives to psychiatry and is significant.

Indian psychiatrists have also expressed discontent about the western practice of psychiatry and have called for its ‘Indianisation’ (Sebastia 2009: 6). Renu Addlakha (2010) argues not for ‘Indianisation’, but rather for what she terms ‘Indigenisation of psychiatry’ in India. Psychiatry, by and large, was an alien discipline, a colonial transplantation. After independence what has transpired is the indigenisation of psychiatry, wherein ‘a strong cultural relativist perspective permeates psychiatry in India’ (ibid.: 47).

The first hospital for mentally disturbed persons was started in Bombay (now Mumbai) in 1745, followed by Calcutta (now Kolkata) in 1787 and Madras (now Chennai) in 1794. These institutions mainly catered to European soldiers, and their functions were more diffused, treating not just mental disorders but also problems of vagrancy and delinquency brought forth amongst mostly lower-class British men situated as they were in the midst of unfamiliar alien culture and practice (ibid.: 48). These institutions housed Indians, but there were clear differences in the attitude and treatment.
towards them. Administratively, these institutions were in charge of the inspector general of police and only during the early 19th century were they put under the charge of civil surgeons. This also implied a contiguous shift from custodial care to medical treatment.

Though there are reports of earlier places of confinement of the mentally ill, the mental hospitals of the present stem from British conception. Lunatic asylums were set up in India from the late 18th century and continued to about mid-19th century. It was the British Lunacy Act of 1858 that laid down the guidelines for the construction of asylums and laid out the procedures for admission; the latter were modified for India, including elaborate procedures for admitting the mentally ill with pending criminal charges. Asylums were then used more to protect the public and less for treatment.

It was only during the 20th century, prior to Independence, that authority over asylums was transferred from prison administration to health service administration, with the passage of the Indian Lunacy Act of 1912, marking a shift from asylums to hospitals (Fabrega 2009). This period saw the growth and addition of facilities like that of occupational therapy and other rehabilitative services, efforts to educate psychiatrists and psychiatric nurses and establish links with families and caregivers through family units in hospitals.

In September 1962, the Mental Health Advisory Committee was founded to promote mental health and to draft the Mental Health Act, 1987. The Mental Health Act was enacted by Parliament in 1987, but it came into effect in all the states and union territories of India only in April 1993. This Act replaced the Indian Lunacy Act of 1912 (ibid.). Two decades later, the National Mental Health Programme was launched by the Ministry of Health and Family Welfare under the control of the Central and State Mental Health Authorities (Sebastia 2009a).

The first out-patient unit was set up in 1933; the 1960s witnessed a growth in their numbers (ibid.) The Indian Psychiatric Society (IPS) was set up in 1949 and the Indian Journal of Neurology and Psychiatry – later renamed Indian Journal of Psychiatry – was inaugurated. In 1954, what is presently the National Institute of Mental Health and Neurosciences (NIMHANS) was set up and became a centre for ‘education of

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17 European inmates were expected to read and ‘participate in games compatible with polite English company’ while the Indian counterparts were ‘made to engage in combative games and animal husbandry’ (Addlakha 2010: 49, see also Waltraud Ernst 2013).
psychiatrists, clinical psychologists, and psychiatric nurses’ (Fabrega 2009: 557). By and large however, ‘colonial discourse played a crucial role in shaping the nature of asylum psychiatry in India’, with colonialism interpreted as a ‘narrative of social control’ (Mondal 2009: 236, 237).

Significant developments in the discipline of psychiatry coincided with Indian independence, mostly in terms of the use of psychoactive drugs. This also meant long-term incarceration was not necessary and mental disorder could now be managed at an out-patient level as well. Medicalisation marked an important transition in the history of psychiatry in general and more so for India in terms of both policy and practice. Much of the current trend continues along similar lines, but with a certain confluence of biological with psychological and social intervention (Addlakha 2010).

Research on mental disorder has undergone several phases as well. Initially it was conceptual and more psychoanalytical aimed at improving psychological functioning. Between 1960 and 1972, the scope of research became broader, moving beyond individual pathology to look at group behaviour and even interface between society and the individual. Psychiatric epidemiological studies involving the Indian population were undertaken in the 1970s. Another important development was the focus on modern clinical neuroscience psychiatry, and much of the current trend follows suit. 19

**Shifting Epistemologies**

The development of approaches to mental disorder has not followed a linear order; rather, there has been a simultaneous existence of differing epistemological positions, with one assuming more attention and thus getting mainstreamed. Thus, historicity is important, and seeks to refute the belief that, in the words of Byron J. Good, ‘diseases are biological, universal, and ultimately transcend social and cultural context’ (1994: 8). This rational and objective definition deems as ‘incoherent’ any practice that is to the contrary, including healing systems of traditional societies (ibid.), and, by and large, overrides the local context. This process ensures the essential hegemony of the biomedical model and denies the multiplicity and plurality that other systems of medicine provide to the wide

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18 The Health Survey and Development Committee, known as the Bhore Committee, surveyed mental hospitals in the 1940s. Besides calling for improvements in the nation’s seventeen mental hospitals, the Committee’s report of 1946 also recommended placing a system of mental health under a director-general of health services and demanded more trained personnel. It was under the recommendations of the Bhore Committee, that the All India Institute of Mental Health, now called NIMHANS (National Institute of Mental Health and Neurosciences) was set up in Bangalore in 1954 (Fabrega 2009: 579).

19 Further details about the history of psychiatry in India have been provided in Chapter 3.
arena of treatment approaches. Acknowledgement of the latter includes ‘denaturalising’
disease states and viewing the latter within a cultural domain (ibid.).

In the European context, there is ample literature (see Kiev 1964; Alexander and
Selesnick 1967; Rosen 1968; Gijswijt-Hofstra et al. 1997; Cockerham 2000) underlining
the multiplicity of ‘notions of illness and practices of healing’ (Gijswijt-Hofstra et al.
1997: 4). Scholars have conceived and explained illness, including mental illness, in
varied ways. For instance, Gijswijt-Hofstra et al. in their work look at some of these
varied perceptions in Western Europe from the 16th to the 20th century and are concerned
with what they term the ‘cultural repertoires of illness and healing’ (ibid.: 1). These
included notions of the devil, demons, healing saints, the practice of magic, etc. all rife
with religious symbolism. Concepts of sorcery (Kapferer 1997), shamanism and
possession (Crpanzano and Garrison 1977) are particularly significant in this respect.

Multiple systems of medicine, in terms of practices and as a more nuanced
understanding about health, illness and healing, need to be given due cognisance. Such
alternative practices are found to have existed in all parts of the world, including Europe.
Outside of Europe there is an abundance of literature documenting healing practices,
including those dealing with mental disorder. This includes literature from South-East
Asia, Middle East, Africa and also Latin America (see Kiev 1964; Good 1994; Kapferer
1997; Smith 2006; Obeyesekere 1984; Gombrich and Obeyesekere 1988; Obeyesekere
1990). There is little doubt that, ‘human knowledge is culturally shaped and constituted in
relation to distinctive forms of life and social organization’ (Good 1994: 21). Practices
that are deemed to be irrational need to be examined within this framework. Such
practices include black/white magic, voodoo and even sorcery, invoking the supernatural
to heal. Explicating about sorcery, Bruce Kapferer in the preface to his book on the
practice of sorcery in Sri Lanka states ‘sorcery practices expose some of the vital
dynamics engaged in the way human beings construct their psychological and social
realities’ (1997: xi). Social science research in recent times has attempted to articulate just
those experiences that fall within the realm of the ‘subjective’.20 The attempt has been to
move away from the objective and the rational and examine experiences that are
subjective and inter-subjective. Here subjectivity becomes a ‘synonym for inner life
processes and affective states’; of interiority, in other words (Biehl et al. 2007: 6). What is

20 In the words of Good et al., ‘The increasing use of the terms “subject” and “subjectivity” in anthropology points to
a widespread dissatisfaction with previous efforts to understand psychological experience and inner lives in
particular cultures, characteristic of an earlier generation of psychological and cultural anthropologists...’ (2010: 2).
significant is that there has been a shifting between the two epistemological positions on the part of practitioners as well as caregivers of people living with mental illness.

India: Indigenous Systems of Medicine
As far as multiple systems of health and healing go, India epitomises this plurality. The Indian subcontinent has been privy to ‘a rich intellectual tradition of enormous scope and power’, that addressed among other concerns ‘emotional and behavioural disaffections, human predicaments, moral dilemmas about the self and spiritual standing, and conditions viewed as disturbances of physico-mental health’ (Fabrega 2009: 6). These are found in ancient texts that outline distinctive philosophies, spirituality, soteriology and medicine all seeking to explain how to attain relief from human suffering. These texts include the Vedas and Upanishads, the practice and philosophy of yoga, tantra and alchemy and tracts on Ayurveda and Siddha and Buddhist medicinal systems as well. Mental disorder/illness has been a part of this ‘amalgam of suffering and disequilibria of the self that constituted central preoccupations of India’s scholars, moralists, gurus, priests, healers, philosophers and physicians’ (ibid.), even householders and lay people. They established and developed ‘knowledge structures, social practices and institutions’ to address and ameliorate mental health problems (ibid.) and constitute ‘culturally evolved structures’ (ibid.: 15) for coping with human problems and suffering including mental disorder. The latter was seen not as disconnected phenomena, but deeply influenced by ‘social structures, cosmological and cosmogonic’ forces (ibid.).

Apart from textual traditions, India is also the repository of a range of popular, folk-based, shamanistic, indigenous medical traditions as well. While Ayurveda and Siddha represent a more rational and secular approach to disease and are cosmological to a certain extent, these folk- and healer-based practices are far more ‘proactive’, seeking to ‘preserve, relieve, transmute and extend health’, not just in a time bound manner, but at a larger moral and spiritual level, transcending time and space (ibid.: 17). India thus has both codified as well as non-codified systems that are folk- and healer-based addressing issues of health and wellbeing including mental disorder.

Two renditions of history vis-à-vis mental disorder are possible here. Given the significance of the sacred texts, one is to look at the history in terms of a pre- and post-Vedic age, underlining the influences on mental health and illness therein. The other is an outlining of the folk and traditional healing practices that are not necessarily associated
with the sacred texts, but have made a significant contribution to the repository of health practices and continue to do so.

The other important framework that can be used to postulate this history is to look at it in terms of pre- and post-colonialism, given the pervasive impact of colonialism in India, including in the context of mental illness. Both these histories overlap to some extent. Pre-colonial history is that of the sacred texts and folk practices and the most significant post-colonial feature vis-à-vis mental disorder is that of the advent of modern psychiatry and how that brought about a profound shift in the landscape of aetiology and treatment of mental disorder.

**Pre and Post-Vedic Medicine**

Pre-Vedic medicine is seen as the medicine of pre-historic India (Kutumbiah 1962). The period of prehistory of medicine in India extends from the earliest times, including the Palaeolithic and Neolithic ages, to the to the Indus Valley Civilisation, the Aryan invasion of India, that is about 1500 BCE, moving on to Vedic medicine. Not much is known about the culture and practices of the Stone Age people in India, but certain tribes have been deemed to be the remnants of the earliest known races in the country (ibid.). A study of the customs, habits and modes of living of these tribes suggest that their religion is animistic, consisting of the worship of demons and spirits; they practised animal sacrifice, they worshipped snakes and trees and had totems. Disease was believed to be caused by malevolent supernatural forces or even human beings, alive and dead. Accordingly, treatment involved magic, incantations and other rituals. Preventive aspect included the use of charms, amulets and talismans. These tribes are deemed to have followed ‘primitive’ medicine (ibid.).

The pre-Vedic period was epitomised by the belief in the external causes of diseases. Exorcism, use of amulets, magic and witchcraft were deemed to be a part of this paradigm. Diseases were believed to be caused by external agents like angry gods, possession by demons, angry spirits, sorcery and breach of taboos. The influence of planets and stars, the loss of the soul were other causes. Medicines were not disconnected from the sick person, but congruent with her/his social environment. Physicians were mostly priests, prophets, magicians and herbalists and diagnosis of diseases were based

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21 These tribes are thought to belong to two classes anthropologically, the Kolarians and that of the Dravidians. The chief representative of the former includes such tribes as the Kols, Koches, Santhals and the Savaras. The Dravidians include the Khonds, Gonds, Oraons and the Todas (Kutumbiah 1962).
on astrology, dreams, magical trance, invoking gods, divination through chanting as well as examination of the urine and liver. Primitive medicine had elements of empiricism, based on ‘seeing’, using herbs as natural medicine as much as ‘believing’, underlining elements of mystic faith and magic (http 1). The frontiers between magic and medicine were blurred.

The Vedas provided a rationale for medicine and therapeutics; gods in the Vedic pantheon included deified natural phenomena and natural forces and gods who were physicians. Knowledge about Vedic medicine has been derived from the Rig Veda and the Atharva Veda, but more the latter. Atharva-Vedic knowledge is an amalgam of religion, magic and empirico-rational elements. Pernicious activities of demons like pisacha, rakshasa, atrin and knava cause diseases, as much as gods and punishments for sins committed. Vedic medicine believed that diseases were caused by evil spirits, angry gods, evil deeds and sorcery. Treatment included propitiatory rites, offerings, auspicious oblations, penances, purificatory rites, fasting and incantations (Kutumbiah 1962). 22 Vedic medicine is deemed to have a metaphysical basis (Fabrega 2009), but as it evolved into Ayurveda, it crossed an epistemological divide and moved into a more naturalistic and empiricist approach. 23 Besides prayers, the Vedic texts mention ‘drugs (ingested and externally applied), mechanical interventions, surgical operations, and use of natural remedies such as the sun’s rays, fire, water and air’ (ibid.: 199).

With regard to psychiatric disorders, Vedic medicine was holistic and addressed all kinds of medical, spiritual and psychological problems causing suffering and disorder. Vedic medical theory applied to mental disorder was based on benevolent and malevolent deities and spirits populating the cosmos that needed to be controlled. Vedic medicine was also the product of peasant communities and their popular folk cultures. Some of these wandering medical healers joined and were amalgamated with Buddhist medical practitioners.

A few key points need to be reiterated by way of concluding this section. By and large, Vedic medicine emphasised magical and religious healing as much as following rational and empirical approaches (Kutumbiah 1962; Fabrega 2009). This mix of epistemologies is a significant feature of Vedic medicine and also post-Vedic medicine. Remnants of it will be seen in Ayurveda as well, as an instance of a codified post-Vedic

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22 Further details about pre Vedic medicine have been provided in Chapter 4 of this thesis.

23 Scholars have mentioned differences between the two systems, Vedic and Ayurvedic, with Vedic being more magico-religious and Ayurvedic, more physiological, anatomic and somatic (Fabrega 2009).
medical system. Ayurveda represented a formulation of holistic health, wellbeing and disease that includes scientific, moral, spiritual and cosmological aspects. Horacio Fabrega describes Ayurvedic psychiatry as comprising of ‘an epistemology and therapeutics based on Indian medicine that was rooted in careful observation, description, empiricism, and naturalistic forms of reasoning and evaluation’ (2009: 323). With the coming of Ayurveda, ‘the construction of psychiatric phenomena changed’ (ibid.). A vocabulary and idiom based on naturalistic and organic ontology and epistemology was added to the spiritual, religious and philosophical approach in a way that did not displace but complemented the pre-existing framework of meaning (Fabrega 2009).

Another key point is that, while there was the practice of a priestly Vedic medicine, there was also a more popular, practical and less esoteric and intellectual Vedic medicine existing alongside priestly medicine. This drew from a rich folk knowledge and expertise of the section involved in agrarian pursuits (ibid.). Both are important features of the pre-colonial history of medicine in India. At the village level, and in the peripheral sectors of towns and cities and among the poor, among migrant populations handling of illness and disease, including mental disorder, was through religion, ritual, magical beliefs and practices that were less Sanskritic and more popular and folk based. The plethora of practitioners were accordingly approached, including yogins, tantrics, Siddha experts, herbalists, practitioners of black magic, sorcerers and shamans often practising without supervision or a system of evaluation and regulation (ibid.).

The advent of Ayurveda altered the landscape of approaches to mental disorder further. In time, especially in South India, the ‘academic, scientific and indigenous tradition’ (ibid.: 326) of Siddha medicine became another important addition to the systems of Indian medicine. Siddha drew from Dravidian cultures and Tamil literature but also had connections to Ayurveda. Siddha and the Siddhars embodied a complex intermix of tantra, yoga and alchemy. Later on, to this existing amalgam was added Unani medicine and, eventually, western bio-medicine. As a result, ‘the cultural infrastructure of psychiatric phenomena by and large retained its religious/spiritual and moral/ethical character but a superstructure of professional and secular interpretations acquired significance in some spaces’ (ibid.: 327).24

Consequently, besides modern psychiatry, three codified indigenous systems of medicine address mental disorder in India, namely, Ayurveda, Siddha and Unani, apart

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24 It was not just Siddha and Unani that constitute the systems of medicine in India. To this can be added yoga, tantra, and medicinal practices of Buddhism and Jainism as well (Fabrega 2009).
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 origin of Ayurveda is generally traced to the Atharva Veda (c. 1000 BCE) which has details of religious and priestly medicine similar to early Egyptian medicine (Subbarayappa 2001). The Caraka Samhita, the oldest of the major Ayurvedic texts, mentions three kinds of therapy for the treatment of mental illness, namely, spiritual, rational and psychological (Smith 2006: 471).

An important phenomenon that occupies an interstitial space between madness and sanity is possession. While, when it is deliberately invoked, it carries profound religious symbolism in almost all religious systems of the world (see Crapanzano and Garrison 1977), at other times it is seen as mental illness, including within the aegis of the Ayurvedic system that locates possession within a category called ‘unmada’ or ‘manasik- roga’, that is, mental illness (Smith 2006: 473).

Ayurveda recognises the interrelatedness of body and mind, of food and medicine and within the body of various physiological processes. Central to disease conception is the concept of balance or equilibrium necessary to the attainment of human goals. It further recognises the dynamic interaction between an individual (microcosm) and the universe (macrocosm) and its theory of loka-purusa samya (equivalent of microcosm and macrocosm) ‘envisages that an individual’s health would be sound and vibrant, if the interaction is natural and wholesome, while a disharmonious interaction would lead to a diseased state’ (Subbarayappa 2001: 139). A seminal concept in Ayurveda is the tridhatu-tridosa (vata, pitta and kapha), a three-pronged humoural theory that encompasses physical and physiological processes in the human body along with pathogenesis of disease and their symptoms. Health is a state of equilibrium in the tridosas and disequilibrium would be a disease-state. 25

Siddha is a cosmological unitary system of medicine. 26 Around the 4th century CE, the beginnings of a new system consisting of esoteric practises and inspired by Chinese alchemy began to sprout. In the succeeding five or six centuries, this manifested itself in the form of Rasa Sashtra (Sanskrit tradition) and Siddha (Tamil tradition). Both were concerned with rejuvenation and life-prolonging methods. It was originally confined to

25 See Chapter 4 for further details about the history of Ayurveda and for mental disorder and Ayurveda.
26 It was believed to have been developed by ancient saints named ‘Siddhars’ who gained knowledge through deep meditation. The Siddhars were a class of popular writers in Tamil and they wrote in the language and were believed to be men of high culture, intellectual and spiritual faculties (Kannan 2000).
Tamil Nadu and adjoining areas and was popular among Tamil speaking people (Subbarayappa 2001). Akin to Ayurveda, disease is believed to be caused by disequilibrium of the three humors, namely, *vatha*, *pitha* and *kapha*. Multiple factors are deemed to affect this balance, including such extraneous factors like climate and environment, diet and stress.

The Unani Tibb system of medicine can be traced to the system of Greek medicine developed during the Arab civilisation, called the Greco-Arab system (http 2). In the succeeding centuries, under the patronage of Muslim kings, the Unani system began to take roots flourishing under the Mughal rule. Ayurvedic practitioners did not deem Unani a threat to their own practise. In fact, *hakims* (Unani practitioners) and *vaidyas* (Ayurvedic practitioners) worked in tandem whenever the occasion demanded and were patronised equally by the Muslim kings (ibid.). Not surprisingly, Unani is similar to Ayurveda. The basic philosophy of the Unani system is that the body, composed of matter and spirit, is taken as a whole and a balance between the physical and spiritual functions results in good health.

Folk therapies or religion-based therapies are also popular in India. Scholars include under this category all those practices that fall outside of the purview of the Indian State (Quack 2012). Studies have been conducted to examine the effectiveness of such therapies (cited in Sebastia 2009a: 12). But, within the aegis of psychiatry, these are seen as ‘irrational and non-scientific’. Terms like folk and traditional therapies are often used as an umbrella term for a set of ‘heterogeneous practices’, and include such practitioners as healers, astrologers, *tantriks*, oracles, religious specialists practicing at temples, *darghas* and churches (Kakar 1982; Quack 2012: 2).

Here what is important is that illness and healing is not necessarily the central focus; problems like finance, bad luck, and marital problems are also dealt with (Quack 2012). Many factors appear to determine recourse to folk therapy, including beliefs about the aetiology of the illness, familiarity with the healer and approachability, the stigma associated with psychiatry, the social network that promotes folk therapy etc. (Sebastia 2009a). Folk healers are seen to play an important role in ameliorating stigma associated with mental disorder; how effective they actually are in doing so is an important question.

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27 Some authors (for example, Krishnamurthy and Mouli 1984) state that there was a single system of medicine called *Ayurveda* and there are thus vast similarities in the two systems.

28 Details about Unani system of medicine and mental disorder have been provided in Chapter 4.
The fact is that folk healers are a part of the cultural milieu of the people who approach them for help. The attitude that the people and community as well as other practitioners hold towards them are also important in determining how effective they are in de-stigmatising mental health problems. J.S. Neki, an Indian psychiatrist, estimated way back in 1973 that 80 per cent of the Indian population approach folk healers and traditional healing centres for the treatment of mental disorder (Quack 2012; see also De Souza and De Souza 1984; Pakaslahti 1998).  

Religious therapies have always found important space in the rubric of treatment and healing within the Indian cultural framework. For instance, Pilar Galiana Abal (2009) in Sebastia ed. (2009a), studied the role of ‘darsana’, a major religious ritual which consists of visual contact with a deity, symbol or person considered worthy of respect or a saint. Abal focused on what the Siva lingam means to the psyche of the devotee, and the devotee’s emotional and affective ‘transference’ onto a non-human object or an object of worship. Through a ‘darsana’ performance the sufferer expresses the longing to be free of his/her persecutory anxiety and destructive impulsions (ibid.).

The repertoire of treatment approaches in India has always been wide and plural. How effective these are is a moot point. The role of culture including religious idioms cannot be denied within this context. The role of the community in bringing about change in the lives and conditions of those afflicted has also been emphasised. All these practices find their condition of inception rooted in pre-colonial times.

A major shift that took place with regard to systems of health and healing is during the advent of the British rule – first through the establishment of trade relations in the form of the East India Company and later through their the process of colonisation. Modern medicine and psychiatry were transplanted into the country during this period. Because of the official patronage that it enjoyed and the power that it came to wield, modern medicine came to be recognised as the medical system par excellence and all the other systems got clubbed together under the residual category of ‘alternative’ systems.

29 Further details about traditional healers have been provided in Chapter 5.
II

Interface:
The Problem of the Study

For the purpose of this research interface will be defined as a point where two systems meet and interact. It is an area that links two or more fields of study or disciplines. Given the plural medical landscape in India, interface between systems is a given. The main aim of this study is to examine the interface that takes place between systems of health as well as practitioners of various systems of health and healing. Despite the diverse histories and conditions of inception of different systems of health in India, these systems operate in the same socio-cultural space and provide a wide array of treatment options to people for a wide range of problems including mental disorder. The important question is what transpires when these diverse systems interface?

Psychiatry in India stands at the crossroads between being modern and traditional. Its practitioners espouse a western-centric scientism, adopt a pre-dominantly neurobiological approach, take on a more public health view of their work and strive to maintain a biomedical emphasis, not just by way of distinguishing themselves from other practitioners but also to maintain credibility among the larger medical fraternity. Psychiatry in India has to also compete with the other systems of health and healing. At the same time, psychiatry is connected to traditional/folk/codified systems because people approach these systems actively, sometimes even before they approach psychiatrists; and folk practitioners have known to refer patients to psychiatry. Traditional healers are integrally connected to the community and the family, and the latter is integral to caregiving as well as making decisions relating to treatment and consulting a practitioner.

Most psychiatrists would agree that mental disorder is a collective term for many different conditions, differing in their causation: some show clear disease process of the brain, others a result of biochemical processes and still others a result of the breakdown of vulnerable personality in the face of stress. This is the result of an interaction between one’s genetic heritage and the stress one is exposed to (Carstairs et al. 1976).

While taking on these views about mental disorder, the Indian psychiatrist is keenly aware of the impact of culture and the idiom of religion, especially on mental disorder. For instance, the psychiatrists who took part in preparing The Mental Health Act, 1987 were concerned about the beliefs, traditions and perceptions in relation to mental disorders. This interest is epitomised by the anthology Psychiatry in India (De Souza and
De Souza 1984), which is a compendium of articles written by psychiatrists on therapies and symptomatology with regard to Indian culture.

Psychiatrists have stood out and made efforts to integrate cultural elements into their practice in a bid to understand their clients/patients. Dr Neki, a prominent psychiatrist, advised his colleagues to ‘listen to their patients, to show interest in the aetiology and to pay attention to the idioms that they are employing, to use the psychotherapy and therapeutic techniques of traditional medicines, and to make religious references’ (cited in Sebastia 2009a:4). He also advocated the use of the Bhagavad Gita to help patients suffering from depression and use the guru–chela (teacher–disciple) relationship to improve prospects of recovery (ibid.: 5). Indian psychiatrists thus occupy an interstitial space between modern biomedicine and culture/tradition and this brings to the fore a distinct rendition of psychiatry.

Renu Addlakha looks at changes in trends through examining various psychiatric journals including what she terms ‘cultural re-interpretation of major psychiatric syndromes, their phenomenology and therapy’ (2010: 55). For one, Hindu scriptures and indigenous systems of medicine are the filters through which western psychiatric concepts have been questioned (ibid.). Research has also been undertaken to examine the impact of the ethno-medical and religious symbolic systems on concepts of mental illness and health.

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 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. 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.

At a broader level, culture becomes a significant determining factor. This is particularly so in the case of the so-called ‘culture bound syndromes’ like possession and sorcery (ibid.). This is situated within the category of dissociative reaction in psychiatric parlance and its classificatory system, but is also an important phenomenon culturally (Kapferer 1997; Smith 2006; Sax 2009), that not only often acts as a cathartic process for community members, but also reflects how communities actually ‘engage with the
fundamental processes by which human beings construct and transform their life situations’ (Kapferer 1997: xii).

Traditional healers are particularly concerned with addressing these issues. Several Indian psychiatrists have looked at the socio-demographic characteristics of traditional healers acknowledging their role as therapeutic resources in the community and stressed upon the need to understand their diagnostic and treatment systems (Addlakha 2010). This again constitutes an important site of interface. Addlakha observes, ‘The interpretation and treatment of possession syndrome in the clinical context requires the psychiatrist to walk a tight rope between pathologising it as a psychiatric disorder and … respecting the patient’s and even the family’s belief in divine visitation’ (2010: 63).

Just as there are multiple perceptions of mental illness and madness, there have always been multiple agencies addressing them. Doctors and psychiatrists are the formal professionals who by virtue of their training and knowledge ‘treat’ mental illness. But every society will also have other people who handle and deal with mental illness and madness. In the Indian context, examples include shamans, vaidas, mantarwadis, and patris (Carstairs et al. 1976; Kakar 1982). These are traditional ‘practitioners’ who have, through rituals, chanting, the use of charms, amulets and even medication consisting of natural substances, ‘treated’ mental illness, and continue to do so. They exist in concatenation with medical professionals in the community; literature shows that community members access both, without perceiving any contradiction (ibid.). 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. Experiences from ethnomedicine, ecosystem management, and community health all suggest that health professionals in the twenty-first century may gain new tools by innovatively combining the best of science with the best of the old ways (Taylor 2001).

**Rationale**

In the context of mental disorder and treatment, India is defined by multivocality; a juxtaposition of psychiatry and indigenous systems of medicine along with non-codified traditional practices of healing together make up a rather vast repertoire of treatment approaches to mental disorder. These approaches can be examined at two levels, namely, ontology, epistemology or theory, on the one hand, and treatment processes and cure or practice, on the other. Usually, one informs the other.
Because of the plural landscape in the context of the systems of health and their differing points and conditions of origins, and the fact that these systems of health continue to exist and flourish, India can be seen as a space for the distinctive amalgamation of the modern and the traditional in this context. Mental health discourse in India is to be located within this framework. There is a predominantly medicalised discipline of psychiatry that is more universal, in a sense that its disease classification is based on such manuals as the International Classification of Disease (ICD) currently used in its tenth revised version and the Diagnostic and Statistical Manual (DSM) currently out with its fifth revised version, and it is presided over by larger international bodies like the WHO and the American Psychiatric Association (APA) and the discipline and its mandates are more or less shaped by these powerful bodies.

But, as stated earlier, pure psychiatry is difficult to practise, because cultural nuances permeate it. This interface between psychiatry and culture has led to the development of a hybrid form of psychiatry, wherein Indian cultural factors are acknowledged and sometimes brief the therapeutic process.

Psychiatry, based on an essentially western system of medicine, and indigenous systems of medicine as well as traditional healing practices belong to different ontological and epistemological positions, and put forth different diagnostic and treatment processes and procedures. Codified systems operate with their own set of rules and regulations cemented through a process of gradual institutionalisation. Theoretically, such reasoning appears to be sound, but at the level of praxis, it is not so: the reality is complex. For one, psychiatry came to India as a part of the colonial project and was seen to be a tool of the latter, whereby it was seen as yet another means of effecting social control (Addlakha 2010). In fact, much of practice and policy to do with the discourse of mental health and illness has been indelibly affected by the colonial attitude and shaped it, even after independence (Ernst 1997; Keller 2001).

Medicalisation was a key event in the discourse of mental disorder that shaped the discipline of psychiatry. The birth of psychiatry as a discipline and its organising principles sidelined the social pragmatics comprising a varied cultural, ethnic and local milieu, within which mental disorder was so far located. Historically, it is possible to identify this rift that marked the demarcation of biomedical from the non-biomedical in the context of mental disorder. Each trend is further defined by its own set of ontological and epistemological assumptions that also moulded contiguous practices.
With regard to mental disorder, India has a significant pre-colonial history as well; a pre-modern history that was steeped in local, indigenous, community-based practices, which were sidelined and relegated as non-scientific and non-rational, as opposed to the modern, scientific, progressive practices that the colonial powers brought forth.

While historically it is possible to locate this dichotomisation between the pre-modern and the modern within the context of mental health discourse in India, the picture is hazier in the present context. The fact of the matter is that psychiatry has not been done away with any more than indigenous practices have been, despite a large body of literature concerning the critique of psychiatry, both in the western context and in the context of India.

An important phenomenon, given the simultaneous existence of multiple systems is the interface of these varied systems. In the western world, the question of interface may not be such a pressing concern because of the larger predominance of biomedicine and psychiatry. In India there are multiple systems of health and healing in operation each with distinctly different epistemological principles, but operating within a bounded field of healing options that caregivers and patients negotiate with. Within this scenario, psychiatry is an extraneous implantation but it necessarily has to engage with already existing systems that pre-date it. Ayurveda as one of these pre-psychiatry systems has two versions: one, a traditional system that involves teaching between an established teacher/practitioner and her/his apprentice and follows a traditional structure that sees a one-to-one engagement between the teacher and pupil. The other is a modern institutionalised and formalised rendition of Ayurveda that follows modern educational precepts with a standardised syllabus and associated regulations, and government approved bodies that monitor these institutions. In a state like Kerala psychiatry will have to contend with both these versions, given the popularity of Ayurveda in the state.

Interface becomes inevitable. 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. The larger argument that is being posited here is that systems do not have agency. Practitioners do. Systems accordingly 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 its practitioners and how closely a practitioner will adhere to the ontological principles of a system.
Caregivers in this respect are the least restrained by systemic and professional concerns. Furthermore, while practitioners may have the luxury of adhering to the principles of their respective practices, 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. Psychiatrists appear to be the most closed to allowing ingress into their system. The modern system of institutionalised Ayurveda structurally interfaces with allopathy by incorporating subjects and topics that traditionally fall within allopathy. The most open to interfacing are traditional healers. Though ontological and epistemological principles of a system account for the degree of acceptance and rejection, but because systems as mentioned earlier do not have agency, practitioners have the option of negotiating and making compromises and in the process creating a leeway for interface with other systems. The question is do practitioners do so acknowledging deficiencies in their own systems.

What allows for both sets of practices to exist within the same space is also the fact that mental disorder/mental illness is a hugely complex phenomenon. Historically too, in terms of treatment and attitude, mental illness has always occupied an interstitial space between the organic and the metaphysical. While doing so, this occupation of a liminal space creates an important space for the interfacing of systems. Interface is thus an important facet of treatment and needs to be examined closely. It has important connotations for the treatment of mental disorder and it animates a principle of multiplicity in treatment approaches, an aspect not necessarily subscribed to by all practitioners. Due to these factors, practitioners like the Indian psychiatrist end up being more ambivalent rather than rejecting outright other practitioners. Spaces for interface consequently emerge.

This study attempted to examine the sites of interface between systems. 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 three different ‘systems’ were chosen for the study. They, no doubt, do not exist or operate in isolation; they exist within the same socio-cultural space in which mental disorder is addressed.
While engaging with the discourse on mental health and illness and treatment in the context of India one would have to address these differing approaches. The important question to ask is: what shape does this discourse take, given the presence of such varied approaches to mental health? Are these systems of medicine and healing practised in their pure forms? Do they, by virtue of their organising principles, negate each other, or do they allow space for confluence? In other words, how do these varied approaches/systems interface and at what level? 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.

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 practise. So the modality of interface needs to be determined. Is it at the level of ontology or practise that the space for interface is greater? Are possible shifts due to interface, if at all, at the level of practise 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 different systems?

**Research Questions**

The research study examined multiple approaches within the aegis of theory (ontology and epistemology) as well as practice. But its concern is not primarily with ontology and epistemology of any approach alone, but how they are negotiated in practise. Therefore, the study examined not only the relationship between theory and practise, but also how the epistemological boundaries are maintained or transcended, as the case may be. Some of the important questions that this research addressed include:

- Why does interface between systems take place?
- What are the spaces for interface between these varied systems?
• How do traditional codified systems of medicine like Ayurveda interface with the biomedical system of psychiatry in the context of mental disorder and vice-versa?
• How do traditional/folk systems of healing and medicine interface with biomedicine in the context of mental disorder and vice versa?
• What are the implications of this interface for the treatment and practice concerning mental disorder?
• Finally how do caregivers contribute to the phenomena of interface between disparate systems of health and healing?

Methodology
This study locates points of interface between systems of health and healing based on different ontology and epistemology. It examines three important categories of practitioners: (i) psychiatry as an instance of a western biomedical system, (ii) Ayurveda as an instance of codified indigenous institutionalised system, and (iii) traditional healers as an instance of a non-codified, non-institutionalised, unorganised sector. Psychiatry, by virtue of its pervasiveness and its predominantly western biomedical orientation, becomes the point of reference for other healing systems. Ayurveda, an indigenous codified system of health and medicine, is a popular health system in parts of the country and abroad too. And the traditional and folk healers, by virtue of the role they have played for centuries in allaying the process of healing, are integral to the mental health discourse in India. While the repertoire of traditional healers is very large, this study has focused on those healers located within or associated with religious spaces, like churches, mosques and temples.

The main objective of this study was to understand the interface between psychiatry, Ayurveda and traditional healers. To realise this objective, the study involved talking to the practitioners of different systems to unravel how the practitioners become the conduit for interface between systems of medicine that are based on different ontological principles. What kind of attitude and motivation mark the interface? In-depth interview was deemed to be the method most suitable to collect data from the practitioners. An interview guide was prepared and questions formulated accordingly.30

Apart from practitioners of different systems, the study examined another key set of people, instrumental in orchestrating interface amongst disparate systems. These are the

30 See Appendix for details.
caregivers of people living with mental disorder. They are not necessarily tied down by institutional or systemic restraints in making choices while dealing with mental disorder. Within the constraints of time, money and energy (or aided by these) they have the freedom to choose both the system and the practitioner. In-depth interviews were the method used in talking to the caregivers as well. The sample of participants in this study could not have been but purposive.

Geographically, the research covered the cities of Mumbai (Maharashtra), Bengaluru (Karnataka) and Kottakkal (Kerala). I interviewed twenty-three psychiatrists in all. Twenty of these psychiatrists were located in and were practising in Mumbai. I identified them by word of mouth initially, but identified a few by looking at lists of psychiatrists available on the Internet as well. A couple of psychiatrists were also identified through newspaper articles about their work. Availability of time on the part of the psychiatrists de-limited my list. All the psychiatrists interviewed had extremely busy schedules, as they moved between hospitals and clinics across the city and attended to their patients/clients. From my interviews with the psychiatrists, I gained important insights about how they viewed the system in which they were trained and which they practise and how they viewed other systems.

Contrary to my expectations, I found very few psychiatrists who actively interfaced with other systems. I thought NIMHANS in Bengaluru would house such practitioners. With difficulty I managed to meet and interview three psychiatrists at NIMHANS. The process of finalising the appointments and getting all the requisite permissions from the concerned authorities took over seven months. Then too the permission letter reached after the dates allotted for the interviews had already passed! Another set of phone calls had to be made and new emails sent out stating the problem. Finally, the appointments were confirmed.

Another reason for choosing NIMHANS was that it houses an Ayurvedic centre in the premises and I had been told that psychiatrists worked with the Ayurvedic doctors here. While in Mumbai, I had conducted a couple of interviews of Ayurvedic physicians working in two separate government and semi-government Ayurvedic hospitals. While the interviews were very detailed about Ayurvedic theory vis-à-vis mental disorder and health and wellbeing in general, I was not able to gain much by way of the practice of Ayurveda in the context of mental disorder. They said, in the city, Ayurvedic doctors usually did not deal with mental illness directly. Most patients were referred to psychiatry. They told me about Arya Vaidya Sala in Kottakkal, Kerala, an institution that treats
mental illness within the Ayurvedic system exclusively. Given its significance for my study, I extended my fieldwork area to Kottakkal. After interviewing the three psychiatrists in NIMHANS and conducting more interviews at the Ayurvedic centre at NIMHANS, I went to Kottakkal and conducted three more interviews with the Ayurvedic doctors working there, including with the Director. In Bengaluru, I was referred to an Ayurvedic physician who heads an Ayurvedic college on the outskirts of the city, with over forty-five years of work experience; I interviewed him as well. I interviewed eight Ayurvedic physicians in all.

Once back in Mumbai, after having completed the interviews with the psychiatrists and Ayurvedic physicians, I set about locating the traditional healers. I identified, located and interviewed eleven healers through word of mouth. I interviewed healers associated with religious spaces, like temples, churches and also a mosque. Nine of the healers were introduced to me by someone who knew them and had consulted them for various reasons. Hence, each time I had a reference; I called them and asked for time and provided my reference. Only then they agreed to meet me. A few asked me questions about myself, before I was allowed to meet with them. For instance, I was asked if I followed a particular religion and belonged to a particular community; if not, why did I want to know about their work and so on.

Initially, I had also tried to go to popular religious healing spaces around the city, known for healing work, and simply asked around for a healer. This did not always work. I found two healers this way, one associated with a temple in south Mumbai and one with a mosque. I was refused an audience in another religious shrine. A renowned healer, about whom, people located around the shrine spoke much, refused to meet me; I was thought to be a journalist and the healer did not want any publicity; I was also identified as an unaccompanied female and therefore refused an audience. All eleven healers were located in Mumbai, with one healer moving between the city and his village.

The last set of people whom I interviewed was the caregivers of people living with mental disorder. With the help of a psychiatrist whom I had interviewed, I was able to attend the out-patient clinic in a semi-government hospital for a week. Here I was able to interview caregivers while they waited their turn to refer their wards to the doctor. I also approached a non-profit organisation that runs a day-care centre for people living with mental disorder and they gave me a list of previous and current caregivers associated with the organisation. I called the caregivers first and then either went to their respective homes to speak with the caregivers or conducted the interview over telephone, depending
on what was convenient to the caregivers. I interviewed a total of forty caregivers.

Besides these four sets of people, I interviewed two social workers associated with a psychiatric hospital in Mumbai and one in Bengaluru, a retired clinical psychologist and Head of the Department of Clinical Psychology at NIMHANS, Bengaluru, a mantarwadi/naturopath and Ayurvedic practitioner and a neurologist both based in Bengaluru and a swami (ascetic) and a teacher of Vedanta philosophy in Mumbai.

Most of the interviews were recorded, with permission. Where permission was not given to record the interviews, with permission, I made handwritten notes. The interviews took between thirty minutes to over an hour and a half depending on the time a practitioner or caregiver gave me. While I followed a similar structure and line of questioning for the practitioners of the same system, I altered the order and nature of the questions somewhat for the other practitioners depending on the context. The line of questioning for the caregivers was different from that of the practitioners; I interviewed them last and used insights from interviews with practitioners to speak with the caregivers.

Once all the data was collected, the recorded interviews were transcribed verbatim. I went through this raw data and identified themes for each set of data, pertaining to each practitioner and the caregivers interviewed. These themes were drawn from the research questions, but additional themes were generated based on the nuances of the interview. The data so processed formed the basis for writing the ensuing chapters. For instance, for the practitioners I identified such themes as theoretical approach to mental disorder and perception of mental disorder, gaps or strengths and weaknesses of particular systems and interface and so on.

**Ethical Considerations**

The study involved interviewing not just practitioners of different medical systems but also people who access these systems, including family members and caregivers. Confidentiality is imperative here because mental disorder is a sensitive issue and considerable social stigma is attached to it. The purpose of the research was explained to all the people interviewed and all were assured that confidentiality would be maintained; assurance was provided that the information collected would be used for

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31 For a list of questions for the different sets of practitioners and caregivers see Appendix.

32 All names of the participants have been accordingly changed and pseudonyms used.
academic purposes only. At all times it was made clear that participation is voluntary and that they are free to withdraw participation at any time if they so desired. The scope and objectives of the research was also explained to the not-for-profit organisation that facilitated the interviews with caregivers.

**Organisation of the Thesis**

The thesis is divided into seven chapters including this introduction, which has outlined the historical background of the study, as also its objectives, research questions and methodology. This chapter provides a brief sketch of the different systems of healing that deals with mental illness in India, in the context of this research. It begins with psychiatry as a modern system; examines the ontological base of this medical specialisation and specifically explores a brief history of its entry and trajectory of growth and development in India. It then examines India as a space for multiple systems of health and healing and briefly enumerates upon these systems.

The second chapter presents a review of the literature on the topic of the study. This includes examining the different systems in the context of its epistemological orientations and underlining the significance and relevance of interface between systems. This chapter explicates upon the idea of multiple and shifting epistemology by looking at the way the various systems of health and healing have been studied and how interface becomes possible.

The next three chapters analyse the data obtained from the three categories of practitioners addressing mental disorder, namely, the psychiatrists (Chapter 3), the Ayurvedic practitioners (Chapter 4) and the folk/traditional healers (Chapter 5) respectively. These examine the data and posit how and why, if at all, interface takes place with the other two systems of health and healing, how they approach mental disorder, what do they think of their own system, do they think there are gaps in the system, how are these overcome and finally what do they think of interface. The sixth chapter engages with the experience of the caregivers with the systems of medicine and practitioners whom they have consulted.

In Chapters 3 through 6, the focus is on the interface between systems, as seen from the perspective of practitioners and that of the caregivers. The main findings of the study are recapitulated and consolidated in the concluding chapter, that is, Chapter 7.