Chapter 2

Approaches to Mental Disorder: A Survey of Literature

Mental disorder is an age-old universal phenomenon that has been dealt with variously across cultures, including in a manner vastly different from that of the biomedical model and psychiatry. In fact, some of these approaches to mental disorder pre-date biomedicine and are in existence even today. The advent and growth of biomedicine, despite the kind of power it holds, has not been able to replace them totally. All the same, the kind of expertise and speciality that biomedicine brings have not found any substitute in any other system of health and healing, and the virtues of modern medicine can hardly be denied. Given the complexity of mental disorder and the search for cure by caregivers, interface between biomedicine/psychiatry and other systems is inevitable.

One way to distinguish between these systems of health and healing that address mental disorder is in terms of their ontological and epistemological principles. A close examination reveals two positions: one that locates aetiology in biology and the other that locates it in the domain of culture. Historically, the boundaries between these two epistemic positions for any system have been blurred. Hence, in earlier times, physicians were priests too. While a separation did take place positioning biology in a dominant epistemic position, scholars have time and again brought forth the significance of the socio-cultural aspect in examining mental disorder.

This chapter will examine how scholars have approached the different systems of health and healing, including their ontologies and epistemologies. The larger argument that is posited here is that scholars have brought forth the significant role that socio-cultural factors play in the discourse of mental disorder, including in determining choices in systems of medicine. The role of culture has been thus examined through various studies concerning mental disorder. The critique of biomedicine is a part of this amalgam of work and has been tangentially approached. Within the medicine-as-culture perspective, the discipline of medical anthropology has played a significant role and has been examined separately. The work with regard to India as a medically plural space follows.

Mental illness/disorder has been the subject of a vast amount of scholarship currently as well as in the past several decades. This scholarship can be clubbed into several strands/trends. For instance, an older trend going back to the 1970s emphatically critiqued
the role of biology in mental disorder and culminated in the anti-psychiatry movement. Studies that critique psychiatry have several strands.¹ Michel Foucault, for instance, propagated a paradigm shift that regarded delusion not as madness or illness, but as a behavioural variant or an anomaly of judgement (Nasrallah 2011). Other scholars thinking on these lines include psychoanalysts Jacques Lacan and Erich Fromm who authored anti-psychiatric writings from a secular humanistic viewpoint. Electro Convulsive Therapy (ECT), used extensively in the United States in the 1930s, and a frontal lobotomy procedure practised in the 1940s intensified fear and aversion towards psychiatric therapies. Anti-institutionalisation (see Goffman 1961) and anti-medicalisation (see Illich 1975) were addendum to this protest (ibid.). The anti-psychiatry movement emerged from a critique of the medical model and the way it treated patients.

Around the same time, social scientists were actively pursuing the study of practitioners² other than the proponents of modern medicine including botanical healers, midwives, and bone setters and so on who worked within communities and were intrinsic to them. In other words, alternative medicine/complimentary medicine as the terms used started to gain attention. The medical profession too started to realise that it is a cohabitant in a ‘postmodern medical network in which consumer preferences dictate the service profile’ (Kaptchuck and Eisenberg 2001: 189).

The connect with alternative healing system can be traced to the late 18th century and more robustly in the mid-19th century when a number of non-conventional medicine systems developed in the West, like Homeopathy, Hydrotherapy, Osteopathy and Chiropractic. These criticised orthodox medical practitioners, emphasised patient-centredness and offered substitute to mainstream medicine. Outside of the West, medical systems like Ayurveda and Chinese medicine evolved historically and became formalised. The point being that non-conventional medicine defined health and illness differently from conventional/modern medicine: in terms of concepts of balance and harmony, illness understood as the accretion of toxins and impurities, to result from magical, spiritual or supernatural causes or arising from energy blockages in the body such that healing action might constitute such steps as regaining balance or even constituting energy transfer from practitioner to patient (Jutte 2001).

¹ The works of R.D. Laing, David Cooper and Thomas Szasz will be discussed in a separate section.

² It is to be noted that a sociological and anthropological interest in non-western societies including practitioners of medicine in these societies is a much older concern. The section on Medical Anthropology in the Chapter will provide some instances.
A related but separate field of study that examines plurality of health systems and underlies the role of socio-cultural factors in health and illness, including underlining the role of the subjective experience of illness and health or the phenomenology of the experience of mental disorder, is that of Medical Anthropology.

Given the increased attention to these non-biomedical/orthodox/modern practices and practitioners, a more recent trend can be located in a larger conceptual field of study termed medical pluralism. An emerging and related field termed ‘integrative medicine’ can be identified as well; this is an attempt to combine elements of ‘varied healing systems in order to eliminate the deficiencies of any single one’ (Adler 2002: 413). The term integrative is used to indicate a ‘collaborative, multi-disciplinary approach’ that calls for an application of different healing systems and focus on ‘the diagnostic and therapeutic strengths of a combination of systems into a comprehensive and individualised treatment strategy that encourages patient participation’ (ibid.). The study of interface between systems can be located in the latter two trends.

To summarise, the period of critique of biomedicine simultaneously saw an increased attention to the alternative practices. Both kinds of systems continued to exist. Medical pluralism was to follow. Interface studies are the logical next step. What connects these varied strands together is the role of cultural factors that these approaches highlight and deem to be central to the process of healing and health.

**Role of Culture in Mental Disorder**

Research about the true nature of mental disorder is,

polarised between those arguing for a social aetiology and those arguing for a physiological aetiology. Psychiatry finds itself at the centre of this debate, its status called into question by those who claim that to treat mental disorder as a physiological ailment is to mask the social origins of the illness (Chakravarty 2010: 55).

There is a large body of literature that critiques the medical model of psychiatry and focuses attention upon the social nature of mental disorder. This body of literature is mainly concerned with the changing conceptions, interpretations and classifications of mental disorder.3

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3 At a larger level, there has been a greater recognition of the contextual nature of knowledge production through the works of philosophers of science like Karl Popper (1959), Thomas Kuhn (1962), Georges Canguilhem (1991) and Michel Foucault (1965).
The understanding of the socio-cultural strand of research is that the biomedical model of mental disorder is lacking in a fundamental way, namely an absence of cultural factors in determining the nature and treatment of mental disorder. Further, it is argued that credence needs to be given to other systems of health and healing that societies and communities across the world have practised and used for generations. These systems in the current parlance are seen as ‘alternatives’ to biomedicine, but the fact is that most of these systems, including traditional healing systems, pre-date modern psychiatry and biomedicine. These are clubbed together by virtue of the fact that they do not approach mental disorder by way of physiology and biology.

For the biomedical school as illustrated by European and North American psychiatry, cross-cultural research is ‘marginal to the purposes of the field’ (Kleinman 1988: xi). Consequently, ‘the entire cultural apparatus of language, symbols, and interpretation is the source of great ambivalence for the contemporary psychiatric researcher’ (ibid.).

The oscillation between culture and biology is the crux of the discourse on mental disorder and it impacts the debate on interface between systems as well. Reacting to the paramount position that biomedicine occupied, scholars have focused attention on culture. According to Arthur Kleinman (ibid.), culture holds particular importance for psychiatry. This is so because, from the cross cultural perspective, the most fundamental questions in psychiatry, that is, ‘how to distinguish the normal from the abnormal; how disorder is perceived, experienced, and expressed; why treatments succeed or fail; indeed the purpose and scope of psychiatry itself’ are intrinsically tied with ‘reciprocal relationship between the social world of the person’ and his/her ‘body/self’ (ibid.: 3). For a researcher, based on the cross-cultural school, the forms and functions of mental illness are not ‘givens’ in the natural world. Rather, they emerge from a ‘dialectic connecting and changing social structure and personal experience. Psychiatric concepts, research methodologies and even data are embedded in social systems’ (ibid.). Culture is deeply interwoven with biology and history and is the central feature of these studies.

Within this larger arch of culture, studies to do with mental disorder have been undertaken within the sphere of several disciplines and fields of study. Within psychiatry too, several sub-disciplines have developed including biological psychiatry, forensic psychiatry, geriatric psychiatry, neuropsychiatry and, more importantly, for our purpose, cross-cultural psychiatry and social psychiatry.

Cross-cultural psychiatry is a branch of psychiatry concerned with the cultural and ethnic context of mental disorder and psychiatric services. Similarly, social psychiatry is a
branch of psychiatry that focuses on the interpersonal and cultural context of mental disorder and mental wellbeing. Psychiatry, while taking recourse to medication and surgery among other treatment methods, as reflected in its history, has attempted to provide due credence to socio-cultural factors in the aetiology of mental disorder. There is a growing conviction within psychiatry that there exists a close interdependence between the social environment within which the individual is located and the development of mental illness. This view has paved the way for the practice of social psychiatry. A changing model of aetiology holds that a multiplicity of causal factors produces diseases. One such model, for instance, proposes that psychological and organic vulnerabilities, together with a precipitating emotional stress, lead to a given disorder. A multidisciplinary approach, studying patterns of physiological and chemical reactions as well as psychological responses to stress situations, embodies modern research of mental illness (Alexander and Selesnick 1967; Rosen 1968; Chakravarty 2010). Looking upon mental disorder as a cultural phenomenon and not just a biological one is a position that has thus seen an immense amount of research, both from within and outside the discipline of psychiatry.

Mental disorder has been examined within the realm of social constructionism as well. The logical corollary to this argument of the social construction of mental disorder is the presence of cultural variations. For instance, what is considered clinical depression in the West may not be so in another culture, or may be evidenced in different ways or may not be present at all. In other words, it has been argued that mental disorder is socially defined and has varied significantly from one epoch to the next. Indeed, huge rises in the numbers of incarcerated insane during the 19th century were due to changes in the concept and definition of insanity (Bowers 1998: 4). Perhaps the most important way that mental disorder can be said to be socially constructed is that it is identified and determined by social criteria. Mental disorder is exhibited by actions and behaviour. Herein lies a whole host of studies which attempt to view mental disorder outside of its biological ontology. What unites these varied studies is their focus on cultural factors and the engagement with the patient as a person and not as a physiological system gone awry.

Way back in 1964, Ari Kiev in his work *Magic Faith and Healing*, an anthology of essays that looked at healing practices across the world including places like Alaska, Nigeria, Indonesia, Australia, Turkey, Israel and also North America among a culturally diverse set of people like the Yoruba and Ndembu, Navaho and Apache tribes, Aborigines in Australia among others, emphasised the ‘significance of social and cultural factors in
psychotherapy’ and focused on the treatment of mental disorder within these cultures (ibid.: 110).

This debate about mental illness and psychiatry cannot perhaps be complete without reference to Michel Foucault (1965, 1973–74). In one of his principal works, *Madness and Civilization* (1965), he addresses the question of the historical conditions during the 17th century for the distinction between reason and unreason, or more specifically, reason and madness. He examines the conditions for the emergence and development of the sciences of psychiatry and psychology and analyses the birth of the asylum at the end of the 18th century. He states that, prior to the mid-17th century and the advent of the ‘Classical Age’, madness or unreason and reason were relatively integrated phenomena. Madness was not judged to be inextricably associated with unreason. The differentiation of madness from reason and the emergence of the concepts of madness and unreason and reason during the Enlightenment constituted, for Foucault, a significant historical watershed from which modern reason and more importantly modern science emerged to dominate over human experience (Smart 2007). Foucault sees the history of madness as marked by distinct breaks in the way people experienced and treated the mad.

Foucault’s critique of the medical model is also based on a specific understanding of the human body. While biomedicine posits the body as a natural and universal given, whose complexity can be progressively fathomed by the scientific method, thinkers like Foucault formulated the body as a socially constructed entity (Addlakha 2008). Foucault published a series of lectures on psychiatry subsequent to his other works,4 which reflect a changing insight into the nuances of what he calls ‘disciplinary power’ that supplement and, in some cases, supplant his ideas in *Madness and Civilization*. For instance, he discusses what he terms ‘dispositif’ or apparatus, and uses the term to refer to the various institutional, physical, and administrative mechanisms and knowledge structures which enhance and maintain the exercise of power within the social body. His lectures delve more into the history of psychiatry instead of the history of madness and briefly discuss the spread of what he calls the ‘Psy-function’ to other arenas, such as schools, prisons and the military. In his course summary, he conceptualises the rise of the ‘depsychiatrization’ movement, what is commonly known as anti-psychiatry (http 3). The latter is another significant landmark within the mental-disorder-as-culture view.

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Anti-Psychiatry Movement

One of the early research initiatives within the socio-cultural framework was what was termed the anti-psychiatric movement, a term coined by psychiatrist, David Graham Cooper (1931–1986) in 1967. The works of three psychiatrists are important in this context. Ronald David Laing (1927–1989) was a Scottish psychiatrist who, in contrast to existing psychiatry-practice norms, took the expressed feelings of patients and clients as valid descriptions of lived experience rather than simply as symptoms of some separate or underlying disorder.

Thomas Stephen Szasz (1920–2012), another psychiatrist, was an avid critic of the moral and scientific foundations of psychiatry and the role played by modern medicine in social control. *The Myth of Mental Illness* (1960) and *The Manufacture of Madness* (1970) are two of his major works that set out some of the arguments with which he is most associated. Szasz argues that mental illnesses are not real in the sense that cancers are real. Except for a few identifiable brain diseases, such as Alzheimer’s, there are neither biological nor chemical tests for verifying or falsifying a DSM diagnosis. In other words, there are no objective methods for detecting the presence or absence of mental illness. Szasz goes on to say that the concept of ‘illness’ is a constructed category. Specifically, he refers to it as a class that included various categories like syphilis, tuberculosis and typhoid fever. This class initially contained a few items, all sharing a common feature of ‘reference to a state of disordered structure or function of the human body as a physiochemical machine’ (Szasz 1972: 57). With time, additional items were added to this list, not by virtue of the fact that they were newly discovered bodily disorders, but by the physician’s attention and interest being focused on disability and suffering as a new criterion for selection.

Thus, this shift saw the addition of such categories as hysteria, hypochondriasis, obsessive-compulsive disorders and depression to the larger class of illness. Soon any form of malfunction that diverged from established norm was seen as an illness (ibid.: 58). Szasz also states that mental illness can only be understood in the context of ‘specified social setting’. While diseases are what he calls ‘events’, mental illnesses are in the nature of ‘actions’, and are ‘made to happen’; this model is best understood in the context of playing games (ibid.: 208).5

5 The game theory has been attributed to scholars like George Herbert Mead and Jean Piaget. Mead’s (1934) thesis was that the mind and self are generated in a social process and that linguistic communication is very important in determining not just behaviour but also distinguishing humans from animals. Mead considered games as paradigmatic of social situations, wherein people took on role-playing. Playing a game presupposes that each player
Principally, Szasz argues that within the medical worldview, only symptoms with demonstrable physical lesions qualify as evidence of disease, physical symptoms are objective and independent of socio-cultural norms, unlike mental symptoms which are subjective and dependent upon socio-cultural norms. Mental problems result from problems of living, and hence it follows that mental disorders are not diseases, but conflicts resulting from inconsistent social values. The medical profession only disguises these conflicts. Mental disorder hence should be defined within a social and ethical context, with psychiatrists acknowledging social aetiology of problems (Cockerham 2000; Chakravarty 2010, 2012).

Cooper was a psychiatrist who believed that madness and psychosis are manifestations of disparities and conflicts between our true identity and our social identity; the latter being that which is prescribed by others and internalised by us. Cooper, in fact, as mentioned earlier, coined the term anti-psychiatry to express and describe his opposition to the prevailing practice and methods of psychiatry at the time. There are other names associated with the larger anti-psychiatry position, but these three psychiatrists are the key scholars who stepped outside of the boundaries of the discipline of orthodox psychiatry that they were trained in and critiqued it and suggested alternatives.

An important model of mental illness that attempted to examine purely psychological factors, instead of physiological factors, was Psychoanalysis, associated mainly with the works of Sigmund Freud (1856–1939), Carl Gustav Jung (1875–1916) and Alfred Adler (1870–1937). Some of the basic tenets of psychoanalysis include the belief that early childhood experiences influence personality development, and that human beings are driven by powerful instinctual forces or irrational unconscious drives, and that behaviour and personality derive from the interaction of conflicting psychological forces operating at the pre-conscious, conscious and unconscious levels (Elliott 2002). Without going into the details, suffice it here to note that the psychoanalytic approach has influenced the training in and practice of psychiatry to a very large extent, so much so that it has indelibly affected psychiatric terminology, ideology and understanding of the human beings as able to take the role of the other players. The social situation is akin to a team (Szasz 1972: 207). Similarly, Piaget talks of games played during childhood, whereby children learn rules and moral behavior is a kind of rule following. Problems of living within this analogy are nothing but the realisation that the rules of the game and the very game itself by which one has been playing are not necessarily the same as those used by others around (ibid.: 220).

Both Freud and Pavlov were physiologists, but sought the psychological bases of human behaviour.
personality. For instance, psychoanalytic thought is deemed to be a very important part of the psychodynamic training and practice of most psychiatrists. Psychoanalytic concepts like ‘transference and resistance, repression and the unconscious motivation of emotion and behaviour’ are seen to be central to psychiatric education and practice (White 1988: 275).

Other models of mental illness include the Social Learning Model based chiefly upon theories of learning and techniques of behavioural conditioning derived from the classical conditioning experiments of Ivan Petrovich Pavlov (1849–1936) and Edward Thorndike (1874–1949). There is also another line of research that attempts to closely examine the kind of stresses that people face and a corresponding relation with mental illness.

Thus, the past few decades have seen a large addition being made to the corpus of research on psychiatry. While a lot of this research has surveyed the history of psychiatry (Alexander and Selesnick 1967; Rosen 1968; Porter and Dynum 1988; Shorter 1997; Fabrega 2009), a few also examined the ontology and epistemology of the discipline (Foucault 1973-74, 1984; Gove 1979; Kleinman 1988; Littlewood 1990, 1991; Bowers 1998; Addlakha 2008). Still other scholars have undertaken a critique of the ways of the biologically oriented psychiatry, as epitomised by the anti-psychiatry movement led by scholars who were practising psychiatrists (Laing 1961, 1967; Laing and Easterton 1964; Cooper 1967, 1978; Szasz 1970, 1972).

Psychiatry has been studied under the aegis of medical sociology as well. In this branch of sociology, researchers study the connection between societal factors and health issues and include a range of topics like socio-economic status, gender, ethnicity or age in relation to the quality and access of health care. Other topics of research include risk taking behaviour, social constructs as related to biomedical innovations, social meanings of disease and illnesses and so on (http 4).

The most important discipline that has heralded and led the research initiatives in critical psychiatry and socio-cultural factors in mental disorder, however, has been medical anthropology and it needs to be examined separately. It allows for cross-cultural studies as well as for examining inter-systemic interactions and interfacing.

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7 Stress is thought to occur when individuals are unable to use their usual modes of behaviour which are seen as inadequate in adapting to a new situation (Cockerham 2000: 76).
Medical Anthropology

According to the *Encyclopaedia of Cultural Anthropology* (http 5),

Medical anthropology is the study of human health and disease, health care systems, and biocultural adaptation. The discipline draws upon... anthropology to analyse and compare the health of regional populations and of ethnic and cultural enclaves, both prehistoric and contemporary. The field is highly interdisciplinary, linking anthropology to sociology, economics, and geography, as well as to medicine, nursing, public health, and other health professions.

Medical anthropology has developed three major orientations since the mid-1960s. One views people as both biological and cultural units. Termed medical ecology, it studies interactions among ecological systems, health, and human evolution. The second, termed ethnomedical analysis, ‘focuses on cultural systems of healing and the cognitive parameters of illness’. And the third, applied medical anthropology, ‘deals with intervention, prevention, and policy issues and analyses the socioeconomic forces and power differentials that influence access to care’ (McElroy 1996: 1). Ethnomedicine and anthropology of health were the two terms used to describe this field of study that closely allied with cultural anthropology. Eventually, the term ‘medical anthropology’ prevailed, ‘coming to represent a diversified range of orientations’ (ibid.). Four trends have been seen to be significant in shaping the discipline of medical anthropology: (i) an early interest in human evolution and adaptation, (ii) in primitive medicine, (iii) studies of psychiatric phenomena within the culture and personality school, and (iv) anthropological work in international health (McElroy 1996).

In the context of interface studies as well as studies of individual health systems, ethnomedicine is the most important. The ethnomedical perspective focuses on health beliefs and practices, cultural values, and social roles and implies the health maintenance system of any society. It looks at non-biomedical factors in determining health: encompassing beliefs, knowledge, and values of specialists and lay people, the roles of healers, patients or clients, and family members, the implements, techniques and pharmacopoeias of specialists, legal and economic aspects of health practices, and symbolic and interpersonal components of the experience of illness. Pluralistic societies often encompass several ethnomedical systems (ibid.).

An important scholar in medical anthropology whose work has led the discipline to new frontiers is Arthur Kleinman. He introduced ‘explanatory model’ that concerns notions about the cause, diagnostic criteria and treatment options with regard to illness.
Within a clinical encounter, practitioners, patients and family often hold different explanatory models and, therefore, the resultant communication and negotiation of decisions for managing illness lead to a cultural construction of illness. Because explanatory models of practitioners are different from that of patients and caregivers, the latter often explore and engage with more than one system to seek treatment for mental disorder. Kleinman posited a difference between disease and illness as well. Disease has been seen to be a western biomedical category and not universal. Thus, biomedical terms such as hypertension and diabetes may not correspond to diagnostic categories of a given ethnomedical system. Illness, in contrast, is the experience of impairment or distress, as culturally defined and constructed. Cause of the illness may be located in social and spiritual realms, so that ethnomedical aetiology may include sorcery, soul loss and spirit intrusion.

The larger understanding within the medical anthropology frame is that negotiating the meaning of illnesses and management of illness occurs within a socio-cultural setting. The process of healing is mediated by symbols and practices that induce conditioned neurophysiological and immune system responses. The placebo effect of the healer’s behaviour and symbols to induce healing or to reduce stress is of central interest in ethnomedical studies. Cultural psychiatry is closely allied with ethnomedicine. Many folk illnesses or ‘culture-bound syndromes’, such as susto, pibloktotq and amok (literally meaning to run amok) (see Good et al. 2010), appear to be psychogenic, although environmental stressors play a role in their onset. Susto is an illness condition primarily found among Latin Americans and Hispanics and literally means to be frightened. These symptoms are characteristic of what western trained medical professionals would likely describe as excessive emotional stress or even clinical depression. Traditionally, susto is cured with a ritual carried out by a curandero (healer) (http 6). Pibloktotq or piblokto, also known as ‘Arctic hysteria’, is a disease that affects people in circumpolar region in the winter months. When a person begins an episode of this disorder s/he will begin to scream, shout, curse, break items, tear clothing, and run out into cold temperatures. Sometimes, this results in coma or seizure (http 7). These folk illnesses do not fit easily into western diagnostic categories (McElroy 1996).

Although, traditionally, researchers have worked in folk societies, increasing numbers are studying pluralistic societies (see Kleinman 1980; Lock 1980; Leslie 1992; Good 1994; Good et al. 2010). Medical anthropology allows for the comparative study of societies and health systems within them. Scholars within the discipline have studied
societies ‘with complex, interacting forms of high technology biomedicine, folk healers, alternative literate traditions, and diverse popular movements and forms of religious healing’ (Good et al. 2010: 9).

Some early studies by anthropologists laid the foundation of medical anthropology and continue to exert an influence on the debates on the medicine-as-culture perspective. For instance, W.H.R. Rivers (1864–1922) conducted basic psychological experiments with local populations and subsequently became a specialist of Polynesian and Melanesian societies (Good et al. 2010). Through his work Rivers acknowledged the importance of local practices and demonstrated through the examination of local practices that it is not possible to maintain a clear distinction between what is deemed rational and superstitious.

Similarly, E.E. Evans-Pritchard (1902–1973) conducted ethnographic research in several African societies, particularly the Azande, and provided formulations about how witchcraft, oracles and sorcery serve to explain illness, suffering and misfortune. Victor Turner (1920–1983) worked with the idea that illness and misfortune call forth a search for underlying causes and efforts at healing while working on Ndembu medicine and healing rituals, what he termed ‘rites of affliction’ (Good et al. 2010: 11). He posited that divination and therapy are processes of making visible and accessible that which is secret. Rites of affliction are ‘social dramas aimed at making evident the underlying social conflicts and resolving them through ritual action that have their effects at the social level’ (ibid.).

Illnesses are explained by cultural idioms and these are important for the healing and treatment process. Robert Redfield (1897–1958), an American anthropologist and ethnolinguist, used the concept of the ‘world view’ to explain this perspective; to investigate culture from the inside, a means to study the cultural world through embodied experience rather than using forms of rationality. Charles Leslie (1992) drew upon the work of his teacher Redfield, and advocated the comparative study of Asian medical systems, that is, literate traditions of Unani (Greek), Ayurveda (Indian) and classical Chinese medicine. The 1970s saw an increase in the interest in complex Asian medical systems. Kleinman (1980) studied medical systems in Taiwan similarly.

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8 Two associated concepts used in sociology and anthropology are emic and etic. An emic perspective is the insider perspective that takes into account how local people categorise, interpret and perceive the world and an etic perspective is that of the researcher, looking in; while studying a group or community.
Within the theoretical framework used by Leslie and Kleinman, contemporary biomedicine is viewed as one form of professional medicine practised within a society, and understood as culturally shaped practices embedded in a larger medical system constituted by professional, folk and popular domains as well (Good et al. 2010). Within these societies, local medical systems were to be studied as symbolic realities, to explore and understand the cultural meaning of symptoms. Referencing Clifford Geertz’s classic phrase, the ‘interpretation of culture’ (Geertz 1973), along with a philosophical hermeneutical tradition, medicine came to be seen as a set of ‘interpretive practices’ that ‘constitute illness as a particular form of reality and as the site of potential interpretive conflict’ (Good et al. 2010: 80).

Benjamin Paul (1911–2005) and Rudolf Virchow (1821–1902) are the other names associated with formulating medical science from social concerns. Cultural phenomenology has been drawn upon to explore how illness is ‘constituted as social, intersubjective, and experiential realities’ and becomes the object of therapeutic attention and the body serves as the ‘existential ground of culture and self’ (ibid.). In all of these, culture is seen to play an important role in producing experiences associated with diseases including what form the disease takes (Good et al. 2010). In order to capture this experience, researchers began to explore the role of narratives in medicine, illness and healing. Within this understanding, the patient within any medical system is seen as both an individual and in her/his nexus of social relations and western diagnostic categories are not seen as culture-free entities. A philosophical inquiry about medicine can accordingly be undertaken and here medical systems are deemed to ‘function along the lines of the cultural dialectic, relating and treating both individual and social realities’ (Kleinman 2010: 86).

This refers to a newer trend in cross-cultural psychiatry and it actively questions such distinctions as between fact and value, or between objective and subjective. It does not propound a unified theory of knowledge, but looks at a dialectical interplay of biology and human society. It understands that what is regarded as a disease by western biomedicine ‘may carry rather different meanings for a community, ones relating to cosmological, moral or kinship disturbances’ (Littlewood 1990: 310). This calls for an examination of the ‘inter-relationship of phenomenon, social context, response and explanatory model’ (Littlewood 1991: 696).

Accordingly, non-western societies may offer a sufferer and caregivers a great variety of solutions, medical and religious. While in the West, professional biomedical therapy is
supplemented with self-help and support group in the context of mental disorder; in non-western societies it is much more complex. Roland Littlewood (1990) cites the examples of a healing centre in western India where women bring their psychotic relatives after psychiatric in-patient intervention has proved unavailing. The women go into trance, that is, the caregivers and not the patients; this trance is seen as a penance for the women and their seeking possession is an attempt to draw the affliction away from the psychotic individual onto themselves. Here the perception of illness is vastly different from biomedicine and reflects the significance of healing systems other than biomedicine and the fact that there is pluralism in healing systems as well.

Medical anthropology has grown and developed because it looks at societies as constituting multiple healing systems. Because of the profound influence of biomedicine, a lot of the studies have focused on other healing systems as a critique of biomedicine and examined their fundamental principles as such. While there has been substantial research examining alternatives to biomedicine, especially in non-western societies (Gilbert 1999), there are not many studies on the interface between these various systems of medicine.

**Interface Studies**

There is, however, substantial literature to posit that patients and caregivers across the world access more than one system for the treatment of mental disorder (Stoner 1986; Littlewood 1990; Taylor 2001; Kalantari et al. 2002; Davar and Lohokare 2012). In Gambia, for instance, a vast majority of people with any kind of mental distress approach a marabout (traditional healer) before considering western medicine (Gilbert 1999). I. Press (cited in Stoner 1986:44) examines the consultation of modern physicians and curanderos (traditional healers) in Bogota, Columbia and focuses on this ‘dual use’. Similarly, people consult suladadores (charismatic healers) in Spain (see Campagne 2007) and charmers in England (see Davies 1998).

The anthology *Paths to Asian Medical Knowledge* put together by Charles Leslie and Allan Young (1992) examines the plurality of medical systems in countries like India, China, Japan and Malaysia that include Chinese medicine systems, Hindu-Buddhist traditions and Greco-Arabic traditions of Islamic medicine. Religion has also been studied extensively in the context of health and is the central element and idiom in health seeking behaviour (see Vanderpool and Levin 1990). Studies have examined healing traditions along the same lines. Linda Connor et al. (2001) examined healing in modern states of
Korea, Malaysia, Indonesia and India where the contributors to their volume examined various idioms of healing and the results of its interface with modernity. Similarly, S.N. Arsecularatne studied the interaction between traditional medicine and Western medicine in Sri Lanka (2002).

In the context of interface between systems, studies in the Philippines looked at the interface between modern medicine and traditional practices with regard to mid-wives, whence the latter retained their indigenous, sometimes magical knowledge and practices and used them along with the elements of modern practice that they learnt through their training (see Aguilar et al. 1999). Again, urban health centres in Mali were studied in the context of interface of modern and traditional medicine in Africa. Data collected among modern and traditional medical practitioners show that most physicians express a willingness to cooperate with herbalists, but with none of the other types of practitioners. Male nurses, medical aides and midwives expressed a similar willingness to cooperate with herbalists (Imperato 1979). Native American traditional healers have also been studied in the context of interfacing with biomedicine (Johnston 2002).

A study conducted by Julie Brown and Nina Rusinova (2002) analysed the forms of alternative healing in contemporary Russia and the attitude of physicians towards the latter among other things. They found that both rural and urban based people consulted practitioners like babki (knowledgeable old women), znakharki (folk healer) and ekstrasensy (psychics). In fact, the study found that people were more wary of western biomedicine and its shortcomings than of alternative healers. Further, with the exception of psychic healing, the majority of the biomedical trained practitioners interviewed regard alternative methods as a valuable therapeutic tool. Some indicated that they have referred patients to acupuncturists, homeopaths, folk healers, and osteopaths. A few physicians even claimed to have sought out alternative providers for their own health problems. The arguments they offer to explain their positive inclinations toward alternative methods were pragmatic: ‘Anything that helps the patient is okay’ (ibid.: 170).

There have been instances where local knowledge systems have worked with scientific organisations in Africa, which has a longstanding tradition of healing as also interface. For instance, traditional medicines are often sold at stands in Cameroon, where such remedies provide a popular alternative to western treatments. Researchers at Cameroon’s University of Dschang have analysed the chemical constituents of West African medicinal plants as well. The new and old ways come together in the
pharmaceutical sciences department at the University of Jos in Nigeria where both medical doctors and traditional healers are a part of the faculty (Taylor 2001).

J.P. Hiegel was involved in the early 1980s in facilitating cooperation between modern and traditional medicine in five refugee camps in Thailand. After three years of close cooperation with almost a hundred traditional healers referred to as *kru*, Hiegel’s study found that the healers have ‘genuine therapeutic abilities and a deep sense of medical ethics’ (1983: 30). People access traditional medical centres including for mental disorder and are referred to by hospitals, clinics, social workers, family members and community leaders. Hiegel states that the involvement of traditional healers reduces the reliance on modern psychiatric drugs, which are expensive and difficult to monitor.

Studies in East Africa show that it is common to seek healing and ritual expertise from sources outside of one’s culture. These studies have redefined the perception of African traditional healers and show that witchdoctors get about the same therapeutic results as psychiatrists do; that they actively integrate new elements into their practice and are open to doing so (see Rekdal 1999). Tanya Wenzel (2011) in her study posited that sixty to eighty per cent people in Tanzania use traditional medicine in everyday health care. Many patients use more than one method of treatment when seeking to cure an ailment.

Thus practitioners are willing and they do in certain countries, interface with other systems and practitioners as well. Moreover, caregivers and patients access several different systems and do so for various reasons, including cost and stigma issues. Concern with getting well is what motivates this exploration of multiple systems that are not seen as modern or traditional; simply as treatment modalities.

Bradley Stoner (1986) is in favour of removing the distinction between modern and traditional systems of healing altogether. Pluralism should be examined as a multiplicity of healing techniques, rather than of medical systems, and the study of health care choices can be in reference to these identifiable therapeutic alternatives, with less emphasis on the particular ‘system’ from which they derive and within which they operate. For individuals and caregivers in times of illness, the immediate material of health care decision-making is neither systems nor sectors, but available health care options. Thus, the investigator of health care decision-making would be wise to focus on the documentation of actual health care options used by members of a community as a first step in the analysis of the ‘logic’ of health care decisions (ibid.). The focus should be on examining actual health care alternatives during the time of an illness. Stoner is asking that the caregivers and the
patients be made the crux of the process rather than beginning with the systems of health and healing.

The fact is that many forms of healing have existed side by side in many a society. India is a good example as well as China and Japan. H. Kristian Heggenhougen (1980a, 1980b) reiterates this view by describing the pattern of medical pluralism in Malaysia that includes practices belonging to systems like Ayurveda, Chinese and local Malay therapeutic techniques. J.N. Lasker (1981), working in the Ivory Coast, mentions the wide range of health care practices that are used by the local people, other than biomedicine. Such practices include the use of herbal medicines, healing work of diviners, cult prophets, and Muslim marabouts, besides biomedicine.

The kanpo clinic in modern urban Japan is an example of the existence and interface between health systems (Lock 1980). The practice of medicine in these clinics is characterised by an integration of biomedical and traditional East Asian medical approaches to the diagnosis and treatment of health problems. Kanpo doctors are licensed doctors who make use of more cosmopolitan biomedical notions of disease causation, and team it with more indigenous diagnostic techniques and therapeutics.

Similarly, Nathan Porath (2008) describes the interaction of psychiatry in Indonesia with indigenous therapeutics wherein physicians try and work with traditional healers. Porath mentions clinics in Jakarta where services provided incorporate biomedical doctors with acupuncturists and herbalists (sinshe), although not spirit mediums.

Instances have been cited from across the world showing not just the extensive use of traditional systems of health and healing, but also efforts to interface with each other. The fact is that continents like Asia, Africa and Latin America have rich and extensive histories of health care that pre-date the advent of modern medicine there. These practices and practitioners are intrinsically tied with the local communities and have not been lost; they continue to thrive and make a vital contribution to maintaining health and treating diseases and illness across the spectrum.

An important group within the context of mental illness and disorder and the therapeutic options available are the caregivers of people living with mental disorder. Research in the past few decades has focused on caregiving and caregivers; deinstitutionalisation in the western countries has meant that the family structure has increasingly absorbed caregiving roles. Studies have shown that prompt intervention on the part of families can arrest deterioration of the condition of people living with mental disorder (Carpentier et al. 1999). Families are seen to respond to an ill family member in
terms of positive and negative adaptive responses depending on the interpersonal
dynamics within the family, access to resources and health care options (Herman and
Reynolds 1992). The role of religion and spirituality has been studied within the frame of
coping and responding to the caregiving role. Studies have found that a sound spiritual,
religious, or personal belief system is associated with active and adaptive coping skills in
subjects with residual schizophrenia for instance (Shah et al. 2011).

Literature has similarly examined American Indian patient’s use of biomedical and
traditional healing services demonstrating high rates of access to both sources of care.
Both systems are used independently as well as in combination. Jay H. Shore et al.
studied collaborations between psychiatrists and North American Indian healers and even
presented a set of guidelines for collaboration to facilitate care (2009). Religion is an
important idiom in healing studies and religion as a source of healing has often been used
to complement and interface with psychiatric treatment. Christina Redko (2003) studied
the role of religion and psychiatry in alleviating psychosis episodes among young people
in Brazil. Similarly Simon Dein (2007) mentions that Chaplains (minister of a religious
tradition) are a part of the multidisciplinary team in the United Kingdom that work with
people with acute and chronic mental illness.

Similarly, Paul Farmer (1992, cited in Halliburton 2009) studied psychiatrists
practising in Haiti and how they attempted to ‘adapt their practice to the cultural, class
and religious backgrounds of their patients, for example, by ‘utilizing explanatory styles
from voodoo religion’ (Halliburton 2009: 59).

A wide repertoire of factors has been studied in the context of culture in mental
disorder. These studies have been undertaken within the aegis of several disciplines, sub-
disciplines and fields. What connects all of these diverse strands, some of which have
been mentioned above is the fact that they all focus on the significance of cultural factors
in the aetiology and treatment of mental disorder.

A close examination of these studies will reveal a trajectory that shaped the trends in
research. To begin with the focus was on the critique of biomedicine and psychiatry. The
aim was to look at factors outside of the physical body and locate illness in the larger
social-economic-political-cultural milieu. Since the trend was to look at factors other than
those medically defined, the focus on societies that did just that through a whole array of
practitioners, all termed alternative, complimentary, indigenous and so on consequently
heightened. The argument now was that any society has multiple medical systems to
choose from; medical pluralism occupied centre stage. The next step to this understanding
is that, if multiple systems of health exist alongside, interface is inevitable. A corollary to this position is that, because culture is such a significant factor here, interface becomes possible. A good case in point here is India.

India
Research on mental disorder in India has mirrored trends at the global level; apart from the biological, studies have examined socio-cultural factors in mental disorder. One related research concern has been to examine the advent, development and growth of psychiatry in India as a larger system as well as to examine psychiatry within the context of colonialism, given colonialism’s intrinsic relation to the inception of psychiatry in the country. A third trend has been to marry Indian religious concepts with those of psychiatry, and reinterpret the latter. This position has been adopted by social scientists as much as by psychiatrists who worked outside of the boundaries of their training and education and engaged with and acknowledged the significance of cultural factors (especially religion) that determine mental health care needs of the people in India, as also incorporating some of these cultural elements into their own practises. The study of healing sites/shrines and traditional healing has gathered increased attention in the past few decades.

A cursory examination of The Indian Journal of Psychiatry since inception in 1958 shows topics/trends researched: in the earlier years this included psychodynamics, psychoanalysis, psychological tests, behaviour therapy, process of diagnostics, the philosophical and phenomenological underpinnings of psychiatry, psychosomatics, cognitive behaviour therapy and psychotherapy in India. Others were mostly biomedical oriented studies – insulin coma, indigenous drugs, drug trials, schizophrenia research, and front temporal dysfunction, disorders of aberrant neurodevelopment, depression and cognition and so on.

The trends are a mix of the socio-cultural and biological, with the latter finding more takers and topics like spirituality and healing and prayers finding minimal representation. A few studies on ancient India’s contribution to psychiatry were also presented along with a few on yoga and Ayurvedic formulations including the idea of mind in Ayurveda and ancient India, the Bhagavad Gita, guru-chela relationship and the epistemology of mental phenomena (Singh 2010). The systems were studied separately with not much focus on interface among them. The 1960s and 1970s did highlight some salient features of
cultural psychiatry but this gave way to a more biological psychiatry during the 1990s reflecting a global development in the disciplines of neuropsychiatry, psychopharmacology and genetics, examining topics like biochemical and electrical brain activity and mood and behaviour altering drugs (Addlakha 2010; Singh 2010).

Social scientists have contributed to the socio-cultural paradigm in the context of research to do with mental disorder in India. Colonialism and its impact on psychiatry specifically and mental illness discourse has been researched extensively along with the history of psychiatry and that of mental illness (Keller 2001; Fabrega 2009; Addlakha 2010; Mondal 2009; see also Ernst 1997; Basu 1999). Scholars have explored ‘the multiple linkages between the colonial state and psychiatry, indigenous medical systems, socio-economic change, and cultural practices’ (Addlakha 2010: 47). After independence, due to the efforts of many Indian psychiatrists, there was a process of ‘indigenisation’ of psychiatry, as Renu Adlakkha (2010) terms it, or what Brigitte Sebastia (2009b) calls ‘Indianisation’ of psychiatric practices. Both terms indicate some level of integration and interface between western and indigenous concepts.

As Addlakha posits, speaking about the Indian psychiatrist, ‘The distinctive socio-cultural contexts in which they, as cultural actors, have been established and in which they practice, have come to impinge on their work and their professional identity’ (2010: 47). For instance, Hindu scriptures and indigenous medical systems have been seen as ‘filters through which western psychiatric concepts have been questioned’ (ibid.: 55). Similarly, attempts have been made to correlate schizophrenia with unmada, a concept in Ayurveda and also test the efficacy of Ayurvedic preparations. Studies have examined the ‘impact of ethnomedical and religious symbolic systems on concepts of mental illness and health’ (ibid.: 56). Scholars like A. Venkoba Rao (1964, 1978), N.S Vahia et al. (1966) and L.P. Verma (1974) (all cited in Addlakha 2010) elaborated upon the process of the ‘interweaving of the ethnomedical and religious idioms in ancient Indian thought’ (ibid.).

Given the presence of multiple systems of health in India, and the exposure that practitioners have to these systems, either at a personal level or through their patients and caregivers, the tendency has been to use concepts from one system to study another, as noted above. The fact that psychiatrists have also undertaken some of these studies tells us that they have not been bound by their discipline, but have attempted to expand its boundaries. The West saw an emphatic anti-psychiatry movement, and subsequent interest in studying alternative systems in varied societies and, subsequently, in examining possibilities of integrating systems. In India, because of a strong presence and easy
accessibility of non-western biomedical systems, comparative studies of different systems, including a few that examined interface, have been undertaken. In fact, because of this plural space, psychiatrists were able to reach out to other systems more easily as also become more cognisant of the drawbacks of their own system. The same plural landscape also meant that patients and caregivers consulting psychiatrists were accessing these other systems as well, sometimes making way for interface between systems.

For instance, Sebastia comparing western psychiatry with traditional healing states that indigenous systems of medicine or what she terms ‘religious therapy’ hold sway due to failures on the part of psychiatry to help people with ‘psychic/psychological pathologies’. This explanation was also provided by psychiatrists while they reasoned why so many people frequented a dargah in Erwadi, Tamil Nadu, where about twenty-eight mentally ill people seeking treatment at the dargah died in an accidental fire in 2001. Studies were subsequently presented by psychiatrists (quoted by Sebastia) emphasising the necessity of ‘integrating Indian practices and concepts into their discipline’ (2009b: 1). The idea was to Indianise their practice so that more people would seek help from their profession. Sebastia, however, states that this attempt has not been entirely successful and the therapies that hold the interest of the reformist psychiatrists ‘do not correspond to the needs of patients who frequent religious places’ (ibid.: 2); in other words, these spaces fulfil a need for patients and caregivers that psychiatry despite their reform efforts simply cannot fulfil. What Sebastia found in her study was that these religious spaces of healing are frequented by lower and middle caste and middle class people from urban areas and villages. A majority of patients who stay in the shrine had consulted a practitioner of biomedicine or a psychiatrist.

Historically, some of the factors that led to a discrediting of psychiatry over a long period include, ‘the use of therapies without reference to caste and religious food regulations, disdain for Indian customs and the practice of autopsy and of vaccination, separation of patient from the family’ (ibid.: 3). J.S Neki, an Indian psychiatrist, at the 29th annual conference of the Indian Psychiatric Society, stressed the importance of developing the discipline with ‘Indian specificity’ (ibid.: 5); western psychotherapy was deemed to be inappropriate to Indian culture because ‘the Indian psyche looks for the sources of problems outside the self, in astrological influences, evil spirits, witchcraft or transgressions, or karma’ (ibid.). The latter concept received some attention in publications by Indian psychiatrists; karma was thought to help discourage suicide, cope with stress and reduce a sense of guilt (ibid.). Yoga and meditation were the other popular
topics of psychiatric research and included topics like the practice of asanas (postures), pranayama (regulation of breathing), yama and niyama (social and ethical observances), dharana (concentration) and dhyana (meditation). Dharana and dhyana were considered efficient in relieving pathologies like psychoneurosis, anxiety states, insomnia, tension, bipolar disorders, asthma and aggressiveness.

Psychiatrists, as mentioned earlier, have shown an equal interest in Ayurveda and Ayurvedic concepts, specifically dhatu and devi syndromes. The term culture-bound syndrome was first applied to the dhatu syndrome by an Indian psychiatrist N.N. Wig in 1960. An associated subject that has garnered much attention from the psychiatric community apart from general research by social scientists is the approach of traditional healers to mental disorder. Some psychiatrists have been interested in the supernatural elements within the rubric of mental disorder as conceptualised by Ayurveda and Siddha traditions as well as folk healers and their relationship with patients, and in determining the socio-demographic categories of patients who consulted traditional healers, diagnostic and therapeutic techniques of healers, understand the symbols, idioms and practices used by the healers to enhance therapy and of course possession (ibid.).

In the introduction to their book Psychiatry in India A. De Souza and D.A. De Souza (1984) highlight the importance of traditional healers in the field of mental health and quote another psychiatrist who has done some path-breaking work with regard to interfacing with Indian concepts and practices like yoga, Dr R.L. Kapur thus, ‘Psychiatrists must learn to work with traditional healers, and make no effort to shake the beliefs of the public but rather utilize these beliefs to bring home new knowledge, as well as utilize traditional healers to bring patients for treatment’ (1984: 10).

Indian psychiatrists are well aware of the limitations of their own discipline, especially within an Indian cultural context. To quote more recent literature, a 2013 published Position Paper of the Indian Psychiatric Society expounding on the fifth revised version of the Diagnostic and Statistical Manual (DSM V) states, ‘Recent technological leaps have focused on the body and have made it easier to standardize clinical symptoms, signs, laboratory results, and treatments, with much less progress in understanding the mind and social factors’ (Jacob et al. 2013: 13). The paper further mentions explanatory models for mental illness in India that have been examined in several population groups: patients with unexplained medical symptoms, those attending traditional healers, patients with psychosis, schizophrenia and bi-polar disorder and also their relatives. The findings of these studies suggest the following broad conclusions: that
patients, relatives and health workers often provide non-medical explanations for the cause of illness like *karma*, evil spirits, black magic, sin, punishment by god and so on; that many patients and relatives hold multiple beliefs including medical, non-medical, supernatural, religious and black magic beliefs; and that these beliefs are held simultaneously and are often contradictory. And, finally, that many patients and their relatives and caregivers simultaneously seek biomedical and non-biomedical interventions (ibid.: 20).

Pluralism is thus seen in the context of families and patients too. D.P. Bhattacharya (cited in Addlakha 2010) identified the conceptual mix characterising the explanatory models of mental illness put forth by patients and caregivers. An important work in this context is *Shamans, Mystics and Doctors* (1982) by Sudhir Kakar. Kakar examines healing temples, consultation rooms and interacts with *vaid*, *ojha*, *shaman*, *tantrik* and *guru* of mystical cults all of which provide a wide range of choices to patients and caregivers. The book explores the various traditions of India that are based on the ‘restoration’ of mental health, the latter defined by the author as a ‘rubric, a label which covers different perspectives and concerns, such as the absence of incapacitating symptoms, integration of psychological functioning, effective conduct of personal and social life, feelings of ethical and spiritual well-being and so on’ (ibid.: 1). Kakar’s work expounds upon some of the differences between eastern and western psychotherapy as well.

A more recent work is the collection of essays put together by V. Sujatha and Leena Abraham in *Medical Pluralism in Contemporary India* (2012) that explores the reasons behind the enduring presence and therapeutic significance of systems of medicine such as *Ayurveda*, *Siddha*, *Unani* and other health care traditions in contemporary India.

Psychiatric care has not been able to replace religious therapy to which caregivers and family members turn to actively. Families and caregivers consult priests, mediums, astrologers and sorcerers and visit temples and shrines (Kakar 1982; Flueckiger 2006; Pfleiderer 2006; Bellamy 2011). Sebastia studied one such Catholic healing shrine in Puliyampatti, a village in Tamil Nadu known for its ‘powers of healing’. What she found was that more than half the people she interviewed had sought the help of biomedicine and also been hospitalised in a psychiatric ward and a few had consulted a *Siddha* practitioner. Some had come directly to the healing shrine, while others had taken recourse to visiting an exorcist and some had stayed in a temple, a *dargah* (Muslim shrine) or a Catholic shrine. Sebastia states that rarely are Ayurvedic and Siddha
practitioners consulted for psychic problems; preference is shown for traditional healers instead.

Sebastia again mentions an interesting instance of interface between psychiatry and traditional healing by describing her observations in a therapeutic shrine of Saint Michael at Rajavur in Kanyakumari district, Tamil Nadu in 2002. This is a healing shrine frequented by people living with mental disorder and their families. Every three weeks a psychiatrist comes to the shrine and sees patients identified by a nun, who then takes care of the therapy, collects data, dispenses free medication and educates the family about the importance of treatment. The psychiatrist who uses the priest’s office is accepted by the people. This process of interfacing and integrating psychiatry into a religious space has been seen to be ‘appropriate for enhancing the treatment of severe pathologies due to compulsory and free medication and for supporting and educating the patient’s families’ (Sebastia 2009b:15). Going to a therapeutic shrine is often a last resort for caregivers (Sebastia 2009a).

In the context of non-western biomedicine, Ayurveda has been the subject of prolific study by psychiatrists, social scientists and medical anthropologists (see Leslie 1992; Banerjee 2002, 2004, 2008; Langford 2002; Bode 2012; Jayasundar 2012). Apart from expounding about the basic tenets of Ayurveda and aetiology, and classification and definition of mental disorder within Ayurveda, scholars have worked extensively on the history of the system, on the changing nature of Ayurveda in the 21st century, on the modalities of practice within Ayurveda like clinical practice, the role of science and experimentation, mental disorder and Ayurveda, philosophy of Ayurveda in the context of mental health and syncretism in modern Ayurveda, etc. Scholars have examined the asymmetries resulting from the practise of Ayurveda within a medical space where the preponderant system is biomedicine as well as the differences between allopathy and Ayurveda (see Kutumbiah 1969; Dube 1979; Balbodhi 1987; Banerjee 2002; Varier 2002; Smith 2004; Fabrega 2009; Wolfgram 2009; Salud 2010; Thakar 2010; Shukla 2012).

Ayurvedic pharmacopoeias have been studied to test their efficacy against standard psychotropic drugs in the context of mental disorder. The general finding is that ‘indigenous drugs are more or less as effective as modern tranquillisers in managing both psychotic and neurotic disorders (Addlakha 2010: 57).

The interface and interaction of Ayurveda and modernity has been a popular subject of study. Studies have examined the sites of contestation that mark the encounter of Ayurveda with globalisation, making it a marginal player in the medical market. With
enormous pressures being exerted by the dominant establishment, including the pharmaceutical industry, alternative medical systems has been confined to marketing alternative products. The real challenge for Ayurveda in the global economy lies in defining the parameters and terms of those parts of its knowledge system that are considered adaptable to the market. However, in the scramble to protect markets and knowledge regimes, it is not yet understood that there is a deeper colonisation being played out in the edging out of alternative world-views inherent in these medical systems. In this context, it has been argued that the modernisation of Ayurveda has been governed by a 'pharmaceutic episteme’ which focuses on retaining the usefulness of Ayurveda as a mere supplier of new medicines while dismissing its world view on the body, health and disease (Banerjee 2002, 2004).

Apart from Ayurveda, scholars have examined healing in the context of India. It has been posited that limited availability of health services especially state-run health services motivates the use of alternative healing options (Raghuram et al. 2002; Pordie 2007). Work has been done on sacred healing spaces like temples and mosques in India and outside of it and the role that sacred spaces and healers play in the treatment of mental disorder. In this context, the phenomenon of possession and trance has been examined at length (see Kakar 1982; Raguram et al. 2002; Flueckiger 2006; Pfleiderer 2006; Davar and Lohokare 2012; Bellamy 2011; Quack 2012).

Not many studies have focused on interface between systems in the context of India. David Hardiman and Gauri Raje (2008) studied biomedicine, traditional healing and Christian faith-healing among tribal areas in Gujarat. They found that the local bhagats (healers) did not oppose the medical work done by Christian missionaries for a range of minor complaints. But, for chronic malady, the healers believed that their expertise was called for, that is, exorcism and propitiatory rites.

Carstair’s et al. The Great Universe of Kota: Stress, Change and Mental Disorder in an Indian Village (1976) is particularly significant. The book is based on a study of the prevalence and patterns of mental disorder in a coastal village, Kota, Karnataka among three community groups. The aim was to examine the socio-cultural differences among them and to seek a relationship between cultural features and the prevalence of mental disorder. The study also examined different kinds of healers that the people approach, namely vaidas, mantarwadis and patris who have undergone training and are deemed to be professional healers, apart from modern doctors.
The study found that people approach both kinds of practitioners and gender and education were factors that determined who goes where and how often. A healer would be approached for a possession related problem, while a doctor would be consulted for other problems.

With regard to interface, however the most recent work examining more than two systems has been Murphy Halliburton’s study in Kerala (2009). Halliburton investigates the different ways in which Ayurvedic, western, and religious (Christian, Muslim, and Hindu) healing systems define psychiatric problems and cures. He describes people’s embodied experiences of therapies that range from soothing to frightening, and explores how enduring pleasure or pain affects healing. He posits that Ayurvedic therapies like talapodichil (applying mudpacks) are often less invasive and painful than psychiatric therapies like Electro Convulsive Therapy. People reported healing to be a more ‘transformative experience’ (ibid.: 161) than what modern medicine offered. Some of the mentally afflicted seeking healing at a temple were reported to undergo a ‘spiritual change, a positive reorientation, or a movement to a state of health and well-being that is more auspicious than their pre-illness state’ (ibid.: 186).

Halliburton’s study is based in the southern state of Kerala where he interviewed patients at length and shows how socio-political changes around the globe may be limiting the ways in which people seek and experience health care, with negative effects on our quality of health and life (http 8). Halliburton mentions the case of certain traditional Ayurvedic physicians, vaidyans who have learnt Ayurveda from family apprenticeship who supplement their medical care with the practise of mantravadam (magic/sorcery). His study showed that people access both Ayurveda and psychiatry, because their primary motivating factor is to ‘get better’ (ibid.: 119). Moreover, he found that people, before visiting a popular healing shrine in the state may have tried Ayurveda, mantarvadam, Homeopathy and visited other temples and mosques as well. With regard to interface, Halliburton’s research assistant, who worked with him, opened his own healing centre that ‘combined aspects of Western psychology, Ayurveda, yoga, naturopathy and Christian teachings’ (ibid.: 9).

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The foregoing survey of literature on approaches to mental disorder brings forth certain key observations: one, that mental disorder as a phenomenon is far too complex to enable any one system to address it adequately. The socio-cultural paradigm/epistemology is
significant in this regard and exists alongside the biomedical one. Two, that from the patient’s and caregivers’ perspective, it is not an either/or scenario wherein they pick one system over another and stay with that. Rather, they go through a whole array of therapeutics and draw different benefits from them. Notions of health and well-being are of central concern here and the definition of these surpasses a mere absence of disease. The process of restoring mental health in India involves a complex cultural and social process that psychiatry cannot address alone; it necessarily involves working with other therapeutic options and concepts and this process involves interfacing with multiple systems. The latter, in turn, helps to meet the complex set of needs of caregivers and people living with mental disorder. This is so because socio-cultural notions of health and healing are so deeply ingrained and embedded in group and individual psyche. Finally, it follows that there are different perspectives to mental disorder. Given this context, the present study is a humble attempt to examine an interface among systems of health and healing addressing mental disorder in India. The next three chapters will examine the interface between three sets of practitioners, namely, psychiatrists, Ayurveda doctors and traditional healers. Following this, caregivers of people living with mental disorder as facilitators of this interface has been discussed.