Anthropology encompasses a wide range of knowledge, regarding how human societies work towards attaining a complete healthy state. The study of health seeking behavior is that crucial process of understanding the human societies. In fact, it enables the reader to know how a human society is struggling for its existence. Thus, the holistic study of different health care systems throw light on several fundamental aspects as well as institutions of human life, Medical anthropology is a specialized branch of Anthropology that focuses on the health issues of human societies in its bio-cultural setting by giving special references and space to the uniqueness of each human –society. Foster and Anderson (1978) define Medical Anthropology as a bio-cultural discipline. They remark world war II as the starting point to the Medical Anthropological interests. Because, at this time a notable number of anthropologist focused on the study of medical systems, bio-ecological and socio cultural factors that influence the incidence of health and disease, both at present and past times of human kind. As it is a biocultural discipline, Medical Anthropology focus on both Biological and Socio-cultural aspects of human behavior, particularly with the ways in which the two interact and have interacted throughout human history to influence health and disease. (Foster and Anderson: 1978:1-3).

Word health organization defines ‘health’ as “a complete physical mental and social well being and not mere absence of disease or infirmity”
This definition stresses on total wellbeing in which physical health, mental health and social wellbeing are involved to form the meaning of health. Any disease could not be studied in isolation in human society. Disease and culture always go hand in hand to make a complete sense. Diseases is viewed as an unavoidable aspect of the human condition by Brodwin (1996). Brodwin further adds that genetic nutritional and infectious diseases have profoundly shaped both biological evolution and the emergence of complex societies humans respond in infinitely. These differences largely diverse ways to bodily disorder and suffering make up the ethnographic record of medical anthropology (ibid).

Even though the experiences such as pain, suffering, uneasiness disability, helplessness are seems to be the universal features of illness, it is not easy to understand and treat an illness in reality. Because each illness is defined and expressed in a cultural context. Helman (1994) makes dual category of definitions of both ‘health’ and ‘illness’ viz a) lay definitions and b) medical professional definitions. By taking the both emic and etic perspectives, into consideration, Helman explains the process of becoming ill through two aspects viz. a) subjective experiences of physical or emotional changes and b) the confirmation of these changes by other people. Both the presentation of illness and response to it, are largely determined by socio cultural factors. Every culture has its own ‘Language of distress’ which bridges the gap between subjective experiences of impaired well -being and social acknowledgement of them. (ibid).
And ethnomedicine is that sub filed of medical anthropology which focus on the study of each cultures 'Language of distress' Logan M.H. (1996) gives the meaning of ethnomedicine as a field of knowledge that explores the impact of environmental, biological and cultural factor on disease patterning and the peoples way of responding to it.

Ethnomedicine has traditionally been referred to any system whose theory and practice fell outside the western bio medical model. However, growing awareness of the biases of ethnocentricity has led to the realization as pointed by Rubel and Hass (1990) that Western biomedical science is simply the “ethno medicine” of western physicians (cited in Logan 1996). Even though this understanding is both valid and timely, there are significant differences between the beliefs and behaviors of peoples who follow the western biomedical model and those who follow other ethnomedial traditions (Logan 1996). There differences could be summarized in this way. Ethnomedical system typically exhibit great historical depth, in which the particulars are shaped by tradition and reflect long –honored beliefs and prentices. Where as western biomedicine model has much less historical depth. Ethnomedical is more geographically and culturally constrained the other hand western biomedicine is known for its vast global diffusion and uniformity in the process of knowledge sharing and learning. Ethnomedical system are deeply embedded in the fabric of a culture’s daily life and religious worldview. But western biomedicine has developed into a separate entity (ibid). Apart from the growing popularly of pluralistic medical systems, where in western
biomedicine seems to the dominating over the alternative medical system, the ethnomedicine is working as the health maintenance-system of any society. The key concepts of ethnomedicine as summarized by Elroy A. M. (1996) are as follows; The first concept is a) "Explanatory model" (EM) introduced by Arthur Kleinman (1980). Explanatory Models are notions about the causes of illness, diagnostic criteria and treatment options. b) The second concept is the disease–illness distinction. Disease is clinically defined as deviation from medical norms, is considered to be a western biomedical category and not universal illness in contrast is the experience of impairment or distress as culturally defined and constructed he thinned key concept in which the current research falls is cultural psychiatry. Focus of the study is folk illnesses or culture bound syndromes as these folk illnesses do not fit easily into western diagnostic categories.

Disease etiology is a crucial starting point to understand any medical system. Foster and Anderson (1978) finds a dual division as sufficient viz. personalistic and naturalistic. Personalistic system involves the purposeful intervention of a 'sensate' agent. This agent may be a supernatural being (deity) or a non human being (such as ghost, ancestor or evil spirit) or a human being (witch or sorcerer). The illness is a result of aggression or a kind of punishment targeted towards the particulars person for reason concerned to the sick person alone. In contrast the naturalistic medical system, explain the causality of illness in impersonal, systemic terms. The illness is explained to be caused by damage took place to the balanced state of body by insensate
elements in the body such as the heat, the cold the humors or dosha, the yin and yang, the patients age.

Hence, the natural and social environment is considered to be the cause of disturbed body-equilibrium and there by illness. Eventhough personalistic and naturalistic etiological systems are not mutually exclusive, Foster and Anderson say that, in spite of much overlap, most people seem to be committed to one or the other of these explanatory principles to account for most illnesses (ibid). There are several similar dichotomous classificatory system with varying labels given by other anthropologists, Seijas' “Supernatural” and “nonsupernatural” categories; and Nurge discusses of ‘supernatural’ and ‘natural’ causes of illness (cited in Foster and Anderson 1978). Young classified belief systems about ill-health as either externalizing or internalizing (cited in Helman 1994). The categories such as ‘nonsupernatural’ ‘natural’ and ‘internalishing’ etiologies of illness explains the naturalistic causes of sickness which are comparatively flexible and open to the people of other culture. Because the treatment of naturalistic illnesses involves concentrate objects. And their categories have several similarities with modern biomedicine as physiological aspects form the center of both nonwestern naturalistic medical system and western biomedicine moreover disease etiologies direct the whole process of diagnosis, therapy, material medica of a medical system. Foster and Anderson (1978) summarized the correlates of causality in a comprehensive manner. They call disease causality as sub-cultural systems which reflects the basic harmony, basic structural principles, patterns and
premises of the particular culture. At the same time other major aspects of a given medical system viz diagnosis and therapeutic process are logically derived from causality concepts. The focus of current research is largely rests with the personalistic etiological aspects of a non-western tribal culture viz. ‘Karevakkalu’.

It is in this sense any study that falls under the purview of ethno-medicine cannot exclude the ethno-psychological aspects that are implicit in the disease etiology of given a culture.

Basically, it is most significant part of medical anthropology because, ethno-psychiatric studies explores the new concepts of etiology and directly contributes to the theories of disease etiology. The roots of ethno-psychiatry are in traditional societies wherein spirits, deities, ghosts, witches bring on sickness by infiltrating their victims, acting through them, stealing souls, controlling their wills, creating several risky behavioral factors and like fears, bad dreams, confusion followed by physical pain. Ethno-psychiatry reveals about culture-specific modes of handling abnormal behavior and mental illness.

The term “ethno-psychiatry”, was coined by the Haitam psychiatrist Louis Mars in 1946, to refer the local presentation of psychiatric illness (cited in Littlewood, 2002). The origins of ethno-psychiatric knowledge is marked in the late eighteenth century wherein clinical-psychiatry recognized that, mental illnesses might be influenced, some times, even caused by a society’s mores, roles and sentiments. Before that, the patterns of psychosis identified in
European hospitals were taken as universal. Emile Kraepelin gives the first explicit cross-cultural compassion way back in 1904 that local understanding could allocate the illnesses such as, possession or a call to a shamanic role to categories quite different from that of western medicine. Littlewood and Lipsedge (1989), say that Kraepelin was confident that he could distinguish the universal from the particular when attributing atypical ‘illnesses to a lower stage of evolutionary development’ (ibid). Major issues that fall under the scope of ethno-psychiatry have been discussed by the scholars such as Musphy and Leighton (1965), Foster and Anderson (1978), Helman (1994), Pollock (1996), Hughes (1996), Littlewood and Dein (2000), Littlewood (2002). Apart from the difference in the focus on the issues, all are successfully contributed towards a quality of “culture-sensitivity”. This enables the researcher to overcome ethnocentricity and thereby reach the research objectives especially in an interdisciplinary research like ‘Ethno-psychiatry’.

The Ethno-psychiatric studies are rooted in these fundamental issues viz. a) Culture and Personality studies, b) Normality and Abnormality – behavior c) Culture bound Syndromes and the d) Issues of labeling a Behavioral Disorder or Mental Illness.

The initial interests of anthropologists in the field of personality and culture is, marked as the beginning of Ethno-psychiatry which falls appropriately between 1920s to 1960s. In this period, the anthropologists were involved in working on the various fundamental issues viz. understanding the relationship between culture and personality and sources of culture which
shapes the personality. An important concern was to test the hypothesis of Freud to determine whether the Oedipus complex is universal. A number of researches took place to test these hypotheses with field data collected from a number of societies by scholars viz. Malinowski in 1920s, Margaret Mead, Edward Sapir and Ruth Benedict in early 1930s. And also there was a seminar offered on culture and personality from 1936 to 1940 in which psychiatrist Abraham Kardiner took part in conjunction with a group of anthropologists viz. Cora Dubois, Ralph Linton, Edward Sapir and Ruth Benedict (cited in Foster and Anderson, 1978). Other major studies took on the people of both North American Indian groups and of modern nations from 1930s to 1950s that were focused on the questions of “basic personality structure”, and “Model personality” (ibid).

The process of identifying psychiatric disorders in a society begins with the knowledge of identifying ‘normal’ and ‘abnormal’ individuals in the given society. Because, the pattern of ‘normality’ and expansion of ‘abnormality’ also differs according to the cultural norms in which the individual is socialized. The normal behavior involves a set of manners that are visible in the routine life of each individual such as division of labour, exchange of goods and services, interaction with kinsmen, marital obligations, and reverence to the spirits. Aberle et al (1960) opines that the shared norms of behavior are essential to the survival of any society (cited in Hughes 1996).

Hallowell (1934:2) urges the need for an outsider-investigator, studying “deviant” or “abnormal” behavior should have an intimate knowledge of the
culture as a whole. He must also be aware of the normal range of individual behavior within the cultural pattern and likewise to understand what the people themselves consider to be extreme deviations from this norm. He must develop a standard of normality with reference to the culture itself as a means of controlling an uncritical application of the criteria that he brings with him from our civilization (cited in Hughes 1996). Murphy (1982b) identifies that psychiatry deals with abnormal behavior and mental illness and no society is free from mental disorders (cited in Hughes 1996). Hughes (1996) adds that, when we speak of ethno-psychiatry the need for some specification of "abnormality" that can carry meaning across cultural barriers becomes paramount. In a classic article, Wegrock (1953) drew a distinction critical for understanding the difference between deliberate norm-breaking and deviance on the other hand and abnormality of psychiatric interest on the other. He spoke of "statistical" abnormality (which depends on the frequency distribution of the parameters that define the object of interest) and "functional" abnormality which is based on an assessment of how a given behavioural pattern figures in the total context of the personality the psychodynamic purposes it serves (cited in Hughes 1996).

The next task distinguishing the abnormality pattern that could be culture specific (emic categories) as well as universal (etic categories) become essential towards operational phase viz. pathology of ethno-psychiatry.

"Culture is an abstraction which encompasses the total way of life of a society. It is a precipitate of the group’s history and expresses its adoption to
the physical environment” (Alexander, Leighton and Murphy: 1965:15). They also add that culture is characterized especially by what Hallowell has called a “psychological reality” (cited in Alexander Murphy and Leighton 1965). It refers to the shared patterns of belief, feeling and knowledge, the basic values, axioms and assumptions that members of the group carry in their minds as guides for conduct and definition of reality. Ruth Benedict has spoken of “the unconscious canons of choice” that characterize one group in contrast to another (ibid). Foster and Anderson (1978:83) summarizes the current focus of ethno-psychiatry in the following way: 1) The cultural definitions of ‘normal’ and ‘abnormal’, 2) non-western explanations of mental illness, 3) the cultural modes of handling deviant behavior defined as abnormal, 4) the incidence of mental illnesses in societies of differing complexity and 5) the demography of mental illnesses when it comes to the etiologies of non-western mental illness.

Foster and Anderson (1978) remarked that unlike people’s explanation on physical ethnographic records on the mental health-seeking behaviour is much less systematic because, these people do not ‘make sharp distinctions between physical and mental etiolo of disease. Clements (1932) gives a classical summary of five major causes of diseases in the non-industrial world sorcery, soul loss, breach of taboo, intrusion by a disease/object and intrusion by a spirit (cited in Rubel and Hass 1996). Fabrega (1974) illustrates about a small town of Southern Mexico in which the psychotic disturbances are not judged as different from those of other types of illness (cited in Foster and Anderson 1978). In the same way, one could observe a range of etiologies
given by scholars such as Kennedy (1961), Leighton and Murphy (1965), Leighton (1969), Cawte (1974) collected by Foster and Anderson (1978), which in turn suggest that "majority of non-western mental illnesses is explained in personalistic rather than naturalistic terms; possession of the patient's body by a ghost, spirit or deity, punishment for breaking taboo or witchcraft (Foster and Anderson 1978: 87). If we are to generalise about differences in western and non-western mental etiologies, a significant distinction would be that among the psychological factors, life experiences and stress are seen as playing a far less important role than among the former. The personal, predisposing factors, mental illness, assigned so much significance in western psychiatric medicine are for the most part of limited or little interest within tradition systems (Foster and Anderson 1978: 88).

The process of diagnosing psychiatric disorders in a given culture requires dealing with challenges viz. understanding of the consequences of "labeling", stigmas and culture bound syndromes. Then only the process of treatment to the mentally ill could be projected in its totality. 'Labeling theory' sees mental illness as a 'myth'. Helman (1994) explains that, society decides what symptoms are to be defined as 'deviant'. The findings of Waxler (1977) disproved the universal applicability of a major label of western psychiatry viz 'depression' (cited in Helman 1994). On the other hand, Rosenhan and seven others great task of experiment on the risks of labeling by presenting themselves as pseudopatients of Schizophrenia (1973) also proved the dangers of labeling. The labeling theorists Lemert (1951, 1967), Szasz (1961), Becker
(1963), Scheff (1974), Schur (1971), argued that, mental illness is a ‘myth’, a sociological phenomenon, the product of the ‘straight’ members of the group who feel they need a device to explain, sanction, and control dangerous behavior on the part of their fellow behavior, sometimes simply ‘different’ from their own. They argue that once a behavior is labeled as deviant it is stereotyped and stigmatized even though the symptom is very slight and temporary (cited in Foster and Anderson 1978). But there are arguments against labeling which are proved through the intensive anthropological studies such as the study of Edgerton (1969), Kennedy (1973) which concluded that there are real disturbances through affect and conduct that require medical management (ibid). In this situation the suggestions of Hughes (1996) towards improving ICD-10 (International Classification of Diseases) and DSM IV (1994) American psychiatric Association diagnostic manual by stressing and including more about cultural components of disease symptoms such as “culture-bound syndromes”.

The ‘culture bound syndromes’ are most fascinating colourful and much discussed part of Ethno-psychiatry. Because this is the sphere which establishes a direct channel of interaction with many other sub-disciplines as well as disciplines such as behavioral sciences, environmental studies and medicine, psychological anthropology, cultural anthropology, clinical-psychiatry, ethnography and mythology. Culture bound syndromes refers to those behavioral and mental disorders that are highly culture-specific in nature and therefore they offered challenges to both western-psychiatry and medical
anthropology as the symptoms were not easily fitting to the existing categories of mental and behavioral disorders and mental illnesses. These are two basic arguments regarding the validity of studying culture bound syndromes. One is about evolving, applying the cultural methods of solving, treating culture bound syndromes and to make separate category of culture bound syndromes by keeping them apart from the western psychiatry’s category of psychiatric disorders. This approach considers the culture bound syndromes as a product of socio-cultural issues rather than a disease caused (also) by biological problems. The second argument considers the culture bound syndromes as a local expression of mental illness and behavioral disorders which are universal phenomenon due to neurophysiologic causes. However, apart from these two extreme arguments one cannot deny the inherent quality of culture bound syndromes in exploring the ground realities and meaning in a given culture that suggests the essence of understanding the ethnographic insights on the part of ethno-psychiatrists and other behavioral scientists towards making a fruitful research in their area. The classic culture bound syndromes as summarized by Foster and Anderson (1978) are as follows: Pibloktog among the Eskimo (ascetic hysteria); Windigo (Cannibalistic obsession among the north-eastern North America); running Amok (a frenzied killing spree of Melanesian males) Latah (a hysterical imitative reaction similar to the Siberian form of arctic hysteria); Kora (a ferl among Chinese males that the penis will withdraw into the body); Susto a depressive anxiety condition described for many parts of Latin America).
Helman (1994) discusses the biological approach of diagnostic categories in which he quotes Kiev's (1972) view that, form of psychiatric disorders remains constant throughout the world, irrespective of the cultural context in which they appear. For instance, the schizophrenic and manic depressive psychotic disorders are fixed in the form of the biological nature of man; while the secondary features of mental illness.

The content of delusions and hallucinations are by contrast, influenced by cultural factors. On this basis Kiev (1972) classifies the various culture bound disorders within the diagnostic categories of the western psychiatric model:

- Koro, Susto and bewitchment are forms of anxiety
- The Japanese Shinkeishitsu is an ‘obsessional compulsive neurosis’
- Evil eye voodoo death are ‘phobic states’ and
- Spirit possession, Amok in Malaya and Hsich Ping in China are the examples of ‘dissociative states’ (cited in Helman 1994). However, apart from the socio-biological aspect of psychiatric disorders, there is a need of effective synthesis that could be achieved in a best way through comprehensive treatment methods. The non-western healing practices are closely inter-related with the each religious, psychological and the total world-view of the specific community in which implicit material medica are operating. The scholars (Lederer 1959; Leighton et al 1963; Prince 1964) illustrate a wide variety of healthcare practitioner viz
herbalists, bone-setters, midwives, diviners, acupuncturists, magico-religious healers and others who are developed as essentials of human societies. Ethno-psychiatrists or folk healers who are specialized in treatment of mental disorders that are emically derived in the respective diagnostic systems are also found in small societies (cited in Hughes 1996). Janet (1919) pointed as early as in 1919 that psychotherapy has often been said to derive from traditional and religious healing patterns (cited in Wood 2010). There are two categories of methods falling in the sphere of treatment of mental illness. A) The first one is psychoanalytical methods developed by etic approach and b) the second are in ethno-scientific methods evolved by emic approach. Even though both categories are essential to achieve better mental health status in reality, the researcher has to distinguish them at this level in order to specify the design and findings of the current research.

The psychoanalytical methods as marked by Kennedy (1973) ranges from symptomatic treatment such as tics and phobias to ‘massive personality over hauls (cited in Foster and Anderson 1978). The western though focus on reduction of patients ego-strengthening and personality modification measures. The patent is encouraged to develop a positive view on himself, with greater self-esteem to be relieved of subjective feelings of pain, anxiety and stress and thereby to become more independent and to function more effectively in the society (ibid). The psychoanalytical works and views of Deverux (1961) as summarized by Littlewood (2010) illustrates that focus on the medical study of
illness, psychiatric theories and practices in a particular community, an
aboriginal group through looking at its ‘social and culture’ setting and
comparing this to the then established procedures of ethno botany also Deverux
focused interest on the problem of etic and emic normal abnormal distinctions
in psychiatry. When we think of the validity of applicability of ethnographic or
non-western methods of curing the psychiatric disorders, the biggest opposition
from psychoanalysts is about the mental state of shamans. Ackerknecht (1971)
argues that the shaman cannot be categorized as abnormal in a
psychopathological sense because shaman is well adapted to his society and
serves a useful function (cited in Foster and Anderson 1978). Where as
Devereux (1970) provides an etic analysis by declaring shamans to be
‘surrogate schizophrenics’ on behalf of their community insane in what he
expresses their ‘ethic unconscious’ yet able to generate new ideas for their
stressed fellows he warned that such solutions could only be irrational and lead
to further ‘catastrophic behavior’. He later developed his theory of
complementarily where by any cultural pattern could be understand similarly
where from both psychoanalytical and sociological directions, but in practice
he reduced sociology to psychology. Devereux’s ideas were taken to full all
cultural innovators, successful or otherwise have been schizophrenic (cited in
Littlewood 2010). Littlewood remarks, psychiatric anthropology now favors
Ackerknecht’s more modest approach whilst shamans and other inspirational
healers may on occasion be psychic by western criteria, practicing shamans are
rarely psychotic. Our etic (psycho analytic or psychiatric) formulation may fit
variously with emic (local) categorization of illness. Foster and Anderson (1978) summarized the ethno psychiatric methods. They say the non-western psycho therapy as pragmatic in approach, aiming at providing remedies for which they call reduction or elimination of the abnormal symptoms found in patient. The treatment is comparatively of short term in which most of the introduction takes place between healer and spirits rather than healer and patient. One can find verbal similarities between orthopsychiatry and western regarding confession.

By the patients with their therapist yet in spite of these differences many anthropologists and western therapists have found that shamans and other healers often achieve remarkable results in treating the mental illness. However, it is empirical data extracted from ethnographic fieldworks, that evidence the efficacy of ethnopsychiatry. And this leads to the further research such as clinically applied ethno-psychiatry. It is on the basis of this review of literature, the recent study is undertaken

The essence of current research is rooted in understanding the tribal mental health conditions. In India, the tribal people are adversely affected because of rapid changes especially in the field of health, education and economic pursuits. The works of Vidhyarthi and Rai (1976), Hasnain (2002), Majumdar and Madan (2004) and Kalla and Joshi (2004) gives a comprehensive picture of tribal-status and problems in India. In this regard in a multi-cultural country like India, one could find rich cultural diversities among the tribes also. As India is caste based society, the status of tribe also swings
from a tribe to caste overall decades. As a result a researcher cannot reach to 'real' conclusion without being extra-cautious and indepth study-oriented while conditioning his/her research. Hasnain (2002) identifies the characteristics of a tribe a) simple pre machine economy, b) unique rituals and social customs c) lack of a script for their speech which itself is not developed and d) small local community organization and homogeneity. Hence the essence of studying and reading the tribal culture becomes imperative. Because oldest cultures are either dying or are being exterminated due to the world wide process of Mankind turning towards a huge process of cultural, linguistic homogeneity. Gupta (2004) and Chadda (2004) discussed various serious issues regarding the tribal mental health issues in India. The health status of tribal population is marked by several risky factors such as poverty, illiteracy, malnutrition, lack of personal hygiene, poor sanitation, poor mother and child health services, ineffective coverage of national health programmes and consanguineous marriages. It is an alarming fact that, mental health issue in different populations are not taken seriously in India. By referring to the census of 2001, and 1919 Gupta (2004) remarks the inequalities found in the distribution of resources in healthcare sector. She identifies that, 70 percent of India lives in villages, but 70 per cent of the facilities are invested and located in metropolitan or similar cities. The tribal area in India is about 15 per cent of the total geographical area. But it is the most inaccessible and underdeveloped area. The tribal perception of etiology is dependent mainly on the magico-religious practices. Among the very few pioneering work in this field are

The condition of healthcare system in the national and international levels is also not very promising. Ganguly summarizes the situation in this way: At the international level, mental health is receiving increasing importance as reflected by the WHO’s focus on mental health as the theme of the World Health Day. 4th October 2001, and in World Health Report 2001. This is because the mental and behavioral problems are increasing world over. The burden of illness resulting from psychiatric and behavioral disorders is enormous. The psychiatric disorders account for 5 out of 10, leading to causes of disability as measured by the years lived with a disability. The overall burden for neuropsychiatric disorders is projected to increase 15% by the year 2020 (Ganguly 2005). Kumar (2005) summarises the NMHP in this way: National Mental Health Programme (NMHP) started in 1982 by the government of India was an outcome of various initiative aims of providing mental healthcare to the population utilizing the available resources. However, the programme did not do much fruitfully in the seventh or eight five-year plan. The states have not provided sufficient funds for the mentally ill providing treatment for inpatients despite the supreme-court having directed the centre and the states to make necessary provision for their hospitals. The Central
Council of Health and Family Welfare recommended that mental health must form an integral part of the total health programme and should be included in all national policies and programmes in the field of education and social welfare and the importance of mental health must be raised in the courses/curricula for various levels of health professionals. The characteristic features of the plan for implementation of NMHP are:

1. Programme of Community Mental Health at Primary Healthcare level.
2. Setting up of regional centres for community mental health.
3. Formation of a national advisory group on mental health;
4. Setting up of a task force on mental health;
5. Prevention of mental illness and promotion of mental health;
6. Integration of multipurpose training schools in NMHP;
7. Involvement of voluntary agencies in Mental health education for the under graduates;
8. Evaluation of community mental health programmes;
9. Preparation of manuals and records; and
10. Training programmes for mental hospital staffs;

An outcome of these recommendations,

On Order was issued by the government which outlined the pattern of assistance in 1987 during the seventh five year plan to the states (2005).

Kumar (2005) gives the summary of District mental Health programme also which was developed National Institute of Mental Health and Neurosciences (NIMHANS) during the eighth plan as a District mental health
care model in Bellary district later it was adopted by all states under the National Mental Health Programme 1996-97.

Key Features of DMHP:

1. The states will set in motion the process of finding suitable personnel for manning the DMHP teams. They can take in services candidates who are willing to serve in this pilot project and provide them the necessary training in the identified institution.

2. The patients will be from the district itself and the adjoining areas.

3. District Mental Health Team will be expected to provide service to the needy mentally ill patients and their families such as daily out patient service, ten bedded in service facilities, referral services and liaison with the primary health centre, following service, awareness programmes and also community survey if feasible.

Along with these two major programmes NMHP (1982) and DMHP (1997) Basua (2011) adds two acts viz adoption of Mental Health Act (1987) persons with disability Act (1995). He remarks that delays in expansion and lack of effective implementation with IEC (information education and communication) resulted in a failure of there programmes even though the plan was very comprehensive. Therefore Barua (2009) urges for a realistic mass gradual implementation of district mental health programmes in a phased manner with support of adequate managerial and financial inputs, with more and more participation of voluntary organizations along with the private health
care sectors. Because India with a population of billion and very limited numbers of mental health facilities and professional one bed per 40,000 population and there psychiatrists per million population, needs an innovative initiatives mainly in the sphere of de institutionalization and community care in the field of Mental Health. Malik (2005), Kakar urges Kumar (2005) urges for the incorporation of inter disciplinary approach both at the level of planning and implementation of mental health programmes; by incorporating the insights from culture religion and alternative tharaptic systems. Since there has hardly been in depth studies in the field of mental health issues of the tribes of India, the present study on Ethnopsychiatry is intended to throw useful light on an essential but least addressed area of Anthropological research in India.

An ethno psychiatric study has to be conducted mainly in two phases viz ethic and psychiatric levels diagram shows four levels through which the process of mental health seeking takes place and this will direct the system of ethno-psychiatry. The whole process takes place in bio cultural setting which is shown in dotted circle. Each indicial of a community is bound to act according to the specific norms of a culture in which the individual in born and broughtup.

The individual basically performs 3 kinds of membership in any community viz family, settlement and locality broder area, which is shown in Conceptual Map, Diagram M. Duo the bio cultural factors, the individual is exposed to the incident of mental health problems that place the persons into the sick-role. After successfully coming out of the role of the patient the
individual learns to be care taker with in and outside the family. The experiences of suffering and knowledge of medicine and care taking, directs the most individuals to out as. Care takers to the family and kins where as, it inspires few to take the big venture of caring the whole community by learning the behavior and abilities of current that is frequently found in one’s own community from one’s childhood, in which the process of socialization takes place.

This phase is shown as M3. The last phase in which the current research on ethmopsychiatry largely rests is shown as M4. Here the process of Mental health seeking takes place mainly in four directions namely a) options, b) Channels, c) Availability and d) Affordability of mental health care services. The present research is conducted on a tribe called ‘Karevakkalu’, ‘Karevakkalu’ is listed under most backward class viz category (S.L. H Govt. order no. SKE 225, BCA 2000, Bangalore dated 30-03-2002) category 1 is categorized to those people who are socially educationally and economically.

The population of ‘Karevakkalu’ (according to 2011 (census) is 75,817 (ref. Office of Devaraja Arasu Backward class corporation Karwar). The ‘Karevakkalu’ are struggling to attain the status of scheduled Tribe, through their community union called ‘Karevakkalu Samudhaya Samagra Abhivradhdhi Sangha’ (‘Karevakkalu’ community’s total development union) The ‘Karevakkalu’ are mainly living in the North Karnataka region which is known to a backward area in almost all fields of development viz literacy rate, poor acceptance of health care systems. Due to all of these factors. The present research is taken with an intension to meet the below noted objectives.
The Objectives of the Research:

- To study the basic concepts of Health and illness, along with the disease etiologies by focusing mental illness.
- Understanding of the diagnosis, treatment methods.
- Interactions of traditional and modern medicine.
- Document those objects and practices that are believed to be caring psychic and other illnesses in given culture.

Methodology of the Research:

- Ethnographic field work was conducted in order to get first-hand qualitative data about the ‘Karevakkalu’.
- Unstructured in depth interviews were used to interview the ex-mental patients and structured in depth-interviews are done to interview the herbal medical practitioners, shaman’s and bio-medical doctors and other personnel of modern healthcare.
- Key informants interviews have been conducted to cross-check the data collected by other techniques.
- House hold survey was conducted by using census schedule technique to gather baseline data.
- Participant-observation was done to understand the live process of shamanic healing sessions and annual community worships that includes possession by shamans.
- Focused group-discussions have been conducted in order to get an idea of levels of interaction at the community and to understand a pattern of health-seeking behaviour.
Along with the primary data, secondary data was also collected from government and non-governmental organizations viz. Primary Health Centre, Taluka Health Centre, and District level government hospitals, offices of social-welfare for backward classes, village and taluka panchayath offices, Tehsildar office (taluka level revenue collector), NGOs and research institutions for social-welfare and environmental studies. The current research on Ethno-psychiatry is conducted on the basics of Emic perspective and theoretical frame of Ethno-science. The methods of Ethno-science are evolved within the given culture. The categories and components of that culture are extracted and analyzed according to the 'insider' views i.e., emic perspective. Emic perspective is essential for any behavioral and ethnographic researches as it explores the ground realities through people's perspective. Intensive field-study has been conducted by the researcher for nine months in 2004, in order to collect first-hand in-depth qualitative data, finding a settlement to stay. The researcher covered both scattered and structured settlements and later selected a big settlement having about sixty households. The people suggested the researcher to stay with two lady teachers staying in the same settlement, and one family of the 'Karevakkalu' constituted the neighborhood to the researcher. The people were (as compared to other co-habitant communities,) so shy by nature and they were reluctant to share their experiences as the current research largely rests with the sensitive issues of religion, supernatural beings and the experience of mental disturbance and emotional elements of individuals. This became manageable as the researcher became familiar to the routine life and
especially native terms used by the ‘Karevakkalu’. There is another significant point that affected the research from both side viz the status of the researcher. The people happily received the researcher who was from the same region, But on the other hand the researcher was expected to work as a typical girl of the region; this obligation restricted the researcher in several ways, viz. not to stay alone and to share accommodation (especially at night) with the lady teachers, not to eat the food cooked by the ‘Karevakkalu’ and not to wander in the ‘Karevakkalu’ settlements after six clock in the evening and to have minimum interaction with male folk. However the task of collecting a comprehensive data was made easier when the researcher established good rapport with the people by giving stress initially to the positive cheerful and auspicious topics of their routine while interacting with the people. And then slowly shifting the interactions towards the ‘other’ sides of life such as disease, pain, sufferings, death, soul, evil, supernatural-beings became fruitful in gaining necessary in-depth information.

The current research on “Ethno-psychiatry among the ‘Karevakkalu’ is presented totally in five chapters;

The first chapter gives an introduction to the theme of the research, review of literature, conceptual map of the current research, objectives and methodology of the research.

The second chapter is about cultural profile of the ‘Karevakkalu’ environment of the ‘Karevakkalu’ settlements are discussed. Food habits, dress pattern, settlement pattern, Family, marriage, kinship, tribal features,
occupation, festivals, life cycle rituals, status among the other co-habitant people and traditional politico-judicial system of the ‘Karevakkalu’ are described.

The third chapter discusses on the ‘Karevakkalu- world view and shamanism. Concept of health and illness, is being explained by focusing the peoples’ perceptions, beliefs regarding mental health and also the etiology of health and illness. It also contains the ‘Karevakkalu’ shamanism and its functions.

The fourth chapter focuses on the pattern of mental- health seeking behavior among the ‘Karevakkalu’, which reveals the four different domains of medicine namely ‘home remedies’ and herbal medicines, shamanic healings and biomedicine. The diseases found among the ‘Karevakkalu’ are discussed in detail, covering four as aspects of viz. 1.etiology, 2. diagnosis, 3. therapy and 4. materia and medica of illnesses found among the “Karevakkalu”.

The chapter fifth is about theme of findings and remarks of the current study. This stresses on the strength of ‘Karevakkalu –nota’, peoples’ problem in understanding the modern psychiatry. And also necessity of improving the interaction between people and biomedical health care provides. It also gives suggestions to improve the public and private health sectors regarding mental health care issues.