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Healing, Madness and Stigma: A Study of the Jaunsari Tribe of Lakhwar Village (Dehradun District, Garhwal, Uttarakhand)

Guneeta Kaur Gill and Shruti Singh

Department of Sociology, Amity Institute of Social Sciences, Amity University Noida Campus, Sector 125, Noida 201 31, Uttar Pradesh, India
E-mail: gkgill95@gmail.com

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ABSTRACT The Jaunsari people are a tribal population residing in the Jaunsar-Bawar region of Garhwal, known for their unique culture of faith healing. A qualitative study was conducted in the Jaunsari village of Lakhwar to comprehend how *personalistic dos* (various forms of suffering and misfortunes caused by supernatural factors) are conceptualised, resulting in sociocultural perceptions towards madness, stigma and witchcraft. The research employed a phenomenology approach using snowball sampling to identify informants and conduct in-depth semi-structured interviews, resulting in primary data. The study indicates a strong belief in supernatural phenomena such as evil eye, magic and possession, with faith healers holding a position of respect in the village. While modern education and healthcare facilities have led to the coexistence of traditional healing practices and modern medicine, faith healers are still highly regarded. The community does not practise stigma or social boycotts against individuals deemed mad, possessed, or accused of witchcraft.

INTRODUCTION

Illness and healing are two concepts around which perceptions vary significantly due to the personal and the individual, and the social and the cultural, which further influences a community's health-seeking behaviour (Kaur 2016). Outside the modern Western world, the conceptions of illness and healing are often closely tied to religion and supernatural powers. Belief acts as a powerful tool, which affects the health-seeking behaviour of individuals and communities. Belief becomes even more critical when the discourse broadens to include conceptions of madness and mental illness. Foster and Anderson (1978) have spoken in depth about non-Western disease etiologies, namely the personalistic and the naturalistic. Naturalistic refers to illness described by natural factors like climate and humoral imbalance. Personalistic refers to illness caused by the active and intentional intervention of some 'sensate agent' that is supernatural, like a ghost, evil spirit, angry gods, or a human in command of such forces as a witch (Foster and Anderson 1978).

In the Indian scenario, people's attitudes towards madness, mental illness and health-seeking behaviour are determined primarily by perceptions created through religious beliefs, cultural practices, and superstition, especially among the rural and tribal populations. According to Kishore et al. (2011), such perceptions lead to the view that mental illnesses such as depression, schizophrenia and fits, among others, are not medical illnesses but a result of supernatural causes. The supernatural includes witchcraft, evil eye, possession, and divine punishment. Such perceptions ensure that patients and families turn to folk healing and temple healing as the first resort in a considerable percentage. Biswal et al. (2017) reveal that 75 percent of patients in India turn to folk healing in case of mental illness, which leads to a dependence on folk healers such as shamans, exorcists, diviners and *pujaris* (Hindu temple priests), among others, for treatment, and a subsequent distrust of professional health service providers, which in turn can lead to the hold of the folk healer over the understanding of madness, mental illness, and the culture around its treatment in the community. Such perceptions are also the main reason for the stigma surrounding madness, mental illness, and the use of professional health services, predominantly in the case of women.

Due to the rapid changes in society, the unique way of life, beliefs, culture, and social interactions of tribes are being threatened. This can make them more vulnerable to experiencing mental health problems. Different tribes have varying beliefs and interpretations of mental health issues and how they arise, leading to inconsistent mental and emotional distress expressions that

do not align with standard diagnostic practices. As a result, those experiencing symptoms of depression, anxiety or substance abuse may turn to spiritual, traditional, or folk healers instead of seeking medical attention from a hospital or physician. Unfortunately, high poverty levels and limited awareness and knowledge create economic barriers that prevent most tribal communities from accessing necessary treatment.

The health-seeking behaviour of tribal populations reflects their beliefs and cultural traditions. Tribes have developed a robust traditional medicine system based on their knowledge gained through observation and reasoning since time immemorial (Che et al. 2017). Devarapalli et al. (2020) found limited research has been conducted on the health of the Scheduled Tribes population, with a lack of attention given to tribal mental health in healthcare services. Additionally, there is limited information on mental disorders in tribal communities. According to Verma et al. (2022), there has been a lack of research on mental health issues among tribal populations in India over the past thirty years. Previous studies have only addressed a narrow set of concerns, such as alcoholism, anxiety, depression and suicide.

Determining what qualifies as a mental illness in tribal communities is complex and uncertain due to the impact of cultural perspectives on disease perceptions (Verma et al. 2022). According to Subudhi and Biswal (2021), India has the largest tribal population in the world. However, there is a shortage of health statistics on the prevalence of mental illness within this population. Although the National Mental Health Survey (2015-2016) study included some tribal people, the specific prevalence rate of mental illness among them has not yet been reported (Subudhi and Biswal 2021). They go on to say that the perceived aetiology of mental illness is divided into four categories of stress, Western physiology, non-Western physiology, and supernatural, wherein 44 percent patients reported 'stress' as the leading cause of mental illness, while 40 percent believe in supernatural causes as the aetiology (Subudhi and Biswal 2021).

The study by Hansda et al. (2021) examined the views and practices of tribal communities on mental health in the Ranchi and Pakur districts of Jharkhand. Based on the findings, over 60 percent of the results indicate that the population believes in supernatural phenomena like *bhoot pret* (ghosts), *opari kasar* (spirit intrusion), and *jaadu tona* (sorcery/witchcraft). Additionally, 76.7 percent of people believe that *Devi/Devta Prakop* (divine wrath) can cause mental illness. The study also revealed that the participants had superstitious beliefs regarding mental illness. When someone falls ill, they are usually taken to an *Ojha* or *mati* (sorcerers or folk healers), and most participants had limited knowledge about mental health. Hansda et al. (2021) suggests launching community-based mental illness awareness programs at tribal weekly marketplaces in collaboration with local health workers and community members.

In their study on mental health in Nagaland, Ningsangrenla and Rao (2019) found that traditional healing methods are commonly used in rural areas to alleviate mental health problems, while urban areas rely more on modern approaches. The study revealed that mood disorders were the most prevalent issue, and traditional psycho-spiritual therapies were effective in most cases. The authors recommend combining traditional healing practices with modern psychiatric methods for optimal results (Ningsangrenla and Rao 2019).

A recent study conducted by Sutar et al. (2021) on the health camp in Mandla town found that a significant number of patients from financially weaker sections and tribal communities from remote areas of the district were diagnosed with common mental illnesses, with psychotic spectrum disorders being the most prevalent individual diagnosis. Additionally, the research revealed that patients who relied on magico-religious treatments were more likely to suffer from severe mental illness (Sutar et al. 2021). Subudhi et al. (2022) interviewed 50 tribal study participants from the Department of Psychiatry, Ispat General Hospital (IGH) in Rourkela, Sundargarh District, Odisha, India, and discovered that mental illness put a strain on the tribals and their families' socioeconomic lives.

A study was conducted by Sindhu et al. (2022) in 12 tribal hamlets located in H.D. Kote taluk, Mysore District, Karnataka, India. Their findings revealed that 8.2 percent of individuals were affected by anxiety, with 16 (4.7%) experiencing mild anxiety, 10 (2.9%) experiencing moderate anxiety, and 2 (0.6%) experiencing severe anxiety. Additionally, the study found that 22.4 percent of individuals suffered from depression, with 64 (18.9%)

experiencing moderate depression and 12 (3.5%) experiencing severe depression (Sindhu et al. 2022).

Sadath et al. (2019) suggest that mental health training programs should be provided to grassroot workers like tribal promoters, and clinics should be established in remote areas to serve tribal communities, highlighting the importance of increasing the understanding about mental health and reducing stigma among tribal populations. According to Raghavan et al. (2022), people with mental illness or those associated with them do not experience stigma differently in urban, rural or tribal communities. The study found that traditional methods are commonly used as the first approach to treating mental health disorders in both rural and urban areas of Kerala. However, doctors and psychiatrists are also sought if traditional or spiritual methods are ineffective (Raghavan et al. 2022).

According to Lakhan (2020), many tribal people in rural India prefer traditional healing methods over seeking medical help from professionals, and this preference may stem from various sociodemographic factors, such as a lack of awareness and resources, physical barriers, limited availability of services, biased attitudes of medical professionals, inherited perceptions of mental illness, and a lack of successful examples of medical care within their communities. Lakhan (2020) further states that it is crucial for researchers to delve deeper into the perceptual and attitudinal factors that affect mental health care pathways for tribal people.

Uttarakhand, an Indian state located in the Himalayas, is divided into two administrative divisions, namely, Garhwal and Kumaon (Home: Office of Commissioner Garhwal Pauri 2021). Himachal Pradesh borders the Garhwal division to the northwest, Tibet to the north, Kumaon to the east, and Uttar Pradesh to the south. Chamoli, Dehradun, Haridwar, Pauri Garhwal, Rudraprayag, Tehri Garhwal and Uttarkashi are the districts that are a part of the Garhwal administrative division. The inhabitants of Garhwal are collectively called 'Garhwali' and speak Garhwali, Urdu, Jaunsari, Nepali and Punjabi, among other indigenous languages.

The Garhwal region has a rich tradition and culture of faith healing, with local deities and superstitions playing a significant role in the healing practices of the area. According to Bindi (2012), the region holds the belief that having complete faith in their deities can prevent illness and eliminate the need for medical professionals. Faith healers are treating everything from snake bites, viral fever and jaundice to madness. In Garhwal, belief in possession, sins of the past, the evil eye, witchcraft, and displeasure of the deities are seen as significant causes of illness and misfortune (Berreman 1972). Supernatural possession is also seen as the cause, diagnosis and cure of all sorts of illnesses and misfortunes in Garhwal, and women are viewed as most prone to harmful possession. The above perceptions lead to a strong belief in the existence of witches in the region, where madness in women is classified as the work of malevolent causes. The only solution to this is the faith healers who are greatly respected in the region and play a significant role in the culture of traditional medicine in Garhwal.

Background of Jaunsari Tribe

The Jaunsari people of the Jaunsar-Bawar region in Garhwal are a tribal population who are divided into castes such as the Brahmins, Rajputs, Bajgis and Koltas, where the Brahmins and the Rajputs are the landowners. They also have a distinct language called the Jaunsari language. The region is divided into two development blocks, namely Chakrata and Kalsi, which are a part of the Dehradun district. The Jaunsar-Bawar region is ecologically and culturally distinct due to its history and geography. It lies within the latitudes of 30° 31' and 31° 3' 30" N, and longitudes of 77° 45' and 78° 7' 20" E, with an area of 343.5 square miles. The Jaunsaris trace their ethnic origin from the Pandavas of the 'Mahabharata' and claim to be their descendants, thus explaining certain practices like polyandry.

The Jaunsaris were recognised as a Central Himalayan tribe under the Gazette of Government of India No. 107 in 1967. The Jaunsaris won the status of Scheduled Tribe (ST) after a long struggle by the community's local leaders. They used a rationale of unique culture and backwardness to justify their claims. The Rajputs and the Brahmins led the struggle and stressed their polyandry customs and folk songs to consolidate their

claims of Scheduled Tribe status. Accordingly, the Jaunsar-Bawar region was acknowledged as a 'Scheduled Tribal Area', thus conceding the status of a Scheduled Tribe to all inhabitants within the territory (Kumari et al. 2021).

According to Mitra (2020), 'the Census of India 2011 lists the Jaunsari as a Scheduled Tribe and records their total population at 88,664, including sub-tribes such as Khasas and Koltas (artisans). Most Jaunsaris are transhumance pastoralists, moving their herd depending on the season.'

The social stratification and caste differentiation of the Jaunsaris consists of three broad groups based on occupation. The higher group includes Brahmins and Rajputs, the intermediate group consists of Nath, Bajgi, Jadgi, Badhai and Lohar, while Koli, Kolta, Shilpakar, Dom, Chamar and Mochi belong to the lower group (Majumdar 1962).

According to Kumari et al. (2021), 'Khasa' and 'Kolta' are used to describe broad categories of the communities inhabiting the region, wherein 'Khasa' comprises upper castes communities, like the Brahmin and the Rajput, and the 'Kolta' consist of lower caste groups like the Kolta, Dom, Chamar, Koli and Shilpkar. The Brahmin and the Rajput are the main landholding and cultivator communities of the Jaunsar-Bawar.

Indigenous Healers in Jaunsari Community

The Jaunsaris have an extensive and rich cultural tradition of faith healing distinct from the rest of Garhwal and even Himachal Pradesh. Faith healing in the region includes Tantra and Mantra (against the evil eye and supernatural causes) and an extensive knowledge base and tradition of using local herbs, roots and plants. The Jaunsaris believe the supernatural is responsible for many diseases, disabilities and mental illnesses. They have a strong belief in destiny, luck, magic and horoscopes. These beliefs have led faith healers and traditional medicine practitioners to occupy an essential societal position.

The Jaunsari culture boasts various folk healers and traditional medicine practitioners, all of whom are masters with many specialisations ranging from dealing with possession and madness casting away the evil eye, jaundice, and snake bites.

Joshi (1981) has given a hierarchy of folk healers in the Jaunsar culture, namely, the *baman*, who is the priest and the astrologer, the *mali*, who is the diviner and the shaman, the *jariyara*, who is the herbalist and the pulse specialist, and the female specialist.

Joshi (1981, 2013) states that the first two in the hierarchy of folk healers, the *baman* and the *mali*, deal solely with *personalistic dos*, while the other two deal with naturalistic illnesses referred to as *bimari*. *Dos* relate to all types of sufferings and misfortunes due to supernatural causes affecting individual illness and misfortunes affecting larger groups. *Bimari*, on the other hand, refers to the bodily troubles of an individual (Joshi 1981, 2013). Rizvi (2013) states that ailments like colds, fever, snakebite, body aches, headaches and scabies are treated as natural ailments due to imbalance in the body and the outside environmental risks. Joshi (2010) explains that the shaman for the Jaunsaris provides family therapy, counselling and rehabilitation to psychosocially troubled individuals (such as in cases of madness, hysteria, and witchcraft accusations) and thus, not only mitigates illness but also acts as an agent of social justice within their cultural norms.

The use of medicinal plants by the Jaunsaris has been a source of great fascination and study in ethno-medicine and ethno-botany over the decades. Jain and Puri (1984) surveyed a hundred plants used to treat various ailments by the Jaunsaris. Kshatriya et al. (1997) have analysed the healthcare practices of the Jaunsaris of Chakrata development block, especially regarding their fertility and mortality rates, and reported that there is a preference towards traditional systems of medicine in case of any illness. Chantia (2003), using the survey method, has created a repository of medicinal plants used as household remedies by the Jaunsari people in the Dehradun district, such as a concoction of the *Kachoor* plant being used to treat stomach aches, rheumatism, and arthritis. Recent research by Semwal et al. (2021) has also analysed the medicinal plants folk healers in the Jaunsar-Bawar region used for medicinal purposes. The studies mentioned here are part of the research conducted on ethno-botany and the wider culture of ethno-medicine among the Jaunsaris.

Although there is extensive research on Jaunsari culture, religion, ethno-botanical traditions, and ethno-medicine, further research is required to specifically investigate the relationship between *personalistic dos* and madness/mental illness. Further research is required on the perceptions of stigma surrounding Jaunsari healing practices, mental illness, and accusations of witchcraft. This is the rationale behind this paper.

Objectives

This paper focuses on the prevalent healing culture of the Jaunsaris concerning the conception of *personalistic dos* (various forms of suffering and misfortunes caused by supernatural factors) by looking at the experience of one village, that is, Lakhwar village, in Kalsi block, Dehradun district, Garhwal region, Uttarakhand. The paper further analyses socio-cultural perceptions concerning madness, witchcraft and stigma as emerging from the healing cultural traditions of the Jaunsaris inhabiting Lakhwar village.

Study Area

The study was conducted in Lakhwar, a Jaunsari village in the Kalsi development block of the Dehradun district, Garhwal region, Uttarakhand. The geographical area of Lakhwar village is around 605.22 hectares. The nearest town Vikasnagar is around fifty kilometres away, and Dehradun is around ninety kilometres. The village has access by road, but due to being a mountainous area, access is restricted during monsoons due to landslides and slippery roads.

According to the Census 2011 Data, seventy-nine families reside in the village, with the total population being three hundred and eighty-six, of which one hundred and ninety-seven are males, and one hundred and eighty-nine are females. The literacy rate of Lakhwar is 85 percent. Within the village, Scheduled Caste (SC) constitutes around 44.3 percent, while Scheduled Tribe (ST) was 51.3 percent of the total population (Census 2011 Data 2022).

Currently, as of 2021-2022, based on information provided by the *sayana* (headman of the village/cluster of villages), thirty families in the main village are Rajputs and are mostly Chauhan, though, in the last few decades, two Agarwal families have also settled in from the plains. One Brahmin family and five families of Bajgis (artisan caste, musicians) are in the village. The Scheduled Caste (SC) community lives in a separate settlement outside the main village. The Rajputs and the Brahmins are the principal landowners in the village. The main occupation in the village has traditionally been animal husbandry and agriculture. Still, due to most people leaving the village for greener pastures, much of the agricultural land remains uncultivated. Any agriculture cultivation being done today is primarily for self-subsistence. The village today boasts of many doctors practising in the government hospitals of Vikasnagar and Dehradun, along with lawyers and even Indian Administrative Services officers. A primary to senior secondary school is in the village, along with one Anganwadi centre and one Primary Health Centre (PHC). All three cater to around six villages. The Primary Health Centre has two staff members comprising a doctor and a pharmacist. They are only available during specific time slots and are not equipped to deal with anything more severe than a common cold, minor cuts, bruises and loose motion. The nearest government hospital is at Vikasnagar, about fifty kilometres away.

METHODOLOGY

This paper is a qualitative study. The research approach utilised is called phenomenology. Phenomenology strives to elucidate and clarify an occurrence or phenomenon from the viewpoint of those who have directly encountered it. This approach aims to comprehend the "lived experiences" of the participants. It seeks to understand why and how participants behaved in a particular manner based on their perspectives. The data collected is primary. The study was conducted in November 2021. In-depth semi-structured interviews were conducted over multiple visits with the three faith healers present in the village. Primary findings are based on key informant interviews of the three faith healers. Snowball sampling was used to identify eight villagers as informants, and semi-structured interviews were conducted. Data was collected via audio recording interviews with explicit permission, field notes and observation.

RESULTS

Lakhwar village, with respect to folk healers, currently has a practising *baman* (priest and the astrologer) along with his disciples and the *mali* (diviner and the shaman). The community presently lacks a *jariyara* (herbalist and pulse specialist) following the death of the previous one before the COVID-19 pandemic in 2019. The chief *baman* lives further up the mountain from Lakhwar, around a ten-minute climb by foot. The chief *baman* is the principal landowner of his area and is culturally and ritualistically extremely important across Jaunsari villages both in Kalsi and Chakrata. For the study, two *bamans* and one *mali* were interviewed.

Case Study I

SU is an elderly gentleman, the chief *baman* of Lakhwar village and the surrounding villages. He is an authority on Jaunsari culture and astrology. He has travelled extensively and is highly esteemed within the Jaunsari culture for his dedication to preserving their traditional cultural and healing knowledge and the principal sacred *granth* (text) of the Jaunsaris. He also claims to have worked extensively over decades to bring the Jaunsari villages out of their beliefs in superstition and possession. One of his sons is a doctor at the government hospital at Vikasnagar. SU seemed aware of mental health and illness, psychiatry and psychology.

According to SU, Jaunsari culture is unique from other types of religious cultures that exist in Uttarakhand. The *Ishta devata* (the favoured deity) of the Jaunsaris is *Mahasu* (tantric manifestation of Lord Shiva). As the *Upâsaka* (attendant/worshipper/devotee), one temple serves around ten to fifteen villages. The Mahasu Devta Mandir at Lakhwar village is a pilgrimage point for the surrounding Jaunsari villages. Throughout the years, it has become a well-liked spot for tourists to visit. SU further elaborated that the *Upâsaka* also worship their *kuladevatâ* (clan deity), and every village has a temple dedicated to them. He states that the *kuladevatâ* of Lakhwar and surrounding villages are the *Pandavas*, as the Jaunsaris claim to be descendants of the Pandavas. Though, in interviews with the villagers, they added that they also worship another *kuladevatâ*, who is *Durga*.

SU also spoke at length about what he called the *granth* (sacred text) of the Jaunsaris, called the *Sancha*. This *granth* is only available with the *baman* and is the only complete Jaunsari text written in the Jaunsari language. SU stressed the fact that this *granth* is different from Ayurveda. The *granth* is divided into *Prakarans* (chapter/section of a book), with *mantra* (sacred utterance) *prakaran*, *tantra* (against the evil eye and hostile supernatural powers especially for protecting one's house) *prakaran*, and *yantra* (refers to *tabeez*, an amulet worn for good luck and protection) *prakaran* being significant. But, in recent years, according to SU, the *granth* has been losing importance due to the pervasiveness of the Sanskrit language and traditions among the younger generations of *bamans*.

SU explained that *dos* are related to any individual being possessed by a *Devatâ* (god), wherein the individual experiences tremors (*kampan*), closes their eyes, prophecies about the surrounding people's lives, and gives solutions to their problems. There are many *Devatâs* and they can all possess a person. He gave examples of individuals being possessed by Gods such as *Nag Devatâ*, *Shiva* and *Mahasu Devatâ*, among others. Though he stressed how true these possessions are today, it is all subject to belief, as there is no hard scientific proof for it, and possession has become commercialised. He did mention that there was a time when possession was genuine and authentic, as belief and conduct in the past were stronger and purer, and *Devatâs* only possess a pure individual. There is no cure for such a possession, as it is not a *bimari*. Possessed individuals tend to become *mali* (in direct communication with the *Devatâ)*. SU did stress that he does not have a strong belief in possession today, as there are many psychological reasons behind what is termed possession, like madness and auditory and visual hallucinations. He advised individuals not to consult *mali* anymore for this but instead consult doctors or psychologists. The possession by a *Devatâ* can happen only for a few days as an individual cannot maintain that possession in their body. Though, he claimed that the ordinary Jaunsari, even today, tends to either consult a *mali* or go to temples like the main Mahasu Devta Mandir at Hanol to deal with issues related to possession, madness, and auditory and visual hallucinations. He added

that *malis* can be both men and women, though men dominate.

SU maintained that what he does as a *baman* differs significantly from what a *mali* does. He is primarily an astrologer and a priest. People come to him for astrology-related issues, prayers and mantras, help against the evil eye, and *tabeez* (amulets worn for good luck and protection). Though he tends to send them to the hospital for more serious matters, as he reiterates, he is against superstition. He explains that the educated population in the village is aware of psychological issues like madness and depression and goes to hospitals for treatment, but still sometimes comes to him for *tabeez*, as it works as a placebo effect in relieving them. But at the same time, belief in the *Devatâs* and possession persists even in most of the educated population.

Case Study II

AJ is a student of SU, under the *Guru-shishya* tradition, and is training to become a *baman*. He is from a remote Jaunsari village in the Chakrata development block. Alongside his training, he is also pursuing a Bachelor of Arts degree via correspondence from Haridwar. He spoke about the *granth Sancha* and how solutions to deal with *dos* are given in the *granth*, such as making *tabeez* and removing evil eye and evil spirits. He stated that there is still a strong belief in the powers of the *baman* and the *mali* among the Jaunsari people, with people being cured by them. He believes only those individuals with a firm belief in the *Devatâ* and truth (satya) can be possessed by the *Devatâ*. He further states that *dag/daayan* (witches) accusations are always on women who are never confronted about the fact, as the situation could turn sour, but they are not boycotted or thrown out of the village. Suppose an individual starts hallucinating or exhibiting signs of madness. In that case, they are first taken to a *mali*. If the *mali* cannot provide any relief, then only they are taken to a hospital. Though he did mention that the *bamans* were more careful and discrete in such matters as they feared a loss of reputation and repercussions by the family if anything goes wrong, the *malis*, on the other hand, are always more upfront and honest about such issues. He stressed that any *baman* or *mali* could not misuse their training or knowledge/power, as it would have more harmful consequences for them. He mentioned that around six years ago, the village had a *dag*/*daayan*, an older woman who reportedly used to cast an evil eye on the villagers, and she lived there until her natural death without any social boycott.

Dos, according to AJ, is a concept related to *Devatâs*. Many older men in the family devoutly believed in some *Devatâ*, and thus, had conceptions towards healing and culture based on causality. For example, an older man asked the *Devatâ* for help and promised some feast or sacrifice in the *Devatâs* honour to fulfil said demand, but could not keep the promise due to his death. The other family members are not aware of his commitment and cannot adhere to or uphold it. In such a situation, *dos* become active, and the family has to approach the *baman* or the *mali*. *Dos*, thus, means the sufferings or misfortune given by the *Devatâ*.

Case Study III

RC is the *mali* of the village and is quite an engaging and busy person. He believes that the *Mahasu Devatâ* dwells within the body, often unnoticed by the individual. The only way to determine if the *Devatâ* resides in the body is by the individual going through a state of volatility and disquiet termed as *bawal*. *Bawal* is different from madness, as it is considered a form of enlightenment. This can happen anytime, and such people then become *malis*. There is no training to become a *mali*, but the individual must meditate, bathe in holy rivers, undertake a pilgrimage to the main Mahasu Devta Mandir at Hanol, and carry out some rituals and prayers that RC was deliberately vague on. The process is tedious and frequently painful. The malis are required to go on a pilgrimage annually to Hanol. At the temple in Hanol, they receive a silver coin called *Chand*, which they use for their prayers and rituals. *Malis* can be both male and female, with the only Goddesses residing in the women and Gods in the men. Though the goddess *Mahakali* is an exception, she can reside in both men and women. According to him, there is still a strong belief in the powers of the *mali* with positive results attributed to them. People who are suffering because of supernatural causes consult the *malis*. It is worth mentioning that RC consistently re-

ferred to the practice and healing techniques of the *mali* as being performed by the *Devatâ* themselves rather than the human *mali* practising them.

RC explained how to deal with *dos*. They use rice from the household of the suffering family to do readings and find solutions. Answers may not always be instant and may take a while to be resolved. He maintained that the rituals *malis* perform cannot be considered tantric as it is emergent from the power of the *Devatâ*. According to him, while belief in *dag*/*daayan* is going down, strong belief in the evil eye persists. To deal with the evil eye, they mix a copper coin, iron nail, and gold and silver bars with equal portions of flour and rice from the household concerned and hang them at particular spots. The *baman* does the hanging part. RC revealed that while they may mention that the evil eye is because of a woman they may know, they may share hints towards her identity but never share the woman's name. He stated that the *mali* never encourages social boycott and stigma in such a case or cases like madness.

RC insisted that he encourages people to consult doctors before approaching him and that most *malis* stress on the same point today. But this was countered by a young college-going girl from the village. The young lady, KC, narrated her cousin's experience, who lives in a more remote Jaunsari village. He suffered from epileptic fits, and his family first took him to the *mali* for a remedy. For one year, the mali made the family run from pillar to post without improving the boy's health. Only by consulting a doctor were the family able to figure out the actual issue and treatment plan. KC held that this coexistence that is seen today, with modern medicine and the *malis* and *bamans*, is only visible in Lakhwar and surrounding Jaunsari villages. In the other Jaunsari areas, she said that "backward" people still rely entirely on *malis* and *bamans*.

RC, like SU, maintains that today, many *malis* have commercialised themselves to earn money and hence are no longer true to the traditions. RC also stated that there is a difference between someone possessed by a *Devatâ*, madness, cursed by the evil eye, and witches. On being asked how the difference is spotted, he said that it is figured out by the kind of activity and behaviour that the individual is exhibiting and by their aura, which the *Devatâ* residing inside the *mali* can recognise. In most cases, the *mali* cannot even remember what actions and solutions the *Devatâ* residing inside them have given.

Stigma, Madness and Witches

The question of stigma is a fascinating one in the village. The village's women accused as *dag*/*daayan* (witches) are not stigmatised or boycotted, even though both the *baman* and the *mali* do the necessary *tantra* and *yantra* to negate her powers and influence.

On being questioned, the villagers reported that they maintain a healthy distance from such an individual without making said individual conscious of the fact due to fear of retaliation. It is to be noted that the belief in *dag*/*daayan* is becoming less in the younger generation. Even individuals, especially women accused solely of madness (which SU identified as hysteria), are not removed or stigmatised from the village and are taken care of by the family and the larger community. These women are regularly seen by the *baman* and the *mali* for some relief from their *dos*, by either removing an evil eye or giving them *tabeez*. People identified as being inflicted with madness are not considered harmful or evil, but rather the community assumes that it is their responsibility to help and take care of them. Hospitals are a secondary resort in case of such *dos*, and it is always either the *mali* or the *baman* who is approached first.

On the question of witches and stigma, SU adamantly stated that he considers belief in *dag*/*daayan* (witches) as stigma (*kalank*), rather than women accused of being *dag/daayan* being stigmatised. He stated his experience when he was younger as behind this. There was an incident with a *Harijan* family where the young son was ill. Doctors had also been consulted and had diagnosed the child with double pneumonia, but there was no immediate relief. The family then consulted *baman* and *mali*, who stated that the child's illness was due to a *dag*/*daayan*, who was then identified as the child's paternal grandmother. They had also approached SU for consultation. SU had already spoken with the doctor, was aware of the child's diagnosis, and suggested that the family take the child to the hospital in Vikasnagar without delay. But the family was not happy with SU's recommendation and stated that they had been informed by the other *bamans* and

malis that the child's illness was because of the paternal grandmother. They were more inclined to believe them. The tragedy was further exacerbated by the fact that the grandmother was very old and had no other family or support outside the child's family. The child's father, her son, declared that she had *dos*, and she needs to correct it as she is responsible for her grandson's illness. The grandmother had no solution to offer here, and in fear, she fled and hid in the forest. Unfortunately, the child died, and in a rage, her son captured her, took her to the riverbank, and beat her to death. This incident significantly impacted SU's psyche and played a role in his working relentlessly within his community to denounce superstition and the idea of possession, madness and witches, as he holds the *baman* and the *mali* as the culprit in encouraging such incidents.

He elaborated that the *dag*/*daayan* is always a woman, and usually an older woman who may display symptoms of madness and reportedly eats an individual's organ. Thus, the survival of the individual becomes dependent wholly on the *dag*/*daayan*'s desires. However, SU maintains that this is not happening today, especially in Lakhwar and surrounding villages. AJ also stressed that social boycott is absent in case of madness and witchcraft accusations. RC supported that by stating social boycott and stigma in cases of women being accused as witches or in cases like madness is never encouraged by the *mali*.

DISCUSSION

Lakhwar village has high literacy levels, with an 85 percent literate population, higher than the 74.2 percent of the Dehradun district (Census 2011 Data 2022). The village also has a primary to senior secondary school. The village boasts of having doctors, lawyers, and government servants. Most of the village's young people have left to pursue a college education and employment in places like Dehradun, Vikasnagar, and Haridwar.

Educated and younger people are aware of mental health within depression and madness. They increasingly consult doctors and psychologists for treatment but still frequently get rituals done to ward against the evil eye or possession. A strong belief and respect for faith healers persist. Belief in the *Devatâs* and possession continues even in the educated population of the village. The faith healers are still consulted as the first or last resort, and the ordinary Jaunsari tends to either consult a *mali* or go to temples like the Mahasu Devta Mandir at Hanol to deal with issues related to possession, madness, and auditory and visual hallucinations, with reported positive results. Though a co-existence is visible in recent years, and the chief *baman*, in particular, increasingly pushes for a second opinion with doctors or psychologists. However, this co-existence seems to be a phenomenon only visible in Lakhwar village and is very recent. In the other Jaunsari areas, especially more remote areas, people still rely entirely on *malis* and *bamans* for diagnosis and cure. The villagers called their fellow tribe members of these remote areas "backward" due to this. The village has a Primary Health Centre (PHC) with two staff members comprising a doctor and a pharmacist. They are only available during specific time slots and are not equipped to deal with anything more severe than a common cold, minor cuts, bruises, and loose motion. The nearest government hospital is at Vikasnagar, about fifty kilometres away. The one Primary Health Centre covers many villages, and government hospitals are still not easily accessible. This situation is also responsible for the village's persisting belief in faith healers.

Recent studies by Ningsangrenla and Rao (2019), Sadath et al. (2019), Lakhan (2020), Hansda et al. (2021), Sutar et al. (2021), Raghavan et al. (2022) support the above findings. These studies have found that a significant percentage of the tribal population retains strong beliefs in supernatural causes behind illness, especially mental illness. Folk/faith healers and traditional medicine practitioners are highly respected, preferred and sought after for treatment relating to mental illness. Such beliefs and attitudes persist due to a variety of reasons such as lack of awareness, physical barriers, lack of health facilities and access to care, biased attitudes of medical professionals among others (Lakhan 2020). In a study conducted by George et al. (2020), it was found that the indigenous community in Attapadi, Kerala, was provided with financial protection and healthcare services by the health system. However, the community resisted efforts to improve access for several reasons. These reasons included the lack of culturally sensitive care, discrimination at healthcare facilities, centralized service delivery, and the inability to negotiate for services that are less disruptive to their lives (George et

al. 2020). Collaboration with local health workers and tribal community members, along with combining traditional healing practices with modern psychiatric methods are some recommendations to improve the situation (Ningsangrenla and Rao 2019; Hansda et al. 2021).

The beliefs of the Lakhwar villagers concerning stigma, madness and witchcraft align with the views posited by Stuart et al. (2013), who state that stigma begins when a person with unusual behaviour is declared ill. The concept of illness implies no hope for a cure or for making the person a valuable community member again. Thus, he contends, the stigmatisation of a person with unusual behaviour will be determined by whether that behaviour is attributed to mental illness (that is, based on what in that culture is a mental illness) (Stuart et al. 2013). In the Lakhwar village, the emphasis is on community responsibility, finding a cure and pushing towards making the person exhibiting unusual behaviour a valuable community member, due to the fact that their unusual behaviour is considered to be because of *Dos* (all types of sufferings and misfortunes due to supernatural causes affecting individual illness and misfortunes affecting larger groups). Folk healers do not encourage social boycotts or stigma towards women accused of being witches or in cases of madness and possession. Such practices are not endorsed or practised by the community. In South India, a study involving individuals with schizophrenia and their family members discovered that stigma was linked to the disease model of illness and non-stigmatizing beliefs regarding karma and evil spirits (Charles et al. 2007).

Further, Jr (1991) points out that great medical traditions (particularly non-Western ones) understand illness in cosmological, environmental, social, and moral contexts, thus defining illnesses and reactions to illness differently. He then contends that various and complex cultural, sociological, and economic factors influence which illnesses are stigmatised and to what extent (Jr 1991). While stigma is a universal phenomenon, specific experiences of stigma and discrimination are local and influenced by cultural factors (Murthy 2002). This is the case with Lakhwar village.

CONCLUSION

In Lakhwar village, the Jaunsaris have a deep cultural heritage of healing that values faith healing and a belief in supernatural elements such as gods, magic, and horoscopes. When it comes to *personalistic dos*, faith healers are still preferred. However, modern education and healthcare facilities have led to a co-existence between traditional healing practices and modern medicine. Despite this, belief in the evil eye, possession, and witches remains strong, and faith healers are respected in the village.

The village does not practise stigma or social boycotts against those accused of madness, possession, or witchcraft. In these instances, the community takes responsibility for providing care. However, only women are affected by these conditions or accusations. Hospitals are only considered secondary options, with the *mali* or *baman* being approached first.

RECOMMENDATIONS

Developing culturally appropriate tools and strategies is essential for estimating the prevalence of mental illnesses in tribal communities and addressing them effectively. Collaborating with faith healers can help doctors and hospitals increase awareness about mental health issues and available services. A referral system can be established where faith healers refer severe cases to hospitals or mental health professionals. Combining indigenous ethnomedicine knowledge with modern medicine can improve access and knowledge. Sensitising and training traditional healers to deliver simple interventions and assess when to refer to higher centres can also be helpful. Community health workers can be trained among tribal youth and incentivised to work in their communities. It is crucial to enhance the primary healthcare system simultaneously. Mental health professionals should be trained to communicate effectively with tribal populations in their native language. To improve understanding and decrease stigma surrounding mental health issues, conducting mental health awareness campaigns in local languages would be beneficial.

LIMITATIONS

The study's primary findings are based on key informant interviews of the three faith healers. Hence, the data may be vulnerable to inter-

viewer and interviewee biases, and it may be difficult to prove the findings' validity. Some informants expressed hesitation about giving interviews about their faith healing experience and perspectives, as healing tends to be very personal. The healers were also hesitant and wary about being interviewed initially due to fear of their occupation, culture and tradition being criticised or mocked. These limitations were minimised by building rapport with the informants during multiple visits.

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DISCLOSURE STATEMENT

The authors stated that they have no potential conflict of interest.

ETHICAL APPROVAL

The names and identifying information of the informants have been changed and coded to safeguard their confidentiality. The Department of Sociology, Amity Institute of Social Sciences, Amity University, Noida, approved the study.

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