Some Thoughts on the Anthropology of Mental Health and Illness with Special Reference to India

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1

India is a multicultural country. It is commonly believed in India that after every twenty-five miles or so we come across people with a different culture and a different dialect. But these differences, glaring as they are, should not shift our focus from the similarities and continuities between different cultures. People are different and they make all possible attempts to keep and highlight their differences. At the same time they know they share several cultural traits with other communities, particularly their neighbouring peoples, which aid their inter-community interactions.

Comparative studies of cultural traits point out that in many cases more similarities than differences exist between cultures and with the passage of time, the number of similarities multiplies. This does not mean that the process of homogenization is underway in India. Efforts of this type have always been defeated, for each culture is a resilient object. It allows sufficient leeway to acquire traits of other cultures that may be of purpose and utility, but it retains its distinctive properties and protects them from being diluted.

Therefore, it may be in the fitness of things to speak of the Indian culture: a culture with unity in diversity (Srinivas, 1980). Mass media and modern education are contributing a great deal in creating a cultural unity in India. It is widely known that local communities share the concepts of different religions. There are religious practices — for instance, those connected with the Sufi saints – that cut across different communities. In the same vein, traditional lore – such as astrology and palmistry – are not particular to any community. All this will guide us to conclude — with caution, perhaps – that there are certain common trends in India that contribute to her unity.

If we were to attempt listing different cultures of India, the list would almost be endless. One may classify cultures on the basis of region, religion, language, ecosystem, or, for that matter, any other social or cultural parameter that one may take into consideration. The People of India Project, which was carried out under the aegis of the Anthropological Survey of India and was concluded in 1992, identified 4635 communities in India, each having its own constellation of characteristics. However, at the cultural level it was found that there existed unmistakable similarities between different communities.

2

Indians keep a distinction between mind and body, and separate terms exist for them in various Indian languages. With respect to mind, Indians distinguish a good (or sound) mental state from a bad (or unsound) one, the latter may be the cause of a series of maladies. When a person is able to act according to his station in life, he is said to possess a sound mind. Similarly, when in a situation a person behaves as he is expected to behave, he is the bearer of a positive mind.

In the traditional Hindu *varnadharmasrama* theory, a man (or, a woman) must live according to the social category (*varna*, *jati*) to which he (or she) belongs. Each individual must also subscribe to the expectations from his (or her) gender (*ling*) and age (*ayu*) categories. A Muslim must adhere to the basic tenets of Islam – namely, one must believe in the One-ness of God and the Prophet Muhammad, one must donate from one's earning for the needy and poor, one must perform the prayer five times a day, one must observe ritual fasting, and after relinquishing one's duties in social life, one must conduct the pilgrimage to Mecca. Similarly, holy prescriptions are found in other communities, and those living in accordance with them are the possessors of a sound mind. As the state of the mind affects the body, those who fail to live according to the prescribed maxims find themselves in an unhealthy state that in turn causes somatic suffering.

When a person behaves differently (or abruptly) or unbecoming to his self, or when his behaviour is bizarre (like talking to oneself or to an absent entity), the people interpret these as symptoms of mental illness. Indians also believe that mental problems may be ephemeral and subside on their own. Therefore, the attention

paid to mental illness is far less in comparison to physical illness. It is when the episodes of mental illness become more frequent and grave that the family (or the community) takes a serious note of them. Even then the relatives and friends of the sick may not approach a psychiatrist for help.

Being multicultural, India presents a diversity of causes of mental illness. The view held in tribal and peasant societies is that it is the supernatural visitation that causes a change in the psychology of a person. If the supernatural entity is of a higher order – for instance, a form of the mother goddess – then the medium is not regarded as sick, although his behaviour may be significantly altered and aberrant. In people's nomenclature, such a person will not be regarded as mentally ill. Many observers have noted that in certain religious contexts it is expected that people will enter into trance and those who do so are indeed blessed. In the nightlong devotional song singing sessions in north India, *jagran* or *jagrata* as they are termed, it is common to come across episodes of temporary possession. The devotees bow before the entranced souls. In some cases, questions about the community affairs – such as the adequacy of rains, quality and quantity of crops, safety of the livestock, possible epidemics – are placed before these 'possessed' beings, who are considered gods and goddesses for the period of trance, and if perils are involved in human affairs, these divine beings are appealed for assistance (Fuller, 1992).

We should not, however, conclude here that people in all communities desire to act as the 'vehicles' of the supreme powers. As a matter of fact, they may be afraid of living up to the expectations of this role, for it may require strict discipline and a regime of highly ascetic lifestyle. A laxity on the part of the person may make the supernatural deities wrathful and punishing. But once a supernatural power chooses a person for its 'service', he will have to accept, howsoever reluctantly, his new role and live according to the divine dictates. The point important for us here is that the medium of the spiritual power – a power of the higher order – is not regarded as mentally sick, although his actions will be treated as symptomatic of a behavioural disorder. In trance, the medium rocks his head, hits it against a hard surface, beats his body with iron chains, pierces his tongue and cheeks with thick iron needles, pounds his chest with clenched fists, walks on fire, and repeats several other acts of these types, which normal people dare not attempt. He also speaks a tongue, not easily understandable, in a tone, either too loud or feeble, that normally is not his. A student of clinical psychology will list all these as the typical symptoms of behavioural aberration, necessitating treatment. But looking at these from the perspective of people, they are culturally expected and patterned when a man is acting as a 'medium' of a supernatural power. This man, to repeat, is not 'mentally sick' from the point of view of the people regardless of the range of 'clinical symptoms' that he may possess.

In case the supernatural power is maleficent – for instance, the soul of an unsatiated human being or the spirit of an animal – then its medium is regarded as mentally sick and advised treatment from the medium of a superior spirit or divine object. Interestingly, the medium of the superior power will decide whether the possession is by a superior supernatural force or by an inferior and maligned spirit. A common cultural explanation of mental illness in tribal and peasant societies is that the enemy gives the diseased substance to his victim in food or drink. Till the time the disease substance remains inside the body, the mental as well as physical sickness will persist. This substance can only be removed by magic. Indians think that certain type of food is a more convenient transmitter of magical substances. This includes milk, white-coloured sweetmeats, honey, and several other pleasant-smelling things. At certain times of the day and night these things should not be transported, and if they have to be, they should be made unattractive so the spirits do not adhere to them. A common practice is to put peppercorn (or sometimes, even charcoal) in these foods, because of the belief that black-coloured things will repel evil powers and the food will remain safe. Perfumes and unguents are also spirit attracting. Young, beautiful women are advised not to wear perfumes for the fear of being caught by spirits. This belief is strongly held in hill-dwelling communities of India. Looking objectively, both the mediums, of superior powers and lowly spirits, have the same set of psychological changes in their bodies when in the state of possession. The power that possesses the being makes the distinction between the 'one who is mentally sick' and the 'one who has the power to heal'.

In addition, there is another important difference. Visitation of a superior supernatural power is usually temporary, for a few hours, or it may be on certain days. When the power departs, the individual may return to the state of normalcy,

recalling nothing of what transpired at the time of possession. The medium may at best complain of a feeling of tiredness, of being drained out emotionally and physically, but that period of possession is *dies non*, meaning it does not exist in the memory of the person though it may be vivid in the memory of the observers. In comparison, possession by a bad spirit is usually an unbroken process. It endures, seems to last forever, and unless there is a robust divine intervention, the effect of the evil forces will not subside.

Thus, the first theory is that mental illness is caused by malignant and nefarious supernatural entities. The main symptom of this illness is possession in varied degrees – it may be grotesquely violent or perceptibly docile. The main adherents of this theory are in tribal and peasant societies, as mentioned previously, however one comes across these ideas not only in small towns but in metropolises also. This would explain the popularity of healing centers that deal with spirit possession in several parts of India. One of the extremely well known centers of this type is a temple of the monkey-god (Hanuman), known as the Bala-ji temple, in the district of Sawai Madhopur in Rajasthan, which is visited by people of all shades of life (Kakar, 1982). Recently, after the Erwadi incident, in the state of Tamil Nadu, in which twenty-seven mentally ill patients who were chained to poles and trees died in an accidental fire, we have learnt of a number of religious shrines in India reputed to render cure to mentally sick people (see Wadhwa, 2001).

Another cultural explanation is that constitutionally weak persons are more vulnerable to mental illness. Why women are more likely to be the victims of mental illness than men is because they are weak and oppressed. The chances of being afflicted with mental illness are far more with those whose upbringing has not been proper. That is the reason why children from broken homes are far more susceptible to the symptoms of mental illness than their counterparts in normal (i.e. complete) families. Childlessness may also contribute to mental illness. Kakar (1982) documents the cases of many barren women who complained of spirit possession and sought cure in the Bala-ji temple of Sawai Madhopur. Certain other conditions – such as divorce, alcoholic husband, domestic unhappiness, protracted illness, and stresses at the place of work – can also give rise to mental problems.

Fast rate of urbanization and industrialization is another contributing factor to mental illness. Migratory populations find it strenuous to adapt to the changes and the culture shock they receive may often culminate in mental sickness. Students of tribal societies have noted that asymmetrical cultural contacts between tribal populations and the outside world, which culminated in the exploitation and oppression of tribals, led many tribal men and women lose interest in their existence (see Dube, ed., 1977). They suffered from a psychological condition known as thanatomania, where the desire to live ceases to exist. There is also definite evidence that overcrowding, which is a consequence of urbanization, also causes mental problems. The gap between the rising expectations of people and the slim opportunities they get also accounts for their psychiatric conditions. These aspects are extremely important in the Indian case due to the fast urbanization that the country is experiencing these days.

The other theory the Indians hold is that a sudden shock – a failure in examination, loss in business, betrayal in love, death of a loved one – is enough to make an individual mentally upset that may in course of time lead to mental illness. Indians also believe that sometimes a windfall – for instance, winning a huge sum in lottery – may also cause mental imbalance. Acceptors of this theory – which we may call 'shock theory' – are definitely more in cities and towns but often the observers have reported that tribals and peasants also speak of social and cultural shocks as culminating in mental illness. To understand this, we may refer to Emile Durkheim's famous work on a sociological understanding of suicide (1897). Among the causes of suicide, Durkheim identified the state of 'normlessness', called anomie, as one where the existing norms suddenly break down and new norms are far from being developed. This state of suddenness causes suicide, which Durkheim called 'anomic suicide'.

That bio-chemical reactions and alterations in the brain cause mental illness is confined to the literate and reflective people in Indian metropolises and cities, those who have knowledge of modern medicine and keep abreast with popular articles on health and disease in magazines and periodicals. Modern India has witnessed the rise of popular publications on the issues of health. Newspapers that hitherto did not devote much to a popular understanding of diseases and the ways to keep them at bay have now started including in their publications

'health capsules'. Articles on mental illness do not appear very frequently but those few carried in the health publications promote the biomedical theory of mental illness along with the role of family and other primary groups in its management.

At one end of the continuum lies the 'supernatural theory' of mental illness, at the other is the bio-chemical theory. This continuum overlaps that of the societies; at one end are the tribal and peasant societies, at the other the complex, industrial and post-industrial societies. It also indicates that as societies change from simple to complex, the theory of causation of mental illness also changes from the supernatural to the bio-chemical. Some grain of truth certainly lies in this proposition, for it is highly unlikely that tribal and peasant societies would subscribe to the bio-chemical theory of mental illness. In these societies it is not only mental illness but also physical illness, which is understood as being caused by supernatural factors. Moreover, it has also been observed that many tribal and peasant societies do not maintain a distinction between physical and mental illness (Becker and Kleinman, 1999). An important observation here is that urban Indians – including those belonging to highly educated, upper classes – often attribute mental illness (and also, some other problems) to supernatural causes. This would explain the roaring business of supernatural healers – popularly known as *tantrik*, *sufi*, *gunia*, *ojha*, *siyana*, *bhopa*, *jankar* – in urban India.

These theories of disease causation have implications for the treatment of mental illness. Those believing in supernatural causation will approach the spiritual healers. If mental illness is viewed as a consequence of a shock, the belief is that in course of time the person will recover from it, therefore counseling will constitute the main treatment. When bio-chemical deviations in the brain are seen as causing mental illness, the people are likely to approach psychiatrists for treatment and counseling. It is also likely that they may combine both supernatural and bio-chemical treatments, assuming the absence of any contradiction between them.

3

Although mental illness is not attended with the same degree of promptness as physical illness, mental health is not less important than physical health in India. Many cultural practices are directed towards attaining a sound mental state. A widely prevalent belief in India is that anger and jealousy are the root causes of mental disorder, therefore they should be consciously abated. One of the emphases in the upbringing of a child is on maintaining mental equilibrium and poise. One should neither harbour evil for others nor be consumed by passions. One is advised to keep one's sentiments and emotions under control. Truly, there are contexts in which emotions run berserk, causing a man to lose his mental balance for a long duration. Death is one such occasion, potential enough to yield tremendous mental turmoil (Parry, 1994). If the grief surfacing with the demise of a loved one is not brought under control with the concerted efforts of the grief-stricken relatives, it may have serious consequences for mental health. Indians believe that ritualized mourning – crying, beating the chest, singing the funeral odes – give vent to pent-up emotions, thereby restoring mental poise. When a mourner becomes shell-shocked, emotionless and flint-faced, and does not participate in ritual wailing, his kin and friends become extremely concerned. They make relentless attempts to make him cry. An internalization of grief has severe effects on the mind of the person; it causes mental illness.

If the mind remains 'cool' – a state opposite of anger – the chances of mental illness are highly reduced. The use of sandal paste on the forehead is an upper caste cultural practice to keep the mind 'cool'. Individuals are also advised to practice meditation and read religious scriptures (for instance, the Bhagwad Gita) for combating and defeating disturbing thoughts and mental uneasiness. One should regard one's predicaments as an expression of the will of god, and be happy in whichever state one finds oneself. When one leans against this ideological bulwark, one is bound to be in a proper mental state. The underlying belief is that the womb of creative thoughts is a sound mind. Many folk sayings also put emphasis on the 'coolness' of mind (and incidentally, the 'warmth of feet').

For understanding these ideas of the people, we need to bring in the concept of culture. For anthropologists (and also, sociologists) culture is the totality of living patterns of a community of human beings. Their thoughts, actions and interactions, the procedures they adopt for fulfilling their needs and wants, the meaning they subscribe to their life and its aims, the shapes of their material objects and their orientation towards them, their attitudes towards their natural environment and other communities of human beings, are all conditioned by culture, which is

pre-eminently transmittable and acquirable. At the same time, with each generation, it undergoes qualitative and quantitative changes, serving like a sponge for several elements diffusing from the other groups of people. But culture is equally resilient; thus it resists the onslaught of many innovations that it anticipates as threatening, endeavouring its level best to maintain its identity. Since culture covers the ideas of the people, their thoughts, interpersonal relations and their creations, no discipline – particularly of social science but also perhaps of physical and biological sciences – can be oblivious to the concept of culture, although the extent to which a subject uses it will definitely vary. Economic botany uses as much the idea of culture as is the branch of pharmacology that records and investigates the people's herbal preparation (Elkin, 1990). For following people's knowledge of the natural phenomenon, as juxtaposed to the scientific, we need the concept of culture. Here, we may say that as the concept of zero integrates the mathematical, physical, and engineering sciences, in the same way culture integrates social, psychological, and philosophical sciences.

A generalization is that culture defines the concepts of positive mental well being. It rewards people who subscribe to positive values and shuns those who deviate from them. It also comprises customs and practices that help in releasing bottled up tensions and stresses, thereby aiding the maintenance of mental equanimity. In this light, we may interpret rituals like mourning or the Hindu festival of colours. To take the latter example: Holi, as this festival is called, is an occasion characterized by permissiveness and licentiousness, and in certain communities, reversal of gender roles. Women temporarily acquire power on this occasion. An aspect of the celebration of this festival in some parts of northern India involves women subjecting their men to beating which they do not object to, rather take it heartily (Marriott, 1968). The horseplay and saturnalia of Holi help in the release of stresses of an oppressive patriarchal society. Old animosity is laid to rest on the day of Holi. Enemies come together, apply colours on one another, publicly announce that the evil they had been nursing in their hearts for months, and sometimes years, is now extinguished in the fire of Holi. This lightens the weight of negative emotions, thereby contributing to a positive mental state.

Seeking ritualized forgiveness is a part of the religion of Jains (Laidlaw, 1995). On Prayushan, the day of universal forgiveness, the Jains tender apologies to their kinspersons and friends (including the non-Jains) for any of voluntary or involuntary acts that might have harmed others or caused pain. In the past, forgiveness was sought verbally but now, in addition, the Jains buy cards (like birthday and anniversary cards) especially made for this occasion, or get them printed, and mail them to the others. One such card (in English) reads the following:

> Forgiveness is divine
> The Jaina Day of Universal Forgiveness
> Shri _____ ,
> Forgiveness is one of the spiritual ways in the faultless temple of love divine. I may have been guilty towards you by speech, body or thought during the past year. So, I present my hearty compliments and sincerely implore you to forget and forgive all sins of such omissions and commissions.
>
> Yours sincerely,

In the first blank space, the apology seeker fills in the name of the person approached for forgiveness, and in the second, he puts his name and address. The day of forgiveness for Jains is an occasion of releasing their emotions. Our submission is that culture not only tells us what constitutes a positive state of mental health but also creates situations so that it is pleasantly obtained.

One of the theories in medical anthropology is that the primary symptoms of mental illness are same throughout the world, but each culture flavours them (Becker and Kleinman, 1999). In rural India, symptoms such as a heavy head, headache and bodily pain, and visions are all interpreted as being caused by the entry of evil powers in the body (Gold, 1988). As this entry is supposed to make the body heavy, patients of mental illness often complain of a swollen body and heaviness on the chest. Loss of appetite and sleeplessness are also interpreted in supernatural terms. These patients also report of seeing bizarre human forms – excessively long or painfully short – at all times.

A common observation in India is that even a grave behavioural deviation is dismissed as a mere idiosyncrasy. Behavioural disorders – like muttering to oneself or speaking to an invisible entity, acute violence, and a state of depression – are initially not taken seriously. It is believed that suitable rest, or complying with the demands of the afflicted, or some mild punishment will cure the sick of the symptoms, but when these techniques fail to generate desired results do

people think of seeking professional advice. That is the reason why when the mentally sick patients are brought for professional treatment their ailment is already quite old. It has also been seen that in several cases unless the sick becomes dangerously violent, he is not taken to a medical professional for treatment. The stigma unfortunately attached to mental illness is another reason holding people back from seeking a proper medical treatment. A mentally sick person in the family often jeopardizes its future prospects (for example, marriage of a daughter). This is further intensified by the locally held belief that mental illness is passed on. All these ideas shape the ways in which families behave towards someone with mental illness. Even when a person has been cured of mental illness, the stigma attached to him and his family continues unabated. Neighbours keep addressing the former mental patient (and now cured) with the same pejorative appellations that are used in their society for mentally disturbed individuals. Even when fully cured, the patient does not really come out of the social stigma, which in fact may account for his relapse.

The traditional ideology being ingrained in Indian mind, the local people do not expect much from the formal health care system. They think that rituals, penances, austere measures, and apology neutralize the supernatural anger; whilst the sick and his family can themselves bring their social conditions under control. It is not uncommon to see in India the close relatives of the mentally sick circumambulating a sacred hillock (such as of Gobardhan in Mathura, Uttar Pradesh) 108 or 1008 times, for these numbers are regarded as sacred. From these acts of austerity, and many others of the same type, the sick is believed to obtain relief. Against the background of these beliefs, the people are indifferent to, if not skeptical of, the formal medical health care system.

A point to be brought in here is that traditional systems are hope generating. For instance, almost everyone in the Bala-ji temple will tell you that the spirit-afflicted people (i.e. mentally disturbed) will be completely cured if they continue to remain in the sacred perimeter of the temple and wait for their recovery. There is no exorcist (or his local counterpart) in the temple and the belief is that the divine power of the monkey-god cures all the sick people, but when god will do it, is known to none, and one has to wait for divine mercy. Therefore, unsurprisingly, the sick and his relatives live in this temple town, within its sacred vicinity, for months. They convincingly believe that the sick will be fully cured in due course of time. One of the reasons for the continuation of the traditional ethnopsychiatric cures in modern society is that they generate hope, and keep promising full recovery. If the sick person does not recover, it is because of his and/or his family's faults, their laxity in performing rituals or performing them incorrectly. An inadvertent infringement of a taboo might annoy gods. The ideology is that if one follows religious prescriptions unswervingly, there is no reason why one should not recover from mental illness.

By comparison, the formal system may nurture skepticism about the total recovery of the sick. At this juncture, we may also keep in purview the distinction between rural and urban, or traditional and modern, divide of Indian society. Urban, modern, educated people with cosmopolitan outlook will still prefer to approach the formal system, although social stigma attached to mental illness may hold them back for sometime, than the rural and traditional people who have an unshakeable faith in their traditional system.

4

Let us have a look at the role of traditional healers in curing mental illness. The term 'traditional healer' is heterogeneous, for it includes several types of curers with differential levels of specialization. The property these healers hold in common is that they are part-time specialists who have acquired their respective skills and arts by seeking apprenticeship under senior healers. Traditional curers include the herbalist, bonesetter, mid-wife, masseur, ethno-surgeon, and shaman and faith healer. Specific societies may also have their own specialists. For example, in rural north India, the belief is that 'navel dislocation' can cause loose motions and stomach cramps. To correct it, there are specialists, generally women, who measure with the help of a cord the length from the navel to both the nipples. If the length to one nipple varies from the other, the 'navel-setter' concludes that the navel has been dislocated and requires correction, which is done by massaging the stomach and tying threads around the big toes.

In a similar vein, one finds in northeast India, specialists who are skilled in removing fish bones in case they are stuck in the throat. The barber in many parts of India performs minor surgical operations (such as cutting protuberances, warts,

boils, and corns) with the help of a razor. We also come across the specialists of cauterization (or 'firing') treatment in which an iron rod is heated, and then either its tip or bar is momentarily touched to the affected area. Regarded as one of the best cures for extra-cellular growth, it is mostly reserved for animals but is also recommended for human illnesses.

People approach the traditional healers because they have faith in the traditional theory of disease causation and cure. Also, these healers are incredibly inexpensive and readily available. Even in metropolitan India, one comes across traditional healers who are popular with fringe populations and slum dwellers. In Delhi, for instance, one finds several of the mobile Ayurvedic practitioners, who call themselves *nadivaid*, i.e. the specialist who diagnoses the illness by examining the pulse. They pitch their tents on footpaths and street corners, and claim to treat all illnesses, particularly sexual ailments. Charging as little as Rs. 10 for consultation, they are popular with those who cannot afford expensive allopathic treatments. We have also found that many men approach them for the cure of erectile dysfunction syndromes, a condition for which they would prefer to seek advice from relatively anonymous specialists rather than consulting their family physician. Some traditional healers have shot into prominence – articles on them appear in newspapers and popular magazines – because of miraculous healing they are reputed to provide in life-threatening diseases such as cancer.

Although some of the aforementioned specialists may be consulted for mental illness in a traditional society, its treatment is usually the prerogative of the shaman. As roles are highly combinative in a tribal and peasant society, the shaman may be a herbalist of repute, a well known navel-setter, or a pulse examiner, and it is also likely that he may not possess any of these skills. The point to be stressed is that for mental illness people will principally look for the shaman and not for, say, an herbalist, unless the latter is popular for imparting a successful herbal treatment to the mentally sick. The term shaman, Inner Asian by origin, implies a person who enters into the state of trance, his psychology undergoes a change, and then, in that fervour of possession, he diagnoses the cause of the illness, whether it is supernatural or just natural. If its genesis lies in the supernatural affliction, he divines the remedies, the rituals to be performed, the taboos to be observed, and the life style to be led. I have observed in my fieldwork in Rajasthan that shamans have sometimes advised their clients to go to the allopathic doctor for treatment (Srivastava, 1997). In one case that I observed in Pali-Marwar, a man suffering from bald patches on his scalp (a condition called alopecia) and always wearing a cap in public to hide it sought the advice of a shaman. Unequivocally, the shaman told him that since no divine power had caused his condition, his treatment should come from the doctor and not from the medium of a spiritual power. However, he might scatter bird feed to obtain general well being. In another case, a shaman advised a man suffering from earache to pour a few drops of lukewarm mustard oil in his ears once a day for a week, which in fact is a common domestic remedy for earaches in Rajasthan.

As noted earlier, when the shaman's condition of possession ends, he does not recall anything. As the supernatural power visits a person – and he becomes its 'vehicle' – his physical self becomes 'inert', almost dead, and all that happens which the visiting power desires. Because the shaman's body lies 'dead', nothing registers in his mind, and thus he does not recall anything. That is the reason why when the shaman speaks, people listen to him carefully. Later, the relatives of the sick pool their notes to eliminate any misunderstandings. In recent years, I have noted that those accompanying the sick write down the commands of the shaman.

Shamans treat the mentally sick using strong symbolic rituals. As the theory of disease causation is that the entry of malicious entity causes mental disorders, the cure obviously lies in driving this power out. The person – the sick – is in no way responsible for his condition; he is an innocent victim of evil powers. He may have violated a taboo or defiled a sacred place, thus becoming a victim of supernatural wrath. Maybe evil forces want to acquire his body for carnal pleasure if he is handsome. The bad entity enters the body either on its own volition, or because the victim has infuriated it, mostly unknowingly. The shamanic mode of cure in India for severe mental patients, as is in many other cultures, is repeated ritual performances so that the malefic spirits are exorcised. There is no scope of counseling here. This explains why shamanic rituals are public in India, in contrast to psychiatric sessions that are usually private. One of the reasons for the popularity of shamanic performances in urban India (and also much of south Asia) is that the shamans are always

hopeful of curing their patients fully. We earlier said that traditional systems of treatment are hope producing. In certain parts of India, the mentally ill are left bound in chains at shrines or the shaman's house, and are only brought home when they start showing clear signs of recovery. One can see persons with mental illness shackled and these shackles are fastened to the doors of sacred places reputed for curing the cases of possession. This pattern exists both in Hindu and Muslim shrines famous for healing.

The distinction modern psychiatry makes between different degrees of disorder is not recognized in the traditional system. In it, either a person is 'normal' or 'abnormal' – the latter is judged from a manifestation of symptoms perilous enough to require treatment. This, however, does not mean that people do not recognize mild deviations. These mild deviations (such as a child refusing to drink milk or one always remaining wrapped up in his thoughts) are initially handled by counseling, sometimes coupled with light reprimand, usually rendered by elders. But when it is discovered that the deviation is acquiring a menacing proportion and counseling is ineffectual, then people approach specialists, initially for diagnosing the cause, to find out if it is a supernatural affliction, and then, in case they are convinced that it is, they may follow the treatment. In many cases, mild deviations and disorders may simply be ignored in the belief that with passage of time they will be corrected. For instance, hardly anyone in rural India, and even in towns, approaches the doctor for treating an enuretic child, because children are believed to transcend this habit as they grow up. Similarly, one is advised to be cautious of kleptomaniac children and adults, rather than taking them for treatment, shamanic or psychiatric.

5

Being multicultural, India has scores of religious beliefs, denominations, sects and cults. The religion followed by almost 83 per cent of Indians is Hinduism, which is further divided and sub-divided into innumerable orders, faiths, creeds, and belief systems. Bearing proximity to Hinduism are those religions, which emerged as a reaction to the caste system in Hinduism, but later established several reciprocal relations with Hindu communities. These religions are Buddhism, Jainism, and Sikhism. Of these, Buddhism survives mainly with the recent converts to its faith who are called Nav Buddhists (or Neo-Buddhists). Islam, which has a following of almost 13 per cent Indians, is another prominent religion. Along with Christianity, which survives mainly with converts from diverse social backgrounds, the outsiders introduced Islam to Indian soil. Represented by a minor population are the Zoroastrians, who are mainly settled in Bombay and are popularly known as the Parsis, and the Jews whose colonies are in Cochin (in Kerala) and Hyderabad (in Andhra Pradesh). In addition to these seven major religious groups, there are innumerable religious practices followed by tribal communities, which are classed in the Census of India under the rubric of Tribal Religions.

One of the main functions of religion is social control. Religion guards many taboos. As mentioned previously, one of the theories of disease causation held in India is that mental illness grips a person when he violates a taboo. Religion provides sanctity to these taboos. Every religion in India offers a set of the styles of living. It forcefully argues that those who live according to its prescriptions will have sound mental health. As mental illness is thought predominantly to be a divine curse, the afflicted and his family members often approach the religious healers. Certain Hindu deities – Hanuman, Bhairon – are believed to protect people against evil powers and their priests are often concerned with the treatment of mental illness. On behalf of the sick, these priests placate the deities to cure. Invariably the shrines of Islamic saints – the Sufis – have healers, usually claiming to be descendents of the saint, who offer solutions to a variety of problems including mental sickness. They suggest appropriate ritual performances and advise the sick to wear talismans that they especially prepare. There are strict rules pertaining to how one should conduct oneself with the charmed objects that not only stand as a sentinel but also exercise a curative impact on the sick (see Troll, ed., 1989).

In the name of oral medication, some magico-religious specialists give a handful of sacred ash from their fire altar, which the patient uses to smear on his forehead and also, swallow it with charmed water (Srivastava, 1997). Certain Sufi shrines have rooms wherein the persons with mental sickness seek refuge till they are cured. Interestingly, the visitors to religious healers can hail from any religious community. Many religious communities in India do not have their own indigenous specialists who care for persons with mental illness, and thus have to depend upon specialists from other communities. Our

observation is that religious healers who deal with mental illness are overwhelmingly Hindu or Muslim, and they offer their expertise to all irrespective of their social affiliations. Many of these religious healers insert regular advertisements in local newspapers claiming their extraordinary skill in curing people of physical and mental illness.

Apparently, there seems to be hardly any relationship between the religious healing system and the formal health care system in India. Both these systems have their own notion of mental illness. Their styles of treatment greatly differ. The formal system often publicly admonishes religious healing and its practitioners, and argues that those who patronize this system are illiterate, non-rational, and gullible. Some religious healers also reject the formal health care system, but many of them submit that people approach them when other systems of cure have proved to be inefficacious. In their advertisements, the religious healers often plead that one should not be disappointed after having tried other systems of cure because the religious system is superior to all and miracles do occur. There are religious healers who do not reject the formal health care system. Their submission is that they modestly try to supplement the other systems of cure that the sick and his family members usually approach. For mental illness, people generally seek the supernatural treatment first before resorting to, if they have to, modern formal system. It is because people believe that the cure of mental illness can be successfully located in supernatural treatment. They are, as observed earlier, skeptical of the formal health care system. However, people may often combine different modes of treatment, from astrological advice to allopathic medicine, a condition technically known as medical pluralism, for their interest rests in quick, substantial, and relatively permanent recovery.

A point we have maintained throughout this article is that culture offers its own explanations to the causes of mental illness. The strategy of cure and therapy is delineated in accordance with the cultural theory of the people. In India, the ready-made explanation the religious system espouses is in terms of the will of the divinity – it is god's wish. Hinduism and other religions allied to it champion the concept of the deeds performed in the past births the effect of which is brought forward to subsequent births. Adopted by a number of new religions, this concept known as *karma* has given a powerful explanatory model: thus, a mentally sick person is supposed to bear the burden of misdeeds he must have performed in his past lives. Suffering is inevitable. It is in this way that one can neutralize the effects of bad *karma*. This ideology built upon the will of god and *karma* generates paradoxically two views: first, one may be indifferent to a person suffering from illness (mental illness included) because his suffering is a pronouncement of divine justice, therefore inevitable. As a consequence, this leads to ridiculing mental patients. Families may also break their ties with those having mentally ill. Marital ties may be terminated with these families. General social intercourse may also be significantly reduced. The family of the mentally ill is bound to become a 'social island' in the process.

The other attitude this ideology generates is of compassion. If one casts aspersions at mentally ill patients, one accumulates bad deeds, for which one shall have to undergo divine malediction in the next birth. Therefore, one should sympathize with the ill and their families and pray that they may be cured.

In recent years in India, religion has staged a comeback in the domain of health, however this new religion cannot be reduced to any established type, such as Hinduism or Christianity. A synthesis of traditional ideology and scientific thinking is also taking place, with the result that along with allopathic treatment people may lend credence to prayer as an effective medium of healing. The New Age writers (such as Deepak Chopra) whose main concern is with the issue of perfect health and retardation of the process of ageing draw heavily upon the traditional religious texts. The idea that health and illness are states of mind has placed a lot of emphasis on the mental aspects. That stresses of modern living cause mental illness has guided us to procedures that reduce stress thereby producing mental equilibrium. Meditation of various species has become central to this idea. Religious discourses delivered by several holy men are also extremely popular, and they all focus upon mental health. If one conducts a content analysis of the religious programmes on television and religious writings in newspapers, one would find that they all exhort to keep one's anger under control, to live according to one's means, to lead a righteous life, for they are a prerequisite to a salubrious condition of mental health.

6

In medical anthropology, we use the concept

of the 'therapy management group' (TMG). It is a group of relatives, friends, acquaintances, and subordinates, formed around the sick. It is a quasi-group, because it starts dissolving when the sick person is on the road to recovery. Although the size of the group is directly proportional to the social status of the sick, its core members are mainly from the family and the extended kin group of the sick. As in other illnesses, in mental illness also, the TMG principally comprises the family members, who take all decisions regarding the treatment and rehabilitation of the mental patient. Apart from the family, there are no institutions of the traditional type concerned with the care decisions for people with mental illness.

Our first observation is that community supports are seriously wanting for mental patients in India. Thousands of mentally sick persons, some of them afflicted quite seriously, who are neither on medication nor are institutionalized, lead the life of a destitute. Discarded by their families and uncared-for by any voluntary agency, their existence is woefully dehumanized. Secondly, joint families are capable of providing human as well as material resources for the care of mentally ill, but as these families are gradually breaking down into nuclear households, it becomes an onerous duty for the already extremely preoccupied and busy family members to look after persons with mental illness. In these families, having a mentally sick person at home would mean that at least one of them will have to resign from his job or extremely limit his preoccupations to extend constant care to the sick. We have observed that parents can still provide – or are able to provide – all possible help to their mentally ill children. But when they are dead or too feeble to offer any assistance, the patients are left to fend for themselves. This marks the commencement of the phase of dehumanization.

The situation is dismal with respect to the issue of community supports. Rather than giving help, many communities in India have an ambivalent attitude towards persons with mental illness. It is not uncommon to see in villages and towns street urchins ridiculing insane persons, often pelting them with stones or chasing them. In many parts of India, beggars and mad persons are placed in the same social category. None of the communities has its own institutional bodies to lend support to persons with mental illness.

Notwithstanding some thirty-two matrilineal communities, India as a whole is patrilineal, patrilocal, and patriarchal. The gender roles are clearly demarcated: men are 'breadwinners', and women 'homemakers'. In urban India, the traditional gender roles have been challenged but not reversed. Workingwomen continue to manage the household and take care of children as well as the elderly. When the latter fall sick, requiring constant attention, it is the woman who is expected to proceed on leave from her work rather than her male counterpart. This combination of working as well as holding the charge of domestic domain has produced tremendous role strain in women, thus raising their vulnerability to psychological problems. Keeping this in perspective, the responsibility of care for people with mental illness is chiefly of women. However, the role of male members of the household becomes important when the mental patient is inordinately aggressive and violent. The males mainly police the mental patient, whilst the task of providing him with food, cleaning him, bathing him, and changing his clothes, monitoring his movements, and of counseling, are generally assigned to women.

Let us have a look at the difference between the ideal and the real, between the normative expectations and the existential patterns. The norm in patrilineal India is that the parents live with their sons. In some societies, the rule is that they live with the eldest or the youngest son. The other sons set up their independent homes after marriage. The parents may choose to live with the son whom they prefer for one or the other reason. Sons and their wives and grandsons and their wives are expected to take good care of the ageing parents and grandparents. If they suffer from dementia or severe mental illness, it is the duty of the male descendants and their spouses to be by their side and make available to them all comforts within their means, even if they have to sacrifice their individual interests.

In reality, however, this cultural expectation about caring of parents in dotage is belied. Children often discard their ageing parents suffering from severe mental illness and dementia. Some reports have also pointed out that being tired of their sick parents, who are seen more as a liability, a drain on resources and energy, the sons have also abandoned them in mental hospitals (Srivastava, 1999). In many cases, especially among urban middle classes, the sons and daughters have moved to better places, often in foreign lands, in search of opportunities, leaving their parents behind, in

old cities, old houses. These children supplement their parents' income handsomely, but are not around to give any physical support to them. Such parents suffer from tremendous loneliness, besides falling victim to criminals who attack them for their wealth.

We have also seen that daughters take care of their sick parents far more than the sons do. The trend in urban middle class families is that they are tilted more to a type where ageing parents tend to live with their daughters. Thus the responsibility of daughters in advancing care to their parents has increased manifold. Today, instead of devoting themselves to the care of their parents-in-law, they look after their parents. This norm is gradually evolving in opposition to the traditional norm where in a patrilineal family, the son takes care of his parents because he lives with them after his marriage while his sister after her marriage moves away to the house of her husband (i.e. her uxorilocal residence). By comparison, in villages, it is the duty of the kin group to care for ageing persons suffering from mental illness and forgetfulness. Here, sons are expected to keep their parents with them rather than admitting them to the secondary, formal, and anonymous environment of psychiatric institutions.

The cases of violence against women, especially those of lower castes, are rising everyday in India albeit the legal protection set aside for them. A significant number of such cases go unreported because female victims (and their family members) do not approach the concerned authorities with their grievances. It is because they do not want to earn the wrath of dominant sections of their society, who wield the instruments of violence. Domestic violence, which in fact culminates in mental illness, in middle class families is also virtually unreported, but there is scant doubt about its increase in recent times. This is happening because of the stronghold the patrilineal ideology still exercises in India, irrespective of the changes education and modern ideology have brought about. In earlier times, women were victims of violence when they did not bear children, especially male descendants. They were taught from the beginning that they should comply with the duties (*dharma*) the traditional order had ordained upon them. It included such heinous practices as following the husband to death, a custom known as *sati*, the instances of which sometimes make their appearance in modern India too. In other words, gender inequality legitimized violence against women whether it was in the practice of chaste widowhood, or female infanticide, or ritual suicide after the husband's demise.

In modern times, patrilineal ideology has not truly declined. The paradox is that at the ideological level the system favours gender equality but at the actual (or existential) level, inequality prevails, with the result that women suffer because they have started claiming equality with men. The irony is that while women seem to do better than men in almost every sphere of life, even then families do crave to have sons. Therefore, the causes of violence against females can be traced to their cultural practices. In such a system, female children often acquire the feeling of being 'unwanted' – they feel they are tolerated, not loved. Broadly, there are two consequences of this feeling and status: they work tremendously hard to prove they can do exceptionally well, better than men, or they may sink into an unhealthy psychic state.

Similarly, the causes of the abuse of various substances lie in culture. Traditional Hindu religion has extolled the virtues of liquor, popularly known as *somarasa*, thereby unintentionally furthering its use. The use of drugs (such as opium) is thought to make one visionary and give one the power to know the unknowable. Many caste men of rural Rajasthan are addicted to opium, for they think that opium consumption increases their sexual prowess besides relieving them of body pain and tiredness. Even children are sometimes given grains of opium so that they may sleep soundly and cause fewer disturbances to their working parents. Many religious cults have liberally promoted the use of narcotics and barbiturates for ritualistic purposes. Moreover, substance abuse is also associated with gender and caste; for instance, males in general – and males of martial castes – are expected to drink liquor, smoke cigarettes, and consume tobacco.

7

According to a recent estimate, around 25 million people need psychiatric care in India, of them around 7 million suffer from severe psychiatric disability. A recently released World Health Organization report points out that one out of four persons in the world requires help for coping up with one or the other form of mental illness, and only thirty per cent of them are able to receive full or partial treatment (see *The Hindustan Times*, 10 October 2001). The

government runs most of the psychiatric hospitals; only a handful of them are private, which provide good care and service. This situation is in contrast to, say, cardiac hospitals, most of which are privately run. Psychiatrists are mostly approached in metropolises and cities, as in villages, their counterparts – the shamans – for whom we may use the term 'ethnopsychiatrist', treat mental illnesses, the etiology of which lies in supernatural factors. Although traditional systems are hope generating, and often shamans flaunt their success, the people know that mental illness requires a long time for cure and there is a possibility of relapse. Because of this, they prepare themselves to live with the eventuality.

According to the Mental Health Act, 1987, the government is supposed to care for the mentally sick. But because of the stigma attached to mental illness, people prefer not to visit government institutions for the treatment of their mentally sick kin. Only when they anticipate possible physical threat from the person with mental illness, do they approach the psychiatric hospitals or the magico-religious centers. When the mental patients are chained or beaten in the religious centers, the people believe that it is the nefarious spirit dwelling in the body of the sick that undergoes the torture and nothing happens to the sick body.

Unfortunately, in comparison to other illnesses – epidemics included – mental illness does not enjoy the same degree of urgency. As it is not like viral fever, which lasts a week, or cardiac problem, which may be corrected by surgery, both time-bound, mental illness generally is neither life threatening nor is cured within a stipulated period of time. That is why it does not occupy the priority status. Here, we do not consider the consequence mental illness has for the patient, and more importantly, for his family members. The families suffer silently – in the absence of community support structures, they are the sole institutions that care for the mentally ill, and, at the same time, suffer from the social stigma that is ineluctably tied to it. We need to undertake some research work on mental illness from the perspective of family – the ways in which families cope up, or come to terms, with mental illness and the juncture at which the process of dehumanization of the sick begins.

In a symposium the Institute of Human Behaviour and Allied sciences (Delhi) organized on 4 October 2001 to celebrate the World Mental Health Week, as declared by the World Health Organization, the chairperson asked the audience to resolve that they would never keep the mentally ill in chains or lend support to this practice. He thought it was extremely important to pass this resolution after the tragic fire accident at Erwadi where the mentally ill perished because they were bound in chains and just could not escape. Chaining heralds the beginning of dehumanization of the sick, in fact, the beginning of his 'animalization'. That is why the mentally ill are subjected to a beastly treatment. The chairperson's resolution was unanimously accepted.

However, a member of the panel of the symposium suggested that in addition the mental health workers and others concerned with health measures should first of all find out from people why mentally ill are kept chained. Reflecting upon his fieldwork experiences, he noted that chaining of mentally ill is not only because of the fear of violence or truancy of the sick. Even mild patients, highly docile and emaciated, are also kept in chains. It is primarily because chaining – one of the foremost steps in dehumanization of the sick – is thought to punish the evil spirit that inhabits the body of the sick.

Besides adopting legislative measures and passing resolutions, there is an urgent need to initiate a dialogue with human communities on the etiology, prevention, cure and therapy of mental illness. The people should be told in simple (i.e. non-technical) terms about the factors that cause and aggravate mental illness, and the ways of controlling them. Evidence contesting their native theories – of supernatural genesis of mental illness – should be placed before them convincingly and firmly. Once people are convinced that chains would do more harm to mentally ill, they would improvise other 'human' ways of dealing with the sick. Legislative actions must be supplemented with the social: a change from above should be supplemented with a change from below. I believe that once you have closely read a book on clinical psychology or psychiatry, you understand so much about human behaviour, your own behaviour particularly, that you are able to control many of your somatic and psychic imbalances and syndromes by autosuggestions, counseling and autotherapy.

Apply the same analogy – once people know in scientific terms what causes a behavioural disorder, their attitudes towards mental illness and mentally ill patients would be qualitatively different. It is well known that endogenous changes are profit yielding in the long run.

KEY WORDS Mental Illness. Shaman. Ethno-psychiatry. Patrilineal Society.

ABSTRACT This paper provides a macro-view of the state of mental health in India, and suggests that ideological changes should be brought out in the ways in which people view mental illness.

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