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POSSESSION, PURGATIVES OR PROZAC? THE EXPERIENCE OF ILLNESS AND THE PROCESS OF HEALING IN KERALA, SOUTH INDIA

By

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Note on Attributions and Notations

Names of patient-informants and other identifying information about patient-informants has been changed. Real names of healers are not used when discussing patient informants, but real names of healers are used when they are describing their methods of healing. And real names of research assistants and friends who gave me insights on Kerala culture are used though in a few cases, where I felt information might be compromising, sources are anonymous. Sometimes information that was clearly private or damaging was simply not used, even anonymously.

Patient-informant quotations are all translated from Malayalam, and quotations from healers were in English in the original. Any exceptions are so indicated. In quotations that are translated from Malayalam, words that originally occurred in English are indicted by quotation marks (e.g., I had lots of "tension" at that time). Reported speech that was originally in Malayalam is also put in quotations marks, but is identifiable by context (e.g., She said "I don't have any problem."). Unfinished thoughts and aborted sentances that occur in quotations by informants are indicated by ellipses (...), sections that I edited out of quotations by informants are indicated by ellipses within brackets ([...]).

Chapter 1 - Introduction

The state of Kerala in south India is renowned for its diversity of medical systems and reputed for its specialists in ayurvedic medicine. This study examines the methods of healing of three systems of treatment for psychopathology, spirit possession and related problems in Kerala: ayurvedic psychiatry, allopathic (biomedical) psychiatry and religious therapies (including Hindu, Muslim and Christian healing centers). This study also focuses on the experience of people who suffer these problems, and examines the philosophies, discourses and phenomenologies that shape illness and healing in Kerala. By focussing on the aesthetic and phenomenological experience of healing, I show how the methods of treatment and the ways of talking about illness in Kerala reveal a concern for the quality of the process of undergoing a therapy--that it should be pleasant or at least non-traumatic. I also describe the "local phenomenology" of Kerala, the concept of the person in terms of which one experiences an illness, as well as ways in which the expressions of illness are changing and becoming more homogenous.

A statement by an informant who was pursuing ayurvedic psychiatric treatment felt like a premonition when I first heard it, and it stuck in the back of my mind as I wrote the chapters of this study. This statement somewhat prophetically embodies the major themes of this analysis of healing in Kerala, and it deserves to introduce this work. My assistant Biju and I interviewed this informant, who I'll call Ajit, while he was seeing an ayurvedic psychiatrist having previously tried allopathic psychiatry. Late in our interview, he broke into an impassioned comparison between ayurvedic and allopathic

medicine:

> In the case of allopathic doctors, after asking two or three questions, they will know which medicine to prescribe. But ayurvedic doctors, they want to take the patient to another level. At that level, things are very different. Right now I am taking treatment for mental illness. For this illness, there is a painful method. It is giving "shocks." After going there and coming here [referring to allopathy and ayurveda], I feel this is better. But now everyone "prefers modern medicine." It is because of "modern society" that some are reluctant to come to ayurveda.

Then Ajit elaborated on the goals of ayurveda and allopathy and the way we maintain our health in "modern society:"

> There might be some good aspects in allopathy when one looks at its research and other things, but if we want to get good coolness/satisfaction [*kulirmma*], if we want to reach a good goal [*nalla lakshyam*]... Right now, speaking about our life, what is it? If I have a fever, I must get better [literally: must get changed - *maranam*]. For what? To go to work the next day. Get a cold, get changed [*maranam*] in order to go to school the next day. This is the level at which we maintain our health. If we have a supreme aim in life, ayurveda will help us attain it. (Translated from Malayalam, though words in quotation marks occurred in English in the original.)

At two points in these excerpts, issues related to the aesthetics and phenomenological experience of illness arise. Ajit describes his problem as a "mental" (*manasika* in Malayalam) illness. "Mental" is one of many idioms, along with a number of terms that mean something like "consciousness" and "intellect," plus an orientation to the body, which make up a local phenomenology, a way of relating to and experiencing the world, in Kerala. I propose that trying to understand specific, local phenomenologies is a meaningful alternative to the tendency in anthropological studies of the body to find westerners articulating experience in terms of mind-body dualism and everyone else in the world living in the body.

Ajit also refers to giving "shocks"--electroconvulsive therapy--as a "painful

method" of treatment in allopathy, which invokes another issue related to the aesthetics of healing. A number of people with illnesses in Kerala left allopathic psychiatry for other therapies because of what they saw as uncomfortable or painful methods of treatment. Whereas in allopathy one had to undergo an occasionally painful or traumatic "healing" process in an attempt to achieve a cure, ayurveda seemed to attend more to the quality of the process of healing, and was able to provide a less traumatic and at times "pleasant" therapeutic experience. In the above excerpt, Ajit labels the positive aesthetic experience in ayurveda *kulirmma,* meaning something like "coolness" and "satisfaction." Some people using religious therapies, meanwhile, had experiences that were beyond being simply pleasant or therapeutic, that were transformative and brought them to a state that was somehow better or higher than the "healthy" state they experienced before their illness. Ajit's reference to ayurvedic doctors bringing the patient to "another level" points to a similar positive transformation that is alleged to occur through ayurvedic healing. There are also people suffering illness who oriented their healing toward process in the sense that they found a way of coping with their problems through living in the aesthetically- and spiritually-engaging environment of a mosque, temple or church--that is, through living in the process of therapy. This analysis of how a therapy feels reintroduces the topic of embodiment and focuses analysis on the aesthetic realm. The healing process is experienced at the mental and bodily level, but the "higher," transformative healing processes work on the self or spirit.

Note that Ajit uses a term, *maranam*, which means "change" to describe what one generally does to an illness. There is no word in Malayalam, the language of Kerala, that

translates as "cure," an English, biomedical term that, I will later argue, is uncritically applied in various cultural contexts and does not capture the sense of moving to another, higher level or living with a problem in an aesthetically-engaging environment reported to me by informants in Kerala.

Issues related to time, which arise at various points in this study, are also invoked by Ajit. The orientation toward process in ayurvedic therapy and among those who choose to live in a temple to resolve their problems is also an orientation to time, one that is less end result-oriented than the orientation to time in allopathy. The former is an orientation that looks at the present while moving forward, and the latter moves through time focused more exclusively on the future. The issue of time again arises in the sense that the world of illness and healing in Kerala is changing as Kerala society changes. As Ajit observes, it is because of "modern society" (and it is revealing that Ajit uses the English words) that people are using "modern medicine" (i.e., allopathy). One manifestation of this change is, ironically, a reorientation toward time. Social, economic, and other changes have caused people in Kerala to experience more time pressure with the consequence that they have less time to undergo a process-oriented therapy. While Ajit says that ayurvedic doctors want to take people to a higher level, he also explains that nowadays when one is ill one must get over it quickly to get back to work or school. Ayurvedic therapy can take weeks, but, as Ajit says, an allopathic doctor prescribes a pill after asking two or three questions. This echoes the view of a number of other informants who believe that ayurveda can bring long-term relief from an illness but explain that they use allopathy because they need *quick* relief.

Another change that is occurring in the world of health and illness in Kerala is that allopathic psychological idioms of distress[1] are becoming more common while spirit possession is waning. Healers report that the number of cases of spirit possession are declining while more people are complaining of problems like "tension" or "depression" and using these English words to describe them.

On an more abstract level of theorization, this study repeatedly comes up against dualistic analyses in social science literature that obscure complex and unique social issues--for example, characterizing a culture as egocentric or sociocentric, as living through the body versus having a mind-body separation, or as modern or local/traditional. Two alternatives to this tendency are pursued in this dissertation. The first is simply to describe a specific, local construction of some practice, ideology or existential state. For example, a local phenomenology is suggested. Another alternative is to look at how one feature of a dualistic categorization exists along with its apparent opposite (that is, opposite in the mind of the academic analyst). By this I mean that certain ideas and practices will be characterized as contradictory--but emphatically and unproblematically contradictory. For example, I will be discussing a sociocentric society in which egocentrism is present and a place where universalist discourses happily coexist with an emphasis on context-dependency.

Jonathan Parry (1989) takes a similar position in a study of bodybuilders and

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[1] I will often use Nichter's (1981) phrase "idioms of distress" to refer to the various forms in which illness or suffering can be expressed. This term has the virtue of not specifying problems as illness or disease but instead pointing to the more basic *distress* that underlies psychopathology, physical disease, family problems and other, more indeterminate suffering.

death rites in Benares, India that involves a critique of the University of Chicago ethnosociologists' conception of India as a "monistic" society. Parry cites a passage by Chicago ethnosociologist Marriott that alleges a lack of dualism in Indian thinking:

> the assumption of the easy, proper separability of action from actor, of code from substance (similar to the assumption of the separability of law from nature, norm from behavior, mind from body, spirit or energy from matter), that pervades both Western philosophy and Western common sense. . .is generally absent [in South Asia] (Marriott 1976: 110, cited in Parry 1989: 493)

People's actions, their transactions, attributes of the land, and essences in food involve "an exchange of bio-moral qualities and consequently transforms the substance-code of the parties to it" (Parry 1989: 493). People, things and concepts are not separably analyzable, and a person's nature/substance is altered by contexts. These are characteristics of the supposedly "monistic" Indian society. Parry wonders how this is reconcilable with the idea promoted by Marriott and many South Asians that people of the same caste consider themselves to be of the same immutable nature/substance (which appears to contradict the notion that bio-moral substance is changed by exchange and context), and says, significantly, "I am prepared to entertain the possibility of a contradiction here" (494). Parry's ethnographic material on Benares also reveals a monistic world where things cannot be divided between, for example, mind and body, or actor and action: for example, his informants explain that bio-moral substance can be affected by food, and thoughts can affect the condition of the body. But he says he could emphasize other material that show "a markedly dualistic universe": for example, he quotes people in Benares who stress the importance of working on the mind and not the body for salvation and assert that each person has a unique and individual soul (511). I

too constantly ran into reminders of this monism during fieldwork, but then I would turn around and find an emphatic contradiction. Parry resolves this problem by claiming that monism works as an ideology--presenting frightening ideas about contamination, the mutability of the person and the potential for chaos--to keep people to adhere to the rules of the caste system. These can be used to uphold the caste system, but one would still have to ask why ideology takes this form and whether all aspects of monism potentially relate to caste (dualism and separability, the supposed opposite of monism, might also make an effective caste ideology). I suggest, however, that such contradictions need not be resolved, that they are not necessarily problematic. We should instead wonder what is wrong with the tools of analysis we are using, and ask why we perceive certain tendencies as contradictory.

The ability to be comfortable or unbothered by what some might see as contradictions was demonstrated by people I met in Kerala. It is perhaps this non-perception of a problem that allows people suffering illness in India to switch easily from one therapy to another. Many people I interviewed informed me that they felt that all the different therapies they had tried, including the ones they rejected, had a correct understanding of their problems. This is reminiscent of a position that Kakar (1982) takes, and which he attributes to his Indianness, in introducing his study of psychological issues in India wherein he emphasizes that cultural relativism and universals comfortably coexist. I do not bring up these examples of comfort in the face of contradiction as Levi-Bruhl did in his effort to reveal a prelogical, "primitive mentality." Instead I wish to analyze the limits of anthropological analysis that are exposed by its unsettled relation

with contradiction, and explore the virtues of context-specific thinking that comprehends how apparent opposites can coexist.

Of course, anthropology has already decided that culture is heterogenous, but this heterogeneity is usually conceived of as different views of culture from different social positions--for example, from the point of view of differences in ethnicity, gender or class. I'm suggesting that additionally there may exist within some aspect of culture, say within the hegemonic, the "mainstream," (apparent) opposites, contradictions which are not constructed as some coercive ideology, not some contradiction in the Marxist sense that covers up another, more consistent reality. Put another way, "contradiction" may be a misleading label which points to the confusion in the mind of the analyst in an area that may not be a problem with "reality."

It often occurs in this study that one side of a dualism and the opposite side coexist emphatically. This view helps give a certain order to contradiction--that is, it's not necessarily, or only, a chaotic accumulation of dissimilar traits. Ramanujan (1989) speaks of "context dependent" cultures that have "context-free" *counter movements*. Likewise, in Kerala and India where the socially-embedded self is striking and pervasive, the dominant religion is very individualistic. Hinduism does not involve congregational worship, but rather one makes the rounds at a temple as one likes, at one's own pace. Or, in an environment that is in many ways context-dependant and oriented toward specificity, yogis and followers of Vedanta philosophy, among others, seek to realize a rarified, individual, true self distinct from all traits and contexts. I do not claim that this counter movement perspective gives a thorough explanation of complexity and

contradiction in India or any culture, but it is one alternative to explaining away apparent contradiction.

Western-versus-Indian is another misleading dualism that is encountered in this study. It is often important to identify ideologies or disciplines that were brought to India by Europeans, but western-Indian, as well as modern-traditional, dichotomies edit out the diversity and complexity within Indian culture. For example, influences that relate to a decline in cases of spirit possession in Kerala can be seen as western or modernizing. But it is also rationalist--one could even call them "modernizing"--discourses in ayurveda and Islam that play a role in eroding spirit possession. In this case, an indigenous discipline, ayurveda, promotes views that are also called "modern." And how does one conceive of Islam in terms of western-Indian, modern-traditional dichotomies? Meanwhile, as will be seen in later chapters, literacy and Communism, which may also relate to this change in the forms of illness, can be considered "home grown" movements as much as they are modern or western products.

Finally, circular-versus-linear time is another familiar dualism (the limitations of which have already be critiqued by, among others, Greenhouse 1996). I propose an additional distinction between process-oriented and goal-oriented time. Both can be seen as linear times, though qualitatively different perspectives on linear time. Put another way, this difference is not geometrical like the linear-circular dualism. Instead, it relates to a certain qualitative appreciation of time, how one watches time. This is not intended as another dualism, and this perspective is not meant to replace the linear v. circular opposition. Rather process-oriented time and goal-oriented time are two, non-mutually

exclusive ways among other possible ways of considering time.

Assumptions and Frameworks

This section presents assumptions and epistemological orientations that underlie this study. These are not offered as major, novel contributions of this research, and some concepts, such as the "sociocentric" self, have already been extensively analyzed by other investigators. However, these orientations are crucial to understanding this analysis of healing in Kerala, and this research further supports and elaborates on some of these issues. As these concepts underlie this study as a whole and will not be discussed in detail in any particular chapter, they require some analysis here.

Throughout this study, when issues and ideas related to informants are discussed, a socially-embedded, relational, view of the self will be assumed. Much has been written about the "sociocentric" self in South Asia. In contrast to the egocentric self, which sees itself as an individual, autonomous entity that is (or considers itself) separate from society, the sociocentric self is only intelligible in context and as part of a social group. This orientation to the self is an aspect of the monistic view of Indian culture suggested by the Chicago ethnosociologists. Examples of this Chicago-style include writings of McKim Marriott,[2] which assert that a self cannot be abstracted from context and Shweder's claim that people he interviewed in Orissa, India generally characterized

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[2] The ethnosociology view is perhaps best represented in two articles by McKim Marriott and is embodied in his articles "Hindu Transactions: Diversity Without Dualism" (1976) and "Constructing an Indian Ethnosociology" (1989) which attempt to devise a way of looking at India through Hindu (sic) categories.

people by referring to specific social contexts (1991: 135). Others, outside of the Chicago school, have made similar observations. Vaidyanathan (1989) asserted:

> An Indian thinks of himself as being a father, a son, a nephew, a pupil, and these are the only 'identities' he ever has. An identity outside these relationships is almost inconceivable to him. It is very common in Indian households to hear a person referred to as 'Rekha's mother' or as 'Babu's father,' and the people concerned don't feel diminished in the least by these self-abnegating nomenclatures" (151).

The assumption of a socially-embedded self is also paradigmatic in the work of Louis Dumont (1970[1966], 1986[1983]), and, as will be seen below, repeatedly asserted itself in my fieldwork. In fact, as in Vaidyanathan's example, I use relational names to identify relatives of ill people, such as "Sreedevi's mother," as these were the only identities these informants presented to me.

One cannot, however, make a neat opposition between a egocentric West and a sociocentric India. There are ways in which individualism is strongly marked in India, and situations when Americans, for example, are sociocentric (Kusserow 1996, 1999), yet the notion that a person is not only connected to but embedded in her/his social relationships, the idea that it is hard to abstract the self from its social context, is crucial to understand when looking at Kerala. Basic facts of daily life underscore this issue. For example, people who were ill went for therapy--and for interviews with my assistants and me--accompanied by one or several close family members and/or friends who did most of the speaking about their problems. Meanwhile, the Malayalam language is almost unintelligible without awareness of the social embeddedness of the speakers. As one small example, my assistant Biju would use the second person inclusive *nammal* (a form of "we" that includes the person one is addressing) when asking about a patient-

informant's problems (e.g., "how did we [you and I] feel inside?").

"Sociocentrism," however, is not quite the right word for this orientation as what it attempts to convey is not quite a "centrism", a converging on a single point. The "centric" metaphor is more appropriate when one speaks of egocentrism where the individual self constitutes a center. With the "sociocentric" self, there is not a center, but rather a number of different relationships that are significant. The sociocentric self might be better characterized, therefore, as a socially-dispersed or socially-embedded self. The term "self" is also somewhat misleading, implying an autonomous entity. The "dividual," the "person" or the "socially-embedded 'self'" would more accurately indicate a person's orientation without assuming autonomy.

The socially-embedded "self" jumped right out at me as soon as I arrived for fieldwork in 1997.[3] When I reached Kerala, I stayed with the relatives of a close friend with whom I had studied Malayalam in the U.S. Based on American assumptions about hospitality, I had planned to stay only a few days until I found my own place (after all, I only knew their niece). This family, however, had assumed I would stay the whole year, and they were surprised and disappointed that I wanted to find my own place (after all, wasn't I a friend of their niece?). I explained that I had to move for my work, that living with them was too fun and distracting. Yet I quickly found that in the city of one million where I was staying, there were no realtors or agencies who advertised or rented places to individuals. If one needs a place to rent, one goes by word of mouth, one uses one's

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[3] It was not as striking during my first, briefer visit to India precisely because I did not have as many contacts.

social network, and only that. I eventually learned--through family contacts, of course--of one person who finds places for rare individuals (sic) like myself who come to Trivandrum, from places outside Kerala, with few connections. I went to see Trivandrum's only realtor with the uncle of the family I was staying with. Simply describing this uncle's, or anyone else's, name reveals the socially embedded "self." His name was Prem, although I only heard this name the first time I met him. He was referred to only by relational names such as Mon (meaning "son", used by older family members), Monchettan (meaning "son-elder brother", used by some younger family members), or Chettan (an appellation literally meaning "elder brother" used by wives to refer to their husbands) since in Indian families one refers to relatives by their relation to oneself and never by their "real" (i.e., autonomous, unchangeable) name.

When we arrived at the realtor's place, Prem spoke for me, telling the realtor what I wanted, and he responded for me as to whether a place was worth seeing. This was exactly analogous to how, I later realized, patients' relatives tended to speak for patients when consulting psychiatrists or being interviewed by me. In the end, I decided not to live in any of the apartments shown by this realtor, and returning to my social connections, I ended up in an apartment attached to the house of my friend, clinical psychologist K. Gireesh, whose insights on health and healing are occasionally cited in this study.

I tried to thank this family for their support, but that felt awkward, like a distancing gesture. The Malayalam word that translates as "thank you" (*nani*) is only used on extraordinary or formal occasions, such as addressing a judge who has just

pardoned you, and it is not used on a routine basis. It was hard for me to understand why people did not say *nani* until I reversed the question and asked why we do say "thank you" in English. I decided "thank you" was a way to give back what someone gave you, to even the balance so that people could go back to being autonomous individuals. "Thank you" is, among other things, a counterprestation so that one does not feel obligated, i.e., connected.

There is also very little privacy in Kerala, and one is generally assumed not to want to be alone. While I was living in Trivandrum, a friend would sometimes visit me unannounced by finding his way in my open back door and appearing in my living room. My assistant Kavitha meanwhile told me that she would look forward to having people to talk to when she commuted to her home town from Trivandrum on the train. Being alone is sometimes even considered dangerous: many spirit possessed people I spoke to became possessed when alone.

One sees the socially-embedded "self" in many aspects of the world of healing in Kerala, perhaps the most immediate and striking example of which is mentioned above: patients arrive at treatment centers with one or more family members who usually consult the doctor along with the patient and usually speak for the patient. This is also the manner in which interviews in this study were conducted. At first I thought I should try to speak to the patient alone to get a more accurate idea of their concerns, but that would have amounted to editing out culture. The manner in which my informants presented themselves made me realize that my interlocutor(s) was not just the person suffering the problem but a familial-social group around the patient, a more unbounded self much like

the "therapy managing group" of family, friends and others which Janzen (1978) focussed on in his study of medical pluralism in Zaire.

One also sees this social dispersion of the self, and that the boundaries of the social "self" are indeterminate, in the language of the interviews. In translating interviews, there were many occasions when my assistants or I had to invent a subject to render a sentence intelligible in English. The subject of the sentence is usually omitted in Malayalam, but the situation is not like, for example, colloquial Spanish where the subject is omitted but can be inferred by the conjugation of the verb (e.g., "fuimos" means "we", not "they" or "she" "went" in a narrative). In Malayalam, the verb has exactly the same conjugation for each person (e.g., "poyi" could be "I", "you", "they" or anyone else "went"). Sometimes the subject is clear from context, but often it is--deliberately, I would argue--ambiguous. In interviews with patient-informants, there are many cases where one cannot tell, for example, if it was the mother speaking for the ill daughter or the daughter, or both, who felt relief after a particular experience. Often, when we were translating interviews, my assistants could not specify who the subject of a sentence was meant to be, but they were unfazed by this as it was not *meant* to be anyone.

The socially dispersed self is also revealed in this study in the analysis of ayurvedic methods of counseling discussed in Chapter 3, where it is shown that it is permissible to give advice to a patient. This is avoided in much western psychological and psychiatric therapy, where it is considered crucial that the patient develop her/his own insight.

This conception of the socially dispersed self is fundamental, but it gives an incomplete picture of the world of the "self" in Kerala. There are many ways in which Malayali and Indian cultures are individualistic. Hindu worship, for example, is individualistic. There is no congregational worship. Instead one decides oneself how to make the rounds at a temple, and one often does alone. Also, some strains of Indian philosophy (such as Yoga and Vedanta) are extremely individualistic, attempting to disconnect the self from any social or phenomenal connections. They are concerned with finding the true nature of the self or *ātman* (also known as the higher self) and transcending all worldly attachments. In these philosophies, the true self is not characterized by any other attributes and is connected only to the divine.

Another issue which underlies the chapters in this dissertation is the question of the degree to which the illnesses and various problems in this study are comparable. I was asked by a psychologist friend in Kerala how I would define and standardize the kinds of illnesses I encounter: for example, how many schizophrenics or depressive patients would I have in my sample, or how would I know what illness someone who was being treated for possession had? I explained that I didn't want to favor the illness definition of any one therapeutic system, and I would therefore use the patient's and his or her accompanying family members' descriptions of his/her problems as the standard definition.

One might also bring up the related issue of whether states of possession and illnesses as understood by western psychiatry or other therapy systems are comparable or translatable to each other's terms. Although this issue has been debated (Kehoe and

Giletti 1981; Lewis 1983, 1989; Bourguignon 1991), I think it is ultimately impossible to resolve it thoroughly, and I do not think it is necessary to try to do so. These problems *are* comparable in the sense that the same people go to different healers for what they see as the same problem. Many people I interviewed had visited, for example, a psychiatric clinic and a temple that is known for healing possession in trying to find relief from their illness. There may be different opinions about the ontological reality of their distress and the patient may have experienced his or her problem differently--may have paid more attention to certain manifestations or symptoms--with different healers; but the patient and his or her family see it as one problem, and they can relate its history, all the ups and downs, through different forms of therapy.

Some healers in Kerala were concerned whether I was comparing problems of similar severity in my research. This was especially true of allopathic psychiatrists who often saw my study as a competition between different forms of therapy to see which was the most effective. These psychiatrists seemed more concerned than other healers about what I would find and often scrutinized my methods of analysis if I had anything positive to say about a non-allopathic therapy. When, in response to their questions, I mentioned that a number of patients I interviewed at Beemapalli mosque had found some relief from their problems, allopathic psychiatrists would assert that that was because there were no seriously psychotic people there. Everyone at the mosque, they thought, was mildly neurotic and easily curable by suggestion. That was a valid concern, but I found it not to be true. Many of the patient-devotees at the mosque would be--or actually had been--labeled by allopathic psychiatrists as psychotic. These people had symptoms psychiatrists

consider serious, such as hearing voices, laughing, crying, screaming, tearing off clothes, violence, and many had previously been inpatients in allopathic psychiatric hospitals.

The concern of these psychiatrists did, however, reflect the need to interview people with problems of varying severity to get a more accurate picture of issues in illness and healing in the multiple systems of psychiatric healing in Kerala. Fortunately, most of my research sites had something like a distinction between inpatients and outpatients, and I tried to balance my interviews along these lines. Both the allopathic and ayurvedic healing centers literally had outpatient and inpatient facilities, and the religious healing sites had similar distinctions. Beemapalli mosque had people who came for occasional visits and then went home, and others were living at the mosque for their devotion-therapy. Some people with serious difficulties who were violent or who were believed by their accompanying family member to be at risk of running away were kept in cells behind bars.[4]

Throughout this study I will use the term *illness* invoking the common medical anthropology distinction wherein *illness* is the problem as it is perceived and experienced by the patient and *disease* is the medical way of understanding a problem (Eisenberg 1977; Kleinman 1988). Obeyesekere (1985) has asserted, however, that in psychiatric and related problems the distinction between illness and disease is not so clear. The

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[4] Allopathic hospitals had similar facilities for violent patients, but the Government Ayurveda Mental Hospital where I conducted research in 1997 did not have such facilities. They could treat people with serious problems if they were not extremely violent. However, when I returned to Kerala in 1999, I found that the ayurvedic hospital had moved to a new, larger facility which contained large cells where they kept violent patients.

underlying "real" disease is largely the same as the illness, the subjective experience of the sufferer. Of course, this puts anthropologists such as myself who concur with Obeyesekere at odds with contemporary biomedical psychiatric views that increasingly see mental illnesses as biological diseases that are uniform across cultures.[5]

Overview of Chapters

The chapters in this dissertation move in incremental steps from the more ethnographic to the more analytical. This should not be perceived, however, as representing an order of importance. Thus the next three chapters, while providing context for the later, analytical chapters, should not be taken as mere background material, but rather they should be perceived as an illustration of the range and complexity of issues relating to issues of health and illness in Kerala which this study cannot reduce to any analytic terms.

Chapter 2 is a short, simple presentation of a few basic facts about Kerala and an outline of how this study was conducted. Chapters 3 and 4 provide most of the ethnographic and contextual foundation for this study, but to make them more meaningful they require some preliminary information offered in Chapter 2 regarding, for example, the language of Kerala, the variety of religious groups in the state, the emergence of the Communist party, and Kerala's impressive "quality of life" standards.

Chapter 3 provides a description of the three systems of healing that are the focus

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[5] Kleinman (1988) and Hopper (1991) also generally agree with Obeyesekere's view. Particularly, they have questioned the use of "disease" categories such as "schizophrenia" and "depression" in cross-cultural psychiatric studies.

of this study as well as information on other therapies in Kerala. Proportionately more attention is given to ayurvedic medicine, which I have assumed would be the most unfamiliar form of healing to most readers. The description of ayurvedic therapy is based on both the theory of ayurveda--the epistemology of ayurveda and the ideal of how it should be practiced--and my observations of actual practice. Allopathic ideology in Kerala--the official texts and the ideas that are taught in the classroom--is largely the same as it is in other parts of the world. However, through observing practice one can seen a certain Indian or Keralite style of allopathic medicine which, among other things, features more family involvement than allopathic psychiatric care in the U.S. Finally, the rituals and routines one undergoes for illness at Chottanikkara temple, Beemapalli mosque and Vettucaud church as well as the histories and legends of these institutions will be presented.

Chapter 4 provides further ethnographic material and context, this time from the point of view of the people who use these therapies. This chapter focuses on interviews with six patient-informants (two from each of the three forms of therapy) and their accompanying family members which are interspersed with commentary on issues that are brought up in the interviews. These commentaries provide information useful for understanding the analytic chapters, but they also go beyond the range of issues in those chapters.

Chapter 5 is more analytic than the previous chapters, yet it is also more ethnographic and less analytic than the chapters that follow it in the sense it required the least theoretical thinking. My informants quickly showed me that this chapter should be

written. Inspired by anthropological studies of the body and embodiment, I went to Kerala looking to find unique embodied expressions of illness and different ways of articulating problems in the indeterminate realm between mind and body that are brought out by different systems of therapy. In the anthropological and medical social science literature, people in India and many other parts of the world are supposed to express distress somatically (that is, through the body) or transcend mind-body dualism while psychologizing problems is supposed to be a uniquely western attribute. While attention to the somatic and mind-body connections were important, people in Kerala did not oblige these expectations and were more interested in talking about things like the mind and consciousness. Descriptions of people's problems focused on behavioral and mentalistic issues and were rarely somatic. This chapter reviews literature on the anthropology of the body, and critiques the construction of an embodied Other and a dualism wherein the West experiences the world through a mind-body dualism and the rest of the world is more grounded in the body. I then claim that the phenomenology I encountered in Kerala can be characterized neither as "embodied" (emphasizing the connections between mind and body or expressing through the body) nor as a case of mind-body dualism. Rather, based on informants' statements and readings from Kerala and Indian philosophy, I describe what I interpret to be the/a local phenomenology of Kerala: a continuum of states from the bodily to the completely disembodied, some features of which are the body, the mind, consciousness and the true self. I propose that anthropologists examine phenomenologies of specific cultures rather than reduce how people experience to either mind-body dualism or living-through-the-body.

While critiquing the direction studies of the body and embodiment have taken, I still consider much of this literature to be an important corrective to earlier anthropological studies and a useful tool for understanding experience. In Chapter 6, I use an aspect of this literature that engages the aesthetic experience of healing. Chapter 6 focuses on the *process* of healing and examines the limitations of the allopathic concept of "cure" for understanding what is accomplished in healing in Kerala. Patient-informants describe what it feels like to go undergo therapy procedures in various forms of healing. Many informants disliked the effects of some allopathic therapies, such as electroconvulsive therapy and injections of psychotropic drugs, and found ayurvedic and religious therapies to be at best more pleasant or at least less traumatic to undergo. This chapter features: a comparison of an allopathic psychiatric procedure (electroconvulsive therapy) and an ayurvedic psychiatric procedure (*talapodichil*, applying a medicated mud pack to the head); a discussion of the use of humor in different healing systems; and reflections by informants who feel they have been positively transformed by religious healing.

As another manifestation of this focus on the process of healing, testimonies will be presented from people who have given up on therapies after years of trying to fight a chronic problem and found a solution to their difficulties not in "cure" but in living in a pleasant or aesthetically engaging environment--in essence, living in the process of healing. Examples of this are mentally suffering or possessed persons who have been living for years at a mosque, temple or church.

Chapter 6 also brings up issues of relations to time. I consider that ayurveda and

allopathy involve different orientations to linear time. Ayurvedic therapy, while having an end goal, also pays attention time passing in its consideration of the process of healing. Allopathy, gazing ahead at the end goal of cure, does not consider as much what happens while time is passing.

The issue of time provides a segue to the next chapter. After having considered its lack of attention to the process of therapy, one might wonder why allopathic psychiatry is popular and what might be the advantages of this form of healing. Many informants explained, as did Ajit at the beginning of this introduction, that allopathy provides quick relief. Even if some--such as Ajit--believe that such remedies are temporary or superficial, they do allow one to quickly get back to work, school or the many other obligations people have to keep up with in Kerala. This time pressure, along with the dissemination of information about allopathic psychiatry through government support and media representations, may relate to the reported decrease in the occurrence of spirit possession in Kerala discussed in Chapter 7.

Healers in Kerala have reported to me that fewer people have been coming to their offices claiming to be possessed, and among the people I interviewed possession was relatively rare as an idiom of distress. Chapter 7 describes this decline of spirit possession and an accompanying rise in allopathic psychological and psychiatric modes of expressing problems. In this chapter and throughout this study, I focus on unwanted, involuntary forms of possession by malicious spirits that are akin to illnesses and from which one seeks relief. Voluntary, auspicious forms of possession, such as when temple priests act as a conduit to the goddess or people at festivals invite prestigious deities to

possess them, were not reported to be declining.

The decline of spirit possession involves not only a decrease in incidence but also an increase in the homogeneity of spirit possession cases. One of the few studies of possession in Kerala's past (Jagathambika 1968) revealed that people in the 1960's were possessed by spirits with specific names, identities and connections to the lives of their possessees. They were saturated with context. The people I interviewed, however, were possessed by homogenous or anonymous spirits that didn't have specific histories or identities. I argue that this change is characterized by an erosion of context-sensitivity. Since "modernization" in India has been depicted as a tension between the context-dependent and the context-free (Ramanujan 1989) and because Malayali informants have related the waning of spirit possession to "modernization," this chapter will also scrutinize local and academic definitions of "modernization," and consider specific trends that have been labeled "modern" such as print and visual media discourse, literacy, Gulf migration, secularism and support of allopathy by the state. These "modern" trends appear to relate to the decline in cases of spirit possession and increases in psychological modes of expressing illness, yet I will show how various discourses and practices that relate to the waning of possession are not simply categorizable as modern or traditional/indigenous (or whatever the opposite of modern is supposed to be).

The concluding chapter, Chapter 8, continues to consider implications of these social changes, especially the tension between context-sensitivity and homogenizing-universalizing trends, for issues that arise throughout this study and for social theory. I will point out issues that universalizing tendencies can obscure and some of the virtues of

context dependancy. For example, Kerala's pluralistic healing system is context-dependant, and I see that as its strength. Although many allopathic healers in Kerala expected my study to produce a winner, a most-effective, universal healing system, I argue that each form of healing is effective for a significant number of people and that effectiveness depends on the specific context/patient. "Cure" can also be interpreted as a universalizing concept that does not allow one to see diverse, specific ways of coping with illness problems. I suggest that universalizing tendencies, and lack of an adequate balance with context-dependancy, result in anthropologists' uneasiness in the face of the contradictions that are often encountered in trying to describe cultural ideas and practices.

Chapter 2 - The Setting and the Study

Although the following two chapters provide most of the ethnographic context in this dissertation, they require some prefacing with a few simple facts and features of Kerala history and culture. Those unfamiliar with Kerala may wish to know something about the language that is spoken there, how Kerala relates to other regions of India and what others have studied about this region, such as it's history of polyandry and its impressive "quality of life" indicators. Information about the methods that were used in this study is also provided.

Setting

Kerala, or "God's Own Country," as the State Department of Tourism and many Malayalis proudly put it, is a relatively small strip of land (39,000 square miles) along the southwest coast of India reaching to within 50 miles of the southern tip of the subcontinent. With 30 million people, Kerala has a relatively low population for an Indian state, but it is also one of the most densely populated areas of India and the world.[1] Kerala is also dense in terms of foliage. Coming in to land at the Trivandrum airport, visitors are not able to notice the city of one million they are arriving at as much of the city is covered by coconut trees. From the ground level, meanwhile, it is hard to tell when you have left the city and entered the countryside. Consistent, significant

[1] For a unit of comparison, imagine the state of Ohio or the country of Switzerland with 30 million people.

KERALA

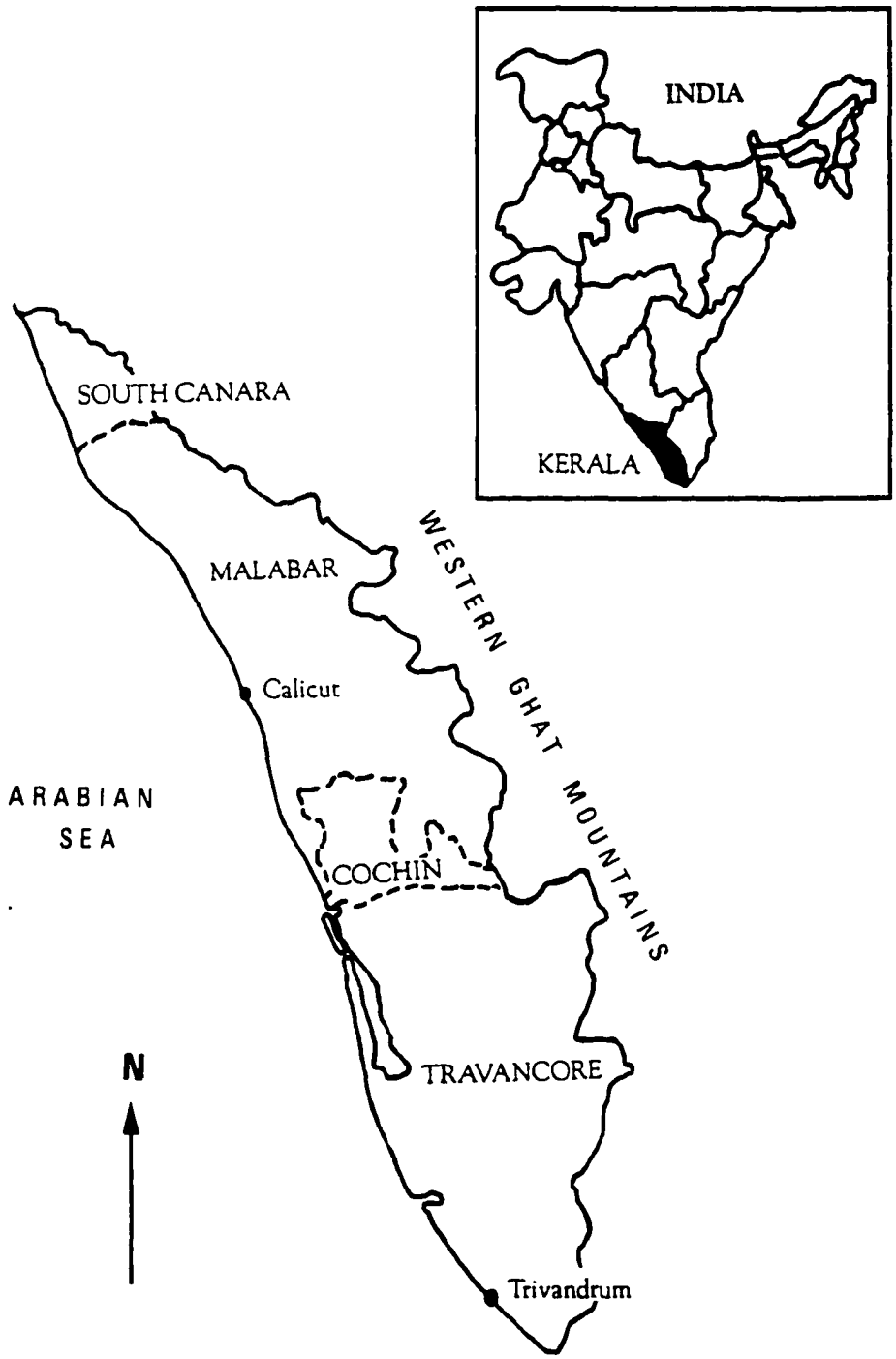

Figure 1 - Map of Kerala showing historical regions referred to in this chapter. (From Franke and Chasin 1994)

rainfall has lead to a dispersed settlement pattern in Kerala, and people have set up homes and villages almost anywhere (Mencher 1966).

The natural fertility of the region has attracted settlers and traders for thousands of years, but resources are strained by today's large population. Coconut trees are ubiquitous, yet there is a coconut shortage. The region has one of the highest rates of rainfall in the world, but there is often a shortage of water and rationing of hydroelectric power.

The regions that make up Kerala have been part of numerous small and large kingdoms and political powers, including the Cheras, the Cholas, the Ays, Venad, the Zamorin of Calicut, the Portuguese, the Dutch and the British, among others, over the past 2,000 years. Trade linkages let us see even further into the region's history. There was a brisk trade with ancient Rome and China and contacts with the Levant some think as far back as 3,000 B.C.E.

The people of Kerala originally followed "Dravidian" (i.e., indigenous South Indian) religious practices which were later mixed with north Indian Brahmanical traditions and labeled "Hindu." Jainism and Buddhism reached the region from north India around 300 B.C. E. Around 300 years later, a group of Jews settled in Kerala, and they were followed shortly thereafter (in the middle of the first century C. E.) by a community of Christians--who were spreading the word to the Jews that the Messiah had come, according to one story. Around the 7th century, Islam made its debut, and today Kerala is about 60% Hindu, 20% Muslim and 20% Christian and one of the most religiously diverse states in India.

The regions that became Kerala consisted of small kingdoms that were occasionally annexed by larger empires, and this trend continued to the British colonial era. During the colonial period, the region that became Kerala was made up of three political entities Travancore, Cochin and Malabar, corresponding geographically to roughly south, central and northern Kerala today. The kingdoms of the Malabar region were conquered in the 18th century by the Mysore empire, which by the end of the same century surrendered the region to the British. Malabar was ruled directly by the British, and Travancore and Cochin were semi-autonomous princely states.

Since Travancore, Cochin and Malabar were joined to make Kerala in 1956, the state has been run mostly by communist parties though the Congress party has also had a few tenures in office. The first communist party developed out of the Kerala faction of the Congress party in the 1930's during the struggle for independence from British rule. Although exactly how much credit to give is debatable, Kerala's communist parties and movements are in large part responsible for the impressive contemporary health care and education in the state.[2]

The borders of Indian states are generally drawn on a linguistic basis. Although India is a single, large modern nation, it is useful to consider each state as analogous to a European country. As one goes over the border from France to Germany, for example, one changes languages and cultures just as one does in going from Kerala to, say, its northern neighbor, Karnataka. Likewise, the analogy to European countries is useful for

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[2] This sampling of Kerala history is compiled from information in Narayanan et al. (1976) and Sreedhara Menon (1990).

understanding the cultural-regional context of this study. Just as a reader familiar with Europe would not expect comments about a cultural context in Spain to be also true for Finland, so one should not expect comments about life in Kerala to relate necessarily to practices in, say, Kashmir or other regions of India.

Malayalam is the official language of the state of Kerala, and it is spoken by about 96% of the population (Prabodhachandran Nayar 1994). Although Malayalam is the eighth largest of Indian languages, with only 30 million speakers, it is one of the largest literary languages because of Kerala's high literacy rate.[3] Malayalam is part of the Dravidian language family which is found only in south India and northern Sri Lanka and includes Tamil, the language of Kerala's eastern neighbor Tamil Nadu, Kannada the language of Kerala's northern neighbor, Karnataka, and Telugu, which is the language of the state of Andra Pradesh. Malayalam was a spoken variety of ancient Tamil until the 9th century when linguists date the emergence of a distinct language and the first occurrence of Malayalam in writing (Prabodhachandran Nayar 1994).

Today, Kerala's literacy rate is the highest in India, but Kathleen Gough has pointed out that Kerala was the most literate region in India in what she calls the "traditional" period of Kerala history (during the feudal kingdoms of the mid-fifteenth to the mid-eighteenth century, before the region was dominated by the British and the Muslim Mysorean empire) (Gough 1968: 133, 151). Gough conjectures:

Kerala's high agricultural productivity, connected with its heavy rainfall,

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[3] Though Kerala has only 4% of India's population one of Kerala's newspapers, Malayala Manorama, claims to have the greatest number of readers in all of India apparently due simply to the high literacy of Kerala's population.

> permitted at least a quarter of the population to be set apart as literate specialists. The growth of overseas commerce, and thus of land sales, cash rents and mortgages, and cash wages for soldiers and urban artisans, fostered the use of simple literacy for accounting and legal documents. The Nāyars and other matrilineal castes gave their women a higher status in many respects than was customary in patrilineal India, and most of them learned to read. (151)

Overall, Gough's study gives the impression that each sector of Kerala society had some reason for becoming literate: the brahmins brought their Sanskritic learning from the north; the Nayar caste became literate in their native Malayalam through their own teachers; the Christians, Muslims, and Jews were involved in trade and their religions relied on literary sources.

Kerala is anthropologically famous as the home of the polyandrous Nayar caste. Until the mid-to-late 19th century, one Nayar woman could have many husbands or consorts, and Nayar families determined inheritance matrilineally. These practices have died out for reasons that have been debated but which involve socioeconomic circumstances that favor monogamous marriage and the fact that polyandry was declared illegal in 1955 (Gough 1959, 1961; Mencher 1965). However, some Nayar families still determine family membership and inheritance matrilineally.

Today, because of its impressive standard of living indicators, such as life expectancy, infant mortality and literacy, Kerala is popular among people who study "development." Though these indicators do not tell all about the quality of life and the problems of a region, it is notable, and admirable, that despite being one of the poorest areas of one of the poorest countries of the world, Kerala has a life expectancy, infant mortality rate and literacy rate that is close to that of the U.S. and other wealthy

countries.[4] The reasons for these achievements have been debated, but they are certainly related to some degree to land reform, literacy, and health care movements carried out by grassroots organizations and the government of Kerala. The reasons such events occurred in Kerala bring up another level of explanation. Some claim that these projects were not due to any largesse or spontaneous generosity on the part of the government. Rather, they came from a demand for a share of power "from below" (Govinda Pillai 1999; Thomas Isaac 2000). P. Govinda Pillai, a member of the Kerala faction of the Communist Party of India (Marxist) and editor of the political journal *Deshabhimani*, claims that the emergence of a Communist government and social reform movements stem from anti-caste movements of the 19th century. Govinda Pillai asserts that Kerala was for a long time marked by an extremely rigid and oppressive caste system, which eventually led low-caste leaders, such as Sree Narayana Guru, to mount popular anti-caste movements. In other words, excesses of the caste system, which were supposedly more pronounced in Kerala than in other regions of South Asia, pushed people at the bottom rungs of society too far and led them to rebel. Communism was later adopted as an ideology that complemented this indigenous social reform movement. And, as Malayalis like to remind people, Kerala has always had democratically-elected Communist governments.

Other features of Kerala history are brought up in the following chapters as

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[4] In 1991: life expectancy was 70.5 years of age in Kerala, 60 years for all of India, and 76 years in the United States; infant mortality was 17 per 1,000 in Kerala, 85 per 1,000 in India and 9 per 1,000 in the U.S.; adult literacy in 1991 was 91% in Kerala, 52% in India and 96% in the U.S. (from Governments of Kerala and India and World Bank statistics compiled in Franke and Chasin 1994:ii). Franke and Chasin (1994) and others claim that literacy in Kerala has reached 99-100% since 1991, though the literacy rate among my 100 informants was around 90%.

relevant issues arise. For example, in the section on the various methods of religious healing in the next chapter, the history of the arrival of diverse religious groups to the region is outlined in more detail, and in Chapter 4 when two informants who formerly worked in the Persian Gulf are introduced, contemporary issues of Gulf migration are discussed.

Methods

This research is based on three periods of fieldwork in Kerala. Preliminary research was conducted for three months in 1994, followed by one year of fieldwork from January 1997 to January 1998 during which all patient interviews were conducted. I visited Kerala again for three months in 1999 to direct a study abroad program for the University of Wisconsin-Madison during which I revisited some research sites and met with some healers I knew. In this most recent visit, I was able to discuss some dissertation chapters I had drafted and receive feedback from friends who are also healers and informants in this study. These informants' reactions are mentioned in the texts of the relevant chapters.

In 1997, myself and my Malayali research assistants Biju, Kavitha, and Benny interviewed 100 patients of ayurvedic, allopathic and religious therapies about their illness histories and their experiences with various therapies. Thirty two patient-informants (22 male and 10 female) were undergoing ayurvedic therapy at the time of interview; 35 (21 male and 14 female) were using allopathy; and 33 (18 male and 15 female) were undergoing therapy at a mosque, temple or church. Sixteen healers were

formally interviewed for this project, and I informally discussed issues related to my research with many other healers. In addition, I observed healing methods used by the various therapies, and kept up on popular culture and the world of public discourse on mental health in a variety of ways that included reviewing popular magazines, television and movies that related to this topic. It was also my experience chatting informally with my assistants and other friends and learning the details of daily life in Kerala that provide much of the information in this study.

Research sites included a government-run ayurvedic psychiatric hospital, two private ayurvedic psychiatric practices, public and private allopathic psychiatric hospitals, one Hindu temple, one Muslim mosque and one Christian church. These healing centers are described in detail in the next chapter.

Although I studied Malayalam, I was not proficient enough to converse smoothly in the vernacular, and thus I required the assistance of Biju, who worked as a clerk at an ayurveda college, and Kavitha and Benny, who were both graduate students in psychology at Kerala universities. Further details about Biju, Kavitha and Benny are presented at the beginning of Chapter 4.

Patient-informants, and/or the relatives who spoke for them, were given unstructured or structured interviews that focussed on their illness history, the current status and features of their illness, the reasons they choose the therapies they used, the reasons for changing therapies, their experiences with different therapies, their views about the cause of their problem and their own prognosis (what further steps are needed and how long they think it will take) for healing their problem. The structured interviews

utilized the questions reproduced in Appendix A. In unstructured interviews, the informant was given more latitude to determine the course of the interview and bring up issues that may have been avoided or obscured by questions in the structured interviews. In practice, the two kinds of interviews became very similar. My planning of the methods could not anticipate the cultural contingencies that might arise. For example, accepted and polite conversational style in Malayalam did not allow one to simply go through all of the structured questions as if one was simply reading aloud a questionnaire. The conversations between the informants and, mainly, my assistants diverged into other issues and questions between the pre-prepared questions. This was just as well as it allowed for a greater range of issues to arise in structured interviews.

All unstructured interviews were taped and transcribed, with one exception (a total of 28 unstructured interviews were conducted). Most structured interviews were recorded with handwritten notes, but some were taped (a total of 72 structured interviews were conducted). At least six months after the original interviews, we attempted to conduct follow-up interviews with as many patients as possible to learn of any change in the status of their illness. In total, my assistants and I obtained follow-up information on 25 patients either by interview or by mail-returned questionnaire. Informants were given the option of returning a questionnaire since follow-up interviews were hard to arrange (especially when the patient was no longer using therapy) and informants often lived a great distance from Trivandrum, where Biju, Kavitha and I resided.

Although I aimed to obtain a fairly even balance in the representation of men and women, circumstances led to me interview more men than women. First of all, being

male myself and being accompanied by Biju and Benny, my male assistants, generally made it easier to interview men. Male informants probably felt more comfortable talking to us and we probably felt a little reluctant approaching female informants since we felt we were more likely to make them uncomfortable. It was easier to interview female informants with Kavitha, my female assistant. However, due to restrictions on women traveling and staying out late and the fact that Kavitha lived further from our Trivandrum-area research sites made it necessary to conduct more interviews with Biju. (Benny lived in northern Kerala and assisted with interviews only at the Government Ayurveda Mental Hospital.) Also, due to logistical reasons, the gender of the informant did not always align with the gender of my assistant. Often I went to a research site with Biju or Kavitha depending on who was available that day, and we often chose people to interview based on who had time and was willing. Benny, my only assistant in northern Kerala, interviewed both male and female informants at the Government Ayurveda Mental Hospital. Biju accompanied me for all interviews at Chottanikkara temple, which is five hours north of Trivandrum and required spending the night. (Taking such a trip with an unmarried female assistant could have been scandalous.) Thus there were many times when Biju or Benny and I interviewed female informants and Kavitha and I interviewed males. This is just as well since there may have been things Kavitha brought out in male informants and that Biju and Benny brought out in female informants that we had not anticipated.

Other methodological issues will be discussed where relevant in later chapters.

Let me turn now to a more in-depth look at the three therapies that are the focus of this study.

Chapter 3 - Three Therapies of Kerala

This chapter will describe the three therapies that are the focus of this study in order to provide a context for understanding subsequent chapters on the experiences of patients of these therapies. However, as mentioned in the introduction, this chapter should not be considered less important or less significant theoretically than those that discuss issues related to anthropological theory and social science research. The world of health and healing in Kerala is impossible to describe in one or several studies, but this chapter and the next, which have the goal of being more ethnographically descriptive, will hopefully give an impression of the range of issues that arise in relation to health and therapy in Kerala.

This chapter will first describe features of ayurvedic medicine--with special emphasis on ayurvedic psychiatry--then reveal some of the characteristics of allopathic psychiatry particularly as it is practiced in India. Allopathic medicine is alleged to be neutral and universal, uniform in its practice around the world. There is a lot of truth to this, but it should not be surprising when I present some of the uniquely Indian or Keralite features of allopathic psychiatry. The third method of healing that will be discussed is what I collectively refer to as "religious therapies." This is a somewhat more spurious category than the other two therapies which have specific institutional histories and canons of knowledge and practice. What I call "religious therapies" are, more accurately, three different therapies: one at a Muslim mosque, another from a Hindu temple and the third at a Christian church. Yet these therapies do have an important

common feature in emphasizing the role of the divine and a person's relation to the divine in healing illness. But they also have their particular, subsidiary methods for this. Furthermore, there is a certain degree of overlap between these therapies and the other two medicines. For example, at Chottanikkara temple, ayurvedic psychiatric medicines are sometimes given. Also, counseling at Vettucaud church has some commonalities with counseling in allopathic psychology and psychiatry --perhaps revealing western psychology's roots in Christian orientations to the self (see Kirschner 1996). Finally, while I chose the three most popular therapies for psychological and spiritual problems for the focus of this study, a number of other therapies are also used in Kerala and some of these will be described at the end of this chapter.

Most of the attention in the present chapter, however, will be devoted to ayurvedic psychiatry. This is partly because this is likely to be the most unfamiliar therapy for most readers and partly because very little research has been done on ayurvedic psychiatry. This dissertation is, in fact, one of the most in-depth studies ever carried out on the practice of ayurvedic psychiatry. The concepts and theories about mental illness in classical ayurvedic texts were the focus of a dissertation by Mitchell Weiss (1977), and Deborah Bhattacharya wrote a monograph on "ethnopsychiatric knowledge" in Bengal that included an examination of ayurvedic psychiatry (1986). On this topic, there are also a small number of articles which will be discussed below. Additionally, ayurvedic psychiatry is highlighted in this chapter since Kerala is reputed for this specialty and for featuring ayurvedic techniques that are not--or no longer--used in other parts of India.

Ayurvedic Psychiatry

Treatment of mental illnesses, or *unmada*, in ayurveda is undertaken by some practitioners in India as an aspect of their general practice (see, for example, Bhattacharyya 1986). Kerala, however, is famous for it's specialists in ayurvedic psychiatry (Kakar 1982: 251), and this state features the only ayurvedic psychiatric hospital in India .

In order to explain these methods of the healing *unmada*, it is important to contextualize them in a discussion of the more general principals and practices of ayurvedic medicine.

Summarizing Ayurveda

In this section, I am going to go ahead and commit the sin of trying to summarize ayurveda. When I explain the kind of research I conducted in India, westerners, or anyone unfamiliar with ayurveda, often ask me something like "could you just briefly tell me how ayurveda works?" It seems there is an assumption that ayurveda is generalizable or can be reduced to summarizable rules. I'm sure it would sound odd to put the equivalent question to a practitioner of biomedicine. Perhaps to one who is raised in a society where biomedicine is dominant, other medicines (collectively labeled "alternative" in the United States) are assumed to be more simple or reducible to neat, holistic concepts. Certainly, this is the image conveyed by contemporary popular writings available in the West on "alternative" medicines, including ayurveda.

My response to requests to summarize ayurveda is to say that in order to learn

ayurveda one has to go to an ayurvedic medical school for three years and then work as an apprentice for a period of time afterward (quite similar to what is required to become a practitioner of biomedicine). This best summarizes ayurveda since it says that it is vast and complex, that it takes years to acquire a working knowledge. When asked to summarize ayurveda, I also try to explain some particular, unique features of this medical system, to at least mention some characteristics without claiming to present a holistic overview. Likewise, in this section I will explain some features of ayurveda with the disclaimer that this discussion will be as comprehensive as trying to explain biomedicine in this amount of space.

Ayurvedic practitioners and researchers today continue to rely heavily on a number of classic texts, the most important being Caraka Samhitā (composed between 1,000 B.C.E. and 0 C. E.), Suśruta Samhitā (composed between 7th century B.C.E. and 0 C.E.) and Astāngahrdayasamhitā (6th to 7th century).[1] These are treatises written by several doctor-surgeons, and they explain principles of relations and attributes of the body and mind (some of which are described below), specific cures for specific afflictions, philosophical and practical rules about practicing medicine. Ayurveda is also influenced and informed by four schools of philosophy which were developed beginning around the 2nd and 3rd centuries: *nyāya*, *vaiśesika*, *sāmkhya*, and *yoga*. These

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[1] The dates of these texts are difficult to establish with any precision. The Caraka Samhitā was originally composed by Agniveśa, possibly as early as 1,000 B.C.E. Later, according to the editors of a recent edition of Caraka Samhitā, "it was redacted by Caraka" and hundreds of years after "supplemented by Drdhabala" (Caraka Samhitā 1998: vi). Zimmermann (1987) dates Caraka Samhitā and Suśruta Samhitā as "stabilized in the present form at the beginning of the Christian era" (xiii).

philosophies are too vast to describe here,[2] but they engage with issues such as epistemology, knowledge about the workings of the physical world (including an atomic theory of matter), reasoning about the origin of the universe, disciplines of the body and mind and the methods of logical reasoning. To highlight one of these schools of thought, *nyāya* is a system of thought, logic and observation that is much like the epistemology that underlies western science. *Nyāya* is positivistic and abounds with references like, "Perception, inference, comparison and word (verbal testimony)--these are the means of right knowledge," or, "Perception is that knowledge which arises from the contact of a sense with its object, and which is determinate [well-defined], unnameable [not expressible in words], and non-erratic [unerring]" (Nyāya Sutra Book 1, Ch. 1 in Radhakrishnan and Moore 1957: 359).[3] But *nyāya* often transcends the western religion/secular dichotomy by describing things such as the soul through syllogisms and other positivistic arguments.

Ayurveda is also informed by thousands of more recent books, journals, and research articles from the age of the Samhitas to the present. Though Caraka and Suśruta are still considered fundamental, research continues today into ayurvedic knowledge and practice. For example, while I was in Kerala, I met numerous students at the Ayurveda College in Trivandrum who were conducting clinical studies of new ayurvedic methods

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[2] A good source for further descriptions of these schools of thought is Sarvepali Radhakrishnan and Charles Moore's well-known volume A Sourcebook in Indian Philosophy (1957).

[3] Parentheses indicate parenthetical comments in the original texts, and brackets, "[ ]," indicate clarifications inserted by Radhakrishnan and Moore.

of treatment. Meanwhile, Aryavaidyan and other journals publish the results of contemporary clinical research in ayurveda.

One of first characteristics that is pointed out when trying to summarize ayurveda is its knowledge[4] of three *dosas--vata* (often translated as "wind"), *pitta* ("bile"), and *kapha* ("phelgm")--which underlie functioning and relationships in the body, and between body and mind. *Dosa* is often translated as "humour," which, while no translation will be adequate, has the problem of implying substances flowing around the body. "Humour" is often seen as a quaint, outdated medical concept--for example, bodily substances in classical Greek medicine. This idea became anachronistic in the West as biomedical doctors learned about the organs and substances--e.g., blood, fat, flesh--that make up the body. Classical ayurvedic physicians, over two thousand years ago, conducted surgery and were aware of the various substances contained in the body, but these were not at odds with ayurvedic theory about *dosas*. In fact, classical ayurvedic texts describe the seven *dhātus*, or substances of the body: *rasa* (chyle, lymph, plasma), *rakta* (hemoglobin), *māmsa* (muscle tissue), *medas* (fat or adipose tissue), *ashti* (bone tissue, including cartilage), *majja* (bone marrow), śukra (semen, sperm, ovum) (Dash and Junius 1983: 30).

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[4] I am adjusting my terminology regarding "knowing" and "believing" here and in other places in response to Byron Good's (1994: 37-47) observation that medical anthropologists and others tend to use the word "know" to describe people's understanding of health in the anthropologist's own, usually allopathic/biomedical, medical system, but refer to "beliefs" about health while trying to characterize the medical views of the Other, the adherents and clients of a different therapeutic system. This is done even while the social analyst claims impartiality regarding the effectiveness, importance etc. of various healing systems.

Dosas are probably best seen as principles of relationship, or, as Zimmermann (1995) suggests, mnemonic devices and a way of thinking about the body. Yet *dosas* should also not be seen as completely abstract. Though they cannot directly be seen, they relate to real, tangible characteristics of the body, as well as characteristics of nature (see Zimmermann 1987, regarding the notion of *dosas*' presence in the natural environment and its products). "Wind", "bile", and "phelgm" are woeful, though common, translations for the *dosas vata, pitta*, and *kapha*. "Wind" is probably the best of the three translations if one can also imagine the more abstract principle that is inherent in wind and also in dryness. "Bile" is improved if one also adds the notion of "fire," and *kapha* contains elements such as "coolness" and "slowness" in addition to "phlegm." The best way to explain it is: *vada* is *vada* and not any other thing, and the same goes for *pitta* and *kapha*.

In addition to *dosas* and *dhātus* (the bodily substances mentioned above), there are numerous other medical categories related to functions and processes of the body and mind in ayurveda, such as *gunas* (mental dispositions), *malas* (bodily waste products), *agnis* (enzymes), and *srotas* (channels of circulation) to name just a few.

Disease can arise from vitiation of dosas: that is, excessive or insufficient activity of one or more *dosas*. This can result from diet, behavior, environmental factors (such as season) and other influences. Healing is effected by prescribing medications, diet and often lifestyle readjustments designed to bring the *dosas* back into alignment. Foods and medicines have properties related to specific dosas and can act on these dosas. Medicines are made from plants and their derivatives and other materials (such as dairy products) and also work on dosas. Today ayurvedic medicines are processed in laboratories, and

packaged and sold commercially. Going to an ayurvedic pharmacy in present day Kerala, it would be hard to tell the difference from an allopathic pharmacy. Both sell pills, capsules, syrups in factory-made packages. This trend, however, goes against what some physicians believe to be crucial to ayurveda: the ability to mix medicines specific to each patient's unique condition, what Obeyesekere (1992) refers to as a "bricoleur" method of treating illness in ayurveda. This classic method, which is still used by a number of individual practitioners, I believe embodies ayurveda's tendency (perhaps a disappearing one) to think not in disease categories but in terms of specific patients with specific symptoms of suffering. This may help to explain ayurveda's orientation to *process* and *care* in addition to cure, while allopathy seems to focus more exclusively on *cure*, as will be discussed in Chapter 6.

Ayurvedic training was taught in the past in a teacher-apprentice manner and one's legitimacy as a trained *vaidyan* (a term like "doctor", a practitioner of ayurveda) was established by word of mouth in the area where one practiced. However, many of these circumstances changed during the period of British colonialism when ayurvedic education became institutionalized to compete with western medicine using western modes of legitimation. Today, ayurvedic medical colleges and hospitals exist throughout India, and in other parts of South Asia, such as Sri Lanka. The state of Kerala has several government-sponsored ayurveda colleges and hospitals, including the only[5] ayurvedic hospital that specializes in mental illness in India, the Government Ayurveda Mental

[5] As far as I or anyone I'm aware of has found in many years of looking for references to another such institution. There are, however, some clinics devoted to healing mental illness run by individual ayurvedic doctors in other parts of the country.

Hospital, which will be described in more detail below.

Before this outline of ayurveda begins to belie the diversity of philosophies and practices within ayurveda, it would be useful to examine some of the actual views and practices of actual ayurvedic practitioners. Nordstrom (1988) asserts that "ayurveda is a dynamic phenomenon that offers multifaceted approaches to healing" (479), and Langford (1995) describes different styles of practice and modes of epistemology among ayurvedic *vaidyans* or doctors (in fact, which of these labels one chooses relates to this diversity). One *vaidyan* Langford describes is very grounded in the tri *dosa* theory of ayurveda and believes this medicine is fundamentally, epistemologically different from allopathy. This doctor probes for a "network of forces unknown to modern anatomy" (336) by *darsan*, examining the face, eyes, skin color, tongue and other parts of the patient, and by feeling the patients pulse. He puts more faith in what a patient says than modern testing methods used by allopathic doctors. This method of understanding or "seeing" an illness differs from what Foucault (1994[1963]) and Kuriyama (1995) describe as a particular western, biomedical mode of visual knowledge that involves looking directly at the interior of the patient. Another ayurvedic practitioner in Langford's study, who gives himself the title "doctor" claims that, fundamentally there is not a lot of difference between ayurveda and allopathy. He asserts that research carried out by any scientific system reveals universal "facts" (1995:345). He de-emphasizes holism in ayurveda, and relies less than the *vaidyan* on the tri *dosa* theory. He believes that diagnosis can only be corroborated with tests that reveal internal process, and will often review allopathic x-rays and lab results giving "more attention to the affected parts

of the body than to tongue and pulse" (344). Meanwhile, Nancy Waxler-Morrison's research on ayurveda in Sri Lanka (1988) found it was hard at times to tell the difference between ayurveda and allopathy in their practice. However, I would stress that as varied as the practice of ayurveda may be, there are attributes, such as the three *dosa* theory, the emphasis on diet, and the utilization of Caraka's and Susruta's treatises, that unify ayurveda to some degree.

I also saw a variety of ayurvedic practice in my research. There were a few doctors who were fundamentalist and believed ayurveda to be the only valid method of cure for virtually all problems. Many more ayurvedic doctors had faith in ayurveda but were willing to concede that allopathy treats certain problems well or better and referred patients to allopathic practitioners when they thought this was appropriate. Some physicians even mixed and matched therapies from ayurveda and allopathy. The variation and syncretism in ayurveda today could even been seen at the institutional level: for example, medical students at Ayurveda College in Trivandrum, as part of their training in psychopathology, also received instruction and observed techniques of therapy at the psychiatric units of the Trivandrum Medical College.

Interest in ayurveda has spread outside of India[6] and is being promoted--outside India and, to some degree, within India--in a way that emphasizes holism, balance, nonviolence, use of natural products and vegetarianism. Zimmermann has described this trend as a commodification of ayurveda that has developed in relation to biomedicine due

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[6] Deepak Chopra is a popular advocate of ayurveda in the U.S.

to "the current quest for gentleness in the competitive marketplace of alternative medical care" (1992: 218). With biomedicine having cornered the market on invasive and toxic procedures, promoters of ayurveda began to emphasize aspects of ayurvedic medicine which are more natural, peaceful and holistic, choosing to de-emphasize the fact that ayurveda used to do things such as practice surgery (1992: 220) or trick it's patients into eating meat to cure an illness (1987: 175). Ayurvedic psychiatrist Dr. Rajendra Varma informed me that a former treatment for psychopathology was to shock the patient by laying him on a table and having an elephant bring down its foot over the patient's head as if to crush his skull and then pull away his foot at the last minute. Some of the abrasive methods of allopathic psychiatry will be compared with gentler and sometimes "pleasant" treatments of ayurvedic psychiatry in Chapter 6.

Kothari and Mehta (1988) propose that an overconcern among allopathic doctors to diagnose a patient's complaints into a disease category, rather than for example a person whose body is exhibiting certain alterations or discomforts, can lead doctors to overtreat patients: "Our inability to distinguish between asymptomatic structural or functional alterations--a breast lump, raised blood pressure, high blood-sugar--and true disease makes us rush in 'treating' every such 'patient'." (196). A characteristic of ayurveda is that it focusses more on patients' problems whereas allopathy seems to focus more on diseases. Although ayurveda does have some named disease entities (e.g., in it's medical texts), it also has a conceptual continuum which is informed by *dosas*, among other things, to explain certain constellations of symptoms in individual patients. For example, a patient who visits an ayurvedic physician with complaints about, say, stomach

cramps and headache will not necessarily be identified as having a particular disease. Rather he/she is likely to be seen as a person with stomach cramps and headache and those particular symptoms, and the excess or insufficiency of a *dosa* which underlies it, will be treated. I often heard allopathic psychiatrists label patients we were about to interview with disease categories such as "Oh, your going to interview him. He's a bipolar disorder case." Whereas I rarely heard ayurvedic practitioners describe their patient's as "a case of *vadottmada*", an example of one of their few disease categories. Likewise, an ayurvedic doctor will mix a specific medicine for a specific patient.

One characteristic that is crucial to understand is that ayurveda is, at some fundamental, epistemological level based on an explicit philosophy. Although its practice is subtle and complex and although I am wary of many contemporary attempts to explain ayurveda in terms of a neat, summarizable philosophy, this practice is to some degree informed by a conceptual system: a combination of three *dosas* which govern the state of the body and relate to substances in food; the six *rasas* ("savors") that are in food, medicine and the land; the twenty *gunas* ("qualities") that exist in different combinations in food, medicine and other elements of nature. This is in contrast to allopathy that doesn't have an *explicit* underlying philosophy. One could say that it has an implicit philosophy of specificity and pragmatism, a medicine that develops particular remedies based on their effectiveness for particular problems, but one that does not have a holistic view of the body--that is, there is no system of oppositions and complementary forces that explain what constitutes health and what leads to disease. It is hard, however, to see the underlying philosophy in the complexities of the actual practice of ayurveda, and

ayurveda is also pragmatic and empirical in its approach to understanding illness and practicing healing. However, there is a willingness to go back to fundamental principles in teaching and practicing ayurveda. It is as if there was some confidence, or a leap of faith, that at some level nature is a system that has some neatness to it. This is not to say that ayurveda has more mystical or religious elements than allopathy. Rather, I would say that ayurvedic physicians have reasonably chosen a methodology/epistemology where empiricism and theory are both necessary. They have created a dialectic method of developing and applying knowledge about health and illness.

Ayurvedic Psychiatry

While ayurveda has been well-studied by social scientists, the psychiatric aspect of ayurveda has been rarely examined. Much of the research that has been done is based on textual sources, and less is known about the practice of ayurvedic psychiatry. Many who have done research in this area refer to ayurvedic "psychology" or "psychotherapy," though I think "psychiatry" is a more accurate term since these doctors prescribe medicines in addition to giving psychotherapy. Mitchell Weiss completed a dissertation on the sections of the Caraka Samhita and other classical medical texts that discuss *unmada* (psychopathology) and researched lay perceptions of health and illness among psychiatric patients who patronize ayurveda (Weiss et al. 1986, 1988). He has also written an outline of classical ayurvedic psychiatry and its relation to classical Indian philosophies which are also therapeutic in the sense that they can help one wrestle with existential issues and overcome some of the vissicitudes of life (1986). Obeyesekere

(1982) describes the theory of psychopathology in ayurveda relying mainly on classical texts. He explains that mental illness results from a disruption of the *dosas* due to shock, consuming improper foods, attacks of lust, greed, fear or other emotions, and other traumas, and he claims that ayurveda does not have a psychodynamic theory of illness (239-240). Pfleiderer refutes Obeyesekere's assertion of a lack of psychodynamic theory by presenting the methods of an ayurvedic psychiatrist, Dr. Shastri from North India. Through his reading of the texts by Caraka and Susruta and his own innovations, Dr. Shastri classifies mental illness into two categories: somato-psychic, which includes problems caused by physical trauma or eating the wrong foods, and psychodynamic, which can come from maladaption to one's social environment (for example, from family problems or adopting western social roles and life styles) (1983: 35-36). Dr. Shastri heals by giving patients medications made from medicinal plants and through counseling. Nichter (1981), meanwhile, has shown how ayurveda is used in negotiating psychosocial distress, where patients will, for example, come in complaining of sleeplessness or not eating, as a way of getting attention or deflecting blame in interpersonal conflict, and the ayurvedic doctor will go along and give a diagnosis thus aiding in solving a social problem by deferring to medical explanations.

In a chapter of his book on forms of medicine in India, Kakar (1982) summarizes ayurveda and then presents an overview of the theory and methods of treatment in ayurvedic psychiatry. He tells us that the person is made up of a physical, a subtle and a causal body, that one has *buddhi* (intelligence, intellect), *manas* (something like mind), *indriyas* (sense organs), *ahamkara* (an "I-ness" or sense of individuality) and other

attributes (238-139). He informs us that mental illness can develop from vitiation of the three *dosas* or excess in the mental humors *rajas* and *tamas* due to excessive desire (e.g., lust or covetousness) and repulsion (avoiding objects that cause pain) (244-245). Kakar's overview is not in any way incorrect--and I am sure I could not do any better--but the summary of ayurveda in his work and the others' cited above give the reader a false impression of understanding an immensely complex system of knowledge. A perusal of Satya Pal Gupta's 500 page treatise Psychopathology in Indian Medicine (Āyurveda) (1977) gives one a sense of the incompleteness of a 20 page summary of ayurvedic psychiatry, and makes one realize that a good knowledge of Sanskrit terminology is important to truly comprehending ayurveda. These text-based and theoretically-oriented examinations of ayurvedic psychopathology (though Kakar and others do give examples from actual practitioners) are also incomplete in the sense that these neat theoretical constructs are rarely manifested in practice. It is interesting to learn, for example, that the three *gunas*, *sattwa*, *rajas* and *tamas*, are important in constituting one's personality and are related to the development of mental disorder, but I never heard these terms come up in the daily practice of healing psychopathology in ayurveda.

The method I will use to introduce ayurvedic psychiatry will be to present descriptions of ayurvedic psychiatry by three well-known ayurvedic psychiatrists in Kerala along with my observations of their practice. This will allow the presentation to unite both theory and practice, as well as allow the summarizing of this healing system to be done by people who actually practice it. In addition, it should be pointed out that the

doctors I present pretty much define what ayurvedic psychiatry is today in Kerala, and that ayurvedic psychiatry has a unique status in this state. Elsewhere, it is the specialty of a few individual physicians or part of a doctor's general practice. Ayurvedic psychiatry in Kerala also has some unique characteristics not found in other areas (such as using the *panchakarma* purification technique described below). Yet, ayurveda colleges do not have a specialized degree in psychiatry. If one wishes to practice ayurvedic psychiatry in Kerala, one would have to get a general degree in ayurveda and then apprentice with one of these doctors whose work I describe below or others at the Government Ayurveda Mental Hospital.

Dr. K. Sundaran is a well-reputed ayurvedic doctor in Kerala, and he is known and highly respected in the ayurvedic community throughout India. When I first met Dr. Sundaran in 1994 he was a physician at the Government Ayurveda Mental Hospital (GAMH), in Kottakkal, Malappuram District, in northern Kerala, the only ayurvedic mental hospital in India referred to earlier. Dr. Sundaran finished his basic degree in ayurveda from Ayurveda College in Trivandrum (Kerala) and completed a post-graduate degree at Gujurat Ayurveda University (in north India). Dr. Sundaran worked at the GAMH in Kottakkal from 1986 until 1994 when he went on deputation from his duties at GAMH, to teach in the Trivandrum Ayurveda College as Senior Lecturer in the Department of Basic Principles, a position which he holds at present. While in Trivandrum, Dr. Sundaran also sees patients in his private practice, and his reputation as a great healer draws clients from a great distance--some patients will take a 9 hour train ride from northern Kerala to consult with him in Trivandrum; some come from other

states to be treated by him. Dr. Sundaran is greatly respected in his field and he is often invited to present at conferences around India and outside the country. I first met Dr. Sundaran in 1994 in Kottakkal, and I developed a close association with him over the course of my research in 1997 in Trivandrum.

My relationship with Dr. Sundaran began while he was still at the GAMH. In my first meeting with him, I realize in retrospect, I essentially asked him to summarize ayurvedic psychiatry for me. Rather than repudiate my naive question, he made a thorough attempt at answering it. (Of course, as an ayurvedic psychiatrist and a specialist in basic principles, there is probably no one more qualified to do so.) He started by explaining personality formation which is important for understanding *unmada* (mental disorder). Six factors contribute to personality formation at birth: 1) father's sperm 2) mother's ovum 3) food of the mother while pregnant 4) activities of the mother while pregnant 5) special characteristics of uterus 6) climate of the region where one is born. Dr. Sundaran later also explained that the *dauhridaya*, or "two hearts," period in pregnancy contributes to the development of personality. The "two hearts" refers to the fetus' heart, once it has become significantly developed, and the mother's heart, and it is believed that the desires of the mother during this period are transferred to the child. After birth, personality may further develop or change due to: 1) one's religion 2) type of family or communal group 3) place: e.g., topographical variation, whether the place is rural or urban 4) ecology-environment.[7] 5) age 6) individual particularities: such as

[7] This includes climate, foliage, quality of the soil, and food all of which are interconnected. See Zimmermann (1987) for a discussion of the relation between climate, ecology, taste, properties of food, the body and nature of a person and illness in

education, nature of friends and travel experience.

Sundaran goes on to explain that there are two basic types of *unmada*: 1) those related to exacerbated *dosas*, an excess or disorder of *vata*, *pitta* or *kapha* resulting in mental and somatic problems, and 2) those related to personality disorders, which involve specific peculiar behavior--such as *deva graha*, acting as if one is a god. The same division is described in Weiss' (1977) study of classical medical texts and Pfleiderer's (1983) discussion of psychopathology in ayurveda, though I did not see this distinction played out in actual practice of ayurvedic psychiatry. Though diagnostic categories aren't often relied upon, I did learn that almost all patients at the Government Ayurveda Mental Hospital received *dosa*-related diagnoses. These include: *vatotmadam*, characterized by laughing, singing, dancing, "manic" behavior; *pittotmadam*, where the patient exhibits anger, destroys things, attacks people, overeats and drinks a lot of water; and *kaphotmadam*, where the patient is lethargic, gloomy and passive. Dr. Sundaran later explained to me that today few people understand how to diagnose personality disorder in ayurveda, and these are rarely used. In addition, there are two diagnoses that don't fit into either the *dosa*-related or personality disorder categories: *bhayam*, which a state characterized by fear, a general phobia; and *vishadam*, which something like the allopathic category "depression" caused by external factors such as shock. *Vishadam* is similar to *kaphotmadam* except that *vishadam* can involve anger which is lacking in *kaphotmadam*. These dosaic problems can result from excessive desire, shock, trauma, dietary problems and other factors. Treatment for these problems involves *panchakarma*,

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ayurveda.

a week course of therapy involving 5 steps (emesis, purgation, medicated enemas, non-medicated enemas, and medicines taken through the nose) , giving medicines, and talk therapy.[8] *Panchakarma* treatment calms and purifies the patient, ridding his/her body of toxins. Many of the medicines, and the methods of administering them, according to Dr. Sundaran, work on the *sringartaga*, an area on/in the head about halfway between the forehead and the apex of the head. This is the point of convergence of 4 senses (taste, hearing, smell, and sight) and is the center of the mind in ayurveda. Other medicines have specific purposes such as aiding sleep. Dr. Sundaran was responsible for developing (mixing together various medicinal plants and other *materia medica*) many of the medicines that are used at GAMH.

Let me shift to a description of the process of treatment at the Government Ayurveda Mental Hospital, much of the information for which comes from Dr. V. Abdu, one of the hospital's psychiatrists. The Government Ayurveda Mental Hospital is located in, Malappuram District, northern Kerala in the town of Kottakkal, which is famous as a center of research, education and treatment in ayurveda. Kottakkal is the home of the Arya Vaidya Sala, a medicine manufacturing center, treatment center, hospital, medicinal/botanical garden, an Ayurveda College, and a theater troupe (sic) all founded by the famous *vaidyan* Vaidyarathnam P.S. Varier in 1902. The Government Ayurveda Mental Hospital is the only ayurvedic institution in Kottakkal not administered by the

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[8] I use "talk therapy" to refer to the aspect of healing that involves speaking and counseling among all the various methods of therapy described in this chapter. Terms such as "psychotherapy" imply a certain ideology or discourse that is not present in some of these therapies.

Arya Vaidya Sala organization. Founded in 1984, the Mental Hospital is operated by the Government of Kerala.

The hospital was staffed in 1997 by a director, two doctors, four nurses, and a number of other attendants. Just over 20 outpatients are seen every day, and at any time about 18 inpatients (about 13 male, 5 female) are staying at the hospital. On my return to Kerala in 1999, I found that the GAMH had moved to a new, larger, modern facility that holds 50 patients.[9] Most of the following description is based on my observations of the hospital at the old facility in 1997. Treatment at the hospital is free for patients who earn less than Rs. 1,500 ($45 U.S., the average annual income in Kerala being around $200 U.S. at the time) per year . Patients earning more than this amount are required to give some contribution, on a sliding scale based on their income, for treatment. Patient contributions go mainly toward the cost of medicines which are becoming increasingly expensive. Dr. Thankam, a chemist at the Ayurveda College Pharmocognosy Research Centre in Trivandrum, explained that the cost of ayurvedic medicines is rising because land that is needed to raise the plants that are used for ayurvedic medicines is disappearing due to urbanization and industrialization.

Patients are admitted to the hospital after an outpatient consultation or a period of outpatient treatment. These consultations involve learning the patient's symptoms, trying to evaluate the patient's normal personality to see to what degree they are deviating from

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[9] The architecture of the old facility made it so that one ward had to be much smaller than the other, and the hospital directors made the larger area the male ward. From my tour of the new facility, it appears that the male and female wards are the same size and that, compared to the old facility, a greater proportion of patients are women.

it, assessing the patient's overall state of health, giving memory tests and using other investigative procedures.

According to Dr. Abdu, the inpatient treatment process at the Mental Hospital lasts 45 days, and patients may repeat this treatment 1 to 3 times, depending on the severity of the problem. Upon arriving at the hospital patients are given medicines to relieve their symptoms for one week. Then medicines are stopped and the patient is given *snehepana* which involves drinking medicated ghee (clarified butter) in amounts that increase by 60ml a day for 1 week. This is for lubrication of the body, and during this time, the patient is on a diet of *kanji*, a unflavored rice soup. After *snehapana*, the patient rests for a day and then over the next two days is given an oil bath and a steam bath to induce sweating. After this, a therapeutic procedure known as *panchakarma* begins. *Panchakarma* is described in the classic ayurvedic texts, though it is rarely practiced today except in Kerala. Satya Pal Gupta in his thesis on psychopathology and ayurveda observed, "Unfortunately, except a few, most of physicians in Indian medicine do not follow the *pañchakarmas* of *samśodhana* [the full name of *panchakarma*]. In some provinces, like Kerala, this therapy is still prevalent and is used in treating the somatic and psychosomatic diseases successfully" (1977: 435).

Panchakarma begins with a day of *vamana*, where a drug is given to induce vomiting, followed by *virechana*, where a purgative is given to empty the bowels. These steps plus the preliminary *snehapana* and sweating and later steps in *panchakarma*, remove impure substances, toxins, from the body. Dr. Abdu explains: "The purpose of *snehapana* is lubrication of the body. ...impure substances are lubricated by this

treatment. Then by way of fomentation [sweating], these impure particles go to the alimentary canal. While in the alimentary canal, some will come to the nose and others to the stomach and intestines. The substances reaching the stomach are expelled by way of vomiting. For other substances, which leave through the intestine, we give purgative medicines."

After *virechana* (purgative treatment) and a day of rest, medicines for specific symptomatic relief are restarted and continued through the rest of the stay at the hospital. The next step is *vasti*: enemas. *Snehavasti*, an unmedicated enema with oil, and *kashayavasti*, a medicated enema, are given alternating with days of rest for a total of 4 *snehavastis* and 3 *kashayavastis* over 7 days. *Panchakarma* ends after a week of *nasya*, which involves steaming the head and giving medicine through the nose.

The remainder of the patient's stay at the hospital--about two weeks--is devoted to *talapodichil* and *picchu*. *Talapodichil* consists of applying a medicated gooseberry "mud" (a combination of gooseberry, buttermilk and other ingredients that looks like mud) to the patient's head and tying it in place with a banana tree leaf. After 45 minutes, an area called the *marma*, halfway between the forehead and the top of the head heats to a temperature of 40° C. At this time, the mud from this area is removed and replaced by a piece of fresh, cool mud. *Picchu* involves tying two cloths around the top of a patient's head, creating a kind of chamber in which a medicated oil is poured. Patients who were undergoing *talapodichil* were in a good humor: they reported that it gave a pleasant, cooling effect and they made jokes about how the banana leaf looks, a radical difference when compared to seriousness and fear that is sometimes seen among patients

undergoing allopathic inpatient treatment procedures. The implications of this difference is described in Chapter 6 on the "pleasant process" of treatment.

A variety of medicines are also given to patients depending on their problems. Dr. Sundaran gives many of his outpatients powder made of the medicinal plant *sankapushpi* (Sanskritic name for *clitoria ternata*) which gives "rejuvinative power for the brain." (Interestingly, *sankapushpi* is also administered by Muslim priests in Kerala to treat mental problems, according to Dr. Sundaran.) Dr. Sundaran sometimes gives a variety of medicines, such as a mixture of *asafoetida indica, acorus calamus, and barbarus aristata*, to be taken by outpatients as *dhumapana*, a method of administering medicine that involves rolling herbs into a cigar which the patient smokes by inhaling through one nostril and exhaling through the mouth. In addition to the procedures described above, inpatients at the Government Ayurveda Mental Hospital are given medicines based on their particular problems. Rather than try to completely describe a complex pharmacopeia, let me present the medication regimen given to two patients at GAMH. Information is from patient charts, and explanations by Dr. Sundaran of the effects of some of these medicines are given in brackets:

> Case #1: Reasons for admission: fear, lack of sleep, restlessness, overly anxious, angry, doubtful, sorrowful.
> Medicines: 1) Special powder [see below] 2) *avipatti* [purgative: a combination of 10 drugs] - alternate days 3) *ashwagandharishtam* [improves general physical and mental health] - 30ml 2X day 4) *kanjunyadiennu* [improves sleep in some people] on the head 5) *manassmitravadakam* [general brain tonic, but expensive as it contains gold - only prescribed if patient can afford it] tablets - 1 per day. After 7 days, give *snehapana* with *panchagavyaghrutam* [one of several medicated ghees given with *snehapana*, made from the five products of a cow].
>
> Case #2: Reasons for admission: restlessness in mind; childish insistence; angry; sleeplessness; lack of obedience; burning sensation in stomach; extreme thirst.

Duration: 2 years.
Medicines: 1) Special powder - 2X day 2) *avipatti churnna* - alt. days 3) *ashwagandharishtam* - 30ml evening 4) *mahachandanadi* [prescribed in this patient's case to help with burning sensation in stomach and thirst] oil on the head. Apply thailam if necessary.

The "special powder" is a mixture of equal quantities of powders of the following 3 plants: *serpagandhi* (a sedative, Latin botanical name: *rauwolfia serpentina*); *gokshura churnam* (a diuretic, Bot. name: *tribulus terrestris*); *swethasanghupushpa* (rejuvinative "brain tonic," Bot. name: *clitoria ternatta*). Also, according to Dr. Sundaran, ayurveda uses "supporting drugs" (e.g., *Pipali* [*piper longum*] and *Haridra* [*cucurma longa*]) to help with digestion, and distributing and balancing effects of the principal, active drugs.

Interestingly, the ayurvedic use of *rauwolfia serpentina* (mentioned above in the "special powder" mixture) on mental patients was adopted by western psychiatry. Two Indian researchers introduced this medicine to the allopathic world in 1931 (Sen and Bose 1931). Allopathic researchers identified the alkaloid reserpine as the active ingredient in *rauwolfia serpentina*. Reserpine, which was first tested on patients by Nathan Kline in New York (Kline 1954), "was the first compound to become available as an effective antipsychotic" in allopathic medicine (Kaplan and Sadock 1995: 1989).

Although ayurvedic psychiatrists spend a lot of time talking about their medicines and treatment regimes, they consider the counseling they give to be a crucial, or even the most important (depending on who you talk to), aspect of therapy. Dr. Sundaran asserts, "With counseling alone, I can manage more than 60 percent of complaints." Generally, there seemed to be little talk therapy or psychotherapy in the treatments I studied in Kerala. Of all the various therapies I became aware of during my research, the one that

would allow the most counseling was consulting a clinical psychologist (western psychology) or allopathic psychiatrist at home during his/her private consultation hours. While they are working hospitals, clinical psychologists and allopathic psychiatrists have many patients and can spend little time with each one. During private consultations, however, patients (who can afford it) can have a much longer session with the therapist. Interestingly, the other place where one could get the most talk therapy was at the Vettucaud Catholic church. On occasion, the priest or the nuns there would give counseling which bore some similarity to western psychotherapy.

Although psychological counseling is important in ayurvedic psychiatry, it is substantially different from western psychotherapy in many of its basic premises and procedures. Western psychotherapy is based on methodological theories and explicit epistemologies (e.g., from a text or a philosophical orientation). It emphasizes exploring past events; it is in the form of a patient-doctor dialogue; it is averse to giving advice. Western psychotherapy is formalized and institutionalized, and it has explicit methods that are taught in schools. Ayurvedic psychotherapy is not formally taught in schools or through texts, though Caraka Samhita does give some indication of how to interact with people who are suffering *unmada*. Ayurvedic counseling could be considered more "organic." It involves the doctor telling stories and giving moral advice and examples from his own life experience. Dr. Sundaran explained:

> I am not generally using my basic learning from any book or from my academic experience or philosophy. I'm from a very big family, and I have many experiences with some many types of people. I have much experience from my family itself. I have some experience with [people who have] problems of intoxication, the problems of alcoholism etc. ... I am in company with some [western-style] psychologists, but their approach is, I think, too much [i.e., very]

> different from mine because they are mostly depending on the classical texts or the text they are learning. But I mostly depend on my previous experience. I am generally not promoting the patients. If a patient's arguments are too much against society, I will claim that your argument is wrong with examples and examples and examples and general stories and general events from general family life or from cinema. From popular cinema also I have used [examples].Popular poems, popular stories, with examples and examples and examples... (Original in English.)

Dr. Rajendra Varma, an ayurvedic doctor who sees a handful of people with psychiatric problems in his general practice at Thaikkattu Mooss' Vaidyarathnam Oushadhasala (a well-known ayurvedic clinic in Thrissur District, central Kerala) describes a similar orientation to psychological counseling. He says his methods are "self-developed," and he also uses stories from his personal experience to help his patients obtain insights: "sometimes we will tell them: I also had such a problem in my early childhood. I recovered from it because I did this and that--to convince them."

Western-style psychotherapeutic encounters emphasize dialogue between healer and patient. Although ayurvedic psychiatrists listen to the patient and their relatives describe his/her problems, there is more emphasis on the doctor speaking to the patient in ayurvedic therapy. One of Sundaran's patients described his reaction to talk therapy:

> Kavitha: Do you talk to the doctor about your problems for a long time? Does he tell you about your problems?
> Patient: Yeah, he talks a lot. I get relief from his talk itself.
> Kavitha: You get relief [lit. - change]
> Patient: He talks. His talk is very loving.
> (Translated from Malayalam.)

What is also revealed in this exchange is a tendency to give advice and to talk about a patient's problems in a teacher-student style relationship. These characteristics are also seen in the following examples from one of Dr. Abdu's consultations.

Examples from Dr. Abdu's consultation with a patient will illustrate some of these features of ayurvedic psychotherapy in greater detail. A man I'll call Hamid came with his mother and another relative to see Dr. Abdu about his problems which include trouble sleeping and eating, excessive anger, and *manassinu vishamam* (sorrow/troubles in his mind). After asking about the history of Hamid's illness and the previous therapies they had used and having inquired about Hamid's family and social life, Dr. Abdu gave Hamid some practical advice and a reminder of his familial responsibilities:

> You have not been able to look after your mom, right? That's a big responsibility/achievement, right? You need to support her. That got neglected. That's an important thing/great blessing, right? Later, when you get married and all, if Hamid is living in a family [i.e., married], all problems will be solved, right? Then there's the matter of a job. Besides tailoring, you're interested in masonry work, right? (Translated from Malayalam.)

Then, concerned that the patient is depressive, spending too much time alone, Dr. Abdu offers some more philosophical advice:

> Speaking about humans, they are social beings, not meant for sitting alone. We can live only through contact with others. Without that, we cannot live, do you hear? We cannot move a single step without the help of others. Everyone wants people's help. Otherwise, nothing would be possible, would it? If we need a job, if someone doesn't give us one, how will we get one? Nothing will be alright without getting involved with others. (Translated from Malayalam.)

Dr. Abdu is doing something here that is taboo in western-style psychology: giving advice. The aversion to moral advice and the importance of equality in the doctor-patient relationship, I believe, is based on the individualistic orientation toward the self inherent in western psychological epistemologies. The self should be autonomous, and no one should speak for it or tell it what to do. And a patient should not be told how to solve her problems. Rather the doctor should assist the patient to find her own solutions. In a

cultural setting such as Kerala where the self is contiguous with many social ties (though, as discussed in the Introduction, it may have realms of individuality), it is okay to give advice, and it is acceptable that the doctor should act as an authority who can "preach" to the patient. Through his advice the doctor becomes involved in the patient's self. It should also be noted that in this case the doctor-patient relationship is hierarchical which gives the doctor the privilege to give advice. The hierarchical relationship comes from the doctor's position as a doctor, but it also comes from the age difference between Dr. Abdu and this patient (Dr. Abdu being around 25 years older).[10]

In addition to the places mentioned so far--the Government Ayurveda Mental Hospital, Dr. Sundaran's private practice, the Vaidyarathnam Oushadhasala--ayurvedic psychiatry is also practiced by a few Namboodiri (Brahmin) families in Malappuram District, northern Kerala. The best known of these families resides and practices at Poonkudil Mana, which is the name of their large house, which has been converted into a clinic. The *vaidyans* (the traditional name for an ayurvedic physician, which I shall use since these healers are more self-consciously traditional) are members of the same family, and their training in ayurveda comes from family apprenticeship, not through study in college. They consider themselves to practice a more pure, traditional ayurveda. Their techniques for healing psychopathology are very much like those of the

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[10] This should not be considered a romanticization or an endorsement of all hierarchy in India. Although the caste system and the sociology of hierarchy is in many ways unique to India (Dumont 1970[1966]), it is also a form of social and economic exploitation (Berreman 1971; Mencher 1974). However, respect for certain professions, and especially for age, is a form of hierarchy that is acceptable to many anti-caste advocates.

Government Ayurveda Mental Hospital, which is just 20 miles or so down the road (or 5 rupees away, as Malayalis more often give distances in terms of bus fare), though they make their own medicines, and they are also qualified in *mantravadam* or "black magic." Thus, in addition to giving medicines and counseling, they are able to repel witchcraft. Such qualifications are not claimed--in fact they are more often condemned as superstition--by other ayurvedic psychiatrists I met.

Allopathic Psychiatry

In this study, I will most often use the term "allopathy" to refer to the medical system that is also known as "biomedicine," "western medicine," "cosmopolitan medicine," or "modern medicine." As "allopathy" (along with "English medicine") is one of the most common terms used to designate this medicine in India, it is appropriate for the ethnographic setting of this thesis. In addition, "allopathy" best characterizes this medicine vis-à-vis the other therapies in this study. The term refers to the treatment of illness by opposites (e.g., toxic substances that will kill a disease pathogen), which can involve attacking an illness and using abrasive techniques. Also, "biomedicine" is somewhat misleading since ayurvedic medicine is also based on biological knowledge.

Allopathic psychiatry is practiced in India largely as it is in western countries--or more accurately, as it is in the international psychiatric community, as "western" medicine is now the "cosmopolitan" medicine in many regions of the world (Leslie 1980). However, biomedical psychiatry has developed unique cultural traits in India as it has in the other settings where it is practiced. Farmer's (1992) analysis of biomedical

psychiatry in Haiti presents a unique example of this. Haitian psychiatrists were aware of the dissonance between the (Euro-American, middle class) cultural assumptions in psychiatry and the cultural context in which they were practicing. Haitian psychiatrists thereby became, in a way, "natural" anthropologists, and made a point of learning the cultural, class, religious and economic background of the patients they were treating. Some even borrowed explanatory concepts from voodoo to communicate with patients. Farmer claims that this marked ability to see cultural contingency comes from a Haitian revolutionary tradition of looking skeptically at European/Eurocentric concepts. Allopathic psychiatry, of course, has culturally unique traits in Kerala, though psychiatrists there seemed less conscious of differences than these Haitian therapists. I asked a few psychiatrists whether there were any cultural assumptions in their texts or practices that seemed inappropriate or unapplicable to their patients. Psychiatrists usually said that generally everything is applicable, though one said that the International Classification of Diseases diagnostic manual mentions that anorexia or obesity can be complicating factors in several syndromes; however, such eating disorders are extremely rare in India. Dr. K. A. Kumar, who has a unique perspective having practiced psychiatry in the U.S. and in Kerala, explained that the main difference he saw between how psychiatry is practiced in the U.S. and Kerala is that there is a greater involvement of the family in treatment and cure in Kerala. This difference was cited by a few other psychiatrists, and it struck me as the most unique characteristic of allopathic psychiatry in Kerala. Patients went for treatment accompanied usually by one or more family members who did much or most of the talking about the patient's problems. Family members are

counseled in addition to the patient as part of the treatment. This is also generally true of ayurvedic and religious therapies, and it appears to be a feature of allopathic psychiatry in other parts of India (Nunley 1998).

Some have claimed that a *guru-chela* (teacher-student/disciple) relationship, where the doctor is considered a source of knowledge who teaches the patient, exists between therapist and patient in psychotherapy in India. Girindrasekhar Bose, the first Indian psychoanalyst and founder of the Indian Psychoanalytic Society, has been said to practice this guru-chela style in his therapy (Nandy 1995). Vaidyanathan (1989) says that this relationship is "the paradigm of *all* relationships in India" (161) and that it characterizes the psychotherapeutic encounter. Although, as mentioned above, I noticed this relationship in ayurvedic healing, it was relatively rare in my observations of allopathic psychiatric and clinical psychology consultations. The exceptions were a few cases when the therapist was an older male. (In fact, I wondered how gender-related this relation is as I saw many older men engage in this teacher-student dynamic in conversation, though women of almost any age or level of prestige rarely did so.)

Allopathic psychiatrists are much more numerous in Kerala, and throughout India, than their ayurvedic counterparts (though this is in a sense an unfair comparison since, as mentioned earlier, psychiatry is usually an aspect of general practice in ayurveda and specialists in this area are rare). Most large cities in Kerala have a government-sponsored Medical College that has psychiatric services. In addition, there are three large, state-run Mental Health Centres, primarily for inpatient care of people suffering serious psychopathology, and a large number of private psychiatric clinics and

hospitals. In terms of general health expenditures for Kerala (not only psychiatry), allopathic medicine receives the most government funding with ayurveda second and homeopathy third (though homeopathy is rarely used for psychiatric problems). Government records on the availability of health services in Kerala, which are reproduced in Appendix B, reveal that allopathy has far more beds and doctors though about the same number of facilities as ayurveda in the public and private sectors (although these records probably undercount healers in the private sector). Overall, health services are much more widely available in Kerala than in other Indian states (Panikar and Soman 1984; Nirmala 1997).[11]

For this research project, patients and healers were interviewed at three allopathic psychiatric centers: Trivandrum Medical College, Peroorkada Mental Health Centre and JJ Hospital. Most of the research on allopathic psychiatry was carried out at Trivandrum Medical College, a large teaching hospital in Trivandrum, south Kerala, which has outpatient services and a small female-only inpatient ward. Peroorkada is a large state-run inpatient facility on the outskirts of Trivandrum that has outpatient services and large wards that have beds for 500 male and female inpatients. JJ Hospital is a small, private mental hospital, not far from Peroorkada Mental Health Centre, that provides outpatient services and accommodates around 20 inpatients. Treatment is free, except for the costs

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[11] A recent comparison of health indicators in Kerala and the state of Andra Pradesh reveals that in 1991 Kerala had 7 hospitals per 100,000 people compared to 1.75 hospitals per 100,000 in Andra Pradesh. Kerala also greatly exceed in the number of dispensaries, beds, doctors and nurses compared to Andra Pradesh (Nirmala 1997 citing data from Ravi Duggal et al., 1995, "Health Expenditures Across States, Part 1" Economic and Political Weekly, April 15.) This report did not specify whether it counted only allopathic facilities or included other medical services.

of medications (which are subsidized) at Medical College and Peroorkada, and patients from a variety of socioeconomic backgrounds, with the exception of some wealthier individuals, use these facilities. The private JJ Hospital was chosen in order to find patients from a higher socio-economic background to balance the patient sample. These hospitals are staffed by psychiatrists and medical students who consult with and treat patients as part of their training for their Diploma in Psychiatric Medicine.

Outpatient care at these hospitals consists mainly of consultation with doctors and administration of medications. During the first consultation with a new patient, doctors will spend 30 minutes to half and hour listening to the patient and their accompanying relatives or friends' complaints and illness history. Like biomedical psychiatrists in the U.S., and like ayurvedic psychiatrists in Kerala, they will try to assess the physical health of the patients and give cognitive functioning and memory tests. After accounting for any physical or neurological disability, doctors will make a tentative diagnosis using the International Classification of Diseases - 10th Edition or ICD-10, which is essentially the international version of the Diagnostic and Statistical Manual used by U.S. psychiatrists. ICD is alleged to have been adjusted to fit all cultures. It should not be surprising to know that the attempt to adjust western psychiatric tools to fit different cultures has been attacked by anthropologists--e.g., Obeyesekere 1985, Kleinman 1988. After the psychiatrists assign a tentative ICD diagnosis, they begin the patient on a regimen of medication. Medication is given to almost every allopathic patient I encountered, even to people whose problems did not appear too severe. The amount of medication given to patients seems excessive to some clinical psychologists in Kerala, who have found

patients they consider mildly and temporarily neurotic to be taking several anitpsychotic drugs.[12]

The variety of medicines given by allopathic psychiatrists in Kerala is the same as that used by psychiatrists in the U.S., though the drugs are made by Indian companies. Fluoxetine, which is marketed as Prozac in the U.S., for example, is known by the brand name Fluex, in India. The most-prescribed medicine in Kerala and India, according to doctors I talked to, is haloperidol (used for schizophrenia), and fluoxetine (prescribed for depression) is second. Though treatment is free and medications are subsidized, poorer patients are sometimes forced to discontinue treatment because they are not able to afford medicines. The same trend occurs with patients of ayurveda.

After the initial consultation, visits with psychiatrists at the large hospitals are extremely brief--around 5-10 minutes--and are mainly devoted to medication management. These short sessions are not due to lack of interest on the part of psychiatrists. They are the result of the large number of patients they must see and a limited number of staff. Many psychiatrists working at government facilities also have private practices at home where, for patients who can afford it, more time can be given to psychotherapy. In any case, it is believed by some allopathic psychiatrists that certain patients, such as people they consider chronically schizophrenic, do not generally benefit from counseling and can only be managed through medication. This emphasis on medication over counseling at the government facilities is likely to relate to the lack of

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[12] This situation is not unique to Kerala however. Some critics find the frequency with which medications are prescribed in the U.S. to be disturbing (e.g., Breggin 1991).

time for consultation with each patient and current trends toward biologizing mental illness in the international allopathic community. There is also reason to suspect that the emphasis on medication may relate to advertising, promotion and research sponsorship by pharmaceutical companies, as Breggin claims is the case in the U.S. (1991). Indian pharmaceutical companies send advertisements and promotional literature to psychiatrists' offices, and representatives of these companies appear during outpatient sessions and distribute literature and free samples of their drugs. One representative even left samples with me at an outpatient center though I insisted that I was not a psychiatrist and did not want them.

Persons whom doctors consider to have more serious psychiatric illnesses are admitted for inpatient care which involves medication and some counseling. Inpatients are given drugs in pill form or through injections. Electro-convulsive therapy (ECT) is used on acutely suicidal persons, extremely agitated patients who are not calmed by other means, or patients who have been psychotic for a short duration and are not responding to medications. ECT appears to be administered more often in Kerala, and perhaps all of India, than in the U.S.[13] Several former patients of allopathic medicine (whom my research assistants and I interviewed while they were using other therapies) reported receiving ECT, and often complained about the unpleasant effects of this procedure and

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[13] The rate of use of ECT in the United States was around 3% of psychiatric admissions between 1975 and 1986 (Rudorfer et al. 1997: 1537). Among my patient sample in Kerala, the rate is around 5-10%. It should also be noted that the last two decades have seen a resurgence in the use of ECT in the U.S., after a decline in popularity in the 1960's and 1970's (Rudorfer et al. 1997: 1535-1537). Nunley (1998) also observed a high rate of use of ECT in Uttar Pradesh in North India.

the injections of drugs they were given. Many patient informants appreciated ayurvedic treatment because the treatment was less painful and sometimes even pleasurable. These issues will be presented in more detail in Chapter 6.

Many more aspects of allopathic psychiatric practice that are unique to the Indian setting could be examined--and to do so thoroughly would be a useful research project--but the intention in this section is to provide a general context and outline the medical ethnographic setting for the following chapters.[14] Finally, it should be pointed out that allopathic psychiatry has a lot in common with ayurvedic psychiatry when compared to the religious therapies described below. For instance, manipulation of the patient physiologically or biologically is part of the method of healing in both ayurvedic and allopathic psychiatry, though this method is not completely unknown in religious therapies. In fact, the adoption of the ayurvedic drug *rawolfia serpentina* by allopathy as the *first* effective antipsychotic (discussed earlier) makes one wonder how much ayurveda might have influenced the direction of modern allopathic psychiatry.

Religious Therapies

The grouping of the therapies I saw at the mosque, the temple, and the church where I conducted research into the category "religious therapies" is somewhat, but not completely, artificial. They could also be conceived as three additional therapies, and in many ways their techniques overlapped with some of the other therapies I examined:

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[14] Other examinations of allopathic psychiatry and western psychology in India include Sethi, Gupta and Lal (1977), Kakar (1982), Nandy (1995) and Nunley (1998).

Chottanikkara temple and Muslim *thangals* (priest/shaman) incorporated aspects of ayurvedic medicine (but did so incorrectly according to one doctor), and some religious officials at Vettucaud church employed talk therapy in a manner similar to that of western clinical psychology. These three therapies did, however, have crucial features in common such as appealing to the deity/God for relief from suffering and a setting that was visually pleasing and featured music and a sensorally engaging environment, which I will argue, in Chapter 6, are a part of therapy.

I chose to conduct research at Chottanikkara Hindu temple, Beemapalli mosque and Vettucaud church in order to represent the religious diversity of Kerala, which is approximately 60% Hindu, 20% Muslim and 20% Christian (Sreedhara Menon 1990). These are also some of the most widely known healing centers in the state, though as will be revealed at the end of this section, they constitute only a small fraction of the number of places where one can engage in spiritual healing.

Chottanikkara: Home of Amma-Narayana

Upon arriving at Chottanikkara temple in Ernakulam District, central Kerala, one is bombarded with the phrase, the appeal, "Amme Narayan", the name of the incarnation of God at Chottanikkara in the vocative. The cassette sellers among the merchant stalls on the east side of the temple are always blasting devotional songs, where the most prominent phrase is "Amme Narayana." On checking into the temple guest lodge, one notices "Amme Narayana" in several forms, in stickers, posters, painted signs, on the walls of the reception office, and halfway through one's first night's sleep at the lodge,

one is awoken by the loud, 4am call-to-worship music that is punctuated by the phrase "Amme Narayana." In fact, this invocation and its many musical and rhythmic incarnations are so ingrained in me from my time at Chottanikkara that they began involuntarily playing in my head as I started to write this paragraph. "Amme Narayana" calls the attention of the divinity to which spirit-possessed persons/mental patients at the temple will appeal for relief from their suffering. This appeal along with a regime of proper diet, the discipline of going through lengthy daily *poojas* (worships, ceremonies), singing devotional songs, the opportunity to thrash about cathartically and yell without anybody bothering you, and most importantly, the grace of Amma Narayana, have helped many people at Chottanikkara overcome their distress.

Chottanikkara temple is one of the important abodes of Amma-Narayana, one of the many female incarnations of God in Hinduism. "Amma" also means "mother" in Malayalam and this word alone is one of the most common names in Kerala for God, which is more often appealed to in its female form in South India. Narayana refers to a male side of this incarnation. This incarnation of the deity also appears as--or is further incarnated as--Lakshmi, Devi, and Kali among others, all well-known female manifestations of God.

Let me digress here to emphasize that I am describing Amma-Narayana as an incarnation, a version, of the one, absolute God, deity, divine or whatever one prefers to call this (naming it is precisely the issue). Too many descriptions and popular, non-Hindu assumptions about Hinduism conceive of it (whether it can be conceived as one tradition is another complex issue - Hawley 1991) as a polytheistic religion based on the

superficial observation that one hears the names of a number of "gods," or knows that there are a number of different figures in temples that must represent "gods." It is largely western, "Orientalist" discourse that has construed Hinduism as polytheistic. A brief conversation with a Hindu who frequents such temples is enough to set one straight: all these "gods" are simply manifestations of the one, absolute deity, which doesn't have one single name. Srinivas emphasizes that Hinduism is monotheistic at the outset of his famous Religion and Society Among the Coorgs of South India 1965[1952], and Fuller more recently asserts: "all Hindus sometimes and some Hindus always insist that there is in reality only one God, of whom all the distinct gods and goddesses are but forms" (1992:30). To perceive the multiple incarnations of God as evidence of polytheism is akin to mistaking the "99 names of Allah" in Islam as evidence of polytheism. In fact, in this description I am trying to call the divinity by different names to maintain this Hindu perspective.

Likewise, incarnations such as Amma-Narayana should not be seen as "a goddess" or a female version of the absolute "God," a word with Judeo-Christian assumptions that tends to imply a male. God in it's most abstract sense is neither male nor female in Hinduism. Thus, possessed people at Chottanikkara are appealing to "God," the absolute divinity, through "Amma", "Devi" and other personalities.

The origin myth of Chottanikkara begins in the days when the area of the present temple was a dense forest inhabited by "tribals" (the term in India for aboriginal people who are supposed to predate Brahmanical Sankritic religion and culture). One day, a tribal named Kannappan, who was alleged to be a notorious bandit, brought home a cow

intending to slaughter it for food. His daughter, however, refused to let her father kill the cow, and soon she herself, Kannappan's only child, died. After this tragic loss, according to one version "Wisdom and enlightenment dawned upon Kannappan. He lost interest in things mundane and turned his thoughts toward god" (Vaidyanathan 1988). After Devi, the goddess, came to Kannappan in a dream revealing that the cow was in fact herself, Kannappan transformed his cowshed into a temple.

After Kannappan's death, however, the temple fell into ruin, and the region became uninhabited. One day a Pulaya (a low caste) woman who was working in the area sharpened her scythe on a stone which began to bleed. She alerted people from her town who came to see this sight, and a Brahmin declared that the *chaitanya* (power, consciousness, presence--as we will see later, *chaitanya* is a word one woman used to described what she attained from her healing experience at Chottanikkara) of the goddess was present there. Thus a shrine, which came to be the present temple, was built at this site. The idol of the goddess in the temple today has a small incision which is said to be the scar from when the Pulaya woman sharpened her scythe (compiled from Vaidyanathan 1988 and conversations with temple priests).

The possessed or mentally afflicted at Chottanikkara number about 20 at any time and, according to the temple staff, come from all over India although the overwhelming majority are from Kerala. Possessed people I met at Chottanikkara were also all Hindu. Non-Hindus are not allowed inside the temple. This restriction exists at other important temples in Kerala, though no such restriction exists in other Indian states or at mosques

or churches in Kerala.[15] Since I am not a Hindu, there were certain things I could not see, but this did not affect my research as dramatically as one might think. I simply had to stand on the outside of a 4 foot-high wall or behind a bar during ceremonies, which usually put me only a few feet or inches away from the rest of the crowd. The only place I could not visit was the central shrine, and much of my information about what goes on there comes from the temple priests and my research assistant, Biju. I was allowed to visit the interior of the temple once in 1994 when I was invited to a wedding there.

Temple priests reported that non-Hindus on occasion have come to seek relief from problems at Chottanikkara. They were warmly welcomed, as I was, but they were asked to appeal to the goddess from outside the temple wall. I did not, however, see any non-Hindu possessed or mentally ill supplicants in the time I spent at this temple.

Before going into further detail about the healing process at Chottanikkara, it should be stressed that this temple is not meant only for people with psychological or spirit possession problems. It is attended mostly by regular worshipers, and is one of the three most sacred temples in Kerala, right after Guruvayoor in north/central Kerala in prestige and auspiciousness and a notch higher than the Sri Padmanabhaswamy Temple in Trivandrum in the South. Chottanikkara is also an important site on the southern Indian pilgrimage circuit especially for devotees who are making their way to Sabarimala, a temple in the mountains that receives about 20 million visitors over the

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[15] This restriction is somewhat surprising because of Kerala's recent history of resistance to religious intolerance (e.g., the movements of the social reformer Sri Naryana Guru) and devotion to secularism (e.g., as manifested by the dominance of the Communist party).

course of its three month pilgrimage season. Regular worshipers are well aware that many possessed people come to this temple, and it is striking to see regular worshipers nonchalantly carrying out their *pooja* (worship, making the rounds at the temple) while the possessed visitors are "acting out" around them. A possessed person may be rolling around the main temple walkway yelling, and other worshipers will casually step around them or, in some cases, over them. The possessed are allowed to act however they want inside the temple, and the regular visitors appear to respect this.

An important thing to know about Hindu temples is that, unlike churches or mosques, they are not single structures. A Hindu temple is more like a complex, and some are the size of an small town. Approaching Chottanikkara from the West one enters the main complex, which encompasses a number of shrines, a dormitory and office building for the temple staff and a main shrine containing a sanctum sanctorum where the principle idol of Amma Naryana is located. The main shrine is surrounded by a large, gravel and dirt open area that contains a walkway for circumambulating the main shrine. Near the western wall of the main complex stand a Siva shrine and a snake-deity shrine. Outside the eastern gate of the main complex are several cassette, book and food vendors and refreshment stands beyond which one encounters the temple "tank," a small body of water with steps leading down to it in which devotees bathe. Beyond the temple tank, continuing eastward, is the *kizhakke kavu* ("eastern sacred grove"), a site that is very important to the possessed at Chottanikkara. The *kizhakke kavu* is a Kali temple that is actually a sub-temple within the Chottanikkara temple complex. This *kavu*, to use the most accurate term for the kind of place it is, is an abode of Kali, a tough, aggressive (not

evil as many assume), incarnation of the deity/the goddess who will manhandle the spirits possessing the afflicted and help drive them away. (Figure 2 shows the main complex of the temple viewed through the eastern gate.)

Possessed people at Chottanikkara have a lengthy and complex regimen of rituals to undergo each day. Most possessed people reside at the temple lodge where they wake up at 3:30am, and convene for a *bhajan*, a devotional song. They then enter the temple when it opens at 4am, circumambulate the main shrine with the regular worshipers and visit the other shrines around the temple as they please. In the main shrine the possessed devotees queue up along with other worshipers to do *darshan* (an exchange of gazes with the deity, a receiving of auspiciousness and power from the goddess - see Eck 1985) at the idol of the deity, and worship the goddess through *thozhuthu*, standing with both hands joined at the chest.

No coffee or tea is consumed by patient-devotees in the morning, but around 8am they are given ghee (clarified butter) to drink, sometimes mixed with *brahmi*, an ayurvedic psychiatric medicine, and *panchgavyam*, a mixture containing the five products of a cow also used in ayurveda. *Brahmi* is a traditional ayurvedic "brain tonic," made from the plant *hydrocotyle asiatica* in some parts of India and from *bacopa monnieri* in other parts of the country (Dash and Junius 1983:103 and Dr. K. Sundaran personal communication). *Brahmi* use has developed into something of a fad recently around India, and it's fashionable for Members of Parliament to use the drug to increase memory and alertness (Times of India, Feb. 16, 1997). *Brahmi* is also used by some Muslim priests in Kerala to treat psychopathology.

Figure 2 - The main shrine at Chottanikkara temple, viewed through the eastern entrance of the main complex. (The people shown here are not among the possessed or ill.)

The next major event of the day for the patient-devotees, as well as for other worshipers, is a *pooja* that occurs around 11 am at the Siva shrine that is on the western perimeter of the temple. I will illustrate this ritual by describing what happened at the Siva shrine on a specific, typical day. I was standing on the outside of the short temple wall about 40 feet from where the crowd, including my research assistant Biju, was beginning to gather around the Siva shrine, a small building about 20 feet by 10 feet. People, possessed and non-possessed, huddled together, oriented toward the small door of the shrine, waiting for the priest to come, conduct a *pooja* at the shrine and sprinkle the crowd with water. During this time, the spirit became active, or came into, some of the patient-devotees, three women, who started swaying a little and gradually began to dance around. One also began shouting unintelligibly. A man danced around briefly, fell down, rolled around on the ground, and then began rolling around the temple ("circum-rolling," head toward the temple) on the foot path as he had done at 4 am pooja. (This rolling around the temple is sometimes done at Hindu temples as an expression of extreme devotion or to fulfill a vow.) Meanwhile, the crowd was giving and receiving *prasad*[16] at the shrine with the priest's assistance. The dancing, waiting and giving/receiving *prasad* had been going on for about 40 minutes when the priest emerged

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[16] *Prasad* involves the giving and receiving of food, money and other materials with the deity. Sometimes one brings a bundle containing a piece of coconut, flowers or other offerings wrapped in a banana leaf, and gives it, or part of it, to the priest acting on behalf of the deity. Sometimes one gives a few rupees and receives a bundle from the priest. There are many dimensions to *prasad* which are too detailed to be explained here (and these are discussed in Fuller 1992 and many other works on Hinduism).

from shrine and flinged *dhara* (water, *tulasi*, a sacred and medicinal plant, plus some grain) at the crowd along with flower petals. Then the crowd slowly broke up, and maybe 15 minutes later everyone, including the priests, was circumambulating the temple as a group, after which people left the temple. On some days at the end of the *pooja* a few possessed persons, mostly women, remained collapsed or rolling around in the sand near the Siva shrine.

After everyone circumambulates the temple, it is closed. The patient-devotees have lunch and then retire to their rooms for a rest. The temple reopens at 4pm and the patients and other worshipers return, circumambulating the temple and visiting shrines on their own.[17] After an hour or so *deeparadhana*, a worship involving waving lights in front of the deity, is performed in the central shrine. At 7pm another worship to Siva is done, and then the temple is closed after a procession where all the worshipers circumambulate the temple following an elephant.

A couple nights a week, after the main temple is closed, a ceremony which is very important for the possessed is held at the *kizhakke kavu*, the separate temple/shrine mentioned earlier that is east of the main temple complex. People begin gathering for this ceremony which is called *kuruthy* around 8pm. The *kizhakke kavu* is like a small temple compound. There is a roof, but no wall. The roof is held up by pillars and some metal

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[17] As mentioned in the introduction, this is one area where individualism coexists with socially dispersed self in Indian culture. In Hindu temple worship, one is allowed to visit the temples as one pleases, making the rounds and visiting the gods in the manner preferred by the individual worshiper. There is no congregational worship as in Christianity, Judaism and Islam, though some *poojas*, such as the one just described, are done for a crowd (but one can arrive and leave when one pleases).

lattice-work between the pillars. Basically, this temple is a large, canopied space containing a small shrine, a tree that is full of large nails, and a lot of open space in which the possessed, worshipers and onlookers gather and dance around. In the *kuruthy* ceremony, several temple drummers play drums while priests ladle blood-colored water onto the base of a small tree that is said to embody the goddess Kali. Possessed persons who are listening to the drumming allow the spirits to fall into them--or the spirits chose that moment to re-enter their possessee (whether spirits possess a person or a person allows the spirit to enter, which is prior, is uncertain as Boddy [1989] suggested) and they begin to move their heads, sway or dance about. The dancing ranges from hopping in place to cathartically thrashing around on the floor.

Rajan, who was possessed at Chottanikkara, says that possession begins with a "shock," feeling of surprise or sudden fright. Then one feels "depression" (Rajan used the English word) followed by a sense of weightlessness and tiredness after which "It will shake the whole body, your head will thrash about completely." Rajan explains that one loses complete control over the body and consciousness, though one retains some awareness--about "10 percent" he specified--of what is going on.

Those who dance about are overwhelmingly women. Men who become possessed generally move a lot less, but some will dance just like the women. A number of studies in various cultural settings reveal that women more often become possessed--or at least act out and make their possession more visible when possessed (see Ong 1987 on factory women in Malaysia; Boddy 1989 on the Hofriyati in Sudan; Skultans 1991 on Maharashtra, India; Pandolfi 1993 on southern Italy). There are few satisfying

explanations as to why this is so. Many seem to gravitate around the credible explanation of possession as a form of protest or cathartic acting out against woman's subordinated position in society, but a more detailed explanation of differentiation of gendered experience around possession would be useful.

In the *kizhakke kavu* ceremony, the participants are appealing to Kali, an incarnation of god in a fierce form. Kali is sometimes wrongly interpreted as wicked or evil. Instead, she is an aggressive deity that is on the side of the good. She is tough, but she uses her power to protect people. Thus the possessed call on Kali to come down and (wo)manhandle their spirits, to scare them and expel them from their bodies.[18]

My assistant Biju asked the possessed Rajan "How does it change?", using a Malayalam idiom "change" for what happens to an illness or problem. In this case Biju meant something like "what happens next?" or "how does it end?" when one becomes possessed at the *kizhakke kavu*. Rajan said: "It changes 'automatically.' After a while, we will collapse, we will fall down. [...] We will be tired 10 minutes then become fresh again." This describes the end of the possession at *kizhakke kavu*. Rajan then explained how, ultimately, after all the worship at the main temple and the *kizhakke kavu*, the spirits are permanently driven from the body:

> That itself [doing the *poojas* at the temple and chanting the names of the gods] will make us "pure automatically." Then when the body gets "purified," the "spirit" inside the body will "spread" and come outside "automatically." Then they cannot survive outside. When we pray like this, they cannot withstand it. Then, what happens is, one way or another, they will have to leave.

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[18] Sometimes this role is performed in cases of possession by the tough male protector god, Hanuman (Freed and Freed 1964).

This is what happens if all goes well following the regular routine of worship. In some cases, where spirits are more intractable, a spirit will demand that a nail to be pounded into the a certain tree at the *kizhakke kavu* (not the one that the priests pour blood-colored water on) before they leave. The spirit will speak through the person it is possessing and specify the length of the nail that should be pounded into the tree. The afflicted person is then taken to the tree and a nail of the specified length is positioned with the patient holding the flat end of the nail to his or her forehead. Symbolically, the nail is pounded into the tree with the forehead. In practice, the nail is placed with the forehead and then pounded in with a coconut.

Interestingly, many people, especially the educated middle class and some allopathic doctors I spoke to, have exotic ideas about what goes on at this temple. It is believed that there is an "inhumane", "barbaric" practice of "forcing" patients to pound nails into the tree, all the way, until their foreheads are bleeding. Similarly, some allopathic and ayurvedic doctors believed that the treatment at Beemapalli mosque was "barbaric," and claimed that mentally ill people are whipped and flogged to get the spirits to leave their bodies. I neither saw nor heard any evidence of such beatings in my observations of practices and interviews with ill people at Beemapalli. When I asked some doctors who expressed these opinions whether they had visited Beemapalli or Chottanikkara, I learned that they had not. In fact, I should point out that the most painful and violent practice that I could confirm at any of the various treatment centers I visited in Kerala was electro-convulsive therapy (ECT), which is used at the allopathic hospitals. Many patients who were seeking ayurvedic or religious therapies after having

discontinued allopathy said that one of the reasons for changing therapies was that they didn't like ECT.

Dr. Krishna Iyer, an allopathic physician who lives near, and has had many social and official connections to, Chottanikkara, explained to us that he thinks the temple is an effective place for healing because it engages all the senses: ie beautiful setting (sight), music (sound), flowers (smell), sandalwood paste (touch), stuff burning, prasad (taste). This importance of the aesthetic engagement in healing is also emphasized by anthropologists Desjarlais (1992) and Laderman and Roseman (1996). This pleasant, sensual setting can be seen as part of the therapy. This is especially so for chronic patients, whose problems continue for several years, though they feel some relief or inspiration from the pleasantness, and religious character, of a religious setting. Chapter 6 will discuss patient complaints about unpleasant treatment procedures such as ECT, and examine cases of patients who have chosen to live in a "pleasant," or, more accurately, an aesthetically- and spiritually-engaging, environment at Chottanikkara temple, Beemapalli mosque and Vettucaud church.

There are many other temples in Kerala where one can go to seek relief from possession or psychopathology, though Chottanikkara is the only temple that has a specific, elaborated and well-known program for people with these problems. Many people in Kerala go to neighborhood or local temples to pray for relief from any kind of problem: for example, a relative who has cancer, a financial crisis, infertility or psychological problems. At these temples, people do more or less the same thing for any kind of problem: *poojas* (prayers, rituals) are performed, such as a simple and

inexpensive flower offering or the more elaborate *ganapathy homam* (rituals done for the incarnation of Vishnu called Ganesh, who is known as "the remover of obstacles"). Though these temples that do not specialize in healing illness, some have practices reminiscent of Chottanikkara. For example, there is a small temple in the neighborhood where I lived in Trivandrum that once a year held a ceremony where people afflicted with possession pounded nails into a tree as they do at Chottanikkara. At this temple, the priest also becomes possessed by the goddess (Amma, Devi) and advises people about how to overcome their illnesses or other troubles. Whether one goes to a local temple or to Chottanikkara depends on the severity of the problem and how much time and money one is able to expend. The temple in my neighborhood was patronized by working-class and poor people who could not afford to travel to and pay for lodging at Chottanikkara. Visiting Chottanikkara is affordable for most families in Kerala, and on occasion one would find extremely poor people staying at the temple and living on handouts.

Beemapalli Mosque: Where Umma Is Buried

Beemapalli is a Muslim mosque located in the city of Trivandrum in southern Kerala in an oceanside Muslim neighborhood of the same name. Beemapalli is a large, Arabic-Mughal-style mosque. The current building, which was built in 1962, is about 80 yards long, with minarets that peak at around 80 feet, and it is surrounded by acres of open, sandy grounds where devotees, merchants and many goats mill about. (Figure 3 shows Beemapalli mosque viewed from the mosque grounds.) Before the current structure, there was a much smaller mosque at the same site for about 300 years,

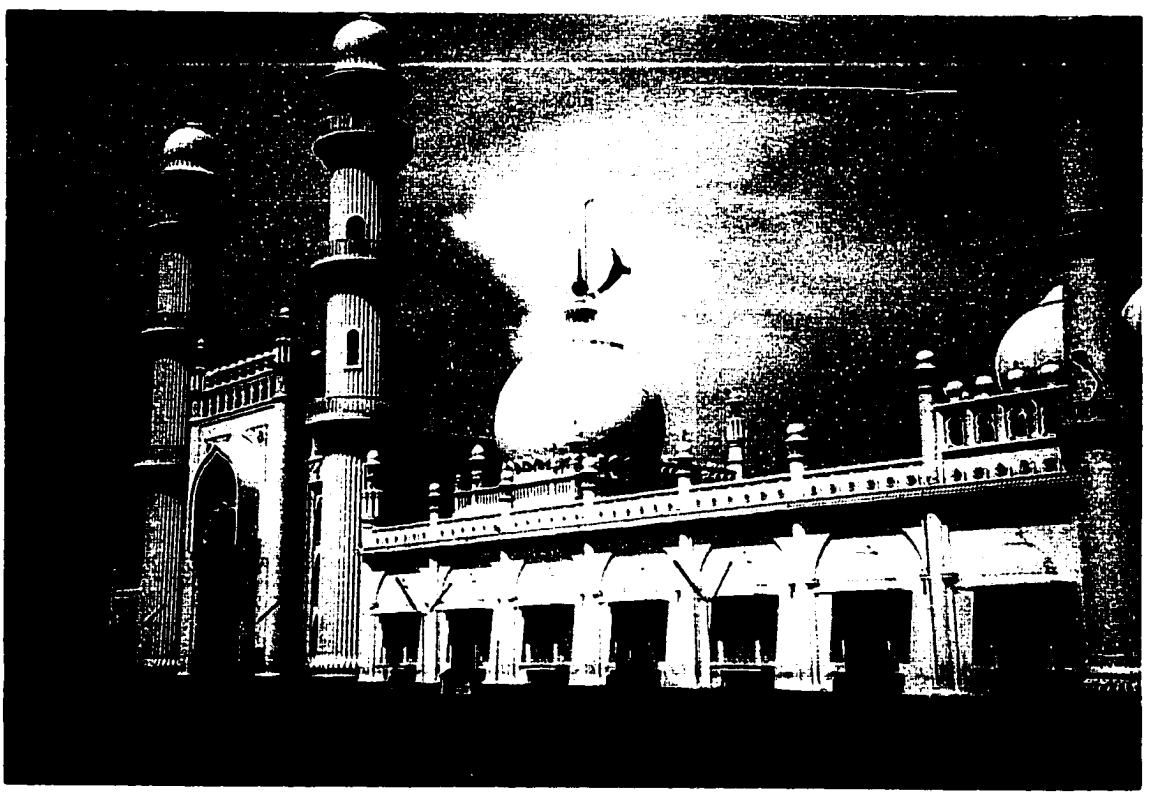

Figure 3 - Beemapalli Mosque

according to one estimate.

At the perimeter of the grounds are lodgings for people who, along with their families, are visiting the mosque to find relief from illness. In the open sandy area at the back of the mosque under the shade of a large tree is a metal post to which extremely agitated or violent mental patients are sometimes chained (one person at a time is attached by chain with one end around their ankle and the other around the post). Fifty yards from the tree is a row of six cells in which violent or agitated possessed or mentally ill people are incarcerated and attended by a close relative. The interior of the mosque contains a room for the daily prayers of male Muslims, usually men from the local community that are attending for routine worship and not for any illness problem. The mosque also contains a larger room where women and people of other faiths worship. This larger room can hold hundreds of people, and it is oriented around an area that contains the two coffins behind a glass wall and retractable curtains.

The story of the origin of the mosque as told by Secretary Maheen, a long-term devotee and the director of the mosque when I was doing research there in 1997, centers around the two people who are interred in these coffins: Umma and her son. Ummachi (the honorific version of her name and the only proper way to refer to her) was a Mother Teresa-like figure who came from somewhere on the Arabian peninsula hundreds of years ago to Kerala to help the poor and the ill. She travelled around regions that are now part of Kerala state and when she passed away she was buried in Trivandrum. The original Beemapalli mosque was then built at the site of her grave.

Ummachi may have chose to come to Kerala since the region may have been

well-known in the Gulf and Levant Arab regions during her time. Unlike north Indian Muslims who converted to Islam through the influence or coercion of settlers and invaders who came overland to India from the northwest (through the area that is now Pakistan, Afghanistan and Iran), Muslims in Kerala were exposed to Islam through relationships and intermarriage with Arab traders who came by sea from the Levant/Middle East (Mohammed Koya 1983).

As was the case at Chottanikkara temple, I was told that devotees and people suffering illness at Beemapalli come from all over India, though I found that about ninety percent of patients came from Kerala, usually areas near Trivandrum, and most non-Malayalis come from the neighboring state of Tamil Nadu. Most of the people at Beemapalli are Muslims who have come for prayers, but there is also a large number of visitors who come to the mosque to resolve a variety of illness problems from heart disease to infertility to psychopathology. The total number of ill people at Beemapalli at any one time is around 150 to 200, of which the possessed and sufferers of mental distress number 30 or so.

I was struck, but not completely surprised, when Secretary Maheen told me that a majority of the non-mental patients at Beemapalli are Muslim but most mentally ill/possessed people at the mosque are Hindu. Among the patient-devotees that my research assistants and I randomly selected for interviews at Beemapalli, 8 were Muslim, 7 were Hindu and 2 were Christian. This kind of syncretism and malleability is something I had seen and read about in other research on India (e.g., Pfleiderer 1988). It was intriguing to hear a Hindu mother who had been living for years at Beemapalli

mosque with her possessed daughter explain, gesturing towards the heavens with the mosque in the background, that her daughter will find relief when Amma--the female, Hindu incarnation of God described in the section on Chottanikkara temple--wills it. It will also be noted in the section below on Vettucaud church that Hindus sometimes show up to pray at this well-known Catholic church. I am also reminded of a woman I know in Trivandrum who prays at a Hindu temple on weekdays and at Beemapalli mosque on weekends, and sings Christian hymns while she works.

Therapy at Beemapalli consists mainly of praying, eating jasmine flowers and drinking water that comes from an underground source at the mosque and is said to be medicinal. Other rituals are performed, such as reading incantations and tieing talismans around the wrist, but relief is sought chiefly through prayer for assistance from Umma and/or Allah/Amma. Many possessed people at Beemapalli wander around the mosque grounds and pray as they wish. Unlike at Chottanikkara there is no lengthy, daily regimented program, but I did once see a female mental patient/possessed person dancing about, much like the possessed at Chottanikkara do, in the middle of the large main mosque room facing/orienting herself towards the "alter" at the focal point of the interior of the mosque, towards where the sarcophagi of Umma and her son are. In general, though, there is much less acting out in public among the possessed at Beemapalli compared to those at Chottanikkara.

When I asked patients when they thought they would get over their problems, many answered that it is up to Amma (it is unclear whether Amma, meaning mother and God, refers to Umma or the absolute divinity or both). Many patients and their families

pray and wait to see a dream in which Umma or some symbol in the dream tells them they are going to get well. The wife of a Muslim man with psychological problems who was seeking relief at Beemapalli said that her husband will recover soon because:

> Umma showed us in a dream. [...] We will dream about it and in the dream we will be given medicines, "operation" and all. If we dream that we are going home, we can go home. We dreamt of being here until the flag hoisting [a festival at the mosque that was a few months away]. So after that we can go.

The references to medicines and an operation may be metaphors (or metonyms if one accepts Daniel [1984] and Ramanujan's [1989] theories about representation in India) regarding the healing they will go through at Beemapalli. The wife soon after referred to the jasmine flowers they eat at the mosque as a medicine.

People drink and bathe in the water from the underground source at the mosque which is said to improve one's health. A member of the mosque board of directors explained that scientists once took samples of the water at Beemapalli, analyzed it at a lab and found it to have curative properties. Similar attempts to scientifically explain techniques of healing were offered to me at Chottanikkara temple. For example, it was explained to me that a large tree that devotees circumambulate at Chottanikkara has chemical properties which ionize the surrounding air, invoking a peaceful state in devotees.

The annual festival at Beemapalli, called Urus, is the most important event of the year at Beemapalli (the mosque is an important site for Muslim festivals in general, such as Ramadan), and this is an important time for patients as well. During Urus, which lasts about a week, thousands of visitors come to Beemapalli to pray and to shop and socialize among the dozens of merchants and attend concerts and other events. The patients at the

mosque and others who are seeking solutions to life problems walk around the mosque several times with a *chandanakudam* pot (a name for the pot based on the word for sandlewood, *chandanadi*, this word is also used to refer to this ritual as a whole) on their head, after which they enter the mosque and offer the pot at the grave of Ummachi. The pots are filled with incense and coins in small denominations. The top of the pot is covered with paper and tied with a string of flowers.

A woman who was at Beemapalli with her possessed son said she believed that all of the patients were a little worse off, a little more symptomatic or agitated after doing the *chandanakudam* pot offering at the festival, but she felt this was a temporary decline which was necessary to get over the problem in the long run.

Off to the side of the main building but within the mosque's grounds is a small building where people receive prayers and talismans. I rarely saw this facility used, however, and none of the ill people I spoke to or their relatives mentioned this area in describing their healing and worship experiences. On one occasion, however, I did see an agitated man who appeared to be possessed standing in front of this small building with tensed muscles, occasionally shouting, while a priest was praying over him. Eventually the priest tied a cord around the man's upper arm. This appeared to calm him somewhat. He then walked out into the sandy area of the mosque grounds, and a crowd assembled as he began shouting again--this time more intelligibly--about money and how it controls people's lives today. This is the only time I saw anyone do this ritual, and the public at the mosque seemed to find it unique and worthy of attention. I never got the opportunity to speak to this man, and he did not appear to be accompanied by anyone.

Vettucaud Church

Just a few miles up the coast from Beemapalli mosque are the Christian neighborhoods Vettucaud and Veli. A number of churches and other Christian institutions are located in this area, the most famous being the Catholic Madre de Deus Church. Popularly known simply as "Vettucaud Church," it is one of the most important and auspicious churches in southern Kerala, and it is known as a place where the seriously ill have found relief from their problems. As a Catholic church, Vettucaud is the result of a second wave of Christianity that came to Kerala along with European colonialism. According to many Kerala Christians, Christianity first arrived in Kerala in 52 A.D. and was brought from the Holy Land by St. Thomas and some of his followers. At the time when many apostles were spreading the word of Christianity to Rome/Europe, St. Thomas is alleged to have headed East following the monsoon winds, possibly with the motivation of informing the Jewish population that was living in (what is today) Kerala at the time that the Messiah had come.[19] The noted Malayali historian A. Sreedhara Menon (1990: 34-37) reveals that there is nothing in the historical record to confirm whether Thomas himself came to Kerala, but someone brought Christianity to the area somewhere around 2,000 years ago. These original Christians are known as "Syrian Christians" as their faith developed through contact with the Persian church and Syrian immigrants who introduced a Syriac liturgy to the Kerala church. A second wave of Christianity arrived in the 16th century with the Portuguese. Rather than being

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[19] This is the version of history presented at the synagogue in Cochin, Kerala. The Jewish population in the state has dwindled to below 100 members since the state of Israel was founded and the Kerala Jews emigrated.

pleasantly surprised that Christianity was already widely practiced in Kerala, Portuguese missionaries and soldiers used coercion and violence to convert what they saw as heretical Christians to Catholicism. Millions of Malayali Christians today practice either the Syrian Christian or the Catholic faith--and there is a growing number of Pentacostal Christians.

George Mathew, a professor of psychology at the University of Kerala who comes from a Malayali Christian family and who was raised in Trivandrum, recalled some of the history of Vettucaud church for me. He explained that churches in the Vettucaud area were first established by the Portuguese about 200 years ago. Vettucaud church was used for many years for exorcisms, though the Portuguese tried unsuccessfully to stop what they saw as this unholy practice. Cases of possession, however, more recently declined at Vettucaud (for reasons that will be explored in Chapter 7). George Mathew and one of his brothers recalled seeing possessed people at Vettucaud when they were growing up (i.e., about 40 or 50 years ago). Today, a number of people with chronic illness problems visit the church or reside in a shed on the church grounds, but possessed people are rarely seen at Vettucaud. Ill people at Vettucaud seek relief from their troubles mainly through prayer, and some receive counseling from the priest of the church or a sister in the nearby Mystical Rose Convent. Sometimes simply residing in the holy, auspicious surroundings of the church makes many of these afflicted persons either find relief or feel able to live with their problems. Like Chottanikkara temple and Beemapalli mosque, Vettucaud church is a beautiful and aesthetically engaging setting. It has the additional feature of being located right on a very large,

beautiful, clean beach. (Figure 4 is a view of Vettucaud church from the beach.)

Prayer, the principle means of seeking relief for one's problems, is done on a regular basis on one's own or at organized services or special events. The first Friday of every month is a special day at Vettucaud church. Over the course of the day, hundreds of people come queue up to touch the feet of the statue of Christ outside the church and visit the shrines inside the church. Many Hindus can be seen among the Christians who file past the statue of Christ on the First Friday ceremony, but all the patient-devotees I met at Vettucaud were Christian.

Interestingly, this church seemed to be one of the only healing centers I encountered that emphasized talk therapy. People did not often go to the priest or the nun at the neighboring convent for counseling, but the method of counseling as it was described to me by the priest and the sister seemed closest to western psychotherapy of all the forms of healing I saw in Kerala (except for a few clinical psychologists I encountered). This kind of therapy involved the belief that talking out one's problems can heal, tried to get at issues inside the psyche of the individual, and treated the patient as an autonomous person. Father Hyacinth, the priest at Vettucaud who gives counseling explained his approach:

> This [referring to a Biblical story he'd just related in which Jesus leads a Samaritan woman to discover her sins] is also a therapy: when we begin to talk to the person, accepting whatever they say. If you are going to argue with them, and they know that what they are saying is not correct, you spoil the situation. So rather, when I begin to accept you, you feel that you are happy.

It was at this point in this interview that the issues I am writing about here occurred to me. I told Father Hyacinth that was he was saying was reminiscent of certain principles

Figure 4 - Vettucaud Church

of psychotherapeutic encounters such as being nonjudgmental and not giving advice, and he seemed to concur:

> Accept the story, and from the story, guide them where they have gone wrong or where they have been cheated. Place the blame on somebody else, and then bring them to a position where they begin to accept their status. After that, you can correct them. Before that, if you correct them they will not get corrected.

This contrasts with the examples given earlier from ayurvedic consultations wherein the psychiatrists gave *advice* to their patients and *taught* them what was wrong with their views. This calls to mind Suzanne Kirschner's (1996)study which traces a genealogical relationship between classical Christian and modern psychotherapeutic ways of knowing the self, and makes me wonder whether the emphasis on individualism and autonomy is more accurately characterized as Christian than western.

About a half mile away from the church and the convent and within a stone's throw of the runway of the Trivandrum airport is the Divy Shanti ashram, a charitable institution for the poor that is run by the Vettucaud church organization. Divy Shanti offers food, lodging and prayer services for indigent and ill people. My assistant Kavitha and I interviewed a man with family problems who was staying there. Divy Shanti is not an explicitly "therapeutic" institution, but people with problems appreciate having a place to stay and eat and find solace in prayer and singing sessions.

Other Therapies

The forms of healing I have described could be elaborated on for many more pages, but though these are the three most popular therapies in Kerala they constitute only a small portion of the variety of healing options for mental suffering, spirit

possession and related problems that are available. Before concluding this chapter, it would be appropriate to provide a brief overview of some of the other options for coping with illness and distress in Kerala.

When coping with psychological or possession problems many people visit astrologers. Astrology is not an explicitly therapeutic discipline, but they can help one discover the source of a problem, which could conceivably help the distressed person at some existential level. For example, a person may learn that their difficulties are due to being born under a bad sign or *dosha*. After learning of the astrological explanation, an ill person will usually seek relief at some hospital, temple or other setting, and astrologers often act as a referral service to help the sufferer find an appropriate form of treatment. They may suggest that their client go to the hospital or perhaps see a *mantravadan*.

A *mantravadan* is a person who performs *mantravadam*, which is usually translated as "sorcery" or "black magic." If a person's problems are believed to be due to someone having done sorcery against the afflicted person or their family, a *mantravadan*'s assistance if often sought to remove the effects of sorcery. In Malappuram district in northern Kerala where the Government Ayurveda Mental Hospital is located, Muslim priests, called *thangals* perform many of the roles that *mantravadans* perform in other areas. Also in Malappuram district, there is a famous family of ayurvedic healers--mentioned in the ayurvedic psychiatry section, above-- who supplement their ayurvedic therapy with *mantravadam* to treat their clients. Many patients I interviewed had used *mantravadam* in the past, but almost no one found it very useful. Sometimes they felt some relief after *mantravadam*, but the problem almost

inevitably came back. Of course, this view of *mantravadam* may be due to the fact that I did not choose a *mantravadan*'s practice as a research site, and I was only seeing people who went on to other therapies after *mantravadam* failed.

A popular healing center for people with medical, psychological or life problems is a relatively new Christian charismatic retreat in Thrissur District, central Kerala, called Divine Retreat Centre and popularly known as "Potta." The Divine Retreat Centre is somewhat like a small, gated city, with lodging facilities, restaurants, allopathic medical services and a huge prayer amphitheater. At any time, there are around 10,000 residents at the Centre. These people come to stay for a week, or more, of prayer and healing. There is another, separate church and prayer ground for people who wish to come pray only for the day. One worker at Potta estimated that 30% of their patrons are "mental patients" or people with drug and alcohol problems. Others come for all kinds of life crises or medical conditions. Relief is sought through collective prayer sessions and listening to sermons. No patients I interviewed had visited Potta, though the parents of Mary, a woman I interviewed at the Government Ayurveda Mental Hospital who will be introduced in the next chapter, had been to Potta to pray for their daughter.

There are a number of other temples, mosques and churches that heal possessed people, though they are less well-known than Chottanikkara and Beemapalli. Also, many local neighborhood temples have patrons who regularly come to appeal for divine help with their afflictions, and some occasionally offer healing rituals somewhat like those at Chottanikkara. There are also a number of self-appointed healers--some of them "faith healers"--around the state who have invented some healing philosophy or claimed some

divine connection. These people usually work out of their homes, or they have founded an ashram and have a small group of followers. For example, when we meet Rajendran in the next chapter we will hear that he was hypnotized and given medicine by Kappal Makkan, a Christian pastor/priest who is said to have training in psychiatry.

People suffering mental distress on rare occasions visit doctors of homeopathy, a medicine from Germany that is popular in Kerala. Others utilize naturopathy, a medicine that was developed in California in the 19th century and, in its Indian version is influenced by Gandhian thought. Naturopathy claims to be able to resolve all mental and physical problems through a proper diet of natural, uncooked foods. There are also indigenous medicines other than ayurveda, such as South India's Siddha medicine and "tribal medicines" of the aboriginal people who live in the mountains of Kerala, that are reputed to have methods of treating all forms of illness, though I did not encounter patients who had used these therapies.

Even my research assistant Benny opened a treatment center, Thanal Institute for Psychological Services, during the end of my fieldwork in 1997. Benny's clinic combines practices and philosophies from clinical psychology, naturopathy, yoga and Christian philosophy.

This chapter provides some overview, or perhaps more accurately, a gaze at the daunting complexity of the world of healing in Kerala. There is of course a lot more that could be said--an entire dissertation could be written on the methods of any one of these systems of healing--but this chapter should provide some useful context for later, more

analytical chapters while also providing a view of the range of issues in the world of health and healing in Kerala that are not covered in this study. The following chapter has much the same intention as this one. I will present the stories of selected patient-informants to provide context that relates to issues of health and healing but also ventures out into features of daily life and culture in Kerala.

Chapter 4 - Introducing the Patient-Informants

Like the previous chapter, this chapter is mainly ethnographic and provides the context to help understand the following, more analytical, chapters. The analytical chapters are intended to make this research relevant to academic readers, to sell my story to my main audience, although this "spin" amounts to what Crapanzano (1986) might call masking a subversive reality, editing out or avoiding issues that don't fit--and therefore may be challenging to--anthropological theory. While getting to know the world of health and illness in Kerala during fieldwork, cramming information about this world into anthropological theory seemed like doing violence to the complex reality of life in Kerala. The breadth of issues I ran into during my research cannot be conveyed in an academic study, but with the patient narratives as the axis around which this chapter turns, a wider view of Kerala culture should appear. Of course, as postmodern sensibilities remind one, this ethnographic description is not pure and unadulterated, but at least it tries to say something about the world of health, illness, and everyday life in Kerala rather than embodiment, medical pluralism or other intriguing anthropological topics.

In trying to keep the informant's worlds and issues of health and healing in Kerala in the foreground of this chapter, I will present excerpts from interviews in the order in which they occur in the original. I will indicate issues that arise in other chapters and make comments on issues in Kerala culture that arise, but I will not splice together

quotations extemporaneously to fit into themes. For this reason not all transitions between topics will seem smooth.

At the end of this chapter, I will review and summarize the themes that arise most often in relating the stories of these informants, key issues about Kerala culture and features that underlie other sections of this study that the reader should carry away from this chapter. I put this summary at the end rather than here in order not to bias the reading of this material towards these issues, and, again, to foreground the narratives of illness and emphasize the diversity of issues involved in shaping an illness experience.

Two patient-informants from each of the three forms of healing that are the focus of this study are presented in this chapter. First, two patients of ayurvedic psychiatry are presented, followed by two patients of allopathic psychiatry and two patients who were using religious therapies. Patient-informants were also selected to represent a variety of features of my informant sample, such as age, religion, gender, inpatient or outpatient status, socioeconomic situation and other characteristics. In addition, I tried to include interviews that were particularly rich and detailed, contained a variety of perspectives (such as where patients and multiple family members are interviewed), and had a follow-up interview. Of course, not all these features could be represented in all, or even most, cases. The fact that both ayurvedic patients are female, for example, is not indicative of the nature of ayurveda but rather an artefact of trying to make sure that Muslims, Christians, good informants, and others are included in this chapter. The interviews presented are chosen from among the 38 patient-informant interviews for which I have full, verbatim transcripts. (These included all unstructured interviews and the structured

interviews that were recorded on tape.)

When I present an informant, I am relating the story of the person suffering distress and his/her caretaker(s), who accompanies the suffering person during therapy and who often does most of the speaking. Thus "informant" often refers to this therapy-seeking group. This is the manner in which patients presented themselves to therapists and to myself and my assistants for interviews. I was immediately tempted to try to interview the ill person alone, separately from his/her caretaker, to get--so I thought--the "authentic experience" of the person suffering the problem. But such a move would amount to editing out culture: for example, ignoring the sociocentric or contiguous self (see Introduction) that is presented by sufferer and caretaker(s). I would be imposing a western assumption that the true self is found in the private realm, that it is more authentic at some interior level.[1]

The involvement of the family and the lack of privacy in the allopathic psychiatric setting has also been observed at hospitals in north India by Nunley (1998) who asserts that "[i]n India, then, most information psychiatrists have about their patients comes from members of patients' families." And, "[t]here is relatively little confidentiality in Indian psychiatry . . . A few psychiatrists provided therapeutic justifications for this lack of

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[1] Focussing too much on the interior, private--i.e., individual--self is likely to be problematic in western societies as well (given, for example, the work of Kusserow [1996, 1999] on the social connections of the self in the U.S.). Meanwhile, as will be seen in the following chapter and in the interview with Lakshmi in this chapter, Malayalis do have levels of interiority and are aware of them. Also, there are occasions where allopathic psychiatrists speak to patients alone. However, I will make the generalization that the self is more socially-embedded more of the time and that the self is more often represented in social context in Kerala.

privacy, but most of these seemed to me to have the flavor of post-hoc apologies for what is actually a culturally grounded status quo" (329).

At outpatient departments in allopathic healing centers, the patient usually sees the psychiatrist along with one close relative or friend who does much, sometimes most, of the talking. At ayurvedic and religious healing centers as well, ill people usually arrive with one or several family members. It was at Chottanikkara temple and Beemapalli mosque, however, that patients were accompanied by the greatest number of family members. When my assistant Biju and I were invited to interview a possessed person at Chottanikkara, we would often arrive at a *crowded* room at the temple lodge, and family members would do all of the talking for their afflicted relative. At any of these healing centers, there are some, but very few, patients who seek therapy on their own.

Generally, patients at any healing center who were receiving long-term care, or were inpatients, were attended by only one family member. It is normally difficult for many family members to take the time off work or school to stay with someone who is in long-term care, and space at inpatient facilities is often limited.

Biju, Kavitha and Benny

Before introducing the informants, I should introduce my research assistants, Biju, Kavitha and Benny, who ask most of the questions in the following interviews. Although I studied Malayalam, speaking this language in the vernacular was a struggle, especially at the beginning of my fieldwork, and thus I required the assistance of local,

native speakers of Malayalam to conduct interviews. Equally important to their assistance in translation, Biju, Kavitha, and Benny revealed aspects of the local culture and otherwise contextualized issues that arose in interviews and events we encountered in the course of this research. In fact, I learned as much about life in Kerala from chatting with my assistants on the bus or while waiting for an interview as I did from my "actual" research. Thus, both explicitly, and in many ways I am not aware of, Biju, Kavitha and Benny informed much of the insights and assertions about Kerala culture presented in this study--though, of course, the gaffes and the misreadings are all mine.

Biju is an easy-going yet enthusiastic man in his late twenties who lives and works and knows everyone in Trivandrum. Biju has a job as a clerk at an ayurvedic research institute though this narrowly defines who he is. He has, and continues to, explore various career options including graduate studies in psychology, civil service and, after working on this project with me, medical transcription. Biju has within his personality opposite characteristics strongly marked, which I think makes him appealing. He is very down-to-earth yet very philosophical and intellectual and interested in new and exotic experiences. He can seem very quiet and "dreamy" (mentally in his own world), yet warm and socially engaging. Put another way, his moments of quietness are not moments of shyness but manifestations of his extreme comfort with people. Biju's sociability is evidenced by his many friends and connections. As we circulated around Trivandrum, he seemed to know people in every corner of town, and he made this city of one million feel like a small village. Though he was interested in medicine and pursued a Masters degree in psychology for a while, I always thought he would end up becoming

mayor of Trivandrum. He is socially savvy but earnest, and often sought-after as a negotiator and mediator: friends frequently brought Biju along when they had to negotiate anything from a business deal to a marriage proposal.

Biju's empathetic and communicative instincts came out in interviews. Patients we spoke to quickly opened up to Biju. Sometimes our interviews even seemed therapeutic. A few patient-informants became friends of Biju, and at their request he met with some of them alone and informally (i.e., not as part of this research project) since they felt they benefitted from talking to him. Biju was very enthusiastic about his involvement in my fieldwork, and he has a great interest in psychological issues and in healing. Although he was also tempted by a career as a clinical psychologist, Biju has discontinued this option, at least for now.

When I saw Biju on my return to Kerala 1999, he had begun working as a medical transcriptionist. Some U.S. insurance companies are now sending recorded medical histories, via the internet, to India where they are transcribed. Biju was able to get a job transcribing for one of these companies partly because of his experience transcribing and translating interviews for my fieldwork. These companies save money by paying workers in India much less than they would have to pay in the U.S., but at the same time these transcriptionist jobs pay well relative to other local salaries. Biju is optimistic that he can do well financially through this work, but he is aware that it can be demanding and tedious to transcribe for eight hours a day.

Kavitha is equally easy-going and enjoyable to be around although not quite as outgoing as Biju. Having recently finished her Masters thesis in psychology on stress

among wives of Malayali men who work in the Persian Gulf (discussed later in this chapter), Kavitha was beginning work on her M.Phil. in psychology at the same time that she was assisting me in my research. At first, she struck me as a polite, earnest listener who didn't offer much information about herself, but this original deference was undoubtably partly related to gender relations in Kerala. Women are often initially deferential in conversation with men, especially in a work relationship. Also, working with a foreign male while a community wherein everyone seemed to know someone you knew looked on brought additional uncertainties that Kavitha had to test and wait out. Slowly I got to know Kavitha well and felt very rewarded by the experience. Behind her quiet and easy-going manner is a tough, strongly-motivated person who is willing to stand up for her convictions. Very few graduate students in India take up jobs while doing their studies, and Kavitha was motivated to pursue the opportunity to work with me more out of curiosity than financial need when she heard through my contacts that I was looking for an assistant.

Kavitha was also great in interviews with people who were suffering distress. Patient-informants felt at-ease and often opened up to her. She knew exactly how and for how long to listen. She was very calm, soft-spoken and never rushed in interviews. Ultimately, I think informants sensed that she was sincere in wanting to know their story, and, as with Biju, people often found talking to Kavitha to be therapeutic.

As I was leaving Kerala in early 1998, Kavitha was beginning her M.Phil. research on suicide, a topic she developed interest in while we were doing our interviews. This is a significant issue as Kerala has the highest suicide rate in India; yet Kavitha is

one of the few people--in addition to myself--to examine this topic in detail.

When I returned to Kerala in 1999, Kavitha was working as a counselor at a drug and alcohol deaddiction and family counseling center, but she wasn't completely happy at this job since the center had very few clients and she had to get through many days with little work to do. Shortly after I left Kerala in 1999, Kavitha left this job and started looking for a counseling position that will allow her to help more people. While many psychology graduates in Kerala decide to pursue more profitable jobs outside of their field of specialization (when they realize it's hard to find satisfying, well-paying work in psychology), it is admirable that Kavitha remains devoted to a career as a counselor and a healer.

I met Benny through my friend, Dr. John Baby, a psychology professor at the University of Calicut in northern Kerala who is devoted to naturopathic healing, the therapy system mentioned in the last chapter that emphasizes a diet of uncooked foods. At the time, Benny was a graduate student in Dr. Baby's department, and he was working part-time as a counselor in an allopathic hospital near Calicut. Benny assisted me with interviewing patients at the Government Ayurveda Mental Hospital, and like Biju and Kavitha, and indeed many people in Kerala, Benny was good with people and engaging in interviews. However, while Biju and Kavitha were easy-going and down-to-earth, Benny was more outgoing and assertive and moved at a fast pace. He had a personality that would flourish in the U.S. Energetic and confident, he showed the signs of someone who would be the leader of some organization or at least his own boss. Sure enough, toward the end of my fieldwork in 1997, Benny suspended his studies in psychology and

opened his own healing center that combined aspects of western psychology, ayurveda, yoga, naturopathy and other disciplines of healing.

Benny was a little more insistent, but gently so, in getting people to talk about their problems. Witness the quicker pace, and shorter exchanges in Benny's interview with Mary compared to the exchanges between Biju and Kavitha and their interviewees. To generalize, Benny seemed to lead the interview, while Biju and Kavitha seemed to get the patient to lead the interview.

When I left Kerala at the beginning of 1998, Benny had almost finished building his clinic which he called Thanal Institute for Psychological Services and which was located in Kaladi, central Kerala, near his home town. On returning in 1999, I found Thanal to be doing a brisk business and Benny quite busy. Benny, his psychologist-assistant and nurses had a combined caseload of around 10 patients at any one time. He reported to me that he had great success in healing people and that he had even given relief to patients that had unsuccessfully sought treatment at the famous National Institute for Mental Health and Neurological Sciences hospital in Bangalore, Karnataka (a neighboring state to Kerala).

All of my assistants had training in western-style psychology, and I wondered to what degree this might bias our interviews and the way we interpreted informants' problems. All three assistants, however, were open-minded toward the perspectives of other healing systems. In fact, they were all referred to me by friends and contacts whom I got to know because of their interest in diverse forms of healing. Still, there was a tendency in our early interviews to look for a patient's "depressive" or "schizophrenic"

"symptoms." However, when I explicitly told my assistants that we should try to drop our allopathic and psychological assumptions, not let our interviewees know if we preferred one therapy over another, and generally be aware of our biases, they did not have too much trouble easing up on their psychologists' perspectives and reducing their allopathic psychiatric terminology. Of course, biases surely remained in ways we were not aware of, but they were not all related to psychological assumptions. My assistants' open-mindedness at times led to something like an overcompensation. Each to varying degrees, they looked critically and skeptically at allopathic psychiatry, and sometimes they celebrated other forms of healing. Biju, for example, became a strong enthusiast for the rituals of healing at Chottanikkara and was often asking if we could fit in just one more trip to the temple. I wondered to what degree Biju, Kavitha and Benny were "natural anthropologists," growing up in a society with diverse forms of healing, aware of multiple perspectives about illness, perhaps realizing that they must all be constructed and have their own histories and biases.

Sreedevi and Her Mother - The Melancholic Daughter Who Wants to Marry

A 22 year old woman I'll call Sreedevi was accompanied by her mother when Biju and I interviewed her in the office of the ayurvedic psychiatrist they were consulting. (The psychiatrist was not present during the interview.) Sreedevi's problems included stomach pains, episodes of *bahalam* (agitation or tumult), loss of energy and a decline of interest in her studies.

We interviewed Sreedevi and her mother using structured interview questions,

which focus on the history of the illness and therapy-seeking, reactions to different therapies, opinions about the cause of illness, and future plans to get over the illness (questions are listed in Appendix A), and we asked additional questions that came to mind as the interview progressed. In our first interview, in January 1997, Sreedevi was quiet and melancholic, and her mother spoke for her almost the entire time. In her first attempt to describe Sreedevi's problems, her mother explained:

> She is not eating, and she has started crying. And when sleeping, she'll suddenly wake up complaining of stomach pain. She shows *bahalam* [agitation/tumult]. There is a doctor near our home. We took her to see her. That doctor had done "psychiatry training." So the doctor said this is a problem. She prescribed some pills and all for my daughter. That's how it first began. It was a year ago. I did it that way because the doctor said to.
> Biju: Is this problem your biggest worry, or do you have any other illness?
> Mother: What's most bothersome now: she'll cry now and then. There is *dukham* [grief]. This studious girl is no longer interested in studies.

Sreedevi is described as sad, having stomach pain and exhibiting *bahalam*, which refers to agitated, tumultuous behavior or outbursts; for example, shouting and striking things, or "throwing a fit." Sreedevi also lost interest in her studies. She had finished her Secondary School Leaving Certificate (SSLC), which one achieve after one's tenth year of schooling. She began working on her Pre-Degree Certificate (PDC - a prerequisite to enter a university) in commerce, but as her illness developed she discontinued her studies. At the time of our interview, she training to be certified as a typist, a less prestigious degree. Sreedevi's mother is a school teacher, which may explain why Sreedevi went as far as she did with her education[2] and why her mother is distressed

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[2] Approximately 15% of people in Kerala pass SSLC, [and this is one of the highest rates in India] (National Family Health Survey-Kerala 1995:33, 189).

about her loss of interest in studies. However, in Kerala there is a great overall concern about education and pressure to achieve in school, as will be seen in some interviews below. Kerala's literacy rate is around 90% and the highest average number of years of schooling per capita of any Indian state (National Family Health Survey-India 1995:53). Informants often spent a great amount of time detailing their successes or failures in qualifying exams for college or college achievement.

We then enquired about some of the therapy-seeking history for Sreedevi's problem:

> Mother: For the first treatment, we consulted for stomach pain. So that doctor is a specialist in this area. Because of that she gave this medicine. Then after seeing her [Sreedevi] continue like this, we started consulting another doctor. That doctor "referred" us to a psychiatrist, a "senior" psychiatrist. We went to his house at Medical College [a part of the city near the allopathic Medical College], though he's not connected to Medical College. He gave treatment right in his home. She was taking a pill called "Hexidol."[3] It was going on like this [she was just carrying on with treatment and things were uneventful] until finally she asked the doctor, "Will I be able to get married?" So the doctor said, "Yes, you can marry." The doctor said, "You should inform the proposed family/husband when you get married."
> Biju: Now are you using a different treatment?
> Mother: Afterwards, she had the problem again.
> Biju: Why did you change treatments? Why did you change to ayurveda?
> Mother: Well, it was a few days ago that we "discontinued." After that, again... Then finally we didn't see the doctor for several days. Then it was ayurveda. Ayurveda is a good treatment. This way, there is a treatment in ayurveda. But if it's the other one [allopathy], there are some "side effects." Since there is a mental worry/sadness [*manasikamaittulla vishamam*], we have been coming here.
> Biju: Who told you about ayurvedic treatment?

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[3] The drug names the informants indicate are brand names, not the chemical names. The same psychiatric drugs that are available in the U.S. are made by Indian pharmaceutical companies and are marketed under brand names different from those in the U.S. Hexidol, which Sreedevi's mother mentions here, is the brand name of a commonly prescribed anti-psychotic. It is a combination of haloperidol and benzhexol hydrocholoride.

Mother: I read about this treatment in the paper and brought her here.
Biju: Are you doing the previous and current treatments at the same time?
Mother: No. They are still giving a pill called "Hexidol."
Biju: Did you have the same symptoms during the previous treatment?
Mother: Yes.[4]
Biju: The previous doctor and the current doctor. Do you agree with the way they understood the illness?
Mother: The two are about the same. I feel they were the "same." Do the two doctors have the same view? Is that what I am understanding?
Biju: That's it.

Contrary to many studies of "hierarchy of resort" (or what therapies people use in different contexts) which find that allopathy was used later in the course of therapy-seeking (Romanucci-Ross 1969; Young 1981; Sharp 1994), an overwhelming majority of my informants in Kerala first sought relief from allopathy. This pattern of resort may relate to the fact that allopathic care is widely available in Kerala, and--as we shall see in Chapter 7--its virtues are promoted through the media (see, Panikar and Soman 1984 and Nirmala 1997 on the availability of allopathic care in Kerala).

The allopathic doctor Sreedevi originally consulted for stomach pain referred her to an allopathic psychiatrist, who prescribed medication. Despite this treatment, the problem continued, and Sreedevi and her mother sought ayurvedic treatment. This is a common scenario: most patients I met at non-allopathic treatment centers had previously tried allopathy and switched treatments when their problem returned. Often patients tried allopathy twice, and when their problem returned a third time they changed therapies.

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[4] There are actually no words that mean "yes" or "no" in Malayalam. One affirms or denies a statement by using the affirmative or negative form of the verb that was used in the question or proposition. A more literal translation for this line would be "Had." But as such translations would be somewhat confusing an awkward, I will use the approximate translations "yes" and "no."

Like many Malayalis who choose ayurvedic treatment, Sreedevi's mother prefers ayurveda partly because it is known to have fewer side effects than allopathy.

In the above excerpt, Sreedevi's mother specifies that her daughter's problem is mental (*manasikamaittulla*), which runs contrary to a trend in anthropology to find nonwestern peoples expressing suffering mainly through the body. This concern for states of mind and consciousness and the local phenomenology that this is related to is addressed in Chapter 5.

At the time of this interview, Sreedevi was continuing to take an allopathic medicine called "Hexidol" while undergoing ayurvedic treatment. "Hexidol" is a combination of haloperidol and benzhexol hydrochloride, a strong anti-psychotic normally given to people allopathic psychiatrists consider schizophrenic. We did not investigate Sreedevi's allopathic medical history, but Biju and I were somewhat surprised that she was given this drug. Sreedevi seemed to be merely quiet and depressed. A clinical psychologist I know says that he has seen a number of patients who were suffering depression and distress related to social and family problems and who were prescribed strong anti-psychotic medications during allopathic therapy. Sreedevi's ayurvedic psychiatrist was planning to get her off these drugs. However, we saw Sreedevi while she was in the early phase of her treatment, and ayurvedic psychiatrists feel it is necessary to slowly wean patients off allopathic medicines.

Finally, in response to our question as to whether Sreedevi/her mother agrees with the manner in which current and previous healers' understood her/their problem (which we asked in all structured interviews), Sreedevi's mother explained that they believe both

the allopathic and ayurvedic doctors had the same view. Often informants told us that they *agreed* with the points of view of all previous healers (not necessarily that they saw these views as being the same, as Sreedevi's mother does). Perhaps it was for a safer treatment, one that has fewer side effects as she says, that led Sreedevi's mother to switch to ayurveda.

Finally, in the preceding passage, Sreedevi's mother says she learned about the ayurvedic psychiatric treatment after reading about it in a newspaper. With Kerala's highly literate population, many individuals learn about different therapies by reading the numerous articles and medical advice columns that appear in Kerala's newspapers and magazines.

Sreedevi's mother then gave a brief but complex recounting of an attempt to arrange a marriage with a young man from their neighborhood whom Sreedevi liked. Marriage is a major issue in Kerala. It is a constant subject of conversation and the topic of most Malayalam films. Failed marriage arrangements related to the onset but were not the only cause of Sreedevi's problems according to her mother:

> Biju: Do you think the main reason behind this problem is "marriage"?
> Mother: Speaking about "marriage," it's not particularly about "marriage." It is from that that this problem developed. At that time we didn't want anything. We didn't make any agreement and all. Otherwise, between them [Sreedevi and this boy] there were no other *bandhangal* [bonds/connections/relations].
> Biju: What else will you do to get over this illness?
> Mother: Like I said, I think her mind must be changed/improved [*maatti*].
> Biju: Will you do any other treatment? You've done allopathy and ayurveda. Anything else?
> Mother: Particularly, before, the head... in the "pipe," she got a strong

hindrance/blockage.[5] So I wondered if there was some problem with her nerves. I still wonder that.
Biju: Are you thinking of taking her to a "neurologist"?
Mother: Yes. I have a feeling like that. That is to say, because of that, I have a feeling like that. I've thought of that.
Biju: Do you have any other plan to get over this illness?
Mother: No specific plan. When this illness started, we took her to a temple and as in our native custom, we took her to a swamy who said prayers and tied a string. That was for mental contentment. At Attukal.
Biju: Are you still going to the temple?
Mother: No. That priest said, go to the next Devi temple, and on the second day *rakthapushparchana* [an offering with a certain kind of flower, *rakthapusha*]. On the fourth day, do *navagraharchana* [nine planets worship]. Do all that, he said. For *rakthapushparchana*, there is a Devi temple near us. We have been going there and doing this every Tuesday. Do this 21 times, he said. We have done 7 or 8. So we are doing all that.
Biju: How much more time do you have remaining?
Mother: Let's see. A month, a year. We still have 4 - 5 months to go.
Biju: What is the next step you will take?
Mother: I want to cure this. I would like my daughter to get married.

Sreedevi's mother explained that they originally went to a temple to see what they could do about Sreedevi's troubles, and a priest recommended them to do 21 *rakthapushparchana*, or flower offerings at a local temple. Attukal temple and the local temple they went to are referred to here as "Devi" temples. As discussed in the previous chapter, "Devi" is one of the names for the incarnation of the divine in female form, and it is one of the most common names for the divinity also know as "Amma-Narayana" at Chottanikkara temple.[6] Many patient-informants carry out this kind of worship while

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[5] This is the best attempt at translation, but it is unclear what she meant here.

[6] I am taking the view, which is expressed by Hindus themselves, which is that the so-called goddesses and gods are incarnations or personifications of a single, absolute divinity. This is also addressed further in the previous chapter in the discussion of forms of healing at Chottanikkara temple. The pseudonym I have chosen for this informant (Sreedevi) is a common female name that means "Holy Devi."

pursuing relief from their illness through medical sources. This kind of worship, while therapeutic, is not specifically oriented toward healing like some of the ceremonies at Chottanikkara temple.

The "pipe" Sreedevi's mother refers to is most likely *dhumapana*, a therapy the ayurvedic psychiatrist used on Sreedevi. This treatment involves rolling ayurvedic medicines into a cigar, inhaling the cigar through one nostril and exhaling through the mouth. The ayurvedic psychiatrist explained that this helped to get rid of Sreedevi's hallucinations, a characteristic of Sreedevi's troubles that we did not learn through our interviews.

Sreedevi's mother says that some way or another Sreedevi's "head" (that is, her mental problems) must be "changed" (*maatti*). "Change" (*maaram*, *maaruka*, and other forms of this word) is a Malayalam idiom that describes what one achieves through healing. As will be discussed in Chapter 6, there is no word in Malayalam that translates as "cure."

Biju and I conducted a follow-up interview with Sreedevi and her mother in August, seven months after our original interview. During pre-interview small talk, Biju and I could quickly tell Sreedevi was doing much better. Her expression was much brighter, she was focussed, and she appeared to have much more energy. She occasionally spoke and showed interest in the conversation between her mother, Biju and myself. Previously, she was tired and distant and mumbled only a few words. Sreedevi was still not outgoing, which was fine. We got the impression that her quietness, her shyness, is part of her normal character. Since our last interview, Sreedevi and her

mother had been to the Government Ayurveda Mental Hospital in northern Kerala, and Sreedevi underwent the 45 day course of treatment there. They both felt that this experience had greatly improved Sreedevi's condition. The only problem Sreedevi still had, according to her mother, was that she felt completely recovered and was bothered that healers thought she should continue to take medicine to fully complete the course of treatment. Her mother explained:

> She has good "change" and all, but she says "I have no illness at all. Why am I continuing the medicine? Now I have no problem at all." Now when I give medicine, this is the reply. She spoke very little earlier. Now... now she is talking very well, going everywhere. She is doing all her work a little "better." That is, after taking the treatment.
> Biju: Have you experienced any improvement or decline in your present state?
> Mother: It is improved.
> Biju: Since we last spoke, what treatment have you been doing?
> Mother: Just this, ayurvedic treatment.
> Mother: [part of Sreedevi's mother's response is obscured by a few comments in English between Murphy and Biju] ...Kottakkal. Even compared to here, there were differences/improvements [*vyathyaasam*] in Kottakkal.

Earlier, Sreedevi's mother used the term *maatti* ("changed"). Here she talks of *vyathyaasam* (which means "difference" but can also be translated as "improvement" in the context of healing), and uses the English word "change" to describe what was accomplished in treating her daughter.[7] We then asked Sreedevi's mother to describe the therapy at Kottakkal:

> We stayed 50 days there. They gave ghee after cleansing the bowels. Ghee was

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[7] English words commonly appear in Malayalam discourse, but using he English word "change" rather than some form of *maaram/maaruga* is somewhat unusual. As a schoolteacher, Sreedevi's mother would be expected to know English well, and she may have been trying to impress me (and/or Biju) or make her story easier for me to follow.

given for 7 days. First two "ounces." Each day, they added an "ounce," step by step. It took one week for that, and 14 "ounces" were given finally. She did not eat anything during that time. That did not take. Speaking of that, she vomited. It was coming out from her mouth right while she was drinking. Then after that, after the ghee drinking, then after *marupathyam*[" a secondary or lighter regimen observed after stopping the main medical treatment" Madhavanpillai 1976], they did *vasti*, *tailam*, *kshayavasti* [names of ayurvedic procedures]. That for one week. After the first three days, then *nasyam*. After *nasyam*, this was done on the head, like this. They put medicine and wrapped [reference to ayurvedic procedures that involve applying medicines to the head], and gave two types of medicine mixed with yogurt at night.

In this passage, Sreedevi's mother is summarizing the 45 day treatment Sreedevi received at the Government Ayurveda Mental Hospital. The purgative she was given is one of the procedures that rids the body of toxins at the beginning of the course of treatment called *panchakarma*. The ghee Sreedevi was given to drink, in amounts that increase by one ounce every day, is intended to lubricate the body before in the *panchakarma* therapy. The *vasti* Sreedevi's mother refers to are enemas and *nasyam* is a medicine that is administered through the nose. Both of these are part of the *panchakarma* treatment. The wrapping therapy Sreedevi's mother refers to is *talapodichil* or *picchu*, or both. In these treatments, medicated mud or oil is applied to the head which is wrapped to hold the medicine in place. These lengthy, complex procedures are described in more detail in Chapter 3 in the section on ayurvedic psychiatry and in Chapter 6 on the "pleasant process" of ayurvedic therapy.

Biju: Are there any new symptoms since we last spoke?
Mother: Nothing new. Then still, when talking, suddenly words, a blockage, they don't come out suddenly like this.
Biju: Do you have any new ideas about your problem? Do you have any sort of new ideas about your problem? Do you have any idea about the reason it began? Any particular ideas?
Mother: I don't have anything in particular. I have scolded her a little for not

> studying. She didn't study in a good manner. She hasn't studied well. She will sleep lying face down. I have scolded her when she shows laziness and all. I don't know whether that made her "feel."

These are Sreedevi's mother's answers to two of our structured follow-up questions. The question about "any new symptoms" is one of a few questions which attempted to get at the issue of change in the status of illness. Our first follow-up question was "Have you experienced any improvement or decline in your condition?," but this was often taken as a rhetorical question and received brief answers. Asking specifically about new symptoms revealed a few more details about the patient's current status. As to whether there were any new ideas as to the origin of Sreedevi's troubles, her mother wonders whether she scolded her too much about her studies. Again, the concern for educational success is brought up. Also, Sreedevi's mother uses the word "feel," meaning in this case something like "upset." Many English terms that have been adopted into Malayalam, and these include a number of idioms for emotional states. Two other informants in this chapter, Mary and Hanifa, describes their problem using the English word "tension."

Biju asked Sreedevi's mother whether there were any problems remaining, and what, if any, further treatment needs to be done:

> She is saying "Why is medicine being given to me." That's her opinion: "I don't have anything, doctor." When we saw the doctor here, we were asked to continue for one year, right? That period is about over, right? "Now why should I continue for one more year." She wants to have a family. That's why she wants to know whether it will take much longer. That's one of her problems. "I have recovered due to the conversation. I understood."

Sreedevi's mother again stresses that the only problem now--clearly a fortuitous one--is that Sreedevi feels she is fine and is questioning why she is required to continue taking medicine. Sreedevi herself even said, "I have been taking medicine for several days now,

and I don't know what my illness is."

The statement above, that Sreedevi feels she has recovered through "conversation," is somewhat unique. With most patients of allopathic and ayurvedic therapies, there is little discussion of the counseling that is given, and the narrative about the therapy focuses on medications. This could be due to the fact that Sreedevi's psychiatrist has more time to counsel patients and, as I have witnessed, enjoys doing so.[8] In fact, this psychiatrist explained to me that he considers the advice he gave Sreedevi and her mother to be a key factor in her recovery.[9] He was concerned that Sreedevi had been idle for 5 years, not doing any work at home. "I tactfully advised her mother to give her more duties" he said, and her mother gave her more work and responsibilities.

The treatment Sreedevi underwent seemed to be working. The fact that Sreedevi's desire to get married is making her impatient about finishing her treatment is, I believe, cause to be optimistic about Sreedevi's future. But more importantly, the mood and manner Biju and I observed on our follow up interview let us know that, as they say in Kerala, something had "changed" in Sreedevi for the better.

Mary and Her Mother - The Woman Who Wanted to Be a Nun

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[8] Few doctors have time to give a lot of counseling. At government hospitals (allopathic and ayurvedic), doctors have to see a great number of patients in a short period of time, so conversations during consultations usually focus on medication management and whether the patients' condition is improving.

[9] Ayurvedic doctors often give advice which is taboo in western psychotherapy. The willingness to give advice is interpreted in relation to the socially-dispersed self in Chapter 3.

Mary is a 29 year old Christian woman who was seeking treatment, accompanied by her mother, at the Government Ayurveda Mental Hospital (GAMH). When Benny and I interviewed her, Mary was on her fourth visit to the GAMH in three years, this time for a suicide attempt. Mary jumped into a well in reaction to difficulties that seemed to start when her parents refused to allow her to become a nun.

Early in our interview, Mary explained "I got mental 'tension'" (*Enike manassinu* tension *vannu* - literally, "mental tension came to me"). "Tension" is one of several English language terms that are emerging in Kerala as idioms for expressing distress. Others include "stress" and "depression." Chapter 7 will analyze the disappearance of spirit possession and the emergence of English language psychological idioms as well as the social context in which these changes occur. Mary did not go into further detail about how this felt, so Mary's mother proceeded to describe the problem as she saw it:

> Mother: One day when she was sad [*vishamam*], she came home laughing.
> Benny: She came home laughing.
> Mother: Yes. Then one day she came home from work weeping. Then we asked, "Why are you sad, daughter? Why did you come home crying?" She did not answer. Then after that day when she would come home from work, she would act strangely and show *bahalam* [agitation/tumult/"throwing a fit"]. Then we took her to the hospital.
> Benny: When she laughed boisterously, did she hit [things/people] and use vulgar language?
> Mother: She used bad words and said that I was immoral and beat me.
> Benny: She will do everything. Is she this way with her father too?
> Mother: Yes. Ask her father.
> Benny: She doesn't fear anyone?
> Mother: No fear at all. When she is angry, nobody knows what she will do. Sometimes she will grab a knife.
> Benny: Did she cut anyone?
> Mother: No. She never cut anyone. When she is angry we act according to that situation. She will throw at us whatever she can get her hands on. She will destroy the door. Then her anger will disappear and she will become calm.

This outburst of anger, *bahalam* and use of bad language is a common constellation of symptoms among patients we interviewed. Indeed, Sreedevi was also described by her mother has having outbursts of *bahalam*. Mary was given the ayurvedic diagnosis *vishadam* during this admission at GAMH. Dr. Abdu of the GAMH explained to me that *vishadam* is very much like the allopathic diagnosis "depression," but is distinct from the ayurvedic *kaphotmadam* diagnosis. *Kaphotmadam* which involves a more phlegmatic, depressive (in the common, non-medical sense of the term), sad disposition, lacking the occasional outbursts of anger that characterize *vishadam*.

Mary and her mother agree that Mary's problems are to some degree related to her parents preventing her from becoming a nun:[10]

> Mother: One reason is that she wanted to become a nun, but we did not support this.
> Benny: Who wants to become a nun?
> Mother: She did.
> Benny: Mary really wanted this, but it was not allowed.
> Mother: So I said, "Daughter, you are my only daughter. Don't go off and do that. That is my opinion." I don't know whether it might have caused her some pain.
> Benny: (To Mary) Did you feel terrible when your father and mother told you could not become a nun?
> Mary: Yes.
> Benny: Do you think that this was the reason for your illness?
> Mary: Yes.
> Benny: Do you think because of that God gave you this illness. That God called on you and you did not go.
> Mary: Yes.

Mary later had additional complaints about her family:

> Benny: What is your problem, Mary? Consider me as a doctor. I am working in a hospital in Kozhikode. My home is in A. My sister is married to M. [a town]. I am

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[10] See Chapter 3 for more details about the large Christian population in Kerala.

telling you this just so you know who I am. Mary, what is your problem? Something is worrying you though you are not showing it on the outside.
Mary: Nothing is worrying me.
Benny: Nothing is worrying you.
Mary: If I get *adi* [hit/slapped/spanked], I am sad.
Benny: From whom? Who will hit you Mary?
Mary: My father, mother and brothers.
Benny: That may be because you did something.

My assistant Benny tries to get Mary to confide in him by revealing who he is by emphasizing where he is from and his sister's husband's home. Revealing one's home town is a key move in identifying oneself and often the first issue raised when Malayalis meet. Mary refers to her concern about being "hit." The word Mary uses--*adi*--is hard to translate and is worthy of some attention as how it is translated has many implications and brings up delicate issues. *Adi* means something like "hit," "spank," "slap" or "beat," and depends on context. In this context, the meaning is something like "spank" in the sense that it is a way of disciplining children (though, as in the U.S., some people think this is an objectionable way of disciplining children), but in many cases in Kerala this may be done when "children" are older. "Slap" or "hit" is more appropriate since "spanking" is often a single cuff on the head or a swat with a "switch" (a thin stick or branch), but "slap" and "hit" implying more violence than is socially perceived in *adi*. There may be more serious violence occurring. Mary may have actually been beaten or may be traumatized by this hitting/spanking, but that sense is not communicated in this statement. Benny interprets that Mary may be talking about a normal use of physical discipline, and suggests there may be a good reason Mary's family hits her. Mary then explained that she was scolded while she was praying and that her family hits her when she refuses to eat:

Mary: [...] When I am eating, they will hit me.
Benny: Who? Your family?
Mary: My father.
Benny: That will be because you were probably doing some mischief while you were eating.
Mary: I can't eat.
Benny: Do you sit without eating? Then they will hit you. That is because they love you. They don't want you to become too thin. So why are you worrying?
Mother: She's not willing to eat anything.
Benny: Is she reluctant to eat now also?
Mother: Yes. Now also I...
Mary: I am eating.
Mother: When I take a stick she will eat.

Refusing to eat is a common characteristic of distress and psychological suffering in Kerala, and is taken very seriously. Ultimately, this issue of "hitting" is difficult to discuss. I hope that this attempt to translate these incidents does not make it sound like these are barbaric, exotic acts. At the same time, I do not think it is right to over-relativize and assume that what is going on is not painful for Mary or more serious than what is being revealed. We will hear a concern about clearly condemned form of violence when Mary reveals that she doesn't wish to get married out of fear that her husband may beat her.

Mary and her mother went on to recount the history of therapy-seeking they underwent. Mary's problem had been going on for about 10 years. Over the course of the first seven years of Mary's troubles she received treatment from two allopathic doctors and from a church "father" (a priest or pastor--from a Malayalam word that translates as "father" and refers to a male cleric of any Christian denomination). The church father was also qualified as an allopathic psychiatrist and he treated Mary with hypnosis.

For the past 3 years Mary has been coming to the GAMH in Kottakkal whenever

her problems return. We asked Mary what specifically led her to come to GAMH on this occasion:

> Benny: Now is the fourth time. What is the problem for which you have come here now?
> Mary: I jumped into the well.
> Mother: She will jump into the well. She doesn't take her pills, and then she takes several pills together. She took 4 pills at a time. She wants to die.
> Benny: Will she say that she wants to die?
> Mother: Yes.
> Benny: Mary, do you want to die? Then how can you get married? [Mary had earlier expressed a desire to get married.]
> Mary: I want to get married, but when I get married, if my husband beats me, I won't be able to bear it.

We did not ultimately learn of the cause of Mary's concerns about domestic violence. It might be that her father hits her mother, although we don't know if this has occurred. Mary's mother then explained that Mary had previously attempted suicide by overdosing on pills. Suicide attempts are common in Kerala. With the national average for India of 9.9 suicides per 100,000 people, Kerala had an astonishingly high 28 per 100,000 suicide rate, the highest of any Indian state and almost twice as high as the state with the second highest rate (Karnataka with 19.1) (National Crime Records Bureau 1994: 58). I have written on this issue elsewhere explaining that Kerala's high suicide rate seems to relate to a gap between high educational attainment and the lack of availability of commensurate jobs and to the processes of secularization and "modernization" of the state (Halliburton 1998). Mary may be attempting suicide because she feels trapped. Marriage would be a way to get some autonomy from her family which scolds her, hits her and didn't let her become a nun, but fear of being beaten makes her dread getting married.

We asked Mary and her mother why they changed to ayurvedic treatment after pursuing allopathic therapy for seven years:

> Benny: So why did you change from allopathy to ayurveda?
> Mother: We believe that they can relieve her illness.
> Benny: To get relief. Is there any change after coming here?
> Mother: There is a great decrease [*kuravu*] in her anger and her attacks on others.

They did not elaborate on what specifically they thought would be different about ayurveda, but like many patients we interviewed who were using non-allopathic therapies, Mary and her mother switched after several years and two or three courses of therapy with allopathic healers.

Mary and her mother also went to a church in central Kerala to seek relief for Mary's problem. They did not give details about the healing process there, Mary said "when I was treated there, I got *sukham* [health]." Significantly, this comment on going to *church* for relief was the most enthusiastic and positive thing Mary said during our interview. Mary also spoke with some frustration about not be allowed to become a nun, and her first complaint about her family was that they scolded her while she was praying. She probably felt well after seeking treatment at the church since she had a chance to engage her spirituality. Likewise, being left home while her parents went to Christian retreat did not seem to help Mary.

Mary's parents visited a relatively new and very popular charismatic Christian retreat called "Potta" (described in Chapter 2) to seek relief for Mary. As Mary's mother explained, it was only necessary for the parents to visit Potta:

> Benny: Then did you go to Potta?
> Mother: We haven't gone to Potta. When we went there, the nuns told us that it is not necessary for the patient to pray. Only the father and mother have to pray.

Benny: I see.
Mother: They said, come to this place with a right mind.
Benny: So if the mother and father come to pray that is enough. They said not to bring her to Potta?
Mother: They said not to bring the person who was ill.
Benny: They told you not to bring her. So you, her father and mother, prayed for her.
Mother: They told us not to bring her.
Benny: Then also there is no change [i.e., even after praying at Potta, there is no improvement in Mary's condition]?
Mother: None.

We also asked whether Mary and her mother had consulted any astrologers or did any *pooja* (offerings at a Hindu temple). Mary's mother explained "We have faith. [...] even if she does not recover from her illness, I am not going to do things like that" indicating that--though some Malayali Christians use Hindu rituals--they will continue with only Christian worship for Mary's troubles.

Toward the end of our interview, for reasons that were unclear, Mary began to claim that she was adopted:

Mary: These are not my real mother and father. You all adopted me. You did not deliver me [followed by something unintelligible].
Benny: What is she saying?
Mother: She thinks that she is adopted by us.
Benny: She is adopted.
Mother: We are not her family. We adopted her. That is in her mind.
Benny: Mary, why did you say this?
Mary: No reason. It's nothing.
Benny: Why? Are they not giving you real love or is it because they did not allow you to become a nun. So then? (Pause.) Why did you say what you said? (Pause.) Mary?
Mother: She will tell me I'm not her mother. She will tell me to go away, and she will say that I am not her mother.
Benny: Do you want me to send your mother away so that I can ask you some personal questions?
Mary: There's nothing. I don't have anything to say.

Mary, on a few other occasions during this interview, would bring up a complaint or

accusation and then retract it. This is an example of some of the more pragmatic or performative aspects of this interview. Such protests, and the elusiveness of the meaning behind them, arose at points throughout this interview. What seemed significant was that this was the point when Mary appeared to assert herself most. She grabbed her mother's and our attention and controlled the conversation for this moment. This momentary assertion of control may, like her *bahalam* outbursts, be an attempt to feel she has some voice in the context of her family not letting her follow her calling. However, the fact that Mary at times made assertions and then retractions like she did here makes one wonder how performative or manipulative some of her earlier accusations might be. Yet again, she might retract some of her assertions out of fear of standing behind them or retribution. Ultimately, Mary was hard to read. At times she acted in a manner that was dramatic and attention-seeking, but she was also genuinely distressed.

Like all the ayurvedic patients we interviewed, Mary was discharged at the end of the 45 day treatment period. Mary and her mother did not respond to our follow-up inquiry which we sent by mail. We did not see Mary or her mother again, or hear that she was readmitted to GAMH. I hope that no news is good news.

Abdul-Rahman - Homesick in the Gulf, Unhappy at Home

Abdul-Rahman was a 29 year-old, Muslim man who was seeking allopathic psychiatric treatment as an outpatient at the Trivandrum Medical College accompanied by his brother and sister. Biju and I interviewed Abdul-Rahman alone at the Medical College psychiatric outpatient center, and afterword we had an informal conversation

with his brother and sister without Abdul-Rahman present. Abdul-Rahman, who like Sreedevi had studied up to SSLC, worked in Kerala as a newspaper distributor for about 10 years, and also spent time working in Bombay and the Persian Gulf. Abdul-Rahman returned from the Gulf because he felt homesick, but after returning he became restless, sleepless and felt *vishamam* (sadness/depression). Abdul-Rahman tried allopathic medicine, homeopathy and a Japanese healing system called "Okiyama" to resolve his troubles.

Three months before this interview, Abdul-Rahman consulted a psychiatrist near his home town outside of Trivandrum. Having heard that the doctors are better and the treatment is free at Trivandrum Medical College, Abdul-Rahman stopped seeing this local psychiatrist, and he and his brother and sister set out for Trivandrum.

When we ask Abdul-Rahman how his problems started he told us how eight years ago he left Kerala to work to Bombay, but he found the experience lonely and depressing. "Everyone's life was alone" and "Only friends were there," he recalled, lamenting that everyone was living alone, without their families. Abdul-Rahman said that because of "homesickness"--he used the English word-- he returned to Kerala. After a few days at home he felt fine.

Biju asked Abdul-Rahman to explain in more detail how his problems felt, and Abdul-Rahman described how he went off to the Gulf, again got homesick and returned to Kerala. (Note that the language in some of the excerpts from this interview is a bit awkward. This is partly because of the impossibility of rendering Malayalam in English and preserving its style and meaning, but also because this particular informant had a

very elaborate and unusual way of speaking. He was also very talkative and spoke at length.)

> Biju: What was your illness like? Were you depressed/sorrowful [*vishamam*]?
> Abdul-Rahman: I was sad [*vishamam*], a sorrow in the mind. So, I wanted to see everyone, to see everyone from home. It was as if I was alone. Then, after that, I went to Bombay again. After that I got a chance to go to the Gulf. So I went to the Gulf. I went as a "fabricator," as a "steel fabricator." When I got there, I didn't get even a "chance" as a "welder." As I had some difficulties in the company, I was forced into a bad relation with "parties" [his employers or the middlemen who got him the job]. I remained with them only one year. After that, for one year I was with my elder brother. So, when I departed I was with my elder brother. Thus mentally, thus when I remained like that for a long time, I was getting letters and things from home. Still there were economic difficulties so I remained there in the hope of solving economic problems. Then one day I felt mental sorrow [*manassikamaittu vishamam tonni*]. I was crying and could not eat food. At that time, I felt that I should simply cry like this, for tears to come to my eyes. When lying down, I would see nightmares. I woke up startled, and then could not get back to sleep. As soon as I became restless/worried [*vepralamaittu*], I got a "ticket" to come home and an "emergency passport" and came home to my native place [*nadu*].
>
> After being home for a few days, I had no illness. Then suddenly there was no problem. Soon after seeing everyone at home, I was able to eat food and everything. My illness was completely changed. After that now, after about one year again I got my old papers from the "agency" and resumed my old routine. I did lots of work and became very "active." I had the ability and self-confidence to undertake anything. Still now, even when I took the papers from the agency and went to distribute them in the morning at 5am, after that, while I was doing this, I started a shop, hoping to "progress." And to start a "book stall" in front of the shop and an "agency office." I borrowed money for the shop.

Abdul-Rahman's homesickness is understandable given that in Kerala there is a strong attachment to place, or *nadu*. *Nadu* has no equivalent in English and is usually translated as "native place" referring to the town or region one is originally from, usually a birthplace. This place attachment is not only sentimental, but also visceral, physical and "biological" (referring to local biology). Daniel (1984) claims that people in Tamil Nadu, Kerala's neighbor, have a visceral attachment to their native town or land, that they feel

that the substance that makes up their selves (their bodies and their character) also exists in the land of one's native place. I heard similar expressions from people in Kerala. Note also that Abdul-Rahman speaks of home in connection to food. Earlier he had said "As soon as I reached home ... right away I had food and saw everyone." Ayurvedic medicine (Zimmermann 1987) and lay medical knowledge claim that the qualities in the soil of a place is also present in the food and in the bodies of people from that place. The food from one's native place is therefore considered to be more compatible with oneself. It has been recently suggested, however, that the notion that South Asians are particularly attached to place is an orientalist, academic construct, a depiction of the Other as fixed in place. It is also asserted that discourses of itineracy and mobility in South Asia have been marginalized (Srivastava 2000). In light of this critique, I would suggest that people in Kerala are place attached and yet mobile--and that these two things can coexist. The description above does not reveal so much the degree of place attachment but rather the characteristics and quality of place attachment.

Regarding the mobility of South Asians, in the past two decades, a great number of Indians, and an especially great number of Malayalis, have been moving to the Persian Gulf to work for a number of years. Migrants from India usually head to the wealthy city-states of the United Arab Emirates, such as Dubai, Abu-Dhabi, and Sharjah, or they go to Saudi Arabia and Bahrain where they can get salaries that are much greater than what they can earn at home. -Although it is hard to find precise figures (Thomas Isaac 1997:277), it appears that Kerala has the greatest rate of Gulf migration of any Indian

state, and a sizeable portion of Kerala's economy comes from remittances from the Gulf (Saith 1992: 114-115; Thomas Isaac 1997; The Hindu April 10, 1997). While many have reaped financial rewards from working in the Gulf, Indian workers are often exploited. They often have to pay usurious fees to middlemen who help them get employment and work permits, and as Abdul-Rahman learned they sometimes do not get the work they are promised. They are also sometimes not paid for their work, and have little recourse for fighting these injustices.

After returning to Kerala from the Gulf, Abdul-Rahman's problems subsided, but after going back to his old job of delivering newspapers and trying to open a shop, his *vishamam* (sadness/depression) returned:

> To tell you the reason I am coming here now [to see a psychiatrist], later when I was working in the paper agency, there was a weight like this in the mind. A crying, complete *vishamam* [sorrow/depression] in the mind. Just like when I was in the Gulf, I will cry.

Abdul-Rahman then explained he was upset that he didn't get the job he expected in the Gulf, and his employers there were not paying his and other workers' salaries. So they organized a strike "like we do in our place," said Abdul-Rahman referring to Kerala's tradition of assertive labor organizing. Kerala's labor unions have significant power, and strikes are almost a daily event in the state. Kerala workers are paid weil compared to other Indian laborers, and Kerala's Communist government deserves credit for aiding and supporting this achievement. However, Kerala's unions have caused industries to flee to other states in search of more exploitable workers, and the state now has a high rate of unemployment and out-migration.

After discussing Abdul-Rahman's return from the Gulf, Biju and I began to

inquire about what other therapies Abdul-Rahman had tried. He said that the previous week he tried taking a homeopathic medication, but he did not continue with that therapy.[11] We asked if Abdul-Rahman had visited a temple or a mosque for his problem. He explained that he went to a mosque not specifically to help his problem, yet he found that prayer decreased his illness somewhat. Abdul-Rahman explained that he used to be "like an atheist" when he was young. Now he says he has some faith and declares "I believe in a single god." Yet he is not a serious devotee.

Abdul-Rahman then described a Japanese healing system called Okiyama, which he began using before trying allopathic psychiatry and was continuing at the time of our interview:

> Yes, it's a treatment system. It's called "divine light Okiyama." It comes from Japan. Divine light. "Divine light." It is a divine light that we cannot see. They give "divine light"... That is, they "just" give it to the forehead at first and to the "medulla oblongata." After that they will do it to our important points.
> Biju: Where is this light coming from?
> Abdul-Rahman: We can't see where the light is coming from. I was going... The reason is that since my problem must change by whatever means, the first "time" there was some change. Before going to Okiyama, I had terrible confusion/restlessness. Before going to Okiyama, I had terrible restlessness and rolling [sic - he may mean something like tossing and turning or dizziness]. So the first day I went to Okiyama for the "first treatment," they gave me "divine light." Having given that the first day, I felt giddiness and swinging in my head. We know that there is only one side to them. They give "divine light" only to the forehead. Thus my head swung and rolled and all that. I fell down... There is a center at Punalur.
> Biju: Isn't God [*daivam*] involved?
> Abdul-Rahman: Yes, God's [*daivam*]... faith in God [*Ishwar*]. They also believe

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[11] "Homeopathic" here refers to a specific, organized system of medicine called "homeopathy" which was developed in Germany and is popular in Kerala. This is distinct from the meaning of this term in American English where it is usually a general adjective referring to many medicines that are considered "herbal" or "alternative" to western biomedicine.

in only one god.

The fact that Abdul-Rahman used Okiyama and tried homeopathy is a reminder of the variety of therapies that are available in Kerala. A number of therapies, such as ayurveda and siddha, are indigenous to the region, but Kerala is also a consumer of imported therapies, such as homeopathy (from Germany), Okiyama and Reiki (from Japan), and naturopathy (from the U.S.). Interestingly, at the end of this segment, Biju brings up the role of God in Okiyama, using the word *daivam*, and Abdul-Rahman responds referring to the divinity as *daivam* and *Ishwar* which are sometimes considered general, non-denominational terms for God in India. However, being Sanskritic in origin and indigenous to the Indian subcontinent, these have a tendency to be associated with Hinduism. This is further evidence of syncretism in South Asian religious practice and the arbitrary nature of the category Hindu (which was also brought up in the discussion of religious therapies in Chapter 3). I did not come across any other description of Okiyama in the course of my research. According to Abdul-Rahman, Okiyama bears some similarity to the Japanese healing system called "reiki," which is also practiced in Kerala.

After Abdul-Rahman's description of Okiyama, Biju asked him to elaborate on how his illness felt:

> Biju: When your illness is intense [when your illness increases] what is your problem? Do you get angry?
> Abdul-Rahman: Not angry. Nothing. When I say I have illness, people at home will say, ... I will say, I don't have an illness. But people at home are terribly "worried" about me. They... Since I do everything at home, they cannot bear it if I get some problem. I cannot tolerate those sorrows. Usually when I get *vishamam* [sorrows/sadness], I am very restless. Sometimes I will want to lie down, and then when lying on the bed, I will feel the urge to get up... no... not to lie down, but to

> sit down. I want to sit down. When thinking about sitting down, I decide "no" I want to walk. When walking, I change my mind and want to come and sit again. When lying on the "left side" normally one turns and lies on the "right side." But when I am lying on my "left side," I will get up and lie on my "right side."

These themes of indecision, restlessness and *vishamam* recur throughout this interview. He later explained that when he thought he should sleep (he didn't say he felt sleepy--he felt that sleeping was something he ought to do), he was unable to and would just keep turning over in bed.

We then spoke with Abdul-Rahman about his experiences with allopathy and Okiyama. When asked to describe how he felt when taking allopathic medicine, Abdul-Rahman began a narrative that was exclusively about medication, naming the different pills he took and the different dosages he was given at different times:

> Biju: How do you "feel" when you are taking "allopathic medicine"?
> Abdul-Rahman: Speaking about allopathy, it's either "tablet" or "medicine." If it is the other one [probably referring to Okiyama], there is nothing to just take inside or apply on the outside of the body. At that time, if I was taking pills... when I first took "Trika", I completely recovered. I myself "stopped" it. I stopped. Later, it was Dec. 30. At that time, the doctor scolded me a lot and prescribed a more powerful drug. He prescribed Amitriptin C+. I "continued" that. Then I was prescribed Anxit 5mg. After that, my illness decreased for several days. Then, again, it increased. It increased again, and when I went to see the doctor he prescribed Trika for me. For the Trika, he first prescribed 1 mg. The illness decreased for several days. When decreased, later on I went to see the doctor who gave me 5 mg. He gave me 5 mg. When again it decreased, I didn't go to see the doctor. In the meantime, later on, one day, it was "sister"[12] who went to see the doctor. I got the illness again that day. When "sister" went to see the doctor, I took a pill. Since "trika" was not available, I had Anixit 5. Now when I take "trika", there is a restlessness in my body. At that time, I had more of a problem. Me, I was in such a state, I couldn't bear the dosage. But it was not possible to take it at home.

Patients of allopathic medicine commonly gave similar medication-oriented narratives

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[12] "Sister" in English in this case refers to a female nurse.

about their treatment. As discussed in the section on allopathic psychiatry in Chapter 2, medication is emphasized over counseling in Kerala partly because of the short time doctors have to meet with patients at government health centers, partly due to the biological bias in the ideology of contemporary allopathic psychiatry, and also due to the marketing and promotions of Indian pharmaceutical companies. Here Abdul-Rahman says he was given Amitriptan C+ (amitriptyline) which is used for insomnia, anorexia and depression, Trika (alprazolam) which is prescribed for anxiety and panic attacks, and Anixit 5 (another brand of alprazolam). In our discussion with Abdul-Rahman's brother and sister, his sister listed the same medications, and confirmed that these medicines helped at first but their effects wore off.

In contrast to his medication-oriented recounting of his allopathic therapy, Abdul-Rahman's description of Okiyama has an embodied and experiential orientation (this might seem to be due to Biju asking him to describe the therapy in terms of "feelings," but Biju asked about allopathy, above, in the same way):

> Biju: What were your "feelings" when you were taking the "Japanese" medicine?
> Abdul-Rahman: Now there are no "feelings" for that. The first time I had "Japanese treatment," when I went there and they gave the "divine light," my "body" totally turned around. I fell down. Even though I collapsed, I was conscious. I have a memory of everything I did, but I could not control my body. I turned around and around and fell down. Though I had fallen down, they kept of giving "divine light." When they gave me this, I fell down. It was like this the first time. The second time it was less. The third time...
> Biju: What differences were there after this?
> Abdul-Rahman: After this there was no problem. Though they were giving the "light," they gave it with my body sitting like this. Now there is no problem, no problem for my body.

We enquired as to whether Abdul-Rahman would consider trying any other forms of treatment in the future:

Abdul-Rahman: Whatever may be the treatment, I only wish to recover completely.
Biju: What treatment are you most interested in trying? For example, going to ayurveda, a temple, or a mosque?
Abdul-Rahman: Well, generally, I don't have any preference. Whatever may be the form, I only need to recover.

When we asked whether he preferred allopathy or Okiyama, Abdul-Rahman gave a similar answer: "By whatever means, I want to be completely recovered [*maari*, lit. changed]." This pragmatism and flexibility about using different systems of medicine were seen in many interviews. In structured interviews I had included the question "Do you agree with how previous and current therapists saw your problem?" which often got answers like "Yes, I agree with both." I had hoped to get some opinions about the merits of allopathy versus ayurveda, the church or other places of healing, but I rarely did. In response to a question about future plans for therapy, I often got answers like those Abdul-Rahman gave above: that is, the informant was willing to try whatever might work. This flexibility is consistent with observations made by Carstairs and Kapur (1976:66), Nichter (1981: 5) and Weiss et al. (1986: 380): that therapy-seekers in India do not see different kinds of therapy and their different conceptions of illness as contradictory or problematic.

I can't help but think that the combination of high educational achievements and the lack of commensurate jobs in Kerala (which many Malayalis and myself [Halliburton 1998] relate to Kerala having the highest suicide rate in India) may have some implications for Abdul-Rahman's situation. Abdul-Rahman gave the impression of being an extremely intelligent person, and he had completed his SSLC (Secondary School Leaving Certificate - a high achievement compared to most other Indians and Malayalis).

It must be frustrating for him to work as a newspaper deliverer and try unsuccessfully to get a job as a steelworker (not that someone less-educated would necessarily enjoy this work). It may be the case for Abdul-Rahman and many Malayalis--perhaps including Sreedevi--that talent or training that is unexpressed can turn inward and be destructive. It is probably Abdul-Rahman's intelligence, turned inward, perhaps made nervous, that contributes to the awkward character of his speech during this interview. Biju and I were constantly tested in trying to interpret and translate his speech. Abdul-Rahman's speech gave the impression of someone who was thinking really rapidly while trying to speak. What he said seemed to have so many meanings, yet he also sounded very indecisive.

We did not receive any response to our letter, sent 7 months after this interview, asking for a follow-up interview. I hope Abdul-Rahman found fulfilling work or at least a way to get some satisfying rest.

Rajendran and His Wife - The Clerk Who Skipped Work

Kavitha and I interviewed Rajendran and his wife at a private allopathic psychiatric hospital in Trivandrum where Rajendran was receiving treatment. Rajendran is a 47 year old university-educated Hindu man who works as a senior clerk at a bank. Rajendran does not feel that anything is wrong with him, though his wife and son brought him to this hospital out of concern that he wasn't sleeping or eating, he was writing strange things and he had missed work.

After learning how Rajendran rose up from cashier to senior clerk over his 24 year career at the same bank, Kavitha asked him about his education. The following,

detailed answer is a typical example of how many people in Kerala speak about their education:

> Kavitha: Until what level have you studied? Have you done "degree" [bachelor's degree] and all?
> Rajendran: Yes. After completing my "degree course," I did not attempt the exam. But I have a feeling that someone wrote the exam using my number because when I wrote the exam the second time and "passed," the "result" was "withheld."
> Kavitha: I see.
> Rajendran: At that time, I couldn't enquire about it in the university. I was busy. After that, I have been without a "degree." I did not write the exam in March [many years ago]. In March, some friends wrote it for me. After that, I wrote, but did not "pass" the exam. I completed "degree" studies. I did "maths main" for my "degree."

Compared to some informants, this is a very brief discussion of education qualifications. Often younger male informants would speak for 15 minutes or so explaining how they did on each exam on each attempt, where they ranked in their class in each subject and related issues. Education is a very serious issue in Kerala. Even elementary school students are expected to study three languages and subjects such as biology, chemistry, and history, and they are given annual exams in each of these areas. One of the first questions encountered when one meets someone who is expected to have some degree of education in Kerala is "what is your basic qualification?" (referring to the highest degree one attained) in English or "until what level did you study?" in Malayalam.[13]

We then asked Rajendran why he came to the hospital on this occasion:

> On March 31st we had to do some "overtime" work on "government treasury bills." So I was preparing for that, but in the end no one asked me to work

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[13] E. T. Mathew points out that from the foundation of the state of Kerala in 1956 until 1990-91, enrollment has increased 77% in primary education, 591% in secondary education, and 1,518% at university level (1997:102)

> "overtime." So I thought that was good and went home and took rest. Working overtime will be a "strain" on our body and mind. After that, I had to go back to the bank on the 2nd, but I was tired so I couldn't. My wife thought that I was doing it intentionally. I hadn't gone to work for overtime, and on the 3rd they took me here. I don't know what complaint they have about me. I don't know what there is to "complain" about. I did not go to work on the 2nd. That's all.

Rajendran felt that he simply failed to go to work one day and he doesn't have any problem (though this conflicts with his wife's account which will be presented below). We then asked if he had had any problem (perhaps inappropriately implying that there was a problem) like this in the past. Rajendran explained that he had blurry vision in 1983 for which we went to see a Dr. R. who we learn later in the interview is a psychiatrist. We asked him to explain further the problem he had in 1983:

> One day in '83, I slept late. The next morning... Not only that, I slept very late. I heard a commotion. I live next to Engineering College. I heard some girls yelling from the Engineering College "compound." I thought of going there with my wife. I wanted to go there with weapons and try to help them. When I thought of this, everyone got up and asked me not to leave the house. So both of us went to sleep, but I couldn't sleep. That day, at 10 o'clock when I counted "cash," I couldn't see the notes clearly. So I gave the "charge" to another person. I was the only person doing "cash" so I gave the charge to another "clerk" and left.

Like his current situation, this past problem had some relation to work, to leaving his office. A little later, Rajendran affirmed, "I don't have any illness. On the 2nd, because I was late, I didn't go." He said that the following day he was ready to go to work when his son said he needed Rajendran to accompany him to enquire about getting admission to a "tutorial" program (a program to help with studies or prepare for college admission). This, however, turned out to be a ruse by his wife and son to bring him to the psychiatric hospital.

When we enquired as to what other solutions he had sought for his problem, he

told us that 11 years ago he saw an astrologer who told him he hadn't done anything wrong that might have caused his difficulties. However, he told us that he has been taking "over the counter" ayurvedic medicines. He uses ayurvedic chandanadi oil to help him sleep, and he is taking Brahmi, an ayurvedic medicine used for mental problems by ayurvedic doctors, Chottanikkara temple and some Muslim priests (as described in Chapter 3). We changed the topic to Rajendran's current illness, at which point his wife took over and spoke for the rest of the interview:

> Kavitha: What is the reason you are here now?
> Rajendran's Wife: We came because he is not getting enough sleep. He won't sleep before 2 o'clock at night, and won't eat any food. He will always watch me serving the food and will eat only if he likes it. He is suspicious of whether the food is clean, and if he doesn't like it he won't eat it. If he likes it, he will eat only a little. He won't eat anything. Now, after coming here, he is looking healthy. Before that, he was too thin.
> Kavitha: Is that the reason for coming here?
> Rajendran's Wife: Yes. He is not sleeping. And we can't read what he writes. There will be no sense to it.
> Kavitha: And when he talks?
> Rajendran's Wife: There is no problem when he talks. He speaks well. When he writes, we can't understand anything. So we thought, how can this be happening. He will make noises with his pen by hitting it on the paper. When we ask why he is doing this, he will say that he is trying to destroy "bombs" and is listening for their sound.
> Kavitha: Is it the first time he is having this sight problem?
> Rajendran's Wife: Yes. He is working in a bank. At the time when he goes for his work, he complains that someone is shining a light in his eyes so he can't work. Then he says, "Someone is shooting at me and small pellets are in my body." He says things like this. "Things were like this." He would say things are like this. Then he would go to work.

Rajendran's wife reiterated her concern for Rajendran not eating and becoming thin at a few other points later in our interview. Suspicion about food--being unclean or poisoned--as recounted above was a characteristic of the problems of some other male patient-informants. One informant complained that his wife was intentionally making bad food

and not serving meals at the right time. Problems related to food--refusing to eat, eating little, eating slowly and suspecting food--were the most common symptoms reported by my patient-informants and their relatives. Though the food and eating problems mentioned here are common among people suffering distress, it should be pointed out that anorexia and obesity are extremely rare in India (according to mental health practitioners and my own observations of patients).

Rajendran's wife explained that the first time Rajendran's problems emerged, he was brought in to see Dr. R. at the same psychiatric hospital where he is now receiving treatment. Rajendran took the medicine Dr. R. gave him, but after a while, on his own initiative, he stopped his medicine and, according to his wife, his problems returned. About two years ago, Rajendran's wife took him to see Father M., a church pastor/priest and psychiatrist she had read about in Mangalam, a popular magazine. Father M. gave medicine and hypnotized Rajendran. "He got lots of change, lots of relief from there," Rajendran's wife recalled. As Rajendran and his wife are Hindu, this is another case of crossing religious boundaries in seeking relief from illness.

When asked to explain how Rajendran's problems started, his wife traced their origin to the death of his father with whom he and his wife had a special relationship:

> First time this happened is when his father died. He was very fond of his father. He married me without his family's permission. He is my cousin. My uncle's son. So his father and mother did not approve. I don't have enough education. I studied only until 7th [year of schooling]. So his family didn't like it, but we got married. My family also did not like the idea. So we got married out of love. So we don't go see our family. Only his father came to us and loved us even after our marriage. He died after we had 3 children. So when his father died he [Rajendran] probably thought that he did not have anyone to love, that he lost his love. So then his father died, and when they took his body he [Rajendran] too was taken to Medical College hospital. He was unconscious so his friends took him. They [the

> doctors] wrote that this was mental and gave treatment for that. His friends did not show that to us or anyone. If he had done something. If he had taken medicine continuously, it wouldn't have been like this.

Despite the trauma of his father dying, there was no indication of Rajendran receiving any treatment other than medications. There may have been counseling, but there is no mention of any. Rajendran's wife also interprets his state of mental health as related to his taking medication.

At the end of the interview, Rajendran's wife said she believes he has improved during this stay at this hospital, and she has heard he may be released soon:

> Kavitha: When will he go from here, get improvement and leave here?
> Rajendran's Wife: Doctor did not say anything about that. The nurse said that we can go on this Sunday. Maybe we can go on Sunday.
> Kavitha: Do you believe that this problem won't come again? Or, if it repeats, will you come here, or...?
> Rajendran's Wife: We will only come here. We won't go anywhere else.

Rajendran's wife did not rule out the possibility of Rajendran's problem coming again, but, as opposed to Abdul-Rahman who will use any means necessary to get relief, she affirms an allegiance to this hospital. We did not see Rajendran again, and were not able to arrange a follow-up interview with him.

Lakshmi and Others - The Gulf Wife, Blessed by Devi

Lakshmi is a 26 year old woman who is not employed and is married to a man who is in Saudi Arabia doing "mechanical" work. When Biju and I interviewed Lakshmi, she and several relatives were on one of the regular visits they make to Chottanikkara temple for general prayer and the maintenance of Lakshmi's health.

We interviewed Lakshmi in the presence of several relatives in her room at the

temple guest lodge where Biju and I were also staying. Lakshmi's relatives did not speak during the interview. Rajan, a young man who works at the temple lodge, was also present and made some comments during the interview. Rajan knew most of the patient-devotees at Chottanikkara lodge, and he arranged some of our interviews.

One of the first things we learned about Lakshmi was that she was fairly well-educated. She completed her PDC (Pre-Degree Certificate) studies which makes her eligible to enter a university. However, she is not working. As we shall see later, this is a distressing combination of life circumstances for many women. Educated, unemployed married women and unemployed wives of men who are working in the Gulf often suffer psychological (and in Lakshmi's case, somatic) distress.

After we learned about her education, we asked Lakshmi what problem she was seeking relief from in coming to Chottanikkara temple. She explained:

> I had illness all over my body. Even when I took medicine I did not get any better. After that, we went to a worship center [religious center - *bhajanamatham*] where Amma's [i.e., Devi, the goddess] blessings [*anugraham*] were readily available. When we went to the place where you receive the blessing, we came to know through Amma that this illness keeps on coming because we have this sin/fault [*dosham*]. After that, we came here for *bhajana* [worship through singing]. Even doing one worship made it so that we needn't go to a hospital.
> Biju: What type of illnesses did you get?
> Rajan: You spoke about many serious *aswasthatakal* [uneasinesses/discomforts]?
> Lakshmi: Yes, there was *aswasthata* [uneasiness/discomfort], always a fever, chronic fever, headache all the time. Pain all over the body.

We learn that Lakshmi's distress is expressed somatically, which is also the first hint that Lakshmi's problems are hard to describe in the secular, illness-related terminology I have been using so far. Although I will argue in the next chapter that people in Kerala do have a clear concept of the "mental" as distinct from the body and conceive of many of the

problems described in this study as, quite literally "mental illnesses," (*manasika rogangal*), a number of people I spoke with expressed problems almost exclusively through the body. Often distress is expressed in a way that is hard to classify as "mental," "physical" or "spiritual" or as originating in social, family or work problems. This indeterminacy of the locus of suffering has been examined by a number of anthropologists and other researchers (Kleinman 1986; Csordas 1990; Kirmayer 1992; Jenkins and Valiente 1994; Low 1994; among others). Lakshmi's explanation of the cause of her problem also defies classification in secular, academic terminology. She says that she learned from Amma, god/the goddess, that her illness is due to a *dosham*, a bad sign, a sin or bad karma, under which she was born. This problem started six years ago at which time Lakshmi saw an allopathic doctor. Regarding her experience with allopathy, Lakshmi said, "I will get relief [*aswasam*], but when I come home, it will start again." Lakshmi also began coming to Chottanikkara six years ago, and her experience there has been very positive:

> I have been coming to Chottanikkara for the last 6 years now. I came here because of the *chaitanya* [power/consciousness/vigour] and blessing of the Devi [the goddess] at Chottanikkara. I started sitting for worship. From then until now, I haven't been to the "hospital." I have no problem at all. I came here, and Devi cured [lit. changed everything] me. So I have been getting *aishwaryam* [wealth/glory] and *abhivridhi* [prosperity] continuously. Because of that blessing, I will be here forever.

These words will be presented again in Chapter 6 in a discussion of the limitations of the concept of "cure." What some people accomplish through healing in Kerala is not just a ridding or reduction of a problem but, as Lakshmi describes here, an attainment of a higher state, a state that is somehow better than one's original, "healthy" state. Not only

does she no longer have a problem (the negative is gone), she has gained prosperity and the blessing of Devi (the positive is present). Such reactions vary with the form of therapy people use. While patients of allopathy say that they got good "relief" or, at best, became "completely healthy," a number of informants who used religious therapy recalled their experience with enthusiasm, nostalgia and even bravado. Like allopathic patients, ayurvedic patients generally spoke of returning to health, though a few described attaining a higher level. When Lakshmi says "I will be here forever" she is expressing her intention to keep returning to Chottanikkara. (Perhaps on another level she is saying she will always be connected to this temple.) Lakshmi lives in a nearby district and her family visits Chottanikkara once a month for one or two days at a time. Lakshmi continued her enthusiastic description of getting to know Devi at Chottanikkara:

> The first time I saw Devi, I had come here before. I came, and I left after only doing *tozhuka* [adoring the deity by putting hands together at chest]. I had not sat for worship like this. The first time I came here to sit for worship, many wonders were worked on me. The reason is, firstly, people came here with the same illnesses. I did not understand what it was. After some time, when we sat there, it felt like something was leaving from our body. It cured/changed all our uneasiness. We were changing in our selves.

Rajan then asked Lakshmi about the first time she became possessed:

> Rajan: How was it when you "first" got possessed [*tullal*]?
> Lakshmi: The "first" time I got possessed, I felt like I was being tied up.
> Biju: Like you were tied up?
> Lakshmi: Like being chained at the legs, unable to walk.
> Biju: Do you feel like someone is coming to "attack" you? Like someone is "attacking" you from behind?
> [Brief exchange between Biju and Murphy in English.]
> Lakshmi: When we do that, we will feel each thing inside us, inside our mind like each thing working on us. That is, whether we do some prayer or when we come to do something else, without obstacles, we... When some obstacle comes, we make some promise [to God]: that after getting beyond that obstacle, we will come back. Sometimes, we will not be able to move our tongue. Finally, we will

be unable to talk. Then when we do offerings, we will be free from that.
Biju: Do you have consciousness [*bodham*] during possession [*tullal*]? Consciousness [*bodham*]?
Lakshmi: No.
Biju: Do you have [literally, see] consciousness inside [*ullil bodham kanumo*] ?
Lakshmi: Inside the inside, there will be consciousness [*ullinde ullil bodham kanum*]. The reason is, however, there is no outside. There is a feeling that something is inside.
Biju: No consciousness [*bodham*] on the outside, right?
Lakshmi: No consciousness [*bodham illa*].

My interpretation of this description of possession is that Lakshmi is saying that during possession, one's normal state of consciousness is gone ("there is no outside"), but at some, deep or subtle level ("inside the inside") she is aware that something is going on. This discussion about consciousness during possession, is presented again in Chapter 5 as part of a critique of anthropological studies of the body and a description of phenomenology in Kerala in which *bodham* "consciousness" is a central concern. I argue that people in Kerala experience problems of distress--and perhaps experience in general--in a variety of states that form a continuum from the more embodied to the more disembodied. In Lakshmi's case, we saw earlier how she experienced problems as pain in the body, and here she is describing a part of the healing process in terms of subtly different levels of consciousness and a change in the self.

A little later, we learned more about the *dosham* that caused Lakshmi's troubles:

Biju: What do you think is the cause of your problem? You have some problems and all, "okay"? You had a problem earlier, right? What do you think is the reason for that problem?
Lakshmi: *Sarppadosham* [snake dosham/sin].
Biju: *Sarppadosham*? How did you learn about *sarppadosham*?
Lakshmi: How I learned it was when we [inclusive] were getting possessed, right? At that time, it comes to us. We will know it clearly.

Lakshmi explains that specific *dosham* was revealed to her during possession.

S*arpadosham* is a bad "sign" (a fault, disorder or negative *karma* someone is born with). Someone born with this *dosam* is expected to encounter adversity. Western academic and popular representations of *karma* and astrology imagine a kind of irreversible fate, but people in Tamil Nadu, according to Daniel (1984: 198), know that any kind of "fate" can be changed through appeal to the divine and through right action. It seems that for Lakshmi the effects of *sarpadosam* have been suspended with help from Devi.

Finally, we were told that Lakshmi got married seven years ago, and for the last five years her husband has been working in "the Gulf," in Saudi Arabia. In Kerala today, there are a great number of "Gulf marriages" where the husband works in the Gulf while the wife remains in Kerala, and the husband is able to return to visit only about once year. My research assistant Kavitha's Master's thesis at the University of Kerala examined mental health among wives of Gulf marriages. Kavitha found that Gulf wives were more depressed and had more "maladjustment traits" than wives whose husbands were in Kerala, yet the two groups showed no difference in "stress" and "mental health status" (terms in quotes here indicate what psychological tests chosen by Kavitha attempt to measure). Additionally, Gulf wives who were not working suffered greater stress than those who were working (Kavitha N.S. 1996). Also, a study by Gulati (1983), referred to in Kavitha's thesis, claimed that incidence of mental illness was higher in the areas of Kerala that had the highest rates of Gulf migration.

A little over six months later, we received answers to our follow-up questionnaire written by an unidentified male, possibly a relative, on behalf of Lakshmi. Informants who lived in Trivandrum District, where Kavitha, Biju and I resided, were invited for an

in-person follow-up interview but given the option to return a questionnaire by mail. Informants who lived outside of Trivandrum District, such as Lakshmi, were only asked to respond to a questionnaire as arranging follow-up interviews in other parts of the state turned out to be extremely time-consuming and logistically daunting. The questionnaire and responses are not lengthy, so I will reproduce them here in their entirety:

> *1) How do you feel at present? Have you experienced any improvement or decline in your condition?*
> She is feeling good. She has experienced improvement..[14]
>
> *2) What treatment have you been using since we last spoke with you (about 6 months ago)?*
> She is taking treatment now.
>
> *3) How many times have you been to Chottanikkara temple since we last spoke with you?*
> Each month we/she[15] are going to Chottanikkara. In addition to that, we/she are doing 2 or 3 days *bhajana* [worship].
>
> *4) Do you have any symptoms you haven't noticed before (since we last met)?*
> No.
>
> *5) Do you have any new ideas about the cause of your illness? Please explain what you believe to be the cause of your illness.*
> Now there is no problem.
>
> *6) If your problems are still continuing, do you have any specific plan to get over this illness?*
> There is no problem, but if anything should arise, we have faith that we can solve the problem by *bhakti* [devotion].

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[14] Although the original Malayalam responses are subjectless, and the verb does not indicate who the speaker is, I added "she" to make the response intelligible in English.

[15] This time the subjectless construction is ambiguous, which I believe is an intentional effect of Malayalam grammar having to do with the contiguity of the self. We and she are two possible but incomplete translations.

7) If your problems are still continuing, when do you believe these problems will be over?
[no answer]

8) Please give us any additional comments you feel we should know.
If you want to know more details, please contact this address. [address deleted]

We are told that, six months after our original interview, Lakshmi is doing well, and there is confidence that any further problems can be resolved through worship at Chottanikkara. In fact, informants using religious therapies reported the greatest degree of improvement--though only slightly higher than those who were using allopathy or ayurveda--in our follow-up interviews and questionnaires.

Hanifa and His Wife - Relieving "Tension" at Beemapalli

Hanifa and his wife had been staying at Beemapalli and seeking relief for Hanifa's problems for a year and a half when Kavitha and I interviewed them. Hanifa is a 30 year old Muslim from Trivandrum district who did janitorial work for five years in the Persian Gulf. Hanifa developed a "tension" (he used the English word) in the Gulf and came home approximately 10 years ago.[16] Hanifa first consulted an allopathic psychiatrist in Trivandrum. He described his problems and his treatment at that time:

> Sleeplessness was one problem, and he would give medicine to be taken at night. I should take pills at night, and get up only in the morning. He said not to take that medicine in the morning. He will give me the "prescription" and I will get it from "medical shop." Then he asks me to meet him next "term," and then I will

[16] As will be seen below, the timeline given by Hanifa and his wife seems unusual. It would put Hanifa in the Gulf at age 15, yet we are told he studied up to Secondary School Leaving Certificate (which he failed). He probably would not have made it to the Gulf until at least age 18, and he may have returned more recently than 10 years ago.

go and consult him. He will again give some prescription for medicine and we will buy it and it will go on like that "continuously."

Like Abdul-Rahman, Hanifa's recollection of his allopathic treatment focuses almost exclusively on medication. We imagined he would have received some counseling since he saw this psychiatrist in his private practice at the psychiatrist's home (where therapists are supposed to have more time to talk with patients). We later asked whether he had received any talk therapy, and it appeared that he did not. Here, Hanifa mentions sleeplessness as part of his difficulties. We then enquired whether he had any other difficulties, and he explained "Something like a 'tension' has come," using the same English language idiom that Mary invoked.

When we asked how Hanifa's problems started, he explained that shortly after returning from the Gulf his father had died. Yet later, he told us that his problems started in the Gulf. After seeing the allopathic psychiatrist described above, Hanifa sought therapy from a clinical psychologist for one month, and we also learned that Hanifa and his wife had been coming to Beemapalli since the onset of Hanifa's problems. At first they were coming once a week, but for the last year and a half they have been living at Beemapalli--and Hanifa's wife reports "There is a lot of change [improvement] after coming here." We asked Hanifa's wife if they were still pursuing allopathic treatment:

Kavitha: Are you taking "allopathy" medicine now?
Hanifa's Wife: No, no.
Kavitha: Now he is not taking any medicine.
Murphy: Now it is finished.
Hanifa's Wife: Now that he is not taking medicine, there is a lot of improvement. When he was taking medicine, he had memory problems [lit. reduction - *kuravu*].

We later asked if it was because of memory problems that they discontinued allopathic care:

> Kavitha: Was it because of memory problems that you stopped, or...?
> Hanifa's Wife: Yeah, because of memory problems and a lot of "tension." Thinking, and he was like this. So we changed. Now there is relief after coming here. After he came here, he sleeps without taking medicine. Before this he wouldn't sleep even after taking two pills.

Our discussion with Hanifa's wife about medications will be revisited in Chapter 6 which focusses on how "pleasant" it is to undergo treatment in these different forms of healing and examines several patients who left allopathic psychiatric treatment because they did not like the effects of medications or electroconvulsive therapy. The fact that Hanifa has been living at Beemapalli, where he gets "relief" and can sleep, brings up a secondary issue in Chapter 6 which is that many informants appeared to have found a solution to their problems not in pursuing medical therapy but in living in a pleasant process of therapy. In Hanifa's case, his problem is not resolved or "cured," but he gets some relief residing in the aesthetically- and spiritually-engaging environment of Beemapalli mosque.

Regarding Hanifa's wife's assertion that Hanifa has improved since coming to Beemapalli, allopathic psychiatrists were incredulous when I told them that there were patients at Beemapalli who had gotten relief after giving up on allopathy. Psychiatrists often looked upon Beemapalli as "unscientific" and backward. They did not believe it could be effective for anything except minor problems, and suggested that people with serious disorders did not visit the mosque. Yet I found that 15 out of the 17 people we interviewed at Beemapalli had previously sought allopathic treatment and many of these as inpatients in psychiatric hospitals (which means that they would have had a serious problem in the view of allopathic psychiatrists).

Allopathic healers asserted the effectiveness of their therapy by claiming that many patients had taken undergone one or two rounds of therapy or institutionalization and were never seen again. Some of these people may have found permanent relief for their problems, but others would have ended up at other healing centers such as Beemapalli. A story I heard a few times at Beemapalli was: a person tried allopathy twice, but when the problem came back a third time they decided they should try a different therapy. However, it was not only allopathy that did not work for these patients. Some had tried ayurveda, *mantravadam* (sorcery), homeopathy, and visiting temples. Meanwhile, three patients of allopathic therapy I spoke to had previously been to Beemapalli and did not find a solution to their problems there.

As our interview moved on, we brought up an interesting discussion about talk therapy:

> Kavitha: Did the "doctors" give you "counseling"?
> Hanifa: What does that mean?
> Kavitha: Did they talk to you for a long time to get everything in your mind?
> Hanifa: Yes, they will ask me some questions.
> Kavitha: They will talk for a long time, and after that do you get any "relief"?
> Hanifa: "Are you sleeping well?" They will ask me if I have enough sleep now. Then they will ask me if I can hear some voices talking to me. Only when I take medicine I will sleep. Without that I can't sleep, even in the daytime. They told me to continue the medicine.

Hanifa shows here some unfamiliarity with counseling or psychotherapy. Hanifa recalls only diagnostic questions doctors had given him, and concludes his response with a return to the topic of medication. As mentioned in Chapter 3, I did not encounter a lot of talk therapy in the various forms of healing I examined. Ayurvedic and allopathic psychiatrists give counseling--and we heard reports of advice from Sreedevi's therapist--some at Vettucaud church talk to people about their problems, and clinical psychologists

heal with talk therapy, but most of the conversational interactions with healers that are reported by my informants focussed on diagnosing their problem and managing medication.

We soon returned to discussing Hanifa's troubles, and his wife told us that Hanifa was under tension in the Gulf partly because of financial worries. Like many migrant workers from India, he had to borrow a lot of money to get a plane ticket, visa and other things one needs to get to the Gulf at a time when he and his family were not financially secure. Now they are doing fine financially according to Hanifa's wife. Hanifa has worked "in a friend's house" since he came back from the Gulf, but we did not obtain further details about this work. His wife then gave us a few more details about his troubles:

> Since he came back, if we ask him anything, he will get *vepralam* [confusion, worry, dilemma] and will run off. He will run off without asking anyone. When we look for him, he won't be in the house. He began to spend all of the money. So then for some time we thought it might be *kaivisham* [a mysterious poison] or *sheitthan* [a spirit]. So we were looking into that.
> Kavitha: Did you do any *pooja* [worship, ritual] for that?
> Hanifa's Wife: We didn't do a lot of that. His sister is educated so they consulted a doctor. There was no relief with that. So only when we came here to this mosque was there any change [*maattam*].

"Running off" from home is a common characteristic of informants' illnesses. Again, Hanifa's wife emphasized that Hanifa's problem improved only at Beemapalli mosque. Hanifa's wife then told us that they did try doing *poojas* (Hindu worships and rituals) to counter *kshudram* (sorcery) in case Hanifa's troubles are due to *kaivisham* or a *sheitthan* as suggested above. These efforts did not produce any changes in Hanifa's condition however. We see here another case of religious syncretism. Hanifa and his wife are

Muslim, and they tried *poojas* which are Hindu practices to rid Hanifa of his problems.[17] Also, it is revealing that Hanifa's "educated" sister urged that Hanifa see a "doctor" when his wife was considering the possible involvement of sorcery or spirits. In Chapter 7, I will consider how secular education and the promotion of allopathic views through the media may relate to a decline in the incidence of spirit possession in Kerala.

Hanifa's wife told us earlier that they had to remain in Beemapalli only five more months for Hanifa to get relief. Toward the end of the interview, we asked her to explain how she knew this. She explained that "Umma [the woman who is buried at Beempalli, described in Chapter 3] showed us in a dream:"

> We will dream about it and in the dream we will be given medicines, "operation" and all. If we dream that we are going home, we can go home. We dreamt of being here until the flag hoisting. So after that we can go.

The "flag hoisting" refers to the annual festival at Beemapalli.

Finally, we then learned some of the details about what Hanifa and his wife do at Beemapalli for worship/therapy, which is basically the general routine that everyone suffering illness follows: eating jasmine flowers, bathing with water from the medicinal well, circumambulating the mosque and praying. At the end of the interview Hanifa confirmed that he has faith he will get relief from his problems at Beemapalli.

Biju, Kavitha and I returned to Beemapalli a number of times and conducted

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[17] Practices to counteract sorcery could also be considered simply part of Kerala/Indian culture rather than "Hindu." Sorcery and counter-sorcery are not usually practiced in a temple, and practitioners may be non-Hindu. Yet one can also do *poojas* at a temple to help counter the effects of sorcery. As mentioned in the previous chapter, it is difficult to draw a line between what is Hindu and what is non-Hindu, especially as this term has been used to label virtually any practice in South Asia that is not clearly identified as Muslim, Christian or belonging to some other religion.

follow-up interviews with any informants we encountered, but we did not meet Hanifa and his wife again. Perhaps we simply did not see them among the many people who circulate through the mosque every day or did not happen on the guest room or the part of mosque grounds where they were staying. Hopefully, Hanifa and his wife completed their five months, got some "change," as they say in Kerala, and returned home.

This chapter should provide a useful context for understanding the people, circumstances and settings that are involved in the following chapters. Certain issues repeatedly came up that emphasize features of the contemporary cultural scene in Kerala and topics that are the focus of later chapters. Education and marriage are two important themes in Kerala culture that arose in these interviews. Several informants had 12 or so years of schooling, which is high given the average number of years of schooling in India, and we got a taste from Rajendran of how people discuss their educational qualifications and the exams they passed or failed. We also heard about Sreedevi, the daughter of a school teacher, and her mother's distress about her loss of interest in studies. Sreedevi also revealed, along with Mary, concerns and anxieties about marriage which is one of the grandest themes of life in Kerala.[18] Marriage came up Rajendran's story as well. His problems related to the death of his father, the one person who

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[18] The significance of marriage is too big an issue to cover in this chapter or to elaborate on here. It is the subject of almost every movie or television show. It is one of the first issues brought up in meeting or discussing a new person ("Are you/he/she married?"). Suffice it to say that I went to as many weddings in a year in Kerala as I did in more than 30 years of living in the U.S.

supported Rajendran and his wife in a marriage that was condemned by most members of their families. Gulf migration is a big issue in Kerala today, and this topic raises its head many times in the stories of these informants. Abdul-Rahman and Hanifa worked for a while in the Gulf, and Lakshmi's husband had been in the Gulf for several years. We also saw evidence of literacy and the dissemination of knowledge about health and methods of healing through the press in Kerala. Sreedevi's mother learned about ayurvedic psychiatry through the newspaper and Rajendran's wife learned about a church "father" and psychiatrist who she took her husband to meet. One informant also visited an allopathic healer who writes a column in a popular magazine (though this fact wasn't mentioned earlier since it could help identify the informant). Allopathic psychiatric and psychological views dominate this forum, and thus the media promotes the hegemony of allopathy. Yet at the same time, people such as Sreedevi's mother and Rajendran's wife become aware of the various forms the healing that are available through the press.

Additionally, many of the informants here used words that describe what one accomplishes through therapy such as different forms of the verb *maaruga* "to change" (*maatti, maari, maarum*); *vyathyaasam* ("difference" in a positive sense--i.e., improvement); *aswasam* ("relief"); *kuravu* ("decline" or "lessening" or negative symptoms). None of these terms translate precisely as "cure," (though Lakshmi's *ellam maatti*, "changed everything," is close) and Chapter 6 attempts to go beyond the cultural boundedness of "cure" and look at these other ways of coping with illness problems. Finally, we saw in the case of Lakshmi how some people express distress through the body in Kerala. But Lakshmi also describes the different kinds of consciousness that one

experiences during possession, and other informants, such as Sreedevi's mother and Mary, clearly identify their problems as occurring in the *manas* ("mind"). As will be discussed in the following chapter, this runs counter to the trend in anthropology of finding "nonwestern" people living in the body and claiming that distinctions between mind and body are a uniquely western phenomenon.

Yet this chapter should not be seen as merely supplemental or background material. Though they are *key* issues I cannot say that they are greater or more important and the smaller issues, the details taken collectively. This small selection from the spectrum of issues and experiences evoked in lives of persons suffering illness is as important to understanding health and illness and its implications as the material in more analytical chapters. It was the largesse of ethnographic reality and the humility felt when trying to comprehend issues of health and illness that had the greatest impact on me during fieldwork. The main thing I came away with after 15 months of research and 3 visits to Kerala is a glimpse of how much I *don't* know about the world health and healing and everyday life in Kerala and a realization that to truly understand these issues would take a lifetime of research, at least. What I mean by this is hard to relate: the meaning is after all in the details of life in Kerala. My presentation has the feeling of a photo one has taken of an awe-inspiring sight that requires an apology or an explanation that the photo doesn't quite reveal what was so impressive about the sight. But hopefully this chapters shows enough to remind the reader that this dissertation reveals only the smallest sliver of the world of health and healing in Kerala, and makes her/him aware of some of the range of relevant issues that aren't covered in this analysis.

Chapter 5 - Consciousness, Mind and Body in the Phenomenology of Kerala

This chapter will turn a critical eye to the large volume of current research on the body and embodiment in anthropology and present a phenomenology of patients in Kerala who distinguish between body, mind, consciousness and other non-bodily states. The trend in the 1980's and 1990's of examining bodily and lived aesthetic experience was an important corrective to anthropological studies that looked at illness, and life experience generally, in cognitive or mentalistic terms and through the assumptions of western mind-body dualism. However, there has developed a trend to exoticize and generalize non-western cultures as grounding experience in the body and lacking a phenomenological orientation that distinguishes mind from body. "Mental" patients and spirit-possessed people in Kerala have many mentalistic and non-bodily modes in which they express their suffering which actually present more levels of rarification away from the body than are contained in western mind-body phenomenology. These expressions of suffering do not simply replicate western mind-body dualism. Instead, they constitute a unique cultural phenomenology that includes the bodily and a number of modes of the non-bodily, non-physical.

I would suggest that anthropologists examine cultural phenomenologies, orientations to experience--such as Csordas (1990, 1994) suggested in proposing a paradigm of embodiment--which are not simply about the body but about the phenomenological condition in which a person necessarily lives as a combination of mind, body and other locally-construed modes of experience. Csordas described

embodiment as an orientation towards "being in the world" (1994: 10) which characterizes, more accurately than the term "embodiment," the perspective I am advocating and the phenomenology encountered in Kerala (though one might refer to "being outside the world" in the case of certain philosophical traditions, discussed in this chapter, that emphasize transcending the phenomenological world). Thus, this chapter not only critiques the focus on the body in anthropology, but also asserts a paradigm of phenomenology and presents a phenomenology of South India.

As a response to analyses which explore the western underpinnings of mind-body dualism in western philosophy, such as in the epistemologies of Aristotle and Descartes, I will present some of Indian philosophy's many exegeses on the self, the soul, the body and related issues before presenting the testimony of persons seeking relief from psychopathology and possession. I will also argue that there is reason to believe that assumptions of these philosophies exist to some degree in popular expressions of illness. The combination of arguments from Indian philosophy and excerpts from patient interviews reveal a phenomenology in Kerala that includes the body and several increasingly non-physical realms, a kind of continuum of states of increasing disembodiment from the bodily/material towards the absolute, disembodied higher self, or Ātman.

Focussing On the Body

It would not be hard to convince the reader that in anthropology, and other disciplines, studies of the body and embodiment have been prolific in the last decade. It

is difficult to quantify the amount of published work in this area, but as an indicator of the popularity of these topics a search of Dissertation Abstracts Online on the subjects "anthropology" and "body" or "embodiment" reveals about 75 dissertations every year relating to these topics in the 1990's, 40 or so in the 1980's and virtually none in the 1970's and earlier (Online Computer Library Center 1998). As a great number of works could be cited to reveal the emergence of the anthropology of the body and more comprehensive reviews have been done (e.g., Lock 1993), I will review developments in anthropological approaches to the body and embodiment that are relevant to the arguments in this chapter.

Until the mid-1980's, anthropological studies of health and illness were interested mainly in views of illness and mental models of health and disease (e.g., Kleinman 1980; Marsella and White 1982), and it could be argued that a mentalistic perspective predominated in anthropology generally until medical anthropology in the mid-1980's started looking at how people experience the world and express themselves bodily and emotionally. By 1993, Margaret Lock could declare the state of the art in the anthropology of the body as follows:

> Interpretations that seek explicitly to collapse mind/body dualities, or that are essentially dialectical or montage-like in form, are now privileged. The body is no longer portrayed simply as a template for social organization, nor as a biological black box cut off from 'mind,' and nature/culture and mind/body dualities are self-consciously interrogated. (136)

Collapsing mind/body dualities and viewing the body as integrated with the mind allows us to see cultural variations of embodiment, but there are places, such as Kerala, where people do separate mind from body, self and other attributes.

A few works predate yet have influenced the current turn to the body. These include Marcel Mauss's essay "Les techniques du corp [Techniques of the Body]" (1936), which examines how people are socialized through their bodies--how culture is also located in the body--and Mary Douglas's Natural Symbols (1970), which views the body as a metaphor, a cultural trope that helps make sense of the world and society. Also important to this trend are Michel Foucault's Discipline and Punish (1977) and his History of Sexuality series (1978-1986)--perhaps even his whole *oeuvre*--which reveal how people are trained to become modern subjects, citizens etc. through the body, how society inscribes itself in the body. Regulating (e.g., of sexuality) and disciplining (e.g., in the military) of the body are part of how subjects are constructed for Foucault.

In 1987, Scheper-Hughes and Lock's "The Mindful Body" was an influential appeal to transcend western mind-body dualism in anthropology and a call to examine different cultural conceptions of the body, which inspired many subsequent works in the anthropology of the body, such as Strathern (1996), discussed below. While Scheper-Hughes and Lock were writing this article, linguists, philosophers and scholars in other fields were also focussing on the body. Mark Johnson's The Mind in the Body (1987) examined how the condition of being in a body shapes our perception and experience of the world: linguistic metaphors, such as prices "rising" or "falling," developed out of the embodied condition of human beings, the perspective of the world as seen from one who inhabits a body. There also developed a number of studies that focused on women and experiences and objectifications of the female body that spanned many disciplines including anthropology (Martin 1987), philosophy (Bordo 1993) and literature (Gilbert

1997).

One could draw this genealogy of the anthropology of the body to include anthropological studies of emotion (works such as Rosaldo 1980, Lutz 1988, Abu-Lughod and Lutz 1990). Studies of emotion and the body are certainly intertwined. However, the anthropology of emotion in itself is a field too large to outline here except to say that consideration of emotion arises in contemporary works on the body, such as Desjarlais' Body and Emotion (1992), which examines the aesthetic, visceral and emotional experience of illness and healing in Nepal.

Influenced by the phenomenology of Merleau-Ponty and Bourdieu, Thomas Csordas offered "Embodiment As A Paradigm for Anthropology" (1990), an article that did just what it hoped, launching a variety of studies that centered on embodiment, though this concept was understood in very different ways by these studies. Csordas' work (1990, 1993, 1994) differed from that of Scheper-Hughes and Lock and other predecessors in that while others were looking at *concepts* of the body or bodily metaphors, Csordas was suggesting one consider the actual, lived experience of being in the body or "being in the world." In the 1990's, a number of anthropologists applied various interpretations of "embodiment" to ethnographic contexts (e.g., Scheper-Hughes 1992; Pandolfi 1993; Low 1994; Jenkins and Valiente 1994; Kleinman, Das and Lock 1996), and emphasized visceral, emotional and aesthetic aspects of the illness experience (e.g., Desjarlais 1992; Laderman and Roseman 1996), signifying an overall trend to focus on the tangible and visceral.

Let me just clarify that there is a difference between Csordas' work on

embodiment and contemporary anthropological studies that focus on the body. Csordas, and the phenomenology of Merleau-Ponty which informs Csordas, see embodiment as a universal human condition. All people experience the world from the perspective of being in a body, and obviously this applies to people in Kerala. But considering this existential condition is distinct from the trend of focussing on and scrutinizing the body in anthropology. Additionally, I argue that the term "embodiment" has been appropriated by many anthropologists, not to identify the existential condition Csordas described, but as a synonym for the body or somatization. When I critique studies of embodiment, it is this narrow use of the term as a synonym for the body that I am most concerned with.

Attention to the body and embodiment was, and continues to be, an important reorientation in anthropology away from a tendency to examine how people think about things like illness and away from the assumption of western mind-body dualism in examining health and illness or experience generally in various cultures. However, anthropologists have seemed to overstep this corrective, and there is a tendency now to depict virtually all non-western cultures as locating experience in the body. I will highlight certain key works in relation to this trend, which embraces a vast amount of literature.

Kleinman in his work on depression and the expression of pain in China informs us that, around the world, somatization is a more common form of expressing distress than psychologization and is particularly found in non-western societies:

> Psychologization is the result of the Western mode of modernization that now influences the elite of non-Western societies; somatization is the product of more traditional cultural orientations worldwide, including that of the more rural, the poorer, and the less-educated in the West. (56)

Psychologization, he claims, is unique to the middle and upper class West and emerged around WWI (1986:55-56). It's possible that what Kleinman says about the predominance of somatization is correct, but psychologization or mentalistic idioms of suffering are not confined to westerners.

Frustrated by biomedicine's need to see all suffering as "either wholly organic or wholly psychological in origin," Scheper-Hughes and Lock propose, among other things, that medical anthropology try to go beyond mind/body dualism (1987: 9). While they do not claim that all non-western cultures locate experience more in the body or are more holistic, they tend to treat the material as if one can generalize in this way. For example, their article contains frequent contrasts such as the following: "Non-Western and nonindustrialized people are 'called upon to think the world with their bodies'," yet "[b]y contrast, we [westerners] live in a world in which the human shape of things...is in retreat" (23). Also, in a section called "Representations of Holism in Non-Western Epistemologies," the balance, holism and monism of Chinese, Buddhist and Islamic cosmologies is contrasted to a western emphasis on exclusion, tension and contradiction (12-13). Of course, when one begins to suspect something, such as mind-body dualism, to be a western construction, one looks to other cultures to further investigate this issue. However, research on the body has tended to generalize and reify the non-western embodied subject.

While many anthropologists flirt with the notion, but don't explicitly say, that all non-western cultures tend to locate experience more in the body, when one looks at the *corpus* of research on the body (i.e., when one looks pragmatically at what anthropology

is doing) one gets the impression that all non-westerners are more likely to ground experience in the body. The ethnographic work subsequent to the articles of Scheper-Hughes and Lock has not (yet) discovered that variegated reality that is inevitably encountered after someone initiates an exciting new paradigm.

Andrew Strathern's Body Thoughts (1996) is devoted entirely to the topic of orientations to the body in the West and in other cultures. There are a number of statements like: "...many peoples around the world...in whose own cultural concepts emotion and reason are closely linked..." (8)--where emotion and reason are considered as aspects of the body-mind distinction. After discussing an article that refers to the prioritizing of knowledge over emotion in European cultures, Strathern asserts "Yet in other cultures this kind of hierarchical ranking of knowledge versus emotion does not exist," (151). "Many peoples" and "other cultures" are not the same as saying "all non-western cultures," but in this book, as in many others, the narrative contains a dichotomization between western culture and something else, some Other, often referred to as "other cultures." Strathern also gives numerous examples of how nonwestern peoples locate emotion in different parts of the body, which contrasts with material I present below from informants in Kerala

Further evidence of the tendency to see non-western cultures as more bodily oriented is revealed by a closer look at the numerous anthropological dissertations on the topic of body and embodiment referred to earlier. These dissertations are overwhelmingly studies of non-western peoples, and when dissertation research on the body is done in the U.S., it tends to focus on non-western immigrant groups. Also, some research focuses on

Latin America, and looks to *prehispanic* culture for evidence of more holism and embodied modes of experience (Online Computer Library Center 1998). When one also considers that much of the contemporary research on the body in western culture outside of anthropology focuses on women (e.g., Bordo 1993; Gilbert 1997) and that some have associated expressing suffering through the body with low socioeconomic position (Kleinman 1986; Scheper-Hughes 1992), one gets the impression that--either due to fact or through anthropological interpretation--it is people who have less access to power that locate experience more in the body or transcend mind-body dualism. Contrary to these studies, the examples of non-bodily expressions from Kerala given below cut across class, gender, and (an important factor of stratification in India) religious lines. (If anything, my sample is somewhat low in representatives from the highest social classes.)

I have referred to the *corpus* of anthropological work as generalizing the non-western other as being more in the body. Much ethnography on the body contains convincing analyses of bodily ways of experiencing, and the ethnographic material in this chapter can be taken as a cultural exception to cases of embodied experience that have been presented. In other words, I'll allow that it could be a question of fact: that research up to this point has encountered only non-western peoples, and marginalized peoples in the West, who locate experience in the body or do not engage in mind-body dualism. My research in Kerala would then present an ethnographic exception to this trend.

Kleinman claimed in 1986 that the tendency to somatize distress in non-western societies is what the research conducted so far had shown:

> In many non-Western societies *somatization* (the presentation of personal and interpersonal distress in an idiom of physical complaints together with a coping

> pattern of medical help-seeking) has been shown to be the predominant expression of difficulties in living. That is to say, individuals experience serious personal and social problems but interpret and articulate them, and indeed come to experience and respond to them, through the medium of the body. (51)
>
> The research literature indicates that depression and most other mental illnesses, especially in non-Western societies and among rural, ethnic and lower-class groups in the West, are associated preponderantly with physical complaints. (52)

The patients I interviewed in Kerala, across class lines, present an exception to this alleged tendency to express "difficulties in living" somatically.

Ethnographers have asserted that peoples in New Guinea locate emotion and moral issues in the heart or the skin (Strathern 1996), that "consciousness...cannot be disembodied" and sorcery is always "body seeking" in Sri Lanka (Kapferer 1997: 44), and that "[t]he Yaka [of Zaire] perceive of the body as the pivotal point from which the subject gradually develops a sense of identity" (Devisch 1993: 139). However, people in Kerala do not seem to experience things this way. They do to some degree live through the body, but they also--and emphatically so--are concerned with thoughts, consciousness, and the self.

Anne Becker made an interesting comparison between the mode of embodiment of westerners and that of Fijians. She doesn't claim Fijians are more in the body than westerners, but she makes the interesting observation that Fijian orientations to the body are to a collective body or others' bodies while westerners see "bodily experience as personal and circumscribed" and as controlled by a "governing self" (Becker 1995: 2, 134). Regarding the "governing self," Becker explains that in western discourse, "[t]he experience of the self is *separate from* the body" and "the self is portrayed as *trapped within* the body" (31). These statements also perfectly characterize Indian philosophical

statements about the self's (non)relation to the body described below.

A partial exception to this tendency to generalize the phenomenological experience of non-westerners can be found in Johnathan Parry's "The End of the Body" (1989). This is a partial exception since, at the level of theory, Parry does not engage with anthropological studies of the body but with the Chicago school of South Asianists' characterization of India as "monistic." Parry says that some of his ethnographic material on the dispensation of the body at death in Banaras, north India, and informants' explanations of the conditions of birth and rebirth shows a monistic relation between body, mind and soul--that food one consumes and one's thought can alter one's body and bio-moral substance and that the state of the body reveals the state of the soul. Yet Parry also claims some of his material reveals a dualism of matter and spirit--that mind is more important than body for salvation (512). But whereas Parry suggests that one could interpret his ethnography to exhibit characteristics of both monism and dualism in the consideration of material and spirit. I would suggest that the phenomenological distinction made by patients in Kerala may be monistic but is not dualistic. Kerala phenomenology does not contain a local version of western mind-body dualism. Rather, it is a conception of several states that include body, mind, consciousness and the self.

I see Csordas' original concept of embodiment as one of phenomenological contingency, one's way of being-in-the-world and not just an orientation towards the body. I believe that this perspective allows us to perceive local phenomenologies such as I encountered in Kerala. Mauss' "Techniques of the Body" (1950 [1934]) also tried to maintain this multi-level approach after bringing the body into the picture. Mauss

proposes a "triple point de vue, celui de 'l'homme total' [triple point of view, that of 'the whole person']" that takes into account the psychological, social and biological elements of using/being in a body (369). The emphasis here is on the *whole* person and not just the body. Like Csordas' emphasis on being-in-the-world, Mauss explains that his study of the techniques of the body is also a study of "le mode de vie [the mode of living/way of life]," or "le *modus*" creating a term, somewhat like his *habitus*, that refers to the intersection of body techniques, a way of life, psychology and other influences constituting a space in which one lives (375).

Finally, an article by Mark Nichter (1981) that is not regularly cited in discussions of anthropology of the body presents a useful concept, "idioms of distress," that will be often referred to in this and other chapters. Like the sense of embodiment that I propose here, this is a concept that is open to many modes of expressing illness. Nichter demonstrated how Brahmin woman in Karnataka, south India, expressed somatic symptoms or behavioral traits (such as not eating)--different "idioms of distress"--to express suffering due to problems that originate in family or social conflict. This term is used often in this dissertation as it is appropriate for revealing suffering, through the body, mind or other media, without expressing a preference for one of these orientations.

Indian Philosophy and Phenomenology

In this section, I will highlight aspects of Indian philosophy and popular mythology that address the distinctions between the self, the mind and body and other attributes. Indian philosophy is teeming with discourses on the distinction between the

self and its many layers, the self and mind, the self and body, the material and the transcendent and many more issues on the nature of phenomenological experience. In turning to Indian philosophy, I may seem to be invoking an elite discourse that is not necessarily articulated in popular discourse and practice. However, using philosophers such as Sankara to demonstrate a cultural phenomenology is an attempt to make an account of Indian phenomenology that parallels the use of philosophers, such as Descartes, to characterize the Western mind-body dichotomy as is done in almost any key work in the anthropology of the body and embodiment (Scheper-Hughes and Lock 1987; Csordas 1994; Strathern 1996: 41-62). In any case, there is reason to believe that some Indian philosophy has found its way to popular discourse, as will be discussed below.

Describing *ātman* is the concern of much Indian philosophy. Usually translated into English as "self" or "soul," *ātman* refers to the higher self which is totally disembodied and eternal and often wrongly, according to philosophers, identified with the mind or other attributes. *Ātman* is also a term that some patients I interviewed used to refer to their non-bodily self.

Identifying the nature of *ātman* was a major focus of a Kerala philosopher known as Sankara. Born in the 8th century in central Kerala, Sankara is well-known throughout India for his Advaita Vedanta philosophy, which aimed to reveal that the true self, *ātman*, is the same as *brahman* or god/the absolute. Much of Sankara's writing is devoted to revealing phenomena that are wrongly attributed to *ātman* and must be recognized as such to realize this true self. Thinking that one's self is the body or that one perceives

reality though the senses is wrong attribution according to Sankara. Even states such as the mind, that are not quite of the body, are falsely believed by some to be part of a person's true identity. One perceives in Sankara a scale of decreasing physicality and decreasing tangibility as one goes from what are false attributes to what is true and valued: from body to senses to mind to intellect to *ātman*.

Early on in his treatise, Upadeśa Sāhasrī, Sankara emphasizes the self's separateness from the body:

> The Self, if in contact with the body, would be existing for the benefit of another and be non-eternal.... Moreover, the Self, supposed by other philosophers to be conjoined with the body must have an existence for the sake of another. (Sankaracharya 1973: 37)

In this passage, Sankara states his difference from certain other philosophers including some whom he calls the "materialists," supporters of the Cārvāka school of skepticism dating back to 600 B.C.E., which advocates that reality consists only of what is perceived by the senses and that the self/soul exists only in the body. Interestingly, Cārvāka philosophy is reminiscent of contemporary western psychiatric epistemology that essentially sees the mind, possibly the self, as reducible to brain chemistry, which one could argue is a very body-oriented western phenomenology.

In a chapter of Upadeśa Sāhasrī called "Eyelessness," Sankara narrates in the voice of *ātman*, and describes the nature of this self:

> Ever free, ever pure, changeless, immovable, immortal, imperishable and *bodiless* I have no knowledge or ignorance in Me who am of the nature of the Light of *Pure Consciousness only*. (Sankaracharya 1973: 121). [My emphasis.]

This passage is interesting to note in the context of the following excerpts from interviews with people suffering illness who are very concerned about their *bodham* or

"consciousness."

Sankara also asserts that the self can observe what is going on in the body, indicating that it is not directly connected with the body:

> The Witness [another term for the Self] of the pain in the body, which is a combination of limbs etc., does not feel pain. (160).

Interestingly, Sankara also distinguishes between things such as intellect, memory, mind and knowledge, concepts that might be considered contained within the mind in western epistemologies. For example:

> The peculiar characteristic of the mind is reflection and that of the intellect is determination... (164)

This is useful to note when examining the different terms used by informants, below, that translate as "consciousness" or "intellect" and are distinct from the concept of mind.

Sankara is well-known throughout Kerala and India. His birthplace is a large, well-maintained public monument in his native town of Kaladi. Additionally, the extremely popular contemporary guru/religious leader Sai Baba, whose photo is sold by many stores and street vendors and can be seen in homes and businesses around Kerala and India, promotes Sankara's philosophy that the true self is the same as the divine.

Vaiśesika, which is one of several philosophies that epistemologically inform ayurvedic medicine, states a clear phenomenological division of labor similar to what is seen in Sankara's philosophy. In a discussion of the nature of *ātman*, a 4th century Vaiśesika text Padārthadharmasamgraha, says:

> In the cognitions of sound, etc., also we infer a "cogniser" {the witness/the self}. This character cannot belong to the body, or to the sense organs, or to the mind; because all these are unintelligent or unconscious. Consciousness cannot belong to the body, as it is a material product, like the jar; and also as no

consciousness is found in dead bodies.

Nor can consciousness belong to the sense-organs; because these are mere instruments, and also because we have remembrances of objects even after the sense-organ has been destroyed, and even when the object is not in contact with the organ.

Nor can it belong to the mind; because if the mind be regarded as functioning independently of the other organs, then we would have perception and remembrance simultaneously presenting themselves (and if the mind be regarded as functioning through the other organs, then it would not be the same as *ātmā* [*ātman* [self]); and also because the mind itself is a mere instrument.

And thus the only thing to which consciousness could belong is the self, which thus is cognised by this consciousness. (Radhakrishnan and Moore 1957: 405)[1]

In this passage, Vaiśesika draws distinctions between consciousness, body and mind based on logical arguments and, as in Sankara, shows the self witnessing phenomena as indicative of its character. This same division between consciousness, body and mind can be seen in the interviews with people suffering possession and illness below.

Chakrabarti and Chakrabarti, in an article called "Toward Dualism" (1991), discuss Vaiśesika and a related philosophy, Nyāya, and conceptions of the self and body. Nyāya-Vaiśesika describes how the self and consciousness are distinct from the body. Nyāya-Vaiśesika critiques the Carvaka materialist view, which Sankara also challenged, that self is part of body, and denies the Buddhist view of the non-ownership of self.

Also, a recent dissertation analyzing the writings of Caraka, a physician and founder of ayurveda whose work is still intensively read by ayurvedic doctors, sees Caraka as being concerned with mind, body and spirit making up a "tripod" of existence

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[1] From Padārthadharmasamgraha of Praśastapāda, translated by Ganganatha Jha (Allahabad: E.J. Lazarus & Co., 1916). Reprinted in Radhakrishnan and Moore (1957). Comments in "[ ]" brackets are Radhakrishnan and Moore's. Comments in "{ }" brackets are mine.

and with balancing mind and body for health (Thakar 1995). Mind and body are analytically distinct in Caraka and contemporary ayurveda, though Caraka and ayurvedic physicians understand that mind and body--and spirit--influence one another.

One aspect of Indian world view/phenomenology that is very popularly disseminated and that causes one to question the valuation of the body in Indian culture is the doctrine of reincarnation. One goes through several lives and inhabits several bodies--some human, some non-human--in the course of one's existence. This implies that one's true identity is not the body, which is transitory, but something like the higher self, or *ātman*, that is consistent and transcends and experiences different bodies and lives.

Finally, what is probably the best known of Hindu classic texts, the Bhagavad Gita, is saturated with teachings about how one transcends (or how one should not act with orientation to) the body and the senses. The divinity Krishna, in his conversation with the human Arjuna which constitutes the entire text of Gita, explains that to one who has chosen the path of right action:

> The body and the mind,
> The sense organs and the intellect,
> Are instruments only (The Song of God: Bhagavad Gita 1944: 58)

Throughout the Gita, Krishna continues to emphasize the importance of transcending the body in verses such as:

> Once more I shall teach you
> That uttermost wisdom:
> The sages who found it
> Were all made perfect,
> Escaping the bonds of the body. (106)

This begins a section of the Gita where Krishna describes the three *gunas* (something like

"qualities"), *sattwa* (like "knowledge"), *rajas* (relating to passion), and *tamas* (dark and phlegmatic), which make up the body, mind and the environment. This concept of three *gunas* also informs ayurvedic understandings of psychopathology--as described in Chapter 3.

The Gita is popularly disseminated in Kerala and around India. Many Hindu households display a picture of Krishna and Arjuna in Arjuna's chariot and a quote from the Gita. A particularly large mural of Krishna and Arjuna dominated the waiting room of a well-known clinical psychologist in Kerala. The Gita is also dramatized on television and promoted in other media.

Only the smallest fraction of the perspectives on phenomenology in Indian philosophy can be covered here. The range of phenomenological perspectives--conceptions about the relationships between body, mind, and self and related issues--in India is much greater than the range of concepts about the body and embodiment in anthropological theory: Indian philosophy contains premises that are like mind-body dualism, perspectives that are seen in embodiment concepts in anthropology and a range of other orientations.

A division of phenomenological experience similar to that described in the philosophical and mythological excerpts above exists in the following quotes from patients. One shall see that afflicted people in Kerala do distinguish mind from body, and show a particular concern for their states of consciousness and other modes of being.

Patients and Problems of *Bodham* and *Manas*

Inspired and intrigued by embodiment theory and the anthropological focus on the body, I hoped to find in Kerala confirmation of unique bodily forms of expression in the local culture and in each of the three forms of therapy I examined, but I was frustrated by my informants' tendency to talk about their problems in mentalistic and other non-bodily terms. I tried retooling some of my questions and advising my research assistants, Malayalis who had some training in psychology, to veer away from questions that I thought might contain assumptions of mind-body dualism, but I couldn't get patient-informants to stop talking about their "minds" and their "consciousness." Finally, I decided to let them be right, even if they didn't fit current anthropological theoretical trends. Certainly some patients demonstrated somatic ways of expressing suffering. However, not one of the 38 patients for which I have verbatim transcripts of interviews described their problems in purely somatic idioms or without referring to concerns about "consciousness," the mind or other non-bodily modes of expressing suffering. In fact, the frequency and elaborateness of the mentalistic and disembodied terms in which informants described their experience was striking.

Emphasizing the Mental

A number of patients described the explicitly mental nature of their suffering and how this related to the treatment they pursued. Two informants who were being treated at allopathic psychiatric hospitals, explained that they sought help from a psychiatric hospital rather than magic or sorcery since their particular problem was explicitly mental.

A 30 year-old male Muslim inpatient a research assistant and I interviewed at a private psychiatric hospital in Trivandrum had been working, like many Malayalis, as a laborer in Dubai, United Arab Emirates before he returned home to seek relief for his problem. His brother, who was present at our interview, explained how they decided to seek treatment at a psychiatric facility:

> Brother of patient: ... near Beemapalli [a mosque and research site for this project] there is a place where we did *mantrika chikitsa* [black magic treatment].
> Kavitha: What all did they do?
> Brother: They tied a thread and did their ritual/ceremony [*karmmam*]. They did the rite in the Quran. Still he didn't get relief. So we saw another person who told us about the illness. He said the treatment for this can only be done in a hospital, and he can't do any black magic [*mantrikaparamayi*] for this. This occurred through thoughts [*chinthagathi*]. This began by thinking [*chinthichu undayathanu*].

The daughter of a retired school teacher, a 60 year old Hindu woman who was a psychiatric inpatient at the Trivandrum Medical College Hospital, explained why they were seeking treatment at a hospital rather than through magic:

> Kavitha: No. Do you have some belief in that [referring to the possibility of involving magic or worship] relating to this problem?
> Daughter of Patient: Not for this problem. This is because of the mind [*manas*].

Here and in many excerpts that follow, the speaker uses the term *manas*, which is a Sanskritic word for mind also used in the Indian philosophies described above. "Mind" is the common dictionary translation from the Malayalam and Sanskrit *manas*, though *manas* refers to a realm of attributes that are not completely the same as those contained in the English concept of "mind." For example, in many philosophical treatises *manas* is distinct from *buddhi*, translated as "intellect." Malayali patients also use *buddhi* and *bodham* ("consciousness") in addition to *manas* in describing their experience. Cognition

and thinking are capacities of *manas*, but intellect and consciousness are not. (A list of these and other phenomenological terms and their definitions is provided at the end of this chapter.)

Occasionally, the distinction between mind and body is rendered in English terminology. In his first attempt to describe his troubles, a 20 year-old male inpatient at Peroorkada Mental Health Centre described his problem using the English word "mental" and saying that it relates to thinking:

> I have a "mental" [i.e., a mental problem]. I will think something. When asking someone something, I will feel different things in my mind. [...]
> When I think like that, sometimes the anger inside me rises up to my mind. It will come up again. When I become like that I feel that I want to attack someone. Like that the thoughts will not stop [lit. change - *maarum*].

Note that this person also speaks about anger, which is an emotion that is connected with the body in many of the ethnographies referred to earlier that tend to find non-western peoples living in the body (for example, among the Wiru and the Melpa of New Guinea anger resides in the nose and the heart respectively - Strathern 1996: 45, 120). In this case, anger is merely "inside" and rises to the mind manifesting as thoughts.

Interestingly, the interview just cited occurred somewhat early in my fieldwork, and my assistant and I were still trying hard to bring out the somatic expressions, which weren't appearing and we assumed were just hidden, in patients. Such questions got answers like this:

> Biju: Something else, do you have any other "strange physical feelings"? In your body, some kind of "strange feelings"?
> Patient: Nothing like that.
> Murphy: "Okay, okay." [my indication to my assistant that we had pushed the embodied symptoms questions too much and we ought to drop them]
> Patient: No, this is only a "mental" illness. Other than that there is no illness.

Bodham and the Many Modes of Consciousness

A 44-year old Muslim fisherman who was seeking relief for his problems at Beemapalli mosque was suffering an illness "in the head" according to his brother who was attending to him at the mosque. This brother also related the onset of the problem to being without *bodham* or "unconscious." The Malayalam term *bodham* and other idioms in the following examples are roughly translated as "consciousness" with modifications or translation options occasionally indicated since English words, obviously, cannot reproduce the nuances of these Malayalam terms.

> Kavitha: What all was he showing [i.e., what were his symptoms] when you took him to [name of mental hospital]?
> Brother of Patient: I can't say exactly what he was showing when he became mentally ill [literally, ill in the head - *talakke sukhamillattappam*]. He will say things in reverse. He was brought back unconsciously [*bodhamillate*].

Several other patients' illnesses were described as beginning with an episode of unconsciousness. A 32 year old Hindu manual laborer was staying with his son who was incarcerated in a cell (for uncontrollable or violent persons) while he sought relief for his suffering at Beemapalli mosque. The son was around 18 and training to be a welder when his problem started. The father explained to me that a loss of *bodham* was the beginning and defining characteristic of his son's problem:

> Murphy: What all are the boy's problems?
> Father: The problem is that one day when he was returning home after going to the road[2] he had a feeling that about 10 to 500 people were chasing him. He came

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[2] "Going to the road" in village Kerala refers to going to the nearest place where there are businesses and shops to buy things or do errands. Usually there is one paved road somewhere near a village that is accessible from homes by footpaths.

and fell unconscious [*bodham kettu*] at the doorstep. That's all there is to the illness. There is nothing other than that.

Ajit, the ayurvedic psychiatric patient who was presented in the introduction, revealed how *bodham* can relate to the idea of happiness (in both English and Malayalam).

> Both happiness and unhappiness are there, though I am aiming for eternal happiness. One morning I'll think "happy," but my *bodham* [consciousness] will be different in the afternoon.

Lakshmi, the Hindu woman who was introduced in the last chapter and had been attending Chottanikkara temple to seek the goddess' help with her problems described how consciousness relates to the experience of possession on several levels of interiority:

> Biju: Do you have consciousness [*bodham*] during possession [*tullal*]? Consciousness [*bodham*]?
> Lakshmi: No.
> Biju: Do you have [lit. see] consciousness inside [*ullil bodham kanumo*] ?
> Lakshmi: Inside the inside, there will be consciousness [*ullinde ullil bodham kanum*]. The reason is... however, there is no outside. There is a feeling that something is inside.
> Biju: No consciousness [*bodham*] on the outside, right?
> Lakshmi: No consciousness [*bodham illa*].

It's hard to say whether Lakshmi is talking about the inside of the mind, body, self or something else. She is referring to a certain level of interiority where there is consciousness of awareness of what is going on during possession though--I am interpreting--her usual consciousness is not aware of what is going on around her.

The distinction between consciousness and mind seen in Indian philosophy is not explicitly spelled out in these informants' testimonies, but it is brought into relief by an apparent exception to this distinction. The daughter of the retired school teacher mentioned earlier, described the origin of her mother's difficulties as follows: "The

problem started in her subconscious mind [*upabodha manas*]." "Subconscious mind" is a dictionary definition of *upabodha manas* (Madhavanpillai 1976) implying that as in western phenomenology, consciousness can be a part of the mind. However, this term has the feeling of a neologism, an awkward construction of three Sanskrit/Malayalam terms, trying to represent something not covered by the straightforward terms such as *bodham* or *manas*. Madhavanpillai's 1976 dictionary lists its origin as "psychology;" in other words, this is a term that was created to convey this concept from western psychology. *Upabodha manas* is an unusual, bookish-sounding term, and this is its only occurrence in informant interviews. Usually a concept brought in from western psychology is rendered in English. Some of these English idioms--which are actually bodily-oriented metaphors--and the effect of the proliferation of western psychology and psychiatry on illness experiences in Kerala are discussed at the end of this chapter.

A nineteen year-old Hindu female psychiatric outpatient at Trivandrum Medical College, in her first attempt to describe her problem, resorts to the idiom *bodham*, but also uses a term *ormma*, which sometimes has a meaning like "consciousness" but also refers to "memory":

> Kavitha: Why did you come here now?... You have nothing to say?
> Patient: I lost memory/consciousness [*Ormmayillatheyayi.*]. Yesterday night, I fell unconscious [*bodhamillatheyayi.*]

An unemployed Hindu woman who is married to a "peon" (a low-status assistant or errand person) who works for the railways and was a psychiatric inpatient at Trivandrum Medical College, explained the main characteristics of her illness using *ormma*:

> Like this I was unconsciously/without awareness [*ormmayillathe*] saying things, called my mother bad names. I was unconscious [*ormmayilla*]. I could not eat anything.

In this passage, it is hard to ascertain whether it is better to render "ormma" as "memory" or "consciousness," two of its English glosses. The following description of an incident by an elderly patient and his wife at the Government Ayurveda Mental Hospital helps clarify some of the meanings of *ormma*:

> Wife of Patient: We can't sleep here. Yesterday, his son was here with him. He beat him [the son] with a torch.
> Benny: His son?
> Wife: Yes. There was a cut here, and a tooth was hit and loosened.
> Patient: I don't remember [*ormmayilla*] that.
> Benny: He did it unconsciously/unaware [*ormmayillathe*].
> Wife: Unconsciously [*ormmayillathe*], he did it. So they chained him. I told him to bring tea in the morning. His son had not had tea. It was to sooth him. So ask your son. Father did that unconsciously. So let him call his son and ask him whether he had tea. Then he started crying. At that time he was not in his conscious mind [or, he was of little intellect - *buddhikku lesham*]

Note also that the wife of this patient referred her husband as lacking *buddhi* which is the same word used in some of the philosophies described above to refer to the intellect, a capacity that in Nyāya and Vaiśesika philosophies is not the same as mind/cognition/*manas* or the body. *Buddhi* is a level higher than mind and body in these philosophies' valuation, though it is not as high as *ātman*, the true self. *Buddhi* is a tool of *ātman*, though not a part of *ātman*. Interestingly, the first Malayalam-English dictionary ever written (Gundert 1872) defines *buddhi* as "understanding (higher than *manas* & *chittam* [thinking])."

The ambiguity between "memory" and "consciousness" in *ormma* is seen in this exchange with a Christian woman who was at Vettucaud church appealing for relief for

her daughter, a fish vendor who had started acting violent, swearing and causing trouble for the family:

> Kavitha: When she is having this problem, are there any memory [*ormma*] problems?
> Mother of patient: Sometimes she will be unconscious [*ormmayillathe kitakkum* - lit. lie without consciousness/memory]. Then we will warm her up by giving her something hot to drink and all.
> Kavitha: No, *ormma*. Does she have *ormma* for past events and all?
> Mother of patient: There is no problem like that.[3]

The relative of a young Muslim man who was an inpatient at the Government Ayurveda Mental Hospital had another expression which one of my research assistants felt was also best rendered as (loss of) consciousness:

> He lost consciousness [*talakke oru marichchal* - lit.: a turning in his head] is what he is saying. He lost consciousness [*talakke oru marichchal*]. After that, he won't talk. He speaks only with his arms and legs.

Yet another term that my assistants and I thought best translated as "unconscious" was used by a young man who was seeking treatment at the Government Ayurveda Mental Hospital:

> Patient: They made me sick.
> Benny: Who did this, and how did they make you sick?
> Patient: They made me unconscious [*mayakki*].
> Benny: Made you unconscious [*mayakkiyo*]?

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[3] One could also translate this sentence as "She has no problem like that" to make it more readable for an English-speaker. Westerners in this situation would make it clear that they are speaking about another person--and reveal a degree of separateness between themselves and the person they are speaking about. Yet this sentence, like many others I have had to alter in translation, contains a subject-less construction which is very common in Malayalam. There is no subject in the sentence in such cases, and the verb has the same conjugation for all persons in Malayalam. The ambiguity about who is experiencing and who is speaking is maintained throughout many conversations in Kerala, and is indicative of a more sociocentric orientation to the self (as discussed in Chapter 1).

Patient: Made me unconscious and scolded me [*Mayakkittu parihasichchittu*].

Mayakku/mayam also has meanings like intoxication, confusion, coma, enchantment, and dimness (Madhavanpillai 1976). One could interpret, given these additional meanings that *maya--* is a more embodied form of unconsciousness, states like intoxication or coma requiring some sort of a bodily relationship to be experienced. Or perhaps, consciousness being absent, one has dropped down to the level of the body.

A 35 year-old Hindu man that is sometimes unemployed and sometimes works at a photo studio was an inpatient at Peroorkada Mental Hospital in Trivandrum when we met him. His first attempt to describe his problem invokes another idiom that is best rendered in English as "consciousness":

> Biju: What are the symptoms [*lakshanangal* - lit., characteristics] of your illness?
> Patient: Symptoms of illness? When I sleep I will fall into a deep sleep without any consciousness [*ariyan vayathe urangum* - lit., without being able to know anything, I will sleep].

The variety of terms translated as "consciousness"--assuming that they all have at least something in common to warrant this translation--refer to what these people suffering distress consider to be the predominant area(s) of concern relating to their suffering. That is, these states that are like consciousness are more significant than idioms of mind and body for expressing and understanding one's illness.

Other Non-Bodily Expressions

Additional idioms of non-bodily realms of experience arise. For example, a male Christian in his twenties who had consulted a psychiatrist and a psychologist at

Trivandrum Medical College explained that his condition had radically improved. He also expressed a desire to go to a popular Christian faith healing and prayer center in central Kerala known as "Potta" (see Chapter 3 for further description of Potta). Whether it is for greater relief from his problems or further spiritual improvement is unclear, but it is clear that what he wants to achieve from visiting Potta is in the non-bodily realm:

> Biju: You are about to go to Potta. At Potta... what are you seeking by going to Potta? After going to Potta...
> Patient: I will get mental concentration [*Manassil oru eykagratha kittum.*], and get close to God. Healing all that is afflicting [*badhichirikkunnathu*] our mind [*manassil*], we, a "concentration"...[4]

Some patients and their caretakers describe their problems in terms of somatic or bodily idioms, but they always additionally make reference to "consciousness," the "mind" or other non-bodily concerns. A Hindu woman who was receiving inpatient treatment at the Trivandrum Medical College demonstrates an interesting combination of bodily and non-bodily idioms in expressing her difficulties. Note also that she has another idiom that is something like "consciousness" in English. In a description of the current state of her illness, she focusses on bodily and aesthetic modes:

> When I try to sleep in the daytime, sometimes I feel like my legs are shaking. Like my legs are moving and my head is heavy. And when this head is heavy, I think I will loose my normal state/mind [*samanila tetti pokum*].

Note, however, that her descripiton culminates in her concern about losing her state of mind. She continues emphasizing that her worries relate to her non-bodily state:

> Kavitha: Are you afraid you will loose consciousness [*tetti pokum*]?

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[4] This sentence translates awkwardly because the patient was cut off before the end of the sentence which is where the verb is placed in Malayalam. The verb, if known, would be inserted between "we" and "a 'concentration'."

Patient: I'm afraid I will loose consciousness [*tetti pokum*]. Then I think, who will look after my children. No one is there, and that troubles me.

Shortly afterward, she returns to the somatic aspects of her suffering:

Patient: Now when my body becomes numb/limp/stiff [*chenattu kayaru*] and when I am tired.
Kavitha: What is "chenattu kayaru" ?
Patient: All this hair will stand up straight. It will go away after a while.
Kavitha: Is this the only thing you feel, or is there anything else?
Patient: Sometimes I will have stomach pain, burning in the chest. Sometimes burning in the stomach, then headache. Everything is there.
Kavitha: You felt that. You had that.
Patient: I wonder whether I am possessed.

In what follows, this woman follows the interviewer, Kavitha's, prompt to talk about mental and bodily states, but she emphasizes that her fear--what in this dialogue seems to be the most crucial concern regarding her illness--relates to her mental state:

Kavitha: You said that this will happen [that you will be possessed]. When that happens, how do you feel in your body? And in your mind, how do you feel?
Patient: In my mind, I will be afraid.
Kavitha: Will be afraid. Other than that?
Patient: Nothing other than that.
Kavitha: Nothing more than that.
Patient: I am afraid. I feel that I will loose my normal mind [*samanila tetti pokum*].
Kavitha: That's how you feel. Then you don't feel any pains or any other feeling in your body?
Patient: Here and there in my body I'm feeling pain like I'm being pricked by a needle. After that, it is "normal."

The mother of Sreedevi, the woman introduced in the last chapter who was seeking ayurvedic psychiatric treatment and was worried about whether she could get married, described Sreedevi's difficulties through bodily and (the ambiguous areas that one might call) behavioral and emotional idioms of distress:

Biju: What is the problem for which you are seeking treatment?
Sreedevi's Mother: She is not eating, and she has started crying. And when

> sleeping, she'll suddenly wake up complaining of stomach pain. She shows *bahalam* [agitation/boisterousness].

But then Sreedevi's mother explains:

> Because there/this is a mental problem/worry [*manasikamaittulla vishamam*], we have been coming here.

With these ethnographic details about people suffering from difficulties in Kerala in mind, it would be helpful to return to the earlier discussion of how this research is an exception to much anthropological research on the body. My findings in Kerala allow for an interesting comparison to recent analysis by Jean Langford (1998) of an ayurvedic psychotherapy practice in north India. According to Langford, many patients of ayurvedic psychologist Dr. Singh have somatic symptoms (e.g., weakness, stomach pain, constipation) which the doctor diagnoses as vitiation of the dosa, *vata* (89-90). Langford claims that this confirms Obeyesekere's (1982) position that ayurvedic treatment is somato-psychic (Langford 1998: 90). One patient Langford observed was described as unusual in that he complained of "extreme depression" (90). Regarding this case, an ayurvedic psychologist said "In India...there is not much awareness about psychological problems. Usually people with psychological disorders come to the out-patient department complaining of physical ailments and are diagnosed by Dr. Singh with depression and/or anxiety" (91). By contrast, a great number of the patients I have talked to described their problems as "depression" (using either the English word or the Malayalam, *vishadam*, meaning "sadness, depression, despondancy") and clearly understand their experience in terms of what a westerner would call psychological states, by which I refer to the concern for the states of *manas* (mind) and *bodham*

(consciousness) described above.[5]

It is worth considering the possibility that the difference between my findings and those of Langford may be due to the proliferation of allopathic psychiatry and psychology in Kerala. My research provides some evidence that a form of medicine and its practices, such as consultations with doctors, invoke awareness of or attention to certain symptoms (much like Csordas' "somatic modes of attention" 1993). Symptoms among ayurvedic and allopathic patients seemed to correspond greatly to categories and attributes in which healers of those medicines show most interest. Thus, the greater popularity of allopathy and western psychology in Kerala compared to other Indian states[6] may breed a greater awareness of psychological categories through patients who have been given diagnoses such as anxiety or depression disseminating psychological concepts to their community or by proliferation through the media of psychological and psychiatric concepts. Allopathic psychiatric and psychological columns are very common in popular Malayali magazines, such as Mangalam, Manorama, and others which circulate widely in Kerala's extremely (over 90%) literate population. These magazines are easily found even in small villages and remote corners of the state, and some of the patients introduced in Chapter 4 chose their therapy after reading about it in one of these

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[5] I am interpreting the division between physical and psychological in Langford's work to refer to what I describe as the bodily and mentalistic in this chapter. Remembering that "psychology" is a western or modernist ethnopsychology (Lutz 1985), I am not interpreting these patients' experience to be psychological in the western or academic sense.

[6] With only 4 percent of India's population, Kerala had 30 percent of the mental hospitals in India in 1991 (Franke and Chasin 1994:v citing India Abroad, Dec. 13, 1991, p.32).

magazines. Psychologists regularly appear on Malayalam television shows, and psychiatrists are often depicted as heroic characters in Malayalam films. Indeed the ayurvedic diagnosis, *vishadam*, that was developed at the Government Ayurveda Mental Hospital in the last few decades was described to me as being like the allopathic diagnosis "depression," and may have developed through influence from and competition with allopathy.

So it's conceivable that prior to the influence of allopathy and western psychology, patients in Kerala may have been more somatically-orientated. Kleinman was cited above as saying that psychologization is unique to middle and upper class westerners, but he also says that the trend to psychologize is also spreading as part of a modernization process (1986:56). And, with many decades of Communist government and wide access to secular education, there is reason to believe that Kerala is more exposed than other Indian states to modernist ideologies. I stress, though, that there is the *possibility* that people were *more* somatically oriented, but this does not undermine the phenomenological orientation described above. Regardless of the degree of influence of allopathy and western psychology, Kerala and India still have the tradition of very disembodied philosophies that exist to some degree in the contemporary discourse of patients in Kerala. Additionally, as seen below, the western psychological idioms that are borrowed into Malayalam are best characterized as bodily metaphors of distress.

Sanskritic vocabulary (borrowed into Malayalam) indicating different non-bodily states exists alongside a variety of English language terms for distress. For example, in Chapter 4 we saw both Mary and Hanifa describe their problems using the word

"tension." Meanwhile, Rajan, who had sought treatment at Chottanikkara temple, used "depression" in describing the experience of possession:

> Biju: Can you talk about how it "feels" when we get "possessed"?
> Rajan: I will tell you. We now suddenly when someone scares us from behind we get frightened, right? Then what "depression"we would feel. That is, that "depression" is the "first" thing we will feel.

The elder sister of a woman who had suffered *manahaprayasam* ("mental problems") for years describes the onset of her troubles as "She got a 'feeling'." I would argue that these English words represent more bodily or embodied idioms of distress than do the Sanskritic and Malayalam terms *bodham*, *ormma*, *tetti pokum* etc. "Tension," "feeling" and "depression" imply physical or kinetic states, metaphors of physical torsion felt in the body. In other words, these can be conceived of as bodily or embodied idioms of suffering that are imported from the West.

Overall there seems to be a tendency among people suffering possession and psychopathology in Kerala and in the philosophies described earlier to talk in terms of intellect and consciousness. I wonder if people suffering similar afflictions in the U.S. would speak in these terms or settle more on the concept of mind. Lacking a comparative study of the discourse of U.S. and Kerala patients, an anecdotal illustration might be suggestive. I took a few yoga classes at a Sivananda yoga center in New York. After doing the physical postures at this yoga center, the (Euro-American) instructor would tell the class to relax various parts of our bodies and finally to relax our minds. I also took classes at the Sivananda yoga center in Trivandrum, Kerala, and after the physical exercises, the Malayali instructor asked us to relax various parts of our body, then our

minds and, finally, our intellect.

What is seen in these patient interviews could be described as several modes, or several variations on a single mode, of culturally-defined phenomenological experience. I would propose that rather than a mind-body dualism, there is in Kerala a phenomenology of multiple modes of experience that range from the more material to the more disembodied and rarefied: that is, from the body to the mind/*manas* to consciousness or intellect. The informants cited above do not explicitly say that these modes of experience lie on a continuum of increasing disembodiment though they do use a variety of terms that are found in the philosophy described above, which lie along a continuum of body-mind-consciousness-ātman. However, there are modes of experience that are difficult to classify as more or less material or embodied, such as the nuances of *ormma* which invokes "memory" as well as "consciousness," *bodham* as "consciousness," and *ariyathe* meaning something like (being without) "consciousness" but having the meaning of "knowing" as well. What is clear is that, unlike so many other ethnographic examples in the anthropology of the body, people suffering affliction and illness in Kerala do distinguish mind from body and locate experience in non-bodily realms that are extremely important to them. Yet, mind and body are not diametrically opposed in Kerala. They are simply different. They are part, and not even the focal part, of a complex phenomenological orientation that, if anything, is more concerned about states of consciousness.

A Postscript

I described the topics of my dissertation with my friend and informant, ayurvedic psychiatrist Dr. Sundaran, when I returned to Kerala in 1999. This chapter and my description of local phenomenology as *sarira* (body), *manas* (mind), *bodham*(consciousness) and *ātman* received the most interest and support. Dr. Sundaran said this description of Kerala phenomenology was reminiscent of an ayurvedic model of the different aspects of the person: *sarira* (body), *sattva* (mind/wisdom/intelligence/consciousness) and *atma* (the true self), adding a new term, *sattva*, to the many rarifications of phenomenological states.

Key Terms:

ātman - the true, or higher, self. The same as *brahman*, the divine, in the philosophy of Sankara.

buddhi - mind/intellect - translated as "intellect" (and described as an "unconscious instrument") in Radhakrishnan and Moore (1957:360)

bodham - consciousness

eykagratha - concentration

manas - mind (in some philosophies, distinct from intellect)

ormma - memory, consciousness, awareness

upabodham - subconsciousness (or close-consciousness)

Chapter 6 - The Importance of a Pleasant Process of Treatment

This chapter focuses on *process* in healing, and reconceives the allopathic way of looking at the final dispensation of an illness. A basic allopathic orientation to treating illness focuses on an end result called "cure," a term that has no translation in Malayalam, the language of Kerala. If getting to that end result is at times painful or unpleasant, that is an acceptable part of pursuing a cure. This is a reasonable position regarding certain maladies, but often self-defeating in psychiatric or spiritual problems where the pleasantness of the process of treatment may be intimately linked, or identical, with the resolution of the illness. Undergoing long periods of unpleasant treatment can make irrelevant the issue of "cure" if, for example, the patient and his/her therapy seeking group, dreading the effects of medications and electroconvulsive therapy, leave the allopathic psychiatrist for other forms of treatment, which often occurs in Kerala. Sometimes the process of seeking healing in a pleasant or spiritual environment can in itself be a resolution to a chronic--"incurable" as psychiatrists say--psycho-spiritual problem. In other words, the process of care overlaps with cure, sometimes completely.

Two moments during fieldwork in Kerala brought forth the ideas for this chapter. The first occurred while I was a the Government Ayurveda Mental Hospital in Kottakkal, northern Kerala, observing the afternoon administrations of ayurvedic psychiatric procedures. One patient who was undergoing *talapodichil*, wherein medicated gooseberry mud was packed on his head and covered by a banana leaf, joked about how silly his banana leaf "hat" looked but also said that it gave a nice, cooling effect. Patients

who were receiving *nasya* laughed because of the tickling they felt as medicines were poured into their noses and their heads were massaged. I thought how strikingly different this was from the atmosphere around inpatient allopathic psychiatric procedures. Electro-convulsive therapy, for example, was always a traumatic procedure--humor was inconceivable.

The second moment that inspired the issues in this chapter occurred after an interview with a the family of a woman who had had behavior problems for years and who was seeking relief only by praying at Vettucaud church, a church on the beach in a Christian neighborhood in Trivandrum (described in Chapter 3). At this point, I realized that I had interviewed a number of informants who had sought relief for their problems for a long time and had been living for years at a mosque, temple or church. Perhaps these informants had given up treatment to a certain degree and found a resolution to their problems by remaining in a pleasant environment, a beautiful setting with music, chanting, incense, flowers, and a chance to engage one's spirituality. Some of these people, who would likely be classified as incurable in allopathic psychiatry, had found a resolution to their problems that was different from a cure: a way of living with their problem that was more spiritually fulfilling and where the contingency of time was de-emphasized.

This chapter will revolve around a concept I will call "pleasant process." Considering the pleasantness of the process of treatment reworks western/allopathic assumptions about treatment and cure in two major ways.

First, how pleasant it is to receive treatment procedures affects patients' choice of therapy and their decision to continue therapy. It probably also affects patients' sense of well-being, their psychological/existential state, and thereby the effectiveness of healing.

Secondly, some patients in Kerala have found a resolution for their problem in continuing to live with an intractable problem in a pleasant environment which moves the frame of understanding of the disposition of illness from cure to the concept of resolution and conceives of treatment less teleologically.

"Pleasant" is the most appropriate word I could find to describe a number of experiences in undergoing treatment that were at times pleasant and at least non-traumatic. Yet this word is still inadequate to cover the range of issues I wish to examine in this chapter. But since I do not want to invent a term to describe the issues I wish to cover in this chapter. The forms of healing and the resolutions to illness problems discussed here are at best pleasant and at least less traumatic. Pleasant is on some occasions too positive a word to describe some aspects of ayurvedic therapies that are uncomfortable, and at times it is too mundane a word to describe the transformative experience, the bringing-to-a-higher-level, some people experience in healing. "Pleasant" does at times describe aesthetic, environmental, bodily etc. comfort or pleasure[1] The therapies I describe as "pleasant" do not always make one feel high, "cooled" (to invoke

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[1] Certainly, there is cultural variation to what is aesthetically pleasurable as Howes (1991) and Classen, Howes and Synnott (1994) have shown. I am using "pleasant" to characterize my informants reactions to therapies and environments. In many of these settings, I could also appreciate the pleasantness myself, and I think there is some element that is universally human in these reactions. Still "pleasant" is a very general word and doesn't characterize the nuances of informants' experiences. This term simply labels visceral experiences informants evaluate positively.

a Malayalam idiom) or comfortable. Ayurveda, for example, can be demanding--requiring one to undergo an austere vegetarian diet, digest a large quantity of *ghee* (clarified butter), or take medicine to induce vomiting. But there remains a difference between the adverse aspects of ayurvedic and allopathic treatments. While ayurvedic treatment could be characterized as at times demanding or challenging, allopathic therapies can at times be painful or traumatic. What I am examing also has the characteristic of being non-traumatic and nonviolent. The demanding nature of ayurveda can be considered part of cultivating self-discipline, or a development of the self. This is similar to a positive spiritual benefit reported by patrons of religious healing in Kerala. Thus healing in these cases is not just "pleasant" in the visceral or aesthetic sense, but somewhat exalted, a raising of the self/spirit to a higher level, not just a healing in the sense of removing a problem or returning to normalcy, but a transformation to an auspicious state.

Examining the process of treatment also problematizes the concept of "cure.". In biomedicine, "cure" generally implies a complete eradication of a problem, when in many cases what can often be done is only to modify--or "change" to use the translation of a Malayalam word (*maaruka/maaram)* that describes what one does to illness--the conditions and make them more tolerable. What one often accomplishes in treatment is "give relief," as Malayalis would say, or "take care," which is the etymological meaning of the word "cure."

Also implied in this examination of process and "cure" is what could be seen as differing orientations toward time. Allopathic medicine in the situations described in this

study can be seen as more end-result oriented, gazing ahead toward the final state and not observing time pass. Ayurveda meanwhile can be seen as paying more attention to time while is it passing--that is, the experience during therapy. Although remission of symptoms and a return to a state of health is often the explicit goal in ayurveda as well, the process of treatment is not neglected while aiming for this goal. For religious therapies, an orientation to process like that of ayurveda, though the process can be part of a larger, spiritual transformation. There are even contexts where healing in relgious therapies is completely without goal orientation or a noticing of time passing. For example, prayer not only helps to gain relief, the actual moment of prayer itself *is* relief from suffering for some people.

The Aesthetics of Healing

Inspired by the focus on embodied and phenomenological experience in anthropology in the 1980's and 1990's, some anthropologists in recent years have examined the aesthetic, visceral and sensual experience of healing (e.g., Roseman 1991; Desjarlais 1992; Laderman and Roseman 1996). These anthropologists asserted that Illness and healing are not something one simply thinks about, as earlier medical anthropologists assumed; rather, they are felt.

This paper supports Laderman and Roseman's position that "if healing is to be effective or successful, the senses must be engaged" (1996:4), but expands upon this insight. Those who have analyzed the aesthetics of healing have neither compared the aesthetics of different medical systems nor examined the aesthetics of

biomedicine/allopathy. Thus, these studies do not explicitly see that the sensory engagements they analyze are positive experiences and perhaps do not fully realize the benefits of this experience. Put more simply, it seems to have been somewhat overlooked that a therapy that feels good might be better than a therapy that feels bad, especially for a problem which is psychological/spiritual.

Marina Roseman (1991) took on the issue of the engagement of sensory experience in examining Temiar healing practices in Malaysia, though her work looks at aesthetics as symbols and how aesthetic elements are interpreted intellectually rather than how aesthetics are experienced in the body during healing. Regarding Temiar music, for example, Roseman claims that "[t]he evocative power of these sounds, however, lies in the way they are imbued with *meaning* and *interpreted* by participants" (172 - my emphasis). Robert Desjarlais then made the link between aesthetics and embodied experience in his analysis of healing in Nepal. Desjarlais explains that Sherpa shamans make an ill person's body feel better, by engaging the ill person/body aesthetically:

> [...] Meme [the shaman Desjarlais observed] changes how a body feels by altering what it feels. His cacophony of music, taste, sight, touch, and kinesthesia activates a patient's senses. This activation has the potential to "wake" a person, alter the sensory grounds of a spiritless body, and change how a body feels (206).

This, I believe, also describes the changes that occur for someone seeking relief from their suffering amidst the sights, tastes, music and smells at Chottanikkara temple or Beemapalli mosque in Kerala, and explains why the therapies at these places can constitute a pleasant process.

Desjarlais' analysis of Sherpa shamanism alerts us to the visceral experience of this kind of healing, but it would be intriguing to learn how this experience compares to

the visceral experience of a biomedical hospital. Desjarlais explains that there is an allopathic medical facility available in the area where he did his research, but it is a general clinic which treats "physical illnesses (a headache, broken bones, and bruises)", not a psychiatric hospital (163). People experiencing "soul loss" who were treated by a shaman were not tempted to attend this clinic for their problem. But if there were allopathic psychiatric facilities available, as there are in Kerala, they would likely claim to heal things like soul loss (which they would call by some other name) and would constitute an alternative therapy.

Having had the chance to compare the aesthetic experiences of patients in multiple therapies, I am invoking what one might call a negative aesthetics of healing to emphasize the value of the aesthetics of healing and the importance of considering the *process* of therapy.

Deconstructing the Concept of "Cure"

There is very little discussion of the concept of "cure" in medical anthropology. "Cure" is applied in many medical contexts by anthropologists and it's allopathic assumptions are taken for granted as what everyone tries to do with an illness. The only article I could find in the anthropological literature that explicitly focusses on cure applies the concept in its ordinary biomedical sense. In this article Herzfeld explains that narrative closure in stories that are told by Greek healers help effect cure (1986).

One exception to the tendency to take the concept of cure for granted comes from Crapanzano's study of the Moroccan Hamadsha healing cult. Crapanzano advocated that

one should consider the particular cultural meaning of cure which may not always involve returning the sufferer to his/her original state. He explained that "the Hamadsha effect their cures by incorporating their patients into a cult which provides them with both a new role--one which is probably more in keeping with their individual needs--and an interpretation of their illness and cure" (1973:6). By incorporation into the cult, the sufferer is given a new social role and a new set of symbols for expressing his tensions (4). Though Csordas (1983) briefly reprised the cultural contingency of the idea of cure (citing Crapanzano 1973), there hasn't been any further analysis or deconstruction of the biomedical (western?) concept of cure. The concept of cure is problematized by both themes related to the process of treatment in this chapter. First, patients dislike an unpleasant process of treatment: if caring is not observed in pursuing a cure, this can mitigate finding relief for a problem. Second, spending time in a pleasant, aesthetically-engaged environment can be a resolution that constitutes an alternative to cure--an alternative to erradication of the problem--analogous to the resolution by incorporation Crapanzano found among the Hamadsha. These reconsiderations of cure have two implications that should be considered by healers as well as anthropologists: 1) one ought to consider taking care of or palliating the sufferer as a necessary part of treating an illness, and 2) it would be useful to use resolutions to illness problems (a category which includes cure as one option) as an analytical orientation for analyzing healing practices rather than assume cure to be a universal orientation.

Let us now turn to an analysis of the medical literature to understand the origins, the historical trajectories, and the emphasis on cure in biomedicine.

Biomedical literature reveals a lack of discussion about the concept of cure. "Cure" is not defined in Black's Medical Dictionary, or in most medical dictionaries and reference books I reviewed. Also, no definition of cure is brought up in any psychiatric or general medical textbook I reviewed.[2] One medical dictionary that did define "cure" did so as follows:

> 1. restoration of health of a person afflicted with a disease or other disorder. 2. the favorable outcome of the treatment of a disease or other disorder. 3. a course of therapy, a medication, a therapeutic measure, or another remedy used in treatment of a medical problem... (Mosby's Medical, Nursing & Allied Health Dictionary 1998: 427).

The Oxford English Dictionary's fifth definition for "cure", "[t]o heal (a disease or wound); *fig.* to remedy, rectify, remove (an evil of any kind)," contains the notion of *remov*ing, which I would argue is an assumption in contemporary allopathic practice that is not covered in the medical dictionary definition above and is an aspect of the concept of cure that I am critiquing in this paper. The Oxford English Dictionary in its first entry for "cure" gives the definition "To take care of; to care for, regard"[3] which, intriguingly is similar to the overlap between process and final disposition, or care and cure that I encountered in Kerala.

This original etymological meaning of "cure" is invoked by a some historians of biomedicine who reveal a division at some point in the past between efforts to take *care*

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[2] In fact, in these textbooks any epistemological or theoretical discussion of general principles of medicine is rare.

[3] The literary citations for the first meaning of "cure" range from 1382 to 1623 while examples of the fifth definition range from 1526 to 1872, perhaps indicative of a range of time when the sense of cure began to shift.

of the ill (make them feel better) and *cure* the patient (remove the disease entity). Medical historians Kothari and Mehta (1988) warn about the tendency in "modern medicine" (i.e., allopathy) to utilize harmful treatments and invasive procedures to remove any abnormality (even those that are benign) and other instances of what they see as violence in medical practice. They then suggest that healers focus on easing dis-ease (the pain in suffering) and thereby return medicine to the original meaning of "cure," which was "to take care:"

> The idea that the chief role of a medical system is to take care of the dis-eased gives the system only a palliative role. This is as it should be. Oliver Wendell Holmes has described his teacher, Dr. Jackson, as one who never talked of curing his patients 'except in its true etymological sense of taking care of him.' Holmes goes to the extent of generalizing that 'the doctor who talks of curing his patients belongs to that class of practitioners known in our common speech as "quacks".'
>
> Modern medicine is in need of humility; it must give back to 'cure' its etymological meaning. It must recognize that with a concerned physician around, no disease, no death, is incurable. A drug to ease, a procedure to palliate, a word of cheer, the graceful stoicism to hold the dying patient's hand--all this and more falls within the curative competence of a compassionate clinician (197).

This proposal is different from the present status of palliative care in allopathic medicine. "Palliative" is defined as "a term applied to the treatment of incurable diseases, in which the aim is to mitigate the sufferings of the patient, not to effect a cure" (Black's Medical Dictionary 1992: 434), and palliative care focuses only on terminally ill patients and hospice care (Doyle et al. 1998). Palliative medicine in contemporary allopathy refers to attempts to relieve suffering after the possibility of cure has passed.

There are, however, cases in which the attitude toward cure is more nuanced in allopathy. Examples of this can be seen in the treatment of cancer. Knowing that complete eradication is hard to determine, success in cancer treatment is measured in five

year survival rates. Also, in advanced cases of cancer, doctors try to weigh the benefits of abrasive therapies against the patient's "quality of life," the degree of mental and psychological suffering they are going through (Hanks and Hoskin 1995; Redmond 1998).

Medical historians Jecker and Self (1991) outline some of the history of American/western medicine's attempts to gain prestige and develop as a profession and the division between care and cure which resulted from these attempts. This included competition with homeopathic healers and lay people (often relatives) who took care of--nursed--the ill which was considered women's work and devalued. Thus Jecker and Self conclude:

> The early history of American medicine suggests a possible explanation for the association of medicine with cure, rather than care. The presence of fierce competition and marginal status during its early years forged a mission for medicine that focused on achieving cultural authority and an elite status for its practitioners. Efforts to gain authority and status required physicians to stand apart from laypersons and develop exclusive modes of language, technique and theory. This put physicians at odds with activities, such as patient empathy and care, that call upon abilities of engagement and identification with others (293).

Jecker and Self thus discuss the devaluation of care and emphasize that doctors--those who cure--also consider the importance of care. I would add that this issue is more acute when the dis-ease involved is of a psychological, spiritual or related character, such as the forms of suffering examined in this study of Kerala. Where the suffering is psychological/spiritual etc. qualities of empathy and care can be the same as cure (in the contemporary sense of ridding a problem).

However, the idea that care, or palliation, could be the final dispensation--rather than a cure--is not applied in this article.

The one commentary on the meaning of cure that I came across in the medical literature appeared in a glossary of the origins of medical words. Under the entry for cure was the statement, "The current use of the word seemingly sprang form the belief that proper and sufficient 'care' was tantamount to 'cure.' Would that this were so!" Then the author cites an "ancient French aphorism" that translates "Cure occasionally, relieve often, console always" (Haubrich 1984: 64). This sense is lacking when allopathic therapists trying, I believe, too hard to cure. Focussed on end results rather than the process, allopathic therapies can drive away patients with, for example, the painful and uncomfortable effects of electroconvulsive therapy and psychoactive drugs, as will be seen in the following examples from patients in Kerala.

Reactions to Ayurveda and Allopathy

Electro-Convulsive Therapy versus *Talapodichil*

A striking and clear example of the importance of a pleasant process of therapy comes from a comparison between allopathic electroconvulsive therapy and an ayurvedic psychiatric procedure known as *talapodichil.*

Electroconvulsive therapy (or ECT - also known as "shock therapy" or "electroshock therapy") is used in inpatient allopathic psychiatric treatment in Kerala for acutely suicidal patients, severely depressed patients, and psychotic patients who do not respond to medications. These are generally the same conditions under which ECT is used in the U.S., although ECT appears to be used more frequently in Kerala than in the

U.S.[4] Aversion to ECT is one of the main reasons people suffering illness in Kerala discontinued allopathic psychiatric care and began ayurvedic treatment.

A 66 year-old Hindu man I'll call Kuttappan who was undergoing the 45-day *panchakarma* inpatient treatment (see Chapter 3) at the Government Ayurveda Mental Hospital (GAMH) having previously tried allopathy for problems that included crying and talking too much, showing too much anger talking nonsensically. These problems started a couple days after his son's wife killed herself and her son (his grandson). Kuttappan's wife, who was taking care of him at the GAMH, explained that they decided not to return to an allopathic hospital people advised them to go to because of fear of the effect of ECT on her somewhat elderly husband:

> They told us we should take him to [name of hospital]. He is old now. If we take him there, they'll give him a shock or something. He is 64 years old. Here they give only native medicine and will get change [*maattam*]. They told us there was improvement [*bhedam*] with this medicine for their son so we took him here. He has a cough and asthma now, but he will get over it. This treatment can do all this.

When Kuttappan previously sought treatment at this same allopathic hospital, he ran away from the hospital claiming the staff was doing black magic on him. (I don't know if this was a reaction to ECT or other aspects of treatment or if he was given ECT during his first stay at the allopathic hospital. I did not specifically enquire about this because at the time of this interview I was not particularly looking for reactions to ECT.) Finally, it

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[4] The rate of use of ECT in the United States was around 3% of psychiatric admissions between 1975 and 1986 (Rudorfer et al. 1997: 1537) though some states have reported a rate of around 1 in 10,000 (Kramer 1985; Finch et al. 1999). Among my patient sample in Kerala, the rate is around 5-10%. It should also be noted that the last two decades have seen a resurgence in the use of ECT in the U.S., after a decline in popularity in the 1960's and 1970's (Rudorfer et al. 1997: 1535-1537).

should be noted that Kuttappan's wife uses terms like *maatam*, which is best defined as "change," and *bhedam*, which is "improvement," to describe what is sought when one goes for treatment. No Malayalam term for the dispensation of an illness has quite the same meaning as "cure."

It should also be noted that in Kuttappan's wife's statement above there is in addition to the criticism of allopathic care a degree of enthusiasm in describing ayurvedic care. One often heard enthusiastic descriptions among other ayurvedic patients and persons using religious therapies, but such descriptions did not occur among allopathic patients.

Mathew John, a 35 year-old Christian man, was being treated at GAMH and was accompanied by his father. My assistant Benny and I interviewed Mathew John and his father later in my fieldwork after I had begun to notice complaints about unpleasant treatments and was interested in reactions to ECT and other aspects of treatment. The following is a segment of an interview where Benny and I were trying to get Mathew John to elaborate about his allopathic treatment:

> Benny: What kind of treatment did you receive in allopathy?
> Mathew John and Father: They gave ECT 5 times plus tablets and injections.
> Benny: Did you like allopathy?
> Mathew John: I didn't like it.
> Benny: What specifically didn't you like?
> Mathew John: I didn't like ECT.

Mathew John had been hearing sounds and was afraid he was being pursued by evil spirits and people who are trying to hurt him. He had been hospitalized in allopathic psychiatric hospitals four times since 1989.

Abdul Aziz is a 27 year-old man who was receiving treatment at the Government

Ayurveda Mental Hospital. He was accompanied by his father who told us that he has been talking incoherently and has been violent. Abdul Aziz also had itching and pain in his body which he says are caused by a demon. During three years of allopathic psychiatric treatment in his home district, he received ECT 9 times and as many as 16 pills a day. Abdul Aziz' father also explained that the "head treatment," which is probably a reference to an ayurvedic treatment called *talapodichil*, at the GAMH made Abdul Aziz feel "cool and calm." In my meetings with him, Abdul Aziz was pleasant, upbeat and eccentric, and was often wearing the mud pack and banana leaf of *talapodhichil* treatment.

While ECT got unfavorable reviews, there were a number of positive reactions to ayurvedic treatments such as the procedure called *talapodichil*. A number of inpatient ayurvedic procedures could be compared to ECT. *Talapodichil* is the most well-known and high profile inpatient psychiatric procedure in ayurveda much like ECT's standing within allopathic treatment, and in this sense it is an appropriate procedure for comparison. What will be said below about *talapodichil* is generally true of the other ayurvedic treatments in the sense that they are reported by informants to be rarely painful and sometimes aesthetically pleasant. They receive a positive or humorous reaction when patients describe the process of undergoing these therapies. What Abdul Aziz' father refers to as "head treatment" is most likely *talapodichil* although he could be referring to *picchu* which is similar to *talapodichil* and an equally pleasant and, according to patients, "cooling" therapy.

I will always associate Abdul Aziz with *talapodichil*. When I arrived at the

GAMH he was one of the first people I encountered. With the top of his head wrapped in mud and a banana leaf--that is, he was undergoing *talapodichil*--he ran up to me, pumped my hand enthusiastically, smiled and welcomed me. In future visits Abdul Aziz would enthusiastically greet me and I would often see him literally marching around the hospital with the banana leaf on his head singing "la illaha il allah" (an Arabic phrase all Muslims know meaning "there is no god but Allah"). This behavior is, of course, unimaginable from anyone undergoing or having recently finished a round of ECT. A short comparison of the procedures involved in administering ECT and *talapodichil* may help us see why ECT is considered unpleasant and *talapodichil* "cooling," a common culture idiom for a pleasant physical effect or a desirable state of mind and body.

The Procedure for ECT

This description of ECT procedure is adapted from Rudorfer et al. (1997). I have summarized the procedure and translated the medical terminology, though sometimes I included the original language, which is striking in the way it tries to distance the reader from the implications of the procedure.

The patient after having not eaten for several hours and having voided his/her bowels is "escorted to the ECT suite" (1548). An intravenous line, electrocardiogram, and other devices are then placed on the patient to monitor heart rate, blood pressure and oxygen saturation. At this point, the patient is often given a medicine (an anticholinergic agent) to reduce "bradycardia," the abnormally slow heartbeat that occurs immediately after the first administration of electric shock. Then the patient is given a general

anaesthetic[5] to induce unconsciousness. Once unconscious, the patient receives a muscle relaxant intravenously "to dampen the tonic-clonic movements from the seizure and reduce the risk of musculoskeletal injury" ("tonic-clonic movements" refers to violent muscle movements) (1547). A mouthpiece is inserted between the patient's teeth and ECT electrodes are attached to the patient's head.

At this point "the stimulus is delivered," meaning that electrical current is sent through the patient via his/her head above the level which causes a seizure. During the seizure, which lasts from 20 seconds to 2 minutes, the patient's jaw clenches, his/her heart rate slows and muscles clench. Two to 5 seconds later there is a significant rise in the patient's heart rate and blood pressure. Certain prophylactic medications are recommended to counter excessive increases in blood pressure and heart rate that may occur at this point (1547).

Once the seizure has ended, the patient is "monitored until breathing occurs spontaneously, he or she is responsive to voice commands, and there is a return of muscle strength" (1548). Once the patient's vital signs are stable, he or she is moved to a recovery room. This whole process is repeated 2 to 3 times a week, and in the case of depression a total of 6 to 12 sessions is recommended (1548).

The most common side effects are cardiac problems, confusion and memory loss. Psychiatrists Kaplan and Sadock (1991) explain, without irony, that memory problems

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[5] The etymology of this word--"non-aesthetic"--is revealing. As opposed to some of the treatments discussed in this chapter and by Desjarlais, Laderman and Roseman, psychiatrists try to *dis*-engage the patient's aesthetic experience of this procedure.

occur most of the time after ECT though almost all patients regain their normal memory ability after 6 months (673). Meanwhile, Rudorfer et al. mention that serious complications such as bone fractures or heart problems occur in 1 in 1,000 ECT patients while the risk of death from ECT is around 1 in 10,000 (1548).

I felt it was too intrusive to observe ECT sessions in India (the awkwardness of doing so and the ease of observing the ayurvedic treatment sessions reinforces the points in this chapter). However, I did catch glimpses of preparations for ECT and its aftermath. After the treatment, patients were wheeled out on a gurney attached to an intravenous unit and some of the patients' bystanders looked worried, even traumatized. This radically contrasts with the mood of patients following *talapodichil*.

The Procedure for *Talapodichil*

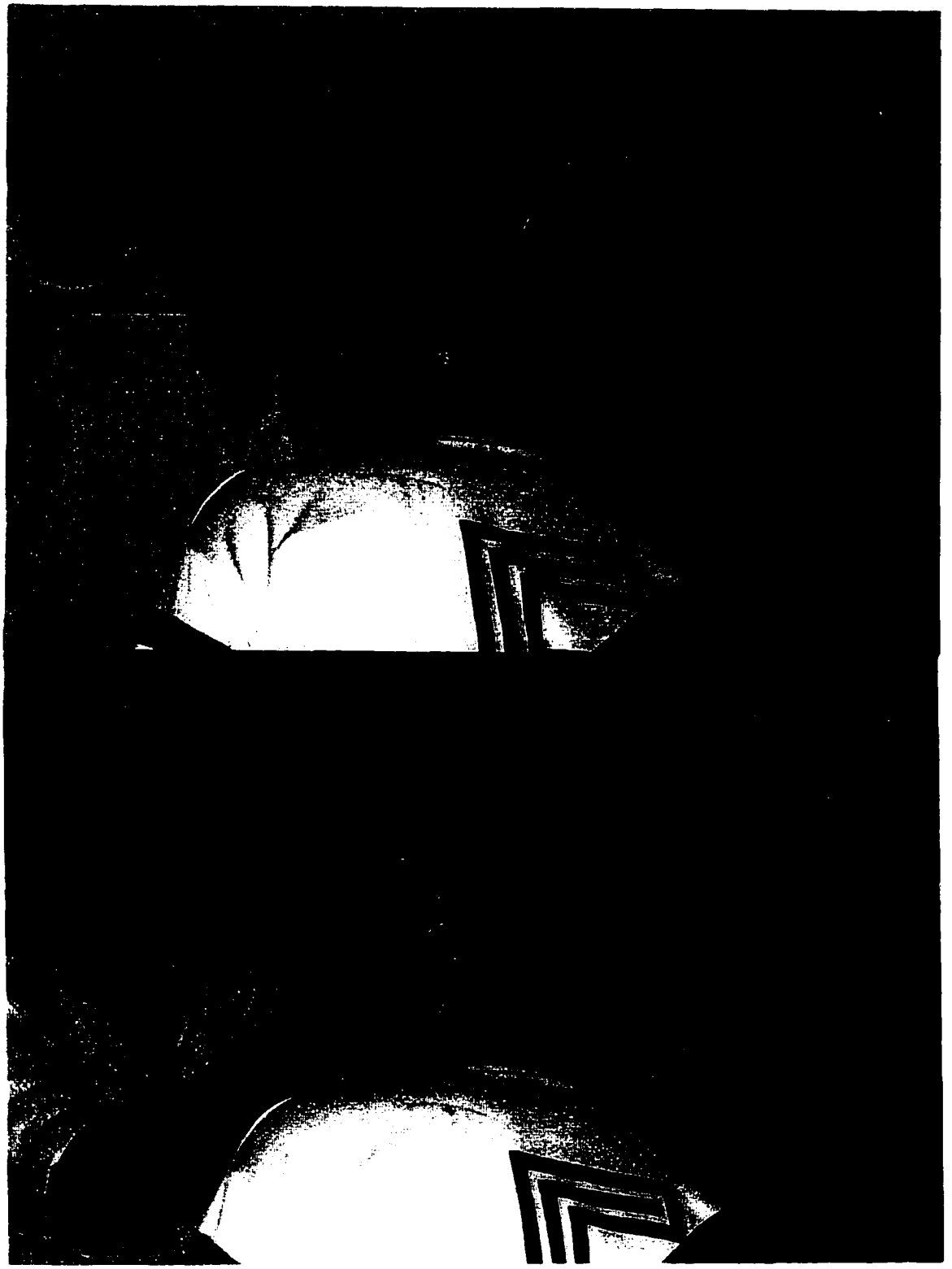
The fact the patient has to go to a *recovery* room after ECT reveals a lot about the importance of a pleasant process of therapy. After *talapodichil* one does not have to wait for the patient to recover vital signs or respond to voice commands. Instead, patients joke and wander around the hospital compound (in at least one case, singing). One has to consider risk of death in ECT while imagining such a consequence from *talapodichil*, or virtually any other ayurvedic inpatient treatment, is almost absurd.

After completing four weeks of *panchakarma* treatment,[6] which includes taking

[6] Much to the point of this chapter, some Americans are paying significant sums of money to receive this same *panchakarma* treatment at centers in Connecticut and New Mexico. One person who did this in the U.S. told me it made her feel incredibly relaxed and refreshed.

purgatives, enemas and nasally-administered medicines while on a special vegetarian diet (as described in Chapter 3), the patient at GAMH receives *talapodichil.*

Talapodichil is performed, along with other ayurvedic procedures, at 3pm on the verandah on the shady side of the GAMH. The GAMH is in an old, large, somewhat dilapidated traditional Kerala house that is surrounded with trees and other foliage on about two acres of land. The patient who is to receive *talapodichil* sits on the short wall surrounding the verandah of the building. A nurse unwraps a ball of medicated mud that contains *nellikya* (gooseberry) as one of the main ingredients then removes and puts aside a small portion of the mud. The nurse then rubs oil on the patient's head, which has been shaved for this purpose, and molds the large portion of the gooseberry mud onto the patients head from the top of the skull down to the top of the forehead and about as far down on the back and sides. A banana leaf is then tied over the mud-pack to keep it in place, and the patient is allowed to walk around the hospital compound or relax, as he/she wishes. After 45 minutes, the patient returns to the treatment area and a portion of mud is removed from an area known as the *marma*, a region between the forehead and the top of the skull that is the center of many mental activities, which will have warmed to a temperature of 40° Celsius. The mud removed from this area is replaced with the small portion of mud that was reserved at the beginning of the procedure. After another 45 minutes the mud and banana leaf are completely removed and the patient wanders off to socialize or relax. (Figures 5 and 6 show a nurse administering *talapodichil* to a patient at the GAMH.)



Figures 5 and 6 - Nurse administering *talapodichil* to a patient at the Government Ayurveda Mental Hospital

Informants I spoke with who were undergoing *talapodichil* said it had a cooling effect on their head and body. One patient joked that it was like having an "AC" (air-conditioned) hat. Ajit, the former patient of the GAMH mentioned earlier, reflecting on his treatment there explained: "I got some more energy, especially a little improvement in 'memory.' My head got cooled." "Cooling" (*tanuppu, kulirmma* and other terms) is a cultural metaphor or trope for a pleasant physical, visceral state or effect. People in Kerala--friends, research assistants and others--were often telling me what could give a cooling effect: from drinking salt with your lime juice, to building your home a certain way, to visiting certain parts of a temple. Ajit also used the word *kulirmma* to describe what one can attain from ayurveda. *Kulirmma* translates as "coolness," "freshness," "satisfaction" or "delight," indicating a wider meaning that just physical pleasure or comfort.

The Effect of Medications

Another concern ayurvedic patients had that related to processes of healing is less striking but more common: aversion to the unpleasant effects of allopathic medicines.

The comments of the mother of Sreedevi, who we met in Chapter 4, signaled a concern about "side effects" in allopathic treatment:

> Ayurveda is a good treatment. There is a treatment like this in ayurveda. But if it's the other one [allopathy], there are some "side effects." Since there is a mental problem/worry [*manasikamaittulla vishamam*], we have been coming here.

A concern ayurvedic patients had that related to processes of healing that was

more commonly heard than complaints about ECT was aversion to the unpleasant effects of allopathic medicines. Ibrahim was a young Muslim man who had been getting angry easily and causing disturbances at home (making noise, throwing fits). Ibrahim is also very devout and he has been giving unsolicited religious sermons to his family and friends. He was originally taken to a *thangal*, a Muslim priest/shaman, then to an allopathic hospital before coming to the GAMH. A young man who was accompanying Ibrahim during his stay at GAMH said he had problems with "injections" (which are given to inpatients to deliver greater doses of allopathic psychiatric drugs more quickly) when he was receiving allopathic care:

> There [at an allopathic psychiatric facility], after they give him an "injection," he wouldn't eat for two days. They gave him "injections." If they give him injection in the morning, he will get up only the next morning. He sleeps. So he was always tired. Here he has a good appetite. When we give him anything to eat there, he won't eat, but he will drink water.

Ever since Raju returned during the Gulf War from Kuwait where he was working as a mechanic he has been having problems. He has been violent, he laughs without reason and has threatened to destroy his family's property. Raju's mother who accompanied him while he was being treated at the GAMH explained that allopathic medicines were unpleasant, especially tiring, and this caused Raju and his therapy seeking group (his family and others involved in decisions regarding his treatment) to change therapies:

> We changed from allopathy to ayurveda because he felt tired from allopathic treatment. Didn't like the effects of allopathic medicines. They made him feel tired. He/we felt allopathic treatment caused memory loss.[7]

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[7] This excerpt, and some that follow, are from structured interviews that were recorded with hand-written notes. Thus the words here are not, necessarily,

Interestingly the characteristics of Raju's illness changed as he changed therapies. During allopathic treatment, he was violent, depressed and tired. During ayurvedic therapy, he feels as if his "head is empty" and something is in his throat.

Bindu, a 36 year-old Hindu woman who was receiving treatment at the GAMH had similar comments about allopathic (aka "English") medications. Bindu had been depressed and "lost mental control" when she attacked her brother's wife and son. She was sent to an allopathic psychiatrist, but she changed to ayurveda because she didn't like allopathic treatment:

> English medicines made me too tired, I couldn't even respond when spoken to. I felt less tired with ayurvedic medicine. I felt weight in my head during English medicine which is now gone.

We interviewed a 26 year-old man, Mohammad Koya, who had returned from working as a waiter in Abu Dhabi (in the Persian Gulf) because of his illness, and several of his relatives, after they had consulted with GAMH psychiatrist Dr. Abdu about being admitted to the GAMH. This relatives of Mohammad Koya told us that he had been to an allopathic hospital and was taking allopathic medicines. He could function on allopathic medications, but they made him tired and he did not want to have to be taking pills all his life. The family decided to pursue ayurvedic treatment because they had heard that through ayurveda one could get off pills (patients who are admitted to the GAMH and who are taking allopathic medicines are slowly weaned off allopathic drugs over the

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verbatim. The "he/we" translation here refers to the Malayalam subjectless construction were the subject is left out, and it is identifiable from the verb. This, I believe, is a deliberate ambiguity that relates to fluid boundaries of the self. Intentionality and experience are not assigned to any particular person in much of Malayalam speech.

initial period of treatment).

A 30 year-old woman who was being treated at the GAMH had previously been to an allopathic hospital, and she explained that she changed therapies because allopathic medicines intensified joint pains she was having and thickened her tongue so that she couldn't talk.

The father of Abdul Aziz, who was cited above as enjoying the effects of *talapodichil*, explained that Abdul Aziz was tired when he was taking allopathic treatment but is more active while undergoing ayurvedic therapy.

In all, 9 of the 32 ayurvedic patients interviewed offered (without our asking) some complaint about ECT or the effect of psychiatric medications during previous allopathic treatment.

But it was not only former allopathic patients presently seeking ayurvedic treatment who complained about the effects of allopathic psychiatric medications. The wife of a 30 year-old Hanifa (introduced in Chapter 4), who was seeking relief for his "tension" at Beemapalli mosque, was concerned about memory problems her husband had from taking allopathic psychiatric medications:

> Kavitha: Are you taking "allopathy" medicine now?
> Wife: No, no.
> Kavitha: Now he is not taking any medicine.
> Murphy: Now it is finished.
> Wife: Now that he is not taking medicine, there is a lot of improvement. When he was taking medicine, he had memory problems [literally, reduction - *kuravu*].
> [...]
> Kavitha: Was it because of memory problems that you stopped, or...?
> Wife: Yeah, because of memory problems and a lot of "tension," thinking, and he was like this. So we changed. Now there is relief after coming here. After he came here, he sleeps without taking medicine.

Finally, a woman who was visiting the allopathic Trivandrum Medical College psychiatric outpatient complained "I am always tired because of the medication." She was basically over her problems and just seeing the doctor for a follow-up/check up visit.

Interestingly, Richard Warner has pointed to allopathic psychiatric studies which show that "patients who find the first dose of these drugs [neuroleptic drugs for schizophrenia] particularly unpleasant are most likely to show little benefit from their use and to relapse early" (Warner 1994 citing Singh and Kay 1979 and VanPutten et al. 1979). Although I am not able to make claims about the improvement or relapse of these particular patients, it's worth considering the problems that may result from an unpleasant reaction to medication. I cannot establish here any direct connection, but it is possible that the studies cited by Warner above may help explain my finding, discussed below, that patrons of religious healing seemed to have found the greatest improvement in their condition on follow-up studies.

Use of Humor in Ayurveda

Related to the issue of pleasantness of treatment, ayurvedic healers often use humor in their interactions with patients, something I rarely observed, or heard of, in allopathic psychiatric healing. I saw ayurvedic psychiatrist Dr. Abdu joke with some of his patients, and engage in friendly teasing. Ayurvedic physician Dr. Rajendra Varma who sees some psychiatric patients at Thaikkattu Mooss' Vaidyarathnam Oushadhasala ayurvedic clinic in central Kerala told me "I don't approach the patient as a doctor seriously" explaining that he was willing to use humor with patients as well as not take

himself too seriously. Meanwhile, ayurvedic psychiatrist Dr. Sundaran who was teaching at Ayurveda College in Trivandrum and seeing patients explained that he used jokes and stories to establish rapport with his patients saying:

> So I can easily take a patient in my custody with joking or some type of ... I can be very close with that patient within minutes, with a joke or some stories.

During the ayurvedic inpatient procedures, including *talapodichil*, the nurses administering the therapies sometimes joked or laughed with the patients. This atmosphere was lacking in the administration of allopathic inpatient procedures such as ECT. Preparing for and returning from ECT (which is all I felt appropriate to observe) is quite the opposite of a humorous experience. The attending psychiatrists appeared concerned and kind, but joking would have felt inappropriate. The patients' relatives and bystanders looked beyond serious, sometimes traumatized. I can't account for the mood of the patients after ECT because they were unconscious or catatonic.

I saw little use of humor in allopathic healing sessions. In fact, there were times when allopathic patients would joke during consultations and meet with a stony response from the psychiatrist. Not accepting or reciprocating humor had the appearance of maintaining the doctor-patient hierarchy. This is reminiscent of Jecker and Self's comments, cited above, about the separation of care from cure: "Efforts to gain authority and status required physicians to stand apart from laypersons and develop exclusive modes of language, technique and theory. This put physicians at odds with activities, such as patient empathy and care, that call upon abilities of engagement and identification with others" (293). Humor could be considered one of these empathetic orientations associated with care, and denying the use of humor can be a distancing mechanism that also marks

authority in allopathy. Meanwhile, when ayurvedic physician Dr. Sundaran says "I can be very close with that patient" through humor, he demonstrates an orientation toward care--and thereby toward process-- in his treatment.

Finally, this comparison between allopathic and ayurvedic therapeutic measures should be qualified with the observation that the distinction between painful, invasive therapies in allopathy and gentle, pleasurable therapies in ayurveda was not always so clear. In the past, treatments were used in ayurveda that were more analogous to ECT. I was told by Dr. Rajendra Varma of the Vaidyarathnam Oushadhasala that "in the olden days," "instead of this psychiatric treatment--shock treatment--we used to take the patient to the execution room and we bring an elephant and ask the elephant just to show its leg to squeeze the head, to press the head of the patient." The elephant would raise its leg over the patient's head as if to crush it. The patient would become frightened, and then the elephant's leg would be removed. Alternately, Dr. Varma said uniformed men would drag the patient before the king who would accuse the patient of a crime and demand that he be executed. Then the trial would be revealed as a hoax. I guess the theory was that these events would so shock and traumatize the patient, that he (she?) would become distracted from his obsession with his mental problems. These procedures are also described, along with suggestions to beat patients with certain kinds of mental illnesses, in the classical ayurvedic medical text Caraka Samhitā (1998: 436-437 [Cikitsāsthānam, Ch. IX, Verses 79-84]).

Although he doesn't mention either of these ayurvedic "shock" therapies, Francis Zimmermann in writing about the "flower power of ayurveda," claims that many invasive

therapies have been discontinued in modern ayurvedic practice (1992). Classical ayurveda, Zimmermann explains, had a number of more violent and cathartic procedures, but now in the context of competition with allopathy--recognizing that allopathy has essentially cornered the market on invasive procedures such as surgery--ayurveda emphasizes the balanced, gentle and nonviolent aspects of its practice. Regardless of whether the emphasis on gentleness is a modern innovation, it is something that clients of ayurveda appreciate. This is perhaps a case of effective resistance, or maneuvering around, the hegemony (in terms of funding, government support and patronage) of allopathic medicine in India: ayurveda emphasized nonviolent approaches to health and illness and attracted some patrons away from allopathy. These new patrons celebrate the gentle features of what they call *nadan* (native) medicine.

Positive Evaluations of Treatment

A strong endorsement of a pleasant treatment process comes from the positive evaluations of healing experiences by some patient-informants. The enthusiasm some informants showed in recalling their process of healing indicate that one should consider not just the deterrent to continuing treatment that may result from a painful process of therapy but also the pleasure, enthusiasm, and even spiritual transformation that can occur in therapy. There is reason to believe that such positive experience enables healing. The current mood and positive recollections of some patients indicate this, but even the skeptical scientist might consider the power of (what he/she calls) the "placebo effect" that occurs via an enthusiastic engagement in therapy. The most positive descriptions of

therapy came from informants who were using the religious therapies I examined.

Rajan, a young man who was formerly possessed, revealed some of the color and variety of the procedures possessed/ill people engage in at Chottanikkara temple. Rajan was so strongly affected by this experience that he has decided to live at Chottanikkara temple and work at the temple lodge. The following excerpt reveals Rajan's enthusiasm and also gives an impression of the daily routine, the environment, and some of the color and variety of the procedures possessed/ill people engage in at Chottanikkara (though his excited description in Malayalam, laced with English terms and Sanskritic Hindu religious terminology, does not translate smoothly):

> The "first" *bhajan* [singing worship] starts at 3:30 am. Then the "temple" will be open at 4. Then there are the remaining demi-gods: Ayappan, Sivan, Murugan, Ganapathy, Sarppan. It will open "completely", then we will walk around the temple. Then there are *poojas* [worships] and consecrations. There will be *dhara* [a sprinkling of water ritual] at the Siva shrine. Then almost at the same time, it will start. We will start shaking like this [the possessing spirit will become active]. It will start at 5 o'clock in the morning. Then at 8 we have ghee. After that, we will have fruit or something. We are not allowed to eat any food prepared outside. *Naivedyam* [food offered to the deities before being eaten by worshippers] will be done at noon. That food will be the meal we eat in the afternoon. Have you seen *kuruthy* [a worship invoking the goddess Kali]? You will see *kuruthy* pooja tonight.

Notice that Rajan is excited that my assistant Biju and I should see what is essentially part of the healing process, the *kuruthy* ceremony. After this mention of *kuruthy*, Rajan's description moves right into the beginning of the next day:

> Then we are ready to go again at 4am. We will bathe again, become "fresh" and will go to the temple. After bathing, we will walk around the temple. There are four poojas: at 6 o'clock is *deeparadhana* [waving lamps in front of an idol], *seevali* is at 7 o'clock. At 8:30 at night, *kuruthy* begins again. It will be over at 9:30. Thus "full time" we are in this temple or under its "treatment." We will not know anything about what is going on outside. "Full concentration, full prayer." We will be "fully" praying. [...] we chant the mantras of Saraswatham [pertaining

> to the goddess Saraswati] and Garudarudam [for Vishnu] and the Garuda *panchakhara* [a hymn]. We enter while chanting these mantras. These mantras have a good relationship with nature. They will make us "pure automatically." Then when the body gets "purified," the "spirit" inside the body will "spread" and come outside "automatically." They cannot survive outside. When we do this prayer like this, they cannot withstand it. By whatever means, the spirits will leave.

In addition to a good degree of enthusiasm, even bravado, in this narrative, one gets a sense of the aesthetically-engaging environment at Chottanikkara temple. The temple, which is described in Chapter 3, is a beautiful setting. It's a large complex of shrines and several acres of open grounds in a small, hilly village. All of it is beautifully decorated and painted. A great variety *poojas* (worships) are carried out at many different shrines over the course of the day and evening. Music is often playing, incense is often burning. The environment emphatically engages the senses. This is an important part of the process of healing according to Desjarlais, Laderman and Roseman and others who have written on the aesthetics of healing. But, just as anthropologists mentioned in Chapter 5 who write about the body simplify the nonwestern phenomenologies by emphasizing embodied realms of experience, much research on the aesthetics of healing overlooks the intangible: the spirit, the self, consciousness etc. Desjarlais, countering the mentalistic biases of earlier analyses of healing, asserts that Yolmo shamans through engaging sensory experiences "alter the sensory grounds of a spiritless body, and change how a body feels" (1992: 206). However, it would also be useful to understand the *spiritual* transformation that occurs in a "spiritless body."

The spiritual change is a key experience for many people I interviewed. It is not just a healing--the restoration of health, a return to a normal state--that goes on in such cases, but a transformation, a positive reorientation, or a movement to a higher level.

Consider, for example, how Jayasree, a woman who previously tried allopathy for her chronic fever, headache and tiredness, relates her positive healing/worship experience at Chottanikkara:

> I have been coming to Chottanikkara for the last 6 years now. I came here because of the *chaitanya* [power/consciousness/vigour] and blessing of the Devi [the goddess] at Chottanikkara. I started sitting for worship. From then until now, I haven't been to the "hospital." I have no problem at all. I came here, and Devi cured [lit. changed everything] everything in me. So I have been getting *aishwaryam* [wealth/glory] and *abhivridhi* [prosperity] continuously. Because of that blessing, I will be here forever.

While most patrons of allopathy and ayurveda talk about getting "relief" or "reducing" their problems--an absence or reduction of the negative--Jayasree talks about things like prosperity and blessing--the presence of a positive experience. Jayasree did not find a "cure"--a ridding of her problem--but rather she went through a positive transformation.

Pleasant Process as Resolution

What does one do if one has been pursuing treatment for one's psycho-spiritual problems for years, going in and out of psychiatric hospitals, having tried homeopathic medicine, *mantravadam* (magic) and other measures? At what point does constant treatment become a burden? Some people experiencing suffering whom my research assistants and I interviewed had been living at a temple, mosque or church for years, having previously tried more medically-oriented treatments for a number of years. These informants had reached a point where a pleasant process became a "cure." Or, more accurately, if one dispenses with the specific English term "cure" and looks at the wider category of *resolutions* of illness problems (not temporary or final resolutions--just

resolutions, with less time contingency), one might say that the pleasant process, living in the pleasant and spiritually-engaging environment of a temple, mosque or church, becomes the resolution of the illness problem. Rather than try to "cure" in the sense of removing some alleged pathogen, one might find a resolution to one's problems in obtaining *ashwasam* (relief) or *bhedam* (improvement) to invoke two Malayalam terms that describe what one does with an illness.

Mariyamma is a 65 year-old woman who lives and does cleaning work at Vettucaud Church (described in Chapter 3 - a Catholic church that is famous for its healing powers) in Trivandrum. She has been taking allopathic medicines for the last 6 years for sleeping and breathing problems related to family tensions. She also prays at Vettucaud Church to find relief from her problems. This should not be taken to mean that Mariyamma is praying to find some *future* relief for her problems, though that may happen. Her prayers *are* her relief at present. When asked what plans she has to get over her difficulties, Mariyamma explained, "I want to remain here until the end of my life."

Sasi is a 27 year-old Hindu man who is possessed and has been living at Beemapalli mosque with his mother for years after spending a good portion of his life trying other treatments. Eight and a half years ago when Sasi's problem started, his family went to see a *mantravadan*, a specialist in magic, to counter sorcery. Sasi then spent a year seeking treatment from a private allopathic psychiatric hospital in Trivandrum and two years in the state allopathic psychiatric hospital in Trivandrum. For the last 5 years, he has been at Beemapalli, and his mother says that it is only at Beemapalli that he gets relief. During a follow-up interview seven months after our original interview, Sasi's mother told

us that Sasi's condition has been "up and down." She said she believes one gets relief by going through ups and downs, and affirmed that she and her son "have complete faith in Beemapalli."

The younger brother of Mustapha, a 44 year-old Muslim fisherman who had been seeking relief for his problems at Beemapalli mosque explained:

> Brother: No this is the 5th time, the 5th time it has come. The problem has been coming and going for the past 8 to 10 years. We don't go anywhere else now. We took him everywhere and lost a lot of money and he didn't get any relief [lit. become healthy - *sukhamavilla*]. When we take him here, he is becoming healthy [*sukhamavunnundu*]. Now we came here 3 months ago.
> [...]
> Brother: We are giving him no medicine other than that. Now there is some relief [lit. lessening - *kuravu*]. He will get some relief during these months. We are "sure" about it.
> Kavitha: When he is sick, how long do you have to stay here?
> Brother: Till he gets relief. Now it won't take more than 2 months.
> Kavitha: Two months.
> Brother: Yes, 2 months. If we take him to the hospital, he won't get relief even if he is admitted for 5 months. Here it won't take more than 2 months.

Mustapha had been hitting and swearing at anyone who comes near him and talking strangely, among other things, for many years. He had been treated at the state-run psychiatric hospital where he received electroconvulsive therapy, and his family had tried *mantravadam* (magic - in this case, counter-magic to someone's sorcery). While Mustapha and family have not decided to live at Beemapalli mosque, their explanation shows some degree of being resigned to live with this problem and seek relief from it at regular intervals in the environment of the mosque.

Explanations and Conclusions

It is possible to attribute some of the unpleasantness of allopathic treatments and

the pleasant or nontraumatic character of ayurvedic treatments to philosophical and methodological orientations of these medicines. This could help explain why there are differing orientations toward cure, care and process in these therapies.

One could argue that allopathic medicine thinks in terms of disease *entities*, that behind every disease there is a an identifiable cause which, if removed, would constitute a cure. Diseases have names such as cancer, malaria, depression or Attention Deficit Disorder that give the impression that autonomous entities are the cause and essence of these diseases. Some diseases, such as malaria, may be clearly identified by the existance of a known pathogen, but others such as Attention Deficit Disorder constitute an arbitrary (i.e., not natural but rather agreed upon by specialists) range on a continuum of behavior. Allopathic practitioners are aware that some diseases don't have an identifiable cause (or they don't have one *yet*, is often the thinking), and can only be healed by treating symptoms. However, where a cure is considered possible, a patient can be put through an unpleasant treatment in a hurry to destroy a disease entity. This approach to treating illness is reflected in the allopathic tendency to use war metaphors in talking about handling, or "fighting," illnesses (e.g., Martin 1994). In fact, an article on ECT cited earlier refers to ECT as an important part of the "armamentarium" for treating mental illness (Rudorfer et al. 1997: 1535). When the problem is psychological or spiritual--though allopathy increasingly sees these as biological entities--"attacking" the illness is particularly painful and problematic.

Ayurvedic medicine does not rely as much on the concept of disease entities. There are diseases that have names in ayurveda, but often doctors address a specific

constellation of symptoms in a particular patient and treat those particular symptoms and the humoral imbalance(s) involved. Often, a patient is seen as someone who has a fever, dizziness and sleeping problems, rather than someone who has disease *x*, an entity indicated by these symptoms.[8] It is suggested here that such an orientation, toward treating the patient's discomforts rather than destroying a pathogen, would lead one to consider how painful a process of treatment is. The process and the end result in such an orientation are more palliative, though "cure" in the allopathic sense is also often achieved.

This patient-specific orientation may be declining in present-day ayurveda however. Traditionally, I was told, the ayurvedic *vaidyan* (to use a classical name for an ayurvedic physician) mixed a different medicine for each patient based on the patient's particular problems. I met one *vaidyan* (he was actually called *vaidyan* while most ayurvedic physicians today are called "doctor") in the city of Trivandrum who still practices medicine this way, and there are other ayurvedic physicians throughout Kerala who apply this method in varying degrees. Yet today, in the context of "modern" economic trends, ayurvedic pharmaceutical companies are mass-producing premixed, standardized medicines, and few *vaidyans* can find the land or resources to keep a supply of the raw plant materials and other *materia medica* needed to create medicines at their practice. I believe that, likewise, a trend to treat disease entities rather than specific patient complaints might also be underway.

It should also be pointed out that, consistent with the assertion I am making that

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[8] The ayurvedic method of creating specific medicines for specific patients has also been examined by Obeyesekere (1992).

allopathy is in a rush to cure, allopathic medicine does "cure," or complete treatment, more quickly than the other therapies presented here. For this reason, many people feeling time pressure from work and other obligations (as Ajit pointed out above) prefer allopathy. Between the economic trends in the ayurvedic medical industry and the time pressure that sends people for allopathic treatment, the care and nonviolence in ayurvedic treatment might become another casualty of the "modernization" project in India. Or, perhaps healers will listen to critics like Kothari and Metha, who were cited earlier, and emphasize care and process in treating illness--and thereby ayurveda may maintain its niche as a nonviolent alternative to allopathy. Only by paying attention to the quality of the process of therapy and by widening our understanding of the variety of ways of coping with an illness--to include care, living with a problem, and curing--can we be aware of such trends and their implications.

But what of allopathy psychiatry after having criticized its assumptions and procedures? Does it have any uses or virtues in contemporary Kerala? It certainly is the most popular medicine, probably because it receives the most investment from government and industry in India. Some patients did enjoy the effects of allopathic treatment, though such experiences were rare. But what was most often pointed out in terms of a benefit of allopathic care was that it could bring quick relief to a problem. Ajit earlier explained that allopathic treatment could fix a fever or other problems so one could go back to work or school. A woman who was receiving inpatient psychiatric treatment at the Medical College Hospital in Trivandrum explained that her in-laws are ayurvedic healers and she comes to allopathic treatment for quick and temporary relief:

> Patient : My husband's family is full of ayurvedic people. Ayurvedic vaidyans. "Husband"'s father and uncle are vaidyans. So the whole family are vaidyans in ayurveda. So for quick [*pettennu*] relief only we came here. After this we will do ayurvedic treatment.
> Kavitha: You believe in that?
> Patient: I very much believe in that. For immediate relief only we came here.

Also very few people have the time needed to pursue ayurvedic treatment--which takes 45 days at the GAMH--in the modern socio-economic situation of Kerala. This invokes the themes of the next chapter: illness, medicine and social change/modernization in Kerala. The decline of possession and the increase in expressing one's problems in psychological/secular idioms may relate to certain cultural projects of "modernization" and the demands of contemporary life in Kerala.

Chapter 7 - The Waning of Spirit Possession

In 1999, I returned to Kerala for two and a half months to direct the University of Wisconsin-Madison's Kerala Summer Performing Arts program. One day during this program, as I was trying to find the right vignette to introduce the variety of issues in this chapter, I was called away to take a student who was ill to see an allopathic doctor. At the doctor's office, after the consultation, the doctor asked me to describe my research project. I explained that I was working on a chapter that attempts to account for the decline in cases of spirit possession in Kerala, and this doctor immediately started talking about the film *Manichitrataẓhu* (1994) which dramatizes the relationship between allopathic psychiatry and spirit possession. Right then I realized that when I explained my research in Kerala very often someone would bring up *Manichitrataẓhu*. Since this film was clearly a strong signifier, an image in the forefront of people's minds, regarding the issue of spirit possession and psychiatric pluralism, I decided that it should be the vehicle for opening this chapter.

In this film, one of the main characters, a newly married woman, played by Malayali actress Shobana, is acting strangely. She is aggressive and emotional, and she has outbursts where she breaks things. Some members of her family and a *mantravadan* (sorcerer, magician) believe she is possessed, but others, including an allopathic psychiatrist, played by the most famous actor in Kerala, Mohan Lal, interprets her problems in psychological terms. The psychiatrist appears authoritative and confident,

and he asserts that he knows the true cause of the woman's problems. The *mantravadan* and the psychiatrist, who already know and respect each other as great healers, agree to work together to heal the woman. They do this by staging a scene in which this woman in an hypnotic/possessed state attacks a dummy which represents her husband, or some man with whom the possessing spirit had conflicts, depending on how one interprets her problem. Through this drama the woman acts out her desires and frustrations (the psychiatric solution) while exorcizing the possessing spirit (the *mantravadan*'s solution) and becomes cured (sic).

There are many messages about the ambivalent views of the ascendance of modern psychiatry in contemporary Kerala, and the film appears to carefully avoid privileging one interpretation of the woman's problem over the other. The family of the afflicted woman and her husband take sides, some supporting the psychiatrist's interpretation and some supporting the *mantravadan*'s view, and their support is not predictable based on clichés about who will be traditional and who will be modern. That is, family members from a variety of ages and degrees of education and both genders support both views. Yet there are a greater diversity of interpretations of the film than what is presented here. Some people I spoke to say that the film clearly does not take sides privileging one interpretation over another, that the message is one of indeterminacy and relativity. Others, however, strongly assert that the film favors the psychiatric view of the problem, that though some deference is made to the *mantravadan*, the psychiatrist ultimately frames the method of healing. He is in the film for a longer time, and his interpretation is more pervasive and authoritative. Whatever the reading of

this film, it is clearly a pivotal text that taps into issues some Malayalis are thinking about and find intriguing.

Let me now add a second vignette to highlight another dimension of this chapter. At a conference on "stress" in 1997 (an idiom of suffering that appears to be becoming increasingly popular in Kerala), V. George Mathew[1], a psychology professor at the University of Kerala, gave a paper based on research he has been conducting among "tribals"[2] who live in the mountains of southern Kerala. George Mathew explained that in the past 7 years--since the first time he visited these people--they have experienced several incursions of "modernity." Some tribals started a sandlewood business, buses started serving the area they lived in, and alcohol became more widely available. Along with these changes, George Mathew reported that these people showed increases in internal disputes, alcoholism and cases of psychopathology. This scenario is analogous to what many mental health practitioners feel has been happening to Kerala as a whole.

This chapter will examine an alleged decrease in the incidence of spirit possession

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[1] I feel it is necessary to point out that V. George Mathew is a Malayali from a Christian family. Often when I mention the names of Malayali Christians, people who are not familiar with Kerala tend to think that I am referring to westerners who have settled in Kerala or people from colonial families. Also, these Christian names, though familiar to the western reader, are not divisible into the western first-name-last-name system. "George Mathew," for instance, can only be referred to as "George Mathew" or "Dr. George Mathew." "George" is not a "first name" people close to him would use, and calling him "Dr. Mathew" would sound nonsensical.

[2] "Tribals" is the term used in India for the original inhabitants of India who pre-date the arrival of Aryan peoples. Aboriginal peoples intermixed with Aryans (which is a label for a non-homogenous group of settlers, allegedly from outside the Indian subcontinent), and it is hard to draw a clear line between these categories. The term "tribals" most accurately refers to indigenous people who live in less-accessible areas of India often as hunter-gatherers and pastoralists.

and a simultaneous increase in psychological modes of expressing illness in the context of social influences that, like those described by George Mathew, are considered "modern." I will also discuss the negotiation, assimilation and transformation of psychological, psychiatric and spirit possession discourses. Put another way, this chapter will focus on changes that are occurring in the illness and therapy scene described in previous chapters.

Although several anthropologists have examined changes in the *form* of spirit possession in various societies (e.g., Stoller 1989; Vecchiato 1993; Kenyon 1995; Sharp 1995; Strathern 1996), there have been few accounts of the diminuation or disappearance of spirit possession, or of changes in the form of expression of illness in general. Several psychological and spiritual healers in Kerala have reported to me that cases of spirit possession are becoming less frequent and that more people are coming to healers expressing their problems in western, psychological idioms. Specifically, this decrease is reported for involuntary, illness-like forms of possession. No change has been reported in the incidence of voluntary, pretigious possession (such as possession associated with rituals and festivals wherein deities are called to enter the body of a priest--further details about the various forms of possession in Kerala are provided below). In general, when I use the term "possession" in this chapter, I am referring to the unwanted kind of possession, possession as an affliction akin to an illness.

At the same time, I have noticed from my interviews and by studying an account of possession in Kerala in the 1960's that cases of possession seem to be less *specific*. Possessing spirits, according to the descriptions of them by informants, seem to be more

anonymous and more vague than they were in the past. Meanwhile, people suffering distress use a number of English terms, such as "tension" and "depression," to describe their problems, and allopathic psychological and psychiatric discourse is widely disseminated through television, movies, and the print media in contemporary Kerala. These changes involve a homogenization or an erosion of context in the world of healing. As "modernization" has been characterized by some as a movement toward the context-free (Ramanujan 1989; Prakash 1999) and as many Malayalis characterize the elements of social change described here as "modern," I will also probe discourses and issues related to "modernity" and "modernization" in academic analysis and in popular discourse in Kerala.

"Modernity" is of course a complex, sometimes unwieldy, label that has been attached to a number of social trends, ideologies and epistemologies. I do not claim to have a clear or comprehensive definition of this trend, and I can't even be sure that it is ultimately a meaningful or coherent concept or practice. I do not view "modernity" or "modernization" in their common sense or referential meanings as attempts to achieve some end goal along an evolutionary trajectory of increasing "enlightenment" or "development." I consider modernization to be a label for relatively recent ideological, discursive, and economic trends that embody certain western cultural assumptions. However, "modernity" is a meaningful, though polysemic, sign or category for Malayalis (and probably most everyone else in the world). Many ideas and events described in this chapter are classified by people in Kerala as part of the "modern" project. These include rationalist ideologies promoted by the Communist government of Kerala, the secular

education that is widely available, the knowledge and practice of allopathic (also known as "modern") medicine, and effects of incorporation into the global economy, such as migration. Another shift that can be seen as "modern"is a change in the people's relation to time. Many informants explained that time pressure affected their decisions about what kind of therapy to pursue (having little time to spend in therapy leads many to use allopathy). Meanwhile, some of the English language idioms that are used--such as "tension" and "stress"--connote problems of time pressure.

It will also be observed that modernist discourses, such as claims to rationalism, also exist in Indian disciplines, such as ayurvedic medicine. In this chapter we will also see how in some instances Islamic ideologies are invoked to provide the same discourse as allopathy and "modern" scientific knowledge regarding spirit possession. Thus modernity, while it can be seen as a western product, is not wholly distinct from Indian disciplines and is not intelligible in terms of an Indian-Western dichotomy.

It should also be noted that this analysis of change in the world of psycho-spiritual suffering is largely exploratory and suggestive. Complex issues which themselves could be the subject of an entire dissertation are brought up in this analysis. To a certain degree, every chapter in this work is an incomplete interpretation, but this chapter especially merits stressing that its propositions are explorations and suggestions for interpreting complex events. Even the premises that inspire this chapter--the changes in idioms of illness from possession to psychological modes--are hard to establish. For these reasons, I will linger longer than usual in analyzing perspectives from the relevant literature, and showing the various insights they bring to issues in this chapter.

Analyses of Possession and Interpretations of Change

The disappearance or diminuation of possession appears to be a rare phenomenon when one examines social science literature relating to possession. It could be that it is in fact a rare phenomenon--or perhaps few anthropologists have chosen to examine this issue when they've come across it. There are a number of studies that analyze changes in the form and theme of possession and attempt to connect these to social, political, religious or other changes. (These studies analyze either the unwanted affliction type of possession or the voluntary, auspicious kind or both, and many conflate these forms of possession.) Other research has focussed on changes in the form and incidence of psychopathology. Insights from these two sets of studies plus an analysis of attempts to define "modernity" will help make sense of the currents of change that are the focus of this chapter.

Possession and Social Change

Paul Stoller's ethnography Fusion of the Worlds (1989) reveals innovations in the world of possession among the Songhay of Niger that respond to changes in the social order and government policy. In the past, under an imperial Islamic movement and European colonialism, "new deities came into existence in response to profoundly stressing social change and reflected, often with mockery, the influential Other" (178). In more recent times, under the "prudish" policies of Niger's neoconservative Islamic government, a possession troupe emerged which depicted sexually explicit scenes and portrayed Songhay themselves as sexually promiscuous, which is interpreted by Stoller

as a movement of cultural resistance. New deities and new themes have been introduced but possession does not seem to have waned.

A 1995 issue of Anthropological Quarterly was devoted to the issue of possession and social change in eastern Africa. Many of the contributors in this volume depict possession as historical consciousness, reaction to change, or resistance. In most papers, changes in the frequency of possession are not discussed, but in some cases--Kenyon in an analysis of contemporary Sudan and Sharp in a study of Madagascar[3]--"possession religion" (to use a term from Bourguignon's article in the same volume 1995: 72) is gaining *more* adherents and performing more ceremonies.

Andrew Strathern (1996) reviews a number of ethnographies of possession in order to make the point that possession is a mode of historical consciousness. It operates (as in Stoller's and some of the Anthropological Quarterly studies) in a variety of cultural settings as a parody or critique of a hegemonic power, whether it be European colonialism, male dominance, or Islamic governments (153-176). One gets the impression, though, that in all historical periods and all alignments of power that were examined, the popularity of the idiom of possession has been static.

Norbert Vecchiato's examination of possession and social change in Ethiopia (1993) shows how "traditional" modes of possession, which he defines as "animistic," are declining in popularity and people are using Christian and Islamic methods of exorcism to rid themselves of unwanted spirits. Again, we see a change in the style of

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[3] Sharp has elsewhere (1996) shown that characteristics of possession have reacted to change but appear to be as popular as they were before.

coping with possession, but no indication of a change in the prevalence of possession.

An exception to the studies which either don't find or don't examine the prevalence of possession is Mariella Pandolfi's (1993) account of women's expressions of suffering in the Samnium region in southern Italy. The well-known (in Italian and francophone anthropology) medical anthropologist Ernesto de Martino did research on possession in this region in the 1950's and 1960's. Pandolfi also observed cases of possession in this area in the 1960's, but on her return to Samnium in the 1980's, she discovered that spirit possession had disappeared as an idiom of distress. Pandolfi does not focus on trying to explain why possession disappeared though she mentions, in passing, that this disappearance may relate to urbanization and economic development in the region (64). Pandolfi's focus is on ways of speaking about illness which have replaced possession as a form of suffering yet have a continuity with past idioms of possession:

> pour les femmes, le récit qui aujourd'hui parle du corps se substitue à la possibilité qui existait autrefois de parler *à travers* un corps possédé ou malade.
>
> Le language corporel et le langage psychosomatique s'y voient remplacés par un langage iconique. Un corps fragmenté est «vécu» à travers le récit, lequel tend à reproduire le rythme de la possession grâce à une stratégie rhétorique des émotions, des passions. (65)

> (for the women, their narratives about the body are a substitute for the possibility that existed before of speaking *through* a possessed or ill body.
>
> The bodily language and the psychosomatic language are replaced here by an iconic language. The fragmented body is "lived" through a narrative which tends to reproduce the rhythm of possession through a rhetorical strategy of emotion, of passions.) (My translation.)

She goes on to further elaborate this continuity between these spoken and embodied modes of expression:

> La continuité est marquée par deux formes de ritualization, l'une «agie», l'autre narrée, qui interprètent une «crise de la présence» subjective et collective. La continuité réside dans le fait de parler de sa propre souffrance par un récit sur le corps, qui évoque, dans le rythme et la scansion, dans les métaphores utilisées, le souvenir des rituels de possession disparus. (71)
>
> (The continuity is indicated by two forms of ritualization, one "acted," the other narrated, that interpret a subjective and collective "crisis of presence." The continuity resides in speaking about one's suffering by talking about the body in a way that evokes, in the rhythm and stress and in the use of metaphor, the possession rituals that existed before.)

I did not, however, see a similar use of metaphor and rhythm invoking bygone idioms of possession in the illness narratives of my informants, perhaps because I am lacking detailed past accounts of cases of possession. As opposed to what Pandolfi saw in Italy, Kerala may be marked by more of a rupture in modes of expressing distress. Yet there are strains of continuity and hybridity between possession and expressing illness in contemporary psychiatric idioms as will be seen below in the example of the "uncleanliness" that was "possessing" a woman described in Dr. George's psychological advice column.

Pandolfi's study also takes the position that there is some consistent level of experience of suffering that underlies different idioms of expression. The consistent, underlying problem is labeled using DeMartino's term "crisis of presence," which is inspired by Gramscian social thought and similar to Marx's alienation and Heidegger's *dasein*.[4] Another view that is implicit in some research in allopathic psychiatry, cross-

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[4] "Crisis of presence" refers to a disturbing dissonance between one's self and one's social context, an alienation that is grounded not just in the world of labor and production but in the context of hegemony, ways of being that are caught in relations of power. It is a universalizing label for problems that include illness, much like the term "suffering," "distress" and "social suffering," which I and other anglophone medical

cultural studies of psychiatry and anthropology is the position that a change in the idiom of illness indicates a change in the fundamental, inchoate distress. Put another way: there is no experience of suffering prior to the idiom in which it will be expressed. I think it is hard to determine whether one of these views is correct. Rather it is the theoretical tension between these two views which underlies issues in this chapter. There is one position that this chapter does not take: what one might consider a biomedical view that it is not possible to change idioms as there is only one underlying, real illness, one biological entity. My position is that there is a consistent, underlying problem that could potentially be expressed in a variety of ways. Yet I also believe that the form of expression affects the experience of the problem.

Another exception to the lack of studies of disappearance or waning of possession can be found in Shigeyuki Eguchi's study of *kitsune tsuki* or "fox possession" in a mountain town in Japan. Cases of fox possession were common in this town until bus services became available and economic transformation leading to occupational changes occurred (1991: 440). Along with these changes, biomedical psychiatry became available as an alternate form of treatment and competing interpretation of illness. Now, due to availability of a variety of diagnoses and treatments, the meaning and ontological status of *kitsune tsuki* has become ambiguous. This same ambiguity exists in Kerala in defining the meaning of problems that could be seen as "mental" or due to "spirit possession."

Perhaps another exception to the lack of ethnographic cases of the diminishment

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anthropologists use to try to avoid separating illness from a wider array of social problems (e.g., Kleinman, Das and Lock 1996)

of spirit possession can be seen in Shirley Lindenbaum's recent analysis of changes in the characteristics of *masalai*, or bush spirits, in Papua New Guinea (1999). This is a partial exception as this is an examination of a certain kind of spirit and not an analysis of spirit possession. However, it reveals similarities to changes that are occurring in Kerala. Lindenbaum examines how the character of a *masalai* spirit named Nokoti changed in different historical periods. In the precolonial era, Nokoti was a noble spirit guide, but with the advent of colonialism, Nokoti becomes a thief and steals money, colonial currency. In post-colonial times, Nokoti raids a local trade store, a symbol of the current economy and rural differentiation. Recently, he has become a regional and national symbol, and his image adorns the Eastern Highlands Provincial flag. Yet with the conversion of many Fore to Christianity, which discourages belief in non-Christian spirits, Nokoti is no longer sighted by the Fore, who have instead been encountering *duwops*, dwarflike spirits who are short, mischievous and non-prestigious. This is not a case of disappearance of spirits, but it can be interpreted as a diminuation and a homogenization of spirits which also seems to be occurring in Kerala. *Duwops* do not have specific, local names, and people no longer name children after them as they did with former *masalai* spirits. *Duwops* also don't talk and do not develop personal relationships with Fore people as former *masalai* spirits did. Likewise, possessing spirits in Kerala have decreasingly specific identities and characteristics.

Psychopathology and Social Change

There also exist a number of studies that try to relate psychopathology to social

change, though none of these include discussions of possession. These studies are interested in illness as defined in allopathic psychological and psychiatric terms, yet their insights offer some suggestions for interpreting events in Kerala.

Ian Hacking's Rewriting the Soul (1995), which attempts to comprehend the emergence of the idiom of multiple personality disorder, has a bearing on the issues in this chapter in a number of ways. First, methodologically, Hacking's attempt to explain--or do an archaeology in the Foucauldian sense--the sudden, almost epidemic emergence of cases of multiple personality disorder in North America in the 1980's by examining a variety of sources--historical, psychiatric, fictional and other--is analogous to the attempt in this chapter to understand the waning of spirit possession and the proliferation of psychiatric and psychological modes of expression. There are also substantive relations to Hacking's work. Hacking's main thesis is that multiple personality cases emerged as part of a project of secularization of the soul by positivist psychologists and psychiatrists and, starting in the 18th century, the development of "sciences of memory" which saw memory as the key to understanding the person. First of all, though Hacking claims not to take sides on empirical matters (such as what causes multiple personality or whether multiple personality is a "real" illness), one can perceive in Hacking's work the possibility that the florescence of cases of multiple personality derives from the promotion of the concept by professional specialists, researchers and supporters of multiple personality awareness movements. Paraphrasing the position taken by skeptics of the proliferation of diagnoses of multiple personality disorder, Hacking states:

> How can it be everywhere in North America and nonexistent in the rest of the world until it is carried there by missionaries, by clinicians who seem determined

> to establish beachheads of multiple personality in Europe and Australasia? The only place that multiples flourish overseas is in the Netherlands, and that florescence, say skeptics, was nourished by intensive visiting by the leading American members of the movement (14).

Similar trends are happening in Kerala on a more general level: not the promotion of awareness of one particular psychiatric concept, but the promotion of allopathic/western psychological/psychiatric idioms of distress in general. The dissemination of information about these problems, and the increasing availability of healers who can make the relevant diagnoses, make it possible for people to express their distress in these terms. That is, people in Kerala describe problems using English words such as "tension" and "stress" in part due to the availability of western psychological discourse. This, however, does not negate the possibility that new phenomenological experiences may become more salient as a result of social change--for example, modern jobs and time demands causing feelings like "stress."

Hacking also relates Mary Douglas' work on the concept of the person in "enterprise cultures" (examples of which are Western Europe and the United States): "Douglas argues . . . that Locke's notion of the person as forensic and as linked by chains of memory and responsibility is a characteristic of the enterprise culture (146)." Hacking asserts that "Locke's forensic person is a relatively new figure who arises from new practices of commerce, law, property, and trade" (146). And, "The more quickly a nation developed new technologies, the earlier its concern with accidents, with laws of negligence and liability" (185). One could argue that "modernization" in Kerala has entailed the development of many of the institutions and laws described above, and, following Hacking, these favor Locke's "forensic person," a person whose liability needs

to be established and for whom consideration of external responsibility for problems, such as in spirit possession, needs to be limited.

Louis Sass (1992) explains that there is a great deal of similarity between contemporary psychopathology and characteristics of modern and postmodern art, literature and philosophy, especially in the area of hyperreflexivity, extreme relativism, an excess of consciousness and reasoning.[5] This brings up a different ontological position from some of the works described above, where one can simply transfer the form of illness from, say, possession, to a (post)modern, psychological idiom like schizophrenia. The latter is alleged by Sass to be an ontologically unique condition that comes from certain behaviors--extreme self-analysis and intellectualization--that developed at a certain historical moment.

In Kerala, with a highly literate and educated population, that is also highly unemployed and underemployed, one could argue that opportunities for the hyperreflexivity Sass discusses are common. The change to psychological idioms may relate to these conditions in addition to the dissemination of allopathic psychiatric and psychological knowledge.

Richard Warner's Recovery from Schizophrenia - Second Edition (1994)

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[5] Sass is referring to "modernism" in the arts and philosophy, and what is being described in Kerala are considered to be aspects of "modernization." While one term tends to refer to arts, literature and philosophy and the latter to socio-economic trends, there is some overlap in that they develop in the same broad period of European history and they have common and complementary positions such as claiming legitimacy through appeals to "reason." Rebellions against modernism, such as surrealism and postmodernism, I would argue, still have characteristics in common with modernism, such as a significant (even if negative) relation to reason and glorifying intellectualism.

examines changes in the incidence of schizophrenia in relation to changes in political economy. Warner asserts that the rate of schizophrenia rises along with the advance of industrial development, though the number of cases of schizophrenia later falls (193-197). Warner believes that this relates to alienation--from the fruits of one's labor as well as from other people--in industrial societies (190).

Also focussing on change in the political economy and psychopathology, Fortes and Mayer learned that the Tallensi of Ghana, a society they had studied since the 1930's, developed a high rate of psychopathology by the 1960's. Fortes and Mayer considered this to be due to the fact that in the intervening years a large portion of the Tallensi population had changed, or been forced to change, from subsistence agriculture to migrant labor (Fortes and Mayer 1969). While political and economic changes are a substantial part of the changes that either affect, or at least coincide with, the changes discussed in this chapter, there is no indication of a change in the total incidence of psychopathology in Kerala. I am arguing that there is a change in idioms of distress--forms of illness--although there are healers who believe that the incidence of psychopathology is higher in Kerala than in other Indian states.[6] It is true that the incidence of suicide is extremely high in Kerala, and that this may relate to underemployment (Halliburton 1998).

Leith Mullings' study of forms of mental healing in urban Ghana focussed on changes in healing practices in relation to political and economic changes, and has

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[6] This has not actually been studied though an epidemiological survey of cases of psychopathology in Kerala is being considered by Dr. Suraj Mani of the Kerala Mental Health Authority.

implications for the context of healing in Kerala. Mullings asserts that the goals and techniques of therapies "cannot be adequately explained without analysis of the international social relationships that condition them" (5). That orientation and methodology is shared by this chapter, though the social changes and their implications in Kerala provide an interesting contrast to those revealed by Mullings who examined healing in a city in Ghana which had changed from a village and community-centered mode of production, in which extended family ties were emphasized, to a capitalist mode of production in the context of colonialism. Traditional Ghanaian healing which predates this transition, worked by resolving conflicts within the lineage or the extended family (121). Christian spiritualist healing and allopathic psychiatry, which became popular with the emergence of a capitalist economy, aim at healing the *individual* and stresses individual responsibility in explaining and treating illnesses, orientations which support the ideology of individual ownership and responsibility in the capitalist market economy (133-185).

Although socioeconomic changes have also to some degree eroded the extended family in Kerala, unlike Ghana, Kerala is a Communist society. One could point out that Kerala is only a state within a larger, part capitalist-part socialist country, but in Kerala's political and social system individualism and the market economy are not dominant ideals. In fact, movements such as Kerala's literacy campaign and land reform acts run contrary to individualist ideologies promoted by western psychology. Still, as Mullings and other proponents of critical medical anthropology suggest (for example, Baer, Singer and Susser 1997), there are aspects of the international political economy that affect the

world of health and illness in Kerala, such as the state's intense migration to the Persian Gulf region.

I would suggest, though, that there are features that capitalist and communist ideologies and the international cultural and economic sphere have in common such as discourses that are considered "modern," like rationalism and secularism, and these contribute to the context in which healing is undertaken in many societies.

Identifying Modernity

"Modernity" and "modernization" are, as suggested earlier, vague, taken-for-granted terms that relate to a complex system of discourses, philosophies, economic trends and historical contingencies. Comaroff and Comaroff assert that modernity "is profoundly ideological and profoundly historical" and "it is difficult to be certain exactly what 'it' is" (1993: xi). The concept only holds together in its emic sense as a myth that began in Europe about the course societies should take; as Comaroff and Comaroff say, modernity is an "epic story about the passage from savagery to civilization, from the mystical to the mundane" (xii). It is also a story that tells of "the advancement of the primitive: of his conversion to a world religion, of his gradual incorporation into civil society, of improvement in his material circumstances, of the rationalization of his beliefs and practices" (xii). The volume from which this Comaroff and Comaroff material comes reveals situations in Africa where aspects of modernity have been resisted, critiqued, transformed through appropriation or parodied. Kerala, however, seems to be a place where, despite some intellectual critics, aspects of modernity were well-received and

promoted. This is, as Appadurai and Breckenridge (1996) point out, not simply a case of the outside/western world influencing India, but rather India using, participating in, and promoting modernity itself.

Finally, and significantly, aspects of modernity--such as a claim to rationalism and objectivity--are not foreign to India, and in fact have a prominent place in classic and contemporary indigenous philosophy and science (though these are not always applied in the same way as in "modern" disciplines). Additionally certain not-necessarily western or Indian traditions that have existed in Kerala as long as they have in the West--Christianity and Islam--promote some of the same ideals that modernist, western psychology does regarding issues in this chapter. In practice, adherents of these faiths do tolerate diverse practices such as possession. However, in all these traditions possession is considered a kind of false belief, and some healers in Kerala appeal to religious ideals or reason via ayurveda to disabuse patients of their notions about possession.

If we consider rationalism or reason as an aspect of modernity that is promoted by allopathic psychiatrists, some ayurvedic healers, communist advocates and others, Ashis Nandy's claim that a "monologue of sanity" in modern, urban India replaced social relations that normally incorporated, assimilated or otherwise took care of neurotic and psychotic people, helps us make sense of the situation in Kerala:

> These relationships and the worldview that informed them were being replaced by a new network of social relationships sanctioning a new set of 'superstitions'--constructions of mental illness derived from remnants of traditional ideas of lunacy and available scraps of modern psychiatric knowledge. The first victims in this change were the psychologically afflicted; they were no longer seen as aberrant individuals deserving a place within the family and the community, but as diseased and potentially dangerous waste products of the society. As Bijayketu Bose puts it, the shock-absorbing capacities of the society had declined

> considerably at the time. And as a Michel Foucault of a Ronald Laing might have said, the dialogue between sanity and insanity had broken down; the society was now dominated by a monologue of sanity. (1995:110)

A society that is fetishizing reason and modernity may see the irrational in an exaggeratedly negative light and the people who are less sane as "waste products." Or perhaps, following Ramanujan, this is a case of overemphasis on the "context-free."

In his analysis of "modernization" in India, A.K. Ramanujan (1989) argues that India is a predominantly context-sensitive society. He cites Daniel's (1984) observation that in Tamil Nadu certain people are compatible with certain types of soil, food, houses and sexual partners and points out that times (e.g., season, eons, times of day) provide context: ayurvedic medicine has different treatments for different seasons and each musical *raga* has an appropriate time of day when it should be played. Even people's names in India reveal a lot of context--such as, birthplace, father's name, caste etc.[7] There is "a constant flow...of substance from context to object, from non-self to self (if you prefer)--in eating, breathing, sex, sensation, perception, thought, art, or religious experience" (52). After pointing out that Protestant Christianity, post-Renaissance sciences and other traditions endeavor to find universal laws and strive to be context-free, Ramanujan suggests, "One might see 'modernisation' [sic] in India as a movement from the context-sensitive to the context-free in all realms: an erosion of contexts, at least in principle," (1989: 55). The decline of possession and its replacement by psychological

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[7] Interestingly, Ramanujan cites an example from Kerala as an indication of a move to the context-free in the world of names. He recalled, "I once found in a Kerala college roster, three 'Joseph Stalins' and one 'Karl Marx'." (1989:55). These names indicate an erosion, or a change, of context, but they are also a reminder that Communism is a significant discourse of modernization.

idioms, if we agree that the latter are more context-free, could be considered part of such a trend. This decreasing specificity in the transition from possession to psychological idioms is complemented by my finding that a few decades ago (based on research conducted by Jagathambika in the 1960's) afflicted people described their possessing spirits in more specific terms (e.g., with names, personalities and histories) than the patients I encountered in 1997.

But modernization for Ramanujan is not simply an unstoppable erosion of context. He explains that "When Indians learn, quite expertly, modern science, business, or technology, they 'compartmentalize' these interests" (57) and cites an ethnography that shows how Hindu *poojas* are done to consecrate instruments of modernity such as computers and typewriters. Finally, Ramanujan signals the ambivalence, or the tension, between modernization and the context-specific: "The 'modern', the context-free, becomes one more context, though it is not easy to contain." (57).

Finally, and very significantly, Ramanujan suggests that Indian society is not exclusively context-sensitive. A number of context-free countermovements have arisen in India such as *moksha*, *sannyāsa*, or *bhakti* (movements that seek ultimate release from all attachments or devotion to the divine without any relation to attributes or characteristics), and I would add to that list the generalist and universalizing schools of philosophy such as Samkhya, Nyaya, Yoga and Vendanta. Ramanujan suggests "India, where context-sensitivity rules and binds, the dream is to be free of context" (54). Although anthropologists already know that culture is heterogenous, Ramanujan makes the interesting point that a culture can be marked by having a certain tendency and its

opposite.

Somewhat similar to Ramanujan's position, but not engaging the issue of context sensitivity, Prakash (1999) has recently argued that India's claim to be "modern" is based on upholding classical philosophical treatises and tradition of science and medicine (such as ayurveda) which contain rational criticism and the ability to universalize.

An additional aspect of the project called "modernization" that is not covered in the works outlined above is a change in the relation to time. As Kerala "develops" or "modernizes" in the sense of increasing access to health, education, technology, and attempting to make the economy more productive, people seem to lack time. English language idioms such as "tension", that can be interpreted as relating to time pressure, have entered Malayalam popular discourse, and many choose allopathic treatment because they feel they can get *quick* relief.

Ethnographic Features

Varieties of Possession

As indicated earlier, in this chapter I am focussing on the unwanted form of possession that is akin to an illness. There are other forms of possession that are invoked intentionally and voluntarily in a controlled ritual environment and are considered prestigious and auspicious. This is similar to Ioan Lewis' (1989) distinction between "peripheral" involuntary, illness-like possessions and "central" prestigious, shamanic-style possessions.

In involuntary possession, one may fall ill and later learn, often through

divination, that one is possessed; or one may perceive a change or disruption in the self or behavior and realize that it is due to spirit possession. Involuntary possession affliction involves possession by *spirits* that are mischeivous or malicious, such as "Chattan" from local cosmology, or the spirits of deceased relatives--though, as this chapter shows, the identities of these afflicting spirits are becoming more homgenous. Thus the term "spirit possession" tends to refer to this form of possession as it is usually minor spirits rather than prestigious deities that are the possessors.

A typical story of involuntary, illness-like spirit possession involves the afflicted person feeling a sense of shock or fright, which often occurs when she is alone--a common, almost cliché, location where is happens is a *kavu*, a forested preserve or glade. Sometimes the afflicted person reports seeing a dark, numinous figure. The afflicted person does not usually describe these events or say that she is possessed at first. Often the possessee starts behaving strangely, such as refusing to eat or acting emtionally distant. Others eventually learn that the afflicted person is possessed when the possessing spirit declares its name--"I am [name of spirit]"--through the voice of the possessee or when a diviner declares that a problem is due to possession. This ideal-typical protrayal of affliction possession is very general and does not cover the wide variety of courses of development possession can take. Relief from affliction possession is sought from a *mantravadan* (sorcerer), a psychiatrist or a temple or other religious site.

Voluntary possession by deities, somewhat like Lewis' "central" form of possession, also occurs throughout Kerala. In these cases, possession is sought after and the possession state is auspicious, prestigious or powerful and is acheived in order to,

among other purposes, prevent problems and maintain cosmic order. One such form of possession is the famous Teyyam ceremonies of northern Kerala wherein specially selected participants paint their faces, put on costumes and invoke possessing deities. This is a form of worship, a way of increasing one's consciousness and enlightening others and a means of bringing bringing divine power to a region (Freeman 1993). Meanwhile, *pambin tullal* is a possession ritual performed to stave off the anger of serpent deities who may be offended due to violations of their sacred groves and to maintain the general well-being of Nayar families (Neff 1987). Another example of auspicious, voluntary possession-mediumship occurs at an annual festival at a temple in Trivandrum that is devoted to a serpent deity. In this festival, a huge picture of the deity is created on the ground with colored powders, and selected men who have become possessed by the snake deity and brought in and thrash about on the powder "painting" while priests pour pudding and noodles on them. The ceremony is accompanied by a packed audience, photographers, video cameras and reporters. But these auspicious possessions also occur in more routine contexts. A priest at a small temple in the neighborhood where I lived in Trivandrum became possessed by Amma, *the* goddess (described in Chapter 3) every Tuesday and Friday evening, during which time people would come to the temple and consult the goddess through the priest for advice about health, schooling and other issues. This possession ended when the ceremony ended, and this form of possession was the opposite of a pathology or a problem. The possession was considered empowering and helpful, and people (including myself) admired and respected this priest for his ability to connect with Amma.

There is not, however, a clear line demarcating these two general forms of possession I have outlined. For example, some Teyyam possessees are selected for Teyyam ceremonies because they became spontaneously possessed by Teyyam deities in the past (Freeman 1993). The most consistent characteristic of the kinds of possession I am discussing in this chapter is that one seeks from these states from an exorcist, psychiatrist or other therapist.

The Waning of Spirit Possession

Although a number of healers reported to me, on each trip to Kerala, that cases of spirit possession were becoming less frequent, most of these healers couldn't specify how they knew this. They just had the impression from the clients they had seen that the incidence of possession is declining. There were some particularly convincing accounts though. Dr. Jagathambika, one of the first people to ever practice clinical psychology in Kerala, explained that when she first started practicing in the 1960's, every day several possessed people came into her practice for treatment. Nowadays, she said in 1997, only about one possessed patient comes to see her every month. (This is not because the total number of her patients has declined. She is a very popular and well-reputed healer and her waiting room is often crowded.)

Another clinical psychologist K. Gireesh affirmed that possession is becoming more rare. When I pressed him to more specifically explain why he thinks this, he said (in 1999) that 7 or 8 years ago, when he began practicing, 30-40% of his patients were possessed. Now only 5% of the people he sees say they are possessed. Shortly after

saying this, however, Gireesh qualified this statement. He had seen this decline over the years he worked in Trivandrum, but in the smaller city of Kottayam, where had been working for the last year, he says he noticed more cases of possession than there were in Trivandrum.

It is of course possible that possessed people no longer visit clinical psychologists (or psychiatrists and ayurvedic doctors who also report decreases of cases of possession) and are now going to see other kinds of healers. Yet among the 100 patients I have interviewed at numerous healing centers, including three religious institutions known for healing possession, only 13 (plus a few ambiguous cases mentioned below) reported being possessed, which is close to the rate Gireesh and Jagathambika report for the present period.

In addition to the 13 informants who were clearly characterized as possessed, one woman thought she *might* be possessed, and a man we spoke to was possessed in the past but does not describe his current problem as a case of possession. In addition, three people seeking relief at Chottanikkara temple did not describe their problems as a possession though they became possessed as part of their therapy at the temple. One informant reported a fear of becoming possessed, and another explained that he was afraid of spirits that were lurking around him. Twelve of the 13 who were reported as possessed were seeking relief at Chottanikkara temple or Beemapalli mosque, yet several of these informants were previously treated at allopathic psychiatric hospitals.

Interestingly, though informants at Chottanikkara temple described the healing methods in terms of getting rid of possessing spirits, only 3 of the 9 people we

interviewed at Chottanikkara temple reported being possessed. The others simply *became* possessed and got rid of their spirits as part of their therapy. It almost seemed that people became possessed to imitate the style of healing that Chottanikkara is reputed for, though prior to coming to the temple they didn't see possession as a meaningful way to understand their problem.

Although these 13 possessed informants, plus the additional ambiguous cases, can be used to support the notion that possession is becoming less common, they also indicate that possession continues to be a significant mode of expression of illness. I refer to the "waning" rather than "disappearance" of spirit possession in this chapter since possession seems to be becoming less common though it is still significant. As was seen with the ambiguous cases mentioned above, possession is still a symbolic idiom for many who aren't possessed, and as we will see with Dr. George's column, the style of possession can influence the way a healer thinks about illness. "Waning" is an appropriate term also because it describes another dimension of change: the homogenization of possession.

Decreasing Specificity of Spirits

Alongside the apparent reduction in cases of possession, there appears to be another kind of diminuation or attenuation of spirit possession in Kerala. The characteristics of possessing spirits appear to be less specific and more anonymous and homogenous. People were formerly possessed by spirits that had names and detailed, colorful personalities, whereas most of the possessed people my research assistants and I

interviewed were afflicted by generic spirits: "some spirits" or "Malayali spirits" was all that was usually reported.

The best source on the decreasing specificity of spirits comes from examining the work of Dr. Jagathambika, the informant who also reported the reduction in the number of spirit possession cases in her psychology practice. In 1968, Dr. R. Jagathambika became the first person to earn a Ph.D. in psychology in Kerala. She studied at Union Christian College of the University of Kerala under Kerala's first clinical psychologist, Dr. V.K. Alexander, a Malayali Christian who completed his Ph.D. in psychology at Princeton University in the U.S. Dr. Jagathambika's dissertation research was carried out in the early 1960's at Dr. Alexander's clinic and research center in Aluva, Kerala and was based on her treatment of spirit possessed people, whom she considered to be suffering from multiple personality disorder, through hypnosis and psychotherapy.

In Dr. Jagathambika's research, she treated patients who were possessed by specific spirits with specific personalities. For example, a patient Jagathambika calls Kamala, a 19 year-old, married Hindu housewife, was possessed by the spirit of her deceased aunt Laila and her deceased sister Bhama. Aunt Laila was considered insane and because of that never married. After Laila died, Kamala saw her deceased body. It was the first time she saw a dead body, and she was shocked by the experience. Laila as a spirit speaking through Kamala explained "I made use of this opportunity to enter her body" (83). Bhama, a sister of Kamala, died at age two. Bhama's spirit explained that she had always been in Kamala's thoughts since she (Bhama) died, "[b]ut luck and bad time

[astrologically] only turned the thought about me into my evil spirit" (85).[8] Jagathambika also describes the case of "J,"an 11 year-old Muslim boy who was possessed by the spirit of his deceased grandfather. J's grandfather was a large man who was notorious for chasing women and was considered immoral. When J became possessed by his grandfather's spirit, according to Dr. Jagathambika, he would speak in the voice of an old man and use abusive words. The spirit of J's grandfather also would threaten to take J away with him (61-64).

Jagathamika also treated Bose, a 16 year-old Hindu boy who said he was possessed by Jesus Christ. When possessed, Bose would claim to be Jesus, and he would ask his family to worship him and do special things for him. All except his skeptical mother, took his possession seriously, believed Jesus was possessing him, and obliged his demands. Finally, Anna, a 35 year-old Christian woman, was possessed by Chattan and Kutty Chattan (both mischievous spirits from local Hindu cosmology), Namboodiri (a 22 year-old Brahmin boy), a woman named Thressia and a Parayan (low Hindu caste) version of Anna herself.

In contrast to these spirits with names and personalities, sometimes representing real people in the afflicted people's lives, the spirits that were possessing people I interviewed in 1997 were quite homogenous and anonymous. Although 13 of the 100 patients interviewed (or the relative taking care of them) said they were possessed, details

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[8] The position and use of the word "only" is typical of the style of English spoken in Kerala and may be confusing to some readers. A rendering of this statement in American English would be, "It was because of luck and bad/inauspicious time that the thought of me turned into my evil spirit."

about these possessing spirits were not offered. When we would ask which spirits were possessing the ill person, we received answers such as "just some spirits." Of all the informants we spoke with, only two identified specific, named spirits.

An example of the anonymity of spirits comes from Sasi a 27 year-old Hindu man who was introduced in Chapter 6 as someone who found a way of coping with his problems through living at Beemapalli mosque. Sasi's mother told us that Sasi had been having headaches, that he attacked his family, and that he was possessed by "several spirits." When I asked about the identity of these spirit's, Sasi's mother explained simply that they are all Malayali. The possession seemed almost peripheral to Sasi's problems. His mother spent most of our interview talking about Sasi's behavior: his attacking people, running away from home, singing for no reason and refusing to talk. Although they first went to a sorcerer eight and a half years ago and now they were at a mosque which could, among other things, relieve possession, they had also spent many years pursuing relief at allopathic mental hospitals, places which don't claim to cure possession per se.

Biju and I spoke to the brother of a Hindu woman, Rekha, who was pursuing treatment for her "mental" difficulties and problems with excess anger at Chottanikkara temple. Rekha's brother mentioned almost in passing toward the end of our interview that Rekha is possessed, and he did not elaborate on the possession or the character of the spirits.

One possessed person whose family did describe specific, colorful spirits was one of the few informants we interviewed who came from the neighboring state of Tamil

Nadu. The fact that this exception to the homogeneity of spirits comes from Tamil Nadu reinforces the notion some healers have that it is specifically Kerala, with its unique social processes described in this chapter, that is experiencing a decline in spirit possession. The afflicted person, Lalitha, had come with her family from Tamil Nadu to find a solution to her problems at Chottanikkara temple. When asked to describe Lalitha's problems, her older brother explained that she gets very angry with family members and has hallucinations. He also said that she is possessed by five spirits: Kali, three young bachelors, and one old man (a list that is reminiscent of Jagathambika's patients from the 1960's). When possessed by the young bachelors, Lalitha/the men say "We come from a wealthy family, and we don't like girls." When possessed by Kali, Lalitha's brother explained, Lalitha speaks in Hindi. Then Lalitha herself told Biju and me that she sometimes hears voices of three men asking her questions, especially when she goes to the temple: one asks why she doesn't like her mother, another asks why she doesn't like her brother, and the third one asks why she doesn't like her father. If she says "But I do like mother" or her brother or father, the spirits will argue with her and say "no, you don't." We didn't hear nearly as much detail about spirits in all of our other interviews, and this information was offered without us asking for further information on possessing spirits.

The second most specific description, comes from Parvati, a 27 year old Hindu Malayali woman who has been living at Beempalli mosque, accompanied by her mother, for four years. Parvati's mother emphasized early in our interview that her daughter was possessed--as opposed to most other informants who mentioned it later and as an aside--

and described many of her "symptoms" in terms of possession. Parvati's mother said that Parvati uses bad words, tears her clothes, tries to run away and attacks her. The three possessing spirits are male, and when possessed Parvati will act like a man, pretending to smoke and to have a moustache. One of these three males is Gandharvan, a mythological person who sings to the gods, and when possessed Parvati will sometimes sing. Her mother also said that when they arrived at Beemapalli, she was possessed by 6 or 7 spirits, but Ummachi, the spirit of the woman who is buried at Beemapalli, has removed all but 3 spirits.

Parvati's mother also believes that Parvati had a needle in her body which travels around to different areas. Sometimes it is in her arm and sometimes in her foot or other locations. Kavitha and I had many follow-up interviews and conversations with Parvati's mother since we would often run into her at Beemapalli. Her mother seemed to become increasingly worried about the alleged needle in Parvati's body--it appeared to take priority over the possession. Upon my return to Kerala in 1999, I learned that Parvati and her mother had left Beemapalli and were pursuing treatment for the needle problem at an allopathic hospital.

The decreasing specificity of the characteristics of spirits fits neatly with Ramanujan's thesis of modernization as a movement from the context-dependent to the context-free. The more specific spirits, those described by Jagathambika's patients in the 1960's and the two patients I interviewed mentioned earlier, were context-specific in the sense that they have particular personalities that are also known through mythology or they have connections to the life of the possessed. One spirit, (Kamala's aunt) even

entered into the possessed (Kamala) during a certain event or context (Kamala's reaction to her aunt's death) in the life of the possessed. Possessing spirits, in losing their unique personalities and their connections to the lives of the afflicted, are losing context. They are becoming generalized, anonymous--i.e., context-free.

A trend that parallels the homogenization of spirit possession can be seen in ayurvedic psychiatrist Dr. Sundaran's description of the classic method of diagnosing mental disorders and the diagnostic methods used today at the Government Ayurveda Mental Hospital. Dr. Sundaran explained that mental illnesses in ayurveda are classified either as relating to the *dosas* (vata, pitta, and kapha) or as *grahas*. *Grahas* refer to very specific psychopathological behaviors that are not considered to be due to problems with *dosas*. For example, *serpa graha* diagnosis would be given to someone who acts like a snake, someone who hisses and pretends to slither like a snake. Or, someone who thinks and acts as if he is a deity can be diagnosed as *deva* graha. There are many other pre-existing *graha* diagnoses, but *graha* categories can also be invented to fit the behavior of a patient. One could say that the *graha* categories are reminiscent of possession, that they name similar behaviors, though the existential condition is interpreted differently. The patient who is considered *serpa graha* acts as one who is possessed by a snake deity. Today, at GAMH, however, patients' problems are diagnosed according to which *dosa* is affected (*vadotmada, pittotmada,* or *kaphotmada* and the newly introduced category *vishadam*) and *graha* diagnoses are no longer given. This could be considered another manifestation of the decline of possession--or, more accurately, the behavior that is seen by some as possession and by some as *graha*. As the *graha* behaviors are specific and

context-dependant while *dosic* diagnoses are more general, this could also be considered another manifestation of a move toward the context-free.

This tendency to generalize was brought up when I asked psychology professor George Mathew, whose study of psychopathology among "tribals" was mentioned earlier, about the decline of spirit possession. George Mathew explained that this was due to "modernization." I asked George Mathew to define "modernization" expecting to surprise him, expecting that he would realize that it is an ambiguous and loosely constructed concept. George Mathew, however, did not skip a beat as he launched into what was a complex and precise definition of what modernization meant to him, emphasizing the ascendance of a scientific worldview which he described as a belief in objectivity, that there are measurable, provable things in the world external to the observer which multiple observers can see by using rational methods of comparison that isolate variables. And he went on to give further details. This told me that "modernization" was not an ambiguous term for George Mathew, but one that had meaning for him which he had reflected on. Of course, George Mathew is a "modern," secular, educated person who teaches in a university. Yet he is also someone who has been very critical of many of the effects of modernity. He has turned his intellectual attention to indigenous traditions of philosophy and psychology in India while maintaining faith in "modern" scientific method. For these reasons one would expect him to have a well thought-out definition of "modernization." I also realized, however, that much of what George Mathew describes as modern is also reflected in and promoted by popular and media discourse in Kerala society.

For example, many (not all) Malayalis talk about how they are more "sophisticated" or "advanced"--or they invoke other notions of evolutionist ideology--than people from other parts of India. When I have asked what is meant by such statements, they often point to practical issues such as the high level of literacy in Kerala or they invoke ideals such as "rationalism." The officially atheist, secular and modern Communist parties (Communist Party of India and Communist Party of India (Marxist)) which have governed Kerala for most of its existence as a state claim to, and in many ways do, promote rationalism, objectivity and other generalizing ideals. One of the founders of the first Communist party, and figurehead of the nation of Kerala, E.M.S. Namboodiripad, celebrated "the movement of intellectuals for the development of a modern progressive culture" (quoted in Narayanan et al. 1976) and rationalist, evolutionist ideals. As an example, appropriately from the area of mental health, the text of "Mental Health Policy for Kerala State" asserts that "*modern scientific* knowledge can help us to prevent and treat disabling mental illnesses" (my emphasis) (Mani 1997:1).

This ideological, theoretical level (discussing ideals such as rationalism) is one area where one can perceive trends of social change, but the issues of change and possession are most easily viewed through examining certain, more specific practices of modernity like psychology and psychiatry. A return to Dr. Jagathambika's dissertation thesis serves as a useful introduction to this topic. Dr. Jagathambika believed that her patients who claimed to be possessed were in reality suffering from multiple personality

syndrome.[9] More importantly, Dr. Jagathambika saw possession as *false belief* asserting that the alleged spirits were in fact aspects of the patients' personality that develop due to repressing fears, worry, guilt and other emotions and not fulfilling desires. She explained, "When the problems are expressed and when the patient is helped to find better ways of adjusting and when his attitude to the evil spirits is changed, the symptom vanishes and the primary personality becomes integrated and stable" (267). Healing is effected by dispelling the belief in the spirits and resolving conflicts. Such views about the nature of possession exist, of course, in the minds of psychologists and psychiatrists, but these views are also disseminated to the public through the media. It is significant I think that the wife of Hanifa, the man who was seeking relief for his "tension" at Beemapalli in Chapter 4, mentioned Hanifa's "educated" sister recommended they see a "doctor" when Hanifa and his wife were wondering whether they should do some *poojas* or counter-sorcery in case Hanifa was affected by spirits.

One vehicle for the dissemination of allopathic psychological and psychiatric knowledge is the proliferation of psychological advice columns in popular magazines. This example should be preceded by a reminder that Kerala's literacy rate is extremely high, around 90%, compared to an average of 52% for India as a whole. If dissemination of psychological idioms through the media affects the modes of expressing suffering in Kerala, the literacy rate might make sense of the impression some healers related to me that Kerala more than other states is experiencing a decline in spirit possession. Sudhir

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[9] Dr. Jagathambika did not believe possession was exactly the same as multiple personality--possessed people's problems had a "shorter duration and frequent attacks" (1968: 264) when compared to multiple personality.

Kakar (1982) and Ashis Nandy (1995) reveal that psychology in India is generally consumed by a small urban elite, but in Kerala there is reason to believe that the awareness of psychology and its embodiment (and en*mind*ment?) in the actual expressions of people in distress is more prevalent.

A number of clinical psychologists[10] are writing columns in popular magazines that give advice or provide informational examples of cases from clinical practice. Dr. James Joseph writes a psychology advice column in Mangalam, one of the most popular magazines in Kerala.

The following example from a column that appeared on October 9, 1996 gives an example of the type of questions Dr. James Joseph receives and the kind of advice he gives:

> Dear Doctor:
>
> I am a 20 year-old student from a middle class family. I decided to write you because I have a pain in my heart. I'll tell you the reason for this. I am in love with a young man. He is a friend of my neighbor. I called him up and told him that I love him, but he acts as if he doesn't love me. We are of different religions, but I still love him. Every day he comes to see his friend. When I hear the sound of his bike approaching, wherever I am I'll come running. I know he doesn't love me, but I can't forget him. In every book of mine you can see his name. Without even thinking, I write it. I call him, but when he picks up the receiver I will hang up. Because of this behavior of mine, I am in a crisis/very worried [*vishamam*]. Is this a mental illness? Please give a reply and help me. (James Joseph 1996: 28)
>
> (Translated from Malayalam.)

Dr. James Joseph responded with some "tough love" and advice that would not be uncommon in an American advice column or radio call-in show:

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[10] Some may be psychiatrists. They are usually identified as "Dr. (their name)," and their speciality is not always indicated.

> Attraction between a man and a woman is normal. You have to view this attraction as a natural behavior. Attraction between men and women and the pleasure in sexual relationships is actually important to the existence of mankind.
>
> For everything there should be a reason. To fall in love is a fate. The reasons for attraction between men and women may be due to a lot of things such as occasions of meeting each other, resemblance to your parents, or good personality. But these reasons may not lead to marriage. When you decide to marry, there are certain other factors to consider: attraction to one another and similar interests are things to be considered.
>
> Now let's consider your problem. You feel love for the guy who comes to your neighbor's house. That is good and as it should be. But what happens after that is the problem. He is not interested in you, sister. He did not respond when you told him you loved him. You should have stopped loving him from that moment. But you lost sleep, concentration on studies, and mental health now, sister. You can't control yourself. When you take a book to study, you will see his face only. Unconsciously, you write his name in books. When you hear the sound of his bike you will be attracted to that as if you were under some spell.
>
> You call him often and you will hang up when he picks up. These are all symptoms of an illness. The name of this illness is "love." But the problem here is it is only one-way. It can cause only mental troubles.
>
> So, sister, you consider all things as a joke/something not so serious [*tamasha*]. Consider it a teenage attraction. There is no benefit in considering it more than that. You don't know who he is or how he is, so don't dream about him. Consider everything as a little joke/fancy. If you consider it more than that you will invite more problems. (28)

It is easy to see contemporary, western psychological style, tone and tropes in this exchange. Dr. James Joseph medicalizes love, worries about this woman's obsessiveness, and warns of "mental troubles" if things don't change. The woman with the problem even asks whether her troubles indicate a "mental illness," putting authority in the psychologist and privileging this way of understanding psychological and emotional problems.

Dr. George also writes a psychology column in Mangalam in which he presents selected cases from his practice. A few examples from these columns allow us to see another psychologist's view and a case of syncretism between idioms of possession and

psychological interpretation. On February 26, 1997, Dr. George presented the story of Suhara, a woman obsessed about, and apparently possessed by, uncleanliness. The column opens by relating an incident: Suhara's neighbors heard someone crying for a long time at the local pond where people do their washing. When they went to the pond to investigate they saw Suhara intensively washing her son. Later they saw Suhara's husband taking their son to the hospital. Then Dr. George explained:

> Suhara is a peculiar type of person. She likes and hates water. No one in her house has clothes without a tear in it. Suhara will wash clothes for hours. She will bathe until the water in the tank runs out. A while after she spreads clothes on the ground for drying, she will have a feeling that a dog has walked on them. So she will wash them again. When she draws water from the well, she will pour it out and draw again. (George 1997: 27).

When Suhara's husband brought Suhara to Dr. George, he decided to hypnotize her to learn the cause her excessive cleanliness. Under hypnosis, Dr. George told Suhara that she is near the bathing pond and when he claps his hands she should begin washing. When he claps his hands a second time, he told her, she should stop bathing. When he clapped his hands she began to act like she was bathing and swimming. Upon clapping his hands a second time, Suhara stopped, and Dr. George asked, "What is your name, you who is causing all this?" Suhara (or Suhara's possessing spirit?) responded "I am called 'Uncleanliness.'" *Mlechchhatha*, the Malayalam word which is translated as "uncleanliness" here also means "barbarism" and "abomination." (Among people who are possessed, the spirit often identifies itself by saying "I am..." and then its name.) Dr. George asked Suhara (or the "uncleanliness" possessing her) to explain more. "What is this uncleanness/abomination?" he enquired, and the *mlechchhatha* (uncleanliness/abomination) possessing Suhara declared, "I will tell you, but her

[referring to Suhara] husband can't hear. Send him out."[11] Dr. George asked Suhara's husband to leave, and the *mlechchhatha* possessing Suhara told Dr. George about some things that happened when Suhara was seven years old. Dr. George then explains that Suhara was molested when she was a child. To resolve Suhara's problem, Dr. George recalls, "So I used some psychological techniques to wipe out the unwanted things in her unconsciousness mind." Then Dr. George advised Suhara's husband on how to take care of her, and he sent his patient home. At the end of the column, Dr. George reports that Suhara is now fine and living happily with her family (George 1997a).

One can see in this example how the idiom and style of possession still pervade this problem as it is presented to a psychologist. The form of conversation shows the healer speaking to the patient, or the possessor (depending on one's point of view), and the possessor, or the patient playing the role of possessor, responding and referring to the patient in the third person. Dr. George, however, does not actually say that Suhara is possessed, and there is no spirit in the traditional sense afflicting Suhara. That is, there is no spirit with a name or personality. Rather, the possessor is an abstract concept. In the end, Dr. George treats the problem using psychological techniques and working on Suhara's "unconscious mind." Interestingly Dr. Jagathambika would probably have disagreed with Dr. George's method of simply ridding the patient's mind of unwanted things. This is akin to the exorcist's method of simply driving away the spirit which Dr.

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[11] I am saying that the *mlechchhatha* possessing Suhara is speaking since the speaker here is referring to Suhara as "her." The Malayalam word "ival" is used in the possessive in the speaker's statement. "Ival" is the proximate form of "she" meaning "this here (female) one" or the "woman right here."

Jagathambika criticized since it does not allow the patient to gain insight into his/her problem and realize that the patient's self was in control of the possessing spirit/entity. Because of the lack of insight, Dr. Jagathambika believes that problems often return for people who have been treated by exorcists (*mantravadans* or black magicians) (Jagathambika 1968: 249). Clearly, clinical psychology is not uniform in its application.

Another case of Dr. George's, while described in secular, psychological/psychiatric terms, also has characteristics of a case of possession. In his column of April 16, 1997, he discussed a patient he called Korakkunya who had begun acting like a dog. Korakkunya would bark before he spoke and when he saw dogs. He also believed he had rabies. Korakkunya had a dog which he had beaten to death thinking it had rabies, though he later found out it didn't. Dr. George hypnotized Korakkunya who began acting like a dog and spoke in the voice of his dog, as if he was possessed. The dog/possessor spoke of how "he" (referring to Korakkunya) had killed him. Similar to the "uncleanliness" possessing Suhara, the possessing dog spoke about Korakkunya in the third person. The dog said that Korakkunya must put candles in the place where the dog died and get another dog. This demand stated by the possessor is exactly how many problems are resolved for possessed people at Chottanikkara temple. At that temple, the more intractable spirits will eventually make some demand, usually asking for a nail of a certain length to be pounded into a certain tree at the temple. Upon this demand being met, they will leave the body of the person they are possessing. Korakkunya barked several times and the dog was gone. Then Korakkunya woke up from hypnosis and has not barked since (1997b).

Once again, the style of possession is present, though Dr. George does not explicitly describe the problem as such, and he uses psychological techniques for therapy.

Dr. James Joseph and Dr. George's columns are popular, but they constitute only a small fraction of the dissemination of psychological and psychiatric knowledge in Kerala. A magazine called Manashastram, (the title is the Sanskrit-derived Malayalam word for "psychology," and it literally translates as "science of the mind") is devoted entirely to psychology, mental health and the world of the mind. It is available at many news-stands throughout Kerala though it is not as popular as Mangalam (according to my informants and my informal survey of news stands). This magazine contains many articles on mental health and hygiene, book and television reviews, opinions, and fiction pieces and poetry on psychological topics written by Malayali authors with training in western psychology and allopathic psychiatry. To give examples of the kinds of topics that are featured in an issue, the October 1997 edition of Manashastram opens with selections of poetry from various contributors and essays recalling important experiences in people's lives. The magazine then moves on to the feature of this issue, an article eulogizing Princess Diana and Mother Teresa (written by a senior psychiatrist from Trivandrum Medical College Hospital where I interviewed several patients), followed by a feature explaining how readers can test their "hypnotic suggestibility" (as is often the case in this magazine, these terms were in English written in Malayalam letters), then articles on daydreaming, laughter therapy, the Guru Bhagwan Sri Rajneesh, the relation between diet and medications, headache and other topics. This issue also contained an advice column, a book review, a fictional piece, and other items.

There are also a number of shows on television channels such as Asianet, a popular Malayalam cable channel (cable TV is very common and inexpensive now in Kerala), that feature psychologists and psychiatrists speaking about mental health. My friend, clinical psychologist Dr. K. Gireesh, once even discussed my research on Asianet on a show that tried to explain Kerala's high suicide rate.

In addition, films in contemporary Kerala often tackle allopathic psychological and psychiatric themes. A number of contemporary (i.e., in the last 20 years or so) Malayali films feature mental hospital settings and mental patients and psychiatrists as main characters. This chapter began with a discussion of the 1994 hit Manichitratazhu wherein a psychiatrist and an exorcist team up to heal a woman whose troubles are characterized as psychological problems or spirit possession, depending on the point of view of the different characters in the films.

Another film on psychiatric topics, Talavattam (1987), also featured Mohan Lal, the star of Manichitratazhu, this time as a patient in an allopathic mental hospital. In this film, a psychiatrist falls in love with Mohan Lal's character. But, her father, who is the director of the hospital, is opposed to their relationship, and gives the young man (Mohan Lal) a lobotomy even though he had recovered his sanity by this point. Another psychiatrist, who was a childhood friend of Mohan Lal's character kills him because after a lobotomy he was no longer his true self. According to my assistant Biju, after this movie came out people used the term "talavattam" (the title of the film) to refer to insanity or people they considered crazy. In 1997 in Ulladakkam, Mohan Lal again played a psychiatrist. In this movie, one of his patients becomes excessively attached to

him--a case of "transference" he explained using the English word. Through hypnosis, the psychiatrist learns that his patient's troubles stem from the fact that her fiancé was murdered in her presence. The patient later attempts suicide, and eventually, during a traumatic flashback to her husband's murder, ends up killing the psychiatrist's fiancé at his wedding. It is hard to say whether these films promote psychological concepts or merely reflect popular consciousness about a trend toward psychological/psychiatric idioms. In any case, they do show that psychiatric themes are significant--sometimes even romanticized--in this popular medium.

So far, this discussion has emphasized the dissemination of psychology and psychiatry, but let me now turn to the reception of these messages. We saw that media information about psychology and psychiatry reaches the public with some of the informants that were introduced in Chapter 4. Rajendran, the middle-aged bank employee who was skipping work, went to see a healer his wife had read about in one of these magazines. Also, Hanifa, the ex-Gulf migrant who was seeking relief for his sleeplessness at Beemapalli mosque, had previously sought help from a psychologist who writes a column in a popular magazine. It is also possible that the dissemination of psychological and psychiatric discourse through the media relates to the emergence of English language psychological idioms to describe distress, which will be discussed in the next section.

But it is not only allopathic psychology and psychiatry that are discussed in the press. There are some non-allopathic healers who express their views in the Malayalam media. In fact, the mother of Sreedevi, who was also presented in Chapter 4, had decided

to pursue ayurvedic psychiatric treatment after reading about it in a newspaper. A magazine which went into print around the beginning of 1997, Arogya Masika, discusses health issues from a variety therapeutic perspectives including ayurveda, allopathy, homeopathy, naturopathy and many other systems. The August 1997 issue, for example, focussed on monsoon season illness, and had articles on remedies used in ayurveda, homeopathy and naturopathy. However, I did not come across any issues related to psychopathology and related problems. Although non-allopathic voices are significant in popular representations of illness, my examination of the mass media in Kerala indicates that allopathic views are more prevalent.

An additional factor that promotes the spread of allopathic knowledge and expressions of illness is that the government of Kerala heavily favors allopathic institutions in its health services funding priorities with the result that there are more allopathic than non-allopathic medical facilities and services available in the state--though it is hard to compare the number of allopathic services to the number of religious healing facilities as the latter are difficult to count. Appendix B indicates that the government of Kerala supports more facilities and many times more beds and doctors for allopathic medicine than they do for any other medicine. The private health care sector offers more ayurvedic than allopathic facilities, but it supports more allopathic beds and doctors (according to government records - see Appendix B). The same tendency is true when one looks specifically at mental health services. The government operates three allopathic mental hospitals (and several psychiatric wards in general allopathic hospitals) and one ayurvedic mental hospital.

During fieldwork in Kerala in 1997, I met allopathic psychiatrist Dr. V. S. Mani of the Kerala State Mental Health Authority. He had recently prepared a document called "Mental Health Policy for Kerala State," a plan for more expansive and effective psychiatric services throughout Kerala state and a program of community-level intervention to identify and treat mental problems. This plan would greatly increase the presence of allopathic psychiatric knowledge and practices. For example, general health workers, nurses, and others would be given some basic training in the allopathic system of identifying mental disorders, and lay people would be made more aware of allopathic views about mental illness in an effort to destigmatize mental illness in the community. In its 1997 form, this document had a brief reference to "Different systems of mental health care...folk healing, ayurveda, unani, homeopathy, allopathy naturopathy etc.," and explained that little was known about the effectiveness of these systems of healing (Mani 1997:4). Dr. Mani asked me to comment on the effectiveness of some of these systems, and I explained that many patients and their families have reported improvement after using ayurvedic and religious healing and that some have reported improvement *only* after changing to these therapies. After I left Kerala in January 1998, some of my friends and informants who are healers lobbied the Mental Health Authority for more inclusion of therapies other than allopathic psychiatry in the proposed mental health policy (supporting their case, in part, by citing my research). When I returned to Kerala in 1999, the "Mental Health Policy for Kerala State" was revised to include more information about other forms of healing with an intention to provide funding for research in those areas of healing, though the plan is still principally oriented toward providing further

allopathic psychiatric services and interventions.[12] While this mental health plan had the approval of many within Kerala's government, it still had not been enacted. I was told by sources in the mental health field that this was for a number of political reasons including the fact that people who operate private healing facilities (including allopathic and non-allopathic centers) were afraid of losing clients to the proposed government program.

There are, meanwhile, numerous temples, mosques and churches one can go to for the same problems. Every neighborhood has a place of worship that could potentially be used to help heal spirit possession or mental health problems. No study I am aware of has attempted to quantify the number of religious facilities that could be used to treat possession and psychopathology, and it would be methodologically near-impossible to do such a study. The largest and most well-known religious healing facilities are the three religious healing sites in this dissertation plus a fourth place called Potta (discussed in Chapter 3). Some of these rival Kerala's state allopathic mental hospitals in size and the number of patients treated, but also there are unknown numbers of individuals who will go to local temples, not known specifically as healing centers, to seek relief from a problem (such as Sreedevi and her mother who visited a number of local temples around Trivandrum). Overall, it is hard to determine whether Kerala has a greater number of religious or allopathic facilities and healers, but we can say that allopathic psychiatry does at least have the government of Kerala and its ability to fund projects and spread

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[12] In 1999, I also informed Dr. Mani, who was still in charge of drafting Kerala's mental health policy, of the findings presented in Appendix C which show (depending on how one interprets them) that either all three therapies were equally effective or that religious therapies were more effective after 6 to 9 month follow-up interviews with patients.

information to the public on it's side.

"Tension" and Other Contemporary Idioms of Distress

Having examined the waning and the homogenization of possession and the dissemination of western psychological and allopathic psychiatric knowledge and practice, let me now turn to the psychological expressions of distress that appear to be becoming more popular in Kerala. Most people I interviewed who were seeking treatment, or their accompanying family members, described their problems in terms of behaviors and mental and somatic symptoms among the most common of which are sleeplessness, headache, outbursts of anger, refusing to eat and memory loss. These same characteristics are listed by informants for problems that are explained as spirit possession as well as for illnesses defined in ayurvedic and allopathic psychiatric and psychological terms. In addition, a number of informants identified problems using English language terms such as "tension" and "depression" that indicate states of emotion or distress as seen by allopathic psychiatry and western psychology. The use of English terminology in describing psychopathology in India was also observed by Langford (1998:94).

Hanifa, the Gulf returnee who was introduced in Chapter 4, was trying to cope with his "tension" at Beemapalli mosque. Hanifa's problems had manifestations such as sleeplessness, running away from home, becoming easily distressed (*vepralam* - confused, worried), but in Hanifa and his wife's narratives, "tension" is the key term around which discussions of his problem turn. In one of his first attempts to articulate his

problems in our interview, Hanifa declared that "Something like a 'tension' has come." His wife explained, "This 'tension' began when he was working in the Gulf. So he resigned from the job and came back." She also recalled that allopathic medicine caused him "memory problems and a lot of 'tension'." Similarly, Mary, the woman introduced in Chapter 4 who wanted to become a nun, also characterized her problem as involving "tension." In her first attempt to describe her problems, Mary recalled "I got some mental 'tension'" ("*Enike manassinu* tension *vannu*"--more literally, "mental 'tension' came").

There was even one case where an informant used an English psychological/psychiatric term to describe possession. Rajan, whose description of the daily routine at Chottanikkara temple was presented in the previous chapter, used the term "depression" a few times in explaining possession experiences. For example, he explained that when a spirit enters the body or becomes active, one experiences fear and "[t]hen what 'depression' we feel." When asked how to tell when one's spirit possession illness has gone, Rajan said "Things like 'depression,' we are not getting anything like that." Rajan also described to us problems his mother had. She suffered "hysteria," he recalled, and she was "depressed."

In Chapter 4, Sreedevi's mother mentions that she scolded her daughter for being lazy, and said "I don't know whether that made her 'feel.'" I had heard other informants use the English word "feeling." I asked my research assistants what this meant when used within Malayalam discourse, and they said it means something like "depression."

Although it is not used by any informants for whom I have verbatim transcripts, I have also heard the English term "stress" come up in informal conversation in

Malayalam. Handling "stress" has been the topic of psychological and psychiatric columns in magazines, and there are numerous conferences and workshops on stress management in Kerala.

Some of this terminology was discussed in Chapter 5 to illustrate that, contrary to social scientists' expectations that westerners live in a world of mind/body dualism while others live more in the body, these English language terms are metaphors of embodiment, tactile, visceral images of physical "tension." These terms also invoke feelings of time pressure.

Another aspect of modernity and a trend that relates to the popularity of allopathy in Kerala is a change related to time. This isn't necessarily a change in the genre or fundamental epistemology of time, but rather a development of a perception of a lack of linear time (alternately seen as a speeding up of time). As Greenhouse (1996) rightly claims, anthropologists have too often thought in terms of a linear-cyclical time opposition, and she suggests that an analysis of time should involve more dimensions, more diversity. Gough (1968) has explained how Kerala has for a long time had a notion of linear time that coexisted with conceptions of circular time. I argued earlier that in healers' and patients' understandings of illness, a linear sense of time is assumed. However, a different style of linear time (from what anthropologists have seen as the linear time of "western" cultures) is evoked. Implicit in the concern for a pleasant process of therapy is an awareness of the unfolding, or the moment of passing, of time, while at the same time the therapy is working toward a goal of relief or transformation. But the issue of time arises here in a different sense. That is, people feel that they are lacking

time. They sense that life in Kerala has sped up (though I'm not implying that this sensation is new or unique to Kerala), and when they are ill they often use allopathic therapy since the treatment doesn't take long.

Most of the information I have about time pressure in Kerala is anecdotal: healers have told me that more people recently have been complaining about "stress," and they say this is due to greater time pressure. Also, many friends in Kerala have told me they feel they don't have enough time, that they have "too many balls in the air" as they try to juggle the demands of work, school, family and social life. Malayalis spend a lot of time in school, many pursue advanced degrees or special certificate programs, and many are scrambling for a better job. Computer training certificate programs are extremely popular. I often thought of the pressure and expectations put on young people every time I saw an advertisement in the neighborhood where I stayed in Trivandrum that enticed students to join a computer training program with "Want to emulate Bill Gates?" But jobs commensurate with education are hard to find (Kannan 1997), and many Malayalis migrate to the Persian Gulf countries for better opportunities.

As one illustration of job and time demands, in 1999 I learned that my friend Gireesh and his wife had found coveted government sector jobs, which they had hoped for for some time. However, they, like many Malayalis who find their dream job, had to pay a price in time. Gireesh's job was in a city that was 1 ½ hours from his home in Trivandrum (when the trains are running on time) where he lives with his two young sons. Gireesh's wife, however, was now working 9 hours from home in northern Kerala, and she was able to visit only once every two weeks or so. When I saw Gireesh in the

summer of 1999, he was waking up around 3:30am, in time to get his children ready for school and make it to his job on time. Then he would return home around 7pm, receive social and professional calls, help his sons with homework and, with luck, get to bed with enough time to get 4 or 5 hours of sleep. Needless to say, he was always burnt out and yearning for more time. Upon learning of Gireesh and his wife's new work situation, I became aware of other similar situations. Friends in Kerala told me that many people now commute 4 ½ hours each way from Trivandrum to Ernakulam to work at a job that is commensurate with their skills or expectations. I was even told that there is a small marketing niche forming around this new commuting pattern: food sellers jump onto the women's cars at the Ernakulam stations to sell vegetables and other foods to women commuters (who are still responsible for making dinner after their long trip home from work).

Not everyone is under as much time pressure as Gireesh, and this is a problem that may vary by social class and profession. But few can afford to take the time to complete the 45 day treatment at the Government Ayurveda Mental Hospital or spend the weeks that are sometimes required to perform prayers and rituals at Chottanikkara temple. Remember the remarks of Ajit in the introduction to this study when he was explaining why so many people use allopathy in Kerala: "If I have a fever, I must get better [literally: must get changed - *maranam*]. For what? To go for work the next day. Get a cold, get changed [*maranam*] in order to go to school the next day. This is the level at which we maintain our health." As we saw at the end of last chapter, even the daughter of a family of ayurvedic healers used allopathic treatment because she felt it would

provide quick relief.

I can't claim to be able to trace all the socio-economic factors that might have led up to this level of time pressure, but it would be an important topic for further study, perhaps something like E.P. Thompson's "Time, Work-Discipline, and Industrial Capitalism" (1967) or Cecil Helman's "Heart Disease and the Cultural Construction of Time" (and other essays in Frankenberg, ed. 1992), on how historical changes in work patterns change people's relations to time. It would be useful to analyze this in terms of the lack, or speeding up, of time, which has been rarely discussed in anthropological literature.

Implications of This Chapter

Every chapter in this study, and indeed any topic of social research, is "complex," but this chapter especially merits the cliched disclaimer and suggestion that more research needs to be done to understand these issues. In fact, the topics covered in this chapter could be the focus of an entire, separate dissertation. Still, important insights and trends were revealed. First of all, this section provides some important social change context regarding other issues brought up in this study. For instance, it is interesting to learn about the mind-body-self relations in Kerala phenomenology, but what changes might this be undergoing as people adopt psychological idioms of expression and characteristics of possession become watered down? Or, alternately, to what degree might the local phenomenology reform contemporary psychological idioms? After having celebrated the "pleasant process" of therapy in ayurveda and religious healing, it

is important to realize that many people will still choose allopathy, the therapy of quick relief, not having the time for such a pleasant or transformative experience.

The most consistent story that was told in this chapter was that of the weakening--the homogenization and declining incidence--of spirit possession. This fits in well with Ramanujan's (1989) characterization of "modernization" in India as a struggle between the context-dependant and the context-free though Ramanujan's model obviously does not tell the whole story about modernity. In engaging the topics of the waning of possession and modernity, the drawbacks of a simple dualism between modern, western practices pushing in one direction and indigenous Indian/Malayali forces pulling the other way were encountered. An indigenous discourse, ayurveda, also contributes to the waning of spirit possession, and Islam, an ideology that cannot easily be classified as native or modern/western, has been used in the same effort. Even the foreign discipline of clinical psychology is not purely western or uniform in it's application as we saw in the subtle differences in its application by Dr. Jagathambika and Dr. George.

In the future, it will be interesting to see what transformation of "modern" practices and daily life occur in Kerala, but this is not an aberrant or new kind of engagement between practices and ideas. Kerala's history is one of absorbing and adapting to different religions, people, practices, and languages, and thus "modernizing" is, in a sense, very traditional. Perhaps this constant absorption of new ideas and practices allow people in Kerala to work within multiple contexts and apparently mutually exclusive ideologies. For example, informants rarely reported struggles over different--what some would see as conflicting--ideologies inherent in radically different systems of

healing. Let me now consider this relation to (what many social scientists might see as) contradiction while continuing to evaluate trends of social, cultural and medical change in Kerala.

Chapter 8 - Conclusion: Contradiction and the Virtues of Context-Dependancy

This study of mental and spiritual illness and healing in Kerala has examined some of the forces, disciplines, philosophies and phenomenologies involved in shaping the ways in which one expresses distress, seeks therapies for such problems and "changes" them.

First, one articulates one's suffering verbally, behaviorally and through the body in terms of intelligible (even if they are considered "crazy") idioms. The local phenomenology of Kerala, just as in any other place, orders and defines options and possibilities for how one understands and attends to distress. One may use words such as *vishamam* (worrry, troubles), *vepralam* (confusion, distress), "tension" or "depression" to describe problems--alternately or additionally, a person might be considered possessed.

Once someone is ill or afflicted, several healing options are available. The ill person and their relatives and friends must decide whether allopathy, ayurveda, the famous mosque across town, the *mantravadan* or some other source of therapy should be utilized. After pursing therapy for a while, one might feel that it is not producing results or is painful to undergo, and consider changing systems of healing. A relative might have read about a certain kind of therapy which the family wants to try, or a decision on changing therapy might be financial. (Can one afford private therapy or should one go to a public hospital? How far can a patient and his family afford to travel?) Hopefully, one finds relief, a cure or a positive transformation through healing. Unfortunately, some

struggle for many years with a problem without much change. A person with such a chronic problem could join others who live with similar problems in the auspicious and aesthetically-engaging environment of Vettucaud church, Beemapalli mosque or some other place of worship and therapy.

Having reviewed the ideal-typical person suffering distress and the influences and practices that shape illness and healing, let me consider what else can be learned from these issues. With the last chapter the topics began to move in a historical trajectory, and this "conclusion" will continue that flow; like the process-oriented approach to healing, this chapter will watch a process of change unfold, rather than offering a final definition or a "cure" for these issues.

Although there are other ways of interpreting the social changes described in this study, I will continue to focus on the issue of homogenization and the erosion of context dependency. Chapter 7 showed that the increasingly anonymous and homogenous identities of possessing spirits and the discontinuation of specific *graha* diagnoses in ayurveda could be interpreted as a waning of context-dependancy. Likewise, the tendency to treat disease entities in allopathy, when compared to the (possibly disappearing) ayurvedic practice of treating individual patients' specific constellations of symptoms, discussed at the end of Chapter 6, can be seen as a universalizing, homogenizing trend.

With this in mind, let me turn to an issue many of my readers in Kerala will have been awaiting from this study. That is: who won? Many healers and other, lay people I knew in Kerala tended to see my research as a competition between the three forms of

therapy I was studying. Despite my insistence that that was not necessarily what my research would reveal and that there were other issues I was examining, many assumed I would prove that one therapy was more effective than the others. I should admit that I too was curious about who might win.

In trying to consider how, and whether, I should investigate this issue of effectiveness, I also began to ask, for whom was this "who won" question most interesting? I realized it was more often allopathic psychiatrists and physicians who watched my research with this interest in mind, and there were a random assortment of others, all of whom were well-educated with modern, secular credentials. Allopathic healers would often "look over my shoulder" to learn how the other forms of healing were doing and would scrutinize my methods if I reported that some people benefitted from a non-allopathic form of therapy. Of course, allopathic physicians may have been concerned because they are the dominant medicine in terms of funding and endorsement by the state, and they may have been doing their hegemonic work of surveying the field for threats and incursions. Yet I also wondered whether they (perhaps from some epistemological stance that comes from allopathic training) simply felt that *some* medicine should win, that there should be one *universal* way of treating mental health problems. Such a universalist way of looking at effectiveness was also revealed by the fact that if I mentioned that *some* people found relief at, say, Beemapalli, allopathic healers would suggest problems in my methods or interpretations. In other words, the idea that even a few people could get relief from another therapy was unsettling.

Ayurvedic healers, to give an example from another form of healing, did not seem

concerned about which would turn out to be the most effective form of therapy. In fact, they did not give me any indication that they thought my study was a competition between forms of healing, and rarely did they question that another form of healing might be sometimes effective. They sometimes indicated that they felt ayurvedic treatment brought more long-term relief, and some questioned the abilities of *mantravadans*. Although they could have benefitted if I had conducted a study that found ayurveda to be the most effective form of healing, they did not appear to be concerned that one form of healing should "win."

While "who won" was not the focus of my research, I did conduct follow-up interviews with patients about the status of their illness after at least six months, and, as demonstrated in Appendix C, I made an assessment of the degree to which patients' conditions improved or declined after using these therapies over this period of time. The people who used religious therapies seemed to see the greatest improvement. Patients of ayurveda had the next highest score, and those who were using allopathy came in third. However, given my relatively small sample size (n=25), these differences may not be that significant, and it may be more accurate to say the three therapies were equally effective. Most importantly, all therapies appear to be effective for many people.

We could also look at this issue less quantitatively. I met people who had completely different experiences with the same therapy. For example, after trying allopathy unsuccessfully, Hanifa found relief through worship at Beemapalli. Meanwhile, a woman we interviewed at the Medical College psychiatric outpatient center did not get relief at Beemapalli but was finally doing well after allopathic treatment. Even if further

research shows one therapy to be more effective than others, clearly no one therapy is effective for everyone. Put another way, there is no universal--i.e., context-free--solution for all problems. Perhaps this is what people with problems in India instinctively know when they find it so easy to switch from one therapy to another and see different methods of therapy as non-contradictory, as we saw with Abdul-Rahman and other informants and as Carstairs and Kapur (1976:66), Nichter (1981: 5) and Weiss et al. (1986: 380) have also observed.

I am not trying to predict how the context-dependant/context-free tension might or should resolve itself (or whether it will resolve), but the question of efficacy and other issues teach "us" (the analyst, the social scientist and healers in Kerala) some of the virtues of context-dependancy and specificity. I have just suggested that a context-dependant approach allows us to consider the benefits of a pluralistic therapy system rather than focus on which therapy is best. One can also see the virtues of context-dependancy and the vissicitudes of a universalist approach in the discussion, in Chapter 6, on the limitations of the concept of "cure" for understanding what one accomplishes through healing. I suggest that "cure" is a universalizing concept. It alleges to be what one aims to do for all illnesses in all patients. Too strong a focus on "cure" screens out from one's view the varieties of "change," such as when one goes beyond "cure" and reaches a state somehow higher or better than one's pre-illness state of "health," and the resolution to live with an intractable problem in a pleasant environment. That is, what happens after healing is context-dependent.

Additionally, I would suggest that there is tendency for anthropologists and other

social scientists to think in universalist ways that causes us to be unsettled by contradiction (or perhaps *apparent* contradiction). A good example is Pfleiderer's dismay at the "contradiction and inappropriateness" of a "modern," educated allopathic doctor who decided that his son's intractable illness was due to sorcery and took him for faith healing at the shrine of a Muslim saint (1988:420). There is what I see as an absolutist, universalist tendency in social science that is manifested in dualistic, mutually exclusive forms of analysis--a tendency to believe that things fall into one of two categories. This is universalist because it tends to assume things must be complete, wholly in one category or another. If something exists in two apparent opposite categories--or more, unanticipated categories--the homogeneity, the universality is disturbed.

Unschuld makes a similar point about "modern western science" in an examination of the history of Chinese medicine. At several points, Unschuld suggests that the variety of ideas and practices regarding health and illness that Chinese medicine allows to coexist would be seen as contradictory and disturbing to western science which is accustomed to Kuhnian-style revolutions wherein old paradigms are thrown out and replaced by a new ones. Unschuld explained:

> [T]he "either/or" question that might be posed by a scientist used to deductive reasoning obviously did not concern a Chinese theoretician or practitioner who thought in terms of systematic correspondence.

And,

> [O]ne should regard all those attempts as questionable and misleading that try to eliminate this distinctive feature of traditional Chinese thought by artificially isolating a coherent and--in the western sense--consistent set of ideas and patterns from ancient Chinese sources. (1985:91)

I bring up this example not to suggest some affinity between Chinese and Indian

medicine, but to point to an observation regarding "western science" that is similar to what I am asserting about western/academic social science.

Though there are innovative works that transcend such dualisms, an "either/or" style of analysis remains in much anthropological research. I have shown how the corpus of anthropological studies of the body have a produced a dichotomy that conveys the impression that western people live in a world of mind-body dualism and everyone else lives more in the body. It is as if other options were not conceivable. I have encountered, however, in contemporary Kerala and in Indian philosophy, a way of experiencing the world that is neither living-in-the-body nor a case of mind-body dualism, and I am confident that many other unique, local phenomenologies that do not fit any of these models have yet to be described. I have also tried to demonstrate that we often think of ideologies and practices relating to social change as modern, global, capitalist or traditional, indigenous, yet in the case of the decline of spirit possession in Kerala indigenous traditions provide some of the same discourses that modern disciplines promote.

Perhaps anthropologists and social scientists could take a cue from people suffering illness and their families in India who find it easy to change therapies, view the practices of different therapies as non-mutually exclusive and feel comfortable with the idea that monism and dualism, social-embeddedness and egocentrism emphatically coexist.

I can't help but think of the apparent irony that I am making a case for context-dependancy using universalizing, scientific methods through my quantitative analysis of

patient-informants' prognosis after treatment. I would suggest that both modes of understanding coexist. And perhaps--just as arguments that used reason, logic and other intellectual means of persuasion were used to reveal the trappings of positivism--we need to unpack terms like "reason" and "science." Maybe this too will help us understand the coexistance of apparent contradiction that bothered social scientists more than it bothered my informants. I don't claim to know *why* it is that contradictions should co-exist, but the fact that they do reminds us that reality is bigger than our analytical tools. During fieldwork, I knew, experienced, and relied on the fact that there were universal human problems, experiences and ways of feeling. Otherwise I would not have even been able to communicate with people and "click" with those who became friends. Simutaneously, I was constantly tripped up, surprised and excited by the unique, by pieces of culture that I could not have imagined. Then, perhaps because of some universalizing or homogenizing agent, the striking and unique would eventually appear ordinary and routine to me. I would suggest simply that anthropologists are familiar enough with the universal and ought to further develop the ability to see the context-dependant, the particular and unique. This is another way of saying that reality is always bigger than our analytic ability and that we should constantly be willing to be deferential.

Appendix A - Structured Interview Questions

(Where, when interview occured and name of assistant is noted.)

Speaker (s): [e.g., patient, patient's mother, husband etc.]

Biographical/Demographic

1) Where are you from? [Where is your "sthalam"?]
2) What is your occupation? For how long?
3) What is your age?
4) What is highest level of education you have attained?

Illness/Affliction

5) What is the problem for which you are seeking treatment?
6) What bothers you most about this problem? What are you current symptoms?
7) Is this the first treatment you have sought for this problem? For example, have you sought help help from a temple, an astrologer, ayurveda, allopathy or anywhere else?

If answer to question 7 is "no," go to question 8. If "yes" go to question 11.

8) (If previous treatment was different therapy) why did you change therapies? or are you still using the previous therapy in addition to the current one?
9) Did you experience the same symptoms during the previous therapy?Have you experienced any new symptoms or feelings since beginning the current therapy?
10) Did you/do you agree with how previous and current therapists saw your problem?

Social Implications

11) Has this problem cause you any social inconvenience or financial hardship?
12) Has your difficulty caused any family tensions?

Nature and Prognosis of Problem

13) What do you think has been the cause of your problem? Have you always felt that this is the cause? If not, how have your views changed?
14) What do you think needs to be done to end your affliction/illness?
15) What specific plan do you have to end your affliction/illness? How long will this take long? What is the next step you will take?

Appendix B - Health Infrastructure of Kerala

This only includes healers for whom the Kerala Government has information. Many healers are not recorded in this list. For example, the temple, mosque and church discussed in this dissertation are not officially considered part of the health structure of Kerala.

Health Infrastructure of Kerala - Public

Medical System	*Facilities*	*Beds*	*Doctors*
Allopathy[1]	1,249	42,438	9,998
Ayurveda	686	2,309	621
Homeopathy	405	950	621
Other Systems	0	0	0
Total	2,340	45,697	11,240

Health Infrastructure of Kerala - Private

Medical System	*Facilities*	*Beds*	*Doctors*
Allopathy	3,565	49,030	6,335
Ayurveda	3,925	1,301	4,130
Homeopathy	421	2,078	2,168
Other Systems	95	139	100
Total	8,006	52,548	12,733

[1] The State Planning Board report uses the term "Modern Medicine," but I am using the word "allopathy" to keep the terms consistant with the terms in the dissertation text.

Complied from: State Planning Board Health Infrastructure and Development Indicators (1996), in Dr. V. S. Mani "Major Mental Health Issues in Kerala." Paper. Kerala Mental Health Authority (1998)

Appendix C - Degree of Improvement in Patient-Informants' Illnesses After Follow-Up Interviews

Follow-up information was obtained on the status of 25 patient-informants' illnesses and their current therapy-seeking situation through either questionnaires or interviews. The degree of improvement or decline in the patient's condition was evaluated and given a numerical score from -3 to 3 (with increments of 0.5). Descriptions of current symptoms (the character and intensity), literal statements about current condition (e.g., "There was some improvement" or "Now I have no illness."), expectations about the future and other factors were taken into consideration to evaluate the degree of improvement or decline.

All interviews occurred at least 6 months after the original interview. Some informants had changed therapies since our original interview. Therefore the average degree of patient improvement is first calculated counting patients as users of the therapy they were undergoing when they were originally interviewed; then the average degree of improvement counting patients who changed therapies as users of the new therapy was calculated. The improvement and decline scores average to an overall improvement in all therapies. In other words, the condition of the average patient in all therapies improved after at least 6 months.

1. Degree of Improvement Counting Patients Who Changed Therapies Since Original Interview as Users of the Original Therapy:

Allopathy	*Ayurveda*	*Religious Therapies*
0.41 (n=11)	0.25 (n=6)	1.31 (n=8)

2. Degree of Improvement Counting Patients Who Changed Therapies Since Original Interview as Users of New Therapy:

Allopathy	*Ayurveda*	*Religious Therapies*
0.25 (n=12)	0.88 (n=4)	1.11 (n=9)

Average of Above Scores:

Allopathy	*Ayurveda*	*Religious Therapies*
0.33	0.57	1.21

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