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RESTORING MENTAL HEALTH IN INDIA

Pluralistic Therapies and Concepts

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The Last Resort

Why Patients with Severe Mental Disorders go to Therapeutic Shrines in India*

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Religious Therapy: Therapy Which Transcends the Boundaries of Modernity

In an article on the public conception of mental illness and the practices surrounding it, Prabhu *et al.* (1984: 4) quote Dube who points out that:

> (...) a great deal of misconception, superstition and ignorance exists in respect of mental disease. Much stigma is often attached. Mental illnesses are viewed as a visitation of evil spirits of a goddess of a curse. This takes the form of exaggerated belief in mystic influences, excessive faith in the powers of saints, priests and medicaments. Among Muslims, the visitation takes the form of Sayyad. The medicaments, sorcerers, faith healers, priests etc. are frequently engaged to cure cases of mental illness, snake bites etc. There are a number of places of worship reputed as centres of treatment endowed with healing power due to a deity. One such place in this region is Balajee, where a large number of persons from this region go in the hope of a cure of mental disease. Many usually return disillusioned and come to Mental Hospital.

Such comments, which denounce recourse to religious therapy for the treatment of mental illness, and implicitly valorize psychiatry, give little

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attention to the reasons why patients make this choice. Moreover, the WHO's 1979 follow-up study of severe mental disorders from which Murthy Halliburton (2004) quoted some remarks reflected Western common-sense 'caricatures' about practices and beliefs in 'developing countries': 'researchers lament the "ignorance about the nature of mental illness" and "misconceptions and superstitious beliefs about mental illness" which lead people to seek help from "faith healers"'. Yet, at the period when Dube published his study, in 1970, psychiatry was not only unpopular with the Indian public, but also criticized by specialists who demanded the reform of their discipline; and the concept of supernatural origin attributed to mental illnesses was still very widespread.

Admittedly, recourse to folk healers such as magicians, astrologers, priests, and exorcists, who treat patients suffering from odd and asocial behaviours and somatic illnesses, has existed for a long time in the history of the treatment of mental illness in the world. Mentally ill people tended not to be considered as patients and might be perceived either as prophets and saints, or, more currently, as victims of supernatural entities, the latter perception having induced recourse to religious therapy. Parallel to this aetiology, psychological and physical causes were evoked and especially a naturalistic causality founded on humoral imbalance. This change of aetiology, derived from Hippocrates, is also found in the Indian medical treatises of Ayurveda and siddha. These classify forms of insanity (*unmāda*) according to symptomatology and their origin, considered either internal, due to humour imbalance, or external, caused by spells or evil spirits, poison or spoiled foods. In spite of the change in aetiology which minimizes evil spirits and sorcery as responsible for illness in favour of a physiological origin, the supernatural conception has endured until today, not only in developing countries, but also in Western countries where psychiatry began and is well developed. It is notable that the Catholic church, after a two-decade attempt to ban exorcism, has been forced to introduce a new rite for exorcism, on 26 January 1999, in order to respond to the increasing demand of parishioners.

The hospitalization of mentally ill patients began in the ninth and tenth centuries in the Islamic cities of Baghdad, Cairo, Fez, and Damascus. It spread, during the fourteenth century, to countries under Islamic rule, such as Spain (Duffin 2001) and certainly India where hospitals were established for charitable purposes (Jaggi 2000). According to Jacalyn Duffin, given that mentally ill people were considered 'divinely inspired',

these hospitals were comfortable and were not places of custody as were the asylums established from the eighteenth century onwards. Nevertheless, if hospitals as we know them today were non-existent before this period, the system of hospitalization existed under different forms, in temples or in the homes of practitioners. The custom of staying at religious places was very widespread in antiquity; the temples of Asclepius, the Greek god of medicine, for example, were particularly famous for treatments which used hydrotherapy, prayers, incubatory dreams, sacred substances, and herbs. In India, such places are also testified to by epigraphic evidence on the walls of some temples. The Veskateshvara temple at Tirumakudal in Tamil Nadu, for example, could accommodate fifteen patients who were treated conjointly with herbal medicines and religious therapy through attendance at the pūjā[1] (Jaggi 2000). This kind of double treatment combining religion and medicine continues to be given in a few temples as well as by some categories of healers, such as practitioners of witchcraft, *mantiravāti*,[2] astrologers, priests, exorcists, and also in Tamil Nadu, by siddha practitioners (*cittavaittyar*) some of whom, especially the older ones, are also mantiravāti. Apart from staying in the temples, some patients lodged with the practitioner during the treatment, as is still the case in remote rural areas. These forms of hospitalization, unlike the asylum-concept established by British rulers, which aroused the disgust and fear of Indian people because of the seclusion of mentally ill patients and inhuman and punitive treatment, did not provoke any rupture with the relatives acting as caretakers. The role of caretakers in the management of patients that I met in the village of Puliyampatti is a feature that particularly drew my attention.

The Catholic shrine of Puliyampatti, located in the south of Tamil Nadu near Tirunelveli, is dedicated to Saint Anthony of Padua. It is a famous pilgrimage centre and welcomes numerous patients suffering from either severe mental disorders, such as bipolar-unipolar affective disorders, psychosis and schizophrenia, or with symptoms of depression, anxiety, and stress, generally classified as common mental disorders

[1] Pūjā is the adoration of deities with appropriate rituals such as lighting lamps, chanting mantras, and offerings of holy substances, fruits, etc.

[2] Magicians who use the power of mantra to cure, or put a spell on somebody.

(CMD), or with physical illness such as retardation, cardiac malformation, cancer, or motor degeneration. Except for some who have been living in the shrine for many years, patients are accompanied by one or several relatives (spouse, children, mother/father, in-laws).

Recourse to religious therapy implicitly means an approach motivated by belief and faith. However, the therapeutic route of patients who frequent the shrine reveals that belief is not the prime motivator of the stay for all of them. A clear distinction appears depending on the symptoms: the religious motivation being much less strong for patients suffering from severe mental illness than for those affected by CMD. This invites us to explore when and why religious therapy is chosen for the treatment of mental disorders so as to define the place of religious therapy; and how the aetiology, nourished by previous therapeutic experiences, is elaborated in order to justify this choice of therapy.

Difficulties in Managing the Severely Mentally Ill

Apart from the period devoted to the Mass, which is amplified through loudspeakers, the atmosphere during the day in the compound of the shrine of Puliyampatti is calm. But sometimes, the quiet is disturbed by shouts and insults ringing out from a group of newcomers trying to control a person with violent behaviour. After a more or less long period of fighting, the violent person, defeated, finds himself bound hand and foot, or tied to a tree in the compound. Everyday, twelve to fifteen patients are chained or tied with ropes or cloth near the shrine and in the old cemetery of Puliyampatti. Relatives justify the use of bonds as a means to manage the violence of the patient and to prevent him/her from escaping and injuring himself/herself or somebody else. A few among them, however, also emphasize the properties of iron which, in Indian medicine, is thought to reduce certain symptoms such as convulsions (*valippu*).

Selvi and Gopalan: Stories

Selvi, a tall forty-eight-year old woman, arrived one day at the shrine, brought by her husband, Jeyaraj, and her thirteen-year old daughter, Malavika, who had great difficulty in subduing her. Finally, they managed to calm her without having to tie her up. They stayed for four months at Puliyampatti, during which I often discussed Selvi's illness with Jeyaraj and Malavika; Selvi's hyperactivity symptoms—she was diagnosed as bipolar—did not allow direct discussion with her.

Selvi is Jeyaraj's friend's sister. When Jeyaraj met her, he liked her straight away and so asked his friend if he might marry her. The couple got along very well and all was fine until Selvi gave birth to her second daughter. According to tradition, she went back to her maternal house for the delivery. While she was delivering there was a power failure and so nobody noticed that she had lost a great quantity of blood. When the power came back, Selvi's condition was so serious that her brother took her to the hospital at Tuticorin. After a few days, Selvi returned to her maternal house. However, her behaviour was very odd: she refused to feed her baby and showed no interest in it. She slept all day, refusing food. She was taken to the hospital again where she stayed ten days. The doctor diagnosed a mental illness (*maṉanōy*) and advised the family to hospitalize her in the psychiatry unit of High Ground, Palayamkottai. She stayed there for a few days during which she received several shock therapies, injections, and chemotherapy. The doctor sent her home with a prescription for medication. Instead of going straight home, Selvi's mother, on the advice of her neighbours, decided to go to Puliyampatti and stayed there for thirteen days in order to increase the efficacy of the psychiatric treatment. They then returned to Tuticorin, promising to come on the last Tuesday of every month for thirteen months and, at the end of this cycle, to offer an *acaṉam* (food offering) to thank Saint Anthony and to put an end to this difficult period.[3]

For eight years, Selvi remained well, but in 1996 there was a new crisis: hallucinations and extreme excitation began following a high fever. At this time, Jeyaraj was working and when he came home, he found his wife in a state of great agitation in the middle of a completely empty main room: she had thrown all the furniture and objects outside. He immediately took her to a private clinic in Tirunelveli recommended by acquaintances for the skill of the psychiatrist there. She was hospitalized for five days. The doctor diagnosed a bipolar disorder and prescribed

[3] The number 13 corresponds to the date of the death of Saint Anthony of Padua, 13 June 1231, at Campietro, near Padua, and Tuesday is the day of his burial. This number and this day are linked with the cult of the saint in Western countries as well as in India where, in popular Hinduism, numbers and days hold an important place in the cult and in penances. The food offering corresponds to the 'bread of Saint Anthony', i.e., the distribution of bread to the poor in thanks for a favour received from the saint.

medication which she took until 1998 when her health had stabilized. Once again, in 2001, a high fever and loss of consciousness made it urgent to hospitalize her in a private hospital in Tuticorin. After an improvement in her state which allowed her to go home, her symptoms reappeared with intensity; this time, Jeyaraj refused to take her to the hospital:

> I had to borrow 10,000 Rupees to care for Selvi and now I don't know how to pay off such a sum of money. Each coin I earned was to treat Selvi. So, on the advice of a friend, I consulted a Catholic *mantiravāti* in Tuticorin to know what to do. The *mantiravāti* explained to me that she was victim of a spell (*ceyviṉai*) sent by her brother who wanted me to leave her because he considered me responsible for her illness. From the relapse of Selvi in 1996, her brother refused to see me. The *mantiravāti* advised me to go to Puliyampatti. But, I don't believe that Saint Anthony will be able to cure her. In fact, I've chosen to come here because the neighbours could not tolerate her behaviour and they forced us to leave. As I knew Puliyampatti, I decided to go there and to wait until she is better.

As Jeyaraj makes clear, his choice of Puliyampatti does not reflect his adhesion to the advice of the mantiravāti, but rather his incapacity to deal with the situation financially; this is very much corroborated by his lack of diligence in carrying out the religious rituals. While devotional exercises, such as circumambulation of the church, prayers, contemplation in front of the sacred statue, church attendance, and rosary saying, make up a great part of the activities of patients and their relatives because they are considered as essential in moving Saint Anthony, and concomitantly, in being cured, I never saw Jeyaraj, who is a Catholic, walk around, or even enter, the church. He knows that the drugs will lessen his wife's symptoms, but his debt does not allow him to foresee either hospitalization or chemotherapy. Nevertheless, a universe such as that of Puliyampatti, where Jeyaraj and his daughter can count on the understanding and solidarity of other families with whom they share a similar situation, allows them to wait for an improvement in the behaviour of Selvi and for a lessening of the tension. Looking after a patient like Selvi will inevitably provoke physical and mental exhaustion in her caregivers as well as conflicts with neighbours. The insistence by neighbours on Jeyaraj going to Puliyampatti is a feature mentioned by the relatives of many disturbed patients.

Finally, confronted with his incapacity to put up with his wife whose symptoms were increasing, Jeyaraj decided to borrow a little money

and to go to Rajavur, a Catholic shrine devoted to Saint Michael. In contrast to Puliyampatti, this shrine benefits from the visit of a psychiatrist and from the presence of nuns trained in psychiatry who dispense medication and intervene when the patient becomes too violent. When Jeyaraj heard about this place, he again felt hopeful about the possibility of Selvi's recovery and return to normal life.

Jeyaraj and his family stayed four months at Puliyampatti. This duration corresponds to the average time spent by relatives accompanying severely disturbed patients before resigning themselves to leaving the shrine in the absence of any improvement in the behaviour of the patient. The length of stay may, however, be much greater, as illustrated by the case of Gopalan, a thirty-year-old man diagnosed as schizophrenic by the psychiatrist of a private clinic. He was in the shrine when I arrived in June 2001 to attend the feast of Saint Anthony. Easily identifiable by the chain tied round his ankles and carried on his shoulder, he walked like a robot, with a fixed stare, in the midst of devotees who were following the three carts of Saint Anthony, Saint Michael, and the Virgin. He and his family were living in a lodge situated in the compound of the shrine but when I came back in October, they had rented a small house in the village. They explained to me that the priest had asked them to leave because they refused to remove Gopalan's chains. The priest was, in fact, respecting rules imposed by the government to avoid a tragedy such as that of the Erwadi dargāh in August 2001,[4] where a fire in a private mental home killed twenty-eight patients who were chained to the pillars of the shelter. Nevertheless, Gopalan's family never wanted to leave Puliyampatti and if Gopalan could no longer attend Mass or make circumambulations of the church, they could continue to perform the devotional exercises for him. Gopalan and his family were still at Puliyampatti when I came back in 2004 and 2005. Finally, in June 2006,

[4] This tragedy, the focus of large-scale media attention, caused a stir. The measures that the government of Tamil Nadu introduced were: (1) to close mental homes or hostels managed by private individuals not having the necessary authorizations; (2) to remove chains from the patients; (3) to present the patients suffering from a mental pathology before a magistrate in order that he undertakes admission to the psychiatric hospital in Kilpauk (Chennai); and (4) to oblige the families of patients little or not at all affected by a mental disorder to come and fetch them, and to commit persons abandoned or without families to various institutions.

after the feast of Saint Anthony, they left for Bombay, Gopalan's elder brother having asked them to come.

At first, Gopalan was accompanied by his wife, his younger brother's wife, and their baby. His parents, his brothers and his in-laws regularly came to visit and sometimes stayed a few days. Compared with other families staying at Puliyampatti, Gopalan's family was rich: the father was a landowner at Kovilpatti and owned a big hotel at Madurai managed by his elder son, but he had sold it to pay Gopalan's hospital fees and his son had had to go to Bombay to look for work.

Gopalan's illness began when his parents prevented him marrying a girl with whom he had fallen in love. The mother of the girl, a widow without a son, met with Gopalan's parents in order to arrange the marriage, but his father flatly refused to allow it because of caste difference. Confronted by this opposition, Gopalan's behaviour changed. He became violent and irascible with his family and others. He was working as a jeweller but he lost his job because of his aggressiveness and his absenteeism, and from this period, he spent his time in the street, drinking and looking for fights. Thinking that marriage might stabilize his mood, his parents found him a bride, a classificatory maternal uncle's daughter.[5] However, the marriage changed nothing; if Gopalan did not beat his young wife, as often happens in such cases, he neglected her and made no effort to find work and to make the family secure. His parents decided to take him to a well-known private clinic in Madurai. According to the report notified in Gopalan's health book, the doctor diagnosed him with schizophrenia and hospitalized him for three months during which he underwent numerous electro-convulsive therapy (ECT) sessions and strong chemotherapy that exhausted him. Back at home, as he was manageable, that is to say, calm and obedient, and his parents stopped his medication; but he had a relapse a short time later. Rather than return to the private clinic of Madurai where the fees were very

[5] To arrange the marriage of a mentally ill person is very difficult, but it sometimes happens that, in solidarity and according to preferential alliance, a family agrees to provide a marriage partner. It is in fact widely believed that marriage helps to cure a mentally ill person, especially a schizophrenic. At the same time, however, insanity is legal grounds for divorce (Dhanda 2000), and is sometimes used as a pretext for getting rid of a wife in order to marry a mistress, as several relatives of people involved in such cases have confided to me (Sébastia 2007).

high, his parents took him to a siddha mental health clinic at Courtallam, a village renowned for the therapeutic action of its water on mental illnesses. But, after a forty-eight-day treatment, corresponding to a *mañkalam*,[6] the practitioner informed the family that their son's illness was incurable (*tīrāta*) by siddha medication and advised them to go the psychiatry ward of the general hospital of High Ground, Palaiyamkottai. Gopalan was hospitalized there for one month and released with a prescription for medicaments of which the family, now too impoverished, bought only five days worth. A few weeks later, the family arrived in Puliyampatti.

The relatives explained to me that Gopalan's behaviour was not the sole reason for the stay at Puliyampatti. In spite of the Rs 200,000 spent and the financial ruin of family members, there had been no improvement in Gopalan's state; the father had had a heart attack and was hospitalized for a few weeks. How is it possible not to attribute such events to an evil spell (ceyviṉai)? Even if Gopalan was responsible for the onset of the afflictions, his relatives did not think of abandoning him, even though the situation in which they were forced to live continued to impoverish them. They were persuaded that the mother of the girl Gopalan wanted to marry had sent them a ceyviṉai, and that as long as Gopalan did not recover, their family would not be protected from misfortunes (*tuṉpam*). That explains why Gopalan's brothers contributed to the expenditure caused by his long stay at Puliyampatti. Finally, this illness and its consequence for the father's health have impoverished the family and, after selling their lands, hotel, and finally their house, the parents came to Puliyampatti. They lived there four years altogether thanks to help from their two other sons, until the eldest invited them to Bombay.

Severe Mental Illness: A Hard-to-bear Disability and Its Cost

The financial aspect of treatment is at the heart of the stories of Selvi and Gopalan, and is a factor about which the relatives of severely mentally

[6] *Mañkalam* (*mañgalam* in Sanskrit) signifies 'auspiciousness'. This term also corresponds to a period of time (forty-two, forty-five, forty-eight days) during which the devotees perform spiritual exercises to a chosen deity in order to force her to put an end to the period of affliction. This concept is also used in siddha medicine, in government hospitals, and in some clinics to define the duration of the treatment necessary to cure or relieve.

ill patients often complain. Surprisingly, this criterion is not emphasized by Indian psychiatrists who criticized the practice of psychiatry after the tragic fire at Erwadi dargāh: criticisms no different, in fact, than those pronounced during the reform of the Mental Health Act 1987. This is also noticed by R. Parthasarathy (2005) who points out that the economic cost of severe mental illnesses is threefold, consisting of direct costs such as medical expenditure, indirect costs corresponding to reduced, or lost, productivity of the patient, and support cost which is tantamount to the time lost in caring for the patient. However, the financial aspect of mental illness is no longer mentioned in anthropological studies on religious therapy. For example, the article by Halliburton (2003) considers that the choice between three therapy systems in Kerala—allopathy, ayurveda, and religious therapy—is defined according to how pleasant the treatment is. He mentions in passing that allopathic medicine and ayurveda are expensive therapies, and focuses on the perception of each treatment, 'allopathy'[7] being considered the most disagreeable because of its iatrogenic and side effects and its overuse of ECT. This perception of biomedicine was also confirmed in its entirety by the relatives and patients I met in Puliyampatti who express their horror physically when they mention the term 'shock therapy' and its extensive use.

The treatment given in government hospitals, such as High Ground at Palaiyamkottai, nearest to the settlement for those who frequent Puliyampatti, is in principle free of cost, but expenses of clinical tests and some therapies are payable by the family. This explains the insistence on the frequency of shock therapies which drastically increase the cost of hospitalization. The use, and overuse, of ECT in India is a question that has been tackled by psychiatrists in India. The studies of Agarwal and Andrade (1992, 1997), notably, have estimated the attitude of psychiatrists towards the practice of ECT. They find that 79.8 per cent of them consider it the safest, cheapest, and most effective therapy, in spite

[7] Allopathy is a term widely used in India as a synonym of Western medicine, and nowadays of biomedicine, versus Indian systems of medicine. The use of this term is problematic because the healing process of Indian medicines is allopathic: the increase of one humour is balanced by the use of substances and bodily practices possessing or promoting opposite properties. Allopathy is, in fact, to be understood in opposition to homeopathy which met with great success in India right from its invention by Hanneman.

of the fact that 38 per cent think that ECT may produce subtle brain damage (Agarwal and Andrade 1997). If, in this article, the authors do not take into account the apprehension of ECT by patients and relatives, in their first article (Agarwal and Andrade 1992), they evaluated willingness to undergo ECT, and, surprisingly, they report that 39 per cent of patients and relatives agree to it, while 13 per cent are reluctant. Ramachandra *et al.* (1992) do not confirm these statements and observe that patients continue to harbour reservations about ECT, in spite of their great experience with this therapy. The authors explain this negative perception by pointing to the lack of information obtained from clinicians before ECT, an issue that concerned 50 per cent of patients of the study, and also by faulty depiction by the lay media, of which they unfortunately give no details. It would be interesting to compare the reasons for this negative perception in India with those analysed by Claire Hilton, in the mid-twentieth century in Western countries, which were connected with fear of electricity and with the punitive aspect of this therapy reminiscent of the inhumane treatment of patients in asylums (Hilton 2007). The overuse of ECT, quite often mentioned by patients and relatives, is confirmed by a study by Agarwal and Andrade (1992) which specifies that 23.6 per cent, 47.1 per cent and 2.7 per cent of patients received administration of ECT respectively twice a week, three times a week, and four to five times a week; 68 per cent received more than one administration a day; 43.7 per cent had ECT daily for at least three days; and 56 per cent were treated for six months or more.

In government hospitals, chemotherapy is free but this treatment is unbearably expensive for the family when the patient has been sent home, especially with a long-term prescription. As I have often noticed in the records on patients' health cards or on the packets of medication sold to them after they leave the hospital or private clinic, eight, ten, and sometimes even more, sorts of medicaments as varied as antipsychotic, antidepressant, anticonvulsant, analgesic, have been prescribed. In a general way, inappropriate and over-medication have frequently been denounced by psychiatrists interested in improving the practice of their discipline. In the West, this is a major reason why many patients, suffering from schizophrenia, affective disorders, or severe depression and incapable of tolerating the side effects, interrupt their treatment, thus running the risk of relapses and chronicity. It is well known that in India, as in developing countries in general, the dosages of medication given

to patients are lower than in developed countries;[8] this difference is often mentioned to justify less chronicity and risk of relapse in severe disorders, but this is not confirmed by comparative studies (Barnes 2004).[9] Nevertheless, if the dosage is lower, the length of prescriptions which give hope of quick relief to patients or relatives soon begin to be an unbearable burden. Due to the fact that biomedicine is currently chosen for its supposed capacity to produce immediate relief of symptoms, a number of practitioners prescribe large amounts of drugs to satisfy their clients.[10] And thus, due to adverse reactions and side effects, lack of immediate improvement and the high cost of prescription, it is not surprising that patients stop taking the medication after a few weeks or even, amongst the poorest families, after two or three days. In the paper given at a conference in honour of Dr Murthi Rao, S.V. Channabasavanna (1996: 72) advises that: 'When a prescription is written, due consideration must be given to the choice of drug. This is not such an obvious issue as it appears'. In addition to wrong prescriptions, the author emphasizes the lack of communication with the patient about his therapy: the patient should be informed about his prescription and given a basic understanding of the need for medication, the benefits from drugs, short-term and long-term adverse effects, and the possible use of complementary therapies; a well-informed patient will be more compliant

[8] A study in Austria on the pharmacological treatment of patients with schizophrenia shows that in spite of the recommendation of antipsychotic monotherapy, lower doses and the duration of treatment thanks to the new antipsychotics, there are no relevant differences in psychiatric practices between 1989 and 2001 (Edlinger *et al.* 2005).

[9] This study considers possible pharmacological strategies for avoiding relapses in cases of schizophrenia. It emphasizes some studies which conclude that, for recent and onset cases, a prodome-based intermittent treatment which requires a close monitoring is as good, if not better, than standard maintenance for relapse prevention.

[10] Involved currently in anthropological research on the practice of siddha medicine in Tamil Nadu at different levels (government hospitals, private doctors trained in college, hereditary practitioners), I observe that the practitioners, whatever their training, in college or by traditional ways, tend to prescribe many drugs. This is to satisfy and reassure their clients but, for non-governmental practitioners, there are financial incentives, given that their income depends solely on the sale of medicines, their own preparations as well as ready-made ones.

and cooperative with the practitioner. In the West, as has been widely confirmed, better outcomes for people with severe mental illness were connected with a good therapeutic alliance between the clinician and his/her patient; negotiations between them regarding the illness and its treatment are now widely fostered. However, a qualitative study conducted by Clive Seale *et al.* (2006) reveals the commitment of psychiatrists to sharing decision making with their patients to be weak; their lack of respect for patients' opinions which is a reflection of medical dominance and power. The psychiatrists consulted in the course of this study recognized that patient-centred practice is desirable, but find it very difficult to represent the adverse reactions and the side effects of medicaments to patients and to negotiate the therapy with them. Channabasavanna specifies that psycho-educational and pharmaco-educational processes require flexibility in order to fit the great variety of levels of understanding of patients and families which depend upon schooling, cultural background, state of health, receptiveness, etc. This is confirmed by the study conducted in a private clinic in south India by Sivasankaran Ponnusankar *et al.* (2004) which shows that counselling sessions on medication (name, timing, dose, duration, prescription) allows for a certain improvement in the drug posology and in the patient's compliance with the clinician. The cost of medication is also a factor he is aware of, and he recommends that the clinician's prescription be given in accordance as much with the patient's purse as with his/her condition. 'The obvious issues at stake are that the expense of medication should predispose to neither non-compliance nor financial burden and hence further stress on the patient or family. In this regard, the clinician must be capable of resistance to the marketing pressure from the pharmaceutical industry' (ibid.: 73). With this as his objective, he strongly advises his peers against poly-drug therapy which increases the cost of treatment, the risk of confusion in taking the medication, adverse drug interactions and drug interference, adverse physiological effects, and drug toxicity while it decreases the potential efficacy of the drug. As I have previously noticed regarding poly-pharmacy practice, the combination of neuroleptics with antidepressants is also mentioned by Channabasavanna (1996) who considers it to be in widespread use and condemns it, except in a few cases of schizophrenia where co-medication can be effective (Edlinger *et al.* 2005).

Bad Reputation and Lack of Means

In India, psychiatry has a bad reputation and suffers from a lack of means. If we consider that, in the Occident, psychiatry is far from having acquired legitimacy, and is one of the least appreciated and most contested medical specialities, its adverse reputation in India is not surprising. It must, even today, free itself from perceptions inherited from the methods of alienists and from policies of seclusion; it has to change public conceptions of mental illness and be effective in countering the temptation to take recourse to exorcism when the disease persists over a long period, exhausting the family and accentuating its feelings of helplessness. Admittedly, in the West, hospital conditions have been humanized and the discovery of psychotropic drugs has improved the condition of patients and their families, but efforts to work out new treatments and to integrate various forms of psychotherapies into the medical protocol remain weak and vary greatly from one hospital to another. In India, except in some pilot centres, such as NIMHANS (National Institute of Mental Health and Neuroscience, Bangalore), the care is of very poor quality, in spite of recommendations made by the psychiatrists who participated in the Mental Health Advisory Committee, founded on 29 September 1962, to promote mental health by launching the National Mental Health Programme in 1982, and to draft the Mental Health Act, 1987. The poor state of the practice of the discipline is clearly expressed by the report of the National Human Right Commission of 1999, quoted by R.S. Murthy (2000). The report specifies that 38 per cent of hospitals are still jail-like structures, 76 per cent use isolation cells, and 57 per cent have high walls; patients are still considered inmates which means that personnel are more involved in surveillance than with treatment; only 25 per cent of establishments employ nurses trained in psychiatry, and less than 50 per cent a psychologist or psychiatric social workers; there is overpopulation and unsanitary conditions of life. It concludes that the deficiencies in psychiatric hospitals are sufficiently explicit to prove that the rights of mental patients are being outrageously violated. The inferior practice of psychiatry was also denounced by several psychiatrists following the tragedy of Erwadi (Krishnakumar 2001a, 2001b; Murthy 2001; Wadhwa 2001). R.S. Murthy, for example, concludes that treatment and living conditions in psychiatric hospitals generally are hardly any better than those to which the patients in Erwadi were submitted. In addition to the inhuman conditions that have contributed

to the adverse reputation of psychiatry in the past, the articles denounce the lack of beds (30,000) and specialists (3500). Murthy (2001) estimates that only 10 per cent of needs are covered; and S. Wadhwa estimates that 32 million Indians are affected by a mental illness, 7 million of these by severe disorders.[11] In addition to these statistics, it is important to emphasize that, in many studies, around 50 per cent of beds are occupied by long-stay patients (37 per cent: two to five years; 38 per cent: five to fifteen; and 25 per cent: above fifteen years), mostly, schizophrenia and psychosis cases: this reduces bed turnover in hospitals (Reddy 2001).

Psychiatrists' criticisms of the practice of their discipline made sense when I listened to patients and relatives recounting their experiences. Lack of interest of practitioners in patient's situations, difficulty in getting any response to questions about the nature of the illness, or the diagnostic and the prognostic, the great frequency of shock therapies and cost of treatment, were the most frequent criticisms. Several visits between 2001 and 2002 to the psychiatric unit of High Ground hospital have allowed me to observe these undesirable practices. In the outpatient ward, there were three psychiatrists consulting in different rooms. The patient, always accompanied by one relative, has to file past a psychiatrist who asks the relative three or four questions about the patient's behaviour, and then gives him/her one of two kinds of pre-written prescription and fills up the care notebook. The consultation never took more than two minutes; it goes without saying that such mediocre consultations, which lack the minimum of communication with patients and take no account of the importance of privacy and of follow-ups to determine the diagnosis and to prescribe suitable medicines, promote neither confidence in psychiatry and its specialists, nor the proper use of medicines. The embarrassment

[11] Soumitra Pathare (2005) quotes the statistics established by WHO in 2001 which show that India spends only 0.83 per cent of its total health budget on mental health while mental disorders account for nearly a sixth of all health-related troubles. The country has 0.4 per cent psychiatrists and 0.02 psychologists per 100,000 persons and 0.25 beds for mental patients per 1,000. In comparison, China and Australia spend respectively 2.35 per cent and 6.5 per cent of their total health budgets on mental health. See also the recent article by Nimesh G. Desai *et al.* (2004) which, focusing on the deficit in urban mental health services, stresses the inequities in distribution and availability of mental health services in different parts of cities, and the significant human resource deficit, especially of non-medical mental health professionals.

of accompanying family members after the consultation is moreover clearly visible. Obviously, the absence of response to questions about the illness of the patient tends to encourage recourse to other types of practitioner and eventually to religious therapy (astrologers, sorcerers, exorcists, temples, etc.). This is what emerges from my interviews: relatives translate the vagueness of the diagnosis given by the practitioner into a non-physical illness and ascribe to the illness a supernatural causality, an act of sorcery, or a spirit attack. To give meaning to their aetiology, they feed it with various biographical incidents, such as quarrels with spouse, a family member or neighbours, and transgression of rules of marriage or purity, jealousy, etc. This kind of aetiology is all the more readily conceptualized given that it involves another sort of treatment, much less expensive and much more acceptable.

Why Religious Centres are More Acceptable to the Families of Patients

Living conditions at the therapeutic shrine of Puliyampatti are rather rudimentary and uncomfortable, but the coexistence of families sharing the same types of suffering and who are victims of similar stigmatization makes the situation acceptable. The stigma of mental illness, which affects not only the patient but the entire family, it is not simply a feeling of rejection, as L.S.S. Manickam and R.S. Chandran (2005) say, but a real social and familial rejection. As do many families' stories, Jeyaraj's reveals that he was forced to leave his house because of pressure from his neighbours who could not tolerate his wife; and he had to sustain, as well, the accusations of Selvi's brother. He often expressed his fears about getting his daughters married, as their choice of a good husband is seriously compromised by the nature of his wife's illness. The families of the severely mentally ill are rarely invited to social functions and are excluded as far as marriage alliances are concerned. If mental illnesses are seen as incurable, they are also considered to be contagious and to affect families with bad morals. So, in contrast to the rejection they experienced in daily life, the families can rely, in religious places, on the tolerance of others towards the odd or asocial attitudes of their afflicted member, and on support and help in case of necessity. The shrine is an institution in which protection is a synonym of solidarity, the opposite of the stigmatization, exclusion and disdain such families suffer outside. Unlike the procedure in the 'totalitary institutions' defined by Erving

Goffman (1961), at Puliyampatti the patients are not separated from their families, or if they are it is not for reasons of shrine administration but in the family context. So, for patients, the change of social landscape is less violent than if they were hospitalized in psychiatric ward. Their conditioning is restricted to the exorcism rituals informally organized each night, and not to any form of exclusion. By following the proscriptions and the practice of penances, the family members manage not to distinguish themselves very much from the patient: they eat the same food, sleep under the *maṇṭapam* waiting for the incubatory dream which will inform them about the prognostic of the illness; they attend Mass and rosary recitations, and make circumambulations of the church, the *koṭimaram* or Mātā kōvil. If they cannot experience the actual sufferings of the patients, they share their illness by accompanying them through the penances (Nunley 1998; Skultans 1991). As I observed during my stay at Puliyampatti, even if the families use violence during exorcism rituals to induce the patients to become possessed, they are always ready to offer them kind attention, tenderness and, when possible, the best food.

The stories of Selvi and Gopalan illustrate the enormous concessions their families have made to assist them along the therapeutic route, in spite of the serious financial, social, and psychological impacts of this. Although the two families are quite different in terms of economic means and number of relatives, fewer efforts are made to treat Selvi than Gopalan. Admittedly, in a context where a supernatural attack is presented as the aetiology of psychic disorders, the mobilization around Gopalan is intelligible in the light of the fear that other members of the family will be infected with the affliction. However, the part of my study that focused on relatives who accompany patients during their stay in the shrine has revealed a difference in the amount of assistance based on gender: women being assisted for a shorter time than men (Sébastia 2007).

Numerous studies have shown that the women are helped less by their families than men. For example, Vieda Skultans (1991: 323) observes that of seventy-three patients, all the men (thirty-one) are accompanied by parents, and often their wives too, while only half the women receive assistance from family members (twenty-one of forty-two). At Puliyampatti, the difference between the genders is less visible. Women unaccompanied by a relative are more numerous than men there, but rare are those who do not receive at least a little financial help from their

relatives to pay for food and accommodation. Such help is not always sufficient and if the women are incapable of working they are obliged to rely on the generosity of shop owners and pilgrims. Men, on the other hand, are rarely reduced to begging because they receive, as soon as may be, the support of their families who do not hesitate to incur debt or sell their property. The particular relationship between sisters and brothers inherent in the privileged cross-alliances pertaining to Dravidian kinship, and in this area mostly between mother's brother's son and mother's daughter, plays an influential role in the context of illness, because many women receive financial help from their brothers,[12] though this help is reduced as soon as the brothers marry. Several women who were living at Puliyampatti during my stay, explained to me they had been hospitalized for long periods until their brothers married and decided to take them to Pulyampatti instead. This change of situation does not always put an end to the relationship, however, and brothers sometimes continue to visit their sisters and to bring them a little money or some rice. But, when their state of health does not show any improvement, they end by being given up for lost. Patients affected by CMD due to stress, anxiety, marital violence, sexual abuse, or post-partum disorders, manage to reassume their existence as *kūli* (seasonal labourer) on construction sites, in the fields, or by making local cigarettes (*pīṭī*), but those with severe mental illness are incapable of working. The future of such patients is very much jeopardized: the priest will not allow them to stay in the shrine without relatives to take care of them,[13] and they are thus kept at home, quite often in chains or locked up in a room,[14] abandoned in government hospitals, or thrown out into the streets.[15]

[12] On privileged brother-sister relationship, see Karin Kapadia (1996), Brigitte Sébastia (2007), Margaret M. Trawick (1996), and Susan S. Wadley (1991).

[13] During my fieldwork, the priest summoned all the patients who were staying in the shrine without caregivers in order to oblige their relatives to come and pick up them. There were forty patients, a large majority of whom were women affected by chronic mental illness.

[14] A study conducted by T.N. Srinivasan *et al.* (2001) on the follow-up of untreated schizophrenia patients scheduled during a door-to-door survey of about 10,000 people in Chennai, reveals that 30 per cent of them had never received any treatment.

[15] The Banyan is a non-governmental organization (NGO) located in the west of Chennai which welcomes women with mental disorders who have been

Until August 2001, some of them were sent to one of the private mental homes in Erwadi paying accommodation charges only, but these homes closed after the tragedy. The present situation of the chronic mentally ill is not, in fact, very much changed from that observed by Nancy E. Waxler in 1977 in Sri Lanka; she concluded that these patients 'are threatened not only by barren lives but also, ultimately, by lack of food and shelter and, most significant, loss of family ties: that is, loss of their own basic identity' (Waxler 1977: 248).

Psychiatrists began to take an interest in the role of the family in the process of therapy only very recently. Admittedly, their articles mostly concern the link between the family pathology and that of the patient, the stress and bad feelings aroused in the family due to inter- and intra-psychic difficulty in taking care of a mentally ill member (Chakrabarti *et al.* 1995; Noh and Turner 1987; Roychaudhuri *et al.* 1995). But some, such as B.B. Sethi (1989), have considered the family as potentially a therapeutic tool, notably in vocational and occupational therapies, and have taken an interest in the rehabilitative role of the family which contributes to prevention through the primary detection of morbidity or relapse. It was precisely in order to define the National Mental Health Programme that the integration of the families into therapy was promoted as a priority (Weiss *et al.* 2001). Nowadays, it is well established under the name of Community Mental Health Movement (Kapur 2004; Murthy 1999; Reddy *et al.* 1986; Sahni and Xirasagar 1999). The programme of this movement is vast and, concerning the families, it covers family counselling, family therapy, and the rehabilitation of patients within the family and social framework. Appreciating the tremendous role of the family, some psychiatric hospitals are equipped with rooms to lodge families with patients. The families play the role of partners in the therapy which gives them a better knowledge of the efficacy of the drugs and their iatrogenic effects, and of mental disorders and their origins. When the troubles of patients are more or less related to the family history, the psychiatrists encourage family or group therapy (Sethi 1989). The presence of the family along with the patient is meant to eventually

picked up by the police wandering the streets. It treats and rehabilitates them and, as soon as it is possible to locate their relatives, works with the family so that they agree to welcome and take care of the patient again. See the website: www.thebanyan.org.

improve the relationship between them, and to avoid the de-socialization generated by long periods of hospitalization.

Conclusion: Psychiatry in Religious Places: Is it Relevant?

For many families, the stay at Puliyampatti is the last resort after everything else has been tried or when finances do not allow for any alternative. But given the great difficulty in controlling the symptoms of these severe mental illnesses, this choice does not mean the end of financial problems, and even tends to accentuate them when the stay goes on for a long time. To deal with Selvi, Jeyaraj had to stop working and Malavika was forced to leave school: that is to say, they underwent a form of de-socialization. During the first few months, Jeyaraj rented a lodge at Rs 3 per day, then, too impoverished even for that, he gave up the room and, like other poor families, stored his belongings near the place he and his family used to stay in all day. The situation has not been any better for Gopalan, even though his family had much more money. The sacrifices made in the interests of his recovery were considerable and his mother did not hide her fear of the defection of Gopalan's wife, wearied by this interminable situation: such cases are not rare. The absence of remission of the disorder, the difficulty in rationalizing the disease and communicating with the patient, the feelings of impotence at being unable to relieve him, and the energy spent in controlling his excessive violence and forcing him to perform the simplest action, add to the cumulative impoverishment; difficult living conditions are equally factors which force the relatives to return home, to go to another shrine, and sometimes to abandon the patient. Nevertheless, when the families lose hope of any recovery and decide to leave Puliyampatti, it is quite often after a long stay of three to four months, and sometimes more, that is, much longer than the time taken for psychiatric treatment in cases where relatives can stay with the patient.

A recent study conducted by psychiatrists in a temple concentrates on the response of patients diagnosed with paranoid schizophrenia, delusional disorders, and bipolar disorder to religious therapy (Raguram *et al.* 2002). The authors observed, over a research period of three months, that the health of a large majority of patients (twenty-five of thirty-one) was much better, and they see this improvement as due to the supportive environment of the shrine. According to my experience in the shrine of

Puliyampatti, I have rarely observed improvement in a severely mentally ill patient. As these illnesses are cyclic, the patients are sometimes calmer and more manageable, but the symptoms are never long in coming back. Moreover, I very often noticed that relatives tended to claim that the state of the patient was improving while no change was in fact visible. Their insistence on improvement seems to me to be a way of reassuring themselves about their choice of therapy which gives hope of a possible recovery, and perhaps an attempt to move the saint by expressing their trust and faith. The supportive environment of the shrine seems to me to be especially beneficial for the relatives of these patients by giving them greater capacity to cope with the situation, even though it does concomitantly have a good effect on the patients, thanks to the benevolence of the relatives. Moreover, the shrines are able to recreate social life and to enhance solidarity and help, and their religious function offers a way to find inner quietness through hours spent in meditation and prayer, or by sitting in the church, or making circumambulations. Obviously, for patients affected by stress, depression, or anxiety, the supportive and protective environment of the shrine plays a central role and contributes a lot towards the alleviation of their sufferings and psychic tension. This enhancement however does not always mean the end of their stay because they dread returning to the external world which so afflicted them.

An article by Padmavati *et al.* (2005) based on a study conducted in several dargāh at Kovalam, Nagore, and Erwadi, and in the Hindu temples of Sholingur and Hanumanthapuram, justifies the attendance at these places by both the shared conceptual model that associates mental illness with sorcery/evil spirit attack and by the basic help given, such as food and social support. It recognizes that a stay in this therapeutic system is much less expensive than psychiatric treatment and more convenient for relatives, and it credits their attendance to the explanatory models regarding choice of treatment, the nature of illness, the socio-economic profile of the patient, and the availability of the healer. The authors conclude with continuity and stability in socio-cultural explanations for abnormal behaviours, but they do not try to understand why patients abandon psychiatry when they have received treatment. Moreover, how are discourses on faith and trust in the power of god to be avoided when the study is made specifically in a religious therapeutic place? Nevertheless, they finish their article by suggesting that: 'The role of the religious healers and places of worship in the care and management of mental health issues needs to be clarified, understood and perhaps made a resource for provision of mental health care' (ibid.: 148). The last suggestion is the cue to turn to an interesting experiment that I observed in 2002 in the therapeutic shrine of Saint Michael at Rajavur (Kanniyakumari district) and that was fleetingly evoked in Selvi's story. This shrine is well known for lodging large numbers of patients affected by severe mental disorders, especially psychosis. Every three weeks, a psychiatrist comes and sees patients that a nun trained in mental health has selected. The nun is charged with giving free medication, collecting data on the history and social context of the illness, and teaching the family about the importance of the treatment and the nature of the illness. This introduction of medicines into the religious sphere, which results from the wish of the parishioners and the agreement of the priest, is readily accepted by relatives contributing to the treatment of patients and they do not hesitate to ask the help of the nun in case of difficulty in managing a patient. Thus, without creating any rupture with the familiar universe marked by social relations, solidarity and belief, the medical treatment provided by the shrine allows the families to observe the effects of chemotherapy on the violent, injurious and incoherent behaviour of the patients and, slowly, to accept the idea that the patients are really ill and need treatment. The nun is vigilant as to the duration of the stay which is as short as possible in order to avoid the de-socialization process. After their departure, the patients and families are requested to come back every month to collect the medication whose price is adjusted to the family's income. The integration of psychiatry into the religious sphere is certainly appropriate for enhancing the treatment of severe mental disorders. This kind of initiative had been proposed in Erwadi in the form of a hospital, but so far no building has been erected and no psychiatrist appointed. However, a recent article in *The Hindu* (Imranullah 2008) shows that the idea has not been abandoned. The Ramanathapuram principal district judge in charge of the Erwadi case, in his report, suggested the establishment of a rehabilitation centre 'on the lines of The Banyan', near the dargāh; the decision will be examined in February 2008. Such centres could be very useful in places such as Erwadi with a concentration of numerous, very severely disturbed patients, some of whom have been abandoned and subjected to abuse. Their success will, however, depend on their policy on the free

distribution of medication and to the openness of the staff with regard to understanding the conceptions of this kind of population, to interacting with the patients and their families, to associating relatives with the therapy and working with them in cases of marital maladjustment, pressure for dowry or for the birth of boys, and sexual abuse, as well as pressure regarding education, all of which psychiatrists now recognize as determinants in the emergence of severe disorders.

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