



A protective fortress

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A protective fortress: psychic disorders and therapy at the Catholic shrine of Puliampatti (South India)*

An opportune event

On 6 August 2001, a fire broke out taking twenty-eight lives in the *Pātuṣā maṇanalakkāppakam*, one of the seventeen mental homes that have been established around the *dargāh* in Ervadi (Ramanathapuram dt.).¹ Press photographs showing charred and chained bodies gave rise to indignation. The government of Tamil Nadu decided to introduce a number of measures to ensure that the Mental Health Act of 1987 would be respected. Following instructions from the District Collectors of Tamil Nadu, teams from the social welfare departments and the health service in each district were assigned to visit the shrines frequented by the “mentally ill persons” and to ensure that the new instructions were namely: 1- to close the mental homes or hostels managed by private individuals not having the necessary authorizations, 2- to remove the chains from the patients, 3- to present the patients suffering from a mental pathology before a magistrate in order that he undertake their admission to the psychiatric hospital in Kilpauk (Chennai), 4- to oblige the families of patients little or not at all affected by a mental disorder to come and fetch them, and to entrust persons abandoned or without families to various institutions.

Thus, on 17 August, the Catholic shrine at Puliampatti received the visit of the director of the department of social welfare of the district of Tuticorin, accompanied by her secretary and a police officer. In her report, she noted that the sixty-two patients counted were all accompanied by their relatives and they lodged in rooms rented out by the church, and that twenty-one persons had been freed from their chains. With the exception of three patients who

* This article results from a research carried out in 2001-2002. The period of fieldwork was made possible thanks to a scholarship granted by the French Institute of Pondicherry.

¹ These mental homes or hostels have multiplied in Ervadi in the last fifteen years. They were founded by former patients who see in the establishment of such facilities an easy way to earn money. These homes consist of a simple room or *pantal* erected with light materials on a piece of land rented to the *dargāh* committee, and the lodgings offer their guests very limited comfort: absence of hygiene, use of chains, bad food when it is distributed, no drinking water. For a study of the genesis of these mental hostels, see the article by Singaravelou (2002).

still resided in Puliampatti² at the time of my stay, those who had been chained have returned to their homes.

The new dispositions caused a decline in the attendance at the shrines frequented by persons affected by a mental pathology. However, because of the closing of the mental homes, the decline is clearly more pronounced in Ervadi than in Puliampatti. The removal of the chains had only minor repercussions because the people take recourse to another type of bond (rope or cloth) should they want to tie up a violent or runaway patient. While the attendance of the shrine in Puliampatti was little affected by the government measures, it has become less since the patronal festival in 2002³ as a result of the regulations put in place by the priest of the shrine. With the unconcealed intention of attracting a clientele of wealthier devotees⁴, the stay of the patients and relatives became more precarious. Patients unaccompanied by a relative were no longer authorized to sleep under the *maṇṭapam*⁵,

² Among the three patients, one showing psychotic symptoms was confined to a small room set apart, another mentally retarded person lived near the church and still has a ring around one ankle typical of the chaining and, finally, the third, diagnosed as schizophrenic by a psychiatrist, has never accepted that his chain, which he was accustomed to carrying on his shoulder, has been removed and since then lives in a small private house rented in the village with his wife and his mother, his brother and brother's wife and daughter.

³ The patronal festival in Puliampatti begins twelve days before the last day of the Tamil month *tai* (mid-January to mid-February). Based on the organization of Hindu festivals, as is the case for annual Catholic festivals, (for a detailed example of a patronal festival, see Sébastia 2002), the first day stands out by the flag-hoisting ceremony and a cart procession, the main day of the festival (Tuesday) is marked by a succession of masses and a cart procession, the lowering of the flag the day after the main day signifies the completion of the festive sequence.

⁴ Every Tuesday, the day of Saint Anthony, and every weekend, numerous more or less extended families, which can have as many as seventy members, come to fulfil their vow of thanksgiving or to place a child under the protection of the saint. Their programme for the day has two basic stages for the successful accomplishment of the vow. The first includes acts symbolizing rebirth and consists in shaving the head of the child to be protected and of the devotees who have made a vow, in purifying oneself in the shrine's tank of sacred water and in donning new clothes. The second concerns the distribution of *cari* prepared with a goat or a cock and ritually offered to Saint Anthony. Although the offering of food would be inherent to the worship of Saint Anthony (the bread of Saint Anthony), the preparation and distribution of meals in the place of worship (with or without animal sacrifice) is a very widespread devotional act in India in all religious communities.

⁵ The structure has an altar where the masses are attended by a large number of faithful (Tuesday midday and evening, Wednesday morning, masses of the patronal festival and the feast of 13 June

although this practice, commonly known by the name incubation⁶, assumes an important place in the healing process. The renting of lodges set up on the sacred space of the shrine was limited to thirteen days, a period beyond which the families should content themselves with a room located near the convent in an insalubrious quarter, without water or functioning toilets. Notwithstanding these difficulties, the patients and their families residing in Puliampatti for a longer period showed a firm intention not to leave by reorganizing their daily life according to the prescriptions stipulated by the clergy. Several of them rented small straw huts in the village to store their things and prepare meals, and the unaccompanied patients assembled to sleep in the sacred area of the Marian chapel.

The refusal of patients and their relatives to leave the shrine, despite the obstacles engendered by the new clerical rules, leads to questions concerning the singular position shrines are given in the therapeutic process, as well as concerning the interpretation of the disorders. The afflictions from which the individuals suffer are perceived as the results of sorcery (*ceyvinaṭi*) or as an attack by malevolent spirits (*pēy*) introduced through a sorcerer (*mantiravāṭi*, “one who recites *mantiram*”) or subsequent to a transgression (*tappu*). Possession by one or more *pēy* can be manifested by the patients’ physical or verbal expressions named *pēy āṭṭam* (dance of the *pēy*), which correspond to an “altered state of consciousness”, according to the expression commonly used by many psychologists and anthropologists (Bourguignon 1973, Crapanzano 1977, Lapassade 1990, Schoembucher 1993). However, when the patient is taken to the shrine, the proof of possession by the *pēy* or of sorcery is not established. To obtain this, the patients must submit to periods of exposure to the divine power, as well as to the violence of certain practices carried out by the accompanying relative(s). The relentlessness with which the relatives exercise their duties and the rapidity with which the patients favourably respond to them by manifesting “symptoms of possession” awakened my interest in the reasons for preferring the possession/sorcery

consecrated to Saint Anthony of Padua). During the day, it serves as living space for the pilgrims-visitors and for regulars, and at night it takes on the appearance of a shelter erected in a state of emergency: it is strewn with recumbent bodies, gathered closely together by kinship groups.

⁶ Incubation is a therapeutic technique that consists in sleeping with the head in the direction of a deity so that the latter would appear in dreams to heal the patient or give advice to achieve a cure. It is a very old practice widespread in most religions. The temples of Asclepius, the Greek god of medicine, are often cited in reference to the practice of incubatory dreams (Kakar 1996, Nassikas 1987, Weatherhead 1995). K. Nassikas states that it was known in Mesopotamia, in Egypt and above all in Greece, where it was practised in 300 to 400 *asklepiades*, therapeutic shrines to the god of medicine Asklepius, in which the patients stayed until they were healed.

aetiology over that of mental pathology. This study, which gives a major place to ethnographic data, will provide a few responses to this central question.

The shrine and its patients

Puliyampatti is a small hamlet in the village of Akkanayakkapatti in the taluk of Ottappitaram, located in the district of Tuticorin. The imposing church, inaugurated in 1959 following the extension of the small original chapel containing the miraculous statue of Saint Anthony of Padua, reflects the renown of the place. According to tradition, it is said that a *nāṭār* family, taking refuge in Puliyampatti subsequent to a caste dispute in its village, founded the small chapel in which to install Saint Anthony⁷. One of the *nāṭār* families⁸ from Puliyampatti, although there is no indication of its precedence, maintains that it descends from the founders of the shrine. The story of the founding of the shrine includes a miraculous healing, that of the founder's thirteenth child. However, the nature of the illness from which the child suffered is not made clear, so that tradition does not establish the categories of patients who visit this shrine. Nevertheless, a connection is found by considering the representation of Saint Anthony of Padua. While the latter is invoked above all in Europe to find lost objects, in India, and more precisely in Tamil Nadu, his fight against the demon conferred upon him his reputation as an exorcist. He shares this reputation with several other

⁷ According to tradition, the statue would have come from Sendapettai (near Sivalaperi), a wild area along the Tambraparni River where the vestiges of a Portuguese church dedicated to Saint Francis Xavier are found. This church, recently reinvested by the Christians in the area and patients from Puliyampatti, who organize prayer evenings there every Thursday, is once again opened to worship with a service celebrated by the priest from Puliyampatti on the last Thursday of each month. Like Tuesday (for Saint Anthony of Padua), Thursday is a specific day for exorcizing malevolent spirits. This choice confirms the exorcizing power attributed by Tamils to Saint Francis Xavier.

⁸ The inhabitants of Puliyampatti belong to two main castes: the *nāṭār* and the *paḷḷar*. Formerly, the *nāṭār* were untouchable agricultural workers specialized in the exploitation of coconut palms and *borassus* palms. The strong economic advancement and the protest activities they carried out at the turn of the last century served them in obtaining *śudra* status (Hardgrave 1969 and Templeman 1996). In Puliyampatti, they hold trade and live in the north of the village, where the shrine is located. The *paḷḷar* untouchables reside in the south of the village and work today on their own lands. They had previously exploited the lands of the *maṛavar* or *tēvar* until, following very violent communal conflicts in 1996, they forced *maṛavar* to leave the villages of the region.

saints, among whom are Saint Michael, Saint Anthony the Hermit, Saint Sebastian, Saint Francis-Xavier, Saint John de Britto⁹. Although these saints, with the exception of the Archangel Michael, are not represented in Puliampatti, a few patients allude to their ability to cooperate with Saint Anthony in the exorcism process. While these enumerations of saints call to mind that the conception of Indian Christianity is shaped by Hindu values, they also underscore the difficulty in fighting off the virulence and tenacity of malevolent spirits. The association of the saints in the therapeutic process is moreover a central fact in Puliampatti; it comprises the whole originality of the shrine.

The patients in Puliampatti are from the district of Tirunelveli or, in lesser numbers, from the district of Tuticorin to which the village is attached. From the religious point of view, they are essentially Hindus and Catholics, but a small minority of Protestants belonging to the CSI (Church of South India) are also to be found, along with a few rare Muslims. The strong presence of Hindus is not only to be explained by their toleration in venerating all divine images, whatever their denominational adherence, it is explained by the fact that, within a radius of 100 kilometres, the shrine of Puliampatti benefits from the best reputation as regards the treatment of psychic disorders. The patients belong to a variety of castes that are well represented in the region, divided between the *śūdra varṇa* (*maṇavar/tēvar*, *nāṭār*, *kōṇār*, *ācāri*, *paravar*) and the category of untouchables (*paṭṭar*). While the *śūdra* still behave very discriminatorily towards the untouchables, as the recent acts of violence that broke out in the region show (Manikumar 1997, Patil 1997), the segregation of patients based on the criterion of caste is not very pronounced because their social profiles are quite similar: schooling that rarely goes beyond fifth standard; a very low economic level. Some complain about the recurrence of discourse on caste, but it should be noted that this criterion interferes neither in the choice of frequentation, nor in the choice of co-residents, where caste difference entails transgressions and pollution (bathing, storage of ingredients and goods, cooking).

⁹ Examining the most venerated Catholic figures in the Tamil district of Ramanathapuram, Mosse (1986) shows that saints such as Saint Anthony of the Desert, Saint Sebastian or Saint James hold the major place, and martyrs such as John de Britto occupy the same position as the category of Hindu deities the author defines as minor because they do not belong to the Brahmanic pantheon. These deities have the function of protecting the village, dispensing well-being and prosperity to the devotees invoking them.

While the aetiologies given by the relatives and patients both refer to the malevolent spirits (*pēy*)¹⁰, to sorcery (*ceyvīnai*), or the two together if the spirits are sent by a sorcerer, the disorders of the patients brought to Puliampatti would be categorized by biomedicine as mental illnesses (psychotic syndromes, depressive, bipolar), as neurological disorders or, for a few dismissed from the hospitals because of incurability, as metabolic or infectious diseases. The supernatural causes of the troubles are confirmed by the succession of family problems of all kinds and the absence of improvement in health after a more or less long therapeutic process. Faced with a failure of medicine, especially biomedicine, on the advice of a close relative or friend or by way of personal knowledge, they turn their hopes towards a priest or a medium specialized in the detection of an evil spell or possession, or towards a shrine reputed for the exorcist powers of its deity or saint. This choice of a therapy by the religious, that is, by a process calling upon a divine force, corresponds to the logic of the supernatural origin attributed to the symptoms.

In a general way, one or several relatives accompany the patient and contribute towards the expenses occasioned by his stay. The unmarried patient is accompanied by the parents, and if married, by the spouse, the mother or both. Nevertheless, it is observed that men are less often present with their ailing wives who, consequently, benefit more from the presence of their mothers. This difference is easily explained by the work which some men are compelled to do. The brothers of the patient can play a very active role in taking charge of the expenses of the therapy and their efforts are often very significant. On the one hand, there is a fear that the entire extended family will be contaminated given that mental illness is perceived as being contagious and, on the other hand, the family order that has been weakened by this crisis must at all costs be re-established. To achieve this goal, many brothers do not hesitate to sell part or all of their property. The financial contribution towards the care

¹⁰ The patients use the term *pēy* to denote categories of supernatural beings that can either be spirits of ancestors (*āvi*) not reincarnated subsequent to a violent death (suicide, accident) or deities of an ambivalent character. It is rare that the patients say they are possessed by a single spirit. They often cite a series of names of deities, a number of whom are specific to the region. A characteristic of the Tirunelveli region is the very numerous *pēy kōvil*, which correspond to what M.L. Reiniche (1979) named '*temples de démons divinisés*' (temples of deified demons). While the erection of these temples is seen from the perspective of propitiation of the *pēy*, the latter can reveal themselves to be virulent and possess bodies of persons who roam around their temples at ill-fated times. This region also has a certain number of deities bearing specific names that are divided between goddesses with ambivalent temperament such as *Icakki* and *Peṭciyammal*, and gods such as *Cuṭalai Māṭan* or *Cāstā*, which possess an ambiguous status (Reiniche *ibid.*, Blackburn 1988).

of a woman is more limited and it is motivated more by sentiments of affection that link brothers and sisters than by family obligations. This difference in investment is explained by the patrilineal rules inherent in the Aryan model (North India), which now predominate over the matrilineal system of Dravidian kinship (South India)¹¹. Because of this, the situation of the affected women is more precarious than that of the men and varies according to their family position: unmarried women, widows or women abandoned by their husband are taken in charge by their relatives, most often the mother, while those who are married are accompanied by their mother, sometimes by their husband and often by one or more of their children. It occurs that a few are accompanied by their mother-in-law or a sister-in-law (husband's sister or wife of the husband's brother), but this is rare because, as a result of tensions underlying their relationship, relatives by marriage are considered to be unable to take care of the patient or, above all, to show her affection (*pacam*, *anpu*), a necessary sentiment for promoting the cure. When the husband and the children accompany the patient, this implies that the former forgoes work and thus income, and that the latter temporarily, or in some cases permanently, interrupt their schooling.

Finally, the last category of patients consists of those who are unaccompanied. Their number is quite large, around forty, although none of them were counted during the two visits by the social welfare department. Besides elderly persons, above all abandoned widows, there are a good number of young unmarried persons of both sexes who have settled at the shrine for one or more years. While at the beginning of their stay in Puliampatti, every youth was accompanied by a relative, the slowness of the healing and family obligations have forced the relatives to depart. Most return from time to time to bring a few things, a little money; others, which is very rare, are unmindful and leave the patient to provide for his own needs. Despite their isolation from the family and the difficulties caused by the clergy who attempt to make them depart, none of them has thought of leaving the shrine. Where could they go, having attempted many times to return to normal social life without having succeeded in being rehabilitated? Similar to Michael, a young unmarried man suffering from depression, some show an unconcealed reticence to return to their family household, where conflicts, pressures and financial problems constitute daily life:

¹¹ For a study on the interactions in the Tamil region of the two Aryan/Dravidian socio-religious models existing in India, see the study by K. Kapadia (1995). She analyses, among other things, the differences in the relations between two brothers or two sisters and between a brother and a sister.

In Puliampatti, Michael says, I feel secure. Under the protection of Saint Anthony, I know that nothing can happen to me. Every time I have left to go see my family, I have had health problems. Respiratory problems (mūccu), certainly asthma. I could no longer breathe. And every time, it took several days for Anthony to give me back my health¹².

For Michael, as for the others, Puliampatti is not only a place of healing. It is a fortress offering protection from the outside world and where it is possible for the patients and their families to communicate without fear of being judged or rejected. These people form a ‘contemporary communitas’, according to the term of V. Turner, cited by I. Nabakov (2000), a small society bound together by a common denominator, their affliction, irrespective of its severity, and subjected to incessant reconstruction contingent upon arrivals and departures, the frequent moves calling for new cohabitation and the ability of some to organize prayer meetings or develop communication among themselves. This community also authors and transmits the unique curative system in Puliampatti. Through the specificity of practices at clearly defined places, the shrine appears as a medical centre in which Saint Michael would direct the “casualty department”, Saint Anthony from the top of the *koṭimaram* would administer the “diagnostic centre”, while with the help of the Virgin at the *Mātā kōvil* (independent chapel), he would work in the “medical care unit”. This therapeutic organization completely evades the priest’s control, but does not elude the activities proposed by the clergy. The offices are heavily attended, and certain liturgical phases, such as the worship of the Holy Sacrament, are very popular because of their capacity to cause a reaction in the malevolent spirits. The therapeutic organization makes up for the institutional vacuum as regards exorcism or the willingness to listen, and it creates new meeting places.

¹² Michael had lived at the shrine for four years. His biography shows a conflict with his father, a violent alcoholic incapable of earning a living for his family. He had to start working very young to help his mother raise his brothers and sisters. Then, following repeated conflicts with those around him, he began to develop a series of depressive symptoms: rashes, respiratory difficulty, cranial pressure, insomnia, anorexia, nocturnal emissions (“culture-bound syndrome” associated by psychiatrists with depression, G. Singh 1985, B.P. Behere 1984, A. Sumathipala et al. 2004; a few patients interpret seminal emissions as ensuing of the possession by the goddess *Mōhinī*, J. Racine 1999). He has been working for one and one half years in the market of Palaiyamkottai, but he continues each weekend to go to Puliampatti.

A shrine organized like a medical care centre

The arrival of a new patient at the shrine can be spectacular if his behaviour is very disturbed. In such cases, the regulars come to the assistance of the relatives and inform them as to where they should transport the patient. The indicated place is not fortuitous, for it is the space behind the church that is under the control of the Archangel Michael. Seated high on the sacristy, he has the power to act immediately on malevolent spirits, neutralizing their harmful effects. Thus, throughout the day and sometimes night, this space is occupied by a few patients, tied up, gesticulating, weeping, singing, speaking incoherently, by a few who are possessed and violently cavorting about or imploring the help of Saint Michael, and sometimes by a dying person who is urgently brought.

However, although the action by Saint Michael is rapid, it is ephemeral and one must turn to Saint Anthony who, gradually, will annihilate the power of the sorcery or will dislodge one by one the malevolent spirits.

In order for Saint Anthony to vanquish the evil spirits, two actions carried out in two different places are necessary. The first consists in forcing the spirits to manifest themselves, then to give their name. Thus, every evening after the mass or the rosary recitation, patients and caregivers assemble in the area of the *kōṭimaram*¹³. The patients take place facing the pole and, their eyes filled with holy oil, they raise them upwards so that the power (*cakti*) of Saint Anthony concentrated at that point can cause the evil power (*tīya cakti*) of the spirits to react. If, after several sessions, the body of the patient shows no sign of possession (*āṭṭam*) or he has made no utterance concerning the nature of the disorder, the caregivers inflict different forms of ill-treatment on the patient in using of sacred items. They can be seen, sometimes assisted by a relative or a simple devotee, pulling back the head of their patient and forcing him to fix his attention on the top of the *kōṭimaram*, applying melted wax from candles on his tongue, on his forehead and arms¹⁴, striking him with a Bible. This violence is not intended for the

¹³ The *kōṭimaram* or “tree of the banner” is a pole facing the main deity of the Hindu shrine on which a flag is hoisted at the time of the annual festival representing the protective power of the deity in its external form. Tamil Catholic shrines are generally endowed with a *kōṭimaram*, which is the object of variable worship. For the symbolism of the *kōṭimaram*: in Hinduism, M.L. Reiniche 1979 and in Catholicism, B. Sébastia 2002.

¹⁴ The burning of different parts of the body with hot wax, which, let us point out, is practised with camphor in Hindu exorcisms, took place during my stay in Puliampatti. A mother used this technique

patient but for the malevolent spirits. Tolerating neither pain nor contact with holy objects, they react violently and make the body of the person they possess dance (*āṭṭam*) by obliging him to circle with his head over a fire of candles or to frantically circumambulate around the *kōṭimaram* to the point of exhaustion. After the first signs of possession, the patient renews his experience every evening until the spirits agree to state their identity and finally depart. From time to time, exorcisms are practised by a relative or visitor. They are concealed from the priest of the shrine who considers these practices as superstition and does not accept the competing power of those who perform them. In addition to holy items (oil, candles, water), these exorcists use the Bible and a cross, which, by virtue of their highly sacred character, cause the evil spirits to react immediately.

However, in order to compel the *pēy* to leave, they must first be harshly mistreated. It is the role of the second action. This takes place at the *Mātā kōvil*¹⁵. Once again, caregivers attend the therapy and oblige the patient to unremittingly circle around the small shrine until he shows signs of possession. The times of densest and most violent activities are the evenings, when the possessed are very agitated following exposure at the *kōṭimaram*, and afternoons, under the effect of the prayer meetings interspersed with chanting and clapping organized by a small group of patients, joined by relatives and visitors. Using repetitive sounds and rhythms with known psychotherapeutic action, these meetings strongly support the state of possession that here assumes a very violent form. Advantage is taken of the architectural elements, such as the space between the wall and the chapel, the parvis, the iron gates or the bars of the small window, for rolling or doing somersaults or for beating the body. This battlefield spectacle is not only engendered by the presence of the Virgin, the virulence of the *pēy* is such that, to neutralize it, the power of Saint Anthony must unite with hers.

After having been vanquished, a *pēy* expresses the desire to free itself from a body that, for it, has become a place of torture. Under pressure from a relative-cum-exorcist, or alone in a corner, at the *Mātā kōvil* or, exceptionally, in the church, the patient grasps a lock of hair at the crown of his head and fights a long and hard battle against it. Then, he pulls it

on her daughter – diagnosed as psychotic – who was impervious to manifesting the signs of possession.

¹⁵ This small shrine, called *kēpi* (cave), contains a statue of Christ on the cross, at whose feet are Mary Magdalene and Saint John. Even though the Virgin is not present, this chapel bears the name *Mātā kōvil* (temple to the Virgin) and devotees go there to worship Her. This shift is understood in view of the very particular devotion shown by Indians to the Virgin (Deliège 1988, Mosse 1986, Ram 1991, Sébastia 2002).

sharply, before falling exhausted to the ground. This ritualized departure is evidence that the patient was indeed possessed and that the powers of Saint Anthony and the Virgin were effective. Nevertheless, although the relatives may rely on an improvement in the patient's condition, they show no surprise when the symptoms persist because, they say, the malevolent spirits rarely attack alone. This leads us to consider the different reasons supporting the choice of the religious therapy, it being given that, on the one hand, the length of the stay is often very long and, on the other hand, according to the pathologies, its effectiveness is not always established.

The choice of a religious therapy

As I briefly noted, it is the biomedical failure that is expressed by the supernatural cause attributed to the behavioural disorders and that sanctions the choice of a religious therapy. This is confirmed by the therapeutic journey comprised of extensive visits to doctors and stays in hospitals.

Following initial reactions to the fire in Ervadi in the local newspapers (*The Hindu*, *Tinatandi*, *Indian Express* 2001) denouncing the unscrupulous behaviour of the owners of the mental homes and the credulous and obscurantist behaviour of the relatives who obliged their patient to undergo this type of therapy, a few articles taking stock of the situation of contemporary psychiatry appeared in magazines (Krishnakumar 2001a and b, Ramasubramanian 2001, Wadhwa 2001). The view of the authors was that the persistence of such beliefs results from the mediocrity of psychiatric care. The shortage of specialists, of specialized hospitals and of beds reserved in general hospitals¹⁶ as well as the social and cultural distance between this medicine imported and practised by specialists educated *à l'occidental*, or in Western countries, and the populations for which it is intended, are factors that explain the indifference and the lack of trust one has in it.

¹⁶ According to these authors, the number of psychiatrists, as the number of beds reserved for psychiatry, would cover only 10% of the real needs. If the growth of mental health departments is considered, it is seen that few psychiatric hospitals were created since independence (Murthy 2000, Addlakha 1998). Excerpts from the National Human Rights Commission 2000 report given in the article by R.S. Murthy are very critical of the state of psychiatry in India. Bad treatment inflicted on patients, absence of hygiene and comfort and deficiency in care and in specialized personnel are the main problems noted in most of the hospitals.

Observation of psychiatric consultations at the High Ground Hospital in Palayamkottai, the government health care unit mentioned by most of the patients in Puliampatti because it is the closest to where they live, amply corroborates the criticism made of the Indian psychiatric system. Consultations come down to distributing pre-established prescriptions according to the symptoms described in a brief questioning that is conducted in public and without concern for discretion, and to filling in a consultation record of the patient in which only the date and the pharmacotherapy are noted. Hospitalization hardly offers better attention. The stay consists only in orally or intramuscularly administered drugs and in electroconvulsive therapy, which is still very current in India, irrespective of the symptomatology. The poor quality of the interviews does not make it possible to gain the trust of the patients or to establish a good diagnosis, two criteria that are indispensable for providing effective treatment.

To the problem of inadequate treatment is added the difficulty in treating mental pathologies that often require a long pharmacotherapy. The limits of biomedical treatment thus only serve to reinforce the belief in evil spirits and sorcery. This is, moreover, corroborated by another factor, which is economic. This having been said, one of the two criteria common to all the patients in Puliampatti is their economic poverty, which is extreme in some cases. This is not always an inherited condition, but is often the result of the illness. Before coming to Puliampatti, the patients have often consulted several doctors (most often biomedical) and *mantiravāṭi*, they have stayed for longer or shorter periods in hospitals or clinics, or more rarely at other shrines. This therapeutic journey has incurred, according to the resources of each, costs for hospitalization and pharmacological treatments, fees for the doctor or the *mantiravāṭi*, eventually dispossessing them. It is after having been ruined and sometimes highly indebted that they turn to a religious centre such as Puliampatti. At this shrine, other than the cost for renting lodges from the church or small private houses, which is low, the families can feed themselves at little cost thanks to the food offerings (*acaṇam*) distributed on Tuesdays, Saturdays and Sundays by pilgrims who come to thank the saint for a boon they have obtained¹⁷.

¹⁷ Not all the patients, even the poorest, accept the *acaṇam*. The reasons they give are that the food is too spicy (*rompa karam*), too hot (*rompa cūṭu*), dirty, impure (*acuttam*), or too oily (*rompa eṇṇayōṭu*). The *acaṇam* consists of a *cari* prepared with a goat or a cock offered to Saint Anthony. According to the classification used in Indian medicines – in the Tamil context: *citta* medicine –, meat products have heating properties that are all the more pronounced as the cooking of them requires a greater quantity of spices than employed in the preparation of vegetarian dishes. Given that mental disorders are

However, although the stay at a therapeutic shrine is less costly than a medical or hospital therapy, it also contributes to the impoverishment and desocialization of some families. These secondary effects are at the centre of the difficulty in accepting the sick persons, as it is known how long one will have to look after them and how devastating this will be for their family circle. In the case of therapeutic failure after a few weeks or after a period corresponding to a symbolic number of days – 13, the number of Saint Anthony; 48, Hindu fasting period corresponding to a *maṅkalam* -, some families decide to leave the shrine and others, out of faith (*nampikkai*) or distress, prolong their stay. Their destitution can become such that a departure from Puliampatti can no longer be envisioned. A few widows, ruined by the illness of their child whom they have never abandoned, ignored by their family and their married children, are in this situation. Their survival is only due to the modest donations of pilgrims or to the generosity of a villager who allocates them a corner in a room of his house.

Victim of a spell or of a spirit: a more acceptable affliction

To consider a supernatural entity as responsible of the troubles is also a way of denying that the family member is *payttiakkārar* (insane), or of making the ‘mental illness’ (*maṇam nōy*) acceptable. The connotation of the latter is such that it can lead to the repudiation of the family. Discriminated against in this way, the family will have great difficulties in finding alliances for the marriage of their children. During my stay, none of the patients who had known of the marriage of a brother or sister had attended the ceremony. Affected by a behavioural disorder, they are unwanted and their very presence would risk getting in the way of the smooth performance of the festivities that require so many precautions.

The problem is even more serious when the patient is a woman. Her status as wife is made precarious because ‘mental illness’ is a valid reason for divorce or desertion (Dhanda 2000). For a young unmarried woman, the marriage perspectives become problematical. The marriage of daughters will be equally uncertain because of the risk of contagion attributed to ‘mental illness’. This representation ensues of the confusion between heredity and the

considered to arise following the heating of the body provoked by the intrusion of malevolent spirits, this food is inappropriate and can even aggravate the illness.

appearance of symptoms, accentuated by an oppressive social context, which is repeated inexorably from generation to generation.

To think that this illness is due to an exogenous agent, sorcery or spirit, lends hope for a possible cure, whereas, if it has a ‘physical’ origin, it is incurable (*tīrātā nōy*). The relatives refuse the ‘endogenous’ origin, basing themselves, on the one hand, on the reports of doctors indicating no “physical” abnormality and, on the other hand, on a personal conflict or a biographic episode viewed as the source of the evil, the confirmation of a spell or of possession by malevolent spirits. As proof, they give a series of problems that began a short time before the appearance of troubles. The loss of work, economic poverty, bad financial affairs, a succession of illnesses and more or less accidental and inexplicable deaths, family break-ups, the absence of descendents, conflicts in the family circle, the consumption of illicit substances, licentious behaviour – these are all elements indicating an act of sorcery, the presumed motive of which is jealousy or vengeance. The reasons for vengeance refer in general to a transgression, very often disrespect of marriage rules. The story of Petchiammal illustrates both dramatically and clearly the consequences incurred by such a transgression.

A widow of thirteen years and mother of five daughters and four sons, Petchiammal lives in Puliampatti thanks to the generosity of pilgrims and a few advantages (free lodging, remuneration for small cleaning jobs) obtained through the intervention of a priest who was moved by her story. She lives today with her youngest son, whose weak physical and mental constitution prevent him from working in any permanent manner and, during school holidays, with her youngest daughter, a victim of polio who is educated in a school for the handicapped, thanks to the financial support of the priest. Every evening, Petchiammal ‘dances’ under the influence of several spirits who, without respite, induce her to frantically cavort (*palṭi*) and she is not the only one in the family to be possessed, three of her sons are also. One of her daughter showed signs of possession a short time after the death of her baby when, because she had not become pregnant again, her husband took a second and then a third wife. Petchiammal’s son in Tuticorin suffers from stomach troubles and constantly falls ill. Finally, an other daughter is constrained to live under the yoke of her husband’s first wife, who, out of vengeance for not having been able to provide descendents, prevents her from feeding her four children. She comes more and more often to Puliampatti, since the violence and frequency of the manifestations of possession have increased.

It was my older brother who cast this spell (ceyvinai). I have several brothers, two of whom are kōṭanki (sorcerer) and live in Kerala, where they learned magic (cūṇiyam). One day, Icakki Thevar, my oldest brother, called us. He asked for our

oldest daughter to marry his son. We accepted and she now lives in Kerala; she is fine. A few years later, Icakki Thevar telephoned for my second daughter. But because she was already betrothed, along with my husband we refused. This made him very angry. A short time later, when I returned from shopping, I found my husband collapsed on the ground. The doctor said it was a heart attack. I still had two sons and four daughters with me.

A little after the death of my husband, my second brother in Kerala, Karuppusamy Thevar, came to see me. He asked me for the third of my daughters. I tried to explain to him that she was still too young; she was only 15 years old. He didn't want to listen. This time I was frightened. I told myself that if I were to refuse, he would do a foul job (tolil ceytal, implicitly, to cast an evil spell), he is a kōṭāṅki. I accepted. I sold two other houses to pay the dowry he demanded of me.

I did not immediately understand that we were already victims of a curse, an evil spell Icakki Thevar cast on us when we refused to give him our second daughter. My daughters who are in Kerala (the oldest and the third) have no problems, whereas the rest of the persons who were at the house when Icakki Thevar cast the evil spell on us have all had problems: my husband, my three daughters (the second and the two youngest), Kannan, my son in Tuticorin and myself. To marry off one girl is a good thing, but if you have to marry two or three, that means that you must do bad deeds (pāvam) and be guilty of betrayals (tudōkam).

At no time during numerous conversations did Petchiammal suggest that the harshness of the social context in which she and her daughters were obliged to live could have an influence on the appearance and intensity of the manifestations of possession. The rationalization of misfortune by sorcery makes the latter more acceptable, more liveable. It also authorizes the removal of guilt because, if one admits to having committed a transgression, the action of the spell is presented as disproportionate compared to the misdeed committed. On the other hand, in a context such as in India, where marriages are dependent on parental choice, to discredit the exogenous cause would be tantamount to admitting to responsibility in the choice of alliances and an inability to develop the familial situation in which one has forced ones children to live.

Sorcery is not alone responsible for possession. Malevolent spirits, like ambivalent deities, can be its cause, often following a transgression. But in distinction to sorcery, the affliction is more exclusive and tends to only affect the person who did wrong. Aetiological accounts tell of a spontaneous attack, at the fall of night, after having passed near a tree or a place frequented by evil spirits or a place that stands out, such as a tank, a well or a tree that

would have been the scene of a suicide¹⁸. Let us take, for example, Ponnumani, a woman of 35 years, accompanied by her husband, who is also ill, and a small boy of 5 years, who spends his days holding out his hand to visitors or pinching a bit of food from the stalls of cheap restaurants.

This is the third time that I come to Puliampatti. I came the first time six years ago. I was not well and had pain in the stomach and head. It was a ceyvinai that my sister's father-in-law sent us, me and my husband. My parents did not want me marry his second son, so he took revenge. We understood because my husband, who worked in a bakery for two years, abandoned his work as soon as we got married. He said that he had bad stomach pain and that his weakness, lack of sleep and the little food he ate prevented him from working. A mantiravāti told us that he had a cāttān kōlāru (disturbance or disorder caused by Satan). That could only be my sister's father-in-law because he is a Christian, while we were Hindus. Since my husband was no longer earning money, I did kuli work. And, I began to have the same problems that he had. Like that I came to Puliampatti and stayed six months. I returned home, but a short time later I began to feel unwell again, and came back here. Five months later, all my problems had ended, but because I was afraid to fall ill again, I promised Saint Anthony that I would be baptized. I spoke about this with my neighbours, who were Christians, and they arranged everything. They took me to the kōvil and the cāmi baptized me. It was not long and I understood that I had made a mistake. My neighbours, to whom I expressed my surprise at not seeing a statue of Saint Anthony or of the Virgin in the church, told me that it was the Roman Catholics who worshipped all those statues, they, the Pentecostals, believed only in the power of the Lord (āṇṭavar). Now, I would like to be baptized in Puliampatti, because of that I fell ill again. This time we knew that it was not because of the ceyvinai, because I began to dance (āṭṭam) at the koṭimaram and two picācu spirits spoke: Icakki and Mamuni. Mamuni was my uncle's wife. She was very unhappy because her mother-in-law made her work hard and always looked for a reason to quarrel with her. One day, exasperated by her mother-in-law's tyranny and the indifference of her husband towards her suffering, she fled the house. They found her collapsed near Māriyamman at the family pēy kōvil. She had swallowed poison. One evening when I was feeling sad, I went to that place, secretly. But, on the way back I began to feel very badly and

¹⁸ For the rhetorical form of harmful possession, see the first part of an article by G. Tarabout (1999). While recognizing their inventiveness and personalization, the author draws up a typology of elements structuring the outline of these accounts.

had sharp pains in the stomach (tiruku, paraṇṭutal, vernacular terms for scratch, contraction), *pressure in the head* (maṇṭaiyil aḷuttam) and *felt sad* (tukkam). Ennai pēy piṭiccitū, 'the spirit had got hold of me'.

In her account, Ponnumani mentions three transgressions¹⁹ that would give rise, on the one hand, to sorcery directed against her and her husband and, on the other hand, to an invasion by malevolent spirits, of which she is the sole victim. It is noted that the symptomatic manifestations of the two forms of 'possession' do not differ: stomach pain, headache, weakness, loss of appetite and of sleep or interest in life. These are the autobiographic elements chosen as reflecting the category *ceyvinai kōlāru* or *pēy kōlāru* allowing the patient and his family a basis for their aetiology. In a place like Puliampatti where the patients and their families belong to relatively low social and economic strata and, consequently, are subject to afflictions of all kinds (malnutrition, poverty, bad marriage, discrimination), the reference to sorcery is the model that predominates over the thesis of possession by a malevolent spirit having nothing to do with magic. In fact, acts of sorcery are considered to be clearly more dangerous and the patients give an account of their virulence by a more or less long enumeration of the spirits possessing them. Nevertheless, whatever the origin of the possession, in order to master it, it must be made visible and the relatives do not hesitate to employ cruel procedures to hasten its appearance. While some patients react by weeping and imploring them to stop, there are many who, after a few days, acquiesce to their will by showing signs of possession. The reasons that support this agreement should be understood.

To be possessed, a new social identity

In general way, anthropologists define the *pēy kōlāru* type of possession as 'spontaneous', as opposed to 'institutional' possession. This type is opposed to the second in that it is uncontrolled, unwanted, occasioned by spirits with strictly destructive temperaments and involves the use of peripheral cults. This opposition, however, must be relativized

¹⁹ The first transgression to provoke the vexed father-in-law's vengeance is not really one, because his marriage demand is not included in the marriage rules. Nevertheless, the permissiveness to wed between *maccān* (affines) in Dravidian kinship, as well as the delicate relations between them, are sufficiently relevant to accuse the sister's father-in-law.

because, while spontaneity can be employed to qualify the gestures and rhetoric specific to the *pēy kōlāru*, the very first manifestations are rarely expressed without duress. It is in the framework of exorcism that the possessions are observed, that is, in the course of ritual sequences, the clearly determined modalities of which contradict any idea of spontaneity.

In an article entitled ‘Gods, Ghosts and Demons: Possession in South Asia’, E. Schoembucher (1993) focused on the main interpretations of the phenomenon of possession as advanced by researchers. She identified the interpretative models as found in psychology (medical and psychoanalytical), sociology and cosmology, as well as a fourth model, which she terms ‘performative’, in reference to the theatricality involved in possession. The author concurs in her point of view with P. Clauss (1979) in deploring the fact that the psychological approach would often be simplistic and tended to disregard the complexity of the phenomenon. In fact, a number of anthropologists influenced by psychoanalysis are inclined to link the manifestation of possession to familial, marital and sexual difficulties. This is the case with S. Kakar (1996) and G. Obeyesekere (1970), the latter of whom goes further to assert that possession constitutes a defence against personality disorders or a psychosis that can emerge when the experience is too traumatic. He underscores the fact that the manifestation of possession functions in the manner of a “public symbol”, a means through which to communicate the causes of the affliction to one’s circle. This is also the view of A.R. Freed and R.S. Freed (1967), who consider that possession works like a message to be deciphered by close relations. A. R. Freed and R. S. Freed, G. Obeyesekere and S. Kakar also share the idea that individuals having ‘hysterical personalities’ are predisposed to crises of possession. The use of this morbid category is, to say the least, problematical because, in the case of those who are possessed, the persons adopt postures, facial expressions and gestures that are identifiable as signs of possession, that is, decipherable by the people around them – the ‘public symbols’ of G. Obeyesekere -, while in the case of hysterics, it is the ‘illness’ that compels them to such conduct. Moreover, it should be noted that all the definitions put forward for hysteria agree that the morbid crises are accompanied by a loss of consciousness and memory (Edelman 2003, Freud 1973, Harrus-Revidi 1997, Thuillier 1996). It is true that those who are possessed assert that they were not conscious of their possessed state and remember nothing. Nevertheless, numerous facts observed would suggest that this loss of consciousness corresponds more to the stereotype of possession than to an established state. Generalization would certainly be imprudent, but the reactions in front of the camera (intensified gestures or refusal to be filmed), the concern to re-cover body parts uncovered during the contortions, the extreme infrequency of collisions between possessed of different

sexes, allow one to suppose a state of full consciousness. It should nevertheless be recognized that the rotations of body and head or other corporeal postures leading to a sensation of dizziness can give the impression of a loss of orientation. Thus, feigning unconsciousness frees one from responsibility for the excessive or unseemly conduct adopted during the period of possession. This conduct is ascribed to the possessing entities, which are well known for their departure from social rules.

E. Schoembucher considers that the cosmological and ‘performative’ interpretative schemata are in many respects more effective than medical and sociological theses or, at least, they can complement them. While some cosmological aspects can be observed, such as the affinity between the souls of those who died a cruel death and the person possessed, the majority of patients encountered in Puliampatti generally make no distinction among malevolent spirits (*pēy*). They are all in their eyes pernicious (*pollāta*) and fearsome (*payaṅkaram*). This absence of a hierarchical structure of the malevolent entities is also underscored by L. Caplan (1985). The ‘performative’ interpretation, that is, aspects of dramatization or the staging of the affliction, on the other hand, seems to me more interesting because, for part of the patients, it explains the recurrence of manifestations of possession and the length of the stays. As was shown when describing the therapeutic and exorcist process set up by the caregivers of the possessed person, possession needs a public to exist, as well as a space, a time and a preparation.

The manifestation of possession uses a number of more or less stereotypic bodily techniques. Swaying and the rotation of the body in front of the saint, staggering, continual circumambulations, the rhythm of clapping hands or chants at the *Mātā kōvil* – for lack of drums and exorcists -, are the only means used to encourage giddiness. This condition stands out through a series of bodily and verbal expressions that, when practised by women, break with the reserved and dutiful conduct imposed on them by culture. The therapeutic shrines such as that in Puliampatti are in fact characterized by an over-representation of young girls and women. That is not the consequence either of a greater religiosity, which is commonly ascribed to them, or of a greater vulnerability to mental pathologies. It is explained by the disorders with which women are affected, which are of a neurotic and depressive nature, provoked by traumatizing situations that have arisen in married, family or social life.

The stories of women and young wives who were repudiated or maltreated are common currency and the bases of the abandonment or ill-treatment are as varied as they are

licentious²⁰. Thus, Jodhi, native of Puliyamkudi, was married at seventeen years of age to a man from Kerala, who beat her violently when he had drunk. Her parents, alerted by a neighbour, took her to their home, where a second trauma awaited her: her sister, suffering from tuberculosis died in her arms when no one else was in the house. Feeling guilty about her sudden death, she spends her afternoons and evenings giving herself blows on head and back at the *Mātā kōvil*. Sarasvati, twenty-two years old, was married at the age of fifteen to her maternal uncle (*tāy māmāṇ*), who was fifteen years older than she. Ten days after their marriage, he repudiated her because, his explanation, she refused to go near him. However, a few days later Sarasvati's parents discovered that he had taken in a new woman. Mansi had had a similar experience, but in order to get rid of her a few days after the marriage, her husband declared that she was insane, a way by which to quickly obtain a divorce, and lived a great romance with his concubine, first marriage with whom caste difference did not allow. Mansi, insane, enters every day deeper into a world populated by persons whom only she can identify. After her first year of marriage, Ramalakshmi's mother-in-law decided her son should marry a second woman. Not because the couple was sterile, for it was too early to assert this. The reason she understood later when she learned that her husband had also repudiated his second wife, who had just given birth to a boy, and taken a third wife. Her mother-in-law had found a good way, through the multiplication of dowries²¹, to easily acquire money. Mary's parents were too poor to provide her with a dowry. They therefore accepted the offer of a friend of the family, which consisted in taking her as third wife for his son, who had married two sisters. Faced with her extremely weak condition and malnutrition caused by the ill-treatment and privations perpetrated by the two women, the parents preferred to take her back.

However, the separation from the husband does not point to a better future for these women who were victims of serious traumas, for they have little chance of re-marrying and

²⁰ The literature devoted to this theme is so vast that it is difficult to give only a few references to works considering the different forms of cruelty exercised on women in India. Among the most recent titles, we can mention the books by P.K. Mishra (2000) and K. Roy (1999), which are concerned with intra-familial violence and with problems inherent in dowry, then by R. Ahuja (1998), who considers all forms of violence with which Indian women are confronted.

²¹ The reasons motivating the second and third marriages, normally contracted in the absence of a child, or if the man is a widower, or, according to caste, if the woman a widow, can be seen as veritable strategies to procure money by multiplying dowries. Although secondary marriages are sealed with a simple verbal agreement between the two families and sometimes with a short ceremony, the payment of a dowry, certainly lower than for a first marriage, is nevertheless required.

leading a normal life. They are stigmatized in their own family because a woman who abandons her husband loses all legitimacy and sullies the reputation of her native family. Also stigmatized are those who have not fulfilled their role as a wife by offering a child, more precisely a boy, to her husband's lineage, those who were victims of sexual aggression and, finally, those women who sank into depression (post-partum depression) owing to malnutrition and the frequency of pregnancies.

All of these women, alienated from social identity, find in the expression of possession a means to exist. Even if their behaviour when possessed is watched over – the family takes care to cover the parts of the body that are bared by gesticulations – and self-censored – no interaction will be seen between men and women, little physical contact between patients –, the discrepancy they manifest in comparison to normality shows that the expression of possession is a way to experience freedom and innovation. Watched by 'spectators', the patients take the stage. Depending on the intensity of their stress, they appear impressive in the rapidity of their movements or in the duration of their representation, aggressive in their visual expressions or in their words, competitive with others who are possessed by playing on the intensity of cries, the violence of gesticulations that oblige the others to step back, the aggressiveness of speech, the creation of new gestures. This dramatization by possession is a means of being seen and of receiving consideration, because while their possession is the work of a malevolent spirit, it provokes in the people around fear and forces respect. In this society where emotions should be concealed, whence an acute somatization (stomach pain, intestinal tract troubles, pressure in the head or in the throat, to cite the most often mentioned), the manifestation of possession is an outlet, a psychotherapy that makes it possible to channel and reduce the insurmountable tensions. This experience, presented in an atmosphere of pain, is offered as a curious spectacle in which the actor's movements exalt violence and suffering, but also pleasure, enjoyment and sensuality. All these sensations, suppressed in ordinary life, but tolerated and even greatly solicited in this particular context, induce in some women an increasingly pronounced need to experience these very intense moments. This factor also explains the willingness not to return to ordinary life. That is why the patients who have been declared "healed" by their relatives – a declaration often with underlying necessity for the relatives to return to their homes – return to spend Tuesdays at the shrine. Under the guise of the obligation to render thanks to the saint and to protect the patients from a possible relapse, the families accord them time during which they can renew the links with the milieu and free themselves from tensions by entering once more into the skin of the possessed. For the close

circle, these manifestations do not signal a relapse, but are the very proof of the cure because, now, it is the liberating saint who expresses himself in the body of the patient.

Conclusion

When I left Puliampatti in July 2002, I wondered about the implications that the restrictive measures imposed on the patients by the priest would have for the future of the shrine. In fact, a diminution of the number of patients began to be perceptible and it seemed to me useful to return to the field to observe the evolution. And this was all the more called for because, at the end of 2002, another priest assumed responsibility of the parish.

Returning two years later to Puliampatti, I expected to see Petchiyammal and one or two patients, such as Michael, who had finally chosen to live there, but hardly more. However, I noted some twenty-five patients who were still living in Puliampatti, most of them without having been away. With the exception of four persons, all showed signs of possession in 2002. This means that the families of violent patients have ended up returning to their homes or choosing a more medicalized therapy, whereas the possessed persons, that is, victims of an often traumatized conjugal or familial context, found in Puliampatti a place where they felt well and above all protected from the difficulties with which they had been confronted. Apart from being able to free themselves from tensions accumulated in the past, they succeeded in forming a small society united by the same experiences and supporting mutual aid, solidarity and friendly relations. All these advantages mean that the shrine at Puliampatti holds a remarkable and unique place in the therapeutic systems of which patients in India avail.

We have underscored how much the failure of biomedicine and a financial situation offering no other alternative underlie the coming of patients to Puliampatti. The stay at the shrine has become for them the last hope for recovery and for some, deprived of any means, the last refuge that makes it possible to escape marginalization. This does not discount faith. Quite on the contrary, it is on faith that the last hope of recovery is based. But, in order to oblige a saint or a deity to ensure this deliverance, it is necessary to make the aetiology agree with the new therapeutic form employed. This aetiological re-definition eliminates the physical origin for a supernatural causality and obliges the performance of specific rituals. However, some of these rituals have advantages that psychiatry cannot offset. This leads one to ask about the pertinence of the *indianization* of psychiatry, to use a term borrowed by Wig

et al. (1974) from two of his colleagues during a tribute to the psychoanalyst Girindrasekhar Bose. Wig and some of his psychiatrist colleagues questioned the causes of the disinterest of Indians in psychiatry and the means of remedying the situation. They formulated a series of suggestions to introduce traditional techniques into the practice of psychiatry. They emphasized the importance of yoga, of relaxation or of mythological references in the exercise of psychotherapy. They underlined the importance of knowing the cultural context of the patients and using a language that employs the same concepts. They suggested collaboration with traditional therapists so that the latter direct the patients they cannot relieve towards psychiatry. However, all these suggestions reflect their interest in evolving the image of psychiatry in India. Thus, when the psychiatrists compare their discipline with religious therapy, some positive aspects of the latter are avoided. The family-patient relation in the therapeutic process and the socialization capacity of the therapeutic shrines are not taken into account. Any questioning of the advantages of the manifestations of possession is non-existent; whereas, socially recognized and accepted, these manifestations have a unique and proved therapeutic function. These lacunae are not surprising because biomedicine tends to disregard social and psychological factors in its diagnosis. This, moreover, distinguishes them from Indian scholarly or folk medicines, which, for their part, have developed a holistic approach to the individual. Few patients encountered in Puliampatti have consulted practitioners of *citta* medicine (a medicine practised in Tamil Nadu quite close to āyurvedic medicine) because the latter are less present nowadays in the field of psychogenic disorders than the psychiatrists. Nevertheless, this does not mean that they are impervious to its concepts. On the contrary, it is not rare that a humoral imbalance would be identified during the interpretation of the psychic disorders. However, the humoral imbalance is not directly responsible for the disorders, it is the result, the evidence of a supernatural intervention. On the whole, we can say that the concepts inherent in each medical system are used and reinterpreted in such a way as to foster the belief in magic and in malevolent spirits. This belief is not only the reflection of the strong religiosity of Indians, it makes the unacceptable tolerable and sanctions a certain distance to social norms.

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