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**WORKS ON THE INDIANIZATION OF PSYCHIATRIC PRACTICES  
IN INDIA IN 1965-1985.  
THEIR PERTINENCE AND LIMITATIONS**

Brigitte Sébastia

**ABSTRACT**

If religious therapy continues to attract people with psychic/psychological pathologies, this is due to failures on the part of psychiatry: that is how some psychiatrists explained the significant frequentation of the *dargāh* of Ervady, where 28 mentally ill people perished in an accidental fire. The criticisms made by these psychiatrists reiterated deficiencies that were underscored by their colleagues who took part in the reform of psychiatry some decades ago. In order to adapt the practice of psychiatry to Indian sensibility, numerous studies were presented by these psychiatrists emphasizing the necessity of integrating Indian practices and concepts into their discipline.

The present study, based on observation and analysis of a particular therapeutic shrine, will highlight the reasons for which patients have recourse to religious therapy, and will present some criticisms on the relevance of the Indian therapies chosen in order to 'indianize' psychiatry.

**Keywords:** Psychiatry, Indianization, Indian medicines, religious therapy, pluralism medical.

## A MUCH CONTESTED SPECIALITY

During the night of 6th August 2001, the *pantal* of one of the seventeen private mental homes situated around the *dargāh* in Ervadi (Ramanathapuram district) caught fire(1). Twenty-five patients perished because they were kept in chains and could not escape. The emotion sparked off by the horrible images in the press of the charred bodies and by the articles accusing the families of patients of superstitious and unscrupulous attitudes obliged the Government of Tamil Nadu to take measures to prevent such accidents happening in the future.

At first, the journalists held the families indirectly responsible for the tragedy: the success of the mental homes and abuses by their owners being consequent on the determination of the family to get rid of a cumbersome patient. In the days that followed, however, articles signed by psychiatrists began to appear, denouncing the failures of their discipline that obliged the families to turn to other therapies. Criticisms were aimed at the inertia of the health services in the application of the reform of psychiatry stipulated by the Mental Health Act 1987 which replace the Indian Lunacy Act of 1912, and at the lack of will of their fellow-members to improve their practices of care and their behaviour.

The reforms purposed by psychiatrists involved in the elaboration of the Mental Health Act 1987 dealt with to improve living conditions and therapy in mental hospitals, to establish psychiatric wards in general hospital, to train a personal specialized in mental health (psychiatrists, nurses, social workers), to educate the staff of Primary Health Centres, teachers and population to detect mentally ill and help them to get treatment. They were also concerned with the adaptation of psychiatry to the Indian sensibility through the borrowing of Indian concepts and practices. This subject was the focal point of extensive articles written by psychiatrists between 1965-1985 exploring various aspects of indigenous therapies, both codified and folk, used to treat mental illnesses. Their objective was to consider ways of “indianizing” their practice in order to attract patients who were normally not treated at all and those who used to consult traditional healers.

In this article, I wish to demonstrate that the therapies which have attracted the interest of reformist psychiatrists do not correspond to the needs of patients who frequent religious places such as Ervadi and that the reasons for which patients choose to go to these places are justified by the fact they afford them some advantages that the psychiatry is not capable to fulfil. For this purpose, I will explore the universe of religious therapy through data collected from patients staying in a catholic shrine where I carried out a research over sixteen months(2). The patients who frequent this shrine belong to the lower and middle castes and live in urban areas as well as in villages; they are poor and quite often illiterate. Although there is widespread idea that people with a low socio-demographic profile are more likely to use religious therapy, than well educated, urban, middle class people, the study reveals that the majority of patients who stay in the shrine have consulted a practitioner of biomedicine or a psychiatrist. So, I will turn my attention to the criticisms of patients and their families towards the behaviour of psychiatrists and the psychiatry. This will conduct me, in conclusion, to examine the pertinence of works on indianization of the psychiatry and their ability to respond to the needs of mentally ill persons and, specifically, of patients who resort to religious therapy, and their families.

## FROM ALIENISM TO PSYCHIATRY AND ITS REFORM IN INDIA

**The beginning of psychiatry in India: unsuitability to Indian society**

Colonial medicine met with a great deal of resistance in India before spreading through the entire country. One reason for the resistance was that the concept of a hospital was scarcely developed; there were a few hospitals established by *yunāni* practitioners (Greco-arab medicine) but they were rarely frequented by Hindus and they had, anyway, nothing to do with mental health (Jaggi, 2000). Patients resorting to traditional systems might be accommodated during their cure by Ayurvedic, Siddha practitioners or within particular temples; these traditional systems of hospitalization did not separate patients from their relatives who rather, moved in with them and looked after them whilst placement in asylums provoked a rupture with the familial environment and regular social life.

The first lunatic asylums were built in the three presidencies at the end of the eighteenth-century: Bombay in 1745; Calcutta in 1787; Madras in 1794 (Jain, 2003; Somasundaram, 1984). At first, they were established by private surgeons to accommodate Europeans, especially British armed forces(3), the main causes of whose psychogenic and mental disorders were addiction (alcohol, cannabis '*ganja*'), deracination, malnutrition, war traumatism and also certain diseases that caused mental confusion, lethargy or fits (Ernst 1991). These asylums hosted some Indians until the 1820's when the British created establishments for 'natives'. This period coincided with the empire developing policy of clearing the cities of people who disturbed law and order (Ernst, 1987; 2001).

From the foundation of asylums, the British were at pains to avoid mixing 1<sup>st</sup> class Europeans (notables and those with military rank, etc.) with 2<sup>nd</sup> class ones (other ranks and civilians) (Ernst, 1991). Segregation by race was added to that by class when the British Empire established lunatic asylums for 'natives' and was based on the criteria of differentiation of Europeans irrespective of the social and religious codes inherent to Indian culture. In other words, whatever their religion and caste, the Indians were gathered in the same sort of cells and shared the same food prepared by the same cooks (Mills, 1999; 2000)

The therapy applied in these asylums was based more on moral standards than on medical practice. These asylums resembled European general hospitals or jails of the seventeenth and eighteenth centuries where criminals, wanderers, beggars, lunatics and idiots, shared the same space (Foucault, 1972; Castel, 1976). And they corresponded to what Foucault called 'le grand enfermement' whose main objective was to socialize the inmates and impose morality on them. As in England, and in Europe generally (Foucault, 1972; Castel, 1976; Torrey et al., 2002), the therapy applied in Indian asylums was organized in two phases: in the first, the patient was humiliated, disciplined and lectured on morality through the use of freezing showers, chains, strait jacket and isolation in cells when chains were discouraged; treatment during this phase was with chemicals that resulted in either a state of lethargy or violent pains. In the second phase, the patient was re-socialized and given confidence through work, responsibilities, obedience, etc. The aim of the doctors being to fortify and to discipline the bodies of sufferers, they were not concerned with the social and family environment. Once the body was strengthened, controlled and socialized, the patient was sent back to his family even if they were reluctant to receive him, and even if they had been instrumental in the occurrence of the particular mental disorder.

To sum up, the limitation of religious activities, the use of therapies without reference to caste and religious food regulations, disdain for Indian customs and the practice of autopsy and of vaccination, separation of patient from the family, are some of the many factors that contributed to the discredit of psychiatry over a long period of time.

### **The sensitization of psychiatrists to the need to indianize practices**

At the time of the Independence of India in 1947, Indian psychiatrists were very rare and had, for the most part, been trained in western countries. They manifested, nevertheless, the willingness to take in hand the future of their speciality. The Indian Psychiatric Society, instituted by the superintendent of the European Mental Hospital at Ranchi, Colonel More Taylor, as a division of the British Psychiatric Society, was dissolved in 1947; Indian psychiatrists reformed this society a few months later under the same denomination. In 1958, they founded the Indian Journal of Psychiatry in order to improve communication and the exchange of information between specialists in mental health through annual meetings and publications. Then, drawing on the report of the Bhore Committee, 1946, that defined mental hospitals as places of detention and custody without adequate facilities for care or trained personnel, they insisted to the government on the need to replace the Indian Lunacy Act of 1912. On the 29<sup>th</sup> September 1962, the Mental Health Advisory Committee was founded to promote mental health and to draft the Mental Health Act, 1987 (the Indian Mental Health Bill was passed by the Rajya Sabha in November 1986). Two decades later, the National Mental Health Programme was launched by the Ministry of Health and Family Welfare under the control of the Central and State Mental Health Authorities.

The psychiatrists who took part in the preparation of the Mental Health Act of 1987 were concerned with the importance of beliefs, traditions and perceptions in relation to psychogenic disorders. This interest is exemplified by the book *Psychiatry in India* (De Souza and De Souza, 1984) which presents numerous articles written by psychiatrists on therapies and symptomatology with regard to Indian culture. This interest is upheld by the occurrence of these topics in the Indian Journal of Psychiatry in the 1970s. To develop this subject, I will rely on articles written by psychiatrists during the period when they were involved in the project to draft the Mental Health Act, i.e., 1965-1985. This is, obviously, not to say that psychiatrists ceased to be interested in the culture in psychiatry after 1987, but, it is noticeable that this theme was dealt with much less often than more recently developed subjects such as psychopharmacology, pharmacodynamics and the phenomenology of mental illness.

Confronted by the difficulty of expanding their speciality, psychiatrists behaved in a manner that represented a real obstacle to the attracting of people who were used to visiting traditional healers, causing some to insist that psychiatry would become attractive only upon its 'indianization' (Wig et al., 1974)(4).

In 1964, two psychiatrists took advantage of the opportunity offered by the 16th annual conference of the Indian Psychiatric Society to express their discontent with the practice of western psychiatry in India:

“The present day, Indian psychiatrist is still a product of the Western training. He has learnt his medical and psychiatric lessons in a language and in conceptual frameworks which are wholly foreign to the milieu of its birth and habitation.”

Quoting the speech of his colleagues during the 29<sup>th</sup> annual conference of the Indian Psychiatric Society that took place in Calcutta thirteen years later, Professor J. S. Neki (1977, p. 3) advised his colleagues to listen to their patients, to show interest in the aetiology and to pay attention to the idioms they were employing, to use the psychotherapy and therapeutic techniques of traditional medicines, and to make religious references. In brief, he emphasized the importance of developing empathy with the patients.

### **Indian practices and concepts for improving psychotherapy**

The 29<sup>th</sup> annual conference of the Indian Psychiatric Society presided over by J.S. Neki, was a homage to Girindrasekhar Bose and, thus, the central theme was the practice of psychotherapy. J.S. Neki stressed the importance of developing this discipline with regard to the Indian specificity. He illustrated his comments by quoting two cultural paradigms: the use of scriptures such as the *Bhāgavad Gīta* to help patients suffering from depression, a sense of guilt or repression(5) and the *guru-celā* (master/pupil or disciple) relationship. He explained that this master/disciple relationship, so important in education in India, could improve prospects of recovery and so the therapist must take care to develop it between himself and his patients. In this perspective, he stressed the need to keep a distance from western psychotherapy that considers the dependency of the client on his therapist as a real obstacle to the efficacy of the therapy. For J.S. Neki, western psychotherapy is not appropriate to Indian culture because the Indian psyche looks for the sources of problems outside the self, in astrological influences, evil spirits, witchcraft or transgressions, or karma.

Certain notions, such as karma, were dealt with in the articles of this period with some psychiatrists considering that the concept of karma helped to discourage suicide, to lessen stress due to life problems and modern changes, and to reduce the sense of guilt (Venkoba Rao, 1973). B.B. Sethi and S. Dube (1982) concluded from their own experience in psychotherapy, that the sense of guilt in the Indian culture has a much more impersonal character, because seen as a consequence of karma, than it does in others societies where this notion does not exist.

Another field of research has been yoga and meditation, two techniques particularly privileged for indianization due to their oriental origin and to their practice being in vogue in the western world too. The reformist psychiatrists have written numerous articles on various aspects of yoga and its advantages in the field of treatment. They have essentially promoted *hatha yoga* with its practice of *āsana* (postures) and *prānāyāma* (regulation of breathing) and its application of *yama* and *niyama* (social and ethical observances) to strengthen the body and stabilize the mind. They showed interest, as well, in techniques of concentration (*dhāranā*) and meditation (*dhyāna*) that they considered efficient in relieving some pathologies, such as psychoneurosis, anxiety states, insomnia, tension, bipolar disorders, asthma and aggressiveness (Vahia et al., 1973; Varma, 1984). In these studies, the practice of yoga is more often promoted as a complement to chemotherapy than as a technique capable of preventing illness(6).

### **The interest in concepts and therapy developed in Indian codified medicines**

Indian codified medicines(7) are: Ayurvedic medicine recorded in Sanskrit and practised all over India, Siddha medicine, recorded in Tamil and practiced in Tamil Nadu, and Yunāni medicine recorded in Urdu and used by Muslims. These three medicines share many concepts and practices such as a theory of humours, a concept on the bodily constituents, an importance given to pulse reading, a *materia medica* using herbs, organic materials, minerals and metals; these similarities certainly appear to attest to mutual influences(8). Nevertheless, the interest of psychiatrists has been in Ayurvedic medicine, which is widespread in all parts of India and enjoys better recognition, thanks to its identification with Indian culture through the use of Sanskrit, whereas Siddha and Yunāni texts are respectively in the Tamil and Arabic languages (Sébastien forthcoming 2009; www.siddha-medicine.org).

The main topics studied by the reformist psychiatrists during this period 1965-1985 were the development of the concept of mental illness through the treatises of Ayurvedic medicine (Somasundaram 1984, 2009; Venkoba Rao 1978), the therapeutic efficacy of medical plants used in this medicine (Ramu et al., 1983; Ramu et al. 1999)(9) and, above all, its nosography and symptomatology which are greatly elaborated (Mahal et al., 1977; Ramu et al., 1983; Varma, 1965; Weiss et al., 1988). They presented numerous categories of insanity described in Ayurvedic medicine that attest to a keen sense of observation and a real interest in mental disorders, and a large variety of therapies according to symptoms. These therapies have biochemical, psychological and psychosomatic effects, that is to say, they act, respectively, by eliminating the vitiate humour (diet, medicines), by restraining the mind from unwholesome thoughts and emotions (psychotherapy) and by invoking the help of gods (spiritual exercises, penances and rituals).

The psychiatrists were very interested in the holistic approach of Indian medicines and in their preventive aspect developed through dietary prescriptions, hygienic rules, ethical values, etc. L.P. Varma (1965, p. 292) stressed that psychiatrists should be familiar with Ayurvedic concepts in order to understand their patients who often use them in their discourse.

“Twenty-five years of practice in psychiatry in India has convinced me that in order to understand the psychology of his patients and to arrive at a correct diagnosis, it is absolutely essential for a psychiatrist to be fairly well conversant with the Ayurvedic concepts and the complicated mythology of the Hindu pantheon. Without their proper knowledge and appreciation, psychiatry becomes barren. Patients frequently impress on us the ravage caused to them by the provoked humors of *vayu*, *kapha* and *pitta*, their frequent fascination for sweet, sour or acid foods, their love for river beds, burning ghats, cemeteries and their charm for music”

However, it must be highlighted that the concepts used by actual people may show variations and discrepancies in comparison with the nosography given by the texts. This is particularly true of the patients I met in Puliampatti, a number of whom considered their illness to be of supernatural origin and, whatever the category of their symptoms (convulsive, neurotic, psychotic, maniac), moaned about overheating of their heads(10). While Indian medicine draws a clear distinction between exogenous illnesses of a supernatural origin and endogenous ones of a humoral origin, the patients explain their symptoms by causalities belonging to both categories: the excess of heat is the result of a humoral problem (endogenous cause) due to the action of sorcery or of evil spirits (exogenous cause). Thus, they follow cooling diets and apply substances (showers, application of margosia leaves paste) on the head(11); and they avoid heating substances and actions in order more quickly to expel the evil spirits, in cases of malevolent possession(12).

### **Works on ‘culture-bound syndromes’**

The concept of the ‘culture-bound syndrome’ has also been thoroughly dealt with in the articles of reformist psychiatrists. In India, these are mainly ‘*dhātu* syndrome’ (Behere et al., 1984; Singh, 1985) and ‘*dēvi* syndrome’ (Teja et al., 1973; Varma et al., 1970).

The expression ‘culture-bound syndrome’ was applied for the first time to ‘*dhātu* syndrome’ by the psychiatrist Wig in 1960 (Nakra et al., 1977)(13). One of treatises of Ayurvedic medicine, *Caraka samhitā*, defines this syndrome as “Sukrameha (spermatorrhoea) in which the patient passes semen resembling urine or urine mixed with semen, Sitameha (Phosphaturia) in which the patient has frequent micutrition which is

exceedingly sweet and cold, and Suklameha where the patient passes urine which is white in colour” (Behere et al., *ibid.*, p. 76).

This syndrome is well known in the Tamil area under the term *vintuskalitam*. Psychiatrists associate it with a depressive or anxious state(14) because patients complain about losing weight and about exhaustion that they consider to be provoked by nocturnal seminal emissions, a link arising from the perception of semen in Āyurvedic and Siddha medicines. According to the theory of the components (*dhātu*), the 5 basic elements that constitute food, water and air, are degraded by the fire of the body into 7 *dhātu* (bone, flesh, fat, organic fluid or chyle, blood, marrow, semen). Each *dhātu* is the product of the preceding *dhātu*, purified by the fire of the body; semen is the final *dhātu*, formed from the successive transformations. According to the tradition, 40 drops of blood are necessary to make a drop of marrow and 40 drops of marrow to produce a drop of semen (Nakra et al., *ibid.*), so that the semen is the most valuable product, rare and difficult to regenerate. Given that it represents vital energy and generates in its turn the six previous *dhātu*, its evacuation causes a progressive weakening of the body. Conversely, its retention produces energy (*śakti*) that, gradually, helps in the achievement of knowledge and immortality. This technique is used in tantric yoga to acquire supernatural powers and, in ordinary life, the preservation of sperm is recommended in an appropriate use, i.e., with the aim of procreating. This explains why nocturnal seminal losses are considered responsible for the weakening of the body and the psychic constitution, and for generating anxiety and fear of death. The importance given to this syndrome is confirmed by patients met at Puliampatti who, when they were very depressed, complained about seminal losses or about the apparition of the Goddess Mohini(15) in their dreams which was sapping their strength.

The second ‘culture-bound syndrome’ that the psychiatrists assimilate with hysterical pathology concerned ‘*dēvi* syndrome’, the expression of a possession state that calls for the help of folk healers and especially religious therapists and is observed in famous religious places such as Puliampatti or Ervady.

Finally, some psychiatrists were interested in studying the impact of certain aspects of Indian culture on the manifestation of mental illnesses. So, the articles of A. Chakroborty and G. Banerji (1975a; 1975b) show that the purity rules and devotional acts in Bengali culture were exacerbated in the case of obsessive-compulsive disorders. These symptoms are called in vernacular terminology *suci bāi* meaning ‘purity mania’. They are easily tolerated by the community with the result that people so affected are seldom treated (*ibid.* 1975a). In 60 cases reported with *suci bāi*, only two persons received some treatment with indigenous drugs, even though certain unusual or odd behaviors may breach the social rules. While this study is specifically on the Bengal area, it can be applied to the entire culture of India, given that the stress on purity and devotion is everywhere shared. In conclusion, the authors point out that if purity and devotion are very often cited by patients affected by obsessional disorders, there is no evidence that these qualities are directly responsible for the disorders (*ibid.* 1975b).

### **Traditional conceptions of mental illnesses and folk therapies**

The last important subject pertaining to Indian culture to be tackled by psychiatrists was the approach of traditional healers to mental health. Psychiatrists were interested, not only in the supernatural conception of mental illnesses in the Āyurvedic and Siddha traditions, but also, in folk healers and their relationship with their patients which subject has been studied by various different psychiatrists. These researches emphasized that the ascribing of supernatural origins to mental illness as old as the Vedic text, Atharvaveda, and



that this conception has endured in Āyurvedic treatises, even if their authors gave more importance to the physiological aetiology (Balodhi et al., 1986). So, due to its continuity and to its contemporary role among therapies for psychic disorders, psychiatrists stressed the importance of folk healing as a source of inspiration.

In the introduction to their book, *Psychiatry in India*, Dr. A. and D.A. De Souza highlight the importance of traditional healers in the field of mental health and quote the remarks of R.L. Kapur advising psychiatrists to collaborate with them:

“Psychiatrists must learn to work with traditional healers, and make no effort to shake the beliefs of the public but rather utilize these beliefs to bring home new knowledge, as well as utilize traditional healers to bring patients for treatment.” (1984, p. 10)

Among these psychiatrists, many were interested in determining the socio-demographic categories of patients who consulted traditional healers (Satija et al., 1982; Sethi et al., 1977; Trivedi et al., 1979a, 1979b, 1980; Varma et al., 1970). Others sought to define the possession or *dēvi* syndrome and the categories of people who expressed it, from the point of view of their socio-demographic identity as well as of their pathology and of the context in which the possession occurred (Varma et al., 1970; Teja et al., 1973). Another subject extensively studied was the diagnostic and therapeutic techniques of healers (Trivedi et al., 1979a, 1979b, 1980). The aim of these studies was to observe the patient/therapist relationship, to compare their diagnoses with those provided by psychiatry, and to understand the symbols, the idioms and practices used by the healers to enhance the effectiveness of the therapy. Lastly, there were many articles on the religious therapy practised in temples and shrines (Carstairs et al., 1976; Meha, 1984; Satija et al., 1982; Satija et al., 1984; Somasundaram, 1973); most of these studies emphasized that the resort to popular therapies was encouraged by tradition, belief, confidence, psychotherapeutic aspects and also by ignorance of patients concerning the nature of their troubles and by superstitious behaviour.

## THE PLACE OF RELIGIOUS THERAPY IN THE FIELD OF MENTAL ILLNESS

Psychiatric care has never entirely replaced the religious therapy to which many families turn when unable to manage a violent or asocial patient. So, this therapy holds a great place within the medical pluralism available for treatment of psychic disorders. One common explanation for this preference is the belief in supernatural entities as responsible agents in mental disorders. Families then consult priests, mediums, astrologers or sorcerers who will perform exorcisms and remove spells; or they visit temples or shrines renowned for the power of their deity to neutralize evil spirits or spells. Nevertheless, long discussions with patients and caregivers reveal that the recourse to religious therapy is consequent to many non-religious/spiritual origin factors.

Puliyampatti is a hamlet well known for the powers of healing and of exorcism of the statue of Saint Anthony of Padua in its church. The shrine hosts three categories of patients: those who are tied up due to their violent and injurious behaviour, those whose behaviour is normal during the day but who became possessed during the rituals of exorcism and, lastly, patients with no mental disorder but who have been discharged from hospital because their physical illnesses are incurable.

There is no specialist in exorcism in this shrine due to the priests who are afraid of competition. This function is played by caregivers, often family members who take charge of the cure. They oblige the patient to be exposed to the power of the saint that is concentrated

at the top of the *koṭimaram*(16), the post raised in front of the church. When the patient manifests the possession state, this is interpreted as proof of the presence of supernatural entities and of their responsibility for the illness. I will not elaborate on the therapeutic process used in Puliampatti since I have already dealt with it in a previous paper (Sébastien 2007a), but in this article, I intend to focus my attention on the reasons why patients affected by mental illness are taken to the Catholic shrine of Puliampatti for stays lasting from a few weeks to several years(17).

As an anthropologist, I am reluctant to refer to statistics but, in certain cases, they can be useful in evaluating a situation or in supporting arguments. Sixty-one patients are included in the study; they were chosen for the long periods they have spent staying in the shrine, i.e., a period of time longer than two months (18), and for the information that is available on the history and the social context of their illness and on their therapeutic recourses. Wherever possible, the information has been collected from the patient directly and, when this has not been possible due to the behaviour of the patient, from one or several caregivers. Regarding the therapeutic recourse: of thirty-seven patients who had visited one or several kind of therapists before coming to Puliampatti, thirty-six (59%) had consulted a practitioner in biomedicine, quite often a psychiatrist, or had been hospitalized in a psychiatric ward, at the Institute of Mental Health in Chennai, at a private clinic or, more currently, at the psychiatry department of the Government Hospital High Ground at Palayamkottai. This is an important point to point out because the experience of biomedical treatment before recourse to religious therapy is not often noticed in current researches (Halliburton, 2004, Pfleiderer, 1984; 2006; Skultans, 1987), and some even claim the inverse (Raghuram et al., 2002; Weiss et al., 1986). Regarding Indian codified medicine -in the Tamil context, Siddha medicine-, it attract very few patients. Only five patients (8%) have consulted a *cittamaruntuvar*, a siddha practitioner, and this percentage is certainly higher than if the study had been done elsewhere in Tamil Nadu because the patients were hospitalized in Courtallan, a small town, situated not far from Puliampattim where is the unique clinic specializing in the treatment of mental illness by Siddha medicine in all Tamil Nadu. The study of M.G. Weiss and his colleagues (1986) on the recourse to Āyurvedic medicine, the scant frequentation of the Āyurvedic department implanted in NIMHANS, and the rare specialized wings in Āyurvedic hospitals with their complete absence in Siddha ones, uphold the lack of interest in Indian codified medicines for cases of mental illness(19). The reason invoked is that these medicines require a very long treatment period before giving relief, even if they are perceived as having permanent efficacy and no iatrogenic effect. This justification may seem incoherent in relation to the long periods patients stay in a temple or a shrine. But the acceptance of a long stay is supported by a change of aetiology elaborated by the absence of any relief resulting from previous therapies, whether folk or codified; aetiology that patients and caregivers justify by social or familial events that took place before, or at the beginning of, the illness. Obviously, the interest of reformist psychiatrists for Indian codified medicine is not in adequacy to the needs of patients and caregivers who search a quick remedy (biomedical medication, exorcism) to their troubles or a sense (sorcery, evil spirits). Regarding the recourse to religious therapy, twenty-five patients had come directly to Puliampatti without having visited any therapist, astrologer, or sorcerer, quite often on the basis of the advice of a relative or friend who had witnessed or experienced the healing power of Saint Anthony and of thirty-seven patients who had visited one or several kind of therapists, eleven had consulted sorcerers or exorcists and fourteen had stayed in a temple, a *dargāh* or a catholic shrine. Although the recourse of religious therapy is not negligible, these statistics by showing a large recourse to biomedicine contradict the view of many psychiatrists who qualify patients who turn to religious therapy as superstitious and uncultivated without questioning their motives.

The major criticism on biomedicine given by patients and caregivers is its high cost; they complain about the loans they contracted, or about the property they sold to pay the consultation or hospitalisation fees and for medication. For example, to defray the hospitalization fees of Munisvaran, a thirty year old man affected by a serious psychosis and treated in the psychiatric wing of High Ground and in a psychiatric private clinic, his elder brother sold his hotel, his parents their house, and a brother residing in Mumbai gave a part of his salary. Wilfred, the husband of a woman diagnosed as ‘bipolar’, lamented that due the debt incurred to care his wife, he was not been able to take her to hospital when her symptoms reappeared for the fourth time. His wife was so difficult to manage that Wilfred was obliged to come to Puliampatti to avoid conflicts with his neighbours. His remarks and his minimum involvement in the religious activities –he scarcely attended masses nor circumambulated around the church, the *kōṭimaram* and *mātā kōvil* (the Mary chapel)- considered as crucial for obtaining the help of the saint and the cure, testified that the stay in the shrine was motivated strictly by economic considerations.

“I have already borrowed 10,000 rupees and I cannot pay off such sum. Jiva has been ill now for 13 years, since the birth of my second daughter. Whereas she was delivered at home, suddenly, there was a power failure and when the current came back, we noticed that she had lost a lot of blood and was delirious. After that, her behavior became strange: she refused to feed or take care of her baby. So, we went to the hospital at Tuticorin. The doctor said her mind was confused (*putti cuvāṭīnam illāmal*) and sent her to High ground, Palaiyamkottai where she had numerous shocks (electro-convulsive therapy). After one-month’s hospitalization, she returned home with medication. She continued to take the tablets for one year. Eight years later, she fell ill with a high fever and her behavior became seriously disturbed. When I came back home after a week of fishing, our house was completely empty; she had thrown all our things in the street and our neighbors were trying to calm her. A friend advised me to drive her to a private psychiatric clinic at Tirunelveli. There, the doctor said she had a maniac-depressive illness and gave her medication. So, for a few years, we went to the clinic to get prescriptions for tablets, and when she felt well, she decided to stop the medication. One year later, she again had a high fever and her behavior became more seriously disturbed. As I could not spend a lot of money, I drove her to the Hospital of Tuticorin where her psychiatrist from Tirunelveli visited her in order to prescribe medication. After she felt all right, we decided to stop the medication because of lack of money. But, a few months later, her illness reappeared... This time, because of debt, I decided not to go to the clinic. My daughter Judia took care of her mother for a few days but when my wife became too unmanageable, the neighbors forced us to leave. So, we came to Puliampatti where we had already stayed for thirteen days after Jiva’s first hospitalization.

All my earnings have been spent on Jiva’s treatment. My daughters have had almost nothing. The sole thing I try to give them is a good education up to 12<sup>th</sup> standard. For the eldest, this is accomplished and she will finish her schooling in May, but Judia has to take care of her mother.... Next week, she will be 13 years old and though it is her birthday, I am unable to give her even a small gift... All my money has gone to treat Jiva.”

Debts can be very high if the patient has taken to a private clinic. The government hospitals have such a bad reputation that even very poor families do not hesitate to go to private clinics if they consider the illness as very serious and a threat to the family harmony. The Puliapura’s case, related by her mother, is illustrative of this. This young woman, beaten and mistreated by her drunkard husband managed to escape and to take refuge with her parents:

When Puliyyura arrived, she was very aggressive and violent and spoke with no sense. Once calm, she stayed silent, refusing to eat, sleep or make any movement. When we tried to approach her, she shouted and became very violent. We tried to contact her husband, but he was away from home.

A few days later, my brother (father-in-law of Puliyyura) came and informed us that his son could not bear the insanity (*kōtti*) of my daughter and had decided to remarry. Thinking that Puliyyura was really mad as she sometimes had fits (*vettivetti*), we took her to High Ground. When the doctor suggested hospitalizing her in the psychiatric ward, we took her to a private psychiatric clinic near where we are living. The psychiatrist told us that her body was all right but that she was very anxious (*vicanam*) and depressive (*tukkam*). He kept her for five days and prescribed some tablets for ten days. We bought tablets for only three days as we wanted to check if they were efficacious before buying more. But as we saw no change, we stopped to give her medication and we went to an astrologer (*jōciyar*). My son went to meet Puliyyura's husband in order to clarify the situation and he discovered that he used to abuse and beat Puliyyura when he was drunk or he wanted to visit his mistress. In fact, Puliyyura's husband continued to keep a mistress whom he had known before his wedding. At this time, my brother did not give his agreement for the marriage of his son with this girl who did not belong to the same caste. Then, we visited a sorcerer (*mantiravāti*) who told us that Puliyyura's madness was caused by a spell put on her by my brother (her father-in-law) in order to promote the remarriage of his son. Finally, we decided to come to Puliampatti(20).

Even though Puliyyura's parents could not afford the high consultation fees due to their great poverty, their sacrifice was motivated by the hope that the doctor of the private clinic would be more capable of curing their daughter than the doctor at High Ground. Nevertheless, they were disappointed by the diagnosis which offered nothing that they could recognize as a particular illness (physical) and the inefficiency of expensive hospitalization. I suspect that, in spite of the mother's Puliyyura explanation, the purchase of only three day's treatment was due to the mistrust in the therapy provided by the doctor and to the lack of money.

These expectations of immediate, positive results from medication are a reflection of the widespread reputation in India of western medicine which is considered to bring immediate relief, even if not permanently and even with side effects. Given this perception, it should be the duty of the psychiatrist to emphasize the duration and the regularity of the treatment in the case of psychotic disorders. This does not, however, seem to be what happens, since many patients complain about the indifference of the doctor, the difficulty of talking to him and of obtaining information about the patient's illness, such as its name, its origin, its nature and its prognosis: "The doctors are not nice with us, they don't look at us, say nothing to us or speak with a reproachful voice" "when we ask for information about the illness, they speak in a way that we cannot understand or they don't answer" "they just write a prescription to buy medicine, and that is all, without any explanation". If the patient has been hospitalized, the families highlight the paucity of care and the frequency of electroconvulsive therapy sessions whatever the pathology(21) is very often used to justify the great expenditure caused by hospitalization and the inhuman treatment given in psychiatric hospitals.

Several visits, in 2001- 2002, to the psychiatric unit of High Ground hospital have allowed me to comprehend these criticisms(22). In the outpatient ward, there were three psychiatrists who consulted in different rooms. The patients, always accompanied by one family member, had to file past a seated psychiatrist who asked the accompanying family member three or four questions, chose one of two pre-written prescriptions from a box on his desk and gave it to him or her, filled in the care note-book, and then turned to the next client.

It goes without saying that the poor quality of consultations which ignore information to patients, communication with patients, importance of privacy, quality of the diagnostic and of the prescription, promotes neither confidence in psychiatry and its specialists, nor the proper use of medicine. Lack of recovery due to misuse of chemotherapy, which needs to be taken for a long period to be efficacious, or of prescriptions due to their high cost, implicitly encourages recourse to other types of practitioner and probably to religious therapy (astrologers, sorcerers, exorcists, temples etc.) due to the fact that people interpret this as proof of the supernatural origin of the illness. To justify the recourse to religious therapy families adapt the aetiology of the illness in accordance with the nature of the therapy proposed in religious places. And thus, they interpret the lack of efficacy of biomedicine and the absence of physical problems -according to the diagnosis presented by the doctor: *utampu ceriya irukku* 'the body is well'-, as proof that the *mananōy* 'mental illness' is not physiological, but the result of a spell or the work of evil spirits. This new explanation, by sidestepping the stigma attached to patients affected by psychic disorders and their families, makes the situation more tolerable. It is important to point out that mental illness is considered in India as hereditary and incurable, and as affecting individuals with bad karma or families with dubious morals. For most of the 36 patients who consulted practitioners in biomedicine or psychiatry before being taken to Puliampatti, the stay there may be perceived as the last chance to get well.

### THE INDIANIZATION OF PSYCHIATRY CRITICAL APPROACHES

The variety of the therapies presented in the articles by reformist psychiatrists reflects the diversity of healing systems available in India and shows that the authors were aware of them. Medical pluralism is supported by the World Health Organization –with certain conditions pertaining to the standardization of indigenous medicines- as being of advantage to developing countries whose the populations do not always have access to biomedicine for either geographical or financial reasons. The article by Halliburton (2004), which studies the treatment of psychic disorders by biomedicine, by Āyurvedic medicine, and by religious therapy in a temple, a *dargāh* and a catholic shrine, is particularly illustrative of the variety of therapeutic systems available in India(23). Nevertheless, the interest of psychiatrists in Indian therapies has been strictly motivated by the wish to improve psychiatry, and absolutely not by the beneficial effect that medical pluralism may have on persons affected by psychic or mental disorders. The psychiatrists did not seek, in the course of their research, to collaborate with the exorcist, the Āyurvedic *vaidya* or the guru. They observed their practices, their theories, their therapies and their relationship with the patient; they noted down the content of their remarks, and the idioms, symbols, and mythic references, with a view to drawing inspiration from their example. Some even did recommend a better 'collaboration' with the healer, in the sense that the healer might advise his patient to go psychiatry if he is incapable to cure him. All in all, they considered the therapies of folk healers irrational and non-scientific but they sought to understand why they can be effective and why patients are attracted to them. Rare were psychiatrists such as A. Venkoba Rao (1978) or R.L. Kapur (2004), who recognized that the priest, the sorcerer and the exorcist are more effective in helping patients with particular kinds of disorder.

The cultural paradigms presented in the psychiatrists' articles are only a part of their proposals, but they are a very important part. Their interest in the indianization of practices does not seem to me always to respond to the needs of patients who do not consult

psychiatrists or who prefer to turn to traditional healing. As I have specified, patients and their families who have experienced psychiatry before going to a therapeutic place, are very critical about the quality of treatment provided in psychiatry clinics and hospitals. The sorry state of the practice of the discipline is confirmed by the comments of psychiatrists following the tragedy of Ervadi, as well as by the report of the National Human Right Commission of 1999 quoted by R.S. Murthy (2000; 2001). The report specifies that 38% of the hospitals are still jail-like structures, 76% use the isolation cells, 57% have high walls; the patients are still considered as inmates which means that personnel are more involved with surveillance than with treatment; only 25% of establishments employ nurses trained in psychiatry, less than 50%, a psychologist or psychiatric social workers; 20% practise biological examinations; overpopulation of these establishments obliges the patients to sleep on the ground; bathing, as well as natural functions, are carried out without privacy; and drainage and sanitation systems are neglected. The report concludes that the deficiencies in the psychiatric hospitals are sufficiently explicit to prove that the rights of mental patients are being violated outrageously. R.S. Murthy, in his turn, concludes that treatment and living conditions in psychiatric hospitals generally are hardly any better than those to which the patients in Ervadi were submitted. In addition to the inhuman conditions that have contributed to the poor reputation of psychiatry in the past, there is a lack of beds (30000) and specialists (3500). Nowadays, only 10% of the needs are covered by psychiatry (Murthy 2000) and, according to S. Wadhwa's estimate (2001), that evaluation of the need comes nowhere near to the estimated 32 million Indians suffering from a mental illness, including the 7 million affected by severe disorders. Although they draw attention to various significant failures, the psychiatrists do not mention the sorts of complaint made by patients and families at Puliampatti, concerning: financial problems, the indifference of psychiatrists, the bad quality of consultations, the lack of information about the illness and its treatment, the 'over-prescription' of medication and the prevalence of electro-convulsive treatment.

Interviews with patients and caregivers show that they have need of more competent and empathic specialist help than can be had through Indian codified medicines or through yoga and meditation. On the one hand, Āyurvedic and Siddha practitioners are very rarely consulted for psychic problems and, on the other hand, Indian techniques such as yoga and meditation, even if they are beneficial in the treatment of certain pathologies are mostly practiced in upper educational and economic milieus. Moreover, these techniques are not used for all pathologies and psychiatrists and psychotherapist are very prudent in applying them to patients who present violent behavior with incoherent speech, delusions, panic attacks etc. due to the risk of exacerbating the symptoms of delirium, panic, or hallucinations (Bhaskaran 1991). These therapies are aimed at patients such as those I met at Puliampatti who are regularly possessed, i.e., women suffering from depression, stress or anxiety due to traumatism that has occurred in their regular life: conjugal violence, sexual harassment, pressure from in-laws, or men depressed by social rupture, unemployment, or anxiety about their sexuality or their future (Grover et al. 1987, 1994; Sahasi et al. 1991). Even if these Indian therapies promoted by psychiatrists for their effectiveness in the relief of anxiety and depressive and psychosomatic disorders can help patients to manage their anguish and to find their balance, they cannot resolve the causes of symptoms. For social problems, called 'hidden burden' by WHO's Nations involved in Mental Health Programme (Weiss et al. 2001), family counseling is obviously much more efficient. Moreover, this category of patients has no need of such therapies because they find, through the possession state, a means of exteriorizing their anger, of releasing tension and of drawing the attention and sympathy of other people, and through prayer and contemplation, a means of containing anguish and negative thoughts.

In spite of their intellectual interest, the indianized practices proposed at the time of the elaboration of the Mental Health Act respond only partially to the needs of the patients and neglect, moreover, certain cultural aspects, such as the dimension of gender in mental pathology (Davar 1999; 2001) and the participation of the community in the therapy, that are relevant to the improvement of the practice of psychiatry. The reformist psychiatrists sometimes deal in their articles with the role of the family in the process of therapy (Chako, 1967; Geetha et al., 1980; Verghese, 1988), but it is only with the National Mental Health Programme that this theme began to be promoted as one of the priorities (Weiss and al.2001). Nowadays it is well developed under the name of Community Mental Health Movement (Kannan, 2002; Kapur, 2001; Kapur 2004; Murthy, 1999; some articles in Sahni ed. 1999). The programme of this movement is vast and covers the training of doctors and staff in Primary Health Care and of general hospital staff in the identification of mental disorders; the training of teachers in the identification of children with emotional problems or mental illness; the training of nurses and social workers for follow up work with patients in their families; and it covers family counselling, including information on mental health and treatment, the rehabilitation of patients within the family and social framework, the organization of camps to identify patients, to inform and to removed misguided stereotypes of incurability, contagiousness and supernatural causality (Kapur 2004). It is necessary to be very clear that, in the context of religious therapy, the patient is perceived as a victim of sorcery or of evil spirits, whilst, in the context of hospitalisation, the patient is considered as mentally ill, and as likely, becomes the subject of discrimination by his or her relatives and neighbours. While psychiatry is perceived as an arena of seclusion and stigma, the therapeutic religious places are seen as protective and integrative, offering some new possibilities of socialization and facilitating communication and mutual assistance between patients and between caregivers. These advantages explain why many patients -25 of the 61 of the sample- were still in Puliampatti in 2004, no matter what the improvement in their health or their living conditions after a so long period when even the family has finally decided to leave. I may add that the way patients or their families currently use the idea of improvement in health or even of a cure has always seemed to me very blurred and irrational because of the discrepancy between the discourses emphasizing the improvement and the absence of change in the behaviour of the patient. This emphasizing of improvement may, I consider, be understood as a means of assuring oneself that one has made a good choice in coming to Puliampatti, of encouraging a cure by assuring the saint of one's confidence in him, and sometimes of justifying the departure from the shrine when the stay has been too long or when the days determined by the vow to the saint are completed.

As I observed during my staying in the shrine of Puliampatti, the role of families in the process of therapy is very important; even if the families use violence during exorcism rituals to induce the patients to become possessed, they are ever ready to offer them many kind attentions and tenderness and to share their illness by accompanying them through the penances (Nunley, 1998; Skultans, 1991). Appreciating the advantage of this, some psychiatric hospitals are equipped with rooms to lodge families with patients. The families have the role of partners in the therapy and that gives them a better knowledge of the efficacy of drugs and their iatrogenic effects, and of mental pathologies. When the disorders of patients are more or less related to the family history, the psychiatrists can encourage the family to participate in family or group therapy (Sethi, 1989). The presence of the family along with the patient is meant eventually to improve the relationship and to avoid the desocialization generated by long hospitalizations. These developments are certainly better adapted to the needs of patients and their families than were previous policies.

I would like to end by presenting an interesting experiment that I observed in 2002 in the therapeutic shrine of Saint Michael at Rajavur (Kanniyakumari district). This shrine is

well known for lodging large numbers of patients affected by severe mental disorders, especially psychosis. One day every three weeks, a psychiatrist comes and sees patients whom a nun trained in mental health has selected, after which the nun takes charge of the therapy, collecting data on the history and social context of the illness, dispensing free medication, and educating the family on the importance of the treatment and on the nature of the illness. This medicalisation inside the religious sphere, which results from the wish of the parishioners and the agreement of the priest who lends his office to the psychiatrist for consultation, is easily accepted by the relatives who contribute to the treatment of the patients. Without creating any rupture with the familiar universe as marked by social relations and links of solidarity, the medicalisation provided by the shrine allows the families to observe the effects of the chemotherapy on the violent, injurious and incoherent behavior of the patients, and finally, to accept the idea that the patients are really ill and need treatment. The medical team makes sure that the patient's time of stay is as short as possible to avoid the de-socialization process. They also invite the families to come each month to collect the monthly medication whose price is adjusted to the family's income. Thus, the integration of psychiatry into the religious sphere is without any doubt appropriate for enhancing the treatment of severe pathologies due to compulsory and free medication and for supporting and educating the patients' families. This kind of initiative had been proposed in Ervadi, but until now, no hospital had been erected and no psychiatrist had been appointed to visit patients. The sole change was the absence of the private mental homes that were demolished after the tragedy.

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## NOTES

(1) For the foundation of one of these Mental Homes, see the article by L. Singaravelou (2002).

(2) This research, financially supported by the French Institute of Pondicherry, was conducted between June 2001 and August 2002. Since then, I have returned for short visits from 2004 onwards. It is a part of my thesis which was submitted in 2004 and published in 2007 under the title *Les rondes de saint Antoine. Culte, possession et affliction en Inde du Sud*, Paris, Aux lieux d'être.

(3) Many British citizens of economically low class, or of bad character, joined the army to escape or jail. Statistics show that, in the 1850's, two thirds of the Europeans confined in asylums were 'second class' soldiers locked up for alcoholism, indecent behavior and vagrancy (Ernst 1991).



(4) The term 'indianization' as applied to psychiatry designates the process by which psychiatry in India is made compatible, in specific cultural contexts, with prevailing pre-existent attitudes to, and treatment for, mental disorders. It is interesting to note that the term was applied to Catholicism, by European missionaries and then by the indigenous clergy. The Church's alien concepts stood in the way of the development and extension of Catholicism in India so the clergy was obliged to integrate Indian practices and customs.

(5) See also the article by A. Venkoba Rao (1984) that discerns in the *Bhāgavad Gīta* a psychosomatic paradigm for the treatment of the body and mind, and the model of Krishna-Arjuna as exemplifying the *guru-celā* relationship, with Krishna representing the Healer of the mind of humanity and the Master and Arjuna the Patient and the Disciple who needs to be instructed and given confidence.

(6) A. Venkoba Rao (1968; 1978) mentions the *Upaniṣads* that recommend the daily practice of yoga to control the senses and the thoughts in order to prevent self-centredness and, consequently, frustrations, depression and anxiety. This technique helps to decrease stress, reduce psychic disorders, and to improve the harmony between the physical and psychological personality, between the rational and emotional aspects and, lastly, between the individual and their social and natural environment.

(7) The terminology 'codified' is used to define medicines supported by elaborated texts. Codified medicine is opposed to folk medicine.

(8) The concept of humors is common to the three systems of medicine but, in the Hippocratic system, there are four humors in Yunāni whilst in Āyurveda/Siddha, there are three humors or *doṣa/tōṣam*: bile or *pitta/pittam*, phlegm or *kapha-sleṣman/kapam-cilēṭṭumam* and air or *vāta/vātam*. The use of metals and the atrochemical processes and concepts are shared by the three systems but a comparison between the two Indian systems shows that they are much more important in Siddha than in Āyurveda (Kandaswamy Pillai, 1998; Venkatraman, 1990; Thottam, 2000). Regarding the mutual influence of Siddha and Arabic alchemy, see K. Natarajan, 2004, and for a discussion on pulse reading, see P. Kutumbiah, 1967.

(9) This book edited in 1999 by CCRAS (Central Council for Research in Ayurveda and Siddha) presents some clinical studies conducted during 1974-1975, notably some double-blind tests used to analyse the efficacy of herbs such as *Brāhmyādiyoga*, *Tagara* or *Sarpagandhā* in the treatment of schizophrenia.

(10) This relationship between mental disorders and overheating takes on its full meaning in the Tamil language, because excess of heat is expressed by the word *pitta* 'excess of bile' (*pittu* 'bile') and *pittan* means 'mad' 'idiot'.

(11) Application of this paste on the head is explained by the fact that psychic and behavioural disorders are conceived as a malfunction of mind (*manam*), intelligence, discernment (*putti*, *putticālittanam*) that resides in the brain (*mūlai*) (also mentioned by G. Obeyesekere, 1977). This is at odds with the more classical Āyurvedic texts that localise *buddhi* and *manas* in the heart (in *Bhela samhitā*, *manas* is situated between the top of the skull and the palate).

(12) According to the Indian conception, cooling substances and actions are associated with purity. Given that evil spirits hate purity, a body that is too pure is inhospitable to them.

(13) A. Bottero (1991) considers that the concept of 'culture-bound syndrome' cannot apply to 'dhātu syndrome' because this syndrome is not specific to Indian culture but is common to many societies. Even in western countries, the concept existed in the 19<sup>th</sup> century; and before that the Church had moralized sexuality. The article of A. Sumathipala et al. (2004) upholds this opinion.

(14) The article by A. Sumathipala, S.H. Siribaddana and D. Bhugra (2004) lists the psychiatric studies that were carried out in India on the topic of 'dhātu syndrome'. It analyses

most notably the relation between this syndrome and the psychiatric diagnosis. The current diagnoses are neurotic, hypochondriac and anxiety disorders. Some studies mention cases of 'dhātu syndrome' completely free of psychic or somatic symptoms.

(15) The apparition of Goddess Mohini (tm. Mōkīni) in the dreams of young men is associated with eroticism. She possesses the body, sucks the penis and obliges the young man to have intercourse with her; he is completely exhausted when he wakes in the morning after such dreams (Racine, 1999; Sébastia, 2007b)

(16) The *koṭimaram* is a post raised in front of the *sanctum sanctorum* of a deity in a temple. During the annual festival it flies a flag or *koṭi* representing the deity in external manifestation. This structure has been adopted into Catholicism and is often the object of great veneration. In Puliampatti, the top of the post is considered to concentrate the power of Saint Anthony due to its situation in front of the statue and of its contact with the flag raised during the annual festival.

(17) Among the sixty-one patients studied during my fieldwork 2001-2002, more than twenty were still in Puliampatti in May 2006 and two have chosen to reside there permanently. Except for two or three patients, they have all stayed there continuously without going back to home.

(18) In order to move the saint (or a deity) and force him to resolve the problems, people make promises to him, such as to make offerings, to perform spiritual exercises including staying a fixed number of days in the shrine, for Puliampatti: 13 days, the sacred number of Saint Anthony of Padua or 42 to 48 days, corresponding to a *maṅkalam*, an auspicious period of time which is necessary to bring the crisis to an end. So as to avoid the duration of time determined by the vow, I chose patients who had been staying in the shrine for a minimum of two months. This allowed for a better appreciation of the relationship between parents and patients, of the taking charge of the therapeutic systems by the families and of their resistance in the face of the illness.

(19) The place allotted to Āyurvedic medicine in the article by M. Halliburton (2004) is contextual since the author has selected a group of patients treated by Āyurvedic medicine in the Government Āyurveda Mental Hospital at Kottakkal, the unique Āyurvedic hospital for mental pathologies in India.

(20) The kinship system in Tamil Nadu is Dravidian. Alliances between maternal uncle and niece and cross-cousin notably between a girl and her maternal uncle's son) are preferred. Traditionally, the first marriage respects the rules of endogamy (alliance inside the family and concomitantly the caste); these rules are not valid for the secondary alliances. Add that, in India, mental illness is a motive to ask and to obtain the divorce.

(21) For a discussion on the efficacy of electro-convulsive therapy in India in relation to different psychiatric pathologies and on its dangers, see A.K. Agarwal et al. (1997); G.D. Shukla (1989).

(22) The quality of psychiatry of the Institute of Mental Health of Chennai (government psychiatric hospital for the State of Tamil Nadu) is much better than that of the psychiatric unit of *High Ground* and medicines are freely provided for poor patients. However, patients are very rarely taken there due to the doubtful reputation of this hospital some of whose buildings belonged to the ancient asylum of Madras; it is situated at a great distance from the residences of the patients who frequent Puliampatti and this involves significant expenditure for transport and for the accommodation of family (there are a few places that accommodate the family with the patient).

(23) In conclusion, this study emphasizes the improvement of the health as perceived by the patients according to the medical system they have chosen.

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