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FINAL PRESENTATION

Women's Pathways to Mental Health in India:
Comparing Psychiatry and Mystical-Spiritual Healing

Prologue

In the August of 2001, a fire tragedy in a small South Indian town became the focus of major headlines in the Indian and international media. The event[1] (since then infamously referred to as the "Erwadi tragedy") occurred in a Sufi shrine, one of countless mystical-spiritual healing centers for people with mental illnesses in the country. It resulted in the death of twenty eight mentally ill persons who had been tied to their cots by "divine chains" when the fire broke out, and were unable to escape. The incident set off massive debates related to mental health policy and practice in the country, and indeed, doubts concerning India's commitment to development in the twenty first century. That practices such as the chaining of people with mental illnesses were prevalent and magico-religious healing systems were popular and thriving in India was a matter of shame for the country. One media report in a leading national magazine drew the readers' attention to the lack of facilities for humane and "scientific" treatment of the mentally ill in the country[2]. The media rhetoric cast the incident in terms of a 'traditional vs. modern' dichotomy in postcolonial India, which clearly indexed the moral superiority of the modern over the traditional. This discourse was espoused by a nation that had, since independence from British rule, valued 'science' as freedom and enlightenment (Prakash 1999, Nandy 1988). Traditional healing had indeed come to epitomize the backward, superstitious and archaic India that conflicted with its contemporary modern image.

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[1] Details of the incident are reproduced here by combining news reports in the daily The Hindu, the fortnightly magazine Frontline and the BBC South Asia reports from the year 2000 and 2001.
[2] 2001. "Deliverance in Erwadi", Frontline, 18 (17)

A series of policy formulations followed the furor and public rhetoric that the Erwadi tragedy instigated. Following the incident, the Supreme Court of India passed the following judgment:

> The Government shall undertake a comprehensive awareness campaign with a special rural focus to educate people as to provisions of law relating to mental health, rights of mentally challenged persons, the fact that chaining of mentally challenged persons is illegal and the mental patients should be sent to doctors and not to religious places such as temples or dargahs. (Order dated February 5, 2002, Supreme Court of India)

This event and its repercussions provide the context for my arguments in this presentation. For it is likely to impact the lives of a vast majority of Indian women experiencing mental distress and seeking help in places such the Sufi shrine in Erwadi. Mystical-spiritual healing sites in India are largely female healing spaces.

Women's Mental Distress and Help-Seeking Pathways in India

In India, women's predominance in magico-religious healing traditions is well documented[3] (Varma et. al 1970; Kakar 1982; Skultans 1991; Ram 1992; Davar 1999; Dwyer 2003). These healing traditions are typically based on notions of supernatural affliction, such as spirit possession, sorcery, and healing practices such as exorcism and ritualized ceremonies (Bourguignon 1973). Women tend to seek healing in mystical-spiritual traditions to a far greater extent than men. In contrast, psychiatric epidemiological data reveals low attendance by women in public health psychiatric facilities; tertiary psychiatric hospital records generally cite a ratio of one woman to every three men attending outpatient clinics (Davar 1995). This is despite the fact that community studies indicate an equal, if not higher, distribution of psychiatric disorders

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[3] Women's predominance in magico-religious healing sites is well documented in anthropological and mental health related literature from across the world (Boddy 1994; Castillo 1994; Bourguignon 2004; Seligman 2005), not only in India.

among women (Chakraborty 1990; Jablensky, et al. 1992). These trends beg the question: why do such a large number of women seek help in mystical-spiritual healing sites and are relatively absent in psychiatric settings? How can India's mental health policy framework respond to these trends in effective ways?

This paper argues three points: one, that India's current mental health policies are detrimental to women's mental health needs. Two, in order to formulate policies that can effectively address women's mental health concerns, the reasons behind their help-seeking strategies need to be better understood. The third point ties in with the second – I argue that present scholarship in the area fails to explain the reasons behind women's help-seeking strategies adequately. I will now present my arguments one by one.

Mental health policy making and implementation in India in recent years has been informed by an international framework of human rights, bioethics and stigma reduction. Set against such a global framework, magico-religious healing sites become problematic at many levels. Healing practices such as the chaining of healing-seekers, flogging to exorcise illness-causing spirits, inflicting pain to one's body as penance are admonished as violations of human rights. The state has difficulty regulating these largely amorphous practices to ensure that they follow bioethical principles just as biomedical practices are required to. The use of 'superstitious' narratives of spirit possession, sorcery and religious healing, state spokespersons believe, tend to encourage stigma in communities (Patel and Thara 2003).

As a result, these sites face potential extinction in the country despite being crucial actors in mental health care delivery, especially for vulnerable populations such as women. Doing away with mystical-spiritual healing risks throwing the "baby out with the bathwater". It would be

worthwhile to understand the reasons behind women's preference for mystical-spiritual healing to better inform mental health policy in the country.

Moving forward to my second point, in order to formulate policies that are sensitive to women's mental health needs, there has to develop an understanding of their help-seeking strategies. I think that attempting such an understanding requires a comparative method, one that looks simultaneously at the two healing options that Indian women usually access: mystical-spiritual healing sites and psychiatric clinics. I believe that in employing a comparative method, some critical anthropological and feminist notions regarding the problem might get reconfigured, and scholarship might be able to better inform policy.

Looking simultaneously at the two treatment facilities from a gender perspective decenters prevailing anthropological and feminist notions that theorize women's preferences for either. This is my third point; existing anthropological and feminist scholarship falls short in explaining Indian women's preference for traditional healing systems over psychiatry. For instance, a number of scholars have emphasized the empowering potential of possession-trance states for women in patriarchal settings – psychological states that form a crucial aspect of magico-religious healing (Bourguignon, 2004). Women's preponderance as the afflicted and possessed, these scholars suggest, speaks of the mental and social distress they experience in patriarchal settings. Possession can become a language of resilience, resistance and rebellion for women, and healing sites provide a safe space for its expression. Bourguignon (2004), for example, argues that possession serves both as a culturally consonant expression of distress and self-assertion for women.

But these arguments do not explain the Indian case in its entirety. Mystical-spiritual healing sites might not just be sites for expressing rebellion or emancipation but rather a reflection of

patriarchy as it exists in the larger society. Skultans (1991), for example, finds in her study of a traditional healing temple in Western Maharashtra that women's mental afflictions are marginalized and stigmatized in comparison to men.. Possession-trance, the activity whereby healing is primarily sought reifies "… the stereotypes of male fortitude and health and female weakness and ill-health…" (p. 352). Why, then, do Indian women prefer mystical-spiritual healing sites if not necessarily for their emancipatory potential?

What about psychiatry? Do women stay away from psychiatry because of its social labeling and social control functions that is so often claimed (Scheff 1999; Foucault 2001)? Feminist scholars condemn psychiatry for seeking explanations of women's mental illness in their minds and bodies, delegitimizing the necessity for social change to end patriarchy (Dennerstein et al. 1993; Davar, 1999; Addlakha, 2001). However, a psychiatric anthropological perspective (Levy 1992) emphasizing how the practice of biomedical psychiatry is distinctively shaped by local cultures poses serious challenge to these feminist critiques in the Indian setting. Addlakha (2001), for instance, notes the dilemma of a psychiatrist in an Indian hospital when faced with the issue of domestic violence against a female patient. Having no other requisite resources to remove her from the situation, the psychiatrist contemplates admission to a psychiatric ward as a 'protection' measure. How would psychiatric labeling in such a scenario be judged? Nunley (1988) points out another distinctive character of Indian psychiatry. In India, families exercise a great degree of control over critical aspects of the psychiatric process including defining the illness and treatment decisions. This reconfigures psychiatry's social control and labeling roles in crucial ways. If gender politics does play out in the practice of Indian psychiatry, it does so in very complex interactions between psychiatrists and families, not just between psychiatrist and the woman.

Thus, superficial dichotomies between the patriarchal oppression inherent within psychiatric practice and the emancipatory potential of mystical-spiritual healing may not offer adequate explanations for women's help-seeking strategies. Such differing claims within anthropological and feminist theory may tend to romanticize traditional healing or vilify biomedical psychiatry and obscure the gendered complexities inherent within both systems. For women in search of healing, *both* treatment facilities seem to echo and reproduce the larger patriarchal structures within microcosmic therapeutic practices (Skultans 1991; Davar 1999).

Conclusion

In conclusion, there is a need for a fresh perspective that centers women's subjective experiences in the analyses and moves beyond superficial dichotomies of the traditional versus modern or that between the emancipatory potential of traditional healing versus the oppression of psychiatric practice. When viewed from a comparative standpoint of options available to women experiencing mental distress in Indian settings, it becomes imperative to untangle the complex processes that inform their help-seeking strategies. Current anthropological and feminist scholarship that theorize women's help-seeking behaviors do not explain the Indian case too well. At the same time, the discourse on 'traditional versus modern' within state policy circles lead to responses that are ill-informed and ultimately inimical to women's mental health needs. A comparative method that looks simultaneously at the two options that women seek might hold the promise of providing more convincing answers to the Indian case.