

WORLD

Zeitschrift für Medizinethnologie • Journal of Medical Anthropology

hrsg. von/edited by: Arbeitsgemeinschaft Ethnomedizin e.V. – AGEM



**Kultur, Medizin und Psychologie im Dialog I
– Bilanzen im interdisziplinären Arbeitsfeld
Ethnologie & Medizin.
Beiträge zur 21. Fachkonferenz
Ethnomedizin 2008, Remscheid**

Zum Titelbild: Das Titelbild zeigt ein Exponat aus dem Essener Museum "Soul of Africa". Das im Ortsteil Essen-Rüttenscheid gelegene Privatmuseum von Henning Christoph besitzt unter anderem speziell zur westafrikanischen Voodoo-Kultur vielfältige Exponate (Rüttenscheider Str. 36, 45128 Essen). Das Museum wurde während der 21. Fachkonferenz Ethnomedizin in Remscheid besucht. Die Abbildung wurde freundlicherweise zum Nachdruck zur Verfügung gestellt. www.soul-of-africa.com © by Soul of Africa e.V. mit freundlicher Unterstützung von www.shikra.de

To the title: The cover shows an exhibit from the private museum "Soul of Africa" in Essen-Rüttenscheid. This museum is specialized in voodoo culture from West Africa. An excursion to this fine museum was part of the Remscheid meeting.

Die nächsten Hefte / forthcoming issues:

Curare 32(2009)3+4: Themen: 30 Jahre Transkulturelle Psychiatrie in der *Curare*. // Beiträge zum 100. Geburtstag von Georges Devereux. (Themes: 30 years transcultural psychiatry in the Journal *Curare*; // Contributions on the 100 anniversary of Georges Devereux); Herausgegeben von / edited by U. KLUGE, E. SCHRÖDER & M. WIENCKE

Curare 33(2010)1+2: New Trends in Ethnobotany and Ethnopharmacology. Proceeding of the 6th European Colloquium of Ethnopharmacology / 20th conference "Ethnomedizin" / Medical Anthropology at Leipzig 8th to 10th November 2007, edited by EKKEHARD SCHRÖDER, RUTH KUTALEK, ANNETTE LEIBING *et al.*

Arbeitsgemeinschaft Ethnomedizin – AGEM, Herausgeber der

Curare, Zeitschrift für Medizinethnologie • Curare, Journal of Medical Anthropology (gegründet/founded 1978)

Die Arbeitsgemeinschaft Ethnomedizin (AGEM) hat als rechtsfähiger Verein ihren Sitz in Hamburg und ist eine Vereinigung von Wissenschaftlern und die Wissenschaft fördernden Personen und Einrichtungen, die ausschließlich und unmittelbar gemeinnützige Zwecke verfolgt. Sie bezweckt die Förderung der interdisziplinären Zusammenarbeit zwischen der Medizin einschließlich der Medizinhistorie, der Humanbiologie, Pharmakologie und Botanik und angrenzender Naturwissenschaften einerseits und den Kultur- und Gesellschaftswissenschaften andererseits, insbesondere der Ethnologie, Kulturanthropologie, Soziologie, Psychologie und Volkskunde mit dem Ziel, das Studium der Volksmedizin, aber auch der Humanökologie und Medizin-Soziologie zu intensivieren. Insbesondere soll sie als Herausgeber einer ethnomedizinischen Zeitschrift dieses Ziel fördern, sowie durch regelmäßige Fachtagungen und durch die Sammlung themenbezogenen Schrifttums die wissenschaftliche Diskussionsebene verbreitern. (Auszug der Satzung von 1970)



**Zeitschrift für Medizinethnologie
Journal of Medical Anthropology**



Herausgegeben im Auftrag der / Edited on behalf of:

Arbeitsgemeinschaft Ethnomedizin e.V. – AGEM
von Ekkehard Schröder, auch verantwortlich im Sinne des Presse-
rechtes V.i.S.d.P. / Editor-in-chief

Geschäftsadresse / office AGEM: AGEM-Curare
c/o E. Schröder, Spindelstr. 3, 14482 Potsdam, Germany
e-mail: ee.schroeder@t-online.de, Fax: +49-[0]331-704 46 82
www.agem-ethnomedizin.de

Herausgeberteam / Editorial Board Vol. 31(2008) - 35(2012):

Hans-Jörg Assion (Detmold) info@gpz-lippe.de // Ruth Kutalek
(Wien) ruth.kutalek@meduniwien.ac.at // Kristina Tiedje (Lyon)
kristina@tiedje.com // Anita Zahlen-Hingurange (Basel) azahlen@yahoo.de

Beirat / Advisory Board: John R. Baker (Moorpark, CA, USA) //
Michael Heinrich (London) // Mihály Hoppál (Budapest) // An-
nette Leibing (Montreal, CAN) // Armin Prinz (Wien) // Hannes
Stubbe (Köln)

Begründet von / Founding Editors: Beatrix Pfeleiderer (Ham-
burg) – Gerhard Rudnitzki (Heidelberg) – Wulf Schiefenhövel
(Adechs) – Ekkehard Schröder (Potsdam)

Ehrenbeirat / Honorary Editors: Hans-Jochen Diesfeld (Starn-
berg) – Horst H. Figge (Freiburg) – Dieter H. Frießem (Stuttgart)
– Wolfgang G. Jilek (Vancouver) – Guy Mazars (Strasbourg)

IMPRESSUM 32(2009)1+2

Verlag und Vertrieb / Publishing House:

VWB – Verlag für Wissenschaft und Bildung, Amand Aglaster
Postfach 11 03 68 • 10833 Berlin, Germany
Tel. +49-[0]30-251 04 15 • Fax: +49-[0]30-251 11 36
e-mail: info@vwb-verlag.com
<http://www.vwb-verlag.com>

Bezug / Supply:

Der Bezug der *Curare* ist im Mitgliedsbeitrag der Arbeitsgemein-
schaft Ethnomedizin (AGEM) enthalten. Einzelne Hefte können
beim VWB-Verlag bezogen werden // *Curare* is included in a
regular membership of AGEM. Single copies can be ordered at
VWB-Verlag.

Abonnementspreis / Subscription Rate:

Die jeweils gültigen Abonnementpreise finden Sie im Internet
unter // Valid subscription rates you can find at the internet under:
www.vwb-verlag.com/reihen/Periodika/curare.html

Copyright:

© VWB – Verlag für Wissenschaft und Bildung, Berlin 2009

ISSN 0344-8622

ISBN 978-3-86135-757-5

Die Artikel dieser Zeitschrift wurden einem Gutachterverfahren
unterzogen // This journal is peer reviewed.



Zeitschrift für Medizinethnologie
Journal of Medical Anthropology



hrsg. von/ed. by Arbeitsgemeinschaft Ethnomedizin (AGEM)

Inhalt / Contents
Vol. 32 (2009) 1+2
Doppelheft / Double Issue

**Kultur, Medizin und Psychologie im Dialog I:
Bilanzen im interdisziplinären Arbeitsfeld
Ethnologie & Medizin.**

Beiträge zur 21. Fachkonferenz Ethnomedizin 2008, Remscheid

Herausgeber / Editors:

MARKUS WIENCKE, ULRIKE KLUGE & EKKEHARD SCHRÖDER

ERNST E. BOESCH gewidmet

Editorial

MARKUS WIENCKE: Ethnologie und Psychologie im Dialog. Editorial 3

Allgemeine Perspektiven

REINER BÜCH: Erinnerung an die Konnotationsanalyse. Zur Methodik der Symbolischen Handlungstheorie und Kulturpsychologie von Ernst E. Boesch 10

BERND RIEKEN: Volkskunde und Psychologie. Gemeinsamkeiten und Unterschiede 18

HORST H. FIGGE: Erlebte Wirklichkeit, Krankheit und Krankheitsbewältigung. Ein Diskussionsbeitrag aus psychologischer Sicht zur 21. Fachkonferenz Ethnomedizin 23

Fallstudien

HELENE BASU: Contested Practices of Control: Psychiatric and Religious Mental Health Care in India 28

MARTIN DESCHAUER: Subjektivität in der Behandlung psychischer Krankheiten – Das Konzept des strategischen Synkretismus am Beispiel der Depressionstherapie 40

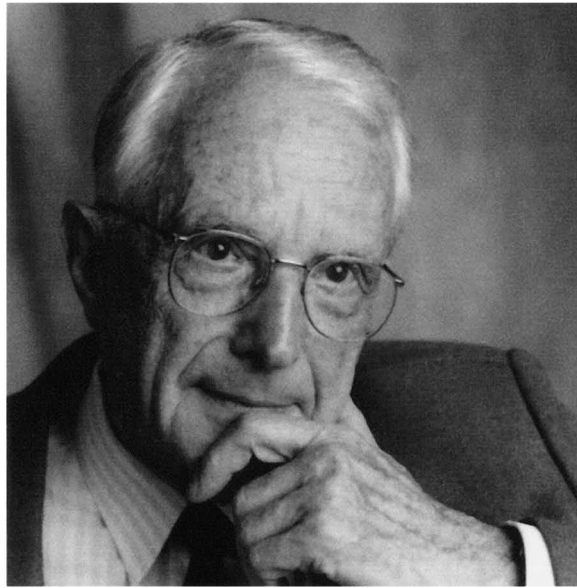
CARSTEN KLÖPFER: Coping-Prozesse bei HIV/Aids-Patienten aus der Perspektive westlicher und buddhistischer Psychologie 48

GUIDO SPRENGER: Die Pflege der Dissoziation. Die Ideologie der Moderne und die Schamanen der Rmeet, Laos	64
MARKUS WIENCKE: Kulturelle Vielfalt als Ressource bei Schizophrenie. Ein Beispiel aus einer interkulturellen Gemeindepsychiatrie für Mapuche in Chile.	78
EVA ZÖLLER: Die Bewältigung chronischer Schmerzen im biografischen und kulturellen Lebenszusammenhang – Eindrücke aus Deutschland, Thailand und Australien	84
Freie Beiträge im Zusammenhang mit der Tagung	
ARNE STEINFORTH: Whose Madness? Diverging Manifestations of Mental Illness in Dialogue	96
WOLFGANG KRAHL: Der Impact-Faktor – ein Instrument zur akademischen Hegemonie? Das Beispiel psychiatrischer Journale und die Auswirkungen auf Entwicklungsländer	106
ERNST EDUARD BOESCH: Die poetische Sicht [Reprint (Privatdruck 2008)]	113
Freier Beitrag	
BERND BRABEC DE MORI: Words Can Doom. Songs May Heal: Ethnomusicological and Indigenous Explanations of Song-Induced Transformative Processes in Western Amazonia	123
Berichte und Reports	
MANTON HIRST: Cape Town August 2007. Promoting Dialogue between Jungian Analysts and African Traditional Practitioners in South Africa – 145 // ASSIA MARIA HARWAZINSKI: Reproduktionsmedizin bei Muslimen: Religiöse und säkulare Ethiken im Widerstreit? Tagung am 20. Juni 2008 in Tübingen – 147	145
Buchbeprehungen / Book Reviews	
THEDA BORDE & DAVID MATTHIAS (Hg) 2008. Frauengesundheit, Migration und Kultur in einer globalisierten Gesellschaft. Frankfurt // OLIVER RAZUM, JÜRGEN BRECKENKAMP & PITT REITMAIER (Hg) 2008. Kindergesundheit in Entwicklungsländern. Frankfurt // ELS VAN DONGEN & RUTH KUTALEK (eds) 2007. Facing Distress. Distance and proximity in times of illness. Wien, Berlin // HELGA JOCKENHÖVEL-SCHIECKE 2008. Soziale Reproduktion in den Zeiten von AIDS. Waisen und ihre Familien im ländlichen Tansania. Berlin // KLAUS-DIETRICH STUMPF (2007). Glaubensheilungen in Geschichte und Gegenwart. Köln // SIBYLLE VAN DER WALT & CHRISTOPH MENKE (Hg) 2007. Die Unversehrtheit des Körpers. Geschichte und Theorie eines elementaren Menschenrechts. Frankfurt	150
Dokumentation Zeitschriften/Journals (EthnoScripts // Ethnologia Americana // Shaman)	157
Die Autorinnen und Autoren in Curare 32(2009)1+2	160
Zum Titelbild	U2
Impressum	U2
Hinweise für Autoren / Instructions for Authors	U3

Endredaktion: MARKUS WIENCKE & EKKEHARD SCHRÖDER
 Redaktionsschluss: 30.06.2009

Die Artikel in diesem Heft wurden einem Reviewprozess unterzogen / The articles of this issue are peer-reviewed

*Die Arbeitsgemeinschaft Ethnomedizin
widmet diese Curare-Ausgabe ihrem im 93. Lebensjahr stehendem Ehrenmitglied
ERNST EDUARD BOESCH aus St. Gallen,
dem bedeutenden Psychologen, Psychoanalytiker und Kulturtheoretiker*



It is the dilemma of psychology to deal as a natural science with an object that creates history. Indeed, the being whose perceptions, thoughts, and emotions we patiently study in time-consuming experiments, is at the same time the inventor of electricity and atom bombs, carrying the names of Mozart, Picasso, Einstein, Churchill, Hitler, Stalin, or Pol Pot; it is the one who inquires, nurses, builds, tortures, kills, and seduces. The real actions of the object of our studies, their profit or loss to society, occupies only a small place in psychological publications. It seems as if there were two kinds of human beings, the ones in the aseptic laboratories of psychologists, and the other ones with whom we live as partners, friends, or enemies.

—E. E. Boesch, 1971

Rückseite des Buches von WALTER J. LONNER & SUSANNA A. HAYES (eds) 2007. *Discovering Cultural Psychology. A Profile and Selected Readings of Ernest E. Boesch*. (A volume in "Advanced Studies in Cultural Psychology"). Charlotte, North Carolina: IAP, Information Age Publishing, 371 S. mit einer kompletten Liste der Veröffentlichungen Boeschs von 1942-2006.

Contested Practices of Control: Psychiatric and Religious Mental Health Care in India*

HELENE BASU

Abstract Care for the mentally ill is of growing concern to the contemporary Indian public. In the early years of the 21st century, psychiatric and religious institutions became the focus of a public media scandal. In the course of an accident that happened at a Muslim shrine, 26 mentally ill people died. They had been chained. The ensuing media campaign not only scandalised a cruel and backward tradition, symbolised by the chains, but also the conditions prevailing in mental hospitals, the successors of the colonial export of lunatic asylums. The controversy debated the legitimacy or illegitimacy of different treatment methods for the mentally ill, and heavily drew on the opposition of a progressive modernity against backward traditions. Body controls provided the implicit focus of this debate. This paper draws attention to the simultaneous existence of psychiatric and religious institutions in the context of the pluralistic medial sphere in contemporary India. The comparative analysis of body control practiced in a mental hospital and in Muslim shrines builds upon ethnographic research conducted in sites that constitute the poles of a continuum of diverse and changing discourses and practices related to the treatment of mental illness in India.

Keywords politics of psychiatry – institutional psychiatry – religious healing – body control – India

Umstrittene Kontrollpraktiken: Psychiatrie, Religion und seelische Gesundheit in Indien

Zusammenfassung In Indien erhält die Versorgung psychisch Kranker seit einigen Jahren wachsende Aufmerksamkeit. Anfang des 21. Jahrhunderts gerieten psychiatrische und religiöse Institutionen in den Fokus eines öffentlichen Skandals. Auslöser war ein Unglück an einem muslimischen Heiligenschrein, bei dem 26 psychisch Kranke ums Leben kamen. Sie waren an Bäume angekettet. Die mediale Verfolgung dieses Ereignisses rückte nicht nur eine vermeintlich grausame, durch die Ketten symbolisierte Tradition ins Rampenlicht der Kritik, sondern auch die Bedingungen der institutionalisierten Psychiatrie, dem Erbe der kolonialen Anstaltspsychiatrie. Die Kontroverse um legitime oder illegitime Behandlungsformen von Geisteskrankheit, die im Zeichen des Gegensatzes zwischen einer fortschrittlichen Moderne und einer rückständigen Tradition geführt wurde, kristallisierte sich im Streit um Körperkontrollen. Unterschiedliche Techniken zur Kontrolle des Körpers von Geisteskranken und die Gleichzeitigkeit psychiatrischer und religiöser Institutionen zur Behandlung von Geisteskrankheit im Kontext des gegenwärtigen pluralistischen Gesundheitssystems stehen im Zentrum dieses Aufsatzes. Die vergleichende Analyse gründet in ethnologischen Feldforschungen in einer Anstaltspsychiatrie und in muslimischen Heiligenschreinen, welche die Pole eines Kontinuums vielfältiger Diskurse und sich wandelnder Praktiken in der Behandlung von psychisch Kranken in Indien markieren.

Schlagwörter Psychiatriepolitik – Psychiatrie als Institution – Heilung und Religion – Körperkontrolle – Indien

In contemporary India, the conditions prevailing in the pluralistic mental health-care sector are of growing concern to a range of social actors. Politicians, law courts, psychiatrists and psychiatric institutions, the public media, temples and shrines, ritual healers, patients, families, nongovernmental organisa-

tions (NGOs) and the World Health Organisation (WHO) are variously engaged in the country in the field of mental health care. Since the 1990s, when liberal policies opened up the Indian economy more to global flows of capitalism and culture, a new public discourse has emerged with a distinct focus on men-

* This is a revised version of a paper presented at the “21. Fachkonferenz Ethnomedizin: Kultur, Medizin und Psychologie im Trialog: Bilanzen im interdisziplinären Dialog. Ethnologie und Medizin”, held at Remscheid, Germany, 5-7 December 2008¹. I thank the Fritz-Thyssen-Stiftung for a travel grant enabling me to carry out fieldwork in 2008 and to the Cluster of Excellency, WWU Muenster, for generously supporting the writing of my research. I also want especially to thank Vasudeo Paralikkar, Chitra Khare, the staff of the Mental Hospital in Pune and all those who have greatly helped me in conducting ethnographic research for this project..

tal health care. Social and cultural responses to those suffering from diseases of the mind became issues of general interest, and the past decade has seen psychiatrists striving more intensely to achieve authority and a symbolic recognition of their knowledge and status. In the arena of cosmopolitan medicine, psychiatrists feel they are accorded less prestige, often being called pejoratively “doctors of the mad”, and they earn less money compared to other medical specialists such as orthopaedists. In the field of medical pluralism, which is shaped by a range of more or less formal vernacular healing systems, psychiatrists compete with a host of healers and healing institutions who deal with mental illness in terms of cosmological concepts. Surveys conducted in the late 1990s record that the vast majority of Indians cope with mental illness by turning to “traditional healers”. One of the most widespread explanatory models of mental disorder encountered by researchers was based on occult theories of sorcery and black magic (GUJARAT 2003: 52ff). Not surprisingly, such explanations prove unacceptable to many psychiatrists, who stress instead the “rational”, that is, biological causes and scientific treatment of mental disease.

While many psychiatrists are critical of cosmologically oriented healing practices for madness, professional psychiatry itself is characterised by heterogeneous approaches and institutions. In India, psychiatric care is delivered through different kinds of institutions, such as specialised mental hospitals, psychiatric sections in general hospitals, outpatient departments, community care centres and clinics of private practitioners. Although the dominant orientation in Indian psychiatry is biological, psychoanalytic approaches being confined to a small section of the elite, psychiatrists apply different theoretical and practical approaches, depending on the institutional settings they are working in. A major issue of debate amongst Indian psychiatrists and other actors in the field of mental health care revolves around relationships between culture and psychiatry (KAKAR 1982; KAPUR 1979). Another, related issue concerns the search for strategies to develop community care as an alternative to institutional psychiatry, especially large mental hospitals (PADMAVATI 2005). The latter, the heirs to the lunatic asylums established by British colonialism in the nineteenth century, have come under special scrutiny. Nonetheless mental hospitals maintained by the government still function as major providers of care for the mentally ill in India.

However, medical pluralism in the field of mental health care does not mean that different paradigms are equally acknowledged. As elsewhere, “modern” (biologically oriented) psychiatry claims in India a superior validity over vernacular healing systems, which are dismissed as “backward” and “superstitious”. The sharp asymmetry between psychiatry and vernacular forms of healing madness was dramatically reinforced by a scandal that broke in the media in 2001 over the discovery that mentally ill persons were being kept chained up at religious healing sites. In the wake of this crisis, however, the condition of institutional psychiatry in India (mental hospitals) was criticised as well. Ways of restraining and controlling the mentally ill became an issue on both types of site.

This particular media scandal provides the starting point for the following analysis of contested practices of control of the mentally ill. I shall then present ethnographic evidence 1) from a mental hospital with 2400 beds, more than 1600 of which are occupied by patients who have been diagnosed with severe psychotic disorders, mostly schizophrenia; and 2) from Muslim shrines offering ritual cures to hundreds of individuals afflicted with occult madness. Each site provides a different way of coping with mental illness for both families and those afflicted. Mental illness, however defined, is loaded with a host of negative connotations and experiences for both the afflicted person and his or her social environment: disorder and the disruption of social relationships, violence by the victim, suffering, fear and stigmatisation are the most common consequences of mental illness. While control is an ‘is an inalienable aspect of healing’ generally (KLEINMAN 1988: 124), historically and culturally constituted forms of controlling mental illness are judged as ambiguously as madness itself. In the pluralistic field of mental health care in India, coexisting institutional (psychiatric) and vernacular (religious, cosmological) ways of healing madness exemplify different systems of classification and corresponding forms of social and therapeutic control. These differ especially in terms of the degree of specialisation: the mental hospital testifies to processes of differentiating a medical sphere from a religious one. Within the medical sphere, different types of disease are further separated according to the division of mind and body, which defines professional treatment in terms of the organs and body parts affected, in this case the brain. Institutions of healing

grounded in cosmological concepts such as Muslim shrines, on the other hand, provide evidence of the fusion of religious and medical categories in accordance with more unified notions of the relationship between mind and body. Thus, both systems produce different understandings of the body as the site of the control of mental disorder.

Heuristic models developed in the anthropological study of ritual may help to understand the choices Indians make today in the pluralistic field of mental health care from a new perspective. Of particular relevance is the typology which Mary Douglas originally suggested as a challenge to evolutionist taxonomies of primitive and modern conceptions of ritual (DOUGLAS 1973). She emphasised the complex web of relationships between worldview, social organisation and body control as producing different forms of ritual, instead of distinguishing ritual practices as mirroring stages of cognitive or historical development. Her model of “grid and group” distinguishes forms of ritualisation in terms of formal or informal social roles, more or less differentiated classificatory systems and stronger or weaker forms of body control along one axis, and different kinds of social organisation, social control and the hold of a group over its members along the other. A good example from the Indian context is trance: Brahmins and other high castes, in which authority is embedded in highly differentiated and formalised ritual and kinship roles, generally do not practice rituals involving trance, whereas these are widely encountered among lower castes with less formal social organisation. Since Douglas’ model rested on the comparison of whole societies, it seemed less useful when anthropologists turned to exploring the intermingling, shifting and de-territorialising movements of global cultural processes. More recently, however, Catherine Bell has suggested a recasting of Douglas’ model by applying it to “the simultaneous presence [in one locality] of competing, complementary, or overlapping social and ritual subsystems” (BELL 1997: 185). In the context of mental health care in India, this more flexible approach allows us to focus on the differences and similarities of institutional world views and their relationships to techniques of body control in both settings, the psychiatric and the cosmological. In this case, I argue, decisions for one or the other institution are closely related to exercising “control over contested control”. The point, therefore, is not whether

one system is modern, the other backward, but rather which forms of control Indians choose or reject.

Contested practices in the public arena: the scandal of chains

In 2001, 26 mentally ill people died during a fire at a Muslim saints’ shrine in the village of Erwadi in South India. Their dead bodies were found chained to trees and pillars. I happened to be in India at the time and closely followed the reports of the event in the print media and on the internet. A major weekly magazine published in English, *Frontline*, covered the event in detail, including the outrageous practices current at the shrine that came to light after the accident. The managers of the shrine knew nothing about mental illness, *Frontline* told its readers, but talked about madness caused by spirit possession and sorcery. Worse, private homes were being run by people who themselves had been “mentally challenged” before they found an easy way to earn money by renting out huts to patients who had been abandoned by their relatives and been chained up.¹ The traditional system was exploitative, based on ignorance and therefore prone to violating the most basic human rights of the mentally disabled.

In the media, the chains of the dead assumed a great symbolic force, epitomizing for many a shockingly superstitious and cruel tradition being mindlessly followed in “faith healing centres” all over India. In its online edition, the *Times of India* stated categorically: “The treatment given in these centres are [sic!] diabolic and inhuman”. According to the article, not only chaining but caning, whipping and beating are routine practices as well, allegedly “in the name of driving away [...] the influence of ghosts”² Psychiatrists suddenly stood in the limelight of media attention when they were asked as experts to explain the “Erwadi tragedy”. Many shared the views offered by a local psychiatrist interviewed immediately after the accident: “Faith-healing has no role to play in treating the mentally ill. [...], most often the patients are chained [...] and they are beaten when they become violent”. It was ignorance and the belief in “myths about mental illness”, he continued, which prevented people from seeking reliable psychiatric help.³

One year later, a team of psychiatrists from NIMHANS (the National Institute of Mental Health and Neurosciences) published an article on temple healing, which they found could have positive ef-

fects upon various psychotic disorders (RAGURAM *et al.* 2002). The authors suggested that such sites be regarded as promising but forgotten resources of psychiatric community care. However, other Indian psychiatrists strongly objected to this idea by referring to the chained victims of faith healing. One of them wrote the following comment:

I am appalled that a team of eminent psychiatrists in this era of evidence-based medicine could even think of designing such a study. The urgent need in India today is to liberate Mental Health from the dark anterooms of black magic and sorcery. [...] the study does not help in the endeavour of demystifying mental illnesses. The tragedy in one such “faith healing centre” in the same state in which a lot of mentally ill people were charred to death is too recent to have been forgotten. The tragedy happened because people were bound by chains. [...] The fact that not a single patient had received Psychiatric help underscores the point that India needs more awareness regarding the rational understanding of mental illness. These kinds of studies will ultimately lead to enforcing the traditional beliefs and myths about mental illnesses. Now the faith healers can quote BMJ!! [*British Medical Journal*] (*ibid.*)

Psychiatrists and journalists translated the unfortunate accident and the deaths of those suffering at the Muslim shrine into the familiar story of a scandalous past not yet overcome by an enlightened presence, of a tradition waiting to be superseded by modernity. Significantly, the same symbols and arguments were evoked that had figured importantly in the European history of psychiatry in the nineteenth century. The liberation of the mad from their chains is inscribed in the master narrative of modern European psychiatry as the watershed separating “enlightened” medical treatment from earlier ways of handling the insane. Foucault in particular has dramatically described how, in the seventeenth and eighteenth centuries, lunatics’ ankles and wrists were chained to the walls of madhouses (sometimes nothing else than a pigpen) or were made to carry iron rings around their necks to hold the chain (FOUCAULT 1978). The ultimate liberation of the mad from their fetters and the birth of medical psychiatry are closely associated with the French enlightenment and the name of PHILIPPE PINEL (1745-1826). Pinel is credited with having “struck off the chains from the lunatics”, thus giving birth to humanitarian medical psychiatry in asylums (PORTER 1988: 106f.). Yet there is a difference: while in the

European history of psychiatry chains are the mark of unenlightened but non-religious practices of handling the abnormal, in India the same symbol is used to signify vernacular religious healing and a discredited cultural tradition.

However, this master narrative of modern psychiatry is subject to conflicting interpretations by historians depending on the theoretical stance taken. Broadly, two opposed lines of argument concerning the role of lunatic asylums in the nineteenth century can be discerned. Because both find an echo in the public controversy on psychiatry and religious healing in India, I shall briefly summarize them here. One line expands on Foucault’s notion of modern psychiatry as an unfolding discourse of knowledge and power creating the “great confinement” of all kinds of deviant people (unemployed, tramps etc.) in specialised asylums (FOUCAULT 1978). Deviant behaviour was no longer simply criminalised but defined and pathologised as “insane”. According to this view, lunatic asylums and psychiatric knowledge systems greatly contributed to enforcing the social order of nineteenth-century capitalism in Europe. Psychiatric knowledge and institutions are techniques of social control. The other line of argument repudiates this interpretation and emphasises instead the benevolent reforms initiated in lunatic asylums by Pinel and his followers. By replacing physical restraint with “moral therapy” and custody with healing, humanitarian values began to govern the treatment of the insane (SHORTER 2003/1999). However, historians admit that this was “a history of good intentions but negative consequences” (*ibid.*: 59). Lunatic asylums soon became overcrowded, and the ideal of therapy gave way to mere custody and new forms of restraint, such as solitary cells and straightjackets. Violence among patients was frequent, sanitary provision negligible and horror stories about naked patients lying in a pool of excrements abounded. In India, the lunatic asylums established by colonial governments—initially for the care of Europeans—more or less followed the same path (ERNST 1991). Nevertheless, the idea of progress inherent in the second interpretation accords well with the development and modernisation narratives that shape the dominant discourse of psychiatry in contemporary India. By contrast, the critical view of Foucault that stresses psychiatry as a powerful tool of social control is largely ignored by psychiatric practitioners, though it is taken up more vehemently by anti-psychiatric NGOs. From their point of view,

the sweeping public denunciation of faith-healing centres is a sign of the growing power of psychiatry as a means of refining techniques of social control.

The public debates following the Erwadi scandal transposed issues that had been of great concern to nineteenth-century psychiatry in Europe into the Indian present. The media had not only discovered the existence of religious healing centres but also Indian mental hospitals. After the shelters in Erwadi had been closed down and their owners arrested, about a third of the surviving mentally ill people—still more than 500—were admitted to the largest mental hospital in the state, the Government Institute of Mental Health (IMH) in Chennai. Originally, this was a lunatic asylum founded in 1793 by the British East India Company. In 2001, it had more than 1500 patients. What was initially celebrated as a delivery soon turned out to be a great disappointment. A year after the incident, *Frontline* announced: “The mentally challenged people rescued from Erwadi are in no better state in their new surroundings”.⁴ The report added:

“Even for the 152 patients brought to the IMH, the only government hospital for the mentally challenged in Tamil Nadu, life is no different except that they are no longer in chains. [...] The death of some inmates in October 2001 owing to diarrhoea, the collapse of the main building a month later, and some incidents of violent inmates killing each other brought to light the abysmal conditions at the IMH”.

It was discovered that more than six hundred of the patients had lived for decades in the hospital, some for fifty or sixty years. Even psychiatrists working there compared it with an “eighteenth century asylum [in Europe]” (ibid.). The reasons for the conditions prevailing in this and other mental hospitals, however, were not sought in the psychiatric system, but in the lack of funds and the government’s neglect of mental health care generally. A major cause of patients remaining for decades in a mental hospital was, according to the hospital administration, the fact that the families and home addresses of many patients were unknown. As a result, even those patients whose condition had improved could not be released. Moreover, rehabilitation measures were difficult to implement because of a lack of trained staff. Thus, psychiatrists and middle-class citizens worked together in putting pressure on the government to reform the mental health-care sector in India. The

demands put forward concerned, on the one hand, control of faith healing centres—if they could not be abolished completely, they should at least be brought under state control through a licensing system—and, on the other hand, the development and expansion of institutional care. The government should take mental health care more seriously and spend more funds on the training of psychiatric staff and the reform of existing psychiatric institutions. In the long run, this should result in wiping out superstitious beliefs in possession and sorcery. By 2002, the Supreme Court of India had issued a series of orders in response to civilian pressure, stating, among other things, that

“Both the Central and State Governments 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 that mental patients should be sent to doctors and not to religious places such as Temples or Dargahs” (AGARWAL 2004: 511-512).

Since then, the Indian government has indeed begun to release more funds for the improvement of mental health care and mental hospitals. And yet, Indians continue to choose from a variety of treatment methods, including those offered at Muslim shrines. In the following sections, the perspective is shifted from the controversy in the public arena to an ethnographic exploration of the contested sites and practices in the pluralistic field of mental health care. How is body control exercised in a mental hospital and a Muslim shrine respectively? How do the two institutions differ? And what kind of experiences do those afflicted by mental illness and madness—whose voices are not heard in the public arena—make in these different institutions?

Control of mental disease in a mental hospital

The Regional Mental Hospital in Pune (Maharashtra) is heir to the lunatic asylum founded by the British in the early nineteenth century in Bombay. In 1915 it was shifted to a barren area outside the city, a place the British called “the village of imbeciles” (Yerawada), near where a large prison had been built at around the same time and in the same style. The name Yerawada has stuck till today and now denotes a modern suburb of Pune close to the airport. The mental hospital—so named in the 1920s—has a capacity of 2400 beds and is thus the largest of its kind in India (some say in

Asia). High walls shield the large area of the mental hospital, with its many old barracks and a few new concrete wards, against the outside world.

Thanks to the influence of a friend and psychiatrist who had worked for many years in the mental hospital, I was allowed to enter the wards and conduct ethnographic observations. In this I was helped by Chitra Khare, a trained psychologist engaging in voluntary work in the same hospital. The collaboration of Chitra, the superintendent and the deputy superintendent, psychiatrists, nurses, social workers, attendants and patients allowed me to conduct fieldwork on the management of mental disorder in this institutional setting, about which no ethnographic data were then available. The mental hospital, with more than 1600 patients and altogether 825 members of staff, is a huge organisation, the functioning of which hinges on the smooth reproduction of the institutional order. I must emphasise that my aim is not to pass judgements about the practices I encountered but to describe them. The mental hospital builds upon structures inherited from colonial asylums and therefore still closely resembles the “total institution” which Goffman had described so well for the American context (GOFFMAN 1961). The problem with total institutions is precisely that they set limits to individual initiative and make the negotiation of practices extremely difficult. As an institution, the mental hospital reflects a worldview which connects psychiatric treatment with specific forms of controlling and disciplining the bodies of patients. From this it does not necessarily follow that individual psychiatrists, nurses or attendants share this worldview personally, although they must embody it in their roles they are given within the institution. As the patients, the professionals are governed by institutional rules that are not of their making—and often not in accord with their own convictions.

There are many rules regulating the possible movements and actions of patients and staff inside the mental hospital, including those pertaining to visits of outsiders. Getting in and getting out are critical moments of crossing borders. Chitra’s and my visits always began at nine o’clock in the morning in the superintendent’s office. The superintendent ordered tea for us and talked about the problems of the mental hospital. Two issues raised in the Erwadi campaign were of great concern here too. One was hygiene and sanitation: new latrines had recently been built in the male wards; the other concerned problems in rehabil-

itating patients because of the apparent unwillingness of families to receive them back. Finally, the superintendent looked at my written application stating the purpose of my visit. He then decided which wards we were allowed to go to, called a social worker to accompany us and signed a paper to be shown to the gatekeepers in different wards to allow us entry.

In 2008, more than 1600 in-patients were staying in 9 male, 7 female and 1 criminal ward. In addition, from 50 to 80 outpatients were treated daily in the Outpatient Department (OPD). The large number of patients is managed by 16 psychiatrists plus numerous medical officers, nurses, attendants, social workers, cleaners, clerks and a few psychologists. Most activities, especially psychiatric treatment, take place in the morning. By noon, when the patients are given lunch, we had to leave the hospital. For a few weeks, we frequently visited one of the female wards to observe psychiatric consultations. This ward accommodates between one hundred and fifty and two hundred mentally ill women. It consists of a spacious walled compound laid out as a park with several sections within it. Trees provide shade in between barracks that extend for long distances. Each time we visited, the female attendant in charge of the gate allowed us to enter only after carefully checking the written permission signed by the superintendent and stamped by the chief psychiatrist. We passed the “Weak Ward”, dormitories with up to thirty beds for ordinary patients. One barrack was referred to as the “Class Ward”, for “class” patients whose families pay a special rate for a smaller room and individual food preferences. At the time of fieldwork, only ten women had been admitted in this “Class Ward”.

The spatial and social order of the mental hospital has hardly changed since colonial times. Although segregation based on race—European and “native” patients were kept strictly separated—no longer exists, the distinction of “class wards” still reflects the categories of the inventors of lunatic asylums. Today, male and female class wards accommodate patients from families belonging to higher castes and communities who care most about their relatives receiving the right kind of food, since only class wards allow food restrictions in terms of caste status to be taken into account. In common wards, social distinctions between patients are levelled, apart from gender. This is still underscored by the uniforms patients are obliged to wear, consisting of blue cotton shirts and pyjamas for men, and green or red cotton dresses (“robes”)

for women. The uniforms are tailored in the occupational therapy programme by the patients themselves. Conversely, differences in power and rank among the hospital staff are clearly marked. White, of course, is the colour of all clinical employees, but subtle variations in the style of dress distinguish psychiatrists from nurses and attendants. At the bottom of the hierarchy are female attendants recognisable by their white saris with blue stripes. They are addressed in hospital language as *maushis*, “mother’s sisters”, and usually come from a lower caste, often sweepers, and have the closest contact with the patients on a day-to-day basis.

Neither admission into nor discharge from the mental hospital are possible without involving judicial agencies. With schizophrenia being the most common diagnosis, the standard categories of behaviour leading to admission include angry, abusive or aggressive behaviour, wandering aimlessly around, muttering to oneself, gesticulating abnormally, illogical or disorganised speech, uncooperative behaviour, irritability, impaired cognitive orientation and reduced sleep and appetite. There are three procedures of admission, of which “VB” or “Voluntary Border” for people admitted with their own consent, is the least common. Most cases are either “DOs”, “Detention Orders”, or “ROs”, “Reception Orders”, both of which have to be issued by a court of law. In case of a DO the family obtains a court order which sends their relative for an initial ten day observation period to the mental hospital. If he or she is diagnosed with a mental disorder, the court of law issues a “Reception Order”. Rumours have it that DOs are often obtained by families wanting to get rid of a troublesome member by bribing a “*kaka*” (father’s brother), a male attendant with good connections to a magistrate court. Others admitted directly by Reception Order are brought by the police. The discharge of a patient from the hospital is in the hands of a “Visitors Committee” consisting of a judge, psychiatrists and social workers. The latter’s task is to organise rehabilitation and to confirm that the family is ready to “take the patient back”.

The hospital regime is governed by the paradigms of somatic psychiatry. It is deeply rooted in the distinction between body and mind, its *raison d’être* being the control of diseases that result in malfunctions of the human brain. According to this logic, bodily defects result in abnormal behaviour, so that controlling the disease necessarily includes controlling the

abnormal behaviour of the person by influencing the functions of the brain. The psychiatrists’ stated goal is to make a patient act “normal” by intervening in his or her disease through psychotropic medication and electroconvulsive therapy (ECT). In the mental hospital, treatment of mental disease is a combination of bureaucracy, medication, punishment and restraint.

As just noted, the almost total control of the embodied lives of patients also includes punishments. Disturbed bodies and brains are subjected to exclusion and isolation. Patients are separated from their life-worlds and their families. This is particularly felt by women, because children are not accommodated in the hospital. If a woman diagnosed with schizophrenia is pregnant and delivers a child in the hospital, the newborn is taken away from the mother and either given to the care of her relatives or, if that is not possible, sent to an orphanage. Pathological behaviour as diverse as “suicidal”, “attacking” or “escaping” all need “special watch”, which means the person is temporarily confined to a solitary cell. In the female ward, a blackboard alerts the staff to those patients who require this kind of treatment. During our visits to the female ward, we encountered women on “special watch”. For example, one woman had attempted to commit suicide twice since she was admitted, once by using her robe to hang herself from the ceiling fan in the dormitory, and a second time by breaking a bulb and cutting her wrists with glass splinters. An attendant brought us to the cell, a bare room behind bars with a bare bed and a drain, in which a naked woman huddled in a corner. Chitra and I were both upset by this sight, but the attendant explained that they had taken away all her clothes in order to prevent her from harming herself. Chitra asked: “How do isolation and restraint help this woman with her problems?” The attendant said: “I don’t know, can’t explain. I only know that if an overexcited and aggressive patient spends two days in isolation, she calms down and her behaviour improves”. Then she added “But we need to do this only rarely. In this case, the patient threatened to escape, too”.

Daily psychiatric consultations are a bureaucratic affair, too. In the female ward, routine psychiatric consultations take place on the veranda, which is furnished with chairs and desks. Each ward is assigned to a psychiatrist. For various reasons, however, psychiatrists often have to shift ward duty. Much information on the everyday behaviour and possible im-

provement or deterioration of the mental and physical condition of individual patients comes from nurses, attendants and cleaners. Dr G., a woman in her early forties, is the psychiatrist for the female ward. She routinely saw fifteen patients in two hours. In this she was assisted by the psychiatric nurse in charge of the observation ward, who had selected the patients and kept their files ready. The files were piled up on the desk to be referred to and filled with new information by the psychiatrist, while the patients selected for the day's consultation were orderly seated in rows on the floor, waiting for their turn.

Most of the newly admitted women seen by Dr G. had been diagnosed with schizophrenia, for example, Lakshmi, a middle-aged woman. Looking at her file Dr G. noticed that this was her fifth admission. In a friendly and concerned tone, she asked: "What happened? Why are you here again?" Lakshmi replied: "Nothing happened. I quarrelled with my husband, so he put me here". Responding to more questions posed by Dr G., she said that her parents were dead and her husband worked in Mumbai. Then she said that her husband was dead and that she was living with her son, who, according to the file, had actually admitted her the day before. When Dr G. asked her about the quarrel, Lakshmi said that there was "too much shopping" in the house (she used the English word). When asked to explain what she meant by "shopping", it turned out that she had ordinary household things (clothes, vessels etc.) in mind. One of the attendants interrupted and asked her teasingly: "Then why don't you say it's ordinary household things you are talking about? Why do you say 'shopping'?" Lakshmi did not respond to this but said that all these "shopping" things made the house stuffy and overcrowded. She said "all those people have taken away my capacity [again English word]". What "capacity"? Dr G. asked. Lakshmi replied that she was "matric" (10th standard school education) and now wanted to take tuition. But "those people" had stopped her taking tuition. Dr G. carefully updated Lakshmi's file by noting her "disorganised speech" and confirming the earlier diagnosis of schizophrenia. The day's mental examination showed that she still suffered from thought delusions and hallucinations. Medication was required.

The interactions between the psychiatrist and the patient focus around administering psychotropic medicine. Verbal interactions are mostly confined to the psychiatrist posing clinical questions to the patient

and silently translating her words, gestures and facial expressions—her behaviour—into categories of psychiatric pathology to be written down in the file. Through this process, attendants and nurses report on how much she eats, on her sleep or sleeplessness, and on her withdrawn and violent moods, as well as completing information on her personal history and circumstances gathered during their own interactions with her. Attendants participate in making sense of apparent senselessness. For example, when Dr G. saw a patient who uttered only a single syllable "pa", "pa pa", one of the *maushis* intervened and decoded her reduced speech: "She says 'my mother is crying at home. I want to go home'".

The psychiatrists' stated aim is to find a remedy for the patient, to make her, if not completely normal, at least more so, e.g. by transforming meaningless ("disorganised speech") into meaningful communication. The psychiatrist decides on the type and amount of medication to be given. Besides psychotropic medicines, ECT is used as a regular treatment because it is deemed very effective for the treatment of all kinds of distorted behaviour, especially if classified as "harmful for Self and/or Others". The patient's part in this process is judged as "cooperative" or "non-cooperative". Uncooperative behaviour, itself a sign of mental disorder, is recorded when a patient does not respond to the psychiatrist's questions, runs away, refuses to swallow medicine, or screams and fights with the nurses when being given an injection or being prepared for ECT.

Like the superintendent, psychiatrists are keen to contradict the impression that, once in a mental hospital, patients remain forever inside, even if their condition improves. If patients overstay, they say, the problem is often families not accepting their relatives back. This problem also came up in Dr G.'s consultation on that day. One newly admitted patient had severe burn marks on her neck. Dr G. asked her about her burned neck. How did it happen? Did she catch fire to herself by mistake? At first she did not reply. Then she said that she had set fire to herself because of "tension" with her husband and her in-laws. Her husband often beat her. Dr. G. asked: "Do you still think of doing such things to yourself?" She did not reply, but looked around as if searching for somebody. Dr G.: "Are you feeling suspicious?" She laughed. "Are you hearing voices?" "No, not at home", she replied, "but here, of course, I do hear the voices of women, so many of them around, what else could I hear?" Dr

G. wrote in her file “psychotic symptoms not clear” and turned to the nursing sisters: “You must always remain alert. Many families simply want to dump unwanted relatives, like this poor girl. We may assume that her husband and his family want to get rid of her”.

Dr G., other psychiatrists working in the hospital and the superintendent himself expressed personal dissatisfaction with its organisation and said they would like to change its closed organisational structure. They felt they were doing their best to look after the patients as best they could and purposely attempting to ease their dire situations. Indeed, for those mentally ill who have been abandoned by their families, the mental hospital has become a kind of home. However, as one psychiatrist put it: “The mental hospital is like a monstrous machine crushing all attempts at change in the routine process of reproducing order against disorder, normality against abnormality”. And yet, the Erwadi scandal not only affected the religious field, but also set in motion many initiatives and attempts to reform institutional psychiatry. The positive effects this may have can be observed in another former lunatic asylum, the mental hospital in Ahmadabad (Gujarat), where spatial and organisational structures have been completely transformed (Basu, forthcoming). Thus one can be quite confident that, even in an institution as large as the one discussed here, basic conditions will eventually change.

Social control of madness at Muslim shrines

If the mental hospital constitutes a social world of its own, so do Muslim healing shrines. Muslim shrines, such as those at Mira Datar and Bava Gor in western India (Gujarat), where I have also conducted fieldwork, are situated at the opposite end of the continuum of institutions available to the mentally disturbed and their families in India (PFLEIDERER 1994; BASU 2009). Those afflicted with mental illness often are familiar with both settings. Quite a few people I met in the course of my fieldwork at shrines in western India had initially sought help for an afflicted spouse or son in a mental hospital. They, at least, did not want to “dump” their relatives. Rather, people were appalled that families were not allowed to stay with the patient in the hospital and look after him or her; others were horrified by what ECT treatment did to their family members. “My brother-in-law became like a vegetable after getting these shocks [in a mental hospital

in Gujarat], so weak that my father insisted he must leave the hospital and never be admitted again”, one man told me at a shrine. People do not go to Muslim shrines because they are ignorant, as the critics of these religious institutions would argue. Rather, they choose to do so on the basis of their own personal experiences of both the formal and informal mental health-care systems.

Although madness is a recognised disorder dealt with only at certain shrines, these are not set apart as healing institutions but remain firmly embedded within a broad religious discourse. In western India, the world views articulated at shrines fuse many of the functions that are differentiated into separate social spheres—moral, legal, medical and cosmological—in contemporary India. Literally, *dargah*, the word for a shrine that contains the graves of Muslim saints (*pir*), means “royal court”. Drawing upon historical traditions of royalty and Sufi Islam, the saint is simultaneously perceived as a “friend of god” (*vali*) and a “judge” who mediates between human affairs in the world and the transcendent. Sometimes, saints are also referred to as “doctor”. A saint’s authority and healing powers are derived from charismatic and/or heroic actions. Muslim saints and their *dargahs* form a hierarchy, with those at the lower end specialising in the handling of occult madness. The epithet of such saints is *jinnat na sarkar*, or “master of the spirit world”. Their shrines are ritual law courts where healing merges with the administration of justice, thereby restoring social life-worlds disrupted by madness and other adversities (see also SAX 2009).

In the discourse of the shrine, disorder and misfortune are brought about by non-human spirits and human acts of sorcery taking possession of a person. Envy and jealousy are highly feared emotions in other people that are believed to make them turn to sorcerers to harm the person they are envious of. These constitute the most common explanations for a host of adversities striking human beings in pursuing their lives, the most severe form of which is madness. Mental trouble arises from disturbed relationships between humans or humans and ancestors. People who are no longer able to conform to the norms and behavioural expectations of their social surroundings are treated as the victims of hostile spirit agents that are most often referred to as *bala* (“power”). Regardless of the terms used to describe mental illness, whether non-medical madness (*ghandavu*, *pagalami*) or medical mental disorder (*mansik ki rog*), possession by

bala provides a general symbolic template, allowing people afflicted with madness to make sense of what is happening to them (or to one of their relatives), and providing a symbolic language in which to talk about conflicts, tensions and personal experiences.

People who behave in a strange or unacceptable way, such as using foul language or attacking their nearest and dearest, display clear signs of occult madness. As in the hospital, those afflicted are said to wander aimlessly around, are easily angered or completely withdrawn, or try to commit suicide, any of which behaviour may be caused by spirits or sorcery. Notions of occult madness are not highly differentiated. This corresponds to the open social organisation of these shrines, which are above all places of pilgrimage attracting large and diverse groups of pilgrims. The guardians of the shrine (*mujavar*) control the *dargah* premises and organise the rituals, but they do not act as healers. They compare their role to a *vakil*, an “advocate” who brings the “case” of his clients before the saint through prayers. Clients suffering from mental illness, the “pilgrims of suffering”, freely mingle with pious visitors who have come to the shrine for other reasons. Few of the mentally ill come to the shrine without relatives. The former are called *savali*, “seekers of answers”. At the time of fieldwork, more than five hundred people were staying long-term at the big shrine, about fifty at the smaller one. *Savalis* and their families either rent a room within the shrine compound or stay in one of the numerous lodges and guesthouses in the village. Pilgrims are connected through ritual patron-client relationships to a particular *mujavar*, who supports them by listening to their problems, praying, giving advice and administering *dava* (ritual medicine) consisting of rose petals and water charged with the healing powers of the saints.

In possession, the body-mind-selves of the afflicted have come under the control of either a spirit or a spell of human sorcery (*bala*); their bodies are simultaneously tortured by the foreign invaders and enact the latter’s personalities in trance. As Moinuddin, a young man who had been staying with his mother at a shrine for eight months, explained: “The *bala* (force of a sorcery spell) pesters my body from within. It wants to kill me. It keeps saying ‘I shall kill you’. It is like the birds building nests in a tree. In the same way, a *bala* turns a human body into its house. It lives inside this house, eats it up from within, brings despair to the parents [of the afflicted]”.

If *balas* remain undetected, the person eventually dies. The “masters of the spirits” prevent this by sending an “order” (*hukm, basharat*) to the afflicted and/or their relatives in dreams or in trance to come to their “court”, that is, the shrine. The agencies of occult madness are brought under trial, which takes place during the dusk and dawn rituals, when the saints summon the agents of distress in the trances of their victims. Possession trance is thus both a symptom of affliction and a therapeutic method. The comparatively loose social organisation of shrines dedicated to the “masters of the spirit world” frames a ritual arena designed simultaneously to unleash the forces of madness in trance and to tame them by various means. The saints also inflict punishment and penances—not upon the suffering self, however, but upon the agents of disorder. These penances may also include the use of chains. The chains that were major issues in the course of the Erwadi scandal are here not considered media of punishment but of controlling or, rather, taming the spirits.

Although the practice of chaining has been officially abolished since Erwadi in the shrines of Gujarat too, many people are still to be met with carrying a chain tied around their ankles or wrists. Sometimes, they even lock themselves close to the tomb before going into a trance. Chains are instruments of healing used by the saints whereby the destructive forces are brought under control. Moinuddin had a chain tied around his ankles. When Chitra once looked at them somewhat disapprovingly, he emphatically said: “The *bala* had broken my foot. I could not move. If you show it to doctors they can’t heal it quickly. Sarkar [the saint] healed my foot in my dream. He told me to put on the chain and the foot was healed in three days!”

Chains tame the violent *bala* and soothe the pains of mind and body. Dinesh, another young man, frequently needed to chain his *bala*. He believed himself to be a military commander; sometimes he was on duty as a guard, then he was quiet and friendly; at other times he was on duty in war, when he shouted in a foul language, turned violent and beat up anybody who came his way. According to his mother, who had been staying with him at the shrine for five years, Dinesh was once a brilliant student of engineering who always came first in class. His career came to an abrupt end when a neighbour performed black magic against him because he was envious (*jalan*), his own son not having done well in his studies. The sorcery

spell afflicting Dinesh was very powerful, sending him into madness. Worse, he cannot go into a trance. The saints, however, send his mother into a trance on her son's behalf. His case will go on for a long time, the mother said. During one of her trances, the saints told her to chain her son in their room when he gets into a rage.

Shrines, then, constitute an arena where body control must be completely abandoned in trance states in order to regain control over a unified mind-body-self. It is also an arena where miracles are possible. The cosmological explanation of occult madness, moreover, does not identify a defect in individual bodies (the brain) but looks to disordered relationships between the living or between the living and the dead. Disorder is brought about by competition, injustice and negative emotions such as envy.

Conclusion

In this paper, I have analysed conflicting social evaluations and practices of body control in two sites of the pluralistic field of mental health care in India. In the course of the Erwadi scandal, contested forms of restraining the mentally ill entered the public arena. Religious places, including Muslim shrines such as those discussed here, were criticised as the embodiments of a superstitious tradition. They were also compared unfavourably to the mental hospitals, the successors of the structures set up along with colonial lunatic asylums, which were depicted as superior to religious places but in need of modern development and political and financial support. By translating the European past of somatic psychiatry into an Indian present shaped by multiple understandings of mental illness, psychiatry has emerged as the single legitimated knowledge system in the plural medical field and has been authorised to control alternative or religious systems of healing.

Nonetheless, Muslim shrines remain major institutions to which Indians affected by mental illness turn. To achieve a better grasp of what is at stake when people choose between a mental hospital and a shrine, I have concentrated here upon the similarities and differences of body control in both institutions as revealed by ethnographic research. Building upon the model of grid and group originally proposed by Douglas helped bring into focus the relationship between institutional world views and differences between the forms of body control practiced in mental hospitals and at Muslim shrines respectively. Differ-

ences with regard to the ordering of space on the one hand, and interactions between specialists and the mentally ill on the other, are particularly relevant.

The spatial arrangement of the mental hospital sets it apart from 'normal' society and reflects strong contrasts of outside/inside. It exists as a bounded space for the exclusion from the outside world of those who are deemed abnormal, while internally it is governed by a highly structured regime of order. Muslim shrines are set apart from ordinary social spaces too: being pilgrimage places they are liminal spaces, passages between the profane and sacred spheres of life. The social organisation of shrines is loosely structured without material boundaries separating the inside from the outside; rather, it provides a symbolic frame of order that allows for the enactment of all kinds of extraordinary behaviour in a protected arena. As a result, the mad are included in, not excluded from, the community of believers.

Interactions between specialists and the mentally ill vary greatly in both settings. In the mental hospital, they are governed by a formal distance between the professionals and the ill and an irreconcilable gap between those who know and those who don't. This contributes greatly to the mental hospital being a place where patients are produced, where bodies are forced into receptive passivity, where "cooperative behaviour" enables treatment to be enacted upon selves. At Muslim shrines, by contrast, ritual specialists help patients and their families to become experts in their own afflictions. A victim of occult madness suffers but does not remain passive; rather, the healing process involves agency that is distributed over multiple selves, family members, *mujavar*, saints, spirits, sorcerers, in short, human and non-human actors alike.

Irritating or even disconcerting for some, these practices still make use of chains. The scandal of the chains symbolises the contest of practices and the claim of the advantages of modern psychiatric institutions over and against religious "superstition". These claims are rarely based on an understanding of the cosmological concepts in which the treatment of the mentally ill at shrines is embedded. As my fieldwork has shown, chains have a function and a meaning for those who use them at a shrine which differ from how they are interpreted in the media. Modern critics of "faith healing" seem to identify these chains with those through which the mad in Europe were constrained or even tortured before modern psychia-

try released them from their fate. In quite a few cases, by contrast, Indians view a shrine as an alternative to turn to after failing to find a cure in a modern psychiatric ward. Finally, it should be remembered that the Erwadi scandal not only uncovered deplorable conditions at religious sites but in institutional psychiatry too. This resulted in a discussion of psychiatric treatment and opened up new perspectives on religious institutions which may allow other forms of interaction between these two ostensibly very different therapeutic approaches.

Notes

- 1) Frontline "Deliverance in Erwadi", 31. 8. 2001.
- 2) *Times of India*, <http://timesofindia.indiatimes.com/articleshow/1182266672.cms>, 7. 12. 2007.
- 3) Frontline "Deliverance in Erwadi", 31. 8. 2001, p. 129.
- 4) Frontline, Volume 19, Issue 15, July 20-August 02, 2002; <http://frontlineonnet.com/fl1915/19151130.htm>

References

- AGARWAL S.P. (ed) 2004. *Mental Health. An Indian Perspective 1946-2003*. New Delhi: Directorate General of Health Services Ministry of Health and Family Welfare.
- BASU H. 2009. Healing madness through ritual trials. *Man in India* Special vol., ed. Karen Leonhardt.
- . forthcoming. Prayers and pills: new horizons of psychiatry in Gujarat.
- BELL C. 1997. *Ritual. Perspective and Dimensions*. Oxford: Oxford University Press.
- DOUGLAS M. 1973. *Natural Symbols: Explorations in Cosmology*. New York: Random House.
- ERNST W. 1991. *Mad Tales from the Raj. The European Insane in British India, 1800-1858*. London: Routledge.
- FOUCAULT M. 1978. *Wahnsinn und Gesellschaft*. Frankfurt/M: Suhrkamp.
- GOFFMAN E. 1961. *Asylums : essays on the social situation of mental patients and other inmates*. Garden City, N. Y.: Anchor Books. 386 p. pp.
- GUJARAT Go. 2003. Priorities for Mental Health Sector Development in Gujarat, Department of Health and Family Welfare, Government of Gujarat, Gandhinagar, Ahmedabad.
- KAKAR S. 1982. *Mystics, Shamans & Doctors. A psychological inquiry into India and its healing Traditions*. Delhi: Oxford University Press.
- KAPUR RL. 1979. The role of traditional healers in mental health care in rural India. *Social Science and Medicine* 13B:27-31.
- KLEINMAN A. 1988. *Rethinking Psychiatry: From Cultural Category to Personal experience*. New York: Free Press.
- PADMAVATI R. 2005. Community mental health care in India. *International Review of Psychiatry* 17:103-7.
- PFELEIDERER B. 1994. *Die besessenen Frauen von Mira Datar Dargah. Heilen und Trance in Indien*. Frankfurt/M: Campus.
- PORTER R. 1988. *A Social History of Madness*. New York
- RAGURAM R, VENKATESWARAN A, J. R, WEISS MG. 2002. Traditional community resources for mental health: a report of temple healing from India. *BMJ* 325:38-40.
- SAX W. 2009. *God of Justice. Ritual Healing and Social Justice in the Central Himalayas*. New York: Oxford University Press.
- SHORTER E. 2003/1999. *Geschichte der Psychiatrie*. Frankfurt/M: Rowohlt.

Eingereicht / received 2.04.2009
Angenommen / accepted 14.06.2009



Helene Basu has studied social anthropology, sociology and comparative religion at the Free University Berlin. PhD 1993 (*Habshi-Sklaven, Sidi-Fakire. Muslimische Heiligenverehrung im westlichen Indien*, Berlin 1994), Habilitation 2001 (*Von Barden und Königen. Ethnologische Studien zur Göttin und zum Gedächtnis in Kacch*, Frankfurt/M 2004). Since 2006 she is professor of social anthropology at Westfälische Wilhelms-Universität Muenster. Since 2007 principal investigator in the Cluster of Excellency "Religion and Politics in pre-modern and modern Cultures" at Münster University. Her main areas of research are contemporary Indian religions (Hinduism, Islam), Indian Ocean studies, and Cultural Psychiatry.

Institute of Social Anthropology
Westfälische Wilhelms-Universität
21, Stadtstrasse, 48149 Muenster – Germany
e-mail: hbasu_01@uni-muenster.de