Disability and the Global South, 2014
Vol.1, No. 2, 266-284

OPEN ACCESS
ISSN 2050-7364
www.dgsjournal.org

Globalizing psychiatry and the case of 'vanishing' alternatives in a neo-colonial state

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Analysing 'modernity' in India is a complex exercise, as the movement of the 'modern' is locally determined and may be non-linear at different sites and contexts. General medicine and psychiatry are illustrative of the *difference* in how 'patienthood' has been historically constructed, with each wave of 'modernisation' changing the subjecthood of the 'mentally ill'. Unlike the public health sector in India, the mental health sector is driven by the 'mental asylum' archetype, continuing through late colonial times into contemporary science in refurbished designs. A related set of changes also concomitantly happened in the domain of indigenous healing, with each epistemic shift pushing this domain to the margins of knowledge and healing practice. The paper is set against the time period covering 1850s until recently (2014).

Keywords: Movement for Global Mental Health, colonialism, indigenous healing, mental health policy, 'modernity' in mental health

Introduction

Medicine of the body (general medicine) and medicine of the mind (psychiatry and allied disciplines) are accentuated by their difference rather than sameness in contemporary Indian society. The asymmetry between medicine and psychiatry can be partly explained by the fracture entrenched in epistemology by the Cartesian division between mind and body, persisting through modernity and its historical variant, globalization. This asymmetry has been accelerated in recent times in the mental health sector by what is popularly known as the 'Erwadi tragedy': In August, 2001, 25 people named 'mentally ill'[1] and kept confined in a thatched hut near a *dargah* (a *sufi* spiritual healing shrine) perished in a fire in a remote part of Tamil Nadu, India. This incident set off widespread alarm among some citizens' groups and professional sectors about modernizing mental health care and complying with international human rights standards. Davar (2012a) has shown how this concern paradoxically led to increasing the power of psychiatrists in relation to communities and to the irrevocable policy, sanctioned by the Supreme Court, of constructing penal-type mental

institutions in every State and District of the country, and placing legal prohibitions on the use of indigenous healing methods (Davar & Lohokare, 2008; Sood, 2014).

In the last decade, this incident has led to new terms of reference and pathways of association between general medicine and psychiatry and their institutionalization and their exchanges with indigenous systems of medicine. The Global Mental Health Movement, partly led by psychiatrists from the Global South and supported by 'evidence base' generated in the North, particularly the United Kingdom, is only one of the ways by which those new pathways are being created (www.globalmentalhealth.org). However, what is concerning is the sweeping panache with which the movement is altering communities, particularly washing over the erstwhile colonized states designated the 'Commonwealth' (Pathare and Sagade, 2013), in the name of 'addressing the treatment gap', referring to the mismatch between an estimated 'prevalence of mental disorder' and available medical treatment (Prince et al. 2007). Global Mental Health (GMH) is one of the ways by which palpable transformations are being effected within mental health law, policy and practice in India. This forms the subject of this paper, and is a process which, as I argue elsewhere, is demonstrably 'neo-colonial' (Davar, 2012a).

This is not a new challenge to the globalization of psychiatry; a process which has its roots in colonialism and after, and is evident from earlier writings by, for example, Higginbotham and Marsella (1988:553), who noted the 'homogenization of psychiatry' in a number of Southeast Asian cities, in the 1970s and the 80s, a process that occurred through international consultations, psychiatric education and the heightened role of the World Health Organization (WHO). Noting the expansion of psychiatry in the region following the demise of colonial states, they explained it thus:

> First, psychiatry was deemed a potential tool by some officials for motivating people to embrace the modernization process. Second, psychiatry offered 'modern' solutions for coping with individual stress produced by rapid socioeconomic transformation. Third, Western experts and indigenous counterparts were convinced that mental illnesses are culturally invariant in character, causes and cures (Higginbotham and Marsella, 1988:553).

Higginbotham and Marsella also noted the effects of these movements on internationally trained newly aspiring psychiatrists under the disciplinary scope of general medicine in their home countries, a project rife with dilemmas regarding culture and context. The process of dialogue with the WHO continues in recent times through world advocacy organizations of users and survivors of psychiatry, such as the World Network of Users and Survivors of Psychiatry (WNUSP)[2] with support of the global disability organization, International Disability Alliance (IDA). Of concern have been the alarmist claims of 'psychiatric epidemics' in low and middle income countries based largely on the WHO estimates on global burden of disease, which some writers have called 'disease-mongering' (Summerfield,

2012).

What is new in this paper, however, is the analytical frame for conducting the inquiry. Some writers have argued that writing the history of a fictitious subject, viz. 'mind' is impossible (Smith 2008). Those of us who grew up on the existentialist and anti-psychiatric literature of the 60s and 70s will also recall the Szazian idea of the '*myth of mental illness'*. However, the reality of 400 or so private mental institutions in India, a growing culture of 'pharmacracy' and the growing trend in the country of treating a 'sick' mind scientifically, suggests that a certain kind of reality, even materiality, has been accrued to this mythical non-subject over the last 200 years or so. So instead of denying the legitimacy of psychiatry as built on fiction, this paper inquires into the materiality accrued to mind and mental illness over the years in India, laying the ground for the globalization of psychiatry.

'Enduring colonialism', modernity and plurality in the South Asian context

In this paper, I depend mainly on the prodigious writings of a contemporary Indian political thinker and social analyst, Raghuramaraju (2005a,b; 2009; 2011), who argues that modernity was not constructed in the same way by all peoples who occupied the emerging nation spaces post-Independence. Analyzing modernity and globalizing processes is made more complex because of the plurality of social systems, their institutionalized processes and inter-generational responses to colonialism. Modernity and globalization is about peoples, their individual and collective responses, in a local context over time. Emphasizing the non-linearity of 'modernity' at different sites and contexts, Raghuramaraju (2011) has argued that, in India, there isn't one 'modernity', but multiple 'modernities'. In a pluralistic country like India, '[M]odernity is confined to certain pockets from where it continues to give a deceptive, spectral feeling of being everywhere' (Raghuramaraju, 2005b:598).

Modernity is a product of India's colonial legacy challenging India's plurality, a project only partially successful even in the metropolises, where a mix of the pre-modern with the post-modern rest side by side. It is not the case that India moved sequentially from a pre-colonial to a colonial to a post-colonial phase. In India, systems, practices and artefacts from different epistemes can be found simultaneously (Raghuramaraju, 2009), exchanging, translating and transforming each other. Latour (2010), too, in arguing against modernity as a master narrative, describes how hybrid systems are created by the confluence of a variety of social actors across time and space as if in an orchestra of translation and transformation. But Raghuramaraju (*passim*) gives a global South context for the debate, not so much from an action theory perspective, but rather talking about plurality and interactions between cultures, groups and individuals in terms of the 'self' and its possibilities.

'Modernity' itself is an image or vision towards which peoples move collectively through stages. As Raghuramaraju (2011) further propounds, the modernizing process fulfils its agendas by recasting the self. This process first involves a disinheritance of its own past. In some countries this could be the religious, philosophical or spiritual past, leaving behind old affiliations, geographical locations, food habits and lifestyles, etc. The second step is the making of new social contracts (for example, creating new groups and institutions, moving to new habitats, finding new occupations, lifestyles and habits, etc.) The erasure is supplanted by imagining an ideal view about the 'bright future', 'a better life' and anchoring the emergent self in that.

In recent literature, there are some illustrations of this cultural psycho-social theory of modernization within a local context. For example, de Leon Espena (2011) writes about the settlement of Sikh communities in the Philippines. The Sikh Philippinos utilized the benefits of modernity, migration and globalization, to then restructure the new spaces they occupy and reimagine, visualize and experience 'India'. Such examples illustrate how epistemes may co-exist, change and exchange locally in South Asian emergent nation spaces, transforming (group) selves.

Elaborating on this theory and further psychologizing it, we can say that in the making of modernity in a local situation, peoples migrate, relocate, reorganize, and form new 'better', 'modern' or 'empowered' selves by erasing memories concerning the old self. There is a dynamism involved in such collective self re-constructions through every change of episteme, accelerated in contemporary Indian society by the advent of virtual technologies, the collapse of space and time, and the fluidity of categories like 'local' and 'global' (sometimes described as 'glocal').

Some memories may survive and become ritualized or reified into structures as a way of maintaining the historical continuity of a self narrative, though those memories may be at odds with the new emergent self. There may sometimes be humiliation, shame, anger or other emotions, associated with recall of the older self, now seen as 'weak', 'backward', 'primitive' 'ignorant', 'unscientific' or 'superstitious', and peoples may drop those redundant selves to 'adapt' to modernity and to create those new social contracts. Also, new rituals and taboos would be created, to contain cognitions and language within the present vision and aspiration of modernity. Whole communities in India pushed for such changes through a cycle of forget-move-reconstruct in the making of a new Indian 'nationalism' (as explicated in Raghuramaraju, 2011). This process of transitioning modernity is not a violence-free or compassionate process, in fact, violence against self and other would be at the core of these processes, making these macro processes relevant for mental health studies. The recent report submitted by the Working Group on Human Rights (WGHR, 2011), India, to the Office of the High Commissioner on Human Rights is evidence to the phenomenal increase in violence against vulnerable groups, including women, children, *dalits*, disabled people and ethnic groups, especially in conflict areas.

We can apply these ideas by studying the re-configurations in the medical disciplines (general medicine and psychiatry) in every change of episteme from the 1850s. The 1850s was significant, due to the Indian Mutiny of 1858, which led to the British takeover of the East India Company. The British consolidated the British Empire in India at this time, and sweeping changes in administration, architecture, and policy making happened in all areas of governance, including 'public health'. Of particular interest is the fact that most of the state mental asylums in India today were built between the 1850s and 1900s (Ernst, 1991). At this time, institutions were created not only for the 'insane' but also for other socially excluded persons ('beggars', 'paupers', 'lepers', 'criminals', 'idiots') through legislations. They were managed by the prisons department or the public works department. Regulation of the lunatic asylums was done through the 'Lunatic Asylums (Supreme Court) Act' of 1958 and later, the 'Indian Lunacy Act of 1912'.

The 'asylum' archetype is a historical and colonial feature of psychiatry, shared in common with a few modern day 'patient' groups such as people suffering from leprosy[3]. However, for the large part, general health care patients are not interned in penal institutions, illustrative of a non-linear development of the 'modern'. This asymmetry between site of care and patienthood in general medicine and that in psychiatry has continued to shape contemporary 'modernity' in public health. Germs and bugs could not always be found (excepting syphilis) as an underlying cause for 'mental' disease, which was an expectation in 'modernising' public health and dealing with epidemics. Psychiatry, a discipline aspiring to be a natural science, set its own frame relying largely on the extant insanity law of running asylums. This frame has been recast from colonial to recent times - from a 'lunatic asylum' to 'psychiatric hospital' to 'mental health establishment' respectively; with the subject of the discourse changing from a 'lunatic', to a 'mentally ill person' and in the proposed Mental health care Bill of 2013 [4], to a 'person with high support need'.

A 'lunatic' of the Lunacy Act of 1858 in India cut a somewhat sorry social figure entitled to 'justice' and protection by the colonial state. Such a person earned a full and robust court procedure because his Liberty was deprived against his will. However, the 'person with high support need' of today, as found in the proposed Mental health care Bill of 2013, is a violent and dangerously 'sick' person, upon whom any civilian or mental health doctor can apply an involuntary commitment procedure for forced 'treatment' without ever entering the justice system. In the intermittent phases of law, through the Lunacy Act of 1912 and the Mental Health Act of 1987, India sees the slow transformation of an imperialist concern to a medical concern. Ironically, this transition of the erstwhile 'lunatic' into a 'person with high support need' envisioned in the proposed Mental Health Care Bill of 2013, is offered as a fulfilment of India's obligations under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), a comprehensive human rights document created with phenomenal participation by people with disabilities, including users and survivors of psychiatry.

I argue that, in this fresh flood of 'modernisation of mental health care' in the country, a new kind of patient-subject eligible for penal treatment is being created - the 'Person with high support need'. The cultural memory that India is trying to shed is its colonial past and what is now being reconstructed as a 'superstitious' self that seeks indigenous healing (Davar and Lohokare, 2008). Under the aegis of what is largely considered to be a policy renaissance of the mental health sector (Sachan, 2013), the country is all set to catapult into a rationalist future, divested of blind faith and superstition; and armed with the promise of new age mental hospitals, delivering electro-convulsive therapy, psychotropics and 'psychosurgery' legitimately, thus 'filling the treatment gap'.

Violence against people with psychosocial disabilities is evident too, as the state legally sanctions treatments and procedures described by the UN Special Rapporteur on Torture as inhuman, degrading, cruel and torturous, such as confinement, forced medication, and forced electroshock [5]. In the post-CRPD era in India, professional organizations such as the Indian Psychiatric Society, Indian Association of Private Psychiatrists, and the Indian Association of Biological Psychiatrists have issued a position paper (Andrade et al. 2012), advancing the role of Unmodified ECT (electroshock without anaesthesia) as a preferred modality in modern mental health care. Advocates for the human rights of persons with psychosocial disabilities are calling these events a caricature of the UNCRPD, wrought by the situation of having being colonized and allowing colonial medico legal insanity and incapacity laws to continue to dictate policies of health care practice (Davar, 2012a).

Mental asylum as the cultural archetype for 'cure from mental ailments'

Promising 'modern' 'cures', the mental health care system in India is a curious mix of the old and the new: 150 year old penal architecture and custodial medico-legal management practices serving as segregated 'total institutions' (Goffman, 1961) and continuing colonial practices of segregation, solitary confinement and physical restraint procedures, alongside use of psychotropics [6] [7]. Scientific realism underlying psychiatry arouses the expectation that a mental 'disease' condition will be proved by sophisticated diagnostic machines, laboratory tests or surgical procedures, or at the least, by anatomical or physiological bio-markers obtained from human samples. But there are no such bio-technologies or bio-markers (Summerfield, 2012).

The recent heated critiques of the proposed Diagnostic and Statistical Manual (DSM-5) contest the 'diagnosis inflation' and 'diagnostic exuberance' that lead, to the 'pathologisation of the normal' (Frances, 2012; Strong, 2012; Strong et al. 2012). As Rose (1996) has argued, closely held values of autonomy, identity, individuality, liberty and choice, are seen as core within the 'psy' disciplines in 'inventing our selves' in new ways through modernity. These are fuelled by modern political economies, which are acted upon not only by doctors and

therapists, but also by politicians, managers, lawyers, media, and a plethora of other authorities. In reference to the making of the DSM, Hacking (1998) has also referred to the 'invention' of the individual self in categorical and pathological terms, as having 'looping effects', i.e. 'providing actionable DSM self identifications for the people taking up such self descriptions' (cited in Strong 2012:8). Thus, we become that which is projected on us textually, through the DSM.

Mental sciences have dealt with the non-linearity of disciplines by hypothesizing parity. The quest to make mental 'illness' a legitimate 'object' of medical science and bring precision and certainty to this matter comparable to medicine of the body, resulted in the creation of special laws and institutions. Through Indian colonial history, certain subjects of the state, designated 'insane' and sharing social status with others such as 'insolvents', 'unfit', 'infirm', 'idiots', 'leprosy cured', 'paupers' and 'criminal tribes' came to be governed by norms of criminal law (Mills, 2000). Those found to be 'mentally ill' are the only health care subjects in India who are treated as both 'patients' and as 'accused' [8], because of the curious historical mix of justice and care encoded within the legacy of insanity legislations. The Indian state has the dubious obligation of providing health care to some subjects by first depriving them of their liberty and incarcerating them in a total institution. The 'mental patient' is seen as a different kind of patient than the one who approaches the health care system for physical ailments.

Asylums as a kind of prison for special subjects

If people deemed to be 'mentally ill' are a special class of medico-legal subjects, an 'institution' refers to a special type of penal architecture. In Pune, a city in western India, as in some other cities, the mental asylum is bound by the prison on one side and the 'beggars' home' on the other side, all sharing the same institutional design and similar local legal procedures through the district magistrate (for example, the Bombay Prevention of Beggary Act, 1959). [See Mills (2000) on various legal analogues to the lunacy acts found *passim* in a variety of laws viz. civil, family, criminal, taxation, and other]. The architectural template for the penal institutions, viz the '*panopticon',* was the idea of Jeremy Bentham, a political thinker, who greatly influenced public administration and the growth of institutional design in colonial India (Ernst, 1991:21-23; Foucault, 1967). The design, found in most such institutions in India, was such that vigilance from a centrally located control room was possible. The panopticon structure, including the pavilion type and the corridor type, was built in congruence with an administrative requirement of surveillance, with emphasis on the need to prevent deaths, escapes and suicides. Both types continue to exist in India. Many contemporary private asylums mimic these old systems and structures (Cremin, 2007).

In India as well as other commonwealth countries, sites far away from the city were chosen ostensibly to serve as a 'retreat', but more covertly permitting segregation (Caplan and Caplan, 1969). Institutional design was tied to the project of classification and control under the guise of care and treatment (Scull, 1989:226). As Scull argues, a medicine of the mind was possible only by fully eliminating subjectivity and reducing a person to basic bodily function, a project simulating general medicine. The institutional 'subject' was stripped of any semblance of subjecthood and expression of personal choices relating to clothing, grooming, behaving, social interaction, eating, sleeping, having their treatment, defecating, etc. Starving the body of its quest for a free, moral and desiring self, or searching for identity, was considered, not as cruelty, but as cure. As the asylum had the overt function of individual care and hospice, care was taken in the design that they should not *look* like custodial homes, but function *as if* they were. When the 'subjects' in these spaces resisted or reacted to their alienation from themselves in this way, their alienation was considered as proved in their 'self-harming' and 'violent' behaviours, and so the overt function of 'treatment' began. Frantz Fanon (1963) also speaks of the alienation of psychiatric and other colonial practices, and how resistance is construed as the result of faulty brain structures. In this way a whole new category of the 'furious' insane was created who were seen as the 'first, and perhaps the most important step in classification', needing complete segregation and isolation cells 'distinct from the main body of the house' (Scull, 1989:225-238). Evidence of self or engagement with moral issues was considered as expression of inexplicable bestial fury that needed to be contained. Physical 'treatments' (physical restraint, confinement) were built into the structure of the building: physical confinement was seen as a special apparatus for the cure of lunacy. Studying these institutions and their legislations, Mills (2004:80) crisply concluded that the '(B)ody is the target of the asylum' in colonial and post colonial India. I would argue further that the colonial project was to empty the self and gain control over the shell, viz the body.

Continuing colonialism in medico legal practices

As the National Human Rights Commission reports show, many of these colonial practices continue unabated in the post Independence period, and today, in the 21st century (NHRC, 1999; 2012). Worse, the strict judicial procedures adopted by the colonial state for depriving someone of their personal liberty [9], to ensure justice is served, is now greatly diluted. The Indian constitution guarantees right to liberty as a fundamental right. In India, Reception Orders (ROs) are an involuntary admission made under the Mental Health Act (MHA), by bringing a person before a court to be certified as 'mentally ill' and adjudicating their right to liberty, in order to subsequently admit that person into an asylum. In the context of UNCRPD monitoring for India (NCPEDP, 2013:130), a study of 20 ROs of people admitted into the Pune mental hospital in 2010 showed the various findings [10]. The persons being admitted against their will are referred to as a 'non-applicant' in these orders. The 'applicant' in each

case is the mental hospital authority. This is a curious twist given to the adversarial system of justice, followed in India, where the nomenclature used is 'applicant' and 'respondent', and where, both have equal right before a court of law. In referring to these people as 'non-applicant', the Indian state legally denies a person subject or citizenship status and with this their right to access justice before a court of law. Names of the person involuntarily admitted have not been mentioned, and their age, sex and other details, or the reasons for deprivation of liberty are not found in the order. An administrative order, repeated word for word in each and every one of the 20 ROs reviewed, is passed off in all cases of this small study sample as a judicial order [11], making it clear that no full judicial inquiry has been conducted. It is also clear from the ROs that the 'non-applicant' never came before the court at any point, whether for admission, or for extension of stay in the hospital. It is evident from the above analysis that legal practices, in mixing the language of criminal justice with that of patienthood has resulted in such 'hybrid' medico legal constructions such as 'non-applicant'.

The continuing presence of hybrid medico legal language explains the question, when and how 'involuntary admission', 'least restrictive environment' and 'physical restraint' became *medical* treatments, changing over from *penal* mechanisms. There is concerted advocacy from Indian mental health professionals for 'evidence based medicine' (EBM) (Desai, 2006; Gambheera and Shehan, 2010). However, there is virtual silence on EBM for practices such as forcible admission through archaic provisions, physical restraint and solitary confinement. Furthermore, how are these practices of forced segregation and control configured within the framework of EBM? For example, the author knows of no peer reviewed articles on EBM for forcible admissions, physical restraint, or seclusion in solitary confinement in the Indian context. The GMH literature, which devoutly advocates EBM, is also quiet on these topics. In my view, this silence is significant of the limits of explanations available in the 'mental' sciences; and it is suggestive of a big gap in our historical knowledge of madness, institutions, knowledges and treatments. I am convinced that these practices are continuing penal elements of late colonial efforts to make a 'body' out of the mind, and extinguish the subjectivity of some persons designated 'persons of high support needs'.

The case of the vanishing indigenous healing systems

Meanwhile, we might ask, what is happening to the indigenous healing systems in India? On the vast landscape of 'healing', a variety of spiritual healing centres have long existed in India, which address the psycho-spiritual needs of communities[12]. Classical texts and other writings (Amarasingham, 1980; Kakar, 1982; Kapur, 1979, 2009) have always included spiritual healing centres within the bounds of mental health healing; and analogically, that is, by comparison of concepts and methods with psychiatry and its institutions (Basu, 2009; Sebastia, 2009; Sethi, Trivedi and Sitholey, 1977). The Indian government has recently been supporting AYUSH (Ayurveda, Yoga, Unani, Siddha and Homeopathy) through a government

Department and some dedicated policies[13]. Some of these healing systems provide 'cures' by using pills, herbs, concoctions, pastes, and other material substances or bodily practices to relieve affliction. However, such policy recognition has not been accorded to faith healing practices, say, for relief of psychosocial affliction by prayer. Most mental health professionals see such practices as 'blind faith', 'superstition', 'cultural' whimsy or simply irrational and insane (Bhakthavatsala, 1993; Chakraborty and Banerji, 1975; Castillo, 1994; Chandrasekhar, 1999; Satija et al. 1982).

A process of discrediting traditional healing practices, that started in the late colonial period with the emergence of the professional disciplines of psychiatry and psychology continues today through different epistemic shifts. While re-inventing the social self through psychiatry and its institutions was one kind of move, simultaneously there was a move to disinherit and outcaste some practices perceived by the emerging Indian elite as 'superstition'[14]. Raghuramaraju (2011) has observed that, in changing epistemes, rewriting the self may well begin with a question about the 'true nature of man'. In psychiatry too, several early writers redefined this question. The modern 'sane' Indian mind, as in other colonial contexts (Swartz, 1995; Jackson, 2005), was created by disinheriting what was judged as 'primitive', 'backward', 'instinctual', 'emotional', 'childish', 'over-sexed' and 'savage', the feminine, the 'tribes', the 'hill people', the 'nomads' and low caste lives. In India, the psychoanalyst Mukherji drew a difference between the 'primitive' and the 'advanced', proposing the Hindu as advanced, because in him, '(S)ex and self-assertion are conducted into legitimate channels' (1929:155). Introspection, self control, textual competency and individualism indicated both religious as well as mental superiority; but not all people were capable of this (Chatterjee, 1940). An early psychologist wrote thus: 'Primitive people are no better at thinking than children' (Alawi, 1939:82). A bit later Erna Hoch referred to the Himalayan hill tribes as 'stubbornly autistic' (1963:67). Women who did not conform to normative sexual codes and moral orthodoxy were ascribed unique diagnostic labels such as 'Married Spinsters' by some professionals (De, 1946). Cross interpretations of psychology and scriptural religion (Hinduism and Islam) were commonly found in journals (Sastry, 1932; Menon, 1940). In this way, 'modern man' was created around the period of obtaining Indian Independence, and like other disciplines, this was a way of contributing to nation building for the emergent mental and behavioural sciences.

The rationale for the erasure of indigenous healing has surfaced in every change of episteme, including the present one, following the Erwady tragedy leading up to the Mental Health Care Bill of 2013. A regulatory action by the Supreme court following the Erwady tragedy has impacted on spiritual healing in India in the last decade (Basu, 2009; Davar and Lohokare, 2008; Lohokare and Davar, 2010; Sood, 2014). It has led various actors - the state, the psychiatrists, state judiciaries, the media and civil agencies – to advocate for bringing faith healing centers within mental health law. In the case of *suo moto* action on '*Erwady deaths versus the Union of India',* the Supreme Court, in an order dated 5th February 2002,

prohibited seeking help from indigenous centres for 'mentally challenged persons', directing that a mental hospital is the right place for such cases. Mass awareness programs were suggested for 'backward' communities selecting spiritual healing. Meanwhile professionals involved in building national policy (e.g. Murthy, 2001) wrote editorials and recapitulations of the global role played by Indian psychiatry, and the need to upgrade their discipline to suit the future. In their critique of these recent developments, Davar and Lohokare (2008) have noted the paradox wherein the Supreme Court appointed the very organizations against whom it had taken action against in the first instance, to regulate the sector. Violating community choices of spiritual and healing practices, several state governments dispatched teams of psychiatrists to visit, inquire, find and treat 'mentally ill' people in these centres (this is described more fully in Davar and Lohokare, 2008).

Currently, indigenous healing is in a double bind policy situation, running the risk of either being forced out as illegitimate practice, or being mainstreamed as a mental institution through the new proposed legislation. In practice, however, their transformation over the last decade is evident in mental health practice. Bhat et al. (2007) describe two projects of the Government of Gujarat to provide '*dava*' (medicines) and '*dua*' (faith) to people within the precincts of spiritual healing centres. Such attempts are growing in India, with efforts at translating local idioms of *traas* (troubles) to the global idiom of mental illness; and substituting locally sited faith healing practice to universal application of allopathic chemical formulations. In this process, the internal dynamics within each system: the pluralism, historicity, strengths of each system, and the community aspects of indigenous healing, are being obliterated and a one sided view is emerging. 'Modern' science is marching ahead, purifying contemporary India of 'blind faith' and 'superstition'. Some may link these developments to globalizing economies, the compelling domination of a private industry in mental illness in India, and the media - and they would not be completely wrong (Das and Rao, 2012).

In this paper, I have not addressed the efficacy of the ritual healing found extant in indigenous healing centres. For some this is a moot question (Sax, Quack and Weinhold, 2010). Michael Winkelman (2000, 2010) has extensively researched the biological healing aspects (2000, 2010) of shamanism, possession and trance. Krippner (2004) has written on the hypnosis like techniques used by traditional healers. Sax, Weinhold and Shweizer (2010) compared Family Constellation Therapy in Germany and Himalayan ritual healing, bringing our attention to the idea of healing the collective, rather than the individual. In our studies on the subject, we have found that intense personal relationships with the healer, and the role of the family and community as participants in the healing are typical and enable recovery (Lohokare and Davar, 2010). We have also emphasized the sensory and embodied aspects of healing (Davar and Lohokare, 2008). The adoption of a humeral, moral-spiritual way of life seemed to facilitate the restoration of a sense of health and well-being (Amarasingham, 1980; Azhar et al. 1994; Razali et al. 2002; Valla and Prince, 1989). Some people living with

psychosocial disabilities have found that a connection with the sacred within oneself can lead up to and sustain their recovery (Minkowitz and Dhanda, 2006; Lehmann, 2007). Spiritual healing systems address the question of identity and belonging, may reflect fractures in communal equilibrium, may reaffirm or alter prevalent social norms and structures, and serve as quasi-judicial moral courts resolving community conflicts and power relations (Claus, 1979; Kakar, 1982; Sax, 2009; Shields, 1987). What makes them 'alternative' approaches to western practice is their cultural continuity with the local communities, adaptation of their processes to the local needs, and the complex web of relationships that the healers and the centres share with communities. But as described below, these systems of community support are slowly vanishing, besieged by new developments in modern mental health care.

Conclusion

The practice of penalizing those who are ostensibly health care patients, continuing into present times with refreshed advocacy on providing modern mental health care based on the colonial archetype, is not often articulated or theorized as a historical question needing study. The GMH Movement is yet another epistemic variant, providing a charged and euphoric atmosphere in contemporary India with its rhetoric of 'burden of mental disorders', 'filling the treatment gap' and the 'right to mental health care' as a basic human right. In all the written literature, the GMH movement has remained silent on the colonial basis of mental health practices in India, or on the question of community choices and alternatives. This absence, I argue, permits penal practices that have, through late colonial history and post Independence in India, entrenched themselves as 'medical'. In recent articles (Patel, 2013; Sachan, 2013), the GMH Movement has affirmed its position as favoring the Mental Health care Bill of 2013, which provides for coercive psychiatry viz. 'High support need admission'.

As argued by several papers in a recent special edition of *Transcultural Psychiatry* edited by Campbell and Burgess (2012), the GMH movement, in universalizing mental disorders is shown to set up fresh barriers for situating mental health care within community development and empowerment. Together, these papers suggest that GMH and its variants around the world, based on alarmist data on the 'burden of mental disorders', may end up creating cultures of sickness, where people and communities are disempowered in cultivating health and well being practices. Summerfield writes, '[I]n what has been called the ''culture of therapeutics'', citizens are invited to see a widening range of experiences in life as inherently risky and liable to make them ill' (2012:520). While GMH movement is leading to a relentless rise in the medicalisation and professionalisation of everyday life, Read (2012) argues that the 'cures' offered, such as anti-psychotics in complex psychosocial settings, have dubious value and preference for communities. Challenging the view that '[M]ind … is to be located inside the body _ between the ears…' (Summerfield, 2012:527), the authors to this *Transcultural Psychiatry* volume suggest several practices that increase the 'health

competence of communities', including facilitating community ownership and responsibility for good mental health; enhancing local individual and group based skills; and enabling local solidarity around collective efforts to optimize mental health in adverse conditions, and leveraging from community resources.

Notes

[1] There were about 40 people, both men and women, abandoned by families in the Badhusa mental home, in Ramanathapuram. They were not diagnosed nor were receiving any kind of medical or psychosocial treatment. They were kept in chains. Following the tragedy, media picked up the issue, and named them 'mentally ill'. The survivors were sent off to the Chennai mental institution at Kilpauk for an evaluation.

[2] WNUSP and IDA, 'The elephant in the room – Involuntary psychiatric treatment and the WHO', October 2010.

[3] With the repeal of the Leper's Act persons suffering from leprosy or cured, are no longer found within penal institutions. They may however experience another kind of institutionalization within homes, families and communities, due to stigma and impoverishment.

[4] Found at the website of the Ministry of Health and Family Welfare, http://mohfw.nic.in/WriteReadData/l892s/6420662643DRAFT%20THE%20MENTAL%20HEALTH%20CARE%20BILL.pdf accessed on 08-04-2014

[5] 'The Special Rapporteur draws the attention of the General Assembly to the situation of persons with disabilities, who are frequently subjected to neglect, severe forms of restraint and seclusion, as well as physical, mental and sexual violence. He is concerned that such practices, perpetrated in public institutions, as well as in the private sphere, remain invisible and are not recognized as torture or other cruel, inhuman or degrading treatment or punishment' and *passim;* 28th July 2008, Sixty third session Item 67(a) of the provisional agenda A/63/150 of the United Nations General Assembly. The Special Rapporteur also included among the practices of concern as torture and ill-treatment, that 'persons with disabilities are exposed to medical experimentation and intrusive and irreversible medical treatments without their consent (e.g. sterilization, abortion and interventions aiming to correct or alleviate a disability, such as electroshock treatment and mind-altering drugs including neuroleptics)'. In 2013, the Special Rapporteur called for an absolute ban on forced and non-consensual medical interventions imposed on persons with disabilities, including nonconsensual administration of electroshock, psychosurgery and mind-altering drugs such as neuroleptics, restraint and solitary confinement for long- or short-term periods. A/HRC/22/53.

[6] Every year approximately one hundred thousand people enter the over four hundred mental hospitals dotting the country- private and public- often forcibly entering these institutions

through complex medico-legal procedures established by colonial law makers in the late colonial period (Ernst 1999; Mills, 2000) and continuing in the independent Indian state through the Mental Health Act of 1987 (Dhanda, 2000). According to the National Human Rights Commission of India (1999, 2012), at least one third or more of these people, particularly women, will never leave the institution and are euphemistically called 'long stay patients'.

[7] National Human Rights Commission 2012, Care and Treatment in Mental Health Institutions–Some Glimpses in the Recent Period, http://nhrc.nic.in/Documents/Publications/Care_and_Mental_Health_2012.pdf; Accessed on 18/10/2013

[8] The Mental Health Act provides a variety of provisions through which a person seen by family members, neighbours or public as 'mentally ill' can be brought before a court of law against their will. These procedures are called 'involuntary commitment' procedures. These provisions have been retained in full from colonial laws such as Lunacy (Supreme Courts) Act of 1858 and the Indian Lunacy Act of 1912.

[9] For a reading of Article 21 of the Indian constitution, on the Right to Life and Liberty, see http://indiankanoon.org/doc/1199182/ accessed on 09-04-2014

[10] A total of 20 Reception Orders were looked at of 2010, from the court of the Chief Magistrate, Pune district court, Pune.

[11] 'Order No _____ of date ____: Non applicant admitted on _____ Medical report is satisfying, advocate for the applicant has been heard. And non applicant can be admitted / RO extended until fully recovered. In the court of _____, judgement date _____, signed by Presiding officer'.

[12] In this category, we include healing churches, Hindu shrines and temples, Muslim tombs (*dargah*s); and faith healers such as mediums, shamans, clairvoyants, exorcists, religious healers, *tantriks* and *mantriks* (sorcerers), *babas* (meaning, 'father' and refers to locally revered saints) and *buas* (native healers).

[13] Find at indianmedicine.nic.in

[14] The fist psychological laboratory was built in 1916 in Calcutta by Asutosh Mukherjee. By 1926, there were 100 university departments teaching philosophy and psychology together as 'mental and moral science'. There were intellectual pressures to separate the two, and also some resistance to joining the anthropology departments. The Indian Philosophical Congress in 1925 had a psychology section. The Indian Psychoanalytical Society was started in 1922 in Calcutta.

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