The Modernisation of Tradition:
Thinking about Madness in Patna, India*

Wolfgang Wagner**
Johannes-Kepler-Universität Linz, Austria

Gerard Duveen
University of Cambridge, UK

Matthias Themel
University of Vienna, Austria

Jyoti Verma
University of Patna, India

* Address for correspondence: Wolfgang Wagner, Abteilung für Sozialpsychologie, Johannes-Kepler-Universität, 4040 Linz, Austria. w.wagner@jk.uni-linz.ac.at

** The data reported in this paper formed part of Matthias Themel's master's thesis, and the paper was written while he was an Erasmus exchange student in Cambridge, and while Wolfgang Wagner was a Visiting Fellow at Corpus Christi College, Cambridge.

The authors are grateful to Pankaj Bharti and Sanjay Bharti for the professional way in which they conducted the interviews, and to Kanchan Singh, Preeti Singh, Nidhi Sinha, Shilpi Sharma and Babli Singh for their equally professional translation of the Hindi transcripts into English.

The authors gratefully acknowledge financial support from the following institutions: The Fondation Maison des Sciences de l'Homme, Paris, for support for Jyoti Verma; the University of Linz, for support for Wolfgang Wagner; the University of Vienna and the University of Linz for support under the EU-Erasmus scheme to Matthias Themel.

The authors also gratefully acknowledge helpful comments by Sunil Bhatia, Derek Edwards, Mirko Fryba, Marcio Goldman, Jonathan Potter, Debra Skinner, Helen Ullrich and Jaan Valsiner on a previous draft.

Lastly, the order of the author's names does not reflect any hierarchy in their contributions.
Abstract

Thirty-nine educated middle-class residents of Patna, India, were interviewed about a vignette describing the behaviour of a seemingly mad man or woman. The interview explored their representations of traditional healing methods and of Modern psychiatric notions. Besides explanations for mental illness and madness, the interviews also covered the reaction of families and neighbours to such phenomena. Respondents think of different causes depending on the context, ranging from frustrated desires, shock, and heredity to spirit possession. The majority's spontaneous preference for modern, psychiatric, treatment often co-exists with a faith in traditional healing. This faith is strengthened by their family's traditional preference. The results are discussed as an example of a process of modernisation of common-sense in which popularised scientific notions become anchored in the traditional setting of social structure and family life. The newly acquired knowledge forms a loosely organised social representation confronting a strongly objectified cultural representation of traditional thinking.
The Modernisation of Tradition: Thinking about Madness in Patna, India

From the Traditional to the Modern

Our first concern in this paper is to investigate contemporary urban North Indian social representations of madness. The cultural traditions of India themselves provide a rich and diverse source of beliefs about the causes and nature of madness, and also about appropriate forms of treatment embedded in diverse forms of social practice. Our question concerns the extent to which these traditions have absorbed "Western" or "modern" ideas based on contemporary medical and psychiatric knowledge. And do such "modern" ideas simply displace more traditional Indian beliefs, or do Indian lay representations reconstruct these "modern" ideas in ways which allow them to co-exist with more traditional patterns of thought?

Framing the issues in this way itself raises a number of conceptual problems about the contrasting notions of tradition and modernity, which seem to imply a narrative idea which has itself been criticised for the way in which it constructs Western values as universal. As Pigg (1996) points out, however, modernity is an enigmatic concept in cultural analysis. Her analysis of the ways in which a discourse of modernity figures in the context of a Nepalese village shows how this idea is used to mobilise a number of key themes -including "notions of progress and development, of rationality and science" (p. 193)- which provide individuals with a social identity located within the dynamics of contemporary Nepalese culture. Pigg's approach, then, is not to avoid using what she acknowledges could be considered as the "tainted adjectives" of traditional and modern, but rather to emphasise that the contrast of these terms has become a part of contemporary Nepalese culture, and to suggest that the task for the cultural analyst is to understand in what ways these terms are being used.

Pigg also notes that even within what can be called traditional patterns of belief there is considerable debate and argument generated for these villagers, as she puts it, by the "problems their unquestioned assumptions about healing, knowledge and illness pose for them" (p. 181). There is an echo here of a point made by Evans-Pritchard (1976) among others, that while to an outside observer traditional cultural systems may seem to be homogenous and static, there are nevertheless contradictions within them (Archer, 1988; Gusfield, 1967) and a certain dynamic to
the society (Bartlett, 1928). Novelty introduced by innovation and modernisation has to operate within this context. As Bartlett recognised, the novel does not come into a cultural vacuum, but exerts its influence within a context of already established meanings. He writes about cultural groups having "preferred persistent tendencies" which express a general direction to the development of a group, and it is this general direction which determines their response to the novel and the new. Ideas and values which can be accommodated within this tendency are likely to be accepted, while those which conflict with it are likely to be ignored. Within the contemporary Indian culture we are concerned with in this study, the motivation to embrace the new seems to be nourished by a general idea of progress. This is the context in which modern psychiatric ideas about mental illness are being re-worked into Indian common-sense. Psychiatric notions and practices offer a more progressive account of these forms of disturbance and deviance than traditional theories and practices.

Framing our questions in this way also enables us to introduce our second concern which relates to issues about the dynamics of social representations themselves, and in particularly this study addresses questions about the socio-genesis of representations. Social representations can be defined as:

"system(s) of values, ideas and practices with a twofold function: first, to establish an order which will enable individuals to orient themselves in their material and social world and to master it; and secondly to enable communication to take place among the members of a community by providing them with a code for social exchange and a code for naming and classifying unambiguously the various aspects of their worlds and their individual and group history" (Moscovici, 1973, p. xiii).

In this sense social representations establish a universe of discourse within which meaningful talk can take place. As Moscovici, echoing Bartlett and MacDougall before him, has emphasised the genesis of social representations is always concerned with rendering the

unfamiliar familiar. Research on processes of innovation in common-sense have described two aspects to this process: anchoring and objectification (Duveen & Lloyd, 1990; Moscovici, 1981; Wagner et al, 1999). Anchoring refers to the process whereby the members of a group attempt to make sense of a new phenomenon by interpreting it in terms of pre-existing knowledge. Objectification is the process through which the elaboration of ideas, interpretations and evaluations of an unfamiliar phenomenon results in a condensation of these elements into a simplified figure, icon or metaphor (Moscovici, 1976, 1988; Wagner, Elejabarrieta & Lahnsteiner, 1995). In a second phase of objectification, this image is projected so that reality is itself constituted in the terms of the representation (Wagner, 1998).

Most studies of social representations have been undertaken in Western cultures in conditions of modernity, and, as Moscovici (1981) suggests, the transition from the traditional to the modern is also a transition from collective representations to social representations, from a relatively static order of unquestioned beliefs, to complex forms of different, even competing beliefs. Both historically as forms of collective thinking, and in the practical actuality of particular bodies of knowledge, social representations emerge out of tension and conflict when gaps or divisions appear within existing patterns of understanding. In short, when the taken-for-granted (Schütz’s fraglos gegeben, 1972) can no longer be taken for granted, representational work is necessary to re-establish stability. In this sense, the socio-genesis of representations is an effort to restore or to gain collective, mental and cognitive stability (cf Duveen, forthcoming). When we talk of social representations we therefore always mean a social representing system which dynamically maintains a complex of meanings in a collectivity (Duveen & Lloyd, 1990).

In the present research we are concerned with two forms of instability. There is first of all madness itself, which, as Jodelet’s (1991) study demonstrated so vividly, always presents a threat of instability in the ordinary business of living. Within the West, the categories employed to represent this disturbing and troubling phenomenon themselves have a history in which, as Foucault (1967) and others have pointed out, a notion of mental illness defined through analogy to physical disease and grounded in psychiatry as a scientific and medical practice has emerged in contrast to earlier notions of madness as a form of otherness. Contemporary representations in the West continue to incorporate both of these meanings. One continues to emphasise a
sense of the radical otherness of the mad, while the other has sought to make this strange phenomenon accessible to the analytical framework of science by identifying causal factors in biological or social processes.

The second form of instability we consider is concerned with the relationships between these different representations. In the West, at least, a certain stability has been achieved with the medical model of mental illness institutionalised in psychiatric practice, while popular social representations, even if they recognise the claims of science, nevertheless, as Rose (1996) has shown, continue also to hold on to a sense of the otherness of madness. De Rosa (1987) too found that the theme of madness continues to evoke archaic images of the mad as strange and bizarre among children and adolescents, as well as more modern, medicalised images. Both of these examples illustrate what Moscovici describes as a state of "cognitive polyphasia" (1976, p. 286, see also Moscovici & Markova, 1998) which is characteristic of social representations in which different forms of understanding are able to co-exist. The continuing debates and arguments about these themes indicate a persistent potential for instability between representational systems.

A recognition of such polyphasia also serves as a reminder that Western representations are not exclusively "modern", any more than Indian representations are exclusively "traditional". Indeed, this study is not presented as a comparative research. Rather, our concern is with the ways in which Indian representations are emerging. In common with most of the non-Western world, the institution of psychiatry is a more recent phenomenon in India than in the West, and traditional representations of madness persist not only as patterns of belief, but also through the practice of traditional healers. But they do so side by side with "modern" medical beliefs and psychiatric institutions. The dynamic established between these different threads of ideas suggests patterns of communication in which new forms of social representations are taking shape, and it is this which is our focus.

Madness, healing and the notion of desire in India

Although a wide variety of different healing traditions can be found in India, our respondents referred primarily to the cure of possession states and some aspects of the tantric
cult. In addition they also drew on ideas and principles of the medical system of ayurveda. A brief explanation of these traditions will help to give the reader some orientation and background to this study.

**Ayurveda.** The complex and elaborate medical system of ayurveda builds on the idea that health and illness are determined by the balance of various elements, humours and qualities in the body. Besides the gross physical body, the person is conceived as consisting of two other bodies, the subtle body (*linga sharira*) and the causal body (*linga karana*), of which only the subtle body is relevant with respect to mental illness. The subtle body consists of five principles: *buddhi* (intelligence), *indriyas* (the five potential sensory organs), *ahamkara* (“I-ness”), *tanmatras* (the five potentials of sound, touch, colour, smell and taste in the form of subtle matter) (Kakar, 1982, p. 239) and finally *manas*, which in psychological terms could be described as responsible for activation and direction of sensory and motor organs, self-regulation, reasoning and the combination of deliberation, judgement and discrimination (Kakar, 1982, p. 244). The balance of *manas* which constitutes mental health (*triguna samya*) is determined by the qualities (*gunas*) purity (*satva*), temperament (*rajas*), and inertia (*tamas*) and can be disturbed by strong emotions such as fear (*bhaya*), grief (*soka*), lust (*moha*) anger (*krodha*), and - notably - by desires (*ichha*) and their counterpart repulsion (*dvesha*) (compare Kakar, 1982; Rosu, 1978; Srikantha Murthy, 1987).

In the diagnostic process, the practitioner of ayurveda (*vaidya*) generally aims to determine the specific nature of the imbalance within the bodily system in order to counteract this imbalance by prescribing herbal, dietary or mineral remedies. However, the ayurvedic medical system also acknowledges alternative explanations for illnesses. Among these, the concept of hereditary (*kulaja*) illnesses, which are referred to as *sukrasoniprakrti* or *adibala pravrita*, and are recognised as having potential ill-effects on forthcoming generations (cf. Raina, 1990; Srikantha Murthy, 1987), is important in the present context.

**Tantra.** The term tantra in its literal sense simply denotes a specific genre of religious and ritualistic writing (Hardy, 1994). These writings generally consist of extensive compilations of *mantras* and descriptions of ritual acts. However, the tantric material also provides its own theory of the human body and the physical processes involved in the pursuit of the ultimate aim
of tantric mysticism, i.e. self-realisation (*moksa*). As with the ayurvedic system, tantra presupposes the existence of a subtle body, which in this case consists of thousands of *nadas* (conduits of energy or nerves) and six centres (*chakras*). The *chakras*, which are situated along the spinal cord, are connected by three major channels of energy, *shushumna* in the centre, the masculine *ida* to its left and the feminine *pingala* to its right (Kakar, 1982). Without meditational practice, the subtle energy only flows in *ida* and *pingala* without ever reaching *sahasrara*, the seat of "cosmic consciousness" (Kakar, 1982; p. 187), situated at the top of the skull. In order to achieve self-realisation, the energy has to be made to rise upwards through *shushumna* by means of meditation until it reaches *sahasrara*, thereby piercing the six *chakras* one after another (Kakar, 1982; p. 187). This simplified description of tantric ideas points to the major reason for severe forms of mental illness as pictured in this tradition: that is the "unplanned and unprepared rising of energy through the central channel. Under severe bodily or mental strain, it is claimed, this energy may accidentally make contact with the *sahasrara* in the brain - with disastrous results" (Kakar, 1982; p. 188, italics in original).

Generally speaking, the accumulation of bad *karma* (i.e. indulging in "bad" thoughts or actions) leads to the malfunctioning of *chakras* and at a later stage to the generation of a malevolent spirit (*bhuta*). The therapeutic intervention for any kind of illness resulting from *chakra* malfunctioning primarily consists in the application of *mantras*, to conquer the afflicting *bhuta* or to restore the proper functioning of the affected *chakra*. Along with *mantras*, cannabis based drugs, hypnosis, massages, hot-water baths and various devotional rituals may be employed by the practitioner of tantra (*tantrika*) (Kakar, 1982, p. 189f). One last remark is important in connection to the *tantrika*: according to a widespread idea of *tantra* the practitioner of *tantra* is involved in quite extraordinary rituals which are said to take place on cremation grounds and may include sexual intercourse with women of low castes, along with the consumption of meat and alcohol. Because of such beliefs that are found among anglicised upper caste urban Indians as well as among poorly educated rural folks, the *tantrika* is assumed to have magic powers and the potential for black magic. Therefore he is often viewed with suspicion.
Bhuta-Vidya. Bhuta-Vidya can roughly be pictured as a form of exorcism although this Christian term implies not only the repulsion but also the destruction of an evil spirit possessing a human being. The Indian concept of bhuta-vidya, however, does not necessarily aim to destruct such a malevolent spirit but alternatively allows for pacification and/or reeducation of the possessing entity.

The Indian mythology differentiates between five classes of living beings, of which the various kinds of supernatural beings like demons and spirits make up one class (Hardy, 1994). These supernatural beings are meant to be able to interfere with human existence and well-being by way of possession. The concept of illness caused by evil supernatural beings can be traced back to one of the earliest Indian scriptures, the Atharvaveda (ca. 1500 BC). From there it found its way into the classic ayurvedic literature (under the term of pisacadi krta), and in particular, in the book Charaka samhita, dating back to 100 AD. Although acknowledged by the ayurvedic medical system, illnesses and mental afflictions caused by spirits are not generally dealt with by the vaidya. Instead, the practitioner of bhuta-vidya who is called ojha or ojha-guni is charged with taking care of these cases (called bhut lagna in lay terms).

The healing ritual employed by the ojha to expel the malevolent spirit is called jhar-phook and usually makes use of a broom (jharna = to sweep) or the wing of a bird and various ritualistic items such as sacred stones, the sacred ashes of burnt offerings to the gods and sacred water. As in the tantric tradition, mantras also play an eminent role in conquering the evil spirit. The use of a broom, however, can take two forms: either it is used in a rather 'symbolic' manner, to gently tickle the spirit, or it can be used in a more concrete manner, to literally beat the spirit out of the afflicted body by using the broomstick as a club. The latter way to make use of a broom is justified by the idea that only the spirit or demon can feel the pain, but nevertheless is a matter of concern and discussion, as many a story told in the interviews illustrates.

The notion of desire in Indian philosophical thought. The notion of desire plays an important role in traditional Indian folk-psychology (Bhattacharyya, 1984) which is distinct from Western indigenous psychological ideas. The preoccupation with desires in Indian religio-philosophical and notably in medical literature reaches back at least as far as the 5th century BC,
when the two most eminent religious traditions of ascetic renouncement, Buddhism and Jainism, were established (Hardy, 1994). The respective 'founders' of these traditions\(^2\), Prince Siddharta and Prince Vardhamana both taught that desires were the link filling the space between birth and death, while at the same time perpetuating the "fundamentally undesirable" (Hardy, 1994, p. 239) cycle of transmigration (\textit{samsara})\(^3\). Desires, here conceived of as the passionate attachment to any possible object including life itself are seen as being responsible for human suffering, since even their fulfilment never yields lasting happiness. Only those who are aware of the profound truth of the interrelation between desires and suffering are able to escape the vicious circle of death and rebirth by way of detachment from all things, i.e. ascetic renouncement. Thus suffering here is also linked to ignorance of the principles behind \textit{samsara}.

We can therefore understand the link established between desires, seen as the major obstacle to self-realisation (\textit{moksa}), and desires seen as the source of sensory corruption which may, in turn, lead to insanity. The Bhagavadgita (ca. 500 BC), for instance, a philosophical treatise on the laws of \textit{karma} (also well-known among lay people) links insanity to desires in the following way (Ch. 2, Verses 62-64):

(62) When man dwells in his mind on the objects of sense, attachment to them is produced. From attachment springs desire and from desire comes anger.

(63) From anger arises bewilderment, from bewilderment loss of memory; and from loss of memory, the destruction of intelligence and from the destruction of intelligence he perishes.

(64) But a man of disciplined mind, who moves among the objects of sense, with the senses under control and free from attachment and aversion, he attains purity of spirit. (Radhakrishnan, 1993; pp. 125f.)

---

\(^2\) According to mythology these traditions were only re-established at that time.

\(^3\) These ideas, however, are not at all exclusive to Buddhism and Jainism. Hinduism also subscribes to them and has produced a great number of ascetics of similar fashion.
Ayurveda too has its own view on desire. While in general in ayurveda desire is thematised as an emotional force able to disrupt the balance of the gunas, thereby affecting the mind and causing mental disturbance, Kakar (1982) points out some passages in classic ayurvedic literature which partly contradict certain well-established metaphysical assumptions and codes of behaviour. Besides questioning transmigration and recommending a beef diet for certain physical conditions, the Caraka Samhita also promotes worldly ambitions: "A person of normal mental faculty, intelligence and energy, desirous of his well-being pertaining to this world and the world beyond has to seek three basic desires, viz., desire to live, desire to earn and desire to perform virtuous acts" (Caraka Samhita, I.xi.3, cited in Kakar, 1982, p. 224).

The present study was conducted in Patna which is a developing city in North-East India. Patna’s population could be expected to be sufficiently rooted in traditional ways of thinking as well as open to new developments. The research aimed at discovering whether, and if so, how, respondents cope with seemingly contradictory representations of aetiology and healing of mental illness derived on the one hand from received common-sense and on the other hand from schooling and education.

Method

The setting: Patna, Bihar

Patna, a city of 1.5 Million, lies in the Northeast of India on the South-shore of the river Ganges. It is the capital and economic centre of Bihar, one of the least developed and most populated states. Despite the underdevelopment of the province at large, there is still a strong contrast between the rural areas and Patna. In some rural areas more than half of the population live below the official level of poverty. Literacy is low in the country-side (20.2%, with women still lower at 6.4%) and reaches 52.2% in urban Patna (Indian Council of Social Science Research, 1983). There is a strong migration from the country-side into Patna. As a consequence, traditional values, caste-hierarchy and arranged marriages are common-place in the city.
Virtually everybody has potential access to TV, radio, the press and libraries in the city which also accommodates a university. There is a university clinic, several smaller hospitals and a fair number of private surgeries and psychiatrists’ practices. A few years ago a psychiatric ambulance was added to the university hospital. The rural areas on the contrary, have much less well-developed medical institutions, with most villages devoid of surgeries. Equally, there is no psychiatric hospital except in the city of Ranchi, 200 km south-east of Patna. Therefore healers are often the only sources of medical and psychiatric aid.

The sample

The sample consisted of 19 men and 20 women from the emerging educated urban middle-class in Patna. Each person had at least started university studies. They included 12 students, 9 teachers, 6 businessmen, 5 housewives, as well as a number of other professions and 3 retired people. The sample covers the age-group from 20 to 55+ years. An overview is given in Table 1.

| TABLE 1 |

The Interview

There are strong cultural norms regulating contact between strangers especially of different sex. People who do not know each other must usually be introduced by a common acquaintance. Therefore interviewees could not be contacted directly. The researchers had to rely on relatives, acquaintances and neighbours of students who could be contacted in the university setting. Sometimes the researchers had to present additional reference to be allowed an interview with a senior woman. Once an appointment was arranged, the interviewers met the interviewees either in their home or in the hotel room of the researcher.4

Interviews were conducted in Hindi by two local male graduate students of psychology, with a Hindi speaking Western researcher in attendance, who followed the discussion and made

4 Some of the problems of contacting and interviewing respondents in non-Western cultural groups are discussed by de Araujo Günther (1998).
occasional interventions. Three women were interviewed in the presence of a chaperon, usually a student colleague. Indian tradition also discourages an older person from being interviewed by a younger one. This was another reason for the interviewees being recruited amongst relatives and acquaintances, i.e. persons who knew each other at least by hear-say.

The interview was introduced as part of a study about mental illness, psychiatrists and traditional healers, and the researchers emphasised that they were not interested in factual or school knowledge, but in whatever the interviewee believed. The interview was structured around a vignette which drew on situations and circumstances described by local people in some preliminary interviews (Verma, 1995). After the introduction the following vignette was read slowly and aloud to the interviewee:

A young woman/man in the neighbourhood is behaving in a striking way: one can always see her/him wandering around and talking to herself/himself. Sometimes she/he starts shouting for no apparent reason and sometimes she/he gets aggressive towards people on the streets she/he does not even know. She/he may sometimes even tear off her/his clothes. Other people who know this young woman/man say that she/he is sometimes very much in fear of something or sad about her/his life or confused and unable to care for herself/himself.

Occasionally the vignette was read a second time to ensure it was understood. For half the sample (ie half the men and half the women) the wording referred to a woman, while for the other half the protagonist was a man. The interviewer proceeded by asking the following questions:

- What is the problem with the person described here?
- Do you know such a person?
- What would you do if a member of your family behaved in this way?
- What would your neighbours think about your family?
- Would you take your family member to a traditional healer or to a psychiatrist?
- What would both, the traditional healer and the psychiatrist do?
The interview was of a semi-structured and focused type which allowed digression and variation according to the course of the conversation (Smith, 1995). Occasionally an interviewee showed signs of embarrassment after having been encouraged to answer a specific question. In this case the interviewer skipped it and proceeded to the next point. At the end each interviewee was offered a compensation of 60 Rupees (equivalent to US$ 2.2, the price of 6 liters milk or a simple meal in a popular restaurant at the time) which was sometimes rejected on the grounds that they had enjoyed being interviewed.

This vignette was the first part of a longer interview, and responses to it occupied about 15-20 minutes. A series of local students assisted in transcribing and translating the interviews into English. Transcripts and translations were spot checked by the supervisor.

The conventions used in the transcript are the following: The interviews were conducted in Hindi. In India, however, many people, especially the more educated, often use English words and concepts. Any text in the transcripts written in normal style are translations from Hindi. Capitalised WORDS were English in the original interview. Material in square brackets has been added to the transcription to clarify the sense of a passage. Numbers in parantheses, eg. (34F) refer to the interviewee's reference number “34”, F (female) and M (male) indicate the interviewee's sex.

Fieldwork was undertaken from December 1995 to February 1996 by Matthias Themel.

**Explanations of mental illness in vernacular thinking**

Open responses to interview questions are always strongly influenced by their context. In the present case, although the interviews were essentially conducted by local students, the Western researcher was always present, and his presence seems to have tuned the responses to a "modern" frame of reference. With many interviewees it was only later in the interview, specifically in the context of healing, that responses became focused on more traditional explanatory conceptions.

Some interviewees differentiate between two stages of severity of mental affliction: a less severe state of mental illness and a "last stage" of madness. The term "mental illness" is used for afflictions which are usually treated within the family and do not require professional
"Madness", on the other hand, not only requires professional intervention, but also very definitely carries negative connotations. It gives rise to fears about what the neighbours and the public might think:

In madness one's BEHAVIOUR becomes very ERRATIC and if you are suffering from a mental illness it is not necessary that your BEHAVIOUR will be that much ERRATIC. You can BALANCE your BEHAVIOUR. (34F)

If we had such a situation [madness] in our family, then in our society the pattern of thinking of neighbours is always vicious. They do not think in a nice way and there would be a lot of rumours. (17F)

The original Hindi terms which have been rendered as mental illness, madness and related words are given in Table 2.

<table>
<thead>
<tr>
<th>TABLE 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The kinds of explanations given by our respondents for these forms of conduct could be grouped into three themes: those where they refer to (a) family, norms and adjustment; (b) ideas of heredity and its moral threat to the family; (c) ideas of ghost or spirit possession. Each of these is discussed in turn in the following sections.</td>
</tr>
</tbody>
</table>

Family, norms and adjustment

**Family and marriage.** It is in their direct responses to the vignette that interviewees give psychic and bodily explanations for mental illness: unfulfilled desires (18 interviewees) including neglect (8), fear (14), shock (12), psychic and physical pressure (13), and depression (5).

Any strong enough desire for goods, love or success, etc., whether realistic or not in the local context, can result in frustration and ultimately in madness. Frustration leads to a "confounded balance" (15M), it may be that

---

5 These figures include multiple entries and therefore do not add up to the sample size.
any of his demands was not fulfilled. Internally suffocated, he wants something, some desire was suppressed inside, this can also be a cause. (33F)

Equally, social neglect frustrates one's desire for being loved:

Maybe her status in the family is negligible. This too can affect the mind. If I am at home and my presence is not noticed, this can bring ill-effects. (25M)

"Fear" also figures prominently in the context of the vignette:

Respondent: I said that fear comes to the mind because of one's wrong behaviour, wrong deeds.

Interviewer: Here is fear again. Is there any other reason except fear?

Respondent: Except fear? This thing [fear] comes into the mind of people suffering from a mental illness. Fear is one reason. (32M)

Respondent: There can be many reasons.

Interviewer: Tell some of them.

Respondent: All kinds of BEHAVIOUR and situations which cause fear. (11F)

Often interviewees contextualise their explanations in poverty or immoral behaviour, but more frequently in marriage, conjugal life, and sexuality. Marriage is a major event in India affecting all members of the extended family in terms of dowry, power and prestige. As a rule marriages are negotiated and arranged by parents, often over years. In economically less developed regions like Patna, pre-marital sex, love marriages and divorce are strongly discouraged. Couples in love relationships are often intentionally separated by their parents through alternate arrangements. Such events are a common topic of conversations and the reason for many personal tragedies. Unhappy marriages, conjugal neglect and violence, and suppressed sexual passion take centre-stage in the interviewees' accounts of mental disturbance and madness afflicting both, men and women:
Yes, there was a famous story about him. Some girl had cheated him in love. He was a fertiliser engineer and the girl's love for him was based on sex. After that her father did not agree to the marriage. He left his job and became mad. (18M)

Respondent: … I know a family in which the father works in the RAILWAY DEPARTMENT in Dhanbad. The girl was grown up but the marriage could not be settled and finally she was CRACK [mentally unbalanced] and it was very troublesome. Finally she was taken to Ranchi [where there is a mental hospital] and after a few days she was all right...

Interviewer: What was the cause of her getting CRACK? Just because the marriage could not be fixed?

Respondent: She was not getting married.

…Respondent: Marriage was the only PROBLEM, because money wise they were prosperous... (25M)

If she has SEXUAL PASSION or anything else, and she can't CONTROL it, she will become violent, then she tears her clothes, weeps, cries. I think that the REASON for her being HYSTERIC is that her SEXUAL PASSION became very strong and she had no place to EXPRESS it or... Then she started to tear her clothes, to beat someone or to cry... (40F)

Family pressures are seen to make children mentally disturbed as well:

Respondent: The problem of this person is that he could not fulfil his desires due to his family. Whatever he had wished, his desires could not be fulfilled. The family members stopped him, and when the mind becomes pressured, then certainly it affects up to some extent. They tried to stop [him], and slowly its impact became so large that he totally lost himself.

Interviewer: Can you give some example when one suppresses his desires and becomes affected?
Respondent: I have seen it often among children or boys who wished to remain independent and no one should pressure them. But parents and family members wish that whatever they ask, the boy should obey. As a result, there is some effect on mind. (3F)

In the interviewees' accounts marriage and family figure as the central elements of social life. Their enactment is strictly regulated by traditional values and norms and they are the most prominent safe-guards to their enforcement. It comes as no surprise, therefore, that they are also seen as the prime cause or source of mental disturbance. Being regulated so as to suppress desires—e.g. arranged marriage—they necessarily perpetuate this suppression through their normal functioning.

**Norms and adjustment.** The tension between desires and social norms prohibiting fulfilment of desires is seen as the ultimate reason for the emergence of mental disturbances. Interviewees critically acknowledge the strict social organisation of Indian life expressed in its caste system, marriage rules, sexual morality, as well as endemic poverty and unemployment as crucial causes of mental illness.

I had a FRIEND who COMMITTED SUICIDE. He was suffering from an ACUTE DEPRESSION. He had an INTER-CAST MARRIAGE and there was much PRESSURE from his home, from his WIFE, PSYCHOLOGICAL PRESSURE. And then the WIFE also used to disturb him. He was a COLLEAGUE of mine in the BANK, then at last HE COMMITTED SUICIDE. (36M)

It may be that this girl is very EMOTIONAL. Maybe this girl is very EMOTIONAL and LIKES someone very much. And due to reasons of social prestige she might not be in a position to take the desired step. Because it happens that the FAMILY does not support such steps. The [head of the] FAMILY maybe used to say "If there will be such a girl in the FAMILY I will kill her." If the boy also LIKES her and the parents understand [what is going on], it might end in
beating [of the children]. They sometimes say that the boy [she loves] can't be hers under any condition. If she is LIKING him very much, then she can go mad. (11F)

Respondent: (...) It is something related to caste also, as in my caste there is no possibility of a second marriage. But at last we will see. Now we have modern times. Initially in our society there was no remarriage but now...

Interviewer: You are slightly deviating. When will this compromise come?

Respondent: The compromise will come. In her family she has been left due to whatever reason. Often it also happens for dowry and also there are many social incidents which occur between HUSBAND AND WIFE and between fathers-in-law and mothers-in-law. (4F)

Even resistance in less institutional activities like house work are bound to be seen as a serious violation of norms with the ensuing label of mental illness:

Today, I am a HOUSEWIFE. I am doing my housework. I am looking after my children, looking after my HUSBAND. I am handling the whole house. Today, if I would lie on bed for the whole day and say that I don't want to do any work. That I can't do any work. If I would have a NEGATIVE APPROACH to everything, then surely I would think... Maybe I do not think that, but others would think that she has some MENTAL ILLNESS. Otherwise a NORMAL person... If I have a stomach-ache daily or I have some problem, it is another thing. But without any reason if I say "No, I will not go anywhere, I will not see anybody, someone has to wake me up. I will not talk to anybody. I don't want to meet anybody. I don't want to talk to anyone. I am not SHOWING INTEREST in anything." This means that I am MENTALLY ILL for sure. (37F)

The strict norms of everyday life require that people to adjust to them or risk the discriminating label of madness. To be "ADJUSTED in society, ... ADJUSTED in family" (16M), even in cases of maltreatment, is normal life:
Interviewer: Do you know any such person?
Respondent: Which is in TENSION?
Interviewer: Whose behaviour is like that which I DESCRIBED.
Respondent: Yes, but she has SHIFTED from our COLONY. She had not such
behaviour but her HUSBAND treated her very badly. He used to beat her and
didn't allow her to go anywhere. Her HUSBAND did such things, she did not have
such behaviour.
Interviewer: What was her behaviour? What did she do?
Respondent: She too couldn't ADJUST. Some days... There were many
DIFFERENCES between them. They were separated for many days, for at least a
year. And you know about our society. She has two children and her father's family
too couldn't keep her with them. Then, at LAST she DECIDED to come back to her
HUSBAND and today it is still the same. She gets beaten. He assaults her but she
lives with him.
Interviewer: If any person in your family would start to behave like this, what would
you do?
Respondent: Any person in my family... It would take some TIME but I would
ADJUST. But you know well that now the women are suppressed in our society. It
would take TIME but I would ADJUST. (29F)

Note that the verb <to adjust> and its derivatives are nearly always given in English and
not in Hindi. One may conjecture that this underlines the critical view many of the primarily
middle-class respondents probably have towards adjustment to traditional norms in a society
which is in rapid economic development and consequently exposed to Western cultural
influences transported by films and other media. It seems that these interviewees perceive
adjustment as a "modern" reaction to a conflict between a tradition enforced by the family and
Western modernity.
The moral threat of attributed heredity

It is in the context of the public and of what neighbours might think about a mentally ill person that interviewees come up with new explanations. The interviews create the impression that, for a family with a mentally ill person, the public and neighbours are a source of danger, attributing heredity and ghost possession to a family with a mentally ill member. Such attribution is seen as a serious moral threat for a family:

Interviewer: You were talking about the sick person. What would be the neighbours' opinion about your family?
Respondent: Most of them would think that there will occur more CASES of that sickness in that family, that this CASE is hereditary. (17F)

Respondent: The BACKGROUND [impression] of my family would definitely become bad, if a girl from that family got this disease. After some time, the marriage of that girl would become a problem [she won't find a husband]. If anything LEAKS and people get to know it, they consider it bad. GENERALLY people think it is bad to go to the PSYCHIATRIST, they start to suspect whether she has become mad.

Interviewer: The position in society deteriorates if someone becomes mad?
Respondent: Yes, people look at this maliciously. (23F)

In the INDIAN CONTEXT, if someone becomes mad in any family, people think that it is a PROBLEM which is HEREDITARY. Even marriage becomes DIFFICULT in that house. People begin to think that it is a family of mad [persons]. They think that if there is one person mad in the family, then certainly every person will be mad to some extent. Neighbours also think like this. (38M)

I know such families which have a mentally ill person [among them] and the behaviour of the villagers towards them [families] is not good. People say that he is mad. The second thing is that in villages there is a concept, if there is one who is
mentally ill in a family, the other members will also be mentally ill for sure, because there is a big contribution of the family in making a person mentally ill. (15M)

Within an Indian cultural context fear of neighbours and the attribution of heritability of a mental affliction makes clear sense, since a juvenile woman or man from a stricken family, even if they are unaffected, lose much of their marriage value once a rumour starts. Moreover, such an attribution also endangers the family's social status.

Heritability in fact was already an acknowledged explanation of mental illness in the ayurvedic text *Caraka Samhita*, 300 BC, and in *Susruta Samhita*, 100 to 50 BC. Knowledge of heritable (*kulaja*) diseases addressed as *sukrasoniprakriti* or *adibala pravrta* lead to prohibitions of marriages between persons with certain degrees of affinity (Raina, 1990; Srikantha Murthy, 1987).6

The differential explanatory use of heritability and of the other causes of mental illness are reminiscent of "ethnocentric" attribution patterns which Pettigrew (1979) described as the "ultimate attribution bias". This is a tendency to attribute the negative behaviour of an out-group member internally and positive behaviour externally. Attributions to in-group members are reversed, so that positive behaviour is explained internally and negative behaviour externally (Hewstone & Ward, 1985). However, what is considered internal or external to the individual in the original theory is internal or external to the group in the present case. On the one hand, attributions of unfulfilled desires, shock and depression, whatever their causes might be, are

6 The reader might wonder whether relating our interviewees’ responses to ancient scriptures in this and the following sections does not construct an artificial continuity between “official” philosophy/religion and vernacular thinking. Of course one cannot assume that people’s statements are a direct reflection of ancient texts of which most of the respondents might not even be aware of (some, however, explicitly refer to these scriptures during the interview). However, just as Judeo-Christian teachings about morality and justice penetrate people’s habitual ways of thinking in Jewish and Christian cultures, the same is true for our respondents and their cultural background.
clearly situational and refer to individual responsibility for reactions to social constraints. The attribution of heritability implies that it is a group, the more or less extended family, which bears responsibility.

**Ghost possession**

Ghost illness and ghost possession are wide-spread themes in much of rural North-India. Such beliefs are embedded in the web of beliefs in souls and moral causality, such as dharma, karma, and rebirth. They are an integral part of ancient sacred literature and local mythology (Freed & Freed, 1993).

Not surprisingly, ghost possession also turns up in the present interviews, although it is the least frequent explanation for abnormal behaviour. It occurs in the context of what the public and neighbours might think and even more often in the context of traditional healing methods. Healing methods will be dealt with later, here it is ghost possession as a category of explanation which is considered.

Only some of the interviewees admit to any personal belief in ghost possession, the majority seeing this belief as “superstitious”. Nevertheless many interviewees think that people continue to make attributions of ghost possession:

This is the thing, it comes from tradition. In [every] family there are some persons who believe in it. In every family, whether it is yours or mine... (32M)

Where our interviewees did acknowledge a personal belief in ghost possession, they also insisted that it constituted a distinct category of explanation which they associated with traditional healing methods:

Respondent: (...) I can only say that there is some invisible power, a ghost possessed him, which was treated by sacred words. Sacred words have power. (22M)

Interviewer: Sir, do you think that those people who are possessed by a ghost cannot be treated by a psychiatrist?
Respondent: No, they cannot treat this. Only the traditional healer can treat them. These things are out of his [psychiatrist's] reach. (22M)

Interviewer: Generally speaking, which are the illnesses for which people are going to the traditional healer?
Respondent: There is one illness, ghost possession. I don't know how much truth is in it. I have never seen this but certainly have I heard of it. There was my aunt who was possessed by a ghost. An ojha came and did the jhar-phook. And people said, my MOTHER said that it was a Muslim ghost and she started reading Namaj [kind of worship practised by Muslims] and doing things LIKE THAT.
Interviewer: If that was not a ghost, what else was it, in your opinion?
Respondent: I am not saying that it was not a ghost.
Interviewer: Do you believe that there are ghosts?
Respondent: Yes, I believe that there are ghosts. I have FELT it. So I believe that there are ghosts. (34F)

These respondents have no problem in speaking about ghost possession and its remedy in a natural way. Their talk here is not ironic, but a direct expression of their convictions.

Demons and ghosts as reasons for illness are first mentioned in Atharvaveda. This is one of the four Vedas, a collection of philosophical and ritual texts, dating back to 2,500 BC. Later some of these ideas about illnesses as ghost possession (pisacadi krtva) were integrated in ayurveda and categorised as having causes beyond human control (adhidiva roga) (cf. Kakar, 1982; Raina, 1990; Srikantha Murthy, 1987).

Whereas evil spirits and malevolent ghosts constitute one class of supernatural beings according to Indian mythology, gods and godlike beings constitute a second class of such beings. Pretas (ghosts of the deceased), bhutas, ghandaryas, vaksas, pisacis (to name but a few kinds of spirits and demons) belong to the former class, devis and devas to the latter (Hardy, 1994). All of these are seen as being able to take possession of humans. However, while possession by devis (or devas) may be deliberately encouraged within particular ritualistic
traditions (Hardy, 1994; McDaniel, 1989), possession by spirits and demons, once diagnosed, demand an intervention by a traditional healer, i.e. an *ojha* or a *tantrik*. As with the framework of *ayurveda*, and to a lesser degree that of *tantra*, this mythology and the ideas relating to possession are well known to ordinary people who as children might themselves have been "threatened" by stories about spirits, or, in this case, a "saint":

Such as we try to frighten the child in the way "don't cry, if you cry then the saint will come and take you away. So it is placed in the MIND of the child that the saint will take him away if he cries. (7F)

**Representations of healing and treatment**

**The family and the representation of the psychiatrist**

In the treatment of mental disturbance it is the family which is viewed as the primary resource, before psychiatric or traditional advice is sought. This may well have to do with the general fear of the public and neighbours getting to know about what has happened. Familial treatment allows the case to be hidden for a while. Only later would a psychiatrist and—as a last resort—a traditional healer be consulted.

Treatment in the family is considered to consist of convincing the ill person that his or her perceptions and thoughts are unfounded, of finding the reasons for the affliction, of being particularly friendly and permissive, and of trying to fulfil the person's desires:

Respondent: A mentally ill person should always be happy. What they want they should be given to eat, to wear. But it is not possible for us [me] because they have big dreams in their mind and we cannot do this. But we will try to convince him to live happily by what you [actually] have, it is enough. We will live happily by that.

Interviewer: What will you do to make him happy?

Respondent: To make him happy we have to live according to his wishes. Whatever he wants, clothes, food, vehicles, we will try to give him. And if we are unable to do so we should PREPARE him MENTALLY that we have [only] this much, and we will live happily by this. (7F)
The general attitude is that each such illness has causes and that the conditions leading to these causes should—perhaps with the help of religion and gods—be changed. Even in the case of unemployment causing the mental disturbance, "the GUARDIAN has the duty to give him EMPLOYMENT" (30M).

When the problems are beyond one's own or the family's control, most interviewees consider consulting a doctor or psychiatrist. Only a few would immediately go to a traditional healer. Somewhat more interviewees would consider to consult a traditional healer if the psychiatrist is not successful.

No one gets mad all of a sudden. SYMPTOMS already start [before]. First it is a MENTAL ILLNESS, [being] mad is the last stage. As I told you in the CASE of my FATHER, as I am FEELING, I started doing what I should do, at my level, a little affection, a little love, even though I have to realise that his condition is worsening, and [only when] it is beyond my control, then I will go to the DOCTOR, to the PSYCHIATRIST. (33F)

Living with her, I would try to remove the shock. It could happen that she is not able to think much if someone is living with her. When I would realise that it is beyond my capacity to keep her under control, I would consider it right to go to a psychiatrist. (17F)

So what is the knowledge the interviewees have about the psychiatrist's and the healer's treatment? The representation of the psychiatrist is relatively restricted: the psychiatrist will talk with the patient and question them in order "to catch the patient's tendency". A general feeling is that the psychiatrist will provide medicines (a few interviewees also mention electroshocks) to cure madness. The doctor will also treat the patient in a friendly and caring way, trying to make him or her happy. This psychiatric treatment will result in "removing a wrong idea", "make him or her understand the situation", increase the patient's voluntary control, and "remove a complex". Exception for the administration of medicines and electroshocks, this representation of the treatment given by psychiatrists is very similar to what family members would provide.
In fact, the strength of the popularity of the psychiatrist in the interviews stands in stark contrast to the weakness of the understanding of psychiatric treatment.

**The representation of traditional healing**

Whereas many respondents hesitated to talk about psychiatric methods and only described them after having been asked repeatedly, virtually every interviewee, even those who firmly denied believing in them, exhibited elaborate knowledge about some types and methods of traditional healing.

The interviewees primarily referred to ghost healers (*ojha* or *ojha-guni*). Other healers and their methods were mentioned *en passant*. Methods were often described in considerable detail, such as *Jhar-Phook* (the "sweep and blow" method) employed by *ojha*, tantric methods like magic and the application of mantras. Medicines, herbs and sedatives figured as methods within the realm of ayurveda.

A specific set of methods—pertaining to the tradition of *ojha*—mentioned by a fair fraction of interviewees is the use of physical force in treatment. It consists of beating, tortures, induction of fear and chaining the patient. According to popular beliefs this rough treatment is not felt by the possessed patient but only by the possessing ghost. As with Western notions of exorcism, it is supposed to make the ghost leave the body.

Religious practices such as prayer, singing, sacrifice and the worship of specific gods, conversations and giving recommendations, as well as the mild methods of yoga complement the stock of traditional healing methods and were mentioned only by a minority.

This simple list of traditional methods does not reflect the intensity with which the interviewees talked about them. This engagement, even if its validity is often rejected in the presence of the Western researcher, gives vivid testimony to the continuing power and significance of traditional Indian knowledge even among the well educated middle-class population of Patna. In fact the rougher healing rituals can frequently be observed in public in the streets of Patna, whereas ayurvedic healers practice privately in consulting rooms. This obtrusive visibility of the rougher methods in everyday life may in part be responsible for the representation of traditional healing as negative:
Interviewer: Do you think that the traditional healers are able to treat such diseases?
Respondent: It is... As I told you, it happened with my aunt. But I think these things are nothing. Many people die, I have read that in books. Haven't you heard that one ojha killed somebody beating him to death? That man died. His story is finished. So I have some faith and at the same time I don't believe in them. (29F)

**The ambivalence of choice between different methods of healing**

Few respondents spontaneously subscribed to traditional healing procedures. While many acknowledged advantages of both, although only under certain conditions, the majority doubted the validity of traditional healing.

Respondent: What do they [traditional healers] have? Nothing! They would worship the Gods and Goddesses, make some promises [for offerings to the Gods] and after that they would say "I have treated you, it will be all right!" What do they have?

Interviewer: The healing ritual doesn't have the power to cure?
Respondent: What are they doing? There will not be a cure from that jhar-phook.
(19M)

The decision in favour of the psychiatrist is based on a strong feeling of the superiority of scientific method which ensures "100% success":

Interviewer: Do you think that there is a TECHNIQUE with traditional healers?
Respondent: NO, I THINK NOT. If a TECHNIQUE would be with them then SUCCESS must be there 100%. But they do not get SUCCESS anywhere, I THINK. (2M)

In popular thinking the scientific bases of their treatment are rarely if at all known. Nevertheless they are believed to be successful:
These people [psychiatrists] are becoming more successful. They are doing research and they are improving everything. They improve their MEDICINES and their GENERAL SCIENCE. (10M)

It is possible that he [traditional healer] is not able to understand the BAD BEHAVIOUR [of the sick person] and it might increase the sickness. It is just possible that he [sick person] can turn mad or become aggressive [because the healer is treating him in a wrong way]. He [healer] might do it unknowingly. But a PSYCHOLOGIST would move in scientifically and would take ACTION continuously. He would always consider whether his ACTION is contributing towards cure or harming him [sick person]. (12F)

Faith in scientific or traditional treatment and a decision in favour of a psychiatrist or healer is not an individual's sole business but depends on the family and the patient. A majority of family members opting for a traditional approach or access to a particularly powerful priest or ojha may well swing the respondent's opinion:

Look, I would not like to go to that jhar-phook, according to my [convictions], I would not like to go for that jhar-phook. But as I said, the decision of the family DEPENDS on the TOTALITY. MY WISH WILL NOT PREVAIL IN ANY PARTICULAR CASE. Because [depending on whether] there are five boys or two girls in my family, the TOTALITY of all people [will make different decisions]. If I said to go to the PSYCHIATRIST and some two or four people say that you have no trouble in the jhar-phook so this should also be done. So it may be that my [wish] does not PREVAIL and the family PREVAILS much. But I PERSONALLY DON’T BELIEVE IN SUCH THINGS. (32M)

Because... Look, suppose in my family or maybe in the LONG RUN if it will happen to my child or my daughter-in-law or with me, then all the people who will come will suggest to show him [the ill person] to that maulavi [Urdu word for ojha],
"in Patna there is a good maulavi. Take him to Biharsharif [a village near Patna] to the shrine." So all minds are of the same kind. Isn't it? So I do this even if I don't want to do it, but I won't get SUCCESSFUL [the patient won't be cured there]. But I do it. And when I am not cured, I go to the DOCTOR at LAST and the DOCTOR does the treatment... (29F)

Indian family life is certainly strongly shaped by the collective (Sinha & Verma, 1994). Individual desires must conform to the norms and beliefs and decisions must be agreed with the family. The weight of the collective also guides the interviewees' trust in psychiatry or traditional healing:

Respondent: I know about one incident. It happened in my family. There was one mahant-ji [priest]. He knew tantra-mantra. My brother was about to get married. He had terrible headache and 120° [Farenheit] fever. The ceremony of the sacred thread was to be held. The question was how should he wear the sacred thread [in his condition]? It happened in front of me. It is an incident of 1969/70. My brother went to the mahant-ji. He [the priest] touched my brother and his fever and headache was gone.
Interviewer: What do you think? Only by touching the fever went away?
Respondent: Yes, due to the mahant-ji and the tantra.
Interviewer: You believe in these things?
Respondent: Yes, I believe in that.
Interviewer: At one moment you believe that by mere touching a sickness is cured...
Respondent: Yes.
Interviewer...and in this case [mental] sickness you would not like to take [the patient to a traditional healer]. Why?
Respondent: No, no. I would like to take him [to traditional healer]. The question is if the traditional healer is of that sort that he can cure the sickness by touching. Then I would take him [patient] to him. The question is if the traditional healer is capable. It is difficult to JUDGE him. (16M)
The relative tolerance expressed in these interviews complements Kapur's (1979) finding that in villages doctors are consulted alongside one or several traditional healers and temples (see also Wig et al., 1980). He found no effect of age, caste, financial well-being or educational background. With our interviewees too, it may be more frequent than they admit: Firstly, the choice of healing strategy is not a single person's decision, and secondly it is the reputed success of either the psychiatrist or the healer which motivates a decision in favour of one or the other. This success can be experienced personally, as in the example given above, or it can be second-hand. A general belief in the superiority of any method, especially the psychiatrist's, is certainly easily overridden by appeals to direct experience or affect or, last but not least, by a method's cultural foundation. The social context in and around Patna is strongly traditional and psychiatry is far from having been transformed into a social representation which can compete with the weight of local traditional thinking.

**Culture and social representations**

**Situated representations**

The visible richness of traditional accounts produced even by interviewees who repeatedly denied any belief in ghost possession contrasts with the poverty of ideas about psychiatry and psychiatrists. As we might expect, there is little indication in our interviews that educated people in Patna have any understanding of psychiatry that would come close to the sophistication of their understanding of traditional healing. The local representation of traditional healing is well structured, detailed, and spontaneously produced. It is "proximal" knowledge, that is, knowledge which is affectively laden and close to the kind of informal knowledge familiar from personal observation or everyday conversations in the family or among friends. There is good reason to call the interviewees' knowledge of psychiatry a social representation in the making and to distinguish it from their cultural representation of mental illness and healing, that is, a hegemonic structure of knowledge corresponding to what Durkheim (1974) described as a "collective representation".

Saito (1996) demonstrates the difference between cultural and social representations in a study of Zen-Buddhism. She shows that the knowledge of Zen in Japan, even of people not
The Modernisation of Tradition/ 32

practising it, differs notably from the knowledge of Zen found among believers in Britain. As in the present study, Japanese respondents produce a coherent, well-structured and proximal account of their local culture of Zen which is strongly connected to all walks of everyday life. British followers of the Zen movement produce a fragmented image which is relatively isolated from other practices.

The two varieties of knowledge about mental illness are located and used in different contexts. As we have seen, our respondents’ beliefs mark a sharp distinction between mental illness in the private and the public spheres. In the private world of the family, mental illness arises as a consequence of frustrated desires, and its treatment is based on communication, talk and discussion which aims at reconciling the person to the exigencies of their life. Madness, by contrast, is recognised by its resistance to such private forms of treatment, and is seen to be in need of some extra-familial treatment. In becoming public in this way, madness is a source of shame and stigma for the family of the afflicted person. This traditional pattern of belief offers a matrix of ideas and values which enables psychiatric notions to be anchored in particular ways. The psychiatric notions which our respondents articulate most frequently are framed in terms which echo those of the traditional Indian representations of mental illness in the private sphere. Psychiatry too speaks in a language in which mental illness is a consequence of frustrated desires, of problems of adjustment, and offers forms of treatment based on talk and discussion. Just as Moscovici (1976, 1981) describes how, for the Catholic, the image of confession provides a point in which to anchor the unfamiliar idea of psychoanalysis, so too in this Indian context, the traditional patterns of belief about mental illness in the private sphere provide a context in which psychiatric ideas can be anchored.

Traditional representations of madness focus on the idea of spirit or ghost possession or heredity, which also marks a clear shift in the representation of the person. In the family context, where mental illness results from frustrated desires, it is the person's own thoughts and feelings which are responsible for their mental affliction, the person here is implied as a psychological agent of their own condition. In the traditional context, however, the person no longer acts upon the situation, but is acted upon. Agents and processes beyond the individual's control take possession of the person's mind resulting in illness. In this context treatments like
"brushing and blowing", beating and mantras are justified because they aim at an agent which is external to the mad person's mind and not at his or her own mind and sensitivity. This sharp distinction in traditional representations is less clearly marked in the emerging social representations of mental illness, where the forms of treatment offered by the psychiatrist continue to be described largely in terms of communicative processes which recognise the agency of the individual (although some of our respondents did remark on the use of drugs and electro-shock therapy by psychiatrists, forms of treatment which do imply a denial of psychological agency). Indeed, the question of agency in the representation of the person provides an important point of contrast between contexts in terms of the relationship between traditional representations of mental illness and the emerging social representations. In the private context, a sense of agency is the thread of continuity which allows representations of modern psychiatry to be anchored in the familiar pattern of communicative processes within the family, enabling our respondents to elaborate their scanty knowledge of the psychiatrist with these more familiar images. However, in the public context, a sense of agency no longer provides this bridge between traditional healers and modern psychiatrists, and it is when our respondents were asked to face a dilemma in the public treatment of mental illness that they most openly spoke of conflict between traditional and emerging representations.

Our Indian respondents and the middle and upper classes as a whole are presently engaged in representational work to objectify psychiatric treatment and a new view of mental illness introduced by modern life and Western influence. This process can be seen at work in the mass media, particularly films and TV, and in the everyday conversations and experience of people as they engage with these new phenomena. In the long run this process of objectification can be expected to produce a more elaborated image of psychiatry and madness. One can already see in the emerging social representations of the psychiatrist an emphasis on the effectiveness of their treatment of the mentally ill and the mad, contrasted with the ineffective treatment of the traditional healer, a contrast which again illustrates the influence of the values of progress. A mark of the shift in values is the belief our respondents expressed in the efficacy of scientific and medical practice. Such shifts do not imply that Indian representations of madness will simply adopt the perspective of scientific psychiatry. It is doubtful whether
traditional ideas would be simply eradicated, anymore than in Europe, where in spite of the longer exposure to psychiatric medicine, popular representations of madness continue to draw on traditional themes and images (see De Rosa, 1987; Jodelet, 1991).

**Innovation in common-sense: Contradiction or complementarity?**

This study illustrates the way in which a particular reality is simultaneously constituted in two fundamentally different ways. On the one hand there is the traditional way of thinking about indigenous healing procedures, while, on the other, there is the fashionable belief in modern science, of which psychiatry is an example. We have suggested that a new social representation of mental illness and its treatment is emerging as "progressive", Western ideas influence traditional cultural representations.

Although the theme of progress gives a certain dynamic to the relations between the traditional and the modern, this dynamic also has to accommodate the extent to which traditional ideas are embedded in established social practices. There is a point where ideational innovation meets the resistance of traditional cultural notions and of living social institutions. In the present case, Indian notions of desire with their emphasis on the renunciation of worldly pleasures in the name of spiritual growth served as the conceptual reference, and traditional patterns of marriage and family life provide the institutional matrix upon which attributions of the causes of mental illness are based. This is further enhanced by the importance of family status in relation to marriage, and implicit fears of gossip about the inheritance of mental instability. However, as many of our interviewees noted, when it comes to efficiency, the psychiatrist is preferred to the inefficient traditional healer.

Hence, when the modern hits the bedrock of traditional beliefs and institutions, it must build upon it and cannot replace it. This is a rather flexible reaction to innovation, where traditional symbolic and institutional arrangements prove capable of absorbing what is new without losing their own identity. For the progressive, emerging middle classes of our sample, their sense of the power of modern notions of psychiatry is circumscribed both by their sense of the limits within which older generations of their own families would accept these ideas, and their own ambivalence towards a tradition which they can simultaneously criticise while
continuing to express some residual faith in it (producing a form of what Moscovici describes as "cognitive polyphasia", Moscovici, 1976, p. 286). As one of our female respondents said about traditional healers: "I have some faith and at the same time I don't believe in them" (29F).

We must also keep in mind that the present interviewees were all highly educated by Indian standards and as such represent but a small and probably atypical section of Indian society which might well be much more inclined towards cultural and technological modernisation than the general public. The picture is further complicated by the fact that some Indian psychiatrists have recently begun working on syncretic forms of psychiatry which unite Western and indigenous conceptualisations, though with mixed success (Pandey, 1988; Verma, 1988).

What is clear from the present interviews is the complex interplay between the symbolic, the institutional and the technical aspects of representations in a context of change. Both the representations of modern psychiatry and of traditional healing may co-exist to a considerable degree and while most our interviewees have a sense of the contradictions between them, these contradictions are not generally experienced as logically exclusive, as a simple "either/or". Rather, any resolution of the conflicting claims of tradition and modernity has to recognise the wider practical context of institutions and relations. It is this context which determines how our respondents would deal with a case of mental illness in their own family.

Traditional beliefs and practices co-exist with scientific notions also in Western cultures. The context for this co-existence in India, however, is rather different from that in the West. While notions of development, under-development or developing, have become problematic ways of offering broad and general characterisations of social formations (and not only in the West), within India, and especially urban India, the idea of the country as one in which social and economic forms are developing towards a modern society remains a powerful belief. This sense of a development towards a modernity is thematised around a notion of progress. Indeed, it is this idea of progress as the overcoming of tradition which provides an important context for the emergence of contemporary social representations of madness, within which a view of madness associated with the scientific claims of the psychiatric profession can also claim to be a progressive view, marked by its modernity in contrast to traditional representations of madness.
as forms of spirit possession. Further, the more humane forms of treatment of the mad person offered by psychiatric medicine also resonate with other discourses about human rights, and may also contribute towards the view that psychiatric models of madness are progressive.

Conclusions

In exploring aspects of culture change this study has focussed on the way that change is reflected in the representations people hold about about a specific field of knowledge. As new influences derived from psychiatric medicine are absorbed into the representations of these urban North-Indians, do they simply displace traditional ideas, or do both exist side by side? Based on the present study neither alternative seems to offer an adequate description of the process. On the one hand, in the interview many respondents flatly reject most of the traditional notions of ghost-possession and healing procedures as ineffective and “superstitious” and uncritically embrace psychiatric medical science. They do so even if their received wisdom about mental illness far exceeds their knowledge of psychiatry in detail and quantity. On the other hand, many of the respondents express a deep faith in traditional healing procedures which contradicts their simultaneously expressed belief in scientific efficiency.

From the interviews it becomes clear that both representational systems, the system of traditional thinking and that of the novel, have their place in different contexts. Each of the two representations is situated at different nodes of the respondents’ social world. They are situated representations in the sense that in the context of public life (part of which was also the interview situation) discourse is oriented more towards the novel. In the context of private and family life talking in traditional ways is more appropriate. This aspect of their thinking was only expressed by our respondents after direct questioning and giving examples. There is little surprise in this, since in India (as indeed in the West) family organisation and family life remain one of the most traditional sectors of society. But it should serve as a reminder that the dynamic feature of social representations arises from the ways in which they are embedded in the contexts of specific sets of social relations, as Moscovici (1976) and Jodelet (1991) have shown.
Finally, our study also questions the assumption that cultural and collective beliefs can be regarded as unflexible or fixed as to be non-negotiable. Where the pressures of development introduce instability and doubt, received wisdom can be questioned, as our respondents illustrated in their expressions of doubt about traditional ways of healing. The first signs of innovative change in culture are seen in the forms and pattern of public discourse, only in the longer run will innovation extend to areas of social life, such as the family, where tradition is most deeply entrenched. In this sense this urban North Indian society is as much a modern society as anything in Europe or the West, for all that it may be constructing a modernity in its own terms.
References


Table 1
Profession and age of respondents and sex of the character depicted in the vignette

<table>
<thead>
<tr>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 student 20 (male)</td>
<td>3 teacher 42 (male)</td>
</tr>
<tr>
<td>2 student 21 (female)</td>
<td>4 housewife 32 (female)</td>
</tr>
<tr>
<td>8 teacher 36 (female)</td>
<td>5 nurse 45 (male)</td>
</tr>
<tr>
<td>9 student 23 (male)</td>
<td>6 nurse 50 (female)</td>
</tr>
<tr>
<td>10 student 23 (female)</td>
<td>7 housewife 32 (male)</td>
</tr>
<tr>
<td>15 student 27 (male)</td>
<td>11 student 22 (female)</td>
</tr>
<tr>
<td>16 lawyer 41 (male)</td>
<td>12 student 21 (male)</td>
</tr>
<tr>
<td>18 student 23 (female)</td>
<td>14 student 21 (male)</td>
</tr>
<tr>
<td>19 postoffice manager 57</td>
<td>17 housewife 27 (female)</td>
</tr>
<tr>
<td>21 student 30 (male)</td>
<td>23 student 23 (male)</td>
</tr>
<tr>
<td>22 businessman 55 (male)</td>
<td>26 teacher 41 (female)</td>
</tr>
<tr>
<td>24 student 28 (female)</td>
<td>27 teacher 45 (female)</td>
</tr>
<tr>
<td>25 businessman 45 (female)</td>
<td>29 teacher 35 (female)</td>
</tr>
<tr>
<td>28 teacher 50 (female)</td>
<td>31 housewife 47 (female)</td>
</tr>
<tr>
<td>30 retired 59 (male)</td>
<td>33 teacher 32 (male)</td>
</tr>
<tr>
<td>32 businessman 51 (male)</td>
<td>34 teacher 31 (female)</td>
</tr>
<tr>
<td>36 businessman 46 (female)</td>
<td>37 retired 62 (male)</td>
</tr>
<tr>
<td>38 no information 32 (male)</td>
<td>39 employee 43 (female)</td>
</tr>
<tr>
<td>41 businessman 28 (female)</td>
<td>40 judge 46 (female)</td>
</tr>
<tr>
<td>42 teacher 47 (male)</td>
<td></td>
</tr>
</tbody>
</table>

Note: The first number in each row is the respondent’s reference number, the second number is the age, the words “male” and “female” in brackets refer to the sex of the character depicted in the vignette.
Table 2
Hindi terms rendered into English

<table>
<thead>
<tr>
<th>Hindi Term</th>
<th>English Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>m:nisk rogI</td>
<td>mansik rogi</td>
</tr>
<tr>
<td>m:nisk ibm;rl</td>
<td>mansik bimari</td>
</tr>
<tr>
<td>mnorogI</td>
<td>manorogi</td>
</tr>
<tr>
<td>rog</td>
<td>rog</td>
</tr>
<tr>
<td>m:nisk rog</td>
<td>mansik rog</td>
</tr>
<tr>
<td>mnorog</td>
<td>manorog</td>
</tr>
<tr>
<td>p;glpn</td>
<td>pagalpan</td>
</tr>
<tr>
<td>p;gl</td>
<td>pagal</td>
</tr>
</tbody>
</table>
AUTHORS:

WOLFGANG WAGNER is University Professor at the Department of Social and Economic Psychology at the University of Linz, Austria. His research interests are social and cultural systems of knowledge, distributed and shared cognition, group processes, knowledge in practice, and public reactions to new technologies. He published ‘Alltagsdiskurs – Die Theorie sozialer Repräsentationen (Everyday Discourse—The Theory of Social Representations, German)’ (Hogrefe Verlag, 1994). ADDRESS: Abteilung für Sozial- und Wirtschaftspsychologie, Universität, 4040 Linz, Austria. [email: w.wagner@jk.uni-linz.ac.at]

GERARD DUVEEN is a University Lecturer in the Faculty of Social and Political Sciences, University of Cambridge and a Fellow of Corpus Christi College. His research is concerned with the development of social representations, particularly in relation to questions of gender, social identity and culture. With Barbara Lloyd he co-edited 'Social Representations and the Development of Knowledge' (Cambridge University Press, 1990) and co-wrote 'Gender Identities and Education' (Harvester Wheatsheaf, 1992). Currently, among other projects, he is editing the volume ‘Moscovici, S. (forthcoming). Social Representations: Essays in Social Psychology. Cambridge: Polity Press’. ADDRESS: Faculty of Social and Political Sciences, University of Cambridge, 8-9 Jesus Lane, Cambridge CB5 8BA, GB. [email: gmd10@cam.ac.uk]

MATTHIAS THEMEL studied cultural anthropology and psychology and received a masters degree in psychology from Vienna University. He is interested in cultural psychology and social representation theory. ADDRESS: Josefständterstr. 20/20, 1080 Wien, Austria.
JYOTI VERMA is professor of psychology at Patna University. Her research interests are cultural and cross-cultural psychology, Asian indigenous psychology, personality, and organisational processes. ADDRESS: Road No. 5, Rajendra Nagar, Patna—800016, India.