
“I have some faith and at the same time I don't believe” -
Cognitive Polyphasia and Cultural Change

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Abstract

Issues of community and health are tightly linked to local cultures and to the system of traditional representations about health and illness. These systems, however, are rarely static but in constant flux through economic and technological developments - what is often called “modernisation” - that entail new representations becoming part of everyday thinking. In this process the novel often plays the role of an icon of modernity in situations that evoke the idea of progress, while the traditional prevails in more static social structures such as the family. This co-existence of rarely compatible representations is called cognitive polyphasia. The present interview-study investigates the way forty residents of the North-Indian city of Patna cope with contradictions implied by traditional and Western psychiatric notions of mental illness, their aetiology and treatment. It is shown that each of the two ways of thinking is situated and used in specific social settings. Some implications of cognitive polyphasia for community development are discussed.
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A common phenomenon reported about the implementation of development programs is the way in which the initial intentions of the sponsors become reworked by the local population. An example often told is the story about South-Indian women who, rather than taking the contraceptive pills they had been given orally, instead hung the glittering package around their neck in much the same way as they habitually use charms to divert bad luck. In the same vein, rural Brazilian women sometimes share their pack of contraceptive pills with their neighbours when their husband is out of town for a few days. According to these women the contraceptive pills work by “blocking the female tract” which consequently needs to be cleaned periodically. What better time for “de-blocking the female tract” could there be than when their husbands are out of town? While they may not accord with the intentions of the sponsors of these contraceptive programs, the practices of these South-Indian and Brazilian women appear to be irrational only if they are considered outside the frame of the local language and cultural practices of their communities. But a Western medical and scientific frame of reference is a far cry from the representations engaged in the daily practices of these women (cf. Wagner, 1997).

The importance of local beliefs and cultural practices in the implementation of developmental programs is now widely acknowledged. Information by itself does not sustain meaning, rather it acquires meanings when it is absorbed into the context of particular life-worlds. Consequently, as Campbell (1997) has shown for the social context of HIV-prevention programs in South-Africa, for example, failure to take account of the cultural complexities of the local community renders it ineffective in the long run. The language of experts must take local beliefs and social representations into account and frame any explanation and recommendation in terms and metaphors that carry local meaning.

In one sense of course, belief systems only ever carry a local validity, but the exercise of power in the modern world also operates so as to constitute in varying degrees the locality within

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1 Oral communication by Angela Arruda, Universidade Federal de Rio de Janeiro.
which particular belief systems have validity. Remote and marginal communities, as seen from
the West, are the sites of strange and exotic beliefs, while the culture of the West and of other
economically powerful nations appears natural and objective. Throughout the modern era there
has been constant communication across and between different cultures, but contemporary
forms of technology have ensured that even the most remote communities experience a steady
penetration of Western cultural artefacts and ways of life. Indeed, the very developmental
programs initiated by international organisations carry the products of scientific and
technological progress to each and every corner of the globe, enriching local language with new
terms and symbolic content that frequently enough stands in stark contrast to established ways
of thinking. Such communication of course does not flow only in a single direction –Western
culture itself has continually been enriched by what it has absorbed from other peoples. As a
consequence of these processes, however, there are now very few cultural areas – if any remain
at all - which can be considered “pure”, however remote they may be from the centres of the
world economy.

Evans-Pritchard (1976) and Gusfield (1967) acknowledged, that while to an outside
observer traditional cultural systems may appear to be homogenous and static, there are
nevertheless contradictions within them. Even earlier, Bartlett (1928) had already pointed out
that traditional societies are more dynamic than many of his contemporaries wanted to see and
that novelty introduced by innovation and modernisation has to operate within this context. He
recognised that the novel does not come into a cultural vacuum, but exerts its influence within a
context of already established belief systems. According to him cultural groups have "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 adopted, while those
which conflict with it are likely to be ignored.

In rural villages of Nepal, for example, even the local discourse includes notions of
modernity. This discourse mobilises a number of key themes that include "notions of progress
and development, of rationality and science" (Pigg, 1996, p. 193) and which provides
individuals with a social identity located within the dynamics of contemporary Nepalese culture and Western influence. This author also notes that even within 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).

On the one hand, then, sponsors of development programmes have come to recognise the significance of framing their own discourse in terms of the local beliefs and cultures of the communities within which they operate. While on the other, the local culture of these communities often already contains within its discourse elements of a modernising medical and scientific discourse. For such communities, this situation can create complex and extraordinary patterns of social life in which these different systems can co-exist. Even if the traditional and the Westernised forms of discourse each serve their own separate functions in the social life of a community, the co-existence of the two remains a potential source of contradictions requiring some adaptive or constructive elaboration. It is this process which is the focus for this paper.

**Cognitive polyphasia in mundane thinking**

Social representations are sets “of concepts, statements and explanations originating in daily life in the course of inter-individual communications… the equivalent, in our [modern] society, of myths and belief systems in traditional societies… the contemporary version of common sense” (Moscovici, 1981, p. 181). They enable communication by providing a code for social exchange and a code for naming and classifying the various aspects of their worlds and their individual and group history (Moscovici, 1973, p. xiii). Representations pertain to a community which is co-constructed by people in their daily talk and action and it is when meaningful talk is endangered by processes of change that new representations emerge (Duveen, 1998). In research representations can be investigated both through the productions of individuals and through the discourses articulated between people. Hence, “a social representation is the ensemble of thoughts and feelings being expressed in verbal and overt behaviour of actors which constitutes an object for a social group” (Wagner, Duveen, Farr, Jovchelovitch, Lorenzi-Cioldi, Markovà & Rose, 1999, p. 96).
Even in the earliest studies of social representations it was clear that everyday thinking frequently embraces representations that carry contradictory meanings. Such contradictions are usually not disturbing so long as each representation is locally consistent and so long as they are not simultaneously expressed in discourse (Wagner, 1994). In fact, it is unusual for people to express utter contradictions in discourse, because they do not live in a single homogenous world, but in many worlds each of which requires its own distinct form of discourse and thought. It is in the context of different life-worlds that holding on to “contradictory” representations makes sense. As social representation theory argues, representations are not primarily more or less veridical reproductions of facts in the world, but above all they are elaborations for social groups serving to maintain the stability of their particular life-world. In this view representations are bound to social contexts, that is to groups and their life-worlds and to situations and events occurring in these life-worlds that demand specific forms of thinking, talking and acting. Apparent contradictions between representations in common-sense thinking can be explained if their situated use is taken into account.

Investigations of the social representations of intelligence by Mugny and Carugati (1989) illustrate the issue of the situated use of representations. Although a parent’s representation of intelligence as a natural gift flatly contradicts the representation of intelligence being the result of educational work, both can be expressed by one and the same person, albeit in different social contexts. Depending on whether they refer to their own or to other people’s children, depending on whether they are required to talk in a school context or about their family, etc, each makes sense if situated in one or the other context. With intelligence being more an evaluative than a descriptive term, parents reject responsibility when referring to the intelligence - or the lack of it - of their children as a natural or divine gift, and they accept responsibility when talking about intelligence being the result of their education. Besides being a self-protective strategy, the existence and use of competing representations of intelligence is a consequence of situating talk in contexts that diverge in their demands for self-reference and identity.

Moscovici (1976, pp. 279ff) observed this co-existence of different and even contradictory modes of thinking in his research on psychoanalysis. In contemporary societies
people are “speaking” medical, psychological, technical, and political languages. By extending this phenomenon to the level of thought he suggests that “the dynamic co-existence - interference or specialisation - of the distinct modalities of knowledge, corresponding to definite relations between man and his environment, determines a state of cognitive polyphasia” (p. 286, emphasis in the original)².

The author rejects the notion that cognitive systems habitually develop towards equilibrium, that is towards a state of consistency. Instead, judgements are based on representational terms being dominant in one field of personal or group interests, while playing a subordinate role in other fields. Contemporaries in Western and non-western societies alike face a variety of situations where particular modes of reasoning fit better than others. Some are more useful in the family and in matters involving relatives, others are more apt to help solving problems in political, economic, societal, religious or scientific matters.

Different modes of thinking, and the representational systems they are based on, are interrelated and at the same time also specialised. While they are the product of cognitive development although they do not represent different stages of validity or value for people’s lives, as normative social cognition researchers have suggested (cf. Wagner, 1994). In this sense the forms of everyday thinking, or common-sense for that matter, open an avenue to establish a link between representations and the social conditions in which they are engaged. If people need to conquer different sectors of their life-space that are all relevant for their social and even physical well-being, the different modes of thinking associated with each one must be considered equally relevant and of comparable worth. As long as people will live their lives in everyday spaces there is no reason to expect that in historical development one mode of reasoning, for example the scientific one, can and will become the only one (Moscovici, 2000; Yang, 1988).

The conceptualisation of cognitive polyphasia highlights two important research areas: One is to identify and make explicit the social characteristics of situations and their exigencies that determine specific forms of reasoning and discourse instead of treating thought and

² Translated from French by G. Duveen.
language as though they were independent of their realms of use. Representations are social precisely because of their articulation with the context of their genesis and enactment. The other is to pay attention to the processes of change and transformation of representational systems. Just as a contemporary society’s culture is rarely in equilibrium but constantly in flux and transformation, so are the modes of thought and representations within it. What was once a dominant mode of reasoning in a realm of life yesterday, can today be relegated to an existence in a marginal sector of life when it is replaced by another dominant form.

**Studying representations of mental illness in an Indian city**

**The setting**

The present study is about ways of thinking about mental illness in a North-Indian context. The various strains of Indian religion and philosophy provide a powerful matrix of traditional thinking about health, illness and specifically about mental afflictions, which confronts Western notions of allopathic medicine and, in the case of mental problems, Western ideas of psychiatric treatment. Indian psychiatrists for some time have also been working on a psychiatric theory that is supposed to unite Western and indigenous ideas (Pandey, 1988; Verma, 1988).

Three of the most important Indian strains of thought about general and mental health and illness are Ayurveda, Tantra and Bhuta-Vidya. The medical ideas of Ayurveda build upon the balance of various elements, humours and qualities in the body. A practitioner of Ayurveda usually tries to determine the specific nature of imbalances and prescribes herbal, dietary and mineral medicines to re-establish a desirable balance (Kakar, 1982; Raina, 1990). The notion of Tantra - in its literal sense - denotes a specific genre of religious and ritual writings. It also contains a theory about the human body and the processes involved in the pursuit of self-realisation, which is what tantric mysticism ultimately is about. In some aspects similar to Ayurveda, Tantra presupposes a subtle body consisting of conduits and centres of energy. Indulging in bad thoughts and actions (bad Karma) leads to a malfunction of energy centres and consequently to a malevolent spirit. Treatment consists in applying Mantras, drugs, hypnosis,
massages and other physical activity that aims at conquering the malevolent spirit (Kakar, 1982). Bhuta-Vidya, finally can roughly be equalled to exorcism. People afflicted by a possessive spirit are treated by a healing ritual, which aims at pacifying or re-educating the spirit. Various tools, such as brooms or the wings of a bird are used in conjunction with a ritual burning of offerings and with sacred water (Hardy, 1994; for a detailed overview of these forms of thought see Themel, 1997).

Method

The present study was conducted in Patna, a city of 1.5 Million, 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. Bihar is a less developed state of India where 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 access to TV, radio, the press and libraries in the city which also accommodates hospitals and a university. The rural areas on the contrary, are much less well-developed in terms of education and medical institutions. Therefore healers are often the only sources of medical and psychiatric aid.

The sample consisted of 19 men and 20 women from the emerging educated urban middle-class in Patna. The interviewees’ age was from 20 to 55+ years.

Interviewees were contacted by an “avalanche method”. Interviewers relied on relatives, acquaintances and neighbours of students, because in the Patna context it is virtually unthinkable to approach strangers. Once an appointment was arranged, the interviewers met the interviewees either in their home or in the hotel room of the researcher. Interviews were conducted in Hindi by two local male graduate students, with a Hindi speaking Western researcher in attendance, who followed the discussion and occasionally intervened. Occasionally the respondents themselves used English expressions in their talk.

The interview was introduced as part of a study about mental illness, psychiatrists and traditional healers. It was structured around vignettes which drew on situations and

3 For details of the method see Wagner, Duveen, Themel & Verma (1999).
circumstances mentioned by local people in some pilot interviews and that were thought to serve as a starting point for the interview. For half the sample (i.e. half the men and half the women) the wording of the vignettes referred to a woman, while for the other half the protagonist was a man. The semi-structured interview was conducted around the following topics: (a) What is the problem with the person described here? (b) Do you know such a person? (c) What would you do if a member of your family behaved in this way? (d) What would your neighbours think about your family? (e) Would you take your family member to a traditional healer or to a psychiatrist? (f) What would both, the traditional healer and the psychiatrist do? (g) Do you think that a mentally ill person can get help from somebody this person does not believe in? (h) Do you think that psychiatrists and traditional healers have a cure for every kind of mental affliction? (i) Are there afflictions which can only be healed by either a traditional healer or a psychiatrist and what are their differences?

The interviews were recorded and each lasted about one hour. Later they were transcribed and translated into English. The study was undertaken in the period from December 1995 to February 1996.

**Situated Indian and Western notions of mental illness**

**Modernity and tradition in the interviews**

In their responses to the interviewers’ questions, our Patna interviewees exhibit a rich knowledge about the aetiology and treatment of mental illness. They discriminate between less severe forms of mental illness and madness as the “last” stage. As principal causes they spontaneously mention unfulfilled desires, such as sexual passion, neglect or poverty etc, fear, shock, pressure and depression which primarily result from family and conjugal problems. These problems are the outcome of personal wishes conflicting with social norms and the required adjustments to the strict ideas of what is right or wrong in Indian society. They see the family as the first resort to deal with and to try and treat mental problems afflicting family members. The hospital and the psychiatrist would be consulted in more severe cases and if familial treatment were not effective. Interestingly, the psychiatrist would basically use the same
kind of treatment as that used within the family. Both, family and psychiatrist, are expected to try to find the reasons for the problem, to talk to the person with the aim of removing “wrong” ideas, and to be friendly and permissive with the patient (cf. Wagner, Duveen, Themel & Verma, 1999, for a detailed report).

Modernity and its supposed advantages took centre-stage with many interviewees. At this stage of the interview some respondents mentioned traditional healers as not having a “technique”, that their doings do not cure and that they might not understand the “bad behaviour” of the patient, such that they “personally don’t believe in such things [traditional healing]”.

Interviewer: If any member of your family would start to have such a behaviour as I told earlier, what would you do?
Respondent: I would take him to a psychiatrist, who does an up-to-date treatment.
Interviewer: Would you do anything more?
Respondent: No, nothing… Once a boy came to me and got ill. The people told me to go for traditional treatment, but I said I would not do it… What would the traditional, the traditional healer do? The jhar-phook? That is nothing!

(19M)

Psychiatrists are deemed to “improve their medicines and their general science”, “psychologists would move in scientifically and would take action continuously” and in general “the process of treatment should be scientific” because such a technique has “100% success”. While all respondents acknowledged limits to the competence of traditional healers, only about half of the interviewees acknowledged such limits for psychiatrists, without, however, being able to give examples of specific areas of competence.

The interviewees’ uncritical belief in psychiatric science stands in stark contrast to their critical stance towards the efficacy of traditional healers. Nevertheless, when asked about traditional forms of healing, all interviewees exhibit a very elaborate and detailed knowledge of aetiology and healing procedures. In fact, their account of traditions is much more elaborate than the one they show when talking about the activities of the psychiatrist. They are able to give
detailed descriptions of the activities of ghost healers and the method of jhar-phook (a method applied to treat ghost possession). In terms of Indian tradition these accounts are accurate, though they stress the healer’s use of force in treatment, which is probably due to the higher public visibility of these practices. Besides that, elements of tantric and ayurvedic treatment receive due attention. When it comes to naming specific areas of competence for traditional healers, a slight majority of respondents attributes a wide and very general area of responsibility to them. Despite their preference for psychiatric treatment most interviewees acknowledge an overlap of competence between healers and psychiatrists.

The ideas about aetiology and treatment procedures associated with psychiatry show a marked difference to those associated with traditional healing. In the representation of psychiatry, the role of the patient is that of an actor having desires and fears and having been affected by shock and depression. Treatment consists in removing the patient’s false ideas and in being friendly, that is appealing to him or her as a sensible and responsible person. The psychological principle underlying this social representation is the personal agency of the mentally affected patient (Table 1).

The representation of traditional healing departs from spirit possession and a disequilibrium of humours as the causes of mental illness, which consequently entails a treatment that is directed towards “taming” the malevolent spirit or towards re-establishing the bodily equilibrium. In contrast to the psychiatric representation, agency in traditional healing lies not with the patient, but is external to his or her will.

Agency of the patient as a person vs. agency of the illness-causing powers and processes mirrors the socio-cultural background from where each emanates. In the traditional pattern of Indian life the individual agency of a person is emphasised less than their position within a network of social – especially kin - relations. On the other hand, individual responsibility – and the sense of agency which goes with it - is a primary feature of the modern economic and Western style of social organisation. These divergent underlying principles already point to the different situations and contexts where each representation has its place.
Ambivalence and cognitive polyphasia

When asked to compare and evaluate traditional and psychiatric healing procedures, a certain ambivalence comes to the fore. At this point in the interview numerous respondents clarified what they saw as the appropriate fields of traditional and Western healing. Living in a strongly collectivist society (Sinha & Verma, 1994), none of the interviewees felt him or herself free to act against their family’s majority will, if they had to take care of a mentally ill relative. That is, they acknowledged that traditional Indian healing has its proper place in the context of the family. Even if they expressed a strong personal preference for “modern” psychiatric treatment in the interview setting, they would willingly give way to their family who were depicted as generally being in favour of traditional procedures.

“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) [Words in capital letters were English in the original]

In a pragmatic vein many respondents would consider traditional healing along with psychiatric treatment if one or the other did not turn out to be as effective as expected.

“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 Biharsarif [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)

Such mention of the family’s preference for traditional treatment is sometimes accompanied by success stories, where traditional healing relieved physiological or psychological pain:

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 rhetoric of modernity that dominated the responses in the initial phase has its origin in the situational demands of the interview. No interview is free of context and neutral to meaning. In a series of investigations Fournier, Schurmans & Dasen (e.g. 1994) could show how the
conditions of an interview determine how interviewees talk about a representation. When an interviewer declares his or her group affiliation in an interview situation, e.g. to a particular language group in Switzerland, interviewees tune their utterances and examples to the knowledge supposedly shared among the participants in the situation. Interviewees pay attention to the status attributed to each language and to the status of interviewers as far as they are linked to the dimensions of social representations that anchor them to the society as a whole or to specific social groups. A shared world of thinking allows the use of representations that create and sustain a sense of intimacy and understanding.

In the case of our interviews the cultural affiliation of the attending, though not interviewing, Western researcher was obvious to the indigenous interviewees. Being educated members of the Patna middle class, the Westerner’s presence made many interviewees tune their responses to the supposedly shared ideas and ideals of modernity. While it is impossible to determine exactly the extent to which the respondents’ answers were motivated by the perceived situational demands of the interview, it is clear to us that it was one of the reasons for most of them to refer spontaneously to the modern institution of psychiatry while needing to be prompted to talk about traditional healing. It was only with such questions that the interviewees gave more or less full accounts of their cultural knowledge.

It is interesting to note that professional psychiatrists might themselves be influenced by the rhetoric of modernity as well as by what is seen as the essence of modern medicine. A recent study of psychiatric forms of treatment in two clinics in Northern India showed that there is a tendency for psychiatrists “to rely heavily on multiple drug prescriptions and electroconvulsive therapy in the treatment of their clients” (Nunley, 1996, p. 165). Ironically, psychiatrists, although they occupy relatively high status positions, are nevertheless individuals with motives and attitudes that are in large part culturally determined and whose choices are socially constrained. In an attempt to stand out against tradition Nunley concludes that psychiatrists engage in “competition or comparison with other elements of a pluralistic system of care for affliction [that] encourages drug prescriptions to establish difference from folk practitioners and similarity to other allopathic physicians” (p. 188).
“Modernity is quite literally a worldview: a way of imagining both space and people through temporal idioms of progress and backwardness” (Pigg, 1996, p. 163); a worldview that has its place in specific social settings and that does not find expression in other settings. Nowadays a traditional healer seems to be somewhat archaic and behind the time, while a psychiatrist represents modernity. A state of modernity is distinctly separate from a past that is characterised as traditional. Thus, for those for whom a sense of modernity is at the centre of their representations, ideas associated with it take on positive values, while ideas associated with tradition and backwardness take on more negative ones. The idea of progress becomes an idiom of social differentiation, a classification that places people on one or the other side of this great divide.

In our interviews it was primarily the younger respondents in the sample who exhibited some insight into this dilemma. When asked whether traditional healing might be an alternative to psychiatry, although slightly missing the point, he responded

Interviewer: Are there any mental illnesses which can be healed only by a traditional healer?

Respondent: Yes, there are certainly some.

Interviewer: As for example, what are those, what is their nature?

Respondent: Those who have great faith in religion. Those who do not believe in doctors and are against this scientific era. Those who have great faith in traditions. (15M)

Responses such as these and others described earlier illuminate how representations and associated discourse are anchored to specific situations and attributed to specific social groups. In the same vein, young Chinese living in England exhibit such ambivalence with regard to traditional, Chinese, and modern, English, notions of health and illness. While the older generation strictly prefers the traditional ways of maintaining health and fighting illness, the younger generation accepts tradition only in the their closer family context (Jovchelovitch & Gervais, 1999).
Many of our interviewees maintained that both ways of treatment have their merits and that deciding in favour of one or the other depends on the context. This can be understood as an example of cognitive polyphasia, such that following the paths of tradition is justified and appropriate in one social context and that following one’s personal “modern” intuitions of psychiatry’s powerful methods is justified and appropriate in another.

We should not forget that our respondents were middle-class and highly educated in comparison to the average Patna resident, which explains their knowledge and personal belief in medical science. They disposed of a social representation of psychiatry even if it was rather incomplete and superficial. When being interviewed by advanced students, one of them Western, this was the place where the representations of science and psychiatry guaranteed mutual understanding between interviewer and interviewee. In the emotionally warm and highly normative context of family life, appealing to another representation, that of traditional healing, is warranted. The cognitive contradiction between the two representational fields is probably only felt, when attention is explicitly directed towards it and when both representations are focused on in the artificiality of the interview. It is the uncommon situation that made a respondent justify herself by saying "I have some faith [in traditional healers] and at the same time I don't believe in them" (29F).

Yet even when the contradiction remains passive and unexpressed, its existence also demonstrates a certain dynamic within this community, a dynamic which is leading towards a revision of traditional beliefs. What will emerge in its place is perhaps less clear, at least from these interviews. While our respondents – especially the younger ones - emphasised their affiliation to what they considered Western scientific psychiatry, it seems unlikely that one form of thought will simply displace the other. It is what they see as the modernity of their image of the psychiatrist which is central to their representation, rather than any specific characteristics. Further, there is no reason to suppose that Indian culture will be any more likely to discard traditional patterns of thinking about mental illness than Western cultures. As several studies have shown (e.g. De Rosa, 1987; Jodelet, 1991) traditional ideas persist in Western representations of mental illness. In India we can see a process of change at work as the
community itself is changing, and we should perhaps expect that what will emerge will continue to exhibit something which is characteristically Indian.

**Cultural change and thinking about health in the community**

Recently, in one of the states in India, a non-governmental organisation (NGO) was engaged in a campaign supposed to bring about awareness of AIDS. When confronted with the material, however, some of the communities were highly offended by its illustrations and language that were deemed obscene and unacceptable. As a consequence the communities sought for withdrawal of the NGO’s registration and appealed for punishment of its members, producing serious legal problems for the organisation and the campaign as a whole.\(^4\) What comes to the fore in this example is that what appears as proper and acceptable in the modern frame of campaigning of the Indian NGO collaborators collided with the local communities’ traditional frame of conjugal and family life that was the natural target of the NGO’s activities. One can surmise that a more participatory organisation might have helped to frame the campaign more successfully and to avoid the embarrassment of both, the campaigners and the members of the community.

Representations are anchored in specific social contexts where they serve as the basis of communication and understanding and as the matrix regulating social interaction. Since everyday life is fraught with a multitude of different social settings and demands, the simultaneous existence of sometimes contradictory representational systems comes as no surprise. The present study suggests that this cognitive polyphasia is itself linked to a dynamic of change within the community. The idea of the modern for these educated, urban North Indians can be seen as the “preferred, persistent tendency” of the group, which will influence both their continuing socio-genesis of representations of mental illness, and the ways in which the community absorbs and re-works communications about mental illness from external sources. From this point of view, community development as a process aimed at creating efficient, sustainable and participatory structures must always take account of the social

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\(^4\) Personal information provided by Jyoti Verma.
representations within the local community and the dynamics of cultural change which they embody.

Pressed by the experience of unsuccessful initiatives, developmental interventions based on "paternalistic" biomedical and "socio-technical" models are more and more replaced by policies that involve a community perspective and community participation in design and execution (Beeker, Gray & Raj, 1998). Since any such development, be it in the realm of health promotion, politics and citizenship or economic welfare, is an intrusion into grown cultural and social structures, it can only be effective and sustainable if itself becomes an integral part of the local culture. Even small steps in development, hence, imply cultural change. Only then the local resources of cultural knowledge and representations can be put to good use for bettering the conditions of health under which the members of a community live.

As the present study showed, local belief systems are often far from being homogenous and frictionless, especially in areas with a prolonged contact with Western cultural products. The ensuing polyphasia of competing representations and their being anchored in different social settings can, at the same time, be an advantage for, and a challenge to participatory development. On one hand, community members with a more than superficial appreciation of modernity can be crucial collaborators in transmitting the message of health promotion programs to their fellows. Their cultural embeddedness and simultaneous openness to the novel allows a critical consciousness of the fissures and cracks separating those cultural goods that are worth of being preserved from those that are conducive to a lack of wellbeing and good health under the conditions of a modernising society. In the present field of research, for example, certain strands of Indian philosophy and art of healing, such as the holistic approach of Ayurveda, have been put to good use in local and Western medicine. On the other hand, an only superficial appreciation of the new and modern can lead to an overall rejection of local cultural achievements. This was the impression we gained from interviewing some of our respondents who saw the solution to all mental health problems in the "unrivalled exactitude" of modern psychiatry. Finding the right way of dealing with more traditional and with better informed but critical members of communities as well as with the superficially enthusiastic "modernists" in
participatory community development requires a deep understanding of a social psychology of participation. Such an approach, as outlined by Campbell and Jovchelovitch (2000, this issue), is urgently needed.

It goes without saying that development and culture change are not only processes happening in non-western cultures. The West itself, even before the massive migrations and displacements of people that characterise our “second age of modernity” (Beck, 2000), is undergoing constant cultural change entailing cognitive polyphasia and oppositional representations. In an ironic turn our experience of failed and successful developmental programs in non-western cultures might fruitfully inform health promotion and participatory community programs in the West. The fragile state of many institutionalised Western health-care systems might soon be a worthy occasion.
References


Table 1

Characteristics of modern and traditional healing

<table>
<thead>
<tr>
<th></th>
<th>Psychiatrist</th>
<th>Traditional healer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aetiology</strong></td>
<td>Unfulfilled desires, fear, shock, pressure, depression</td>
<td>Spirit possession, disequilibrium of humours, etc.</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>Talking, finding the reasons, friendliness, removing ideas, medicine</td>
<td>Exorcism, rituals, sacrifice, medicine</td>
</tr>
<tr>
<td><strong>Dominant principle</strong></td>
<td>Psychological agency of the patient</td>
<td>Agency of the causes of the illness, e.g. spirits</td>
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