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Hegemony versus Pluralism: Ayurveda and the Movement for Global Mental Health

Murphy Halliburton
CUNY Queens College

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Murphy Halliburton, PhD
Dept. of Anthropology
Queens College and the Graduate Center, CUNY

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Abstract

Under the aegis of the World Health Organization, the Movement for Global Mental Health and an Indian Supreme Court ruling, biomedical psychiatric interventions have expanded in India augmenting biomedical hegemony in a place that is known for its variety of healing modalities. This is occurring despite the fact that studies by the WHO show a better outcome in India for people suffering schizophrenia and related diagnoses when compared to people in developed countries who have greater access to biomedical psychiatry. Practitioners of ayurvedic medicine in Kerala have been mounting a claim for a significant role in public mental health in the face of this growing hegemony.

This study examines efforts by ayurvedic practitioners to expand access to ayurvedic mental health services in Kerala, and profiles a rehabilitation center which combines biomedical and ayurvedic therapies and has been a key player in efforts to expand the use of Ayurveda for mental health. The paper argues for maintaining a pluralistic healing environment for treating mental illness rather than displacing other healing modalities in favor of a biomedical psychiatric approach.

The finding by the World Health Organization of a more favorable outcome for people with schizophrenia in developing countries compared to people with this diagnosis in developed countries is one of the most striking and robust findings in the epidemiology of mental illness. This result has been reaffirmed over the last four decades in multiple studies, yet rather than learning what is being done right in those places with better outcomes, such as India, and applying them to places that do poorly, such as the US, mental health professionals and policy-makers have declared a crisis in low income countries that they need to solve. Although the sites

in India show the best outcome of all of the locations studied by the WHO, India has been especially targeted for intervention by a group known as the Movement for Global Mental Health (MGMH) and by the WHO's own Mental Health Gap programme. The Government of India, as they often do with projects designated as promoting "development," has engaged in similar efforts to scale up psychiatric services and displace local methods of healing the mentally ill. Those experiencing psychic distress are sometimes perceived in India as spirit possessed or as suffering psychopathology as defined by ayurvedic medical concepts (Halliburton 2009, Lang 2018). The efforts by MGMH, the WHO and the Indian government would also increase use of psychopharmaceuticals, and pharmaceutical companies would benefit from this market expansion, although many MGMH interventions do not involve pharmaceuticals.[1]

As part of the scaling up of psychiatry in India, in the last decade, new mental health facilities have opened, and community mental health programs have been deployed which promote awareness about mental illness to the public (from the biomedical perspective).[2] These facilities and programs offer interventions that range from pharmaceuticals to employment programs to a telepsychiatry van that plies the highways of Tamil Nadu offering consultations via Skype.

Most of the standoff over the proper forms of treatment for psychopathology has involved religious and folk healers. Religious healing centers such as Hindu temples, Muslim *dargahs* (shrines to saints) and churches that the mentally ill frequent are now more closely monitored by the state, in some cases being barred from serving the mentally ill, and in other cases requiring the presence of psychiatrists or social workers. [3] In the midst of these developments, in the state of Kerala, practitioners of Ayurveda, India's largest indigenous

medical system and a long-time recourse for the treatment of psychopathology in South Asia, have been asserting that they should have a larger role in treating mental illness.

Compared to religious and ritual forms of healing, Ayurveda has more standing in the eyes of the state, being officially recognized as an "Indian system of medicine" and receiving government support to run clinics and medical schools. Like biomedical psychiatrists, ayurvedic *vaidyans* (as physicians of ayurveda are known) treat mental illness through medications and talk therapy, but also through certain spa-like physiotherapies. This medical system has not been endorsed as a bona fide option for treating mental illness in recent Indian government decisions to expand the availability of psychiatric therapy. However Ayurveda's prestige and credibility in Indian society is significant, and in recent years, practitioners of Ayurveda and their supporters in the state of Kerala have been staking a claim for Ayurveda as a legitimate option for treating mental illness.

Based on research conducted in Kerala in 2014 on treatments for people diagnosed with severe mental illness and earlier fieldwork related to this topic, this paper examines efforts to expand ayurvedic resources for mental health care in the state of Kerala at the same time that the number of biomedical mental health facilities is increasing and the state is promoting awareness of mental illness from the biomedical perspective through community mental health programmes. We will see how a psychosocial rehabilitation center, known as Snehaveedu, which was among several centres established in the wake of an Indian Supreme Court decision that mandated the creation of additional mental health facilities throughout India, has combined biomedical and ayurvedic medicine along with prayer and occupational therapy to treat its residents, and has undertaken an effort to scale up training in ayurvedic mental health care in Kerala. Additionally, local ayurvedic centers and physicians that treat mental illness have

emerged adding to already existing resources for ayurvedic mental health care, such as the Government Ayurveda Mental Hospital in northern Kerala.

In an earlier article (Halliburton 2004), I argued that the better outcome for individuals with severe mental disorders in India revealed by the WHO studies may be explained by the existence of a pluralistic health care system. I showed that Ayurveda, biomedical psychiatry and religious healing, including centers like Snehaveedu, were roughly equally effective for patients with variety of diagnoses including schizophrenia and that while some healing systems were effective for certain individuals, they were unhelpful for others. Therefore, an advantage of Kerala's pluralistic healing system may be that people—and their families—are able to shop around for a therapy that fits their disposition and beliefs and is therefore more effective for them. Others have similarly highlighted benefits of India's pluralistic mental health care options (Sébastia 2009, Sood 2016 and Orr and Bindi 2017), and have shown that people suffering schizophrenia in India derive significant benefits from certain non-biomedical healing practices whose viability is threatened by the MGMH and a 2002 Indian Supreme Court decision (Quack 2012, Raguram et al. 2002). I suggest that advocates of the MGMH and the Indian state aim not to replace local healers with psychiatric services but to improve psychiatric services that already exist as an option for mental health in this pluralistic environment. In other words, biomedical psychology and psychiatry should remain an option among several rather than replace other options with a single, one-size-fits-all approach.[4] This paper does not claim that Ayurveda or religious healing is more effective. My earlier work (Halliburton 2004) indicates these modalities are at least as effective as allopathic psychiatry, but this work has limitations such as sample size. Meanwhile, research by the MGMH in India tends to compare their interventions to doing nothing or to other psychological interventions but not to Ayurveda and other non-biomedical

healing modalities. More research needs to be done on effectiveness of different healing systems before Kerala or India's mental health system is remade according to the priorities of the MGMH.

Despite efforts to expand the hegemony of biomedical psychiatry, India's mental health care environment may nevertheless continue to be marked by hybridity and plurality. In the history of borrowing or imposing western technologies, practices and disciplines in India, new practices can become hegemonic or hybridized or, as is often the case, both as they assimilate to and change a pluralistic environment.[5] Snehaveedu, the rehabilitation center created in response to a Supreme Court mandate that aids the ascendancy of biomedical psychiatry but combines allopathy and Ayurveda, is exemplary of this.

The WHO Studies and the Movement for Global Mental Health

This is not the place to offer a comprehensive review of the World Health Organization's epidemiological studies of schizophrenia. Detailed reviews have been published elsewhere, but a recap of the findings is important for understanding a crucial context that is neglected in efforts to scale up psychiatry in "less developed" countries.[6]

Since the 1960s, teams of researchers under the auspices of the WHO, have evaluated the course and outcome of people diagnosed with schizophrenia and related disorders in sites around the globe (including sites in the US, UK, Denmark, Ireland, India, Nigeria, Colombia, China and Japan) and have found that, to their surprise, people in developing country sites showed greater degrees of recovery than their counterparts in developed countries as measured by the degree of improvement in social functioning and reduction in psychotic symptoms. The original *International Pilot Study of Schizophrenia* (World Health Organization 1973) was followed up

by studies that adjusted methods to address factors that might have been overlooked in the earlier studies (Sartorius et al. 1986; Jablensky et al. 1992; Hopper et al., eds. 2007). Yet the results were always the same: people with a diagnosis of schizophrenia in developing country sites fared better, even after 26 years of follow up.

Researchers have attempted to explain this apparent developing country advantage in recovery from of serious mental disorders by examining the role of family (Leff et al. 1990), the flexible labor markets in developing countries (Warner 1994), the benefits of religious therapies that are found in these areas (Varghese et al. 1989, Raguram et al. 2002) and the possibility that hallucinatory experiences are more tolerated and thus more benign in the developing country sites (Luhrmann et al. 2015). Another factor, mentioned earlier, may relate to the fact that the so-called "developing" sites (Agra, Chandigarh, and Madras/Chennai, India; Cali, Colombia; Ibadan, Nigeria; Taipei, Taiwan and Hong Kong) are more medically pluralistic than the "developed" sites (Aarhus, Denmark; Dublin; Honolulu, USA; Rochester, USA; Moscow; Nagasaki; Nottingham, UK and Prague). In my own earlier research, I claimed (Halliburton 2004) that because people living in a more medically pluralistic environment are able to shop around and try out different therapies, they are more likely to find a therapy that fits their personality, beliefs and ideologies (or those of their therapy-seeking community) and is therefore more effective.

Despite the finding of a more favorable outcome for people with the most intractable mental illness diagnoses, the WHO and MGMH in the 2000s declared a mental health crisis in low income countries that they said would require more biomedical psychiatry and western-style psychological interventions. So while the WHO's Mental Health Gap Action Programme (mhGAP) "aims at scaling up services for mental, neurological and substance use disorders for

countries especially with low- and middle-income" (World Health Organization 2016), they do not mention that these people who supposedly lack access to proper treatment are, according to the WHO's own studies, actually doing better than people who have access to these services. Furthermore, when MGMH adherents and the WHO mhGAP declare a dearth of mental health services in low income countries, they count only biomedical psychiatric and psychological services and ignore local healing systems, such as Ayurveda, that are available (Quack 2012: 279, Saxena et al. 2007, WHO 2014).

Shortly before the creation of mhGAP, a collective that came to be known as the Movement for Global Mental Health emerged declaring, in a series of articles in *The Lancet*, that there is "no health without mental health" and called for the scaling up of psychiatric interventions in low income countries (Patel et al. 2007, Prince et al. 2007, Saxena et al. 2007). The MGMH was not unaware of the WHO studies of schizophrenia, and some of its members published an article in *Schizophrenia Bulletin* in 2008 that critiqued these studies. The article does not actually dispute the claim that developing countries as a group do better in terms of outcome, and it offered no new research. Instead it showed that not all developing countries did better than all developed countries and that India had the best outcome of any country studied (Cohen et al. 2008).[7] Oddly, after affirming that India fared the best in outcome in this analysis, it was India that ended up receiving special attention and interventions by the MGMH.[8]

The WHO studies pertain to schizophrenia and related disorders, while the MGMH claims that the mental health gap affects people with these and other disorders such as depression and anxiety. Thus the MGMH's claims are not completely hampered by the WHO studies findings since they can still claim to be saving depressed individuals among others. But it is schizophrenia that is considered the most difficult condition to treat, and research that

demonstrates benefits of ritual healing and Ayurveda have shown that these modalities can be effective for a variety of diagnoses, from depression to psychotic diagnoses (Raguram et al. 2002, Halliburton 2004).

The MGMH regularly implements and tests interventions to improve mental health in local settings. These often involve the use of psychiatric medications, but many interventions are not pharmacological. In fact, many in the MGMH claim to be "putting the 'psychosocial' into biopsychosocial" (Hanlon et al. 2016: s52), and offer cognitive and behavioral therapy and psychosocial support (Hanlon et al. 2016, Patel, Chowdhary et al. 2011). Such "social" interventions have been critiqued for focusing on the "micro" or "downstream" factors such as lifestyle adjustment, coping with stigma or occupational therapy rather than macro-level factors such as poverty, internal displacement or structural violence (White et al. 2017: 8-10). Others have argued that the premises for the scale up of psychiatric services by the MGMH are not well supported and that the movement is a form of neocolonialism.[9]

The MGMH has called itself a "social movement" and invokes the language of human rights to justify its cause (Patel, Collins, et al. 2011, 90). They depict local, nonwestern healing systems that people utilize for mental problems as abusive and unscientific, and claim they are saving people from these healers and directing them to the only healing modality that is effective as shown by evidence-based practices.

In 2002, India's Supreme Court paved the way for the MGMH and mhGAP projects when in the aftermath of a fire that killed residents at the Erwadi religious healing center, it declared that people with mental illness should go to doctors rather than faith healers and demanded that more mental health facilities be made available (Quack 2012, Basu 2014). This ruling resulted in monitoring and restrictions on religious healing centers and the implementation

of “dava aur dua,” or medicine and prayer, programmes where psychiatrists are posted near religious healing centers and priests are called upon to refer people seeking relief from mental illness to a nearby psychiatric dispensary (Basu 2014, Ranganathan 2014 and this issue).

Meanwhile, research has found that people with mental illnesses receive significant benefits from some local, nonbiomedical forms of healing.[10] Most of these are ritual therapies and part of what Quack (2012) and others have called the “folk” sector of health practices which exist outside the purview of the state—although in India since the 2002 Supreme Court decision, they are increasingly within the purview of the state. Ayurvedic medicine represents another recourse for people with mental health problems which is within the purview of the state though ambiguously so. As one of six “Indian systems of medicine” recognized by the central government and overseen by the AYUSH (Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy) department, Ayurveda receives some financial support and a certain legitimacy from the state, but not as much of either as is conferred upon biomedical services.

Ayurveda as a Mental Health Resource

Practitioners of ayurvedic medicine, a formalized and institutional medical system practiced throughout the Indian subcontinent, have been treating problems of mental illness for around two thousand years. Today ayurvedic practitioners treat *manasika rōgam* (an ayurvedic term for “mental illness”) using medications derived from plant materials. They also employ talk therapy and physiological interventions, including medicated mudpacks and oiling and steaming of the body, that aim at purifying the body and calming the patient.[11] Like biomedicine, ayurvedic practice is based on concepts of physiology and theories of the mind. Ayurvedic and biomedical approaches to psychiatry developed a more direct relationship when in the 1950s the

first effective antipsychotic medication in western psychiatry, reserpine, was derived from an ayurvedic psychiatric medicine (known as *serpagandhi* which contains the plant rawolfia serpentina).[12] The availability of ayurvedic psychiatric services today is difficult to quantify since mental health problems are mostly treated as part of general practice by ayurvedic doctors who ordinarily do not specialize in a particular area of medicine. However, in the state of Kerala, a number of vaidyans specialize in ayurvedic psychiatric treatment, and training programs in this specialty are available.

Ayurvedic mental health treatment is offered at the Government Ayurveda Mental Hospital in Kottakkal, Malappuram District, at P. S. Varier Ayurveda College, also in Kottakkal, through families that practice Ayurveda in Malappuram District such as the family that operates Poonkudil Mana (their estate that serves as a clinic), private practitioners and clinics in Ernakulam and Thrissur Districts, and through private practitioners in Thiruvananthapuram. In addition, some Hindu temple priests who work with the mentally ill and some Muslim priests in northern Kerala known as *thangals* are said to utilize ayurvedic psychiatric medications for ill and possessed supplicants—though some ayurvedic doctors claim these priests are not properly trained to do so, interestingly mirroring the biomedical view of ritual healers.

Thus, Ayurveda already has a presence in the public mental health system, but the MGMH, the WHO and the state do not see Ayurveda as a contributor to public mental health. As Lang and Jansen (2013) observe, the Kerala State Mental Health Authority and a WHO report on mental health in Kerala have not made efforts to integrate ayurvedic mental health care into public mental health care (38). However, practitioners of Ayurveda and their supporters have taken it upon themselves to claim such a role that I would argue works within the law and Ayurveda's ambiguous status in relation to the state.

Snehaveedu and Ayurvedic Care

Kerala appears to be the state that is the most compliant to the 2002 Supreme Court decision requiring the creation of additional mental health facilities having opened 150 such facilities in the ten years following the decision.[13] Government and private mental hospitals were established in the major cities of Kerala well before the Supreme Court decision. The Mental Health Centre in Peroorkada, Thiruvananthapuram, where I conducted research in the 1990s and in 2014, has been in operation since 1870. The impetus for the development of biomedical services in the Malabar Coast of southern India originally came from the Rockefeller Foundation, Christian missionaries and several Maharajas of Travancore who were champions of this medical system.[14] The state also features 76 psychosocial rehabilitation centers, institutions that provide housing, rehabilitation, support and healthcare for people with mental disorders, many of which were opened following the 2002 decision. The district of Thiruvananthapuram, meanwhile, has mobilized a District Mental Health Programme that aligns with WHO and the MGMH concerns to expand psychiatric care to community health centres and promote "mental health awareness" through community interventions.

Over the course of eight months in 2014, I regularly visited a psychosocial rehabilitation center known as Snehaveedu that has been in operation since 2008. Snehaveedu, which means "house of love," is run by Father George Joshua Kanneeleth and operates as a charitable organization under the auspices of the Malankara Syrian Catholic church. Christians, who constitute around 25% of the state's population, are heavily represented in nursing and other health professions, and most psychosocial rehabilitation centers in Kerala are operated by local Christian organizations.

Father George Joshua sports a long beard that is typical of priests in the Syrian Christian community which dates back close to 2,000 years on the Malabar Coast. He is upbeat, charming and always brimming with enthusiasm about his work at Snehaveedu. The first time I met him at the Snehaveedu campus, a small compound of buildings surrounded by gardens and animal corrals in a quiet neighborhood in the northern part of the city of Thiruvananthapuram, Father George Joshua explained how Snehaveedu originated out of his and other church officials' desire to help the destitute and mentally ill of Thiruvananthapuram. There are usually about 60 residents staying at Snehaveedu, most of whom were inpatients at a mental hospital with serious diagnoses, primarily schizophrenia and biopolar disorder. Some residents Father George Joshua found wandering the streets of Thiruvananthapuram, and about four or five are elderly, destitute and homeless but do not have mental illness diagnoses.

As per Kerala government regulations that comply with the 2002 Supreme Court mandate, residents of Snehaveedu are brought once a month to the Mental Health Centre in Peroorkada, the local, state-run mental hospital, for psychiatric consultations, and they are given psychiatric medications by a nurse at Snehaveedu. Snehaveedu also offers occupational therapy, which involves training residents in animal husbandry and horticulture. Father George Joshua has also implemented an ecosystem program at the facility that patients help maintain. A water catchment system gathers rainwater for washing, cow manure is collected to create methane fuel for cooking, and the gardens and animals provide much of the food that residents consume.

In addition to the monthly visits to the mental hospital, residents are seen weekly for general health checkups by two ayurvedic doctors who have training in treatments for mental disorder. Ayurvedic doctors are not usually seen at ostensibly biomedical, state-licensed mental health facilities, but Father George Joshua found a way to incorporate ayurvedic care at

Snehaveedu. At a conference of the WHO-affiliated World Association for Psychosocial Rehabilitation in 2009 in Bangalore, Father George Joshua learned of the dangerous side-effects of the antipsychotic drug clozapine which is regularly used in India and can cause heart problems and seizures. This led him to develop concerns about other psychiatric medications and to try to find a form of treatment with fewer side effects for the residents of Snehaveedu. Father George Joshua was right to be concerned about the collateral effects of psychiatric medications as, four months into my fieldwork at Snehaveedu, a 29 year-old resident there died from liver failure mostly likely as a side effect of taking lithium.[15]

As Ayurveda is generally perceived to be a gentler form of medicine with fewer side effects, Father George Joshua looked into the possibility of bringing in ayurvedic vaidyans to provide care at Snehaveedu. It turned out that the Government of Kerala regulations for psychosocial rehabilitation centers, which require regular visits to allopathic psychiatrists, also allow "qualified medical practitioners" from any of the *bona fide* Indian systems of medicine, such as Ayurveda, Siddha or Unani to be employed in general healthcare.[16] Today at Snehaveedu, two ayurvedic physicians provide weekly consultations and treatments for residents. While these are general health treatments using ayurvedic medications, they also provide ayurvedic medicine to counter the side effects of the biomedical psychiatric drugs residents take. According to the staff at Snehaveedu, this has led to patients having more energy than they did before the ayurvedic treatments. Thus, the treatment at Snehaveedu did not constitute actual ayurvedic psychiatric care, but rather Ayurveda served as a supplement to biomedical care—reflecting a kind of hybridity regularly found in medical systems in India while also reflecting the hierarchy of care promoted by the MGMH and India's Supreme Court decision.

With his favorable opinion of Ayurveda and his acquaintance with specialists in ayurvedic mental health care, Father George Joshua decided he wanted to extend the use of Ayurveda specifically for mental health at Snehaveedu and at other psychosocial rehabilitation centers. When I arrived at the office at Snehaveedu one February morning in 2014, Father George Joshua was sitting at a table with one of the ayurvedic doctors that serves Snehaveedu along with two other staff members and a well-known specialist in ayurvedic psychiatry whom I have known since the 1990s when I conducted research at the Government Ayurveda Mental Hospital in northern Kerala. The table was strewn with papers with information on the staff of other psychosocial rehabilitation centers and other documents as the group was planning a workshop on ayurvedic mental health care. Their aim, they told me, was to train 400 nurses and other staff members from psychosocial rehabilitation centers around Kerala in ayurvedic methods of mental health care. To do this, they were going to bring the staff members in ten batches of 40 attendees for a week each of trainings and seminars at a nearby conference center. I was impressed by the ambition of the project, and during the next few visits to Snehaveedu, Father George Joshua and his staff were absorbed in organizing this event. The WHO's Mental Health Atlas (2014) claims there are 3,800 mental health care staff (excluding psychiatrists) in all of India. If these numbers are correct, Father George Joshua and his associates, though only focusing on Kerala, would be training a substantial portion of the total number of India's mental health support staff in ayurvedic methods and concepts.

After weeks of calling participants and arranging speakers from all over the state, the workshop, which was called Ayursevana, was finally underway, and I attended several sessions with two different cohorts of trainees. The numbers were close to what the organizers had hoped for as there were about 30 participants in each of the cohorts I observed. At a conference center

at Thiruvanathapuram's Mar Ivanios College, which is only a short walk from Snehaveedu, doctors of Ayurveda with training in mental health care gave presentations on topics ranging from ayurvedic explanations of the causes of mental illness to methods for maintaining mental health and treating psychopathology to guidelines for caregivers who take care of the mentally ill. The speakers also gave demonstrations of ayurvedic inpatient procedures for mental illnesses. All presentations were in Malayalam, the primary language of the state of Kerala, whereas biomedical seminars and other types of professional meetings I have attended in Kerala and other parts of India were conducted in English. Dr. Durga Prasad gave a presentation on the conceptions of mental health and illness in Ayurveda, explaining factors that shape the personality and predispositions to mental illness such as a person's thoughts, knowledge, habits and nutrition. He also discussed the role of stress and the use of alcohol and recreational drugs in addition to outlining the characteristics of people who are mentally healthy, thus addressing not only pathology but also the factors that promote wellbeing and resilience, including strength of consciousness (*ōrmmaśakthi*), clearness of purpose (vyaktamaya tàlparyaü), and good memory. He outlined methods of therapy such as the various steps of *panchakarma*, a therapeutic regimen which involves purgatives, enemas and the administration of medicine through the nose. He explained the use of *dhumapana*, where medicine is administered by smoking and inhaling through the nose, and *talapodichil*, which resembles a medicated mudpack applied to the head. Then with the help of other doctors and assistants, he proceeded to demonstrate *svedana*, which involves steaming and sweating of the body. These therapies are used for patients with a variety of ayurvedic diagnoses that range in severity from problems similar to mild neuroses to more intractable psychotic conditions. Figure 1 shows the procedure being administered to a nurse from a psychosocial rehabilitation center who was attending the workshop and who volunteered

for the demonstration. The nurse was in good humor, and he asked colleagues to take photos of him undergoing the therapy on his phone. I spoke to him afterward, and he said the procedure made him feel calm and relaxed, reinforcing what I observed in earlier research at an ayurvedic mental hospital where patients reported that ayurvedic inpatient procedures made them feel cool and calm and that the procedures had a pleasant aesthetic effect (Halliburton 2009).

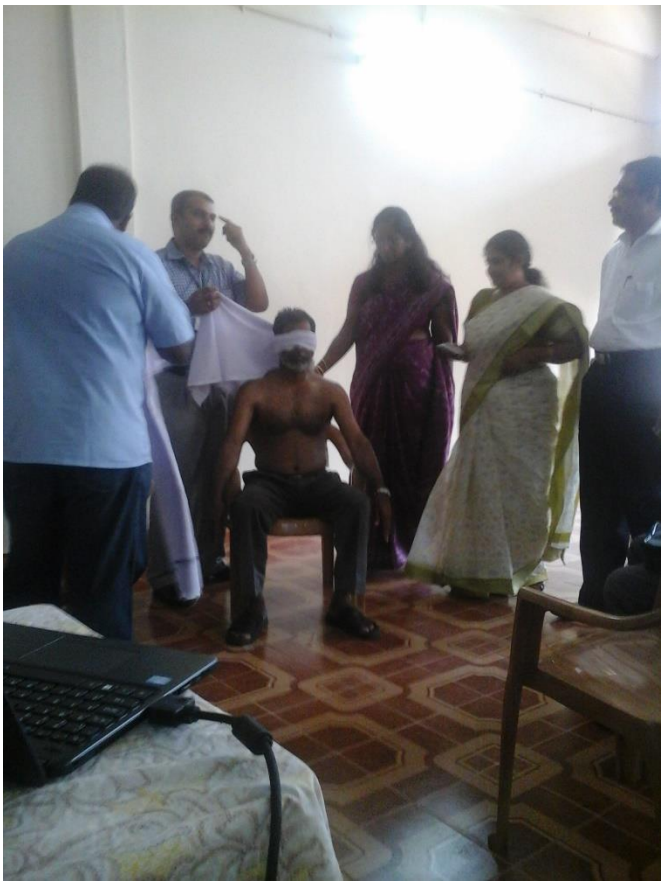

Figure 1 – Demonstration of svedana—steaming of the body—on a volunteer at the Ayursevana training sessions. The cloth over the eyes prevents irritation during the application of steam.

The Ayursevana workshop sessions continued in similar form on subsequent days. Dr. K. Sundaran offered a Powerpoint presentation on nursing care in Ayurveda, and Dr. Sreekala

spoke about the importance of eating the right foods for maintaining mental health as well as the importance of "living according to the season" (*çtuchcharya anusarichhu jãvikkuka)*: Ayurveda takes the season into account in maintaining health and treating illness based on the understanding that human physiology varies by season and that certain foods and habits are compatible with certain seasons.

I spoke to several participants, including nurses, psychiatric social workers and a homeopathic doctor, during lunch and breaks in the seminar, and asked their impression of what they had seen and whether they might apply any of the techniques they were learning in their work. Most said they found the topics interesting and would consider applying some of the insights from the workshop. But they also said it was not clear how they might apply methods of treatment and intervention they learned after only a single workshop. Thus it did not appear this workshop would immediately offer ayurvedic alternatives to biomedical treatments. Nevertheless, through this training, a considerable number of mental health workers from around Kerala had been exposed to ayurvedic techniques for mental healthcare perhaps priming the ground for a future scaling up of ayurvedic practices at psychosocial rehabilitation centers.

Ayurveda Elsewhere

In addition to what has been happening in connection with Snehaveedu, other efforts by practitioners of ayurvedic psychiatry to claim a greater role in the mental health system of Kerala have emerged.

A month prior to the Ayursevana workshops, a group of young vaidyans convened a press conference at a hotel in Thrissur, in central Kerala, to publicly claim a role for Ayurveda in mental health care. This group consisted of a new generation of graduates from Ayurveda

colleges, mainly P. S. Varier Ayurveda College in Kottakkal, who had training in ayurvedic psychiatric treatment. They invited media and other guests, including a German anthropologist who has conducted research on Ayurveda, and received press coverage in local newspapers.[17] Then, while the Ayursevana training was underway, one of the speakers, Dr. Sundaran, who formerly practiced at the Government Ayurveda Mental Hospital, opened his own private clinic, Sutheertham Ayurveda Hospital in Thirvuananthapuram. I attended the inauguration and, because of my work on Ayurveda, was among the guests who were invited to light the camphor lamp, a traditional part of inauguration ceremonies in Kerala. Sutheertham is a general hospital that includes facilities to treat people suffering from psychopathology. It features a droni table, which is used in the application of medicated oil, and other technologies for ayurvedic treatments for mental illness (see Figure 2).

There are additional indications of reclamations being made by Ayurveda of the territory being claimed by biomedical psychiatry. Several doctors I met who were trained in ayurvedic psychiatry were treating patients at small ayurvedic clinics in southern Kerala, while students at the Thiruvananthapuram Ayurveda College regularly do rotations at a mental hospital where they learn about the biomedical perspective on mental illness. Some of the biomedical psychiatrists at this hospital have told me they have respect for ayurveda, and I observed one attempting to rally interest among the visiting ayurvedic students in ayurvedic approaches to mental illness. Many of these students have internalized the hegemony of the biomedical approach to health and defer to biomedical perspectives. Meanwhile, Lang (2018) reports the recent emergence of an Association of Ayurveda Psychiatry which has "demand[ed] the establishment of psychiatric units in Ayurveda general hospitals" (120-121).

Figure 2 – Droni table at Sutheertham Ayurveda Hospital – for *dhara*, a mental health procedure involving oiling of the head

Lang and Jansen's (2013) research on "appropriating depression" by ayurvedic psychiatrists also provides an example of ayurvedic practitioners claiming a place at the table in mental health care in Kerala. "Depression" has become a popular idiom in Kerala and elsewhere in India with people adopting this English language term to describe their distress, and ayurvedic

doctors have been able to assimilate the idiom of depression into ayurvedic conceptions of pathology and into their clinical practice. [18] While Lang and Jansen describe a "scientification" of ayurveda that they say is taking place, the ayurvedic appropriation of depression is not a deferral to biomedical concepts but involves a translation of biomedical concepts to ayurvedic terms in a way that does not destabilize the ayurvedic concepts. *Kapha unmāda*, an ayurvedic diagnosis related to kapha, one of the three bodily dosas, is akin to severe or endogenous depression in biomedicine. Mild depression with primarily somatic symptoms, meanwhile, is understood as a problem with vāta dosa. Ayurvedic mental health specialists also use a concept of ādhija unmāda which is a mental disorder due to loss and stress, a reactive kind of depression. They also distinguish these states from the more common Malayalam term viṣādam which means depressed mood (37-38). The P.S. Varier Ayurveda College, one of Lang and Jansen's primary research sites, offers daily outpatient clinics, including one that is devoted to viṣādam and these other forms of "depression." Arguably, these ayurvedic doctors are not treating "depression" per se, but are articulating the kinds of affect and behavior that are labeled as "depression" in terms of ayurvedic categories. Dr. Krishnan, who elaborated on the differentiation of depression and unmādas for Lang and Jansen, "claims the participation and contemporaneity of Ayurvedic psychiatry in a modern scientific psychiatric discourse" (38).

Pluralism and Hybridity

This paper is written partly from a position of advocacy. Along with Lang and Jansen (2013), I feel ayurveda should be allowed to play a role in public mental health in Kerala, and not just as a referral source for biomedical psychiatry as MGMH proponents suggest for other "indigenous healers." I have also claimed that the premises for the scale up of psychiatry in India

and elsewhere are not supported by the evidence, at least in terms of what we know about schizophrenia and related disorders.

In addition to suggesting what should happen, it is important also to contemplate what may happen as the result of efforts by the MGMH. Whatever success the MGMH does have, they will not likely be able to fully displace local healing systems. Ritual healing is alive and popular, and while it is under more scrutiny than before, it will not be possible to fully monitor this kind of healing practice. Meanwhile the history of medical, religious and other cultural practices in India has been one of pluralism and hybridity. Even the Maharajas of Travancore who were advocates of allopathy along with the Rockefeller Foundation and Christian missionaries—a trio that resembles the current interests promoting the scale-up of psychiatry—did not ultimately displace local healing systems when they introduced biomedicine in the 19th century. In fact, soon after the rolling out of biomedicine in 19th century Travancore, the government established an ayurveda *pathasala* (school/college) and licensed ayurvedic vaidyans.[19] Similarly, the placement of a psychiatric clinic at a Muslim healing shrine in Gujarat did not result in a takeover by psychiatry, but rather a hybrid set of practices where psychiatry does not have the upper hand. People use psychiatric care in addition to engaging in their devotional practices, but only if the *bavā*, the spirit of the saint at the shrine, says it is okay to do so (Basu 2014). Sood (2016), however, says that key healing rituals at the Balaji temple in Gujarat are disappearing because of MGMH-inspired government mandates for psychiatric oversight of ritual healing.

Snehaveedu, which has incorporated ayurvedic and allopathic care, operates as an institution of the Malankara Syrian Catholic Church, itself a hybrid of Syrian Christian practices

that date back around 2,000 years in Kerala and the Catholic liturgy that was brought by Europeans 1,500 years later.

Ayurveda's role in relation to the state is, for now, ambiguous when it comes to mental health care. Government policies do not see a role for Ayurveda in mental health services, yet central and state governments maintain departments of Indian systems of medicine which provide recognition and funding to Ayurveda. Meanwhile, Kerala's rules for psychosocial rehabilitation centers assure biomedicine has a more significant role in these institutions, while allowing Ayurveda to slip in the back door, maintaining a pluralistic and hybrid approach to healing. It should be added that Ayurveda stands in a position of fortuitous ambiguity in another way, since its practitioners and institutions have not been accused of abusive practices in the way both ritual healers and biomedical psychiatric hospitals have.[20] Ayurveda's gentler healing methods may be in part a modern innovation (Zimmermann 1992), but they may also be conducive to less controversial forms of treatment. Biomedical psychiatrists meanwhile have rationalized the use of ECT without anesthesia on certain patients, a procedure some consider abusive that can result in severe spinal injuries, memory loss and death (Waikar et al. 2003). Ayurveda's interventions, such as those demonstrated at the Ayursevana workshop, are less prone to dangerous collateral effects—although ayurvedic treatments are not without risks.[21]

Conclusion

Ayurvedic medicine has not been named by the MGMH or the Indian government as a resource for public mental health, nor has it been criticized as ritual healers have been for allegedly being backward, abusive or ineffective. Ayurveda has served as a mental health recourse in South Asia for centuries, and extensive descriptions of treatments for

psychopathology can be found in classic texts such as the *Caraka Samhitā* and *Suśruta Samhitā* and in contemporary ayurvedic research journals. Today, in the face of the increasing hegemony of biomedicine in the state of Kerala, ayurvedic psychiatrists are claiming—or reclaiming—a role in public mental health. We still do not know for sure what confers the "developing country advantage" reported by the WHO studies. It may be that all of the factors suggested earlier conspire to confer an advantage: that the family plays a role, that labor markets make it easier to find employment for those with a diagnosis and that medical pluralism conveys an advantage. But there is no clear mandate here for organizations such as the MGMH and WHO to save India from their mental health problems.

Biomedical psychiatry does have an important role in mental health services, not through displacing other systems of healing, but as a contributor to a pluralistic healthcare system. Any scaling up of psychiatry should aim to improve the psychiatric offerings that already exist rather than push aside other systems. As a suggestion for improving psychiatric services, there should be less emphasis on medications, which is the main and often all-consuming priority of current psychiatric care India.[22] Several psychiatrists I spoke to in Kerala felt frustrated that they mostly work on medication management, and were interested in utilizing psychotherapeutic and psychosocial interventions. They were unhappy that they have little time with each patient, from one to five minutes as I observed in several outpatient clinics, which leads to an emphasis on medication maintenance at the expense of other interventions. Perhaps the MGMH and the Indian state could promote more psychosocial interventions at existing mental health facilities and hire more clinical psychologists and social workers, so that patients receive more talk therapy and more assistance in transitioning after release from hospitals. While the ratio of patients to psychiatrists that leads to such cursory care could be improved by hiring more

biomedical psychiatrists, it could also be aided by allowing ayurvedic psychiatrists to play a greater role.

Finally, Sébastia (2009) researched efforts by psychologists and psychiatrists in India who tried, from the 1960s to the 1980s, to develop proposals to improve the country's mental health care. Like today's MGMH, they recommended the integration of psychiatry at hospitals and primary health centres and psychoeduction for primary health centre staff and the public. They also conducted research on Ayurveda, concepts from Indian philosophy and the role of yoga and meditation, and argued for the "indianization" of psychiatry.[23] Today's MGMH and the Indian central government policies instead favor the psychiatrization of India. The MGMH might want to revisit this work, for example the writings of J. S. Neki, or the volume, *Restoring Mental Health in India* (Sébastia ed. 2009), which considers how codified Indian systems of medicine, "folk" therapy and psychiatry can contribute to mental health care, and to take more seriously South Asian disciplines of the mind in addressing the mental health needs of India.

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Notes

[1] It is not clear to what degree there may be direct collusion between Indian government policies and the claims of the MGMH and WHO. Davar and Lohokare (2009), and the analysis in this paper, show significant similarities between Indian government, MGMH and WHO discourse on mental health policies, while Sood (2016: 767) says efforts by the Indian government to regulate religious healing are inspired by MGMH claims.

[2] Davar and Lohokare (2009), Basu (2014), Hanlon et al. (2016)

[3] A key figure in the MGMH, Vikram Patel (2011) speaks highly of the contributions of some local, nonbiomedical forms of healing and of their potential as collaborators in the MGMH, but in all of the instances I have been aware of of the use of local healers as collaborators, some of which are mentioned below, such healers are asked to serve essentially as referral sources, directing patients to use psychiatric services. See also Basu (2014), Shields et al. (2016) and Sood (2016) who offer different interpretations of the outcome of collaborations between faith healers and psychiatrists at dargahs and a temple in Gujarat.

[4] Similar suggestions have been offered by Sébastia (2009) in a volume that considers the contributions of India's various healing regimens to improving mental health.

[5] See, for example, Seth (2007), Naraindas, Quack and Sax (2014) and Mukharji (2016).

[6] The most comprehensive review is Hopper et al., eds. (2007). For a recent recap see Luhrmann (2016). The WHO studies and discussions of them use the categories "developed" and "developing" countries. Although anthropologists have criticized assumptions inherent in such

categories, I will use these terms on occasion as I dialogue with these studies while also resorting to less ideologically-loaded labels such as “low income” countries or the “Global south.”

[7] Two leaders of the WHO studies in a response to Cohen et al. in the same issue of *Schizophrenia Bulletin,* defend their studies against these critiques (Jablensky and Sartorius 2008).

[8] This is difficult to quantify, but interventions tested out by key members of the MGMH, such as Patel and Saxena, take place mostly in India, and among the membership in the MGMH, India is the most represented country/area next to Europe and North America (Patel, Collins et al. 2011).

[9] Cooper 2015; Mills 2014; Summerfield 2008.

[10] Warner 1994: 161-169; Raguram et al. 2002; Halliburton 2004, 2009; Davar and Lohokare 2009; Sax 2009; Sébastia, ed. 2009; Quack 2012; Basu 2014; Ranganathan 2014.

[11] See Obeyesekere (1982), Giguère (2009), Halliburton (2009) and Lang (2018) for more details on ayurvedic treatments for mental illness.

[12] Kline 1954; Kaplan and Sadock 1995: 1989

[13] According to Davar (2012, 126), state government affidavits show that Kerala opened this number of facilities which is the highest among the states she reports on. Other states mentioned are Maharashtra with 101 facilities and Andra Pradesh and Chandigarh which are reported as each having “over 35.”

[14] A key figure in the spread of western biomedicine in the 19th century was Sri Uthram Thirunal Maharaja who studied western medicine and treated patients at his palace (Nair 2001, 220).

[15] Kidney failure can occur from taking too much lithium which is not difficult to do as "Lithium is a medicine with a narrow range of safety," and patients need careful monitoring while on this medication (National Institutes of Health 2018).

[16] The Government of Kerala (2012) guidelines for psychosocial rehabilitation centers define a "qualified medical practitioner" as "a person who possesses a recognized medical qualification as defined in the Indian Medical Council Act, 1956," which refers to practitioners of biomedicine, "or as defined in the Indian Medicine Central Council Act, 1970," which refers to practitioners of one of the federally recognized Indian systems of medicine.

[17] I am grateful to Dr. Claudia Lang for informing me about this meeting.

[18] Halliburton 2005, Lang 2018

[19] Nair 2001

[20] See Davar and Lohokare (2009), Davar (2012) and Mills (2014) who discuss allegations of abusive practices of ritual healers made by the MGMH and the Government of India and point out cases of abusive practices at biomedical mental hospitals.

[21] See Saper et al. (2008) on toxicity found in some ayurvedic drugs. Also, some patients who are considered violent are incarcerated at the GAMH and at Snehaveedu, in rooms with barred doors and windows, just as they are at biomedical mental hospitals.

[22] See Jain and Jadhav (2009)

[23] Sébastia (2009: 6)