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The House of Love and the Mental Hospital: Zones of Care and Recovery in South India

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7 The House of Love and the Mental Hospital

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Abstract
The Movement for Global Mental Health has defined the person suffering psychopathology in low-income countries as an abused and suffering subject in need of saving by biomedical psychiatry. Based on fieldwork in Kerala, South India, carried out at psychiatric clinics and a psychosocial rehabilitation centre, this paper examines patients' experiences of illness, the degree and quality of family support, and attributions made to the role of 'sneham', or love, in recovery. The role of love and family involvement may help explain the provocative finding by WHO epidemiological studies that 'developing' countries – and India in particular – showed better rates of recovery from severe mental illness when compared to developed countries.

Keywords: love, schizophrenia, social support, Kerala, Movement for Global Mental Health

In recent years, prominent articles in the *New York Times*, with titles like "A Mission to Heal Minds" and "A Call to Foster Mental Health Across the Globe," reported on psychiatrists and mental health workers who have been addressing the supposedly underserved mental health needs of people in developing countries.[1] These individuals, many of whom are part of the Movement for Global Mental Health (MGMH), have led efforts to scale up psychiatric interventions, counter abuse of the mentally ill, and close what

1 Carey 2015a, 2015b, 2016a, 2016b.

Sax, William, and Claudia Lang (eds), *The Movement for Global Mental Health: Critical Views from South and Southeast Asia*. Amsterdam, Amsterdam University Press 2021
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they claim is a "gap" between the needs of the mentally ill in these countries and the mental health services that are available to them.[2] Such media coverage sometimes includes a photo of the legs of an African or Asian man or woman with a chain around one ankle, iconically representing abusive treatment of the mentally ill that is supposedly the result of ignorance about mental illness and traditional methods of healing employed in these settings.[3] These stories are compelling, but what this media coverage does not tell the reader is that according to the WHO, people with schizophrenia and related diagnoses in these countries are actually doing better in terms of improvement and recovery than the mentally ill in developed countries where psychiatric services are more widely available and the mentally ill are supposedly better treated. Also, such forms of restraint through an ankle chain are infrequently used in sites I have visited in India and are arguably no worse than methods of incarceration and physical restraint used in biomedical mental hospitals (Mills 2014) – though both forms are problematic.

Since the 1960s, the World Health Organization (WHO) has examined the course and outcome of schizophrenia and related diagnoses at "developed" and "developing" country sites across the globe, and determined in multiple follow-up studies one of the most striking and robust findings in epidemiology, which is that people with these disorders in "developing country" sites showed greater degrees of improvement than subjects at "developed country" sites (WHO 1973, 1979; Sartorius et al. 1986, 1996; Hopper et al. 2007). The data from the WHO studies has been further parsed to reveal that among all sites, India shows the best prognosis for these illnesses (Hopper 2004; Cohen et al. 2008).[4] But instead of trying to assess what India and the other developing countries are doing right and applying it to places like the US and Europe that have a poorer outcome, the MGMH, as well as the WHO itself, have created programmes to "save" the mentally ill in India and other developing countries through interventions based on western models of mental health care.

In the last decade or so, anthropologists too have focused on "suffering subjects" (Robbins 2013), including cases of people suffering mental illness, and like the MGMH and WHO, this had led researchers to overlook more

2 Patel et al. 2007, Patel et al. 2011, Patel et al. 2016.

3 Such a photo is featured in Carey (2015a), and was the lead photo on the front page of the *New York Times* that day. See also Dey (2016) and Soudi and Patel (2016)

4 Despite the title of their article, Cohen et al. do not so much "question an axiom" of better results for developing countries as demonstrate that not all developing countries did well in the WHO studies, at the same time highlighting that India showed the best results.

fortuitous, caring encounters with the destitute and those suffering serious pathologies.[5] From December 2013 to August 2014, I conducted fieldwork at mental health centres in the state of Kerala in south India to help explain why people in India fare better in recovery from schizophrenia and related disorders. While recognising the contribution of studies that examine cases of abandonment or apply Agamben's (1998) perspective on thanatopolitics (power that operates by the threat of repression and death) to contemporary ethnographic settings and the need to remain vigilant about cases of abuse of the mentally ill in all settings, this paper answers Robbins' (2013) call to go beyond our focus on the "suffering subject" and build what he calls an "anthropology of the good". Robbins' purpose is not to ignore suffering and oppression, but to also attend to and learn from what goes right and what people strive for. Thus one aim of this paper is to inform medical anthropologists, advocates of the MGMH, and mental health policy professionals about what India may be doing right, in the hope of improving the lives of people suffering psychopathology in low- *and* high-income countries and to rethink current efforts to make India's mental health system over through interventions developed, mostly, in the West. I do so by examining cases of success in treating mental illness in Kerala, paying special attention to the role of the family and caring relations between healers and patients, who are not abandoned or reduced to "bare life"[6] but are treated as qualified life, with dignity and also, often, with *sneham* or love. These caring relations, aside from affirming the humanity of the person suffering distress, also appear to contribute to improved functionality and recovery from psychopathology.

After a discussion of the anthropology of abandonment and care and a sketch of the variety of meanings of "love" in South Asia, this article will consider caring and loving relations in the lives of patients I spoke to at a mental hospital and community health centres. This will be followed by a more explicit consideration of *sneham* at a psychosocial rehabilitation centre known as Snehaveedu or "House of Love".[7]

5 Examples include Biehl (2013 [2005]), Cohen (2005), Marrow and Luhrmann (2012), Povinelli (2011), and Goldstein (2013 [2003]).

6 This term comes from Agamben (1998) for persons also referred to as "zoē", or those who are alive but abandoned rather than living the qualified, social life of the citizen.

7 More literal translations would be "home of love" or "love home" because of the notion of belonging in the term "home", but these translations are more awkward. Another rehabilitation centre in another district of Kerala that is operated by the same church organisation that runs Snehaveedu is known by the English name "Love Home".

Anthropologies of Abandonment and Care

In his influential ethnography *Vita: Life in a Zone of Social Abandonment* (2013 [2005]), João Biehl depicts Vita, a psychosocial rehabilitation centre in southern Brazil, as a place of abandonment where the poor are left to live and die as non-, or formerly, social beings, and he makes his case primarily through his examination of the life of Vita resident Catarina who is abandoned by her family and by the state and apparently left alone with no meaningful social relations. Catarina's case is disturbing and Biehl's presentation is compelling, but I am concerned about how much Biehl's explanation of social abandonment hangs on the experience of this one individual and how we have seen a proliferation of other ethnographic studies of abandonment and examples that speak to Agamben's theory of sovereign power in the neoliberal world, several directly influenced by Biehl's analysis.[8] I am not suggesting that Biehl or those who called our attention to cases of abandonment have nothing important to say about social relations in our neoliberal word or that Agamben's argument is not compelling. However, as with Rabinow and Rose's (2006) critique of Agamben's (1998) and Hardt and Negri's (2000) focus on thanatopolitics (where Rabinow and Rose remind us that biopower works not only by threatening death or abandonment but also by making live, such as through programmes of public health, which also create and discipline subjects), we need to be sure we are capturing the larger panoply of power relations and experiences operative among the abandoned and those who are attended to.

Critiques of the rubric of abandonment are raised in ethnographies by Clara Han (2012) and Anita Hannig (2017) who speak of an anthropology of care that considers how people attend to and care for others who are suffering structural violence or stigmatising illness and how those others can have vital lives despite the challenges with which they struggle.[9] Additionally, Ma (2012) critiques studies that depict pharmaceuticals as simply reducing valued, social lives (*bios*) to bare life (*zoē*). She also highlights the centrality of love in the case of Mei, who is given a psychotic diagnosis, but "complained to me [Ma] that what drove her crazy was a lack of love" (53).

8 See Povinelli (2011) and note 5 above.

9 Hannig (2017) shows that despite great suffering and stigma, women with obstetric fistulas in Ethiopia maintain social relations and engage in other vital parts of their lives, such as their religiosity. She explains that "most women with fistula remain entangled in intimate networks of kin and community obligations that defy their supposed relegation to the margins of society. And while some of their relations might be changed by fistula, they are rarely dismantled by it" (8).

But this is a case of unrequited romantic love, from a significant other who constantly defers plans to marry while Mei is under psychiatric treatment, while the present article focuses on the caring love of *sneham* (although one can receive caring and romantic love from the same person and unrequited romantic love is a source of mental distress for many in India as well).

I did meet people in Kerala whose situation resembled that of Catarina from Biehl's *Vita*. They had been rejected by family and in some ways were abandoned although they were attended to in rehabilitation centres I visited in a way that took their humanity seriously. I could have focused on one of these individuals and depicted a case of abandonment similar to the case of Catarina. But most of the destitute mentally ill I met in Kerala were cared for or, in significant ways, developed a social connectedness that is highly valued by people in Kerala, which they refer to as *bandangal* in Malayalam. *Bandangal* refers to valued and loving or caring social connections. A literal translation would be "relations", but *bandangal* refers specifically to concerned and supportive social relations which can come from family and friends or a romantic partner and which are seen as necessary for a healthy and complete life.

Snehaveedu and Biehl's Vita are both psychosocial rehabilitation centres, though they are in very different parts of the world. Conditions in Kerala, with its communist social interventions and relatively robust social safety net, may be quite different from the context where Biehl worked in Brazil or from Chennai in South India where Cohen (2005) examined the abandoned and the "bioavailable" who were victims of the organ trade. This article does not so much challenge the claims of these studies as show other things that are also going on, although I would like to know how representative Catarina's experience is compared to others in rehabilitation centres in southern Brazil or other parts of the world.

There is a danger in promoting an anthropology of the good and of critiquing the Movement for Global Mental Health by pointing out what works well in mental health care in low-income countries. Following Robbins' suggestion risks romanticising human interaction and obscuring suffering, and, for this reason, I struggle with the terms I use to describe the encounters considered here.[10] It is difficult to name a situation where the individuals I describe in some cases recover or create something like a normal or satisfying life while others who have seen improvement – and are attended to and cared

10 Leo Coleman (2016) discusses the limitations of what he calls "vitalist" ethnographies that, in line with Robbins' proposal, follow stories of hope and caring while he also claims that Biehl does point out moments of hope and agency in Catarina's life.

for – are still abject and living in problematic relationships. These cared for individuals are not necessarily living a "good" or "happy" life. They may be struggling with adversity, but what is significant is that they are living a valued or vital life that includes *sneham* and *bandangal*. Because of the role I believe family involvement and care play in recovery, my analysis also risks romanticising the Indian family as an inherently nurturing institution when in fact, as elsewhere, abuse and abandonment occur in families of the mentally ill in India and family relations can contribute to the onset of psychopathology.[11] Still, I would argue that the taking in of and the interacting with mentally ill members by families in India has significant merits over the frequent lack of involvement in other localities, such as the United States, as we see in Tanya Luhrmann's (2007) work on "social defeat" among the mentally ill in Chicago who have lost connections to family and friends. While both situations merit improvement, this analysis of the role of family and loving relationships helps explain recovery from psychopathology and counters simple caricatures of the treatment of the mentally ill in low-income countries as abusive. Indeed, this work builds on other research that claims a significant role for family attitudes and involvement in explaining the favourable outcome in the WHO studies for people diagnosed with schizophrenia. Such research has considered family "support" and "expressed emotion" (which refers to the *lack* of expression of *negative* emotions toward the ill family members) but not love per se (Leff et al. 1990; Thara 2004; Warner 1994).

Benefitting from the serendipity that often accompanies fieldwork, I was led to consider caring love, or *sneham*, as a salient quality of family and other social relations by Father George Joshua Kanneeleth, who runs Snehaveedu, and by staff and residents at the centre. *Sneham* in Malayalam refers to the love between parent and child, husband and wife, friends, and other relations. Another term for love in Malayalam, *premam*, refers to romantic love, the passionate love of two individuals for each other – although some who share *sneham* also share *premam* for one another. Father George Joshua explained that what people like the residents of Snehaveedu were lacking most in their lives was love: that is, someone who is devoted or loving toward them, which could be but was not necessarily a spouse or romantic partner.

Scholars have examined the various meanings of love in South Asia, including, perhaps most prominently, work on the religious idiom of *bhakti*, which refers to devotional love for a/the deity. David Haberman (1988) considers *bhakti* in the context of a Hindu religious sect known as Gaudiya

11 See, for example, Marrow and Luhrmann (2012) and Kottai (2020).

Vaishnavism. "[L]ove itself" he says, "is identified as an aspect of the essential nature of God", and "[t]he desired aim of Gaudiya Vaishnavism is to participate (*bhakti*) in this aspect of God, defined as love or infinite bliss" (32).[12] *Bhakti* is thus often seen as a form of ecstatic devotion to the deity. This is different from romantic love and from sneham, mainly in the sense that the object of love is divine in one case and human in the others, but there are degrees of overlap including styles of romantic and parent-child love in expressions of bhakti. Love as *bhakti* is also transcendent, implying not just an exalted emotion but, in Haberman's terms, "infinite bliss". Love (*anpu* in Tamil) within the family has been considered as profound affective ties that emerge from slow habituation and are marked by ambiguity and paradox (Trawick 1990).

In her work with women in mental hospitals in northern India, Pinto (2011) depicts love and marital relations as central concerns for women diagnosed with serious psychiatric disorders and to the psychiatrists who treat them. "[P]ractitioners – doctors, residents, social workers, psychologists – read patients' lives for signs of illness by evaluating emotions related to marriage" (378), we are told, and they develop their treatment recommendations based on this. Although Pinto doesn't explicitly reflect on the differences between caring love and romantic love, these cases tend to focus on romantic love, the kind of love that can make one crazy, especially when gone awry, when it remains unrequited or when it results in divorce, as is the case for many of the women Pinto met. This kind of "crazy love" is commonly depicted in South Asian expressive genres: "in Hindu devotional, Sufi, and Urdu poetry, it allegorizes the lover to the devotee, while in Hindu mythology gods go crazy with love, just as people do" (386). Affective relations toward family other than the spouse is also important in the realm of psychiatric scrutiny and for the women themselves. This kind of love along with the love of parents for children is what is referred to as *sneham* in Kerala.[13] In Claudia Lang's work (2019) on surveillance and care in Kerala community mental health work, we see an emphasis on family care and *sneham* in the discourse of patients and healthcare workers. In fact, for junior health inspector Sanjeev who visited patients in their homes, "it was the disruption

12 See also Haberman 2003 and 2006 on *bhakti* and love.

13 In Sanskrit and North Indian languages, *sneham* or "oily love" is the love of the superior for the inferior: paradigmatically of parent for child, although also of guru for disciple and other relations (William Sax, personal communication). This may be the case in Malayalam as well though the hierarchy is less manifest. As in the North Indian context, parent-child relations are the epitome of *sneham*, but in Kerala, friends who are social equals speak of their relations in terms of *sneham* as well.

of caring family relations much more than the neurochemical imbalance in a patient's brain that was key to the etiology of depression, and therefore to its treatment" (600). Patients used Sanjeev's home visits to complain about and mobilise family care and attention. In one case, Sanjeev admonished a patient's daughter-in-law to treat her mother-in-law with "*sneham* and consideration" adding "[w]e can change a person only through *sneham*" (606).

Additionally, *sneham* has physiological connotations in the context of Ayurveda, South Asia's largest formalised, indigenous medical system. *Sneham*, or the prefix *sneha-* in this context, refers to an oily, lubricating substance such as that used in *snehapana*, a treatment where the patient drinks ghee in an effort to lubricate the body as part of the multi-phase *panchakarma* treatment used in ayurvedic treatments of psychopathology. Later, we will see this form of *sneham* also described as "lubricated affection" in the comments of an ayurvedic doctor who attends to patients at Snehaveedu.

It should be added briefly that it is not my claim that it is only in India that love is considered important to psychic healing. Luhrmann (2016) observed that Massachusetts Mental Health Center psychiatrist Elvin Semrad "took seriously Freud's dictum that psychoanalysis was a cure through love, and he taught that a doctor's ability to cure came from his ability to care". He also spoke of "'loving the patient as he is'" (12).[14] Chloe Silverman's study of autism in the US focuses on love as central to treating and caring for autistic children. She explained "I use 'love' because it is the term used by the people and found in the texts that I have studied" (2011, 3). Thus, like me, she was led by her informants to take love seriously in her analysis. But while the importance of love in healing is not confined to India, there is evidence, as will be discussed later, that people with whom those suffering psychopathology have affective ties are present more often at treatment centres and in the lives of the afflicted in India than they are in Europe and North America.

While the role of love is occasionally cited by researchers, this concept is usually left out of scholarship on mental health, according to Tjeltveit (2006), possibly because it appears unscientific and difficult to quantify. While psychological research points to "social" or "family" "relations", I would add that such generic labels elide the caring love, or *sneham*, that is key to the therapeutic power of those relations. In discussing psychological research, Tjeltveit says "love is too bound up with emotions, is too closely linked with religion, and slips too easily into sentimentality. Love, that

14 See also Good (2009) on Semrad.

is, is a topic that is not well-suited for a discipline that is, and should be, striving mightily and manfully to be a 'hard' science" (13).[15] The role of family involvement and love – often but not necessarily from family – is central to the following analysis of the experience of patients at a psychiatric hospital and community health centres. In this analysis, "love" is not always the explicit label for what is experienced, but love and caring interactions that recognise the ill individual as valued life (something more enhanced than Agamben's "qualified life") are arguably what makes family relations and support empowering or, to borrow an ayurvedic concept, "lubricating", and thus aiding in recovery.

Research Methods

As an anthropologist who focuses on cross-cultural approaches to mental health, I utilised methods that are typical of research in medical anthropology and ethnographic research in general. Thus, I undertook largely qualitative interviews with patients and with their family members who accompany them to clinics, and employed participant observation which involved observing everyday routines at healing centres. Research for this chapter was conducted in Thiruvananthapuram District in Kerala, India over nine months in 2013 and 2014. Fieldwork I undertook on treatments for mental illness and related problems in Kerala in the 1990s (Halliburton 2009) also informs the analysis. In Kerala in 2014, I conducted interviews and participant observation at an urban government hospital, neighbourhood state-run primary health clinics, and charitable psychosocial rehabilitation centres, all of which primarily use biomedical psychiatric interventions. I interviewed 43 patients with diagnoses of serious mental disorder, mostly schizophrenia, and I engaged in other forms of observation and interaction at these centres and other locales including interviews with healers. I attempted

15 Psychological research on "social" and "family" relations is so vast that it is not easy to quantify. Psychologists occasionally study love or loving relations, though this, as Tjeltveit (2006) says, is quite rare. He claims this is because of psychologists' ambivalent feelings about love as an analytic tool for research. There is a mystical sense associated with love that makes it appear less scientific, and it is difficult to measure objectively. One of Tjeltveit's concerns is Christian notions of love (rather than romantic/erotic love), which is fitting for this article since it is a Christian organisation, Snehaveedu, that invokes the importance of love more explicitly than the mental hospital. It is Jesus's mandate to love your neighbour and be self-sacrificing or altruistic that is reflected in Tjeltveit's analysis and in Snehaveedu director Father George Joshua's attitude toward the destitute mentally ill, as will be seen a little later.

to assess the degree and quality of family involvement in the lives of those being treated for major psychopathology by obtaining illness histories and inquiring into perspectives on recovery from patient-informants as well as from family members who accompanied patients.

My assistants, T. R. Bijumohan and Tintu James, and I interviewed in-patients at the Thiruvananthapuram Mental Health Centre, a large government mental hospital, and out-patients at this hospital and neighbourhood primary health clinics in order to speak to patients who were ill and individuals who were recovered or recovering. Informants whom we considered to be "ill" were those who were admitted to the hospital while those we considered recovered or recovering were out-patients at the hospital and community centres that psychiatrists identified as being recovered or much improved, and all of these informants were diagnosed with schizophrenia or bipolar mood disorder. I used the English term "recovered" with psychiatrists who used the same term to indicate patients they thought were doing well and were significantly functional. In some cases, as with Sreedevi presented below, patients appeared completely normal and signs of pathology were undetectable, but this was unusual. More commonly, "recovered" patients were able to live with family and work and have some quality to their life even if they did not feel fully normal or were not thriving. The out-patient health centres where we interviewed recovered individuals are known as "primary health centres" and "community health centres" and are part of a state-run network of community-based centres that dispense medicines and offer consultations for people with all kinds of illnesses.[16] Individuals with mental illness diagnoses who were living at home went to these centres to get their medications refilled and occasionally for follow-up consultations with psychiatrists, which were usually brief encounters oriented toward medication management. In addition, we visited three charitable, church-affiliated psychosocial rehabilitation centres which care for people who do not have family to whom they can return after hospitalisation.

Interviews were either semi-structured, enquiring about informants' illness histories and therapy-seeking experiences, or unstructured, addressing the same topics but allowing for more diversions into other areas of interest to the interviewee. Altogether 45 people with schizophrenia and related diagnoses (such as paranoid schizophrenia or schizoaffective disorder) and

16 For more on the network of health centres in Kerala and how their mental health workers constitute a network of care and surveillance of Kerala communities, see Lang (2019). This network can, and to some degree already does, operate as a conduit through which MGMH ideologies and practices are disseminated.

bipolar mood disorder were interviewed. I also spoke to doctors and other staff at the various centres about their experiences working with these patients and observed daily routines and intake sessions at the research sites. Interviews with patients were conducted mostly in Malayalam, the official language of Kerala, while interviews with staff were conducted in English.

Family, Care and Recovery in Kerala

One feature of the hospital where I conducted research that is striking compared to hospitals in the West and to the rehabilitation centre in Brazil studied by Biehl, is the presence of family members on the hospital grounds. Patients are usually accompanied by family members when they go for out-patient treatment, and in-patients are often visited by family or have family members staying with them at the hospital. The women's section of the hospital featured a "family ward" where, usually, mothers would stay with daughters who are patients or daughters would stay with mothers. In other words, a family member lives in this section of the hospital, in the same space as their in-patient relative and helps take care of them. Addlakha describes the same situation at a psychiatric hospital in Delhi, and for her it is not just the care and support of family that is important: "The presence of the family and the relative permeability between the ward and the outside world help in sustaining the social persona of the patient during hospitalisation, and consequently play a positive role in therapy as well" (2008, 110). This, she claims, helps patients in India avoid the "role dispossession" of Goffman's (1961) total institutions. Nunley (1998) examines the heavy involvement of families in in-patient and out-patient psychiatric care in hospitals in northern India in relation to the low level of family involvement in the US, and argues that this high level of involvement benefits patients. He also observes that family attendants in in-patient facilities in India provide assistance that is often provided by auxiliary staff in the US, such as feeding, bathing and maintaining medical records (by keeping prescriptions from previous treatments) for the patient. Nunley says that at the hospitals where he worked in Uttar Pradesh, each in-patient is required to have an attendant stay with him or her at the hospital, explaining that this arrangement "is a case of cultural expectations making permissible what the economics of health care makes necessary" (332). The economic pragmatism aspect is less present in out-patient care where Nunley and my research show that close to 90 per cent of patients are accompanied by family members. In this setting, they do not replace staff functions except for maintaining records,

and their attendance costs the family financially as transportation to health centres is the main economic burden on low income families seeking care. In the hospital where I conducted research in Thiruvananthapuram, there is no requirement for in-patients to be accompanied by an attendant, and the hospital appears to have the staff necessary for the auxiliary functions that are addressed by family members where Nunley worked. However, there are some wards at the Thiruvananthapuram hospital where families are allowed to stay with relatives – suggesting that family presence is due more to cultural expectations than economic expediency in this case.

In examining patient interviews, I found that the quality of a person's family life and family members' involvement in their relatives' care consistently relate to their degree of illness or recovery (as measured by the Global Assessment of Functioning, an instrument used by mental health professionals – see below). I propose that love and caring social relations are at the core of what is beneficial about family involvement in the lives of those diagnosed with serious mental disorder, and illustrate this with the following three sketches of patients, all diagnosed as schizophrenic, which represent a sample of the variety of family relations.

Hari

Hari was a 39-year-old Hindu man and a former teacher whom we interviewed while he was undergoing in-patient treatment at the Mental Health Centre in Thiruvananthapuram. Hari had a degree in electrical engineering, and said he was diagnosed with a mood disorder, a problem that, he explained, has been with him since childhood (though he was diagnosed as schizophrenic according to the staff and his chart). My assistant Biju and I interviewed Hari on the grounds outside the concrete cell block where he and several other male in-patients were staying during their hospitalisation. This was not a family ward like the one described earlier in a women's section of the hospital, but family often visited patients in this ward. When we asked Hari what bothered him most about his problem, he pointed to a lack of home and family life:

> Biju: What problem is bothering you most now?
> Hari: The problem that bothers me is that I have no home. That's my biggest problem: at home, in the home, there is no one. That I am living alone at home is my biggest problem.
> Biju: Are your father and mother still alive?

Hari: Not father, mother passed away. Father is alive. But it has been six years since I have seen my father.
Biju: What is the reason for being separated from your father like this?
Hari: With my father… I fought with my father.

Hari says he fought with his father about money and about his inability to work due to his "*vata* illness" – using a diagnosis from ayurvedic medicine, related to an excess of *vata*, one of the three *dosha*s or embodied essences of physiology. This seems to be a reference to his current problems, but it was not clear whether it may have been a separate health issue or something he had suffered from in the past.

Biju asked whether previously "You and your father had good relations [*snehabandham*]?", and Hari responded, "We did have good relations [*snehabandham*]." The term *snehabandham* in Malayalam translates as "good relations", but literally it means "loving relation/connection". Hari explained that he had two younger brothers who support him to some degree, but "they are staying aloof, saying that I have been coming and just lying around here, without trying to get work." The brothers brought him to the hospital, but now they are aloof, seemingly annoyed and dismissive of Hari, accusing him of being lazy.

Hari was experiencing changing moods, depression, and burning sensations in his body, and he heard voices, though he said the voices had recently receded. He explained that he has no future plans, and that it is hard for him to work because labour is painful for him and he doesn't have the mood for it. Hari was not doing well in terms of his functioning. Earlier he explained that he left teaching to work in security, "because of decreasing memory power and being unable to take any mental strain," since he felt security work was less demanding. He was hospitalised with incapacitating symptoms, and the quality of his family relations seemed to correspond to his moderate- to low-functioning state. His primary complaint about his current condition is what I am claiming is a major cause of the persistence of his affliction: his lack of a good relationship with his family. This was indicated by his estrangement from his father, the loss of *snehabandham*, and the lukewarm support of his brothers.

Satheesh

When we met Satheesh, a 47-year-old Hindu male, he was visiting Malayinkeezhu Primary Health Centre for follow up care. This centre was in a quiet,

tree-canopied neighbourhood away from the bustle of central Thiruvananthapuram in area well off the main road to the city. Just a handful of patients and staff are around at any time at the Malayinkeezhu Centre which is in striking juxtaposition to the out-patient clinic in the city's mental hospital that is regularly crowded with patients and their families.[17] Satheesh's life too seemed calm now, but he was diagnosed as schizophrenic and was hospitalised twelve years earlier at the Mental Health Centre where Hari was a patient. According to his chart, he was talking and laughing to himself at the time, he had little sleep or appetite, and he suffered from persecutory delusions. Satheesh seemed to us to be doing well, though, when we met him. He was very articulate, and it was hard to perceive anything wrong with him. He was doing "coolie work" he said, which refers to the occasional, general manual labour in which many working class and poor people in India engage, and he claimed he was doing okay economically. When we spoke to him, he also claimed he was not having any mental problems, either. "I am not as I was earlier. Now I am married. I have two children," he declared, emphasising that these were the main reasons for his improvement. He had a large, supportive family, but, according to the notes in his chart, this was also the case during his hospitalisation several years before his marriage.

As always, we asked if there were currently any issues at home with the family. With a nurse from the health centre joining our conversation, Satheesh responded by saying that all was well with his family. In response, Biju referred to sneham in his interpretation of how Satheesh explained his family relations:

> Satheesh: No such difficulties in home, no problem at all.
> Biju: Everyone is loving [*ellarumaittu snehamaittu*].
> Nurse: Did your relatives or someone inhibit you in some way or something?
> Satheesh: No, nothing like that. There are no such problems in the family.
> Nurse: Nothing like that.
> Biju: Who among the family is helping you more in connection with this problem?

17 Despite the quite different feel of the place, this primary health centre is connected to the Mental Health Centre hospital due to the outreach programme of the District Mental Health Programme (DMHP) which is based at the hospital and visits the primary health centres. In addition, the DMHP has placed a poster at the Malayinkeezhu centre informing the public how to identify and seek help for mental health problems. According to some in Kerala, such efforts reflect the effect of the MGMH although a direct connection between the Kerala DMHP and the MGMH is hard to establish. Certainly, their methods and ideology are similar.

> Satheesh: Well, I have a mother, a sister, an elder brother is there, then my wife, and his wife. Then I have my children. That's who is helping me. They are helping.

The nurse continued this line of inquiry:

> Nurse: When the problem started, who was the first person to come forward to take you to the hospital?
> Satheesh: That was my father and mother.
> Nurse: After that…
> Biju: Who is caring (*paricharikkunnathu*) for you the most? Caring for you the most?
> Satheesh: It is my wife who is doing the most caring.
> Biju: Because of your problem…
> Satheesh: Then, my sister, mother and elder brother are looking after me well.

Satheesh was dismissive about his problem, claiming he did not have an illness at present, not as if he were in denial about his diagnosis, but casually, as if he no longer had concerns about his state of mind, that he felt stable and content. He was not accompanied to the health centre by a family member. This may have been because he was in a good state of mind and this was a routine follow up visit, with him no longer needing family support to stop into the health centre for this purpose which usually amounted to just picking up a prescription renewal. He said that he had "kutumbatthil santhosham" or happiness in the family, and Satheesh was one of the most completely recovered interviewees we spoke with. It was hard to detect anything unusual about his affect or demeanour, and Biju told him he didn't seem to have any illness at all. He had come a long way from in-patient care with a diagnosis of schizophrenia. Satheesh also reported one of the most supportive families of any person we met, where a great variety of relatives were involved in his care, and it is caring family relations that Satheesh, Biju and the nurse mobilised as an explanation to account for Satheesh's recovery.

Sreedevi

Sreedevi, a 44 year-old Hindu woman we met at the Mental Health Centre's out-patient unit, also seemed completely recovered from schizophrenia. She and Satheesh may represent the kind of patient that make the WHO

studies of schizophrenia intriguing. Complete recovery, in the sense of being not just merely functional and staying out of the hospital but highly functional, symptom free and even thriving, is usually considered outside of the realm of possibility in North American medical and popular discourse on schizophrenia, but both individuals were highly functional and it was not possible to detect any sign of pathology.[18]

Sreedevi was hospitalised in 2002 in the Mental Health Centre, and at the time she was running about, screaming, exhibiting *bahalam* (boisterous behaviour), and hearing voices. Her husband's family beat her for acting this way, she recalled. While she said her problem was exacerbated by her husband's family beating her, she didn't explain what she thought was the cause of the original onset of symptoms. Both her father and mother helped a lot with her struggles with her illness, and, she claimed, did everything for her, but her husband did not help at first. She said she has been working in a variety of manual labour positions for the last ten years, including working as a maid for other families and as a day labourer for a community programme. When we enquired into her views about her future and her prospects for her work life going forward, she explained that she is a workaholic who works hard out of fear of becoming "sad" – a reference to a possible return of her mental troubles – if she doesn't.

Sreedevi's demeanour seemed completely normal to Biju and me when we spoke to her, and she was hospitalised only once, for a week, fourteen years ago. With all other patients we spoke to who had schizophrenia diagnoses, even if they were significantly recovered, we could detect some atypical affect or interaction in our conversations, but with Sreedevi, as with Satheesh, there was no hint of a past episode of psychosis. She has been coming to the Mental Health Centre outpatient unit every couple of months for follow up treatment since her hospitalisation and is still taking medications. She recounted as well that she helped others in her community with similar problems by talking to them about her experience and guiding them to the Mental Health Centre when necessary. When I asked specifically what helped

18 The Mayo Clinic website, for example, describes schizophrenia as a chronic condition requiring "lifelong treatment" (2018) and does not discuss the possibility of recovery. Yet Hopper, Harrison, and Wanderling (2007) say that over half of the subjects followed up in the ISoS, the latest follow up to the WHO studies, at all of the research centres were "rated as 'recovered'" (27) suggesting a general course of improvement in this diagnosis in most settings over the long run. When I report to people in the US that I interviewed patients in India who had recovered from schizophrenia, their most frequent response is that they thought one could not recover from this illness. However, the "recovery movement" in the US claims a greater potential for change for people with serious mental illness (Arenella 2015).

her recover, she said it was because of "my husband's *sneham*". Her husband eventually came around to her side, and he was able to cut off ties with his family because of their abuse of Sreedevi. Her supportive parents and the caring love[19] of her husband who dissembled at first, perhaps because of not wanting to be in dispute with his natal family, seemed to have aided her recovery. Sreedevi's case is intriguing given Kottai's (2020) observation in his work in Kolkata that mistreatment by in-laws was a common cause of women becoming homeless and being deemed mentally ill.

These sketches illustrate the role of family support in general as well as specific claims regarding the role of love/*sneham*. These two factors are hard to isolate from one another, and I am assuming that love, or the caring love that is *sneham*, is a key element of family support. Certainly, pragmatic, financial and other aspects of family support are also crucial to maintaining stability or achieving recovery, and these can be part of *sneham* as well. These sketches represent points on a continuum of family involvement and degrees of illness and recovery I observed in my interviews with patients at the Mental Health Centre and the community health centres. I also used the Global Assessment of Functioning (GAF – from *Diagnostic and Statistical Manual of Mental Disorders IV-TR*) to score those patients with schizophrenia diagnoses for whom there was sufficient data to do so: there were nineteen such patients in all. I also evaluated the quality and degree of involvement of family in patient care on a scale from 1 (lowest) to 5 (highest). Quality of family involvement scores strongly correlated with GAF scores of patients ($r=0.8687$) such that the higher the degree and quality of family involvement the higher functioning the informants were, and these results were statistically significant ($p<0.001$).[20]

While there is a correlation between the quality of family involvement and the level of functioning of people diagnosed with schizophrenia in at least one niche of southern India, this does not tell us whether there is more family involvement in India than in Western/Northern countries, which might help explain the differences in the WHO studies on the course of schizophrenia mentioned earlier. There are, however, many indications along these lines in the research literature. Kallivayalil et al. report that an "important difference in which India differs from the West is that [in India] more than 90% of the patients of schizophrenia stay with their families" (2010, 39), by which they mean patients live with their families. In the US, by contrast, people with

19 This illustrates how *sneham*, caring love for the other, more than *premam*, romantic love, is operative in recovery, though both may be present in this relationship.

20 More details about these results and how work lives correspond to functionality and recovery will be published in a separate article addressing a clinical audience.

schizophrenia diagnoses often live alone and, increasingly, in prison (Prins 2014). Sartorius et al. mention that in the WHO studies, the Aarhus, Denmark site had one of the highest percentages of people with schizophrenia living alone, with 35 per cent, while the percentage of people with schizophrenia living alone in the India sites, Agra and Chandigarh, was "virtually nil" (1986, 916). My research assistant Tintu James, in her Master's thesis on mental illness in Thiruvananthapuram, shows that among out-patients at community clinics and psychiatric hospitals doing follow-up outpatient care, 93 per cent were living with family and 87 per cent were living in joint, as opposed to nuclear, families (2013, 33-34). The majority of these patients were diagnosed with severe mental illness (schizophrenia, bipolar mood disorder, or psychosis) (ibid., 37). Reviewing the Indian psychiatric literature, Addlakha says that several studies claim "to show the lower prevalence of all types of mental disorders in the joint family, accounting for it in terms of the greater social, economic and moral support provided by this type of household to its vulnerable members" (2008, 101). Ethnographic work by Luhrmann (2007), Brodwin (2013), and Myers (2015), meanwhile, indicate that people with serious psychopathology in the United States have little connection to family. Additionally, providing a comparison between India and the US, Nunley says that the problem of where the patient will go after hospitalisation which is "so critical in the practice of acute psychiatry in the United States, essentially vanishes in India, where it is taken for granted that the patient's family will continue to care for the patient" (1998, 334). In a study of a mental health clinic in the US, Myers says that "most members [referring to patients] had lost touch with their families after various kinds of problems – arguments over alcohol and drug habits, legal problems, homelessness, and so forth" (20). This is rare among patients in India. Hari was estranged from his father, but had not lost touch with his family and had some involvement with his brothers. Health centre staff regularly showed me patients' charts when I was conducting interviews, and of all the patients my assistants and I spoke with, there was only one whose chart listed no family contacts, a woman who had the lowest level of functionality of all of the patients we met. Normally patient charts report mobile contact numbers for several family members, even among those who have strained relations with their families.

Snehaveedu: The House of Love

Snehaveedu is one of many psychosocial rehabilitation centres established in Kerala in recent years, partly in response to a Supreme Court mandate to

increase the availability of resources for the mentally ill. These centres are mostly Church-run, charitable organisations that are licensed and monitored by the state government and care for the few individuals who are not able to return to family after leaving in-patient mental health treatment. I visited two other centres, Menni Family Home and Divy Shanti Ashram, but spent far more time at Snehveedu, which means "House of Love" or "Love Home". While "sneha" refers to love, "veedu" means house or home, and this "veedu" provides an illustrative counterexample to João Biehl's "Vita" (which means "life", 2013[2005]) in terms of the quality of relations between people with mental illness diagnoses, their caregivers, their families, and their social context.

Snehaveedu is a project of the Malankara Syrian Catholic church, one of the many constituents of Kerala's large Christian community which dates back two thousand years. Christianity is not a colonial import here, although European colonisers did bring their own styles of Christianity to India starting in the 1500s, and the Syrian Catholic church, as the name implies, is a hybrid of a sect that dates to the first century and a European liturgy brought by the Portuguese in the sixteenth century. Snehaveedu takes in the destitute mentally ill who have no homes to go to or whose families are unable to care for them. Since, as reported earlier, 80 to 90 per cent of people in India with serious psychopathology live with family, institutions such as Snehaveedu are not a primary recourse for the mentally ill but a refuge for those few who have no other place to go.

As a form of psychological and work rehabilitation, residents of Snehaveedu partake in animal husbandry, gardening, and the maintenance of a self-sustaining, ecological system that provides food, water, and fuel for the institution. Residents also pray and eat together, and they are taken to the Mental Health Centre once a month for follow-up assessments; but Father George Joshua Kanneeleth, who runs Snehaveedu, and a college student I will call Suresh who volunteers and lives with the residents, emphasised to me that the key thing that is missing in the lives of their residents that their institution offers is love. "For this rehabilitation process," Father George Joshua explained, "love is the best quality", and he added "quality is better than qualification", explaining that the capacity to be loving and compassionate is more important for rehabilitation than professional expertise. Father George Joshua referred to Snehaveedu residents as his "mukkal", his children, and spoke of his "affection" for them. One does not generally hear this kind of language from psychiatric staff about their patients, even though some hospital staff have been described by patients as caring or loving. One exception comes from a hospital social worker who explained

that when she has success with a patient, it's because of "the love I have for the person across the table." Father George Joshua added that "[t]hose who are working here, my staff, they should have affection as a mother or a father with these people. He [a patient] may be [like] my brother or my father or my sister. Likewise, such kind of family affection we should have".

As per government regulations, the staff at Snehaveedu brings the residents to the Mental Health Centre hospital once a month for evaluations. While psychiatric follow-up is done at the hospital OP by a biomedical practitioner, weekly general health check-ups at Snehaveedu are provided by doctors of Ayurvedic medicine, since state regulations allow psychosocial rehabilitation centres to utilise Indian systems of medicines for regular health maintenance. Father George Joshua is a supporter of Ayurveda and its supposedly gentler methods of treatment, and while I was doing fieldwork at Snehaveedu, he organised a seminar to train rehabilitation workers from all over Kerala in Ayurvedic methods of mental health care.

Father George Joshua explained that Snehaveedu was established after a cardinal from his church saw a mentally ill man wandering in the streets, and decided the church should open a home for the destitute mentally ill. Father George Joshua took on this project, and in addition to receiving patients who are discharged from the mental hospital who do not have family they can return to, Father George Joshua brings in mentally ill individuals he finds wandering in the streets. Father George Joshua explained that when they bring someone in this way:

> After bath and cleaning, after cleansing, we give food and an embrace, and immediately half of the problem is gone away. We just take the patient from the road and within hours, without medicine, half of the problem is [...] It is because of the care and protection.

Regarding his approach to the needy and homeless, he added, "I want to see the face of Jesus in that man," and he recalled how he encountered a destitute man on the streets who was angry and aggressive. Father George Joshua kissed him and touched his feet, which, he says, transformed the man. Summing up his attitude, which acknowledges a role for medication, he said "Care and protection is the important thing. We need medication. At the same time, we need care, protection and affection for these people. If we are affectionate, they are very genuine." Care and affection are ways of enacting the kind of love that is referred to as *sneham*. It is these characteristics of emotional and embodied relations, rather than specific therapeutic techniques, that is emphasised here. Caring, affection, and *sneham* are not

methods developed by the logic and empiricism of a researcher, but are a calling of this member of the church who follows Jesus's model of caring for the marginalised when he attends to people who experience mental suffering.

Several residents of Snehaveedu whom I spoke to reflected the Father's perspectives on love/sneham. One resident identified a lack of love in his life as his chief concern, using the English term "love" while speaking in Malayalam: "My biggest problem is 'love.' […] It is 'love' that I'm lacking". Another resident emphasised the curative power of love at Snehaveedu, "Here they are giving food at the right time. Also, sisters [nurses] give medicines at the right time. Also, they love us [*avar nammale snehikkunnundu*]. Even if we didn't get any food, their love [*avarute sneham*] is enough for the cure of the disease. […] This place is called 'Snehaveedu', right? So there is a lot of love here." Timely food and medicine are seen as a critical part of a health regimen in south Indian society. These are stressed here, but love supersedes in this assessment. The psychiatrist who sees the Snehaveedu residents once a month for mental health evaluations, although he did not use the term "love", praised the caring environment at this rehabilitation centre. At a meeting with me at the mental hospital, he explained, "The acceptance by the officials there, by the people who run Snehaveedu, is more than or equal to that of a family member. They actually give them all of the support. They actually treat them with compassion. They never feel … I have never seen that they are actually looking at them as a patient."

Connections between illness, healing, and love were made in other contexts, outside of Snehaveedu and patient discussions of their families and illness experiences. In 2014, I visited a church in Thiruvananthapuram that, during earlier visits in the 1990s and early 2000s, had served as a place of healing for people with mental afflictions. In 2014, this was no longer the case according to Father Verghese, an official of this church who said that people with mental health problems are now directed to the local mental hospital. This may be the result of efforts by the Kerala or Indian government and the MGMH to direct people suffering psychopathology from religious centres to "proper" treatment at biomedical facilities, efforts that have led to the discontinuation of religious healing practices elsewhere in India (Sood 2016). While Father Verghese felt that sending people to a mental health facility was appropriate, he also thought that the biological model emphasised at such places was limited. He felt that people with mental health problems are reacting to their environment and explained that what they really need is support and love. This shows how MGMH-style changes may be steering patients away from places, such as this church,

that emphasise *sneham*. The notion of *sneham* has also been invoked in patients' descriptions of the staff at the Mental Health Centre and of an ayurvedic practitioner who specialises in treating psychopathology. In an interview I conducted in the 1990s, a patient referred to the talk therapy she received from this Ayurvedic psychiatrist as "loving". "[H]e talks a lot," she said and added, "I get relief from his talk itself" and "his talk is very loving."

In addition to the notion of caring love, *sneham* also refers to an embodied, tangible substance. According to Osella and Osella's (1996) work on *sneham* in Kerala, there are two key aspects of the concept of sneham: "*sneham* as love, concrete demonstrations of care which make social relations run smoothly" and "sneham, as a cooling and lubricating fluid within the body, [which] is critical to good health" (38). *Sneham* is thus necessary for good social relations and for general health. *Sneham/sneha-* is also a term in Ayurvedic medicine that has implications similar to the second of these two definitions. Dr. Bindu, an Ayurvedic physician specialising in mental health who sees patients at Snehaveedu, explained, "*Sneham* means, it's not rough. It's a lubricated affection; it's not a rough affection. When we are talking to a patient with *sneham*, communication becomes more lubricated."

Sneha(*m*) in Ayurveda refers to unctuousness, an oiliness in the body or a lubricating substance used in clinical treatments. One such treatment is *snehapana*, which is administered to patients at Kerala's Government Ayurveda Mental Hospital (GAMH), in Malappuram District. *Snehapana* involves drinking ghee (clarified butter) in increasing quantities over several days in order to lubricate the body. According to Dr. Abdu of the GAMH, this lubrication helps move "impure substances" to the alimentary canal and then to the stomach and intestines during a sweating treatment (*svedana*). Then through *vamana* (drinking a substance to induce vomiting) and *virechana* (taking emetic medicines), two other steps in a regimen that includes *snehapana* and is known as *panchakarma*, these substances are expelled from the body through vomiting and purgation of the bowels. Thus, the lubricating effects of this *sneha-* therapy help remove impurities and detoxify the body. Another step in *panchkarma* used at the GAMH is the administration of *snehavasti*, an unmedicated oily enema which is administered on alternate days, with *kashayavasti*, a medicated enema, administered on the other days.[21]

Perhaps we could say that *sneham* is something like a bio-social lubricant that through affection and caring prepares the body and mind for recovery

21 For more on Ayurvedic treatments for mental illness in Kerala, see Halliburton (2009) and Lang (2018).

among those diagnosed with serious mental illness. That is, *sneham* as caring love may activate *sneham* as tangible substance in the body, although no one I spoke to made this explicit connection – and I did not ask about it at the time. In her fieldwork with a mental health outreach worker in Kerala, Lang (2019) interprets references to *sneham* among patients as lubricated affection, and considers the potential connections between Ayurvedic treatments that lubricate the body and love as *sneham*: "Although Ayurvedic psychiatrists did not talk explicitly about snehapana in relation to the physio-social notion of sneham as love, these concepts might be related and further studies are needed to explore the relationship of snehapana to Malayali concepts of bodies, morals, care and well-being" (607).

While this idea of *sneham* as lubrication may help explain how, along with care and affection, it enables recovery, what is equally significant is that these cases of love and caring show how people in this low-income setting treat vulnerable people as qualified, even valued, life and have seen success in recovery from diagnoses thought to be intractable. Individuals diagnosed with severe mental illness that my assistants and I met in Kerala have regular, significant social interactions with family, other patients, mental health workers, and volunteers, some or much of which is marked by *sneham*. For those who are abandoned by family (or whose families cannot take care of them), the slack is often taken up, at least in Kerala, by others such as the staff and the community of residents at Snehaveedu and other similar institutions.[22]

Concluding Remarks

The Movement for Global Mental Health – like the WHO mhGAP programme and, to some degree, the Government of India – has declared India a place of deficiency and abuse in terms of its mental health care and vowed to "save" it from these problems. The findings of the WHO studies of schizophrenia should however make us ask what places like India, with its especially high recovery rate, are doing right, and apply whatever that is in places that are not doing as well, such as the United States. The involvement of family and of caring love/*sneham* are areas to investigate further about what is going right and should give pause to claims that mark India more as a place that

22 This may be less common in other states. Davar (2012) claims that Kerala has more psychosocial rehabilitation centres than any other Indian state, even though it has a lower population than most states.

is abusive or neglectful toward the mentally ill than as a model for caring relations toward those suffering mental distress. Similarly, Nunley, writing before the advent of the MGMH but concerned about Indian psychiatrists he met trying to emulate psychiatry as it is practiced in the West, asked "whether in this case the emulation ought not to be running in the other direction" (320) – that is, whether the involvement of families in Indian psychiatry ought to be emulated in the US and Europe.

This study also directs anthropological attention to caring relations by foregrounding the role of a certain kind of love among family and non-family members who attended to destitute people with serious psychiatric diagnoses, treating them not as bare life but as qualified, vital life. We should not ignore abuses that occur in the treatment of the mentally ill, whether in India or anywhere else. Nor should we neglect cases of abandonment in developing what Robbins calls an "anthropology of the good." But as Robbins says, we should also find space in our evaluations of human endeavour to attend to "the ways people come to believe that they can successfully create a good beyond what is presently given in their lives" and we should resist the "strong temptation to dismiss people's investments in realizing the good in time as mere utopianism" (458). Both "the abandoned" as ethnographic subjects in anthropology and "the abused mental patients" presented by advocates of the MGMH can be regarded as examples of what Robbins calls the "suffering subject." If we focus primarily on such subjects, we may miss much of what is salutary about human interactions, even if we feel compelled to recognise, in the spirit of the Foucauldian critique (raised earlier in Rabinow and Rose's critique of Agamben) that positive and caring relations can be confining and also create constellations of power. While there is surely some truth to this Foucauldian perspective, it would ultimately reduce love to power relations and overlook its potential as transformative and as aiding recovery. As pointed out earlier in reference to Tjeltveit (2006), it somehow feels "unscientific" to operationalise love as an analytical category or as a variable in studying clinical outcomes. While the present foray into the role of love is somewhat preliminary, it may help us to take more seriously the role of love in the lives of the mentally ill. It seems indeed to be associated with significant improvements in the lives of those suffering from psychopathology, even if many still experience stigma, second-class status within the family, and other kinds of adversity.

Like the MGMH and WHO's attempts to "save" the mentally ill in developing countries, the focus on saving, or lamenting, suffering subjects may preclude an opportunity to learn from others. Indeed, the point of Robbins' provocation was to revive anthropology as cultural critique, in the sense

of using other cultural experiences to critique one's own assumptions. The explicit valuation of love in recovery from the perspective of healers as well as people diagnosed with mental disorders in Kerala may contain lessons for improving mental health care elsewhere in a way that goes beyond explicit clinical techniques and interventions.

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