How centres of faith can help provide better mental healthcare in India

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How centres of faith can help provide better mental healthcare in India

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Not just clinical models, values and approaches in healthcare also need to be scaled up, say mental health experts.

Image credit: Manpreet Romana/AFP

The calming melody of the *nadaswaram* interspersed with the beat of the *mridangam* rose from outside the sanctum sanctorum of Vishnu in the famous temple dedicated to the Hindu god in Gunaseelam, a village in Tiruchirappalli district of Tamil Nadu. A visibly disturbed woman, perhaps diagnosed with psychosis, was speaking to herself or to the voices she heard. She seemed agitated by the auditory hallucinations, somewhat angry at what they had to say, and yet, strangely comforted by her environment.

Another woman seemed rather sad and withdrawn, displaying a "negative effect" – a classic symptom of depression. Her attention focused sharply on a picture of a god that she believed had the power to heal. Meanwhile a young man was pacing up and down the courtyard, as his father looked on, hopeful that the visit to this shrine would help.

The non-judgmental environment of the temple welcomed everyone regardless of demeanor, attributes and character traits.

The Gunaseelam Vishnu Temple has an attached mental health rehabilitation centre, visited by psychiatrists. The deity itself is believed to have healing powers. It is of little wonder then that people from different parts of the state pay obeisance to this deity.

This is a space where patients with mental illness who cannot afford private care receive acceptance, a therapeutic community in the temple and an empathetic listener in the gods.

Scientific and experiential evidence suggests that faith can have medical gains. God stands as a symbol of hope for a better future, an escape from the inflictions of the mortal world and a means to navigate through hard times in life. Faith somehow externalises the problems of the body and brain to someone or something bigger.

The flipside

Unfortunately, where there are those seeking healing in faith, there are others who are willing to exploit them. Commercialisation of the experience, indirect encouragement of abandoning the ill, physical and sexual coercion, stigmatising and grossly inappropriate rituals like whipping and chaining that infringe a person's dignity and human rights are common.

It takes two sides to leverage the positive effects of a non-condemning community – consent and interest of the person in distress as well as the discerning, proactive and detailed engagement of the caregiver, whether an individual or an institution, such as a temple, dargah or church.

Centres like Gunaseelam that offer medical care along with a spiritual experience include the Dava-Dua programme, which, as the name suggests, recommends medicine as well as prayer for treatment. In Tamil Nadu, it operates out of the Erwadi dargah in the Ramanathapuram district. For years, people with mental illnesses would come to the dargah as the saint was believed to have the ability to perform miracles. In 2001, however, a fire broke out at the premises, killing about 30 mentally-ill patients who had been chained. In 2012, the government, under the District Mental Health Programme, replicated the Dawa Dua approach so that psychiatrists could visit the dargah and supervise the treatment processes.

These are among the several models of care that are available to those who experience mental health emergency situations or *manasusoruvu*, a Tamil concept indicating sadness or distress coupled with listlessness.

Holistic approach needed

In India, people with severe and common mental disorders typically go to primary health clinics or District and Psychiatric hospitals and Nursing homes that offer anti-psychotics, mood stabilisers, anti-depressants, a diagnosis, and, if you're lucky, basic counseling services.

While this is a good start, the government's District Mental Health Programme should ideally also account for predisposing, precipitating, perpetuating and protective factors. Instead, the system resorts to a one-size-fits-all treatment regimen focused on demonstrable results and scale.

Mental healthcare relying on laboratory precision and randomised control trials alone may not always be appropriate, especially when a system aims for greater public good and effective translation in the real world.

Take the example of Radha, an Irular from a tribal community in Tamil Nadu, who belongs to a culture that is not bound by social conventions or stereotypical gender roles – here, women drink like men, and instances of husband- and wife-beating are equally common.

And yet, she experienced a deep sense of inadequacy and despair owing to her inability to fulfill her social role as a mother after she was unable to conceive. She had several physical and verbal altercations with her mother-in-law and alcoholic husband. To worsen things, the floods last year destroyed all of her family's meagre property, spiraling them downward them into abject poverty.

Radha's sleep and eating patterns changed. She experienced a sense of hopelessness, fatigue and fear – classic symptoms of depression and perhaps, trauma. Her mood dipped over a period of two years, with the loss of her thatched hut in the floods, perhaps, making her depression more intense.

Were her symptoms a reflection of neural activity and related psychological distress or an outcome of her social context and critical life events?

Radha's stressors are multi-dimensional. Her greatest stressor might well be living in a globalised world while still engaged in traditional vocations like catching rats, snakes or occasionally fish and living in a settlement far removed from the upwardly mobile majority.

Psychologist and educator Abraham Maslow postulated that in order to self-actualise and achieve one's fullest potential, one had to move up the ladder of structure and safety, seeking orthodox measures of conventional housing, family, work and experiences of belonging.

However, for someone like Radha, the pursuit of these prodigious goals in the background of social change, oppression and deprivation can be formidable. Disconnected literally and metaphorically from a form of development that the world has embraced but is not entirely immersed in, people from Radha's social strata could experience a deep disaffiliation with society. Additionally, moving away from core tribal cultures into states of flux could further disempower women.

It takes an astute and engaged clinician to treat Radha by understanding her family,her social history, childhood and adolescent experiences as well as her support networks, instead of merely prescribing medicines and arriving at a label or diagnosis.

Prescribing anti-depressants as a first line of treatment or using cognitive remediation to change a mentally affected person's thinking maylead the person to believe that he or she is responsible for the distress. While both methods are useful in many contexts, over-reliance may hold those who are victims of structural violence to feel further liable for their own pain.

In Radha's case, facilitation of social care resulting in access to employment and meaningful activity, social support or peer group bonding and perhaps a disability allowance helped reduce her distress.

Beyond neurology and psychology

Between 10% and 15% of most populations are diagnosed with depression. Factors include dissatisfaction with life, deprivation, loss of support networks and a sense of alienation. However, both in India and the world, most solutions remain focused on the biomedical and psychological, seldom with social or sociological causes.

Besides the District Mental Health Programme, India boasts several other mental healthcare approaches that works on the support of the community and volunteers. The Janamanas project run by Anjali, a mental health organisation, in Bengal anchors its outreach around sensitised community members.

The Mental Health Action Trust has a panchayat and volunteer-driven programme in Kerala. The NALAM approach run by the Banyan, relies on community-level social activists –often people who themselves have experienced distress – to promote psychological health and social care through local support hubs.

Optimal health services are needed before one can advocate for nuanced healthcare. But essential to mental healthcare is cultural humility, along with an awareness of the complexity and individualised narratives of mental disorders and related non-linear causal and behavioral patterns. Perceptions of mental illness must account for the sheer plurality of human experience, uniqueness of individual life trajectories and the social ecology of behavioral health.

This is why a Gunaseelam temple exists and is as sought after as a clinic or for that matter, a NALAM worker. People in distress seek solutions in medication, companionship, therapy, work, creative pursuits etc. An ideal mental healthcare system should therefore be open to diverse perspectives that promote personal recovery and integrate multiple approaches be it social, biomedical, psychological and spiritual such that users and their caregivers can choose the most appropriate. Thiswould allow individuals and communities greater investment and control over their own mental healthcare regimens. And isn't that experience of autonomy and participation in one's well being a first step towards positive mental health!

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