OF HEALING, PATHOLOGY AND SPIRITUAL EVOLUTION: REVISITING DEBATES ON POSSESSION AND TRANCE

Dissertation submitted to Jawaharlal Nehru University in partial fulfillment of the requirements for the award of the degree of

MASTER OF PHILOSOPHY

DIVYA PADMANABHAN

Centre for the Study of Social Systems

School of Social Sciences

Jawaharlal Nehru University

New Delhi 110 067

India

2010

जवाहरलाल नेहरू विश्वविद्यालय
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI 110 067

Centre for the Study of Social Systems
School of Social Sciences

Tel. : 26704408
Fax : +91-11-26742539

Date: 21July, 2010

CERTIFICATE

This is to certify that the dissertation titled **"Of Healing, Pathology and Spiritual Evolution: Revisiting Debates on Possession and Trance"**, submitted by **Divya Padmanabhan,** in partial fulfillment of the requirements for the award of the degree of **MASTER OF PHILOSOPHY** is her original work and has not been previously submitted for the award of any other degree of this or any other University.

We recommend this dissertation to be placed before the examiners for evaluation.

S. Visvanathan

Professor Susan Visvanathan

(Chairperson)

Chairperson
CSSS/SSS
Jawaharlal Nehru University
New Delhi-110067

H. Naraindas

Dr. Harish Naraindas

(Supervisor)

Associate Professor
Centre for the Study
of Social Systems
School of Social Sciences
Jawaharlal Nehru University
Delhi

Acknowledgement

The process of writing a dissertation has been both a learning as well as an enjoyable experience for me. The best part of writing on healing and possession was that I got to learn something from almost everyone I spoke to. The discussions ranged from narrating personal experiences to questions why I chose such a topic. For permitting me to choose a topic such as possession and to examine it from the vantage point of healing, I would like to thank my supervisor Dr. Harish Naraindas. Throughout the process of writing the dissertation, he has given me freedom to express my positions and arguments in the manner I chose to do so. Further, he has also helped me to conceptualize and locate my research problem, for which I am extremely grateful. I am also thankful to other faculty members of CSSS, specifically Sujatha Ma'am for giving me sufficient time and opportunities to discuss my topic with her. This enabled me to further reflect and analyze my topic. I am also thankful to Pathak Sir, for his support and encouragement.

It was during my college days at St. Xavier's, Mumbai that I was first introduced to sociology and anthropology. The seminar papers and debates at the sociology department at Xavier's encouraged me to pursue research. I am thankful to Sam, Fr. Frazer, Madhuri Ma'am, Vinita Ma'am for their encouragement. I am specifically thankful to Fr. Arun for introducing me to readings on ethnography which continues to interest me till today and Dr. Eddie Rodrigues for a number of discussions which taught me to think, analyze and more importantly forced me to write my arguments and positions. A few of the arguments in this dissertation have infact been the outcome of some heated discussions with Eddie over the past two years.

In the course of writing my dissertation, I received feedback and suggestions from Bhargavi Davar. I am very thankful for her suggestions and comments. I would also like to thank Bo. Sax for encouraging me to discuss my ideas with him and for helping me narrow my research topic. Another interesting and a learning experience was a short term course at Chennai conducted by Banyan Academy for Leadership in Mental Health, which gave a purview of the existing debates in the field. I am thankful to BALM and specifically to Madhu for her interventions and suggestions.

Much of what I have learnt in the past two years is the product of numerous discussions and debates I have had in this campus. I would like to thank my theatre group SEHAR for supporting me during tough times and for encouraging me to think about a performative aspect towards healing. I would specifically like to thank Mrityunjay and Rikimi for their constant encouragement and support. I thank Suvrat for introducing me to the joy of acting and what he calls the ayurvedic approach to acting! My hostel mates and classmates have helped me in varied ways, from suggestions to criticisms, and at times doing my other work so that I could concentrate on my dissertation. I would like to thank, Amrita, Swati, Srirupa, Bhakti, Vasudha and Ashok for their support and I am also grateful to Sneha, Parineeta Swati di, Nidhi, Sindhu and Ruchi for helping me at many points. I am thankful to Rafi, Renu and Vibha for helping me to articulate my positions clearly and helping me. Thanks to Cheri, Khalid, Manoj, Pranali and Uma for being around.

I express my deep gratitude towards Avinash and Gunjan who were the first people I met when I came to JNU and for the amazing four years of friendship and interaction. For helping me with my dissertation at a short notice, I am indeed grateful to Annavaram and Susrita who responded quickly and efficiently. Thanks also to Samar for the innumerable discussions on my topic and on politics. Thank you for patiently and laboriously reading, critiquing every chapter of my dissertation and most importantly helping me learn to write a dissertation.

I am thankful to Jatin and Ravi for the years of friendship, shared experiences and their unclinching support. I thank them for enriching my life and all the wonderful moments we have had together. I would like to thank my parents for encouraging me and consistently assuring me that I would be able to write a decent dissertation.

To all those who stood by me in times of need and whose lives I have invaded unhesitatingly, I owe them a lot. Mrityunjay for his quiet support, patience and for listening to my cribbing, Samar, for bearing the brunt of my idiosyncrasies and lack of patience and yet without any hesitation having stood by me at all times and Shadi for helping me handle crisis, for the rich discussions and being there whenever I needed her.

The errors and limitations however are my own.

CONTENTS

Chapter I

Introduction.

An analysis of the debates on possession practices indicate that the non-western 'other' still continues to hold an important place in anthropological writings. That anthropological writings on possession should largely focus on non -western societies, or describe possession rituals among the marginalized, Diaspora or minority communities in the west, is ironical given that the devil and the demonic has been an important concern of western societies as well. Nonetheless, possession seems to be relegated to the non-western, traditional societies while modern western and thereby 'rational' societies have successfully managed to address their concerns through other means. Thus for instance, modern, western societies relate to other 'entities' in the form of energies, vibrations etc through the intervention of an expert medium. The ability to 'tune in' with an external entity is consequently a step towards spiritual growth.

Importantly, not only have studies posited a distinction between possession and trance, and similarly between religion and spirituality, these distinctions are also embedded with meanings of growth and progress. Thus to rise on the civilization scale would mean a transformation from being traditional to being modern and thereby a transition from possession to trance. Further, such a civilizational model is supported by constructions of rationality, normality and functionality which enable the formation of not only a singular, fixed notion of growth but also a fixing of the notion of possession itself. The scale of civilizational progress however, would not have been a problem, had not critics of evolutionary thinking pointed out the implicit western bias in constituting categories such as rationality, normality and ability. In other words, an analysis of possession questions the supposed neutrality of these terms, and suggests that certain value preferences are neutralized and presented as universal categories.

The repercussion of viewing certain preferences as being 'natural' has been the pathologization of all those practices which did not meet the indicators of what constituted modernity. Herein, it is important to mention the psychiatric perspectives on possession and trance that have viewed possession practices as a disorder as it does not

meet the criteria of normality. However, such an explanation leads to the formation of other binaries such as normal and the pathological, and, the able and the dysfunctional, thereby leading us to the above mentioned argument that the basis on which universal categories are formulated needs to be reconsidered.

This leads to an important question on whether practices similar to possession can be found in the west or in other words are there any equivalents to possession found in other societies? A vague resemblance is posited between possession beliefs and trance practices. In other words, while non-western societies indulge in possession practices, western societies achieve spiritual development through the process of trance. An important consideration in this dissertation is the transformation from possession to trance and the implicit assumptions of such a transformation. In more ironic terms, as Vincanne Adams (1997) points out, while the western, rational conception has no place for 'magic', clients seem to seek for magical potions and magical practices that would enable them on the path to spiritual growth. Herein lies the paradox that on the one hand, the State as well as the medical systems, try to ban the magical arguing that it stands against rationality, yet on the other hand, what sells is in fact magic. This has led to need to convert magical properties into safe, enhancing substances contributing to growth. Given this it seems that the client/ patient has the option of accessing multiple systems of healthcare from which the individual can choose any one or more forms. The apparent availability of multiple choices of treatment has lead to the notion of alternative and complimentary medicine or conceptualizations such as pluralistic system of healthcare. This dissertation address the question of medical pluralism by asking whether pluralism involves merely plural practices or does it accommodate plural perceptions as well, as plural notions of disease, treatment and cure. The increasing emphasis on rationality has also led to increasing crackdown on possession practices as being unscientific. Hence healers and practitioners find ways to legitimize their practices. For instance the benefits of possession might be accounted for in more scientific terms such as restoration of *normalcy* once a spirit is expelled, or the attempts to legitimize possession as safe treatment might result in reduction of practices seen to be dangerous, such as placing of stones on an individual, a possessed victim/devotee swallowing fire etc.

In the case of comparison of systems of healing, certain crucial questions emerge such as whose treatment is more effective, whose diagnostic standards are more efficacious, what are the notions of risk and safety accompanying a particular form of treatment and whose notion of cure is more valid. Such a positioning however is problematic for the reason that notions of efficacy and validity are not perceived by patients/clients in a singular way. Rather as this dissertation will demonstrate, efficacy and validity are couched within the framework that one operates from. Interestingly, when a possession practice fails (that there is no perception of change from a previously afflicted state) the very notions of validity of the possession itself as a healing systems are questioned, rather than failure of a particular practitioner. In other words, if an analysis of mainstream healing models distinguish between failures of an individual practitioner differently from failure of the system, it is important to extend this distinction to possession practices also, which however has not been the case. In short, relegating possession practice itself as quackery is problematic.

Given the above understandings with regard to possession, this dissertation attempts to examine each of the above-mentioned arguments in detail. Further this dissertation examines certain common perceptions on possession, such as that it is essentially a folk phenomenon, or that it is reflective of traditional societies. It examines whether possession is necessarily part of folk, marginalized communities or if possession practices amongst these societies are just more visible. In other words, as Smith (2006) points out, it is quite possible that possession practices are practiced even by upper castes and class, though they might not admit to practicing possession for the reason that possession is increasingly viewed by dominant models of health care as being superstitious or irrational.

Possession practices highlight the contradictions and ambiguities on notions of health and disease. They also serve as a tool through which notions of science and rationality can be examined. While the purpose of the dissertation is not to provide any solution or strategies to surmount the ambiguities and contradictions, it is a beginning step towards outlining the intricacies of the varied positions. It is an attempt to put forth a few questions on possession itself and engage with the basic premises on which studies of possession have been undertaken in psychiatry, religious studies and anthropology.

The introductory chapter of this dissertation provides a thematic overview of the existing debates in the field, and proceeds to formulate a research objective and specific research questions that shall be considered in the following chapters. This chapter is also an attempt to give a synoptic view of the main arguments that derive from a study of possession practices. The examining of possession practices is closely related to the perspective used to analyze possession. Hence the methodology and theoretical orientations delve into the implications of constituting possession through varied perspectives. Finally the conclusion of this chapter would lay out the chapterization of the dissertation with the aim to systematically outline the objectives and linkages between the various chapters. Finally this chapter concludes with examining the title of the dissertation and the reasons behind a formulation that focuses on healing, pathologies and spiritual evolution.

Literature Review

Debates on the issue of possession have ranged from questions of the meaning, efficacy, and purpose of possession on one hand to examining the meanings of possession itself on the other. Not only have anthropological literature made contribution to understanding possession, but the studies in other disciplines like psychiatry, science, and religious studies have also influenced the main perspectives on possession. While covering all the existing or available literature is neither feasible nor is the intent of this literature review, the following review is an attempt to cover the main perspectives, views and counter views and the varying strands of the debate. It is hence an effort to cover the issue thematically rather than attempt an exhaustive review of literature in this field.

A substantial amount of anthropological literature on possession has viewed possession as being a ritual which serves symbolic and functional needs. Possession thereby fulfills thee needs of societal harmony and integrity, as it strengthens social bonds and pinpoints areas of discord. Thus analyzing the famous Ndembu rituals studied by Victor Turner, Mary Douglas (1970 cited in Ong 1988) states that the symbolic power of these rituals are manifested as removal of intrusive elements in an individual's body leading to removal of intrusive objects from the society as a whole. This is seen as

reaffirming the Ndembu society's high placed importance in matrilineal systems and hence such a practice restores purity. Herein, Douglas states, lays the efficacy of the ritual. Emphasizing the functionality of possession rituals Comparing possession to a performance, Lucile (1953) posits a question on the benefits of possession practices for the medium and for the audience and examines the process by which certain factors remain stable while others change. For instance, depending on the nature of the affliction the procedure of possession practices might change. Importantly, Lucile argues that the reactions of the family and the patient/victim to possession practices are important factors which determine the success of the possession. This is because possession as a performance takes cognizance of societal reactions and thereby presents itself in a manner which upholds societal values and norms. The importance of viewing possession as a performance also means that social performances need to be given equal importance as textual views/perspectives on possession. Jeffry (2004) emphasizes this necessity and states that apart from the textual view of possession, it is necessary to analyze possession practices as social performances These performances are successful to the extent that it enables a fusion of disintegrated elements such a power, contingencies, meanings, material interests etc. Only a fusion of these elements will communicate the authenticity of the 'performance'. In other words, similar to a performance where defused parts need to be brought together, the linkages between varied interests of society are essential for individuals (audiences) to view the performance (re fusion) as authentic and true. A slight variation compared to the performance point of view is put forth by Tambiah (1977) who observes on cults of healing that, Performance forms one axis and cosmology the other axis wherein the latter explores the relation between the human and non-human forms of existence, power, restraint etc. These aspects play an important role in the contribution they make to performative efficacy, in other words, the underlying ideas and application of the above mentioned knowledge impacts the efficacy of the performance, in order to achieve the objectives that it sets for itself, mostly to achieve unity and integration.

As compared to performative efficacy, Nichter argues for curative efficacy. He states, "curative efficacy is generally defined as the extent to which a specific treatment measurably reduces, reverses, or prevents a set of physiological parameters in a specified context" (cited in Waldram, 2000). Thus, Nichter emphasizes the role of context in

understanding the meaning of efficacy. As Waldram elaborates, the use of the term context as generally understood in the context of alternative medicine, involves not just the patient but many others who have participated in the entire sickness episode- the patient, healers, family etc. This does not however mean that there is a pre given notion of efficacy that all participants adhere to. On the contrary, it is possible to find that patients, healers and the family might have differences in the notion of efficacy despite sharing certain common criteria. This suggests that efficacy emerges in the process of treatment, wherein certain procedures are seen as efficacious as they are seen by the patient as bringing about positive change. The understanding of efficacy for the patient emerges in the process of interaction of the patient with the system of healthcare. The notion of efficacy has gained prominence largely in the context of alternative medicine versus biomedicine. The preference for alternative medicine, as per Fabrega, Halliburton and many other scholars is the advantages these practices have as opposed to biomedicine. Inevitably the difference is pointed out in terms of social networks and trust in the encounter. Strangely enough, trust is specific not only to alternative healing but also to biomedical practices. Nonetheless majority of the writings relegate this to the realm of the alternative. Consider for instance Lee- Treweek's (2002) argument that it is the trust in the practitioner which enables the patient to follow a particular mode of treatment. As mentioned earlier, the importance of trust has been invoked specifically within the context of alternative medicine. He argues, "with regard to complementary therapies, the patient's work in the creation of trust is in filling in the gaps and bringing sense to that which is unfamiliar. Trust may be based on a mixture of scant understanding, common knowledge, mystification and practical concerns about whether patients gain relief from a therapy". As shall be emphasized in this dissertation, the choice of a practitioner whether a healer, a shaman or a biomedical practitioner is influenced by patient/victim's perception of the ability of that practitioner to cure. In other words, evaluating the efficacy of the healer occurs across systems of medicine, though the factors that form the basis of evaluation may vary. Rather, anthropological and psychiatric literature has failed to reinforce the observation that while communities go to certain healers because of beliefs in that practitioner, similarly the choice of

biomedical practitioner too is influenced by notions of skills and abilities of the practitioner.

If efficacy is a product of the experiences in the clinical encounter and if social networks and trust form important considerations across medical system, it is then necessary to focus and emphasize on the 'clinical encounter'. A well-known way of focusing on the clinical encounter has been to emphasize on the illness episode. As per Kleinman (1995) what Each illness episode and each clinical encounter presents the anthropologist, who works in medical settings, is an occasion to interpret how illness and clinical realities are organized in particular local cultural systems of meanings, norms, and power. Thus for instance how are notions of body and self understood within different cultural settings? Rather than viewing culture as an influencing factor on the body, Csordas (1990) states, that the purpose of his essay is not to argue that the human body is an important object of anthropological study, but that a paradigm of embodiment can be elaborated for the study of culture and the self. This begins with the understanding that the body is not to be understood with relation to culture, but rather as the subject of culture, in other words, the body is cultural, rather than culture being situated outside the sphere of the body. This then means that the body functions as the existential grounds of culture.

As Nichter (2008) argues body and bodily states are understood in varied ways, for instance, certain bodily states as being hot or cold and certain foods possessing properties of being hot or cold. These influence notions of health, illness and also influence notions of work. Similarly, bodily states are also understood depending on whether an individual is able to function effectively and maintains a state of health. For instance, if a person is predisposed to a particular kind of illness, it is indicative of a particular body type. Thus bodily states influence notion of health and vice versa. Nichter emphasizes on bodily states as these are sites of somatic expression. A particular mode of expression of illness is the outcome of a process of socialization and thereby an individual's notion of health is shaped and influenced by societal notions of body, usages of the body, notions of normalcy etc. Given that incapacity to engage one's sense organs effectively (culturally defined) with one's surroundings is a key indicator of illness,

Nichter emphasizes a need for a sensorial anthropology that outlines the linkages of the body with the external environment.

While the above-mentioned theorists and perspectives primarily posit possession as a local mode of expressing distress, a sharp deviation comes from a purely psychiatric and psychological perspective which views possession itself as a illness. Spiro (as quoted in Chapin 2008: 219) focuses on the question whether possession is curative or if possession itself is a reflection of psychobiological illness which can be addressed only through psychiatric intervention. This position gains relevance as it challenges the very basic conceptualization of possession as therapeutic and classifies it as a disease. Spiro considers these possessions and visions to be "episodic psychotic symptoms, not because religious symbols are regressive or because they reflect the archaic motivations of childhood but because the priestesses have undergone severe traumas, whose pathological consequences are beyond repair, except perhaps by means of prolonged psychiatric intervention." (Chapin: 2008, pp. 220) This then reinforces the position of the Shaman being a madman.

If examining the role of possession would involve reflecting on the work of culture, then it is necessary to outline the linkages between individual needs and societal concerns. Thus, how, do individual afflictions reflect societal trauma or dilemmas. Doing the work of culture would necessitate that individual afflictions serve an extended purpose. In analyzing this, Mageo (1996) argues that possession and "apparent afflictions constitute creative attempts to contribute to collective understandings of these dilemmas." While individual afflictions might be an attempt to resolve societal concerns, nonetheless, possession practices have repercussions on the individual as they impact notions of the 'ego' and the 'self'. Elaborating the importance of possession on the constitution of self, Hippler (1973) asserts that the social and cultural factors might predispose an individual to possession. For instance, marginalized communities might exhibit more cases of possession. Nonetheless, possession practices indicate the anxieties of the individual. Consequently this leads to regressive ego development and are a manifestation of an emotionally disturbed individual. From Hippler's analysis of possession as regressive ego development, it is evident that accounting for possession practices has led to an analysis of culture and nature or in other words linking a cultural

practice to a biological change or transformation. In short, this has led to viewing certain biological transformations as a cause as well as a consequence of possession. Av Ruskin (1988) states that certain features of possession suggest that alterations in neuropsychological functioning must occur as part of trance. Elaborating on the patterns of such alterations he observes:-

> (1) Generally trance occurs following a period of reduced food intake in conjunction with extensive motor activity and regulated by driving rhythms of drums and chanting. (2) During actual possession, marked tremor and convulsions of the head and limbs take place, as well as alterations in thinking, a disturbed sense of time, distortions in self-image, extremes of emotional expression, decrease in sensory acuity (particularly for pain), and an inability to communicate the possession experience with those who have not had similar experiences. (3) Following the possession trance, a return to ordinary consciousness takes place, associated with extreme exhaustion and mild euphoria. Most important, the participant experiences an increased susceptibility to accept uncritically an externally imposed set of statements and expectations. Wishes and commands are accepted as one's own at the close of a trance.

While the above proposition views possession purely from a biological lens it does not consider how transformations, even biological, impact the formation of other categories such as self, body and entities which exist outside the self and the body. That the notion of the self is a culturally constituted one has been emphasized by many anthropologists. Hence what is the impact on the self due to possession and on the oater hand how does self itself influence possession. The role of the self in demonic illness has been examined by Kapferer (1979) who states that the healing process both represents the self and reconstitutes it, i.e. the self. He argues that, "A concentration on the process of the construction, negation, and reconstruction of Self enables some understanding of the operational efficacy of healing rituals, of how healing rituals achieve their transformative purpose of effecting a "cure," a major aspect of their design."(Kapferer, 1979:111). The understanding of the self either as normal or as abnormal thereby indicates a shift from one identity to another. Hence rather positing the binaries of the possessed and the non-possessed, it is important to posit an understanding of possession and non affliction within the same individual. Thus it is necessary to conceive the victim/devotee as comprehending a subjective state which depending on whether the individual is afflicted or unafflicted may or may not be demonic. In other words, rather than comparing the self of an afflicted individual with the other, i.e. an unafflicted individual, it is necessary to compare different states within an individual. This is precisely because in the case of the

possessed individual, the self is conditioned and dominated by demons who have broken free from their lowly position in the hierarchy of supernatural. The world of demons intervenes between the individual Self of the patient and the other non-afflicted individuals. Demons in the mind of the patient are no longer distanced from the world of human beings, but have directly and illegitimately entered it, threatening the patient with their unrestrained capricious, lusty, greedy, grasping, and bloodthirsty natures. The patient subordinated to demons is viewed as either actually or potentially given to consuming and overriding thoughts, which concentrate on the terrible and chaotic world of demons, and is seen to view every aspect of participation in the social world of human beings as marked by these frightening specters.

Given that the self is influenced by the prevalence of other entities, it is necessary to examine the relationship between the self and the body in a context. In other words, possession practices are influenced by many variables such as gender and age and these determine the perception and treatment of possession. Emphasizing a contextualized view of possession, Bacigullapo(1998) in a study of possession among the Mapuche community elaborates, "The boundary between "self and "other" is also fluid and depends on the individual Mapuche who constructs it and whether he or she comes from an urban or rural setting. This also varies along the lines of age, gender, occupation, commitment to the community, and traditional lore (religious, political, social), or involvement with other religions (mainly Catholic, Pentecostal, or Bahai), and experience with Western medicine. In addition, individuals' own ideas about what constitutes the Mapuche self is contextually specific. The Mapuche identity rests largely upon a particular configuration of relationships with other people. This is why the body is at once a person's physical appearance, a household and land and a community. This concept of body determines the way the Mapuche conceive and relate to the outside world. The body, domestic unit, and community become a symbol of Mapuche identity.

Gender as a category influencing possession practices has been highlighted by many studies on possession. The constitution of the gendered self is further related to linkages with class, age, memory, historical developments and other criteria which determine women's position within a particular context. Specifying the above issue Boddy (1988) raises the question of gender and possession and asserts that women get

possessed when expectations and experiences fail to match. In other words, given the cultural image of the woman as a reproducer and the increasing need for women in many cultures to contribute economically to the family and thereby step outside the domain of the private sphere leads to a mismatch between the ideal and the actual situation. The mismatch and consequent stress at fulfilling multiple roles and responsibilities leads women to fall ill and ultimately some of them are diagnosed as being possessed. Being part of a curing rite, that of trance, the individual is given scope to come to terms with the self and thereby regenerate the sense of self and experiences. For Boddy, therefore, possession is related to what she refers to as "cultural overdetermination of women's selves" which makes it necessary for women to negotiate their sense of selfhood. Thus on the one hand selfhood of women is influenced by cultural conceptions of women's role in society, yet on the other, women's selfhood is also influenced by whether certain changes such as circumcision are made to the body. Thus, for instance, based on her study in Sudan, Boddy states that women who are circumcised are seen as being more pure than those who are not. The experience of heat and pain that they undergo in the circumcision ritual is seen as contributing to womanhood. Boddy states, "The trauma of circumcision alone is insufficient to cultivate a prescriptively feminine self: such acts must also be meaningful to those who undergo and reproduce them. In thus complaining of illness, a woman avails herself of a culturally sanctioned medium for articulating her dysphoria". It is hence important to note that since bodily changes are influenced by cultural preferences, the body as it is understood and operationalized is also cultural. In other words, the body is not just a corporeal body but rather it is a cultural meaning which gets inscribed on the body.

The above-mentioned studies clearly indicate the role of possession in largely traditional societies. In what is perceived as modern societies, there is a significant change from the use of possession to the use of the term trance. Nonetheless the opening of the self is no longer viewed as opening oneself to demons and evil spirits but rather as opening the self to new experiences and knowledge. As AvRuskin states, the temporary substitution of other "selves" in the ritual trance serves to open new realms of knowledge and experience, to enhance social status, and to free the individual from responsibility for ordinary actions. In addition, possession trance plays a major role in healing practices in a

large number of societies. Another manner to categorize and more importantly distinguish practices in traditional and modern societies, is the comparison of possession with other terms such as sorcery. Nishiyama (2003) asserts that possession is largely an urban phenomenon while sorcery is rural. Nishiyama further argues that in pre modern times the body belonged to the community rather than the individual. It was after the onset of modernity that the notion of individual free will to make a decision became prominent. He further states that, possession is prominent only in transience, in the phase of transition to the modern period. Hence, Nishiyama (2003) posits: -

> Therefore, it is only during the transitional period from the Middle Ages to modern times that possession was designated to be something completely negative and such designation was requisite to the time. Ultimately, what could be obtained by an accusation of possession at that time was the legitimation of the ownership of one's own body.

The transition from Middle Ages to modern times meant that there was a shift in the understanding of the notion of the body. While earlier the body belonged to the collective, now it was seen as limited to the individual realm. This enabled the use of the body at varied levels. For instance, while the body represented individual distress, it was also indicative of the experiences of an individual based on his or her identity. This then meant that the body was a gendered body which belonged to a particular class, and age group. Thus possession practices indicated the complexity of one's identity- that of being poor and at the same time being a woman. The contemporary existence of possession would seem to be in contradiction to the argument mentioned earlier that possession practices reduce with transition to modernity. The continued existence of possession practices within modernity indicate that pre modern forms of identity persist and modernity has led to its own forms of inequalities. Thereby possession practices are a form of resistance to the dominant forces, a manner by which one's rights over one's body can be reclaimed.

Locating possession within the debates of modernity has led to questions of whether possession practices meet the criteria of science and rationality. In this context, Kapferer (2002) drawing attention to the emergence of anthropology as a discipline, explains that reason and rationality were, and continue to remain, integral to modern anthropology and are vital for defining the object and the scope of the discipline and in the construction of its theory and methods. The very history of anthropology may be

described as an enduring crisis driven by shifting certainties/uncertainties as to what constitutes reason and rationality and the appropriate perspectives for their revelation. Drawing attention to Evans Pritchard's Work, *Witchcraft, Oracles and Magic among the Azande*, Kapferer (2000) argues that the work had a theoretical aim of de-exoticising what is seen as exotic but without destroying the nature of the phenomenon being studied. Critiquing the above conceptualization and drawing attention to rationality and reason as culturally constituted, he posits that there is no singular notion of rationality which can be universally applied. Hence, "no belief is necessarily absurd, true or false in itself but achieves such characteristics in the contexts of the structuring of social relations".

Rationality and reason came to be associated with science. Consequently those practices which did not fit into the construct of western rationality and science were categorized as either religious or as magical (Here too, there is an implicit civilizational growth, wherein tribal societies were seen to be more magical and settled societies evolving into religion). This distinction has been elaborated by Rountree Kathryn (2002) who asserts that the scholarly theories and debates about magic and ritual have frequently been dichotomously constructed: science versus magic, the symbolists versus the intellectualists, causality versus participation, and ritual as action versus belief as thought, and so on. However such dichotomies are not always supported by empirical evidence. On the contrary, the witches who have been the focus of her work do not seem to share the same opinion. Their spells have both instrumental purpose as well as dramatic and aesthetic purpose. Hence magic is not anti science or pseudo science for them, but rather offers them another way of addressing their problem. This indicates that while questions of rationality and scientific thinking are of central concern to the anthropologist, nonetheless for the communities who practice 'magic', the question of science might not be the central concern. Rather what matters is efficacy, in other words whether a particular treatment, analysis and understanding 'works'. Thus it is possible for two contradictory worlds (in the researcher's analysis) to empirically exist together. In other words, the classification of certain practices as those of science and certain others as those of magic might have no relevance for those who resort to them, because for them the primary aim is to find a solution to their distress.

Another corollary of the science magic distinction has led to the perception that non-modern healers are 'quacks' who lack the necessary merit to be healers. This however, leads to an entire system being viewed as quackery and not only an individual practitioner. As Langford (1999) raises, can a simulating doctor who seems to enable the possibility of wellness a doctor or quack. In other words, if a 'placebo' actually heals then how does one call it a placebo! If simulated illness blurs the distinction between true and false illness, similarly, simulated cure should be understood as blurring the distinction between true and false medicine. While the formulation of science versus magic, or action versus belief might be a contentious debate, the role of possession in the context of modernity remains a crucial one. Thus various explanations and positions have been to understand and explain possession as an expression or power to resist especially to the marginalized groups. While examining the changes which have occurred in possession in recent times, Broch (1985) notes that possession-trance rituals have become much more complex than they were in the pre-modernization phase. Broch states that though the knowledge of possession seems to have been limited among a restricted few in the pre modern context, yet possession was not seen as a means of entertainment. Further, given that gender complementarities exist, Broch mentions that during the ritual performances the mediums exaggerate, dramatize, and reverse gender role idioms. This is done in a contrastive way; exactly for that reason that it is important to demonstrate ritually how chaotic society would be if the women went beyond accepted norms of conduct. Precisely because women play a crucial role in the decision-making processes especially the mothers who have gained reputation and social status by giving birth and are equals of men in food production, the mediums emphasize the need for gender complimentarity. In examining the impact of modernity and invasions in ritual healing, Bacigullapo (1998) states the attempt by communities to get adapted in different degrees to the existence of not only often contrary but also antagonistic folk and Western medical systems and Christianity, and their efforts to derive prestige from these "foreign" associations. By adapting themselves into the existing system, these practices are no longer perceived as being threatening but rather assume a new meaning attributed to the practices which lead to selective integration.

The use of appropriate terminology, whether one uses the term trance, possession, ritual or modernity is to a large extent influenced by the prevailing socio political situation. Thus, Kressing (2003) points out to the severe alienation faced by the people of the Trans-Himalayan region in the last decades. Foreign pressures, such as a heavy Indian military presence, the impact of the Muslim- dominated state of Kashmir (of which Ladakh is a part), and Western influences that stem from Ladakh's popularity as a tourist destination, have lead to severe stress within the region. It is within this context, he argues, that the proliferation of shamanism must be understood and located. The impact of political conditions on the usage of appropriate terminology has also been analysed by Vincanne Adams, in a study of Tibetan medicine (1997). Adams asserts that the usage of the term religion is politically unsafe. With the reforms that took place throughout People's Republic of China after the advent of modernization coupled with the state's attempts to erase religious ideology, it was necessary to find a new way to articulate experiences. In this context, Adams states that contingencies –both social and political, play an important role in the translation process where new meanings are found so that the high political stakes that are involved can be addressed. Commenting on the role of Tibetan medicine under changing political contexts, Janes (1995: 19) states that Tibetan medicine was "defined in revolutionary discourse as one of the "four olds"-old ideas, culture, customs, and habits." Many Tibetan physicians, particularly the older doctors and professors, were put into a group known as "gods, ghosts, and evil spirits," a pariah group singled out for particularly harsh treatment by the revolutionaries. Many were sent to labor camps and rural communes where they were forbidden to practice medicine. Religious activities were proscribed, and large numbers of medical texts were destroyed. Possession or use of the tantras was outlawed, and many of the doctors and students were forced to hide their texts. This indicates the role of the dominant ideology in influencing and even co-opting other systems within its purview.

While debates on modernity and the role of possession occupy importance especially in context of marginalized groups, one of the primary questions that emerges is how does one decide that ill health is the result of possession. In scientific words- is it possible to establish a causal relationship between spirit possession and ill health. Hence how does one decide whether a particular incidence of ill health should be ascribed to

possession, to some other cause or, indeed, to both. What then are the basic presumptions that prompt an individual to cure? Specifically in cases which have been evaluated for affliction (it is important to note that evaluation does not always confirm the presence of affliction), the emphasis has been primarily on changed behavioral patterns. Initially, the individual is first treated with home remedies and available patent medicines. The first presumption is that of organic causes (Boddy, 1988). Once these are eliminated the next step is to check for non-organic causes. If doctors can find nothing wrong, or if something is wrong but is perceived by the patient as poorly responsive to treatment (whether medication, diet, hospitalization, and/or surgery), then non-organic factors are implicated. These may be inhibiting biomedical therapy or prolonging a natural illness beyond its normal course. Without forsaking Western medical treatment, the patient (or a family member) may visit a religious doctor who might decipher whether illness is due to invasion by a spirit, or that by an evil eye or due to sorcery. It is important to note that in many cases, the terms sorcery, magic or evil eye are not as synonymous. Rather, on there are certain criteria, which differentiate one from the other. Thus Peters (1982) reports that possession is manifested in different ways from magical flight to a vision quest to that of incoherency and convulsive bodily movements. Referring to the common cause that is given for possession which is an attempt to restructure the world in a manner in which the individual is able to address his/her anxiety and stress and thereby cope with the situation, Peters poses the question as to why are some individuals able to handle crisis more aptly and why does possession occur only amongst a select few of those who undergo crisis. Much of it, according to him, depends on the sociocultural acceptance or non-acceptance of the experience. In other words the trigger factors leading to the conversion of a distress into full-blown onset of possession depend on if experience is met with shame, alienation, rejection and other negative responses or whether positively. These conditions enable the individual to channel and express his/her crisis through ordinary or at times non-ordinary experience. Boddy (1994:407) viewing possession as an understanding of the self as fluid, states that " possession is a broad term that refers to an integration of spirit and matter, force or power and corporeal reality in a cosmos wherein boundaries between an individual and her environment are acknowledged to be permeable, flexibly drawn or at least negotiable". Referring to studies that compare

possession cross culturally, Boddy indicates that though it might be necessary to formulate categories to enable comparison, these categories might not be able to capture an autonomous behavior.

While the above debates attempt to contextualize possession, a substantial literature on possession has viewed possession as a pathology. Largely influenced by the psychiatric approach, possession has been relegated to the sphere of the odd, deviant and ultimately the pathological. While examining the discourse of psychiatry in Samoa, Mageo highlights the manner in which possession has been regarded as either hysterical psychosis or as a culture specific syndrome or as a combination of the two. Similarly, the DSM-IV (TR) has included a category of Dissociative Trance Disorder under the section of Dissociative Disorders. The term 'dissociation' has been used in various ways; as a descriptive term it can be thought of as either some form of experiential detachment (from the self or the environment), or as the lack of integration, or compartmentalization, of personal memory or identity. The basic premise of such an analysis, of dissociation however, is the presumption of a unified solitary self which undergoes a process of dissociation. A slight variation of this psychiatric approach is offered by Gell who while retaining the psychiatric explanation, states the need for mediums to express possession. In other words, it looks at the importance of psychiatric behavior in terms of the importance such behavior has in a particular context. Gell (1980) asserts that certain patterns of motor activity are capable by themselves of producing alterations in consciousness. Ecstatic behavior of the mediums, according to him, is not random but rather it consists of a medium manipulating consciousness and sensory integration. It includes changes such as tightening of the body muscles, slight trembling, fixing the eyes on an object.

While a psychiatric perspective has pathologized possession, anthropological perspectives have relegated possession to the symbolic realm, rarely considering the role of the shaman or the medium in fulfilling therapeutic needs. For instance anthropological writings have emphasized the benefits derived as medium publicly state the strains and stresses an individual faces and the resultant lack of societal harmony which need to be readdressed. Or anthropological writings have focused on the role of charisma in the practice of possession. For instance, Swanson states that it is also important to consider

the role of charisma in spiritual encounters. It consists in a person's seeing himself as not having had a role in formulating the purposes he implements when in a trance and in his not having accepted those purposes before he implements them. "In this sense, possession, like trance, is a common experience. It exists to some degree whenever we are shaped by some traditional or customary patterning of life: by a set of orientations that we did not help to develop but which now operate within our conduct, setting its direction and its style. It is a likely consequence of our growing up in groups like the family or the state" (Swanson, 1978: 254). None of these internal changes, if taken by itself, makes any material change in our environment, but each produces an ordering of the environment and according to, that environment's relevance for some preferred state of affairs and each occasions our acting in terms of that new ordering. " In an older terminology, charismatic influence produces not a universe but a cosmos-a world that is meaningful. Charismatic influence is experienced through our having a special kind of relationship to the superordinate entity that we encounter. The entity has an existence and a creative role apart from our own." It is possible to participate in its existence and activity if we make its purposes our own or if those purposes, by some means, replace our own vision of reality in the shaping of our action. But this does not account for the role of mediumship in therapeutic healing; instead it relegates the efficacy of possession to individual abilities. It is important hence to examine the therapeutic value of mediumship. In other words, the medium actually joins the disconnects in society and by giving objects or prayers to the individual in a true sense helps an individual get rid of afflictions. Such a position is posited by Seligman in a study of mediumship in Brazil. Seligman (2005) argues that individuals are able to reconstruct their identities and interpret their experiences and actions because they are able to identify with the mediumship role. He states: -

> Ritual initiation, articulation of revised self narratives, and positive social expectations combine to give motivational force to this culturally structured identity, and allow individuals to behave differently – as spiritually empowered, rather than spiritually afflicted people. Moreover, no matter what the particular type of distress suffered by individuals prior to the process of identity transformation – whether social or familial problems, alienation, financial desperation or psychosomatic illness – this type of transformation still facilitates their ability to change the way they think and act. The opportunity to reinterpret experiences in a more positive light, to rewrite one's self-narrative, and to change

TH-18984

Jawaharlal Nehru ... Library

> the perceptions and expectations of others has a therapeutic potential that is not limited to individuals with just one type of affliction.

Further, the fact that taking on the mediumship role appears to have the capacity to accomplish the same things as psychotherapy suggests that emulation or incorporation of elements of the ritual process has the potential to lead to uniquely effective therapies in the context of cross-cultural mental health work. However, the biases are not limited to western medicine or psychiatry alone but can also be seen in the anthropological perspective of healing. The biases according to Bolton (1995) are methodological- these include the tendency to formulate formal symbolic analysis rather than creating an understanding of how behavior operates. This separation has led to the romanticization and celebration of the other and the behavioral, emotional and psychological aspects of the other. This has had ontological implications in the formation and creation of anthropological categories- reductionism, failure to elicit responses of the subjects to the interpretations which is made by the anthropologist etc.

The linkages between society and the individual need to be explored further. As stated earlier if the boundaries between the self and the other or between the self and the environment are permeable and negotiable, this would mean that addressing discord in society or in the environment would result in addressing the discord faced by the individual. As Sax (2006) states that the goal of possession is to make the person a whole, i.e. to heal. Such a perspective does not differentiate the mind from the body or the individual from society. Sax argues that family unity is central while understanding possession. Possession can be caused by many spirits at the same time. The individual is seen as important but subordinate to the whole- which is the family. He also finds caste to be closely associated with possession. In other words the suffering of the low caste leads them to place their trust on a local god who would protect them from the dominant and exploitative sections of society. However, possession brings about changes materially, apart from unifying family ties. Thus, it is important to note that possession is used to bring an awareness of social conditions, to further negotiate with family, and caste in order to bring about changes in the material conditions of the lower castes. In the case of gender, a woman oracle might be initially dissuaded and punished for being an oracle, yet the ability to command spirits places her in a higher position than other

women and most men. One of the key attempts by practitioners of possession in contemporary times is to try and make possession seem more rational. Trying to legitimize the practice of possession has led to reduction in the overtly risky practices such as reduction in extreme physical strain, reduction of practices like walking over fire etc. The attempt hence is to maintain the authenticity of possession while at the same time finding various means to legitimize its existence. The attempts to legitimize and give validity to practice of possession is specifically important in a context wherein patients/clients resort to more than one system of health care. Thus the individual might take recourse to biomedicine and healing through possession at the same time. Since there is a continuous comparison of possession with that of biomedicine or other systems, healers continuously try to present possession in a manner which is considered to be scientific. Thus procedures in possession practices for instance the spirit leaving the body, or the end of affliction seen as important indicators of the end or beginning of affliction. The aim of the ritual of possession is to cause the afflicting spirit to reveal itself. The efficacy of the healer then is demonstrated in his ability to convince the spirit to reveal its identity in front of the audience, which is a witness to the act of expelling the spirit. However, Sax states that possession practices do not occur in a fixed manner at every event nor is the outcome always known. He cites instances of possession practice where the healer exposes himself to great risk because of the unknown identity of the possessing spirit. Importantly, Sax argues that accounts of possession rarely highlight this tension and ambiguity. Rather the act of writing almost creates a rigid, and hence fixed category of possession, which seems to be devoid of many other consideration that occur in the practice of possession.

While most studies on possession are ethnographic, Smith (2006) emphasizes on the need to examine possession practices as mentioned in classical texts. One of the primary emphases of such a study is to challenge the notion that possession is essentially a folk phenomenon. By referring to possession practices as mentioned in classical texts, Smith states that the relationship between the folk and the classical needs to be examined further. Smith further argues that in understanding how possession operates it is essential to emphasize on 'self' as being culturally constituted. The individual self hence is seen as permeable in that it is open to outside influences, such as the ability of the spirit to reside

inside the body of an individual. Hence the aim of possession practices is to identify the spirit based on characteristics the spirit displays through the victim/devotee's behavior and finally, to expel the spirit and restore the individual to a previous non-afflicted state. In the context of modernity and the emergence of trance channeling, the notion of selfhood has changed. Thus trance channeling questions the notion of unitary self, though it too views disassociation as cause for possession. Trance channeling is seen as a way for spiritual evolution. It operates on notions of reduced risk and threat as the spirits are under control of the practitioner. In many cases this has raised a question of ownership of spirits. The question of ownership of spirits or energies has however emerged to be problematic as it supports the presumption that spirits or external entities exist. It is difficult to support such a claim within the logic of modernity and hence ownership remains a contentious issue.

Given the above perspectives on possession, it is necessary to formulate the position, which shall be referred to in this dissertation. Deviating from the view of possession as either functional or as symbolic, this dissertation follows the view that it is necessary to view possession from the standpoint of therapeutic efficacy. This is precisely because for the individuals or families who view possession as a healing system, the central concern is that of efficacy, in other words whether possession works. This dissertation also examines the interlinkages between possession and class, caste, gender and other variables as an attempt to re consider whether possession is essentially a folk phenomena or whether possession is primarily resorted to by the weak and the marginalized in a society. Finally, following Mc Guire's argument, it is necessary to formulate approaches that include the role of language in expressing distress. Translating or writing about distress or experiences of an individual does not necessarily mean that the experience is fixed or singular. In other words, depending on the perceived efficacy of the treatment at a given point of time, an individual might report different levels of satisfaction, notions of cure etc. To account for transformation and change in the practice of possession hence remains a challenge.

Research Objective.

Given the vast range of literature on possession, it is evident that the very formulation and analysis of the category called 'possession' would lead to different interpretations and conclusions. The central objective of this dissertation is to explore the underlying assumptions, concerns, on the basis of which possession has been constituted and to examine the implications of framing possession from different perspectives. In other words, what are the reasons why possession the object of enquiry in this case has been framed within a particular theoretical perspective, what are the stated and unstated assumptions and emphasis and finally what are the implications in terms of larger generalizations, cross cultural analysis, and the implications for policy formulation that emerges from viewing possession through a particular approach.

Research Questions.

One of the main questions, which emerge from the study of possession, is whether possession 'actually' works, in other words, is possession therapeutically efficacious. Examining this question requires an exploration of how anthropological and psychiatric approaches have constructed the notion of efficacy of possession? How is efficacy understood from the viewpoint of those who practice it? This requires, further, an exploration of what extent are notions of cure, treatment and outcome influenced by biomedical categories. How are notions of healing constituted in different ways by patients/clients/devotees who resort to 'alternative' or multiple treatments at the same time emerges as another crucial area for understanding possession. Further, how do social structures such as caste, gender, class influence the practice of possession and the meaning attributed to possession demands a careful scrutiny as well. Briefly put, the key questions thus, are whether possession practices depend on other aspects, apart from healing and if this is the case, then what is the relationship between healing and structures such as caste, gender, class etc.

Deciding whether possession works or not is also influenced by questions of whether possession practices enable an individual to function in society Thus the emphasis here is on whether these practices enable an individual to return to normalcy. As a corollary, the question entails exploring whether there can be a universal definition

of normalcy and if it is possible to establish a set definition of pathology. Further, this involves an examination of the relationship between culture and disease? What are the ways by which variations even within a culture, apart from cross-cultural variations can be addressed? How has possession been explained in mainstream medicine and what have been the implications of examining it within a particular perspective. Further, are notions of pre modern and modern practices of possession valid? How is the efficacy of possession evaluated in 'modern' contexts and how is functionality, normality and pathology understood in a 'modern' nosology? (Nosology refers to a system of classification of diseases). This involves an understanding of how notions of body, self are constituted by different cultures. Further, it is essential to examine whether pathology itself is culturally constituted. This would require a cross-cultural comparison of notions of illness, treatment, cure etc. This dissertation also attempts to understand the notion of cure as perceived by communities who engage with a particular medical system rather than referring to a universalistic notion of cure and treatment.

Cross-cultural comparison of possession has led to possession practices being seen as indicative of traditional societies. Given this dominant understanding, does possession occur in contemporary, western societies? How have the terms trance and possession conceptualized? How are new age movements to be understood in terms of the linkages with practices seen as indicative of traditional societies? In other words if possession or trance is seen to occur in contemporary, western societies then what functions, meaning and purpose does it hold and does it vary from earlier notions of either trance or possession. Are there any contradictions between these practices and similar practices in non-western societies? On the other hand if trance/ possession does not occur in western societies, then what is it replaced by? How is the lack of these practices accounted for? I will try to critically engage with all these questions in the course of my dissertation.

Finally, the implications of varied meanings of possession and trance in terms of policies and legislation mark another area of inquiry. I would also try to investigate if there are any legislations on possession practices and if yes then what are the basis and implications of such an act. This would involve understanding if there are attempts to bring changes in the practices of possession- in terms of influencing the patients, healers

or mediums to change or incorporate more 'modern' elements in possession practices? Specifically, are there attempts to influence possession that takes place at healing shrines? The objectives and who undertakes the objective of bringing about these changes in healing shrines will also form part of my research.

Theoretical Orientations and methodology.

The importance of the theoretical perspective and methodology used to understand possession lies not only in the manner in which possession practices have been analyzed, i.e. the 'outcome' of possession practices but more importantly, in the very reasons that possession is sought to be investigated, the choosing of 'relevant' data, the evidences that are posited as supporting arguments and so forth. In other words, the positing of the object of enquiry is itself couched within theoretical and methodological considerations. Thus a functionalist approach to possession, views possession as primarily contributing to the goal of social harmony and integrity. The emphasis, here, is on societal harmony rather than serving individual causes. A similar perspective is that which views possession as being symbolic. In this perspective, possession practices involve bringing together social tensions and replacing them by social harmony. Just as 'evil' is removed from the afflicted individual, which restores the individual to the original state in possession 'rituals', the very procedure of possession brings highlights social discord and means to resolve conflict and bring harmony. Hence possession 'symbolically' removes the evil from an individual while in 'actuality' it has the underlying purpose of resolving social tensions as well. In complete contradiction to these perspectives, the psychiatric perspective views possession as pathology, i.e. a disorder, which is incorporated under the Dissociative Trance Disorder in the Diagnostic and Statistical Manual of mental illness. However none of the above mentioned perspectives, which are mainly used to analyze possession, locate the importance of possession in terms of the meaning that it holds for the people who participate in it, nor does it account for the fact the purpose of possession itself might be culturally determined.

Possession has itself been described in varied ways, as either being positive or negative, or as an alteration of the state of consciousness. Given the variety of meanings that this term entails, the usage of the term possession would refer specifically to the presence of another entity within the host, which influences the action, behavior, and response of the host. The encyclopedia of social and cultural anthropology (Bernard and Spencer, 2002:662) states, "During these often highly framed episodes, voice and agency are attributed to the spirit rather than the host; the host is not held accountable for what occurs and indeed may claim subsequently to have no knowledge of it, or at least no ability to have influenced its direction. The spirits are generally conceptualized and experienced as discrete persons, whether ancestors, foreigners, historical figures, gods or members of an alternate species. These persons may be viewed as more or less distinct from their hosts according to the particular performance tradition at issue as well as the stage the relationship between an individual host and spirit has reached". The orientations which have influenced this dissertation emphasize perspectives such as the embodiment approach and an emphasis on a more culturally based view of health. Csordas (1990) for instance, states that the body is an important aspect while understanding efficacy. Rather than locating the body on which culture acts upon, the very use of the body is cultural. Similarly, culture does not merely act upon a disease, rather what is perceived, as disease is itself culturally determined. In the context of medicine, translating terms leads to the danger of pathologizing phenomena which in the first place might not be considered as pathological at all. (Obeyesekere, 1969 cited in Santiotis, 2009). With pathologizing a phenomena a range of associated terms are involved- patient, victim, cure and therapy. This also means that the individual is no longer in a state of 'normalcy' and the task of medicine is to restore the individual to the state of normalcy. The translating of terms from one system to another involves privileging of certain standards as 'normal' and an indicator against which other systems are measured. This raises a number of questions. The primary question, which arises, is that of validity. The attempt is to distinguish 'truth' from 'belief' and 'science' from 'magical thinking'. Hence, whose diagnostic categories are more valid? Which methods of diagnosis are more 'scientific'? The other questions emerge around notions of safety and expertise, which system is more

competent to deal with the 'problem', which system is safer, more comfortable and finally the contentious issue of what constitutes evidence of cure.

Deviating from the psychiatric perspective which views possession as pathological, and drawing on a perspective influenced by cultural psychiatry (though cultural psychiatry also has its limitations) offered by Littlewood, Kirmayer (2000)), emphasizes on the importance of articulating local nosologies which place disease categories differently as compared to the biomedical system. Thus, a critique of psychiatry is not limited to its contextual approach, but rather also extends to its attempts of formulating a universal nosology.

In short, this dissertation is influenced by three major approaches- firstly, an embodiment paradigm, secondly a critique of universality (ethnopsychiatric perspective) and finally by the considerations raised by cultural psychiatry. Based purely on an analysis of secondary literature, an attempt has been made to cover literature belonging to diverse fields such as religious studies, performance studies, psychiatry and anthropology as possession is often constituted as being at the interface of either two or more of the above mentioned disciplines. The approach has largely been deductive, in that specific arguments have been derived from generalizations, especially in the context of critiquing the psychiatric approaches.

Chapterization.

Apart from the introduction, this dissertation consists of four chapters. An attempt has been made to make each chapter largely independent from others, in that it substantiates and critiques a central argument. Yet the three chapters are linked by certain considerations, specifically, the critique of western bias, universality and pathology and most importantly, in striving to understand possession as a whole and not the sum of its parts. Thus while the first chapter considers possession from the viewpoint of ritual healing and argues for therapeutic efficacy, the second chapter critiques the psychiatry perspective of possession as disorder and as an indicator of 'traditional' societies. The third chapter takes up the argument posited by psychiatry which states that possession is largely restricted to traditional societies and the chapter indicates the existence of

possession and trance in western societies, although the meanings and implications of these might be quite different from those in non western societies.

Chapter one is an attempt to view possession from the point of view of what works for the patients/clients/devotees (depending on whether one examines possession from a psychiatric, medical or anthropological viewpoint). In other words what are the central concerns for those who practice possession and how is ritual, cure, treatment, efficacy to be understood through the lens of those who practice it. This chapter also critiques a singular, rigid, and largely western biomedical view of treatment and cure. Further, this chapter raises the limitations of anthropological approaches which have denied any therapeutic legitimacy to possession practices and hence like psychiatric approaches have the pitfall of denying legitimacy to meanings of those who practice possession.

Chapter two locates two specific disorders as mentioned in the Diagnostic and Statistical Manual for Mental Disorders, published by the American Psychiatric Association. These two disorders are the Dissociative Trance Disorder and the Culture Bound Syndromes. This chapter locates the history of development of psychiatry, the reasons behind the assumptions made by psychiatry and limitations of psychiatric perspectives. It critiques the universal nosology put forth by psychiatry. At the same time, it also raises the limitations of cultural psychiatry in which culture is seen as effecting treatment, cure etc. it argues for giving importance to varied nosologies and not merely to varied treatment.

Chapter three raises the issue of possession practices as being an indicator of traditional and more often non-western societies. It critiques this position by referring to new age trance wherein trance channeling is seen as an important step towards inner growth and spirituality. This chapter examines the manner in which trance practices continue in the so-called 'modern' contexts, by changing the meaning attributed to trance. Thus, risky, uncertain characteristics of trance are changed into safe conditions, supervised by the expert channeling mediums. This chapter raises further issues for consideration, specifically; it states that given the co existence of practices such as possession, to what extent can possession be seen as a vestige of the past.

Chapter four examines contemporary perspectives and legislations on possession and is the concluding chapter of the dissertation. In an attempt to state that possession practices are not exotic or relegated to a stray incidents occurring in the most backward of places, this chapter highlights the bill proposed in the Maharashtra Legislative Assembly on the eradication of black magic and evil practices act. This chapter would attempt to explore the implications of this proposal and the various responses to it. Secondly, this chapter raises questions at the interface between psychiatry and religion, such as providing psychiatric facilities within religious settings, as seen in more recent attempts to make psychiatric services acceptable and accessible. Further, this chapter puts forth the perspective of human rights of the mentally ill, which emphasizes that right to life includes right to basic healthcare. Finally this chapter concludes by outlining questions for further research.

That a practice should be differently termed as being a ritual or a disorder or as new ways of connecting with auras and energies depending on the perspective that one analyses it from, indicates the need to examine the reasons behind such varied understandings. Thus it is possible to locate three distinct points of view. The first perspective considered in this dissertation views possession largely in terms of being a ritual. It is seen as healing an individual not therapeutically but rather as setting right the discords in society. Individual manifestation of possession thus is symptomatic of more underlying causes. The second perspective views possession as a disorder, since it is perceived as reducing the levels of functionality of an individual. This is seen as a departure from the state of normalcy and is hence constituted as pathology. The third perspective views trance in contemporary western societies as an ability of mediums to connect with energies that exist outside the individual. The ability to 'tune in' with a medium is a process towards spiritual growth.

Given the above understandings, this dissertation is titled as 'Of Healing, Pathologies and Spiritual Evolution: Revisiting Debates on Possession and Trance' to indicate that the transition from possession to trance, and from religion to spirituality is not a mere choice of terms but rather is located in a perspective which involves the *progress* of societies from traditional societies practicing possession to that of a modern society practicing trance. The basis for this assertion is the construction of the non-

western (the other) by psychiatry as well as anthropology as shall be examined in the following chapters. Thus, the dissertation is an attempt to find the similarities, differences and more importantly through this process arrive at the basis and presumptions that influence the creation of the category of possession.

Chapter II.

Analyzing Possession: Examining the interface between healing, efficacy and social structure.

Possession practices exist because they work. In other words, possession continues to be practiced as it is efficacious. From the lens of modernity, possession practices exist almost as a vestige of the premodern, and as a substitute for lack of modern treatments for mental illness. Resort to 'faith healing' is also perceived to be an important cause for delayed recognition and treatment of severe psychotic illnesses. For those who practice possession however, this practice continues to give meaning to their illness experience and thereby offers them a mechanism through which their health can be restored. Given this contradiction, anthropologists have focused on the coexistence of multiple systems of health. Nonetheless these approaches limit the benefits of possession to that of restoring the ties of the individual with the social group, and do not take into account that possession primarily addresses the physical discomfort of the client/victim who approaches a healer/shrine. Ignoring the therapeutic efficacy of possession has led to possession being seen as functionally or symbolically efficacious. While it is true that holism, which is sought by possession practices, involves maintaining social harmony, it is equally important to recognize that such a process involves assessing the causality for the physical discomfort and behavioral changes faced by the individual. While highlighting the role of discomfort faced by an individual, it is also important to recognize that possession practices are influenced by social inequalities that exist in society. In other words, there are reasons behind why affliction takes place.

Whether possession is therapeutically efficacious or not is determined by what is understood as outcomes of possession practices. In other words is it possible to have a fixed notion of cure or healing that can be applied to all cases of possession. The question if there are any standard indicators which can be used to measure the efficacy of possession Or, if the notions of outcome are subject to change depending on the concerns of the patient, nature of affliction etc remains unresolved though. The latter would mean that there is no fixed notion of outcome, but rather outcome emerges in the process of the devotee interacting with the system. As pointed out by anthropological studies in the

south Asian context, the notions of efficacy are often contested, for instance, while the patient might report an experience of well being after possession practices, the biomedical indicators, such as blood pressure, temperature might demonstrate no change from the previous condition. In such a situation, the question arises, which practice and system is more reliable and efficacious. Hence judging the efficacy of a practice with indicators extraneous to it is problematic. In other words, testing efficacy of possession by using biomedical notions of testing would be inappropriate. Rather each healing system has its own notion of what constitutes cure and efficacy which needs to be taken into consideration.

Given the above perspectives in anthropological literature on possession, this chapter aims to understand the debates on possession practices and also attempts to relate possession with other factors such as caste, class, gender and modernity. That individuals resort to multiple forms of treatment has been mentioned repeatedly in much of anthropological literature, however what has remained neglected is that the reasons for this are many, ranging from differences in constituting disease to the inability of biomedicine to explain disease in a frame which is understandable to the patient. This chapter hence engages with the notions of what possession means for individuals who practice it and links possession practices with questions of therapeutic efficacy and plurality.

Analyzing difficulties in defining the term possession.

One of the main difficulties in studies on possession is the difficulty that lies in defining the term possession itself. In an attempt to define possession, Beauburn (1980:202) asserts that demon possession generally refers to the "long term state in which the individual believes that he/s is unwilling possessed by one or more intruding spirits and exhibits contingent behavioral responses which he attributes to the spirits influence". In the south Asian context, however, the task becomes doubly difficult because of the ambiguity involved in the nature of the invading spirit itself, which far from being demonic can be a goddess itself. Thus the invading spirit might be either beneficial or dangerous. In those cases where the intruding spirit is recognized as being dangerous and this realization generally occurs during the course of possession, there is an attempt to

convert the dangerous spirit into beneficial one. This is done through varied means by placating the spirit, negotiating with it and at times even threatening the spirit of dire consequences if the spirit refuses to leave the body of the victim. For the spirit dire consequences generally means that it would never transcend the in-between world of human and the ether if it refuses to pay heed to the healer. The main task of the healer hence is to first recognize the nature of the intruding spirit. The ambivalence of the spirits is also caused in cases where the possessing spirits are goddesses. The ambivalence is due to the terrifying mother image which portrays the goddess as both protector as well as being dangerous. It is this dual role as disease giving capacity and sustaining the ability to heal when the spirit is honored in appropriate manner (Shields, 1987:420) that makes it possible to reaffirm a cosmology which involves the relationship of men with spirits. Given a cosmology wherein spirits exist outside the victims upon whom they intrude, sudden behavioral changes and unexplainable differences can be attributed to spirit influences since they choose to attack their victims at vulnerable moments. In a study of possession mediums in South India, Nickoles (1991) points out that in the case of small pox, the goddess appears to the mediums who initially resist as it is an indication of their futures as mediums yet they accept the role over a period of time. Explaining the difference between European and South Asian possession Brockman (2000:30) emphasizes that, "possession in India, unlike possession in the west was never about morality".

Thus while European and American traditions of possession invoked shame and outrage as it was perceived as a consequence of a weak mind, possession was seen and accepted as a chance occurrence in the Indian context. In that it was seen as befalling a victim because of sheer bad luck and not having to do anything with bad character or sin. This meant that individuals with possession were not necessarily pathological and the aim of healing, then, is to remove the spirit to restore the individual to equilibrium which is consonant to cultural definitions of health (Vecchiato, 1993:188). This also meant that the loss of equilibrium and free will of the individual is not a consequence of one's instincts or desires taking over oneself but is rather a consequence of an external entity. Recognizing this view, Brockman (2000), suggests that there is no intrapsychic conflict that takes place in the case of possession.

Causality: What leads to possession.

An important issue in studying possession is finding its causality, or in other words, exploring the factors that predispose an individual to get possessed. The hypothesis that women or those of the lower caste and class get possessed has been generally explained by a perspective that emphasizes deprivation as a cause that encourages possession. This perspectives sees possession as a process by which deprived sections protest against the injustice that they face. A similar argument is made by Low (1988:138) in the study of Latin American healing cults. Low states that the relationship between social discord and political economy can be separated only for analytical purposes.

Possession often reflects social distress though embodied in an individual. Hence possession is an attempt at somatization of a conflict which is in fact social. The importance of somatization has also been emphasized by Nancy-Scheper Hughes and Lock(cited in Moore:1993:525) who argue that somatization is perhaps the most dominant means by which negative symptoms are converted into individual bodily symptoms and are, then, interpreted as pathological. Giving strength to this view, Hughes and Lock (cited in Moore, 1993:525) emphasize, "The body becomes the instrument for the expression of distress and alienation, as it becomes a locus of control and resistance". In the case of gender, this is seen as alternative means by which power is sought. Beauburn (1980), studying the same thing from a slightly different perspective, argues that possession has the advantage of providing direct escape from a conflict situation and diminution of guilt and this is achieved by projecting blame on to the intruding spirit.

While it is true that possession might be used as a means to protest against the structures of domination, it is also necessary to take into account that possession is by no means limited to the oppressed alone. As Sax demonstrates, possession takes place among the higher castes in India too. Further, though there are significant differences in the manner in which possession takes place amongst higher as compared to the lower castes, yet its occurrence across all sections of society is well established and documented. This indicates that possession as a practice is not restricted to one form, nor is it restricted to one set of practitioners. While explaining the forms possession states

take place, especially with reference to variations across different strata of South Asian society, Sax (2004:303) observes:-

> One of the patterns that clearly emerges from these transcripts is that the lower the caste, the more extreme are the linguistic and paralinguistic variations in oracular speech. Lower-caste oracles whistle and grind their teeth; they speak in archaic dialect; their trances are more sudden and violent; their very bodies are sometimes the battleground for different spirits who seek to control them. Meanwhile, oracles from the highest castes tend to be calmer and more self-controlled. They speak in standard Hindi, they do not whistle and shout, and sometimes they are not even possessed. In short, social status is directly related to bodily control: high-status persons are associated with bodily control, low-status persons with its lack. This pattern is to be found in a very wide variety of cultures, and seems to be well-known universal). It is important to remember, however, that this relationship is self constituting and self-reproducing.

More significantly what needs to be taken into consideration is that most of the studies on possession in the south Asian and specifically Indian context, have focused on either one community, or one caste leading to a perspective where the relations between castes, gender and class has not been sufficiently explored. For instance, if the marginalized seek justice through the practice of possession, why do the upper castes- the non-marginalized, too have, and actively perform in, possession rituals. Or do the lower castes necessarily perform possession only to seek justice or are certain practices engaged in by the lower caste a product of dominance of the upper caste wherein they engage in these practices so that the upper castes are benefited? In an attempt to explain the reasons behind this Spiro (2005) argues that it is not only the marginalized and oppressed who have access to notions of spirits and possession, and might resort to possession practices for healing, but even Diaspora communities who are in a different setting resort to possession as an explanation for sickness or unexplainable changes in behavior. This aspect of self-regeneration is also influenced by the group of co sufferers along with whom the patients share the experience of illness and faith in the healer's supernatural connection and healing power.

Possession practices and the impact of social inequality, hierarchy and power.

A recent criticism of the deprivation model underscores the fact that emphasizing on the deprivation aspect leads to downplaying the importance of the illness (Vechiato,

1993:188). While it is important that seeking justice from a deity is a common resort in many possession practices, viewing possession as addressing only social disharmony or conflict leads to reducing the efficacy of possession to that of restoring social harmony and peace while ignoring the healing capacity of possession practices that are claimed by those who seek and practice possession. Importantly, Csordas states that this error of reducing possession to cases for ritual analysis does not address the experiences that individuals undergo during possession, rather it seeks to substitute procedure for process (Csordas:1988). Further, Csordas argues that emphasis on objects, sequence, audience and rites through which healing is carried out leads to comparing healing practices in case of possession with other forms of cultural practices such as rites of passage or other forms of rituals. This is erroneous because it ignores the experience of those who are involved in possession practices, who give specific meanings to possession which is different from meaning given to other situations. In other words procedure indicates the individuals involved coupled with the actions done by the participants, while process reflects to the experience of the participant with respect to the sacred. The failure to distinguish between cases such as rites of passage and ritual healing, leads to reducing the meaning of ritual healing to procedures. Csordas states "because of this failure, studies of ritual healing have been based on description of healing rituals and interviews with ritual specialists and have given less attention to the phenomenology of the transformation process as lived by the participants". (Csordas, 1988:122). This has also resulted in viewing possession as 'inevitable' and 'definitive', i.e. as either successful or as unsuccessful, whereas healing when observed empirically can be partial, incremental or even inconclusive. This indicates that there is no singular or fixed understanding of what is meant by healing. The alternative suggested by Csordas is to focus on the effect of healing-, which is to alter the meaning of illness for the sufferer. The therapeutic aspect can then be understood in terms of participants experience, empowerment and transformation. In other words, given that the effects of religious healing may be incremental, there might be no fixed notion of an outcome but rather as Csordas puts forth only a therapeutic process by which ways of attending to the human world are transformed.

The separation of social power and hierarchy on the one hand and healing practices on the other has significant limitations as it serves to disconnect individuals from their own experiences. Thus if symbolic healing ignored the therapeutic efficacy of possession and focused only on the social equilibrium, viewing possession as purely centered on bodily discomfort ignores the social factors which precipitate discomfort and illness for the individual. Ignoring the social production of disease leads to possession being reduced either to a ritual or to a symbolic practice. Further, as Csordas states, the experience of transformation is related to the existing hierarchy wherein meanings of illness are experienced differently by individuals. The process of possession creates and transforms identities of individuals. There has thus been a lacuna in possession studies conducted by anthropologists who emphasize healing and cross cultural differences on the one hand and those who study rituals, functions and symbolism on the other. The limitation of anthropological perspective is highlighted most strikingly by the neglect of viewing possession as having therapeutic efficacy. Thus, while the critical medical anthropological perspective emphasizes on the social relations of domination and subordination, such a perspective has not taken sufficient note of the performative aspects of possession, which include the experience of those involved in the act of possession. In Sax's view this is because from the critical medical anthropological perspective, these are rituals which are merely expressive and not instrumental. In other words these are 'epiphenomenon to be explained as effects of more basic causal factors'. (Sax, 2004:300). Hence the experience of possession is not seen as curative in itself but rather is seen as the consequence of other, more basic factors. A similar limitation of reducing possession to instrumentality is put forth by psychoanalysis. As Prince (1976) argues, changes due to possession practices will only be seen as temporary and superficial while what is seen, as cure is to cognitively link with the earlier experiences of the self and the current experiences of the individual implying, as a consequence, that the rebuilding of ego remains speculative. However, such a perspective is based on the assumption that self is effected in the practice of possession and has been contested for the same reason. As Finkler observes that the 'ego' building, as posited by psychiatry, is not an attempt by possession practices because the self is not seen as being effected at all. the root cause of

disturbance, rather, is an intruding spirit which has to be removed to restore the individual to equilibrium and it has nothing to do with the self.

Therapeutic efficacy and possession.

Raising the issue of efficacy, Csordas observes that while the anthropological question emphasizes on what meanings shape illness experience, the clinical question is how many religious encounters influence an illness career (Csordas: 1988). He further adds that while it is common that efficacy is contingent upon the problems which are raised, and the process of healing and the manner in which the problems are viewed within cultural perspectives, it is also important to note as to how successful resolution of these problems is understood. Given that spirit possession might affect an individual at any given point of time and that that an individual can be afflicted for deeds done by the individual's ancestors means that affliction and resolution are not limited within the span of one generation and thus challenge the very notion of requirement and possibility of resolution within a specific time frame. Countering that spirit possession is therapeutically efficacious (many who criticize it on grounds of being therapeutically harmful might still view its as functionally efficacious- such as preserving social bonds, norms but not as necessarily healing) is the position offered by those who view possession practices as non-medical beliefs which delay early recognition and prevention of disease. Thus explanatory models for health related behavior on lines of possession are seen as limiting outcomes of the medical model which aims at treating psychiatric illnesses such as chronic psychosis. The belief in spirit possession in many cases was found to exist not only among patients but also among the health workers themselves who held at least one non-medical belief. Thus in many studies conducted at healing temples and shrines in India (Raguram et al: 2002, Kar: 2008) prolonged resort to healing shrines are seen as increasing the tendency for delayed diagnosis of psychosis. However these studies begin with an assumption that temple healing/ shrine healing necessarily deal with 'mental illness' .As Dwyer (2003) argues, for those visiting the shrine there is a significant difference between mental illness and spirit affliction. Secondly, Raguram's study presumes that people with mental illness visit healing temples with the understanding that community mental health services may help people with serious

mental disorders while Kar's study was conducted among the 'psychiatric patients'. In both these studies, there was a diagnosis which was arrived at before the study was conducted. From the perspective of these categories, temple healing was seen at best as a traditional form of healing resorted to by patients who in many cases had no access to psychiatric care or who found explanations for 'psychotic' illness in a worldview which was acceptable to them. The difficulty in accepting possession practices as efficacious has also been put forth by Bhui and Bhugra (2003, cited in Kar, 2008:731) who emphasize that "at the end it has been suggested that if exorcism is helpful for recovery from illness, rather than disease it should not be hindered. On the other hand, if cultural explanatory model is to be accepted, should an exorcist be enlisted in a treatment model, withholding pharmacological treatment with proven efficacy is questionable". Such an approach however does not view possession practices as curative but rather as aiding the process of therapy.

While therapeutic efficacy maybe a central concern for the researcher, for the clients who access multiple systems of healing, the concerns are about the effects that a particular diagnosis and treatment would have on them. To enable this, patients resort to multiple forms of therapy. Hence Brockman (2000) emphasizes that it is essential for physicians to practice medicine effectively, that they should have an understanding of the sociological perspective on possession. This is reflected in that even when patients resort to biomedical treatment, they do not give up religious practices. Rather many of the patients do not see any conflict between them and rather view them as supplementary. For instance, resorting to get the medicines given by the biomedical practitioner blessed by the healer to increase its powers is a clear evidence for this. Finkler (1994), referring to the literature on possession, therefore, points out that while academics focus on epistemological differences, for the patients biomedicine and spiritualism are seen as accomplishing similar ends. Further, patients are seen asking spiritual healers to verify a diagnosis given to them by the physicians. This is a way of making sense out of the diverse diagnoses which have been given by physicians in a manner which is understandable to the patients. Indicating the ambiguity of the term mental illness, and the referral system which exists between doctors, patients, healers and participants, Campion and Bhugra (1998) argue that healers have several models of mental illness

within their repertoire and that healing shrines deal with specific psychiatric problems. They further explain that there are instances wherein healers refer to doctors for further treatment, while in other cases a number of methods might be combined. This clearly indicates that for the healers, possession itself is of varied types, distinguishable from other illnesses which are outside their purview. Based on analysis of Kleinman's writings, Shields (1987:417) puts forth the following factors to indicate the therapeutic setting. These include:

1. Institutional setting- includes where the possession takes place
2. Characteristics of interpersonal interaction- refers to the relationship between the healer and the patient, the healer and the family members etc
3. Clinical reality- diagnosis, causation and treatment
4. Idiom of communication.
5. Therapeutic stages and mechanisms- the modes of therapy which is to be followed, intensity of the illness etc.

Possession and plurality of medical systems.

Given the above positions, it is difficult to claim that there is only one system, which is efficacious and even more so for the patients. Hence there is an attempt to expand the term efficacy to include other systems. As Halliburton (2004) states, there is an increasing attempt to point out the plurality of medical systems which exist especially in developing countries. However, such a perspective of medical pluralism in developing countries uncritically view developing countries as sites where multiple systems exist within the mainstream and are seen as mutually compatible in contrast with the most developed allopathic medicine in western world. In other words, plural medical systems are seen as an alternative to more hegemonic systems in the west. However, this does not consider that different systems of healing might have their own notions of efficacy and hence to expand the ambit of one system does not necessarily make health systems 'pluralistic. 'This perspective hence, has its limitations. Firstly, the distinction between mainstream and alternative/complementary therapy is sharply demarcated. Further, alternative therapy in the dominance of biomedicine is also required to redefine its own

categories and concepts. As Vincanne Adams (1997) puts it, questions of efficacy, reliability and diagnoses arise in assessing which system works better.

The act of diagnosing possession involves linking an individual to the community and this link is caused by the intervention of the healer or the medium. Unlike the science of medicine which separates the ill from the well, the healer acts as a bridge between the two worlds boundaries of which are very blurred for him and the patient.. This is because the healer exposes himself or herself to risk and danger given the ambiguity of the invading spirit (this has been discussed in detail in the previous section of this chapter). Since the invading spirit might have a purpose in afflicting a particular individual (broken kinship ties, animosity etc). For this reason, Brockman suggests that examining possession requires a re examination of the concept of causality. Thus the question which emerges is who is the cause, rather than what is the cause. The role of the healer therefore gains prominence in determining the identity of the intruding spirit and finally expelling the spirit from the individual. However, from the viewpoint of those who view possession from a psychiatric lens, healers are individuals who themselves might be in need of treatment for psychotic illnesses. (Mc Donald, 1988 cited in Kar, 2008:731). From the perspective of those who visit healers for treatment, healers are those who with the gift of discernment and can hence communicate with the otherworldly beings. As against this, those who practice possession see healers as those who have gone through discomfort and pain in the past, before they became healers and are hence seen as being able to understand the pain experienced by those whom he/s treats. As Sax suggests, in order to be effective, it is essential that the oracle must be able to define the client's problems as well as be in a position to suggest a plausible cause and a solution. When either physical problems are not amenable to medical diagnosis or when they strongly suspect supernatural causation, an oracle is visited who in trance answers questions. The choice of an oracle and the expected consequences of possession are also influenced by the diagnosis and treatment that an individual has obtained from other medical systems. This happens especially in a context wherein possession practices are seen to loose their therapeutic legitimacy when confronted by other dominant systems and models of health care. Given this crisis, Csordas emphasizes that religious encounters are often conditioned and influenced by previous experiences with mental health professional both

in terms of knowledge of their conditions and the insights they gained from psychotherapy. The distinction between religious healing and psychiatry hence needs to be revisited. In other words, if these two systems co exist for the patient, then the constitution of cure or treatment would necessarily be a product of the interaction between these two systems.

Are states referred to as possession universal? Comparing Possession and biomedicine.

The question then becomes if is there a common ground between possession and other forms of healing therapy as possession itself is not static and has cure specific to types of what is perceived as mental illness,. In other words are there certain healing factors which are universal and which influence the relationship of the patient and the doctor, healer and client and thus influence treatment. Drawing upon a study in Lucknow, Prince (1976) posits that it is essential to distinguish between exogenous factors that lie outside the individual and endogenous factors which exist within the individual. He states that under conditions of stress, individuals have resorted to a multiple of automatic self healing mechanisms and the most important of these is the so called 'altered states of consciousness', dissociations and a variety of religious experiences and psychotic reactions. These are merely exogenous factors which enable the individuals to handle stress and crisis. There is, however, a difference between disassociation states and that of mystical states. Typically, disassociation has three major characteristics distinguishing it from the mystical. Firstly the individual experiences an altered state of consciousness and yet, secondly, there is retention of more or less full control of ego functions. Finally, it is associated with more or less amnesia for the experience after the dissociation. However, in the case of healing, the healer is seen as speaking in the voice of the spirit, wherein what he says is seen as powerful. Secondly, individuals who experience altered states of consciousness feel privileged to be the 'chosen ones' and thirdly, dissociation states are seen as being cathartic in that they are spaces wherein an individual can act out roles which are otherwise seen as unacceptable or impossible. Reducing mystical states to dissociation states, hence, is erroneous because of different cultural meanings and emphasis attached to factors such as amnesia, change in consciousness etc.

This leads us to explore if it is possible to compare different healing systems, especially in the wake of fact that, the basic conditions on which treatments are constituted differ greatly. Emphasizing this point, Finkler (1994:179) highlights that a comparison between treatments indicates that the nature of medial systems are themselves embedded in dissimilar systems of knowledge and divergent experiences. For instance, spiritualism is embedded in a sacred world while biomedicine is sanctioned by secular science. Consequently these two systems deal with disparate realities and epistemologies. While the perspectives of ritual healing and that of biomedicine are different, to conceptualize this as a distinction between sacred and secular has, nonetheless, its own limitations. In an interesting study, Low reports the increasing secularization of religious healing and the sacralization of medicine. In his study of f healing cults in Latin America Low (1988) reports the manner in which healing cults dedicated to deceased medical practitioners function. This is particularly interesting since the cult is accessed by the marginalized and oppressed sections of society, thus it refers to a process of secularization and accessibility, yet it is the medical power of a doctor and their ability to heal that forms the basis of this cult. Thus in the course of this ritual some patients reported seeing a doctor with his toolkit appear to them and talk to them, while mediums who worked with the spirit of the doctor cured patients where other measures did not apparently work. The transformations of doctors into folk saints thereby raises the question of whether the separation of religion and medicine is possible, or is it restricted to only analytical purposes. Hence Low (1988:137) argues that, " as the technological 'magic' of medical practice challenges religious healings' claim to miraculous power, the number of lay, quasi-religious healing cults increases, sacralizing medical symbols by placing them within religious contexts". Thus, while religious/ritual healing might seem to be in opposition to modern medicine, these are in fact in opposition to the hierarchy of priests of the great tradition. Either through cults or through mediums, possession healing offers a more personal and direct relationship to the divine than that which is available through a hierarchy. In the case of the cult mentioned in Low's study, it may also offer more direct access to the physician to the poor for whom it is otherwise difficult to access medical system because of the hierarchical relationships, social inequalities and high

costs. The symbol of a medical doctor endowed with supernatural healing powers is only one of many examples of the overlapping spheres of medicine and religion. Csordas, based on his study of African and Afro-American spirit possession, states that, Given the cross-cultural prevalence of religious healing, and the fact that both religion and medicine address basic existential problems of life and death, it can be argued that the category of the "sacred" may be just as fundamental to our understanding of health and healing as are the categories of "disease" and "illness" (Low,1988:137).

A comparison between possession practices and other forms of healing also requires an analysis of whether these systems have equivalent categories, for instance analyzing if the categories of the self, body, mind and soul are common to both systems and if yes, are they employed in a similar manner. To begin with, the patients approach either, or both the systems, for healing primarily because of behavioral differences accompanied with some sort of bodily discomfort. As Nickoles (1991) puts it, inferences are made about precipitating causes which include family disharmony and social norms being violated among other. The family concludes that the diagnosis is correct if the symptoms subside after approaching the healer, or else they continue to make subsequent divinations and offerings till they are able to not only identify but also to address the spirits. Establishing the identity of the possessing spirit is of most importance in this process. It is only on revelation of the identity of the spirit that subsequent precipitating factors that cause the disorder can be found out. Further, contrary to the perception that the mind-body differentiation is specific to biomedicine, ritual healing entails that there is a separation between diseases located in the body and that in the mind, though, as Finkler underscores, these dualities might not be constituted in the same way. The differences stem from the notions of personhood and discomfort, as they are constituted in biomedicine and alternative medicine. For instance, spiritual healers discussed male-female relations in terms of rights and obligations whereas within biomedical practice the emphasis was on the body. Spiritual healers hence never reduced social relations to problems concerning the body and sexuality. The difficulty for patients, especially women to leap from sociability to sexuality was seen as baffling and distressing. Further the physician has a wide range of diagnostic repertoire but limited treatment methods-either medicines or surgeries, while for the healer, the diagnostic repertoire is limited but

treatment methods are many. Because there is a lack of multiple diagnoses in the case of healers, there is a consistency amongst healers regarding etiology, diagnoses and treatment of diseases. Given that the physicians have a vast range of possible diagnoses, and consequently, the diagnosis can change at a later point in the treatment, for the patients repeated revisions in diagnosis is distressing. While the physician tends to temporalise and localize the disease, the spiritualist transcends both. For the physician to treat would mean that the locus of the disease should be observable. Further, the disease is seen as progressing in stages. There is also a time duration within which treatment is placed. On the contrary, for the healer, the spirit might affect its victim in more than one ways and the process of recovery might be incremental, progressive or inconclusive. Both fail however, when they are unable to attend to the patients' world with its contradictions and the need for transformation.

The preference to consult a healer along with consulting the physician has led to many studies which have idealized the client healer relationship and state that it is the one to one relationship between the doctor and the patient which leads to better outcomes. On the contrary, healers spend hardly any personal time with the patient and often lack eye contact with their clients. Further, they often fail to recognize the individual standing in front of them as they sit in a trance. This precludes the healer from showing any kind of affect for their patient. Finkler's study indicates that in the consultations, physicians spend about twenty one minutes on average with a first-time patient, whereas the Spiritualist healer-patient interaction usually lasts less than half that time. Healing spaces are also ambiguous in that they cater to more than one section of society. Thus, it is common to find healing shrines being visited by individuals across religions and class. For instance, in the study of an Indian Islamic healing centre, Bellamy (2006) states that Islamic healing shrines are attractive to both the Hindus and the Muslims. This is because they operate with the same spiritual economy and have similar categories, concepts and tropes. Hence it is possible to benefit from a shared worldview. In a shrine where religious identity is ambiguous, what attracts individuals is the meaning they derive in relation to the shrine as well in relation to one another. Similar is the case of Sufi shrines where according to a study by Farida, Dera et al, 2007, Sufi saints act as intermediaries which enable curing.

Possession as performative: Ascribing meanings to the body.

It is evident then that the body is not only an object which is acted upon by the physician or the healer. The body, rather, actively engages in constituting possession itself. In other words, the body is an embodiment of suffering and distress of the individual. Drawing attention to the performative aspect of ritual, Sax in a study of possession among the low castes suggests that the body of the possessed devotee is the most important mode of appearance and this mode of appearance indicate what it means to belong to a low caste such as the Harijans. The onset of possession also indicates a moment of risk wherein it is not clear whether the possessing spirit is that of a ghost or of a god. The physical embodiment of the god is the indication to the community that possession is real.

Sax argues, based on possession observed among a 'community of sufferers', that his study amongst the Harijans of India indicates that it is not only the material relations of production which are important but also ritual relations of production. Further, as Low (1988) states, efficacious 'symbols' are important not only because they indicate the meanings that healing holds for the individual but also for the fact that they express the cultural, social and political order. For example, it must be understood that capitalism and neo-imperialism are not the only systems of exploitation in the world. In the South Asian context, for example, the system of caste is a deeply exploitative and deeply embedded system of hierarchical power relations, one that clearly influences the healing cult of Bhairav. Secondly, it must be realized that the performance of ritual reflects and, even more importantly, often reproduces unequal relations of power. Hence, Moore (1993) emphasizes the need to constitute possession healing in the socio-legal perspective wherein therapeutic efficacy is addressed by dealing with the hierarchies that exist in society. Based on a fieldwork in rural India, Moore states that rural villagers, specifically the women, are often victims of the centralised legal system as the legal systems in reality are arenas which are almost exclusively the domain of the powerful. Hence the practices of possession are also a response to this domination and are, in that, related to the cultural conception of justice and resistance. Drawing attention to gender inequalities that exist in society, Nickoles (1991) explains that the spirit in many cases in south Asian possession

is that of a dead son or a male member. This is because the son's death represents extinction of male line and the death of the future. The appearance of the dead son is a signal to incorporate him into the family's household spirit.

Based on his examination of possession mediums in South India, Nickoles (1991) contends that experiences of possession states of men and women vary across different groups particularly in the context of the mediums incorporating spirits have different dream visitations. Linking gender to the context of a capitalist mode of production Ong asserts that (1987:207 cited in Moore, year: 523) "spirit imageries reveal not only a mode of unconscious retaliation against male authority but fundamentally a sense of dislocation in human relations and a need for greater spiritual vigilance in domains reconstituted by capitalist relations of production". Thus, capitalism retains patriarchy, a premodern structure like many other exploitative structures which continues to operate and influence the current social organize and thus give rise to disaffect leading to possession. In other words capitalism has used pre modern structures to establish and propagate itself.

Possession and gender

Nobokov (1997) emphasizes that there is a need to understand the cultural interpretation of alienation and states that it is essential to reexamine whether the function of possession by ghosts is to express women's dissatisfaction with gender roles imposed upon them. One of the commonly rendered explanations is that women who are going through important thresholds in their lives such as menstruation, puberty are seen as polluting and therefore are considered as having similarities with the demons who are also seen as polluting. This is especially common among young married women because it enables them to use metaphors and symbols to communicate psychological conflicts in an environment wherein women may otherwise be unable to do so. Hence possession is not necessarily distressing. Further the demons that possess young women are seen as individuals who have had a premature death and hence have desires which motivate them to capture young women. Possession, seen this way, can serve as a medium for women to express themselves in an otherwise repressive society. Yet, this ability to express may not necessarily be positive or empowering. In other words explanations such as the above on possession reinforces stereotypes about women. As Nourse (1996) underscores that

possession does not necessarily mean empowerment but it indicates the selflessness of the mediums that deal with the spirits and the belief in the factuality of the spirits agency. Based on a study of the Lauje in Indonesia, Nourse argues that there is an underlying debate between curers (who can see the spirits, but not necessarily cure through spirit possession) and the mediums (who can see the spirits and communicate with them, and this is their primary agents of cure about the identity of the spirit, where it has come from and the purpose it seeks to achieve. There is thus an internal mechanism to check the factuality of possession itself and hence the possibility that mediums use spirit, as a proxy to express what is otherwise inexpressible does not hold good. (Nourse, 1996).

Conclusion

Understanding possession, thus, involves an understanding of the factors which influence possession as a therapy. As Chamberlain (1913:145) states: -

> The modern mind in fact finds little difficulty in believing that within certain limits some forms of disease may have been cured by 'faith' but it does find a most serious difficulty in believing that they were caused by demons. It is prepared to admit the 'suggestion' given by a spiritual healer may liberate the sub-conscious recuperative powers, but it hesitates to accept a diagnosis which implies 'possession' is that by an evil spirit.

So great is this difficulty that possession now reads as nervous disorders. He further argues: -

> The supercilious miracles which do not happen has been softened to the more acceptable, miracles are all around us, only that they are not special. It is hence considered quite reasonable to argue that comparative immunity from demonic possession is not only the result of medical progress but also of moral progress, hence rather than viewing the decline as a difficulty, this raise in moral progress is what should have been expected.

Ignoring the factors which influence an individual to seek possession as a therapy leads to viewing possession as a substitute opted for by the less privileged, weaker and marginalized sections. While it is true that inequality and power influence possession practices, it is equally true that it is practiced and actively engaged in by individuals across caste and class. Ignoring this would lead to viewing possession as an inferior form of treatment opted by less intelligible minds. It is hence necessary to interrogate the notion of possession by analyzing the linkages of possession with caste, class, and gender

rather than seeing possession as a consequence of lack of other alternatives. Ignoring this would lead to a kind of analysis similar to that by Prince's (1976:129) assertion that:-

> Although psychoanalysis may be a superior form of therapy because it brings about more complete integration and understanding of conflictual drives, it is grossly limited in its applicability. Only highly self aware and westernized individuals can become significantly involved in the analytic endeavor. On the other hand, dissociation states, psychoses and religious exercises are much more universally applicable.

It is to highlight the limitations of such an approach that is almost a throwback to evolutionary thinking, that the next chapter analyses the limitations of a psychiatric view of possession which reduces possession to a pathology on one hand and on the other, posits a evolutionary scale of growth and civilization wherein the western societies are seen as more advanced than non western traditional ones.

Chapter III

Trance and Possession Disorder: A Critique.

The question if certain cultures are themselves pathological or if pathologies occur in a cultural setting has been one of the most pervasive quests of psychiatry, and in fact, psychology itself. An analysis of certain important psychiatric literature will indicate that for the purpose of identifying and later treating disorder, specific linkages between practices, cultures and disorders have been formulated, thereby viewing entire cultures themselves as predisposing individuals to illness. It has been possible for psychiatry to posit and later attempt to validate such a proposition, since it views itself as being scientific, rational and hence acultural and ahistorical.

The perception of psychiatric categories as being acultural however is quite problematic, as shall be explored in this chapter. On the contrary, in fact, the basis for identifying what constitutes a disorder itself rests on notions of ability, functionality, and normality, which are cultural preferences. Hence, far from being acultural, psychiatry itself is cultural. Later critiques from anthropology and psychiatry pointed out the limitations of psychiatry in that it presumed diseases to be universal, and thus denying the role of historical and cultural factors in precipitating psychological conditions which might not be a disease in themselves. As a response to this critique, psychiatry introduced the notion of cultural aspects influencing clinical settings; thereby suggesting that previous difficulties which emerged due to application of an overarching term cross culturally has now been successfully resolved. Recent psychiatric literature indicates that Far from resolving the issue of cross-cultural validity, the research in psychiatry has, in fact, reinforced the notion of universal disease.

This has however occurred through the creation of other binaries such as the biology-culture and form -content, which view one category as the 'real' factor causing disease and the other category merely influencing the manifestation and treatment of diseases. Thus for instance the dominant view in psychiatry sees biology, form, nature as the real factors while treating culture and content merely as influencing factors. It is on the basis of such a formulation that it is possible for psychiatry to suggest that disease is

universal and treatment is cultural or pathology is standard and deviations are culture specific. Another limitation is the formulation that if a particular practice is not 'normal' in the sense psychiatry defines the term, it ought to be pathological, and that if a particular behavior is not functional, it is necessary dysfunctional and hence a pathology. As shall be examined later in this chapter, such formulations are problematic for a variety of reasons, since there are many levels at which deviations from established practices and procedures are perceived and dealt with in different societies. While it is true that all cultures have behavioral patterns and characteristics that would be deemed pathological, this does not entail that similar practices would be seen to be pathological universally or that mental illness can be reduced to an all encompassing category. Emphasizing the problem Skultans and Cox (2000:23) assert that the study of mental illness in non-western cultures has resulted in evaluation of cultures themselves as pathological and pathogenic. Thus, disease is presumed to be a universal category, while cultures are seen as locales, which influence the development of disease. Even if one were to accept such an assumption that disease is a universal category, the question of how cross-cultural comparison can be undertaken in different contexts and cultural settings (locales) remains unanswered. For instance, the question that on what basis does one decides whether illness patterns in two locales are comparable remains unresolved. Those who support the proposition that disease patterns are universal would argue that comparison is on the basis of functional equivalents, in other words, on the basis of behavior patterns that are exhibited by individuals in different settings while fulfilling needs that are largely biological and hence universal. Nonetheless this does not account for the fact that behavior patterns appropriate to fulfilling needs might itself be culturally rooted. Further these are also influenced by what priorities exist for a collectivity at a given point.

Thus while cross cultural comparison might be an important and legitimate goal of psychiatric research, merely accounting for cultural variations ignores that different nosologies exist. A closer look at two prominent guidelines on mental health, The Diagnostic and Statistical Manual for Mental Illness published by the American Psychiatric Association and the International Classification of Diseases published by the World Health Organization, indicate that psychiatric categories view disease as universal. Two disorders which indicate the above mentioned limitations of classification through a

universal notion of disease will be explored in this chapter. These include the Culture Bound Syndrome, which views certain diseases as specific to certain cultures and the Dissociative Trance Disorder, which has been classified under the dissociative disorders section in The Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (henceforth referred to as DSM IV- TR or as DSM IV).

Outlining the key features of the dissociative trance disorder would enable me to clarify the objectives of this chapter and would facilitate the introduction of a few key terms and definitions such as disorders, mental illness and an anthropological critique of these definitions. Appendix B lays down the following research criteria for Dissociative trance disorder (DSM IV TR, 2005: 875). It consists of either (1) or (2).

> 1.Trance, i.e. temporary marked alteration in the state of consciousness or loss of customary sense of personal identity without replacement by an alternate identity, associated with at least one of the following.
> (a). Narrowing of awareness of immediate surroundings or unusually narrow and selective focusing on environmental stimuli.
> (b). Stereotyped behaviors or movements that are experienced as being beyond one's control.
> 2. Possession trance, a single or episodic alteration in the state of consciousness characterized by the replacement of customary sense of personal identity by a new identity. This is attributed to the influence of a spirit, power, deity, or other person, as evidenced by one or (more) of the following:
> (a). Stereotyped and culturally determined behaviors or movements that are experienced as being controlled by the possessing agent.
> (b). Full or partial amnesia for the event.

The above classification of dissociative trance disorder betrays its inherent problems. It is important to consider that the definition of the term possession or trance is itself based on the perspective from which it is analyzed. Thus while the psychiatric perspective on possession, as entailed in the definition of DSM IV (TR), sees it as being primarily characterized as alteration in consciousness, replacement of identity and amnesia, other factors significantly emerge when one understands possession from an anthropological perspective. Boddy (1994:407) defines spirit possession as a "broad term referring to the integration of spirit and matter, force or power and corporeal reality in a cosmos where the boundaries between the individual and her environment are acknowledged to be permeable, flexibly drawn or at least negotiable". This is sharply different from a biomedical view of the body, where the emphasis is on the corporeal body. In other words, the body is seen as the limits within which diseases that existing in the body need

to be treated. For instance, even if a particular disease is seen to be the consequence of environmental influences, nonetheless, treatment would mean addressing the body. Thus merely setting right the external conditions would not in the biomedical notion of treatment result in curing the body. This is different as compared to a nosology wherein the body is seen as replicating what exists in nature. Therefore maintaining harmony/equilibrium in the environment would result in changes in the body. This would also mean that the relationship between the individual and the environment are perceived differently in the case of the latter as compared to a biomedical view of disease. Conceptualizing this possibility, Boddy (1994:407) argues that recent studies suggest spirit possession is based on "epidemic premises quite different from the infinitely differentiating, rationalizing and reifying theories of global materialism and its attendant scholarly traditions". Thus depending on the criteria, which are used for observing a particular practice, very different definitions emerge.

The aim of this chapter is to outline and critique the notion of the Dissociative trance disorder and culture bound syndromes as mentioned in the DSM IV (TR). Further the chapter attempts to show that the differentiations within the DSM such as Dissociative identity disorder, Dissociative trance disorder, and culture bound syndromes are at best ambiguous. These 'disorders' are based on certain assumptions, for instance notions of normalcy and functionality that have varied meanings and hence cannot be labeled as containing a single or a specific particular meaning. What this means is that the notions of pathology itself is debatable Situating the debate in the context of the history of psychiatry, it becomes clear that preferences for certain states of body and mind are not biological but reflect cultural preferences for certain practices over others. In other words- psychiatry is not a-cultural but rather it is embedded and shaped in the context in which it has developed. Finally, the chapter aims to raise questions on the incorporation of culture at the level of treatment, and in the process of incorporating different nosologies, meanings and explanatory models.

Understanding Mental illness: Exploring links between culture and biology

The DSM IV TR (2005:xxxi) conceptualizes mental disorders as:-

> A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death, pain, disability or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example the death of a loved one. Whatever its original cause, it must currently be considered as a manifestation of a behavioral, psychological or biological dysfunction in the individual. Neither deviant behavior nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.

Disorders are also described as syndromes which are a constellation of signs and symptoms. Signs are objective to the extent that they are based on the clinician's observations of the patient, whereas symptoms are subjective experiences of the patient, for instance a complaint of feeling depressed. However, the line separating sign from symptom is blurred in psychiatry, and hence the use of the term disorders offers a workable solution to this distinction, nonetheless the problem of sign versus syndrome has been extended to a distinction of the natural versus cultural and this distinction continues to prevail as an important issue in psychiatric research. Littlewood (2000:69) pointing this out, states that since not every individual who was diagnosed with a particular illness reported the same experience, clinical psychiatry makes a distinction between pathogenic (biological processes necessary and sufficient to cause mental disorder) and pathoplastic determinants (personal and cultural variations in the pattern) to deal with variations in symptoms between individuals. The term 'culture', however presented, remains a significant problem to the psychiatrist. Firstly, it meant that culture remained secondary to scientific biological reality and hence there was a need to examine linkages between culture and biology. Secondly, there was still a need to distinguish certain individuals and groups from others; and this was possible only by highlighting 'cultural' factors as a cause. Thus when there were no apparent biological factors that led to disorders among some individuals and not to the rest, the disorders were explained by employing the role of prevailing 'cultural' factors. Hence psychiatry not only perceived cultural practices as different from the supposed mainstream way of functioning, but also relegated cultural 'beliefs', for instance in a soul in the domain of pathologic, arguing that

these non western beliefs predispose them to being pathological. (Pathological of course meant a western discourse of the body and pathology).

This lead to what Ackernecht referred to as wholesale pathologisation of cultures. (Littlewood, 2000:81). Importantly entire cultures were seen being predisposed to pathologies as they indulged in practices that were, in the view of western psychiatry, obsessive, paranoid etc. Nonetheless, the frame of reference on the basis of which deviance has been constituted itself needs to be questioned. For, if a culture permits or even encourages difference, then under which nosology can that behavior be termed deviant or pathological?

Dissociative Trance Disorder: Critiquing notions of pathology, functionality and normalcy.

The DSM has been critiqued precisely for the above reason, that is, its complete ignorance of alternative nosologies. While it acknowledges that certain states, such as Dissociative trance should not be considered as a disorder, if it is in the context of the cultural and religious practices that is accepted by the person's cultural group, and hence it is non pathological and voluntary (DSM IV, 2005:783), yet the DSM fails to recognize that what is construed as a disorder or pathology is equally determined by the culture or religious practices. In other words, pathological and negatively valued trance and possession states are just as religious and culturally defined as the positive ones. However, this aspect has not been taken into consideration by the DSM. To quote, the Dissociative Trance Disorder, stated in Appendix B- Criteria Sets and Axes Provided for Further Study (DSM IV, 2005:783) states: -

> The essential feature is an involuntary state of trance that is not accepted by the person's culture as normal part of a collective cultural or religious practice and that causes clinically significant distress or functional impairment..... However some individuals undergoing culturally normative trance or possession trance states may develop symptoms that cause distress or impairment and thus could be considered for this disorder.

However, the lapse lies in that while a trance or possession trance state might not be a 'normal part', it does not necessarily mean that the culture in which it occurs would recognize it as pathological. For instance, the context in which possession occurs might not be the context in which majority of the cases occurs. Similarly, the pattern in which

possession occurs might be different from the general pattern of possession practices. Yet this despite this deviation from the normal, such forms of possession might not be considered to be pathological.

Nonetheless, to view as pathological and hence to categorize it as a disorder, is erroneous. Further, even if there is a categorization of the normal versus the pathological form of trance, the distinction between the two is quite blurred because these distinctions are also culturally embedded. As Bourguignon (1992:331) explains "even when possession trance occurs spontaneously, outside ritual contexts and is negatively evaluated by the community in which it appears, the interpretation of trance as possession has cultural validation. That is, possession beliefs are not idiosyncratic, personal products, like delusional beliefs, but are shared by cultural groups or based on traditions". An objective, independent of culture analysis of possession, therefore, is not possible within the parameters of psychiatry.

Further, as Leavitt (1993:54) states, both pathological and positive practices are very often part of the same rituals and ceremonies. There is hence an attempt to convert the pathological and often dangerous elements/entities into benevolent and helpful ones. The very possibility of converting a dangerous possession into a positive one makes the psychiatric evaluation of possession irrelevant. Moreover, in many instances, it is only during the practice of possession or trance that the healer or medium is able to decipher the nature of the entity that is present. To presume hence that there exists a clear-cut division between pathological and positive elements is problematic. To cite an instance, Sax (2006) in a study of central Himalayas examines healing practices where there is an attempt to placate the spirit, to transform the ghost into one that is god-like. As many studies indicate, even within a normal healing ceremony, certain unexpected occurrences might occur, for instance, multiple individuals being possessed, or an entire family being possessed simultaneously. While these are not normal (in that they are perceived by the culture in which it occurs as being unexpected or unforeseen), yet they are not seen as pathological either. Rather as Sethi and Bhargava (2009) argue based on their study of a case of mass possession, that the causes for such cases may be located in the ambivalent family relationships. In this whole process, nowhere do the authors state that the family had viewed this 'rare' occurrence as pathological or as a disorder. Evidently, the

pathology part is a cultural construct which does not apply to the settings where trance and possession both can be seen as positive. In short, as Leavitt (1993:51) mentions " the essential point to remember is that western culture is distinctively negative with regard to trance and possession phenomena. In the west, these have been associated with demonic possession, then with madness or medical pathology. In many parts of the word, trance and possession are perfectly normal parts of religious life and they often carry great prestige". Even in cases where madness might be a cause for affliction, the affliction might not be considered to be pathological. Arguing that a western viewpoint of possession should not be imposed on practices occurring elsewhere, Hollan (2000) asserts that irrespective of how bizarre or irrational it would seem from a western point of view, possession should not be considered to be pathological. Rather, it is from the cultural worldview of an individual, that the notions of self, illness and hence pathology are constituted. To understand pathology, hence, it is necessary to locate it within the cultural worldview. For instance, in certain cultures there is a widespread sense of being vulnerable and acted upon by other humans or other outside forces. If the boundaries between the individual and the environment are constituted differently as compared to a western viewpoint, then in itself dissociation cannot be considered to be a pathology and in such societies, disorders such as dissociation are rarely seen by the community as a disorder or as madness. This would mean that associating trance and possession with mental illness is itself problematic as this linkage fixes meanings of both mental illness and trance or possession whereas the meanings of the above categories are not universal or singular. In short, it reduces all individuals who undergo trance and possession to having mental illness which is not often the case.

The question of normality of trance or possession is one important criterion for determining the disorder. The other important criteria is functionality, in other words, if there is a significant difference in the ability of an individual to function effectively when s/he he undergoes trance or possession states, then this 'dysfunctionality' could be seen as a contributing factor towards the disorder. However, such a consideration of functionality presumes that non-functionality or dysfunctionality would be negatively valued and hence would be considered to be pathological. While non-functionality or dysfunctionality is important, in many cases across several non-western cultures such

non-functionality is also appreciated and hence is not negatively valued. Thus the other criteria that accounts for Dissociative trance disorder is "trance or possession trance states cause clinically significant distress or impairment in social, occupational, or other important areas of functioning". (DSM IV, 2005: 785). As raised in many anthropological writings discussed in the previous chapter, distress or impairment is often indicative of a 'calling' to become a healer or a shaman and in such cases can be encouraged by the community. In other words, distress might even be encouraged in certain cases as it prompts an individual to take up the role of a healer and hence might not be negatively valued. Further as Leavitt (1993) suggests, such distress is often a means of expressing dissatisfaction or rebellion. Given these factors, what is seen as pathology itself becomes a contentious matter. As Lewis-Fernandez (1992) states, these lead to the risk of misattributing pathological status to all trance and possession states worldwide due to the application of a overly formalistic nosological category. This reduces context specific meanings of possession and trance to a rigid, bracketed pathological category. Thus while cross cultural comparisons pose a problem in recognizing what constitutes Dissociative trance disorder, variations exist within any given society wherein trance practices might differ. In other words, even within a culture, practices might differ depending on the identity of the possessing agent, for instance, whether it is an evil or good spirit. Thus, as many systems of classification are highly heterogeneous and classify practices in different ways it is arbitrary to attribute all cases of a supposed syndrome into a single psychiatric disorder. Thus there are three issues which are at stake- firstly, whether there is cross cultural acceptance in viewing a particular practice as a 'disorder' and secondly, even if there are cases when certain practices are accepted as pathological within the cultures in which they are practiced, in the sense they are negatively valued, can they be subsumed under a psychiatric disorder. Finally, how does one account for practices which are not overtly positive or negative but rather, as stated above there is a shift from one to the other. In short, how does one account for transformation, rather than emphasizing on clear-cut categories?

Dissociative Identity Disorder and Dissociative Trance Disorder: Similarities and Differences.

Another contentious issue with the classification of the Dissociative Trance Disorder is whether trance disorder should be incorporated within dissociative identity disorder or should it be categorized separately under dissociative disorders [which is also its categorization in the DSM IV (TR)]. The DSM defines Dissociative disorder as (DSM IV TR, 2005: 519) "a disruption in the usually integrated functions of consciousness, memory, identity or perception. The disturbances may be sudden or gradual, transient or chronic". However, disruptions which are commonly accepted in cultural activities or religious experience in many societies do not form part of the Dissociative disorder. The diagnostic criteria for Dissociative identity disorder (DSM, 2005: 529) includes: -

> a) The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of receiving, relating to and thinking about the environment and the self).
> b) At least two of these identities or personality states recurrently take control of the person's behavior.
> c) Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
> d) The disturbance is not due to direct physiological effects of a substance or general medical condition.

The similarities between dissociative trance disorder and dissociative identity disorder such as inability to recall important information and a state which is not due to physiological effects of substances have led to questions on what is the basis of differentiating dissociative trance from dissociative identity disorder. The main differentiating factor between the Dissociative identity disorder and Dissociative trance disorder is stated to be that of the form of dissociation- whether it is due to spirits (and thereby due to an external influence) or due to the split of a single unitary self (and hence an internal process. Consequently, this has led to debates in two different directions. Firstly, that Dissociative trance disorders should be incorporated within Dissociative identity disorder given similarities in form and expression (as stated above). The other position is that the similarities between the two are merely superficial, since Dissociative trance disorder addresses social functions and the role of trance which is different from that of identity disorder and may not necessarily be pathological. Supporting the latter

position, Stafford Betty (2005) in an analysis of psychiatry's response to possession points out, dissociation occurs when (formerly known as Multiple Personality Disorder in the DSM) a secondary personality splits off from the primary one. Secondly, it also means that the core personality is unaware of the actions of the alters. Though in reality, both these assumptions are not always applicable. As observed in many cases, the victims of spirit possession are often aware of environmental factors and casting out a spirit that occurs under trance might not lead to unawareness. In fact many of those who report afflictions by spirits are able to recount significant aspect of their experience.

A critique of the evolutionary perspective within psychiatry: Questioning the concept of linking diseases to 'civilizational progress'.

While the above-mentioned perspectives differ on whether there should be a separate categorization for dissociative identity disorders, the debate has also undertaken directions which are almost a throwback to evolutionary thinking. That those believing in 'scientific' classification of diseases and a 'rational' viewpoint should posit a position which equates certain practices with civilizational development and progress is indeed surprising. Specifically, this perspective views possession as particular to traditional societies and believes that it disappears as societies move up the civilizational ladder. For instance, Cardena (1992) puts forth the view that spirit possession was the precursor of multiple personality disorder in the west. This is because few individuals continue to report spirit possession in the west now and multiple personality disorder has taken its place. Hence multiple personality disorder and currently dissociative identity disorder are seen to be more advanced forms of the possession which occurred in traditional societies. This, further shows the bias of psychiatry, as the symptoms are the same it is just the influence of modern psychiatry that people name it as MPDs. Perhaps it is this understanding that has led to trance and possession being relegated to traditional, displaced and minority population

Apart from the inherent weaknesses, this perspective is challenged by the developments both in the western and other parts of the world. As will be analyzed in the next chapter, many new spirituality movements incorporate trance as an integral part of their healing procedures. Often, this is done through a 'trained' medium who is supposed

to have the expertise to deal with other worldly beings. For instance in many parts of the world, deliverance ministries carry out the task of solving problems due to demons and spirits, mainly possession. To state an example, the deliverance ministry at the Diocese of Worcester states, "The purpose of deliverance ministry is to make real to those who feel possessed, oppressed or afraid, the victory of our Lord Jesus Christ over all that is evil, so that his living presence may bring peace". (http://www.cofe-worcester.org.uk/GI/27). The evolutionary bias is also evident in the DSM, wherein it explicitly states, "Variants of these (Dissociative trance disorder) conditions have been described in nearly every traditional society on every continent. The prevalence appears to decrease with increasing industrialization but remains elevated among traditional ethnic minorities in industrialized societies". (DSM: 784). The statement implies that the Dissociative trance disorder is more common among traditional, non industrialized societies.. And even more importantly, it presumes that cross-cultural forms are 'variants' of a universal form. . It ignores the fact that seemingly similar practices might have different theories about causation, cure, and management of either trance or possession trance. These differences might include observable behaviors that occur during possession or in the context of notions of cure, removal of affliction etc. This then, leads back to the argument in the introductory section of the chapter, which is that the perception of disease itself is culturally constituted rather than cultures play merely a negotiating role to some universal nosology of disease, illness etc and thus influence the way 'disorder' affects the person. That this argument has been repeatedly stated by anthropologists (Obeyesekere: 1989 cited in Santotis, 2009, Lewis-Fernandez: 1998 etc) and is a well known critique of the notion that disease is universal, makes it ambiguous as to why the DSM formulated a separate category known as the Culture Bound Syndromes in Appendix I of DSM IV (TR). Culture bound syndromes have been defined as "denoting recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM IV diagnostic category. Many of these patterns are indigenously considered to be 'illnesses' or at least afflictions though they might have local names". (DSM IV, 2005: 898). This formulation however does not answer the question of how dissociative trance would be distinguished from other syndromes such as

Amok, rootwork, ghost sickness etc, all of which to an extent have similar behavior patterns at least in the domain of functionality.

The perspectives which emerge from the classification of culture bound syndromes have been put forth by Skultans and Cox (2000:19) in the form of three broad categories. The first is the perspective which looks at Culture bound syndrome as indicative of primitiveness or of difference. The second and the more accepted one is to view culture bound syndromes as being 'conceptually equivalent' to psychiatric categories. In other words, psychiatric categories would have sufficed if not for the cultural overlays. The third perspective (and the position that would be emphasized in this chapter) is that culture bound syndromes are to be found in all societies. For instance, if Amok and Zar are categorized as culture bound syndromes, so should Anorexia Nervosa be classified as one, as the latter represents *disorders* within western society, based on 'culturally held' beliefs about the body, individuality and so forth. Critiquing the presumed universality of diseases, Jadhav (2000:43) states, " A recent line of enquiry within the 'new cross cultural psychiatry framework suggests that western psychiatric theory has often neutralized its own cultural distinctions, objectified them through empirical data and then received them back as if they were universal objective 'natural science' categories".

Surprisingly enough, the DSM states that certain conditions and disorders specific to industrialized cultures, such as anorexia nervosa and Dissociative identity disorder, have been 'conceptualized' as culture bound syndromes given that the fact of their apparent rarity or absence in other cultures (DSM IV TR, 2005: 898). Further the glossary of culture bound syndromes lists some of the 'best studied culture bound syndromes and idioms of distress that may be encountered in clinical practice in North America' (DSM IV TR, 2005: 899). Yet the glossary of the DSM's Culture Bound Syndrome does not mention either anorexia nervosa or Dissociative identity disorder at all, despite it being a western specific disorder and despite the glossary being based on what is 'encountered' in clinical practice in North America. Rather, it includes syndromes practiced by cultures in Malaysia, Puerto Rico and Somalia amongst others!! The fundamental assumption is that a disorder might result in a culture, which is particularly predisposed to it. The solution to this problem finds no mention in DSM, probably

because of the underlying assumption that the problem would be resolved by reaching a higher stage of civilization.

Culture bound syndromes and Dissociative Trance Disorder: Is there a necessity to categorize them separately?

An analysis of the criteria enlisted under culture bound syndromes and the criteria mentioned under dissociative trance disorder demonstrates a lot of overlapping and consequently, raises the question if there is a need for separate classification of the culture bound syndrome. This ambiguity shall be indicated by comparing a well-known culture bound syndrome Zar with the trance disorder. To begin with, Zar(DSM IV, 2005: 903) has been defined as:-

> A general term applied in Ethiopia, Somalia, Egypt, Sudan, Iran and other North African and Middle Eastern societies to the experience of spirits possessing an individual. Persons possessed by a spirit may experience Dissociative episodes that may include shouting, laughing, hitting the head against a wall singing or weeping. Individuals may show apathy and withdrawal, refusing to eat and carry out daily tasks or may develop a long-term relationship with the possessing spirit.

Consider this with the research criteria for point 2 of Dissociative trance disorder, i.e. possession trance stated earlier in this chapter. Sub category 'a' under point 2 states that such possession trance includes stereotyped and culturally determined behaviors or moments that are experienced as being controlled by the possessing agent. The similarity is apparent when one considers the other two criteria that both impairs important areas of functioning, and do not occur in the course of other psychotic disorder. The only point of differentiation that can be raised is point B of the Dissociative trance disorder that delineates that such a state is not accepted as a normal part of a collective culture or religious practice. And hence, considering the fact that Zar is a 'normal' part of the collective practice in the cultures concerned, it cannot be legitimately classified as a Dissociative disorder. However, as stated previously, the position of what is considered to be a *normal* part of the cultural practice remains ambiguous. For instance, acknowledging the fact that possession practice maybe perceived as 'normal' in several cultures, does not deny the possibility of variations among possession practices within a culture. Nor does it mean that a certain practice that is not 'normal' would automatically be placed as being a disorder. Rather, instead of accepting the binary of normal-abnormal

which is a dominant feature of western psychiatry, cultures may have a lot of space between the normal and the pathologic. Thus, the criteria of normalcy is faulty as it presumes a given, static notion of normality and this criterion is the only criterion on the basis of which dissociative trance and culture bound syndromes can be differentiated. Hence the distinction between culture bound syndromes and dissociative trance disorder needs to be reconsidered. Another factor that needs to be highlighted is the incorporation of certain practices under culture bound syndromes which are introduced by stating that they involve a trance state. For instance, the syndrome known as spell is introduced as a "trance state", nonetheless it remains within the category of being 'culture bound' thereby displaying the difficulties with the distinction.

In many cases, the DSM itself states that the culture bound syndromes might have similarities with other disorders mentioned in the DSM. What should be the primary diagnosis in such cases of overlapping syndromes emerges as an important question in such cases. The fact that the DSM provides no operational suggestions for taking 'cultural factors' into account further complicates the matter. Hughes (1998:416) in context of the nosological status of the culture bound syndromes, raises the question asking "are culture bound syndromes sui generis different from conventional DSM IV syndromes or is this simply a difference in categorization and levels of semantic analysis employed". Given the problems that emerge with the classification of the culture bound syndromes, it is perhaps helpful to outline shortly the main categories on the basis of which culture bound syndromes have been formulated. As mentioned in the DSM, these include: -

a) Cultural identity of the individual-, which involves the individual's ethnic or cultural reference groups. In case of immigrants it involves the degree of involvement with culture of origin and the host culture.

b) Cultural explanation of the individual's illness- predominant idioms of distress through which symptoms are communicated and the need for social support is indicated. Perceived causes and explanatory models of the individual, the family and community

c) Cultural factors related to psychosocial environment and levels of functioning- this includes interpretations of stressors and available supports.

d) Cultural elements of the relationship between the individual and the clinician- differences in culture and social status between individual and clinician and problems that this might cause in diagnosis and treatment.
e) Overall cultural assessment for diagnosis and care. The formulation concludes with how cultural considerations specifically influence comprehensive diagnosis and care.

The above categories do acknowledge thee variations that exist across cultures and that these influence treatment and cure. More importantly, it recognizes that individuals might have different models of the illness. Yet, it fails to provide any mechanism for different nosologies to be incorporated in the process of diagnosis and treatment. At best, it emphasizes that the cultural factors play an important role in the clinical encounter. But then, such a consideration is important to any clinical encounter, including the mainstream biomedical encounter and in that does not achieve any significant success either in diagnosis or treatment. Hence ultimately, these categories relegate cultural differences to factors which are to be surmounted for effective treatment to be possible.

What both the Culture Bound syndrome and the trance disorder fail to incorporate is the difference not merely in curative and treatment related aspects but in the varied meanings, explanations and thereby different nosologies, notions of cure, functionality and, more importantly, in the values associated with each of these terms. A closer look at the proposed criteria for incorporating cultural factors by the suggestion committee set up during DSM IV (TR) is put forth by Lewis- Fernandez (1998). He states that a total of 36 textual items were proposed to be included of which 15 were included, 18 were rejected and 3 were incorporated in a simplified form. Thus while aspects such as language describing the normality of most trance and possession trance, definitions and associated features, expected complications, emphasis on distress and impairment were included, other important aspects such as diverse social functions of trance and possession trance across cultures, language and the role of culture on the basis of which trance is interpreted as normal or pathological, prototypes of trance and possession trance, gender ratios, particular prevalence from Puerto Rican and Indian studies, were not incorporated. Further the proposal on differential diagnosis; including detailed comparison with

Dissociative identity disorder, other dissociation disorders and psychotic disorders were incorporated in a simplified form. Hence Lewis-Fernandez concludes that that universalistic language was allowed to stand and independent or parallel nosologies or detailing alternate ways of diagnosing a syndrome (different 'kinds' of amok for example) were not included. (1998:395). Further even when the DSM compares disorders such as the Dissociative identity disorder and the Dissociative trance disorder, the main difference lies in the perceived source of alternate personalities (1998:396), i.e. internal or external. Hence the fact that the analysis of Dissociative trance disorder itself is of western origin or shows western bias was not considered. An important symbol of this bias is the fact, as Peck (1983 cited in Betty, 2005) explains, that possession has been studied only in the Third World it and never in North America or Europe. Further, the western bias, not only in categorizing disease but also in privileging certain modes of expressing distress and explanatory models over others, is reflected clearly when non western societies are studied. For instance, Rao (1978:7) states that possession syndrome has a specific name in all Indian languages. The question then is does subsuming them under one category of possession syndrome account for these differences.

Brief Historical overview of the development of psychiatry.

That a psychiatric manual such as the DSM, which is used cross culturally, should indicate western bias and thereby contribute to the pathologisation of nonwestern cultures raises an important question regarding the sources of this bias. The answer to this question is partly rooted in the very development of psychiatry as a discipline. Further, the question, by implication, entails identifying and understanding the factors which lead to the development of criteria such as the culture bound syndromes. The analysis of culture bound syndrome is related to the understanding of culture as a 'civilizing process' and hence to outline the transformation of groups from migratory groups to settled cultivation to that eventually of nation states. Fabrega (2009) states that modern psychiatry is largely a development of twentieth century and was influenced by the social and political problems that were posed by the mentally ill. The importance of history of psychiatry lies in that while cases of behavioral breakdown, asylums and hospitals existed even before the colonialisation of the British, yet in many places such as India, it

was during the colonial rule that modern psychiatry and the institutionalization of mental illness took place. When psychiatry developed as a medical specialty in 18th century Europe, physicians recognized that certain concerns which they examined as sicknesses could appear more commonly in one country or group rather than in another. (Littlewood, 2000:67). Hence mental illnesses were in due course of time seen to be specific to a particular nation or a particular group of people, age, temperament etc. This was based on reasons that individuals neglected their immediate 'obligations' meaning that they were seen as neglecting those aspects which were seen as constituting the 'culture' of a group. As Fabrega outlines, culture became accepted as a term to place all those characteristics attributable to living in a particular society. Culture as a category was generally placed in opposition to the existing term nature. Once referring to the physical world created by divine action, nature now also denoted those features of human life which were found in other living beings, all natural attributes which could be found in human societies to different degrees. Thus physical growth, reproduction, as well as properties such as generosity sociality, were seen as existing in different degrees in different societies. However, when psychiatric practice gained popularity and addressed a wider audience, it was recognized that if patient's versions were doubted or were rejected this would lead to losing the client and therefore other formulations had to be derived to analyze patient experiences and at the same time maintain the biological-culture distinction so that the physician could address the problem 'scientifically'. The form- content dichotomy was therefore formulated in order to serve as a proxy for distinguishing the biological from the cultural. In other words nature was the form and culture was the content, the treatment was to be directed towards the underlying biological cause. This worked smoothly as, Littlewood points out, till the beginning of 20th Century until when psychiatric practice was confined to the Europe especially in the Anglo-Saxon world. Problems of the discipline started emerging soon after, when the psychiatric practice was extended to the people of colonial empires. The apparently different nature of 'mental illnesses' in the colonies and their perception by the 'natives' perplexed the practitioners of psychiatry, not least, by making the disconnect between their worldview vis-à-vis that of 'natives' evident. Littlewood, (2000:70) puts this brilliantly " Many local patterns which suggested novel types of mental illness had been previously recorded by travelers,

missionaries and colonial administrators, sometimes indeed as illness but often as examples of the criminal perversity of native life or just as picturesque if rather troublesome oddities. Perhaps most notable amongst these was Amok". Initially these were taken as rather 'odd' but not necessarily as pathological. The transition from odd or deviant behavior to being dubbed as outright pathological was aided by the argument that these are not new diseases per se but rather they are quite similar to what is known in the west. The argument, in other words, asserted that western societies had an advanced form of diseases found in the non-western world. An extension of this argument would mean that non-western societies are at a stage of civilizational development which the west has already undergone, and hence serves as a model for the non western societies. While this perspective has been critiqued by Littlewood, (2000) Kirmayer(2007) and others by stating that pathologies cannot be universalized, many others such as Fabrega state that knowledge of diseases developed considerably during the colonial regime with many diseases being brought under control and overall improvement of the health conditions and hence though there may be no universal pathologies, nonetheless treatment following a standard model of disease has been beneficial. However, As Kirmayer (2007) states, the process in fact was much deeper than providing health care as aberrant behavior was now pathologized, and even worse, was seen as culture specific pathologies. The development was also aided by a faulty analysis of data from travelers, especially their observations of peoples of cultures different from the West, led to them being viewed as undeveloped barbarians, ignoring the fact that travelers tend to record what seems different more than what is similar is. Hence while colonial psychiatry did serve the suffering individuals, it also served to legitimize and colonial regimes by giving strength to the oft repeated argument of 'white man's burden to civilize the barabrians'. The notion that psychological illness in the west was more real as compared to the colonies led to varied interpretations such as non western cultures do not have depression because of lacking self blame, an essentially western characteristic, which does not exist in the non-western world. The notion, inherently, carries the associations of existence of individuality and reason, modernity in short, with the Western world and denying it to the non-western one.

The arguments which emanated from the notion were even worse, outright racist at times. For Example, Vint (1932 cited in Littlewood, 2000:76) pointed out to a less evolved brain in non-western cultures and argued that this is what predisposed them to certain illness (and not to others). Understandably so, Kirmayer (2007) finds that psychiatry itself has been used to support racist beliefs. This, for instance, is seen in the notion that non-western people had underdeveloped frontal lobes which made them more prone to 'disinhibited behaviors'. Such a view was seen to support both for cross-national differences and to account for inequalities that existed between the metropolis and the colonies. On the contrary, in fact, these inequalities were the consequence of racism, slavery and economic exploitation. Thus, while patterns such as the culture bound syndrome meant that cultural 'beliefs' were pathological. Hence later psychiatric literature contained information of culture bound syndromes as it was argued that comparative psychiatry which focused on the exotic also influenced what can be perceived as the universal psychiatric disorders.

With respect to diagnosing culture bound syndromes, Shimoji and Mjiyakimi (2000) argue that culture bound syndrome is often, erroneously, seen as tactics used by people within their own culture. Rather, in their view, for making clinical interventions appropriate and treatment effective it is important to employ both the indigenous and biomedical treatment together so as to enable people to use them in complementary or simultaneous function. At the level of practice, there might be a gap between the expectations of a patient and the treatment given out to him/her due to the differences in the treatment that the patient is accustomed to and the new treatment the patient opts for. At the level of theory, many indigenous practices are now seen as being negative or harmful as they do not meet set guidelines or required characteristics of standardization. Whether clinical testing incorporates varied understandings of cure and efficacy is what leads to complications when different treatment options are compared. Thus whether alternative and complementary medicine, which is advocated as a middle path between biomedical and indigenous practices, indeed provides legitimacy for not only indigenous treatments but also indigenous nosology is debatable. The influence of dominant modes of healthcare and the need to find categories and modes of treatment to fit into them are seen even in the clinical encounter. Based on a study of clinical encounter at Umbanda,

Boddy (1994:412) states, "In the last this takes a biomedical form. For instance, in Umbanda mediums wear nurse uniforms and spirits acting through mediums had clinics for spiritual healing".

Emergence of cross-cultural Psychiatry: A response to the critique of evolutionary, western bias of psychiatry.

As a response to the critique of western bias of psychiatry, there have been attempts to put forth a cross-cultural psychiatry that takes cultural appropriateness of disorders into account. Fabrega (2009:7) states that a tenet of cultural psychiatry is that "cultural underpinnings of modern scientific psychiatry, including not only descriptive terms but also essential aspects of psychopathology, disorder, disease and the mental as compared to the bodily and physical are distinctive if not peculiar to the western history and culture compared to other cultures". The central aim of cultural psychiatry, then, is to realize that pathologies exist cross culturally and as a corollary, to emphasize that cross cultural differences in treatment, cure, meaning attributed to disease vary. The limitation of cultural psychiatry has been put aptly by Kirmayer who asserts that Cultural psychiatry differs from the social sciences of medicine in being driven primarily not by theoretical problems but by clinical imperatives. (Kirmayer 2007: 3). This means that cultural psychiatry merely finds ways to practice psychiatry in different cultural settings, while leaving behind the different questions that clinical settings might itself give rise to including different experiences and worldviews that emerge in different clinical settings. Further, there is a legacy of colonialism in current cultural psychiatry which continues to have a decontextualized view of mental health problems. In such a perspective, cultural practices are exoticized, essentialised and labelized. What a cultural psychiatric perspective can in fact offer is to locate cultural practices in the contexts in which it occurs. This would involve an understanding of notions of decolonization, resistance, and worldviews all of which shape human behavior. In contrast, cultural psychiatry has its limitations in that it continues to be acontextual and persists with a notion of universal nosology.

Such a limitation, in terms of western bias of cultural psychiatry however, is not restricted merely to theoretical aspects but has important implications for clinical

practice. As suggested by many anthropologists, local terminologies might not have even equivalent translations or terminology in English let alone equivalent diagnostic criteria. For instance, Jadhav (2000) in a study of depression asserts that during the process of clinical encounter the role of language is often minimized identifying many levels at which such a slippage occurs. The patient might converse with the doctor in one language, the doctor 'translates' the patients' narratives or symptoms into the closest equivalents or diagnosis in English. Further, in many cases, while the patient speaks in the native language, the clinician almost always notes in English with terminology that mirrors that of western psychiatry. In such situations, not only local words but rather local worlds, with their cultural values, associated bodily problems and a range of expression are pruned to fit conventional psychiatric systems The process, further, abolishes the role of cultural variables, like gender, migration, poverty, stigma, labels and even situations that influence or, in some cases, even cause the disease. This raises issues of cultural validity in cross cultural settings that extend far beyond the clinical encounter wherein the patient- doctor relationship is said to be influenced by the cultural 'backgrounds' of both. The question rather is, considering that local idioms of distress are quite rich and varied, do nosological categories account for these varied expressions.

Given the above limitations of psychiatry, Fabrega suggests that the emphasis should be on the clinical condition rather than the clinical disorder. In other words, the emphasis should be on the symptoms reported by the patients rather than emphasizing the disorder as laid down in the psychiatric manual. However, the question arises as to what criterion is used for giving treatment. While psychiatric condition might resolve some of the problems posed by culture bound syndromes, in that it would accept nosologies which are non western. Yet, when it comes to diagnosing a patient and, more importantly, to give medications, it is the diagnosis of the disorder and not the condition on the basis of which medication is prescribed. The translation of experience into category thus remains problematic. On the one hand, a universal nosology poses problems of being exclusive to other cultural ways of expression yet; incorporating every local idiom would make it difficult to arrive at any form of generalization, on the other. As Boddy (1994:410) states, spirit possession has been characterized by "a fundamental tension between reductive

naturalizing or rationalizing approaches on the one hand and contextualizing, more phenomenological approaches on the other".

Anthropology and Psychiatry: Exoticizing the 'other'.

In the understanding of the role of psychiatry in cross-cultural studies, it is inevitable to form a linkage between anthropological approaches and psychiatry. However, while anthropological approaches (which critique the notion of universality, normality and functionality) highlight cross-cultural differences, these approaches have also been responsible for exoticizing the other. Anthropology and psychiatry share much more in common than just being rooted in colonial underpinnings. While psychiatry excluded the 'others' and the worldview of the 'other'; anthropology included the 'others' but at the cost of transforming the subjects/native's viewpoint into anthropological categories, and losing, the original meanings attached to them in the process. Translating 'emic' understandings into 'etic' categories was carried out to make the 'exotic' more meaningful to the non-exotic, western viewpoint. Thus, anthropological accounts of spirit possession, account for them in terms of 'rituals', 'symbols', and 'solidarity' and 'social functions' so as to enable the psychiatry practitioners to make sense and choose a line of treatment, even if the condition is not considered pathological by the patients in the first place. Similarly anthropological studies tend to emphasize aspects which seem to be significant to the anthropologists even if they might not necessarily be the only significant aspect for the individual concerned. For instance, in a recent work on healing systems, Halliburton (2009) emphasizes the pleasant process of therapy as a cause for patients resorting to privileging environments that are more pleasant like a temple, shrine or ayurvedic therapies as compared to the biomedical treatment. While concerns such as reduced side effects, more control over the process of treatment do play a role, one of the primary reasons argued by Halliburton for privileging alternatives is that it provides a more engaging and enriching environment. The observations of Halliburton, however, do not present the complete picture as patients do resort to many forms of therapies that include practices which are painful or troublesome for the individual. For instance, though Halliburton refers to cooling mudpacks in ayurveda, practices such as Panchakarma involve procedures that might be painful, which

goes completely unmentioned in his description of ayurvedic treatments. Ignoring this aspect and emphasizing merely the pleasant process leads to reinforcing the other as exotic and thus denying them the original meanings they carry in their cultural settings

While it is necessary that psychiatry and anthropology create typologies, often this is at the cost of excluding the context in which practices occur. As Boddy states, typologies are achieved by not taking adequate consideration of context and this means that even if they are heuristic they should not be taken as criteria for prediction as doing so would blind researchers to the complexities of the situation and that the typologies have been influenced by the interests, values and fascinations that are part of the analyst's society. In the case of the DSM IV (TR) the attempts to reduce the above mentioned limitations seems partial as the DSM IV acknowledges that dissociation states exist across cultures and has included the notion of cultural acceptability, yet in the DSM IV, the view of pathology seems universal. This points out to the need to understand the relationship between 'normal', deviation and pathology. In other words, deviations might perhaps be attempts by the body to create new forms of normativity, which over time becomes the 'norm'. Hence even if they are considered to be as pathology for instance, fevers might be an attempt to establish the norm of homeostasis. Categories of normalcy and pathology also change with changing conditions of environment and human response to these changes. To what extent then do diagnostic categories reflect changes, or if they are adaptable, in other words remains unexplained. For example, psychiatry or medical anthropology, despite claiming to have recognized the need to understand that language and terms used by patients/clients to express their conditions need to be translated while ensuring that the meaning is not lost in the process of translation, have not succeeded in doing that to any significant extent. On the contrary, what one observes is the explanation of practices through dominant patterns of understanding, analyzed, then, on the basis of well-established terms, concepts, categories and theories. As Janice Boddy (1994:408) argues "the very categories that describe the field are inescapably ideological and reconstructed, freighted with cultural meanings and valuations laden with traces of their repeated reformulations as a subject of scientific investigation over time". Although it may be necessary to work with such categories in the interest of comparison, it is not necessary to concede that they transparently capture an essence, an autonomous human

behavior. To find ways of incorporating cross-cultural phenomena without either reducing them to universalistic models or exoticizing them as indicating the past of the advanced western societies hence remains a challenge.

Chapter IV

Modernity and trance practices.

Anthropological writings on possession and trance have posited a clear distinction between shamans, beliefs and possession practices on the one hand and trance channelers, medium and spiritual growth on the other. This distinction becomes clear when one observes that the debates with respect to trance channeling centers on issues of clientèle, expertise of the medium and the ability of the medium to connect with energies to resolve individual needs. On the contrary, possession practices, largely seen as occurring in non-western societies raise issues of societal needs, social harmony and ritual performance. Contemporary trance practices, however, are not based on entities such as ghosts, evil spirits and spells, rather, they are based on notions of energies, auras and spirit visitations. An analysis of modern contemporary trance practices provides an insight into how western, biomedical notions of the body are critiqued, and yet despite this critique, trance practices fall within the boundaries of what is considered to be scientific and rational and hence considered to be legitimate. Hence modern 'believers' are 'rational' believers.

Trance practices in contemporary western society, are not seen as violations of either rationality or scientific thinking, while possession practices that take place in *other* societies are viewed as beliefs. This separation holds importance despite the fact that from the point of view of observed practices, trance and possession might seem similar. For instance, both are considered to be marked by changed behavioral patterns, amnesia after the event and lack of functionality in a state of possession/trance. Despite these overt similarities, certain practices are classified as trance and others as possession, certain practitioners as healers and others as shamans and certain processes as scientific and others as ritualistic. If practices classified as trance and those classified as possession indicate similarities, then what are the basis on which such a classification takes place? Further, what are the implications of such rational view of trance? In other words, the distinction between trance and possession culminates into distinction between societies and classes (rational/ western/upper class on the one hand and traditional/non western/underprivileged on the other). Does a cross cultural comparison permit

interchangeable use of categories, for instance, describe practices that occur among the western or amongst the elite clientèle as possession and those occurring in non western, underprivileged groups as trance? Is it possible to view the choice of categorization as differential power relations- as that of the western researcher versus that of a non-western respondent or a western researcher versus that of a minority population? Anthropological literature on both, possession and trance, seem to reiterate the above-mentioned dichotomies rather than indicate the contrary. In such a case then, examining trance in 'modern' contexts would highlight that these practices are not specific to third world countries (unlike the DSM which relegates possession to third world traditional countries) and that given the similarity in these practices (trance and possession), modern western nations are not at a higher state of spiritual evolution but rather, the construction of what determines spiritual growth is itself a western construct. The emphasis on spiritual evolution is important because contemporary trance practices are seen by anthropological writings as being part of new age movements or new age spirituality movements, hereby indicating a shift from the use of religion (as in the case of possession, with the additional usage of the term ritual) to that of spirituality.

This chapter is an attempt to understand how anthropological literature has accounted for contemporary trance practices, in western society. How are contemporary trance practices analyzed and distinguished from what is considered to be pre modern and hence ritualistic possession practices. Secondly, how are possession practices in contemporary non-western societies accounted for? For instance are these practices seen as a result of colonialism or other forms of crisis, in terms of being a response to a situation or are current trance practices in non western society given legitimate existence in their own right, i.e. as influenced by 'outside' factors but not as the consequence of outside influences and finally how have modern trance practices dealt with western, scientific notions and fixed, corporeal notions of the body. In other words, how have trance practices accommodated for the usage of energies, channels and auras without stepping outside the boundaries of science and rationality. This chapter begins with understanding the relationship between religion and modernity, and the how the category of religion excludes non-institutionalized practice. It engages with how a formalized notion of religion has been constructed with the help of textuality. In the context of India,

this debate has played out in terms of the Brahmanical and the non-Brahmanical. Further, this separation has led to distinctions between the rural and the urban, and consequently a portrayal of rural life as religious, backward and superstitious in contrast to the urban and modern society. A critique of this emerges in the prevalence of 'religious' customs even in non-rural, non traditional contexts, though often it is termed differently as spirituality and new age movements. The chapter then examines new age movements in detail to indicate how notions of individuality, holism are constituted. This leads to an examination of how trance practices in western societies has been analyzed vis-a-vis explanations given for continuance of 'possession' in non-western societies. The chapter then proceeds to make comparisons between practitioners, processes and experiences reported by clients in case of contemporary trance with that of contemporary possession practices to indicate that the use of terminology is often ambiguous. Further possession or trance does not occur in a unilinear manner, for instance, only as a western-non-western dichotomy. Other variables such as gender, class, historical contexts, and memory play an important role. While the chapter does not elaborate any of these variables in detail, it attempts to indicate how these categories are often interlinked and hence possession/trance occurs in a context. Finally, this chapter concludes with raising the initial question of the basis and implications of cross-cultural comparisons and usage of specific categories.

Religion and modernity: Examining categories of folk- textual, Sanskritic-Non Sanskritic and rural-urban.

The interrelation between religion and modernity is one of the primary question with which intelligentsia has engaged. The question inevitably requires exploring religion as a lived reality by individual human beings in the modern set up. In other words the question becomes what does it take to be a 'modern believer'? or, what are the implications of relegating religion to the individual and the private domain? The emphasis is on whether religion can co-exist with modernity and how does religion reinvent itself to suit the context of modernity. Thus, how does religion provide new ways of rationalization which are acceptable within the framework of modernity. In much of sociological literature, the reference to the term religion is that of the institution of

religion- of a formalized system of beliefs and practices, roles and statuses and a practice that has continued to be persistent over a period of time. While institutionalized forms of religion do exist, it is equally important to identify practices that might not be covered under the formal system of 'religious institutions'. Thus, there are many practices which are performed by individuals in everyday life which might not be considered as part of any 'religious' system. For instance, practices such as praying to a 'protector deity', in the form of a stone, i.e. animatism (view that inanimate objects have consciousness) is common among many settled communities. However, these are seen as 'beliefs' as opposed to the term 'religion'.

Thus using the term religion while explaining many practices also precludes many other practices. Smith (2006) states that certain practices derived legitimacy because they were considered to be 'classical' as opposed to the folk which was seen as secondary to the classical, in terms of its importance. The classical-folk binary can also be viewed as the contrast between the book view and the field view, written and oral, Brahmanical and non –Brahmanical practices. In other words, there has been a distinction between popular and mainstream religion depending on the influence of theology and texts. Within sociology, distinctions such as little tradition versus that of the great tradition, and folk versus classical have been formulated to account for variety of practices that exist. The distinction between classical and folk has often been interpreted as the folk being a degenerate form of the classical. However, based on ethnographies and classical texts, Smith (2006) indicates that the classical is infact an appropriation of folk practices. Since the folk preceded the classical, it is necessary to take into consideration the processes by which the folk was co-opted into the dominant model or how do folk practices indicate forms of resistance and try and preserve their own identity when confronted with mainstream/brahmanic practices.

Questioning the notion of a holistic religion: A case from the Indian context.

It is not surprising that the dominant religious structures tried to clamp the development of other possible modes of religious expression in an attempt to maintain their stronghold. As Chatterjee (1995) mentions in describing the development of the

tradition of Vaisnavism, several non Brahman Vaisnava teachers such as Narottam Datta, Narahari Sarkar had Brahman disciples. However, such practices were frowned upon. This was followed by a whole series of stereotypes finally resulting in condemning the low caste gurus. This however, did not mean that lower castes always accepted their subjugated status. Attempts were made by these castes to challenge the dominance of the higher castes and the notion of a universal religion. As Chattterjee (1995:186) states:-

> It will be apparent from the histories of the minor sects that the varying intensities of their affiliation with the larger unity, the degree of 'eclecticism' the varying measures and subtleties in emphasizing their difference and their self identity reveal not so much the desire to create a new universalist system but rather varying strategies of survival and of self assertion. Therefore, resistance within the dominant paradigm meant in many cases, to be at the fringes of society, excluded from mainstream society.

It is hence necessary to problematize the concept of a 'holistic' religion. Sinha (2006) refers to the processes by which various categories were incorporated into mainstream Hinduism. Sinha (2006:102) points out that there are attempts to associate village deities with Sanskritic deities and this gives folk and ritual practices, a higher and more legitimate status. The category of folk and its conceptual utility hence needed to be reanalyzed. This needs to begin with an analysis of the term folk itself wherein the term has connotations such as ordinary, common men and masses. This is associated with peasants and rural populations, further typecast as illiterate and unsophisticated. Hence the divides such as the great and little and Sanskritic- non-Sanskritic needs to be examined.

Given that much of the anthropological work till the 70s was influenced by the dominant paradigm of functionalism and the distinction between rural and urban was translated into a distinction of tradition versus modernity, it is not surprising that possession practices were perceived as folk, illiterate and superstitious practices. The persistence of these practices in modern, urban centers required a new form of analysis to account for this phenomenon as the earlier dichotomies (rural-urban for instance) did not hold much validity. This was done by offering variant definitions of the term modernity, ranging from notions of modernization of Indian tradition given by Yogender Singh to that of multiple traditions of Eistenstdat. Essentially the question was whether there is a form of modernity that is unique to India, i.e. can we have an Indian modernity, a

different form of rationality and if it is possible to have such a conceptualization, then what are the features and variations of this modernity. However, as Sujatha Patel (2000) points out such a question presumes the existence of a universal or mainstream modernity of which other forms are mere variations. Questioning the limitations of the notion of multiple modernities, Patel suggests that we need to re examine whether modernity as a category itself is valid to describe experiences in non-western contexts and whether we need to refer to other terms and categories to document different experiences. While recognizing the importance of these debates and the need to break overarching categories, this chapter nonetheless addresses the question of possession and trance in the context of modernity, wherein modernity, viewed from the viewpoint of western science, signifies an emphasis on individuality, rationality and scientific thinking.

The analysis of the term religion in the context of modernity.

Given the debates on whether religion can exist within sphere of modernity, it is necessary to examine how religion, which is a pre modern institution operates within the context of modernity. Describing the role of religion in modernity Hervieu-Léger (1990) argues that, the role of religion as an institution aimed towards providing salvation has now become diffused to the realm of the individual. In other words, the emphasis is now more on the psychological fulfillment of the individual. Drawing on the role of secularization in contemporary times, this argument lays emphasis on the role of religion being relegated to the private sphere. However, this does not necessarily mean that religion as an institution has reduced its hold on people. This then means that modernity rather than displacing or negating religion as an institution has in fact used religion to establish itself- for instance through the influence of market within the 'religious' domain, wherein religious objects are a commodity. While it is important to recognize that modernity has influenced religious practices, nonetheless this does not mean that pre modern religious institutions were a pre requisite for the development of modernity. Further, modernity has produced its own institutions which need to be examined. Elaborating the manner in which religious institutions function in modernity, Hervieu-Leger (1990:15) argues:-

> The theoretical argument can be advanced that far from being antithetical to modernity, religious renewals are in harmony with modernity especially in respect to the private and individualistic character of their beliefs and fluidity of their organizational forms. Modernity therefore generates its own forms of religion by creating and filling gaps between rational certainties.

In a similar line of thought, Lambek (1980) argues that there is an attempt to control the ambiguities and uncertainties of nature which recreates and at the same time abolishes religious utopia. The creation of religious ideals hence is not permanent as there is a continuous process of negotiation between the individual and notions of religious ideals. This has led to a reflexive endeavor on the part of the individual to find new meanings to religious practices. Hence, Hervieu-Léger D(1990,: 24) states:-

> These reflexions have thus led us to a new definition of secularization. It is no longer considered as the "decline" of religion in the modern world, but as a process of the reorganization of the work of religion in a society which can no longer satisfy (not temporarily, but structurally) the expectations it must arouse in order to exist as such, and which can find no better response (not temporarily, but structurally) to the uncertainties arising from the interminable quest for the means to satisfy these expectations.

Trance and Modernity: The shift from religious to spiritual explanations.

An important aspect in the context of analyzing possession and modernity is the significant change in the use of the term 'trance' or 'possession-trance' and modernity. (The term trance has been used by both anthropologists and psychiatrists largely in the context of contemporary, western practices, while the term possession trance specifically refers to a 'syndrome' mentioned in the Diagnostic and Statistical Manual published by the American Psychiatric Association under the category of Dissociative disorders). While studies on Indian or non western contexts even when they concern contemporary practices use the term possession, or translate an indigenous term into the English equivalent of possession, contemporary practices in western society are referred to as trance practices or trance channeling and are subsumed under the rise of new spiritual movements, or new age religious movements. Trance practices are hence placed under a broader framework ranging from alternative religious movements to that of spiritual movements. Hence, there is a clear shift from religion to spirituality. Thus, a comparison between the perspectives even at an overt level indicates that while modern channelers

are taken over by another entity because of their expert skills at being able to connect and 'tune in' with other entities, non western, third world societies are regarded as having possession practices. However, while the practice of possession (non western countries largely) is visible and hence its existence cannot be denied, the theory of ghosts and evil spirits are not permissible within the sphere of modernity. Hence practices of possession are explained through psychological or psychiatric perspectives. This raises the fundamental question of whether it is possible to delink theory and practice. In other words what are the implications of legitimizing a practice, not on its own accounts but rather by choosing a mode of explanation which is alien to it. Consider the explanation of the shaman performing psychological functions in non-western societies. Demetrio (1978:58) posits: -

> First, the shaman is a psychologist (a) on account of his knowledge of the mind, and of mental states and processes; or, which amounts to the same thing, because of his knowledge of human nature; (b) because he is a person especially sensitive to influences and forces that are extrasensory, or, because he is psychic, even a "mystic in the raw," and (c) because he was the psychiatrist in preliterate society, in that he practiced the healing of mental diseases."

From the above explanations, that focus on knowledge of mind rather than emphasize intrusion by a spirit, that highlight mystical experiences rather than magical practices, it is not too far fetched hence to argue that the western is equated with the modern. Another possible explanation for this distinction is the need for western researchers to account for trance practices in their societies as rational and scientific. It is apparent that not only psychiatric models have limitations in that they reduce possession to a pathology, but rather sociological and anthropological models have their limitations as they emphasize largely on processes of socialization and interpretation as explanations for why certain practices exist. However, Laubach (2004) points out that while doing so, sociological models tend to emphasize more on the reporting of an experience rather than emphasizing on what it means to have an experience. In other words, it tends to be a post facto analysis of an event, while ignoring the possibility of highlighting the meaning that an individual held during possession.

New age movements: A brief overview and critique

The term new age spirituality or new religious movements has been used to incorporate a wide range of phenomena. Bowman (2000:8) argues that the term new age "is used to cover everything from well-established New Religious Movements to contemporary popular spiritualities and recent developments in specific religions, and may be applied with comparatively little historical and structural specificity". Thus, in the context of India, it is used to refer to a wide range of practices such as 'lifestyle gurus' who teach techniques on handling stress and meditation. It is also used for developments such as 'art of living' which are seen as catering more towards spirituality rather than religion. The uniting factor between these movements is that they cater to a specific social class, preferably urban, English-speaking elite.

Nonetheless, this term excludes many movements which are contemporary, that cater to individual as well as societal needs and yet are not classified as new age movements because they cater to underclass groups. Hence even if these movements offer new meanings of religiosity, they are still not considered to be either new religions or new age movements. Rather, they are categorized as deviations, factions, sects and other such terms which point to a splitting off from the mainstream. Consequently they are denied any holistic identity and further there are always attempts to compare these movements with mainstream/classical religions. As (Leger, 1990:21) points out "new religious movements do not appear in backward social categories or among underprivileged rejects of modernity". For instance, in the context of India, the Ad Dharm movement in Punjab, emerged to challenge the Brahmanical supremacy. As Ram (2004:7) explains, "the Ad Dharm movement aimed at securing a distinct identity for the Dalits, independent of both the Hindu and Sikh religions. Its central motif was that Untouchables constituted a qaum (community), a distinct religious grouping similar to that of Muslims, Hindus, and Sikhs, which had existed since time immemorial." Guru Ravidass, the fifteenth-century poet-saint, became the icon of Dalit assertion in Punjab. During the Ad Dharm movement, his image was systematically projected to concretize the newly conceived Dalit cultural space. The fact that he came from one of the lowest castes acted as a catalyst in the emergence of Dalit consciousness. These movements gained mass following as they leashed an attack on the traditions of oppression. Ram (2004:12) points out that.

"Ravidass's popularity among the lower castes in Punjab is kept alive through the network of shrines raised in his memory." Yet despite the popularity of these shrines, these movements have not been classified as new religious movements, thereby reinforcing the fact that the defining of new religious movements itself is limiting and excludes underclass movements.

Given these limitations largely based on the exclusive nature of new age movements, it is necessary to understand the meanings of new religious movements or new age movements in contemporary contexts. The shift form religion to spirituality is generally perceived as a shift towards a more individualistic activity. However, Hedges and Beckford (2000) state that such an assumption is misplaced. Rather they argue that, new age movements are not the site of confusion or conflict but rather they are reflection of increasing process of 'flows' and 'tuning in'. In other words, it reflects the increasing number of practices that are diverse and simultaneously used. Though the term seems to be vaguely defined nonetheless, new age movements offer a scope of potentiality, and a prospect for change. It begins with a hope that a significant improvement in the quality of human life can be achieved and that authentic selves can be discovered. Hence during the 1980s and the 1990s, new age referred to taking responsibility for one's own spiritual life and doing what seems to 'work' for the individual. However, as Sutcliffe (2000: 7) indicates, the shift from institutionalized forms of religion to seemingly autonomous form of spirituality does not mean that picking and mixing practices is new and occurs only with the growth of new age movements/spirituality. On the other hand, practices such as following different doctrines, rites, saints and customs have always existed. What has changed therefore, is not the role of individual or vernacular religion but rather the changing importance given to the perceived official religion.

Hedges and Beckford (2000) similarly emphasize that, individualism or cultural confusion is not the basis of new age movements. Rather new age movements are also depended upon forms of sociality and ideas which are collective and holistic. They put forth certain features, which are characteristic of most new age movements. The main feature is the prevalence of hope – in the possibility of improvement of human life on the one hand and a belief that the seeds for such improvement- human creativity, trust and knowledge already exist. Secondly, these are based on a criticism of the existing forms of

living that are seen as materialistic, shallow and unable to fulfill the human potential for creativity. This might include a criticism of societal traditions and religious systems. Thirdly, there is an openness to new ideas about the interconnectedness of all forms of life and that an individual is personally responsible for his or her life. And finally it includes an awareness of possible steps that can be taken to reduce human disruption, corruption of resources etc and to work towards harmonious and self-equilibrating forces. The challenge of new age movements then is to maintain a middle ground between being too traditional and authoritative on the one hand and self indulgent or individualistic on the other. The process of new age spirituality hence is complex and times subtle. While there is a search for a true or authentic self, there is also a danger of de-identification from the rest of society that needs to be taken into consideration. This is because new age movements cater to individual needs yet these needs are ultimately directed towards the communal, i.e. towards expanding the scope of the 'self', for instance to incorporate other viewpoints/needs apart from one's own while making a decision. The importance of self has also led to debates on whether there can be a singular constitution of the self and consciousness or whether these notions need to be re considered. Influenced by the new age movements and growth of spirituality, Smith (2006) refers to the possibility of spiritual possession as an altered state of consciousness, which involves the desertion of the original personality and the temporary replacement by another one. Further, Bourguignon (1989) compares spiritual possession with curative possession trance and claims that the later shows markedly similar features, though there might be different situations and motivations for its use. In this perspective then, trance is part of the healing process rather than being seen as a deviance.

Contesting explanations for contemporary possession and trance: Analyzing debates on colonialism, memory and external influences on possession and trance practices.

As indicated above, contemporary trance is not devoid of emphasis on community and societal needs. The emphasis on community experiences, has led to accounting of new age possession and trance practices through either functional explanations as a fulfilling a societal need or to view possession-trance practices as the consequence of

some form of crisis, such as that of colonialism. Examining the importance of colonialism and external forces in determining possession practices, Hale (1997) sharply indicates that while one cannot deny the influencing role of either colonialism or other forms of crisis on existing religions and forms of practices, nonetheless relegating the emergence of these systems to these factors ignores that systems of healing might have emerged in very different contexts, even though they are influenced and shaped by colonialism and crisis. The emphasis on the manner in which crisis influences possession and trance, has led to the positing of individual needs in context of modernity, wherein individuals configure ways by which crisis such as colonialism or modernity can be addressed. Interestingly then, studies on trance have pointed to the manner in which it enables individuals to cope with the stress of a 'modern' lifestyle. For instance, Ong (1988), in a study on *production* of possession, refers to the importance of spirit visitations. Spirit attacks are seen as occurring in the context of transition from one phase to the other, where on such occasions they are seen to be a great threat to social norms. In the case of workingwomen in Malaysia, spirit attacks are seen as the result of a "complex negotiation of reality" (Crapanzano1977:16) by an emergent female industrial workforce. Further, spirit possession episodes are seen as speaking in voices that refuse to be silenced by the dominant mainstream perspectives, in other words, repressed voices that voice their opinion in specific circumstances. Ong (1988:35) indicates the importance of the relationship between body and sickness by stating that the woman's body was seen as the site of control wherein gender, politics, health and work intersected. In a situation wherein women are often subjugated, possession practices temporarily reverse or break down the dominant structure. For instance, women in possessed states are known to give commands, shout abuses which is permissible only when they are in a possessed state. However, this is not to say that possession practices break down the existing dominant structure, rather they only temporarily suspend the existing structure. As would be explored later, this often leads to a further strengthening of the dominant structure.

Similar arguments which view trance and spirit visitations as a protest against social practices, structures that have emerged with changes in economy have been put forth by Kelly (1985), Peters (1982) and Pigg (1996) in their studies. Interestingly most of the works on trance and trance possession have been conducted on women, migrant

and Diaspora populations, almost leading one to believe that trance practices do not occur among mainstream, dominant populations. This is contrary to the position on possession as a ritual or the view of possession as performing symbolic/functional needs wherein the common argument put forth is that possession takes places amongst the underprivileged, and is largely a product of 'folk' culture. For instance Lewis (1971) in (AvRuskin, 1988: 292) argues that people who are the most marginalized in a given society would be more likely most likely participate in spiritual possession to solve the problem of illness and that of diminished self-respect. However, new age movements challenge such an assumption. In the 1970s the role of new religious movements was located within the development of a new spiritual culture where the decline of religion was presented as a consequence of the process of industrialization. In such a context then, the new religious/spiritual movements played an important role in fulfilling the individual's need for 'reassurance' in the 'modern' world. The emphasis on individual needs has changed the meaning of possession-trance in that it is now seen as solving individual crisis rather than being a solution to the general societal problems.

In continuance with the above argument that emphasizes the importance of possession for fulfilling individual needs, Smith (2001:430) argues that the possession is a symbolic vehicle through which the vicissitudes and strains of contemporary life are interpreted and acted upon. Based on fieldwork in Kenya, Smith states that economic liberalization produced a transformation in the relationship which people had with the spirit world and this transformation was indicative of the changes that were taking place in Kenyan society. He continues by arguing that possession is a model of cultural expression that enacts prevailing social conflicts, particularly those centering on gender. In other words, he suggests that while gender roles become multiple and complex, women are forced to go outside the private sphere of the home and enter the public sphere. Consequently these practices clash with traditional values concerning the roles of women. Further, from the point of view of women, the complexity of roles increases stress and leads to a responsibility of fulfilling a range of needs. Therefore, possession practices bring forth societal contradictions to the public realm, and this enabled a public mediation on critical matters. However, in many cases there is a privileging of societal mores and values, and hence such practices even if they seem to challenge the dominant

structures, do not necessarily bring about a different understanding of gender roles, but might enable in bringing about a re mediation on social structure as well as societal values. Further, society is a witness to the deliberations and commitments made by the contesting families, groups or individuals.

While resolving individual needs has emerged as an important contribution of new age trance and possession, Lambek (1980) asserts that the prevalence of this reasoning in modern, industrial context, is the pushing of other mutually incompatible ideologies to the fringes, without however overtly violating them. In other words, other forms of reasoning exist; nonetheless they are at the edges of what is considered to be the 'norm' and therefore relegating these other modes of thinking as deviating form the norm and the normal. The role of the dominant ideology in relegating other forms of expression to the fringes has been addressed in many contexts. For instance, Foucault (1990) in the History of Sexuality asserts that the 'other Victorians' such as the madmen, the criminals and the homosexuals were seen to violate the norms of Victorian society. Because they were seen to be deviants, they were repressed, and finally denied legitimate status and were confined to the fringes of Victorian society.

From Shamans to channelers: similarities and differences.

The use of the term shaman, curer, trance channel as equivalent ad substitutable terms u needs to be explored further. Winkelman (1990) puts forth the proposition that agriculture and political integration has led to the transformation from the usage of the term shaman to other types of magico-religious healing practitioners, labeled as shaman/healers, healers, and possession-trance mediums. (The practitioners labeled as shamans, shaman/healers, healers, and mediums shared major characteristics in common. These included the use of trances, interaction with spiritual entities, engaging in activities such as healing and divination, occupying part-time statuses as healers and having mostly informal or charismatic political power, and engaging in professional activities at the request of a client. All shaman/healers in Winkelman's study were found in societies in which the subsistence patterns involved a major reliance upon agriculture, except one healer who was found in a pastoral society. The worldwide distribution of the shaman in hunting and gathering societies that was found in Winkelman's sample supports the

hypothesis of a universal distribution of shamanism, with the presence of shamans in all regions of the world at some time. This proposition has been used to further the viewpoint that shamans are found largely in traditional societies as opposed to other types of healers who are found in modern societies. Consider for instance, Hultkrantz (1978) assertion that as the role of the shaman becomes less important in more complex societies, it becomes transformed from a community function into a private act, similar to the practices of spiritualism found in modern societies. Further, in modern societies, (he equates modern with being politically integrated) Hultkrantz points out that spirit mediums are frequently female. Further these mediums engage with and enter into trance states yet these altered states are not considered to be malevolent. For patients/clients though, modernity is not always contradictory with trance/ possession practices. Pigg (1996) based on his study of shaman healers in Kathmandu, Nepal, shows the coexistence of modern medicine and shamanic practices. In many cases, shamans are the next choice when modern medicine is unable to cure the illness/disease that they face. In the accounts of the urban elite, ritual healers can step in where "modern medicine" inevitably falls short, whether because Kathmandu's diagnostic and treatment facilities are inadequate or because even the most advanced medical knowledge has its limits. In these situations, they, position themselves as modern believers who carefully choose which healers to rely on in particular circumstances. But whereas villagers, (cut off from the main city and who are generally perceived by the urban elite as resorting to shamanstic cures, 'dhami jankaris') are concerned that others perceive them as ignorant, the Kathmandu elite are concerned with a state of modernity they fear is partial or second-rate compared to that of the developed world. The notions of beliefs then are at best relative, as there exists a sense of better avenues and possibilities.

The transition from the shaman to the trance channeler is interesting as shamanic practices are at best magico religious practices, while modern trance practices are forms of spiritual engagements. Thus spiritual practices indicate the spiritual evolution of western societies, as compared to the shaman who is the precursor of evolved societies (and hence a rudimentary psychologist of the preliterate. This also explains why shamans were seen as performing crucial psychosocial functions in pre literate societies). In analyzing the relationship between shamans and trance mediums, a number of important

criteria have been posited. Bourguignon (1989) asserts that possession and trance are no longer seen as an individual act or considered to be a consequence of disturbances or distorted perceptions of an individual, but rather these practices are a 'culturally stylized pathology'. In other words, even if they are seen as deviant, these are seen within socially accepted boundaries of deviations. Such persons exhibit dramatic changes in behavior, expression, even appearance, manifest startling and abrupt transitions between identities, and show little apparent continuity of memory and awareness. Their hosts remember only dimly or incompletely, if at all, what transpires when the alters (largely viewed as alter ego, i.e a second self which takes over the primary personality) take over. They feel no responsibility for their alters' actions. A similar viewpoint that emphasizes the lack of memory and amnesia enabling the possibility of changing conditioned behavior responses is put forth by Sargant (1974) who states that additional mechanisms of therapeutic efficacy might lay in the fact that trance and other collapse states are based in a common psychophysiological pattern that can lead to erasure of previously conditioned responses, changes of beliefs, loss of memory, and increased suggestibility. Since trance states increase suggestibility, this may also increase placebo or other psychosomatic effects, resulting in physiological improvement for the patient. The widespread use of sleight of hand and "object extraction" among shamanic healers also contributes to inducing psychosomatic and other symbolically induced physical changes. However, in opposition to this, Peters suggests that possession trance and amnesia are not necessarily connected. Thus trance mediums might have awareness of their altered state of consciousness. This criteria is important especially in the context of a psychological and psychiatric view, which emphasizes amnesia (either full or partial) as an important criteria of trance. The question however arises that even if mediums are aware of the presence of the alter, to what extent can they exercise control over the action of the alter? In other words are they merely a witness to the actions of the alter. Arguing that amnesia is critical to all forms of dissociation, Hilgard (1978 cited in Peters, 1982:18) in his "neodissociation" theory says that possession represents a special type of dissociation in which "amnesias are not essential."

The importance of mediumship in trance

Winkelman (1990) states that, although both shamans and mediums were characterized by the use of trance states, there were significant differences in trance induction procedures and characteristics. Mediums' role selection was characterized by the presence of spontaneously induced trance experiences involving seizures or illness, compulsive motor behavior, tremors, and convulsions Although mediums also deliberately induced trance through such techniques as chanting and percussion in their training and activities, they did not have the other techniques characteristic of the shaman, such as magical flight, i.e. The ability to be cover distances in seconds or abilities to use magical powers for healing. Further, unlike a shaman or a healer who was 'gifted' with skills or was perceived to be divinely ordained with skills to become a shaman, channelers were seen as possessing certain physiological characteristics that predisposed them to becoming mediums. Thus while in the case of the former other entities were seen to have power and control the individual, for instance, through repeated occurrence in dreams, in the case of the latter, the focus is within the individual or rather on the individual instead of an external entity influencing the independent, modern individual. As, Mandell (1980) argues physiological characteristics of the medium predispose them to trance states. Thus for instance, mediums generally have definable characteristics and behavior patterns which include neurotic, hysterical, nervous, excitable states and these subject mediums tot hallucinations, fits, convulsions, and seizures. Mandell asserts that these characteristics, almost exclusively attributed to the mediums, are seen to be indicative of a nervous system disinhibition similar to that associated with epileptic seizures. Stewart (1946) states that distinction must be made at the outset between two fundamental types of possession- possession, or spirit intrusion, as a cause of disease, i.e. Spirit intrusion as causing illness for instance when a 'tantrik' (black magician) inflicts a 'spell' on an individual with the intent to harm the individual as compared to the inspirational form of possession, i.e. Possession by a divine being which is not pathological but rather gives the individual special powers which can be used for benefit of others, for instance power of an individual when possessed to cure certain illnesses by touch or by giving certain objects to the client/victim inspirational possession is essentially characterized by the belief that a supernatural power, such as a

spirit, has entered the body of the person, and it controls, to a greater or lesser degree, the actions of the host. The existence of the person is temporarily dominated by the spirit, and the words and actions are believed to be those of the intrusive power. The former type of possession caused due to spirit intrusion is termed also as demoniacal possession. Demoniacal possession should perhaps be properly regarded as a specialized form of spirit intrusion, since, without invocation, the evil spirit takes up his residence in the body of the host, makes him ill and causes him to conduct himself in a violent manner, and must be *exorcised* before the host can return to his normal state.

An analysis of the reasons why possession transforms into trance channeling indicates that as occupation, kinship and land holding patterns change, there is a shift in the form of healers in any society. Hilgard (1978 cited in Peters 1982) hypothesis of the transformation of Asiatic shamanism as a result of the disintegration of clan structure and the stratification of society is revised by many cross-cultural analyses (for instance, Albanese, 1999) and which indicate that the central forces transforming shamanism are a sedentary-agriculture lifestyle, the process of political integration of local communities into politically stratified societies, and the presence of classes. However, the danger of extending this principle would mean that magico religious practices or possession should not occur in modern contexts. However, such an assertion might not find empirical support. For instance, exorcising the devil continues to persist (as in the case of Deliverance ministries mentioned in the earlier chapter) though it might occur within the private realm. Further, the basic premises of new age movements are the crisis of modernity, which leads to increased dependence on trance practices and alternate forms of spirituality. As argued earlier from the point of view of observed practice, the usage of the term trance or possession seems to mean the same practice. Hence, even if the term trance were to be preferred, magical practices continue to exist. For instance, in the context of India, possession practices occur in the capital city of New Delhi. Here, a well-known shrine is the Nizamuddin Dargah which is often frequented by individuals who seek a cure from spirit affliction. The procedures that take place at this healing shrine are similar to those observed in other parts of India. It is important to note that victims/clients/devotees (depending on the perspective from which one addresses them) from varied parts arrive at this shrine for healing, and hence it might be argued that such

practices are not characteristic of the city. Nonetheless, these practices are part of the local cosmology and worldviews of people who participate through direct as well as indirect means (for instance through selling objects which are used to ward off evil spirits).

If the possessing spirit was the 'doer' (in that it dictates the actions of the host) in possession practices, in contemporary new age trance, the medium becomes a channel, which connects itself to various energies and auras. Analogous to a radio channel or the TV channel receiving waves of energy from out in space that are trans- formed into sound, sight, and meaning, the medium has become a mere host to the spirit which enters the medium and then speaks through him/her. Thus, in a relativistic quantum universe the human channel provides one point of connection, between those who dwell within the limits of material human bodies and, hypothetically, those other "personalities"- sometimes individual, sometimes collective-who dwell beyond. Trance channels become, indeed, most like radio or video channels, with their own personalities and characteristic responses held, for the most part, in abeyance. Therefore, spirituality in the channeling zone means contacting spirit energy, either directly or through the aid of the human channel who allows to tap in vibrational forces from beyond. Another case of the energetic world of spirit-matter may be found in New Thought formulations and especially in New Thought healing practice. Mind, for New Thought, can bring matter into correspondence- not as one substance fixing the substance of another but as a constant source of in-streaming energy that catalyzes the subtle energies of the body with those of the spirit.

An interesting aspect of new age trance is the possibility of using technology to connect with clients who might not be physically present. Thus new age trance mediums transcend time and space, despite being physically present at one place. Illustrating such a case, Albanese (1991) elaborates: -

> To gain an idea of what this means concretely today, one need only call the prayer line maintained by Silent Unity (sic) at its headquarters outside of Kansas City, Missouri. The voice on the other end of the line will pray with the caller in a rhetorical mix of spontaneity and formula that affirms the good that is desired- calling it out not dryly, as the formulaic might suggest, but with "heart" and with feeling. Thus the words become catalysts for a narrative that is already a form of action. Meanwhile, readers of Unity's small monthly pamphlet Daily Word must

> likewise take each day's printed affirmation to heart, i.e., speak or think it with feeling-as a prompt to inner or outer action. In similar fashion, New Agers evoke the energetic of their spirituality when they tell each other that they create their own reality, affirming the pliancy of matter and its plasticity before the moving force of spirit.

One of the other important factors of such a procedure is to develop control over the possession trance. An ability of learning to play spirit roles under controlled conditions, including induction and, significantly, termination of the possession trance, is established. Spiritual and social well-being is held out as a promise, as is the personal support provided by the group and its leader.

Energies and auras : How new age mediums operate.

For the new age then, it is the energy that is transmitted during channeling that becomes important. The energy gets to be known as aura, which is then visible to anyone who is trained to see and recognize the energy. Quite different from an earlier notion of possession, which can occur on unsuspecting victims and even shamans, here in this case, it is specific training, which enables one to see an aura, in other words 'see' energy. Albanese (1999:308) states:-

> In a straightforward mental magic, the central ritual is some form of meditation. In material magic the mind uses the body as tool in occult practice-which often involves rituals but differently oriented from those of the churches. Ideally, the result in both mental and material cases is the attainment of states of tranquility, with the model person being more of an exemplar than a missionary. More than that, the model person-the exemplar privileges individualism, and, at least hypothetically, the community drops away.

Acknowledging the presence of energy fields is still permissible within the boundaries of modern, rational, thought, unlike acknowledging the existence of a ghost. Displaying behaviors due to being 'in tune' with a different energy field, might not be the norm, nonetheless the case would not be similar to pathological behavior resulting from belief in spirit possession. Many cases of deviant behavior are referred to the psychotherapist. For the psychotherapist then, even if such rationale behind deviant behavior might be unusual, nonetheless the explanation behind it does not constitute an irrational explanation. Rather, the rationale for such deviant behavior might be explained as resulting in individuals who suffer from defective ego development, who use dissociation, or "splitting" and who as a result to develop "multiple personalities."

Labuach's (2004) study of possession trance, however, argues it differently, as a mechanism by which unfinished agendas are sought to be completed through people who have the potential to become mediums. These, however, must be developed through the spiritual guidance of leaders in the context of public and private rituals, at the peril of health and well-being. The aim of the cult, then, is to encourage the expression of these disincarnate spirit personalities. Not only is their reality not questioned, but their appearance and expression are facilitated. Since the appearance and expression of spirit possession is facilitated, rather than hindered it is perhaps helpful to refer to how language plays an important role. However, few anthropological studies have focused on the role of language and translating experiences without altering the fundamental meaning. A quote at this point will suffice to indicate that further explorations in using language effectively needs to be undertaken. Crapanzano (1977) examines spirit possession itself as a language, or a medium of communication, and comments: "Technically, the spirit possessed must learn to be possessed-to enter trance, to carry out the expected behavior grace- fully, and to meet the demands of the spirits.... Symbolically, the spirit possessed must learn ... to structure and evaluate his experience in terms of the idiom at his disposal"

The role of collective memory in determining trance/possession practices.

As mentioned earlier, trance/ possession practices are contextual in that they emerge out of certain forms of social structures and worldviews of the society. A comparison of contemporary trance practices needs to analyse the factors which lead to prevalence of certain types of spirits/energies amongst societies and the impact of these practices. Every society possesses a collective memory of events which have influenced its development. To that extent trance practices indicate the crucial events in a particular culture they also highlight the inequalities, differences that exist in a society. Hale (1997) based on his study of the emergence of spiritual movements in Africa, states that while spiritualists communed with the shades of eminent scientists, statesmen, physicians, philosophers, and other paragons of elite culture, Umbandistas received the spirits of plantation slaves, Indians, backwoodsmen, streetwalkers, and rogues-the ancestors of the common people. Thus who gets possessed by which spirit is based on the class of the

victim/client. Social class might also operate in a different manner with the rich victims being possessed by a ghost belonging to a poor family. Often this occurs due to injustice melted out to the poor. Consequently, a new kind of synthesis emerged which was a form of de Africanization. The repercussion of such a form of synthesis was that it spread to a large number of people and therefore had a widespread base. The collective memories constructed and evoked by spirit performance coincide with mediums' personal, body memories. These memories are based on cultural preferences, experiences and values.

Stoller (1992) examines the relationship between possession and memory. He emphasizes that studies on possession have failed to examine the role of the body in possession practices. This has led to lack of sufficient studies on the role of bodily practices in possession and its relationship with memory. Hence Stoller advocates a performative approach towards possession. The body as a tool of performance is also one in which cultural memories and preferences are embedded. The body is hence inscribed-with meanings, interpretations that emerge from the context in which the performance takes place. Hence, collective memory is seen as a collective knowledge which influences the embodiment of possession. Observing possession practices among the Sanghay, he states that possession is a creative, aesthetic reaction towards the inadequacies which exist in the world. Thus possession practices seek to alter at least temporarily the existing structure by lending the body to the experiences that an individual faces. In other words, possession practices temporarily suspend the limiting structures which exist. Similar to victor turner's notion of liminality, which refers to a temporary breakdown of the existing structure in society, possession practices offer a temporary lack of structure. Turner (1969) views liminality as "neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremony". The participants in the possession act form a communitas, in other words, individuals who in a given context, relate to each other because of a certain common goal or situation or status. As individuals participating in a possession ritual, they share the common goal of expelling the spirit and in many cases, they share a common worldview. This however does not mean that possession practices by themselves bring about a change in the structure of society. On the other hand, these provide 'safe' outlets for the expression of dissent and for challenging the existing structure. Disadvantaged groups thus are

permitted to express their status within permissible limits. Elaborating on the relationship between possession and past experiences, Sharp (1995:75) argues that the performative nature of possession often reflects the embodied, collective and local knowledge and hence can be seen as a socio political critique of the present sufferings in reference to the past. Spirit possession is hence seen as effective medium for providing reflections on past and the present. As a social commentary, spirit possession reflects 'outside' influences on the local system. Collective experience includes both group experience as well as individual experience and hence Sharp argues that experiences of possession vary with reference to the groups who participate in it, specifically in Sharp's study, differences emerge between elders and youth who have varied collective experiences and hence different meanings attributed to possession.

Collective memory: Deprivation and Resistance in trance practices.

While the above perspectives indicate the manner in which contemporary trance practices are influenced by knowledge held by the community as a whole, nonetheless there are internal differences within a society, which are indicated through the practice of possession. Reflecting on the argument of deprivation and disadvantaged groups, I.M. Lewis states that though possession is not completely explained through deprivation theory, nonetheless in a society wherein there are strict norms to be followed with fixed role expectations, spirit possession answers the question of why individuals tend to get possessed. Comparing possession against other forms such as witchcraft and sorcery, he states that possession is the only form that gives explanations only to illness and bad health and not for other aspects such as misfortunes. This is despite the fact that witchcraft and sorcery are more direct forms of retaliation and attack. Thus in the case of witchcraft or sorcery, the witch or the sorcerer is the doer and hence the real or perceived enemy lies outside as opposed to possession, wherein the real or perceived enemy has become embodied within an individual. The consequence of this according to Lewis, is that such elaborate possession cults tend to become prophetic movements. In such cases, the possessing mediums and shamans do not only answer recurring problems but also respond to new stimuli and pressures and receive a great deal of attention, both, within and outside mainstream religion. In the Indian context, this emerged largely in the context

of caste wherein attempts were made to break away from the dominant religion. While lower castes in many cases propagated a 'deviant' religion, these indicate strategies of resistance and assertion such as the Balarami revolt in Bengal. Chatterjee (1995:191) posits the defiance as how power determines the form and outcome of rebellions against the dominance of a dharma, which claims universality. In the Balarami cosmogyny, Hadiram takes place of the supreme lord. "By raising Hadi to the position of the purest of the pure, and by reducing Brahman to a impure and degenerate lineage, it subverts the very claim of the dominant dharma and hence the caste relations which are often maintained in consistency with the universal ideality." (Chatterjee, 1995:194).

Modernity, empowerment and trance: Analyzing changing notions of selfhood, safety and growth.

Locating trance practices in the context of modernity, Smith states that trance channeling in the new age tends to be completely ocular. In other words it is seen as a positive element and does not resemble (the dangerous or uncertainties viewed in trance/possession in previous contexts. Further, all such trance occurs in situations which are decided beforehand either before a client or an audience. Like mediumship, it ends up having a following and an attraction. Further, the messages contained in trance channeling episodes needs to be considered in detail. Most of these messages concern physical and psychological healing, personal transformations, and inner growth. Within this subculture then, spiritual conditions, (in other words, certain individuals are seen to have a predisposition towards spirit afflictions) are seen as the primary cause of illness. Personal empowerment then becomes a major component of possession. The experience of transformation is an important aspect of new age trance wherein the clients are generally upwardly mobile and view trance as a form of inner growth. Unlike Lewis' argument that deprivation predisposes an individual towards possession, new age trance attracts an elite section of society. In such a case the clientèle focuses on connecting with a medium to resolve individual goals. This however is framed within a scientific paradigm wherein the medium is an expert who can tune in with other energies and resolve the conflicts of the client. Hence the meaning and the reasoning for trance is well within the new scientific paradigm ranging from stating that the self is a fluid or

permeable entity, always in a flux to explanations which account for trance by resorting to terms such as energy and aura Trance is the zone of safety rather than being a zone of risk and danger.

Thus, trance practices in the context of contemporary spirituality movements have regarded trance as a positive process rather than a process though which pathology is addressed. However, despite being very much within the framework of modernity, such practices have questioned the assumptions such as the body-mind dualism. For instance, these practices encourage notions such as energies, prevalence of chakras in an individual. Further, these practices also challenge the notion of a closed, individual self. Rather the self is seen as permeable and open to outside forces. The self is not an individualized entity, cut off from the community. But rather selfhood emerges from the ties and linkages with the community. Nonetheless all this is seen as having an 'aesthetic' quality and a safe process for developing spirituality. The emphasis on 'aesthetics' of treatments has many limitations. For instance, Halliburton, in his work on the treatment of mental illness in India through varied forms- biomedical, religious and alternative therapies analyses the reasons why individuals might not prefer the biomedical therapies. He states that alternative therapies are seen as being less harmful and have an aesthetic and even cooling effect on the individual. Hence the individual might prefer to be in a process of cure, rather than subject the body to violent medications. While aesthetic form of treatment might be a consideration, other important aspects would include treatments, which incorporates the family and community in the process of cure and thereby offers a sense of security to the individual in the process of cure. This is however not to ignore the limitations of what are alternative therapies, for they too might be uncomfortable and violent for the patient. Thus essentializing any therapy has its own limitations. Trance, similarly has come to be viewed as a safe way of inner growth and even encouraged. This is despite the DSM's definition and anthropological definitions of trance and possession, which views them as having certain common observable physiological characteristics and behavior pattern. (As discussed in detail in chapter two, the DSM views trance and possession as being disorders, within the category of dissociative disorders. The main characteristics being dysfunctionality, stereotyped behavior and movements and partial/full amnesia) Yet while possession is viewed as dangerous and even harmful,

trance is viewed as an acceptable practice, by the clientèle who engage in it as well as in anthropological writings which do not necessarily view trance as a disorder. While the shaman is seen as a patient who himself needs to be healed, the trance channeler is seen as someone who is developed and 'trained' enough to permit energies to enter the body and communicate through the body. In conclusion, new age trance practices indicate the process by which the modern believer finds a rationality by which he/s can gain access to practices outside mainstream religion. By focusing on changing notions of the self, the modern believer can report experiences of personal growth and transformation, as compared to the victims/clients of possession practices who 'perceive' transformations and hence need to be treated for arriving at the 'real' illness.

Chapter V

Contemporary Processes and Conclusion.

The role of modernity in nation building is often assumed to be a straightforward, non-contentious issue. However, the problem lies in that there exists a major gap between the state's model of development and what it seeks to achieve on the one hand, and the practices of the people, often perceived by the state as being non modern on the other. It can be easily argued that the *scientific route* adopted by the states is backed by the civil society. This understanding is however problematic, given that the civil society excludes a majority of the population of the country in decision making and rather becomes a body of individuals who take upon themselves the right to speak for the rest. Thus the Indian State in its zeal boasts of a growing economy and of mega development projects while not pausing to realize that India lags behind in the basic development indicators. One of the main repercussions of this neglect is that policies formulated by the state do neither have much support nor do they cater to the needs of its citizens. The failure of governments to cater to basic human requirements has led to a situation of chaos at the least and dissent and resistance at larger levels. Thus, for instance, in the case of mental health, the Maharashtra Government has introduced a bill to curb black magic, evil and aghori practices in 2005. This would also result in the banning of many healing shrines where possession practices take place. While the merits of this step is debatable, keeping that debate aside and focusing on practical considerations, it is evident that the bill has no vision as to where would it relocate all the people who visit these shrines for immediate and urgent problems if they were to shut them down given the stark lack of psychiatrists. Just to underline this, at present there are just 3000 psychiatrists in the entire country with the majority being placed in urban areas (BALM report, 2009 and NHRC, 2008). Given the increasing cases of persons with mental illness, as per the government and other reports such as those of the WHO (2005) it becomes necessary to explicate why banning practices is prioritized over building other alternatives. Further, this raises questions that why are malnutrition rates and lack of access to resources among women not given equal priority as banning these shrines, when it is widely known that women are more frequent

at these shrines. (Women in possession states are often known to make varied demands including that of adequate food. This through a functional/symbolic/psychiatric lens would lead to the explanation that repressed populations are more likely to raise issues of repression and patriarchy is a cause for women articulating their concerns which otherwise would not be permitted in a regressive structure) and why are there no attempts to make available basic resources to communities (in many cases of possession especially when the possessing spirit is of a lower caste or class and possess an individual belonging to a higher caste, the demand is to give back land which originally belonged to the ghost's kin. This is often coupled with demands to the oppressor such as demands to dig a well which can be accessed by the descendants of the ghost or some other form of 'punishment'). In short, possession practices do not occur in a vacuum. Rather they occur within specific contexts, even if what is meant by context varies and changes over time. In other words, in its quest for adopting a modern paradigm, there is a complete neglect of other factors and social inequalities which contribute to the practice of possession.

The lack of recognition that it is the social inequalities that influence possession practices as well as determine access to health services is seen in the draft of the amendment to the National Mental Health Act (1987). Thus, while community participation has been taken into consideration, alternative therapies and their role in contribution to mental health services has been left untouched. Currently there is a mismatch between the state's visions of mental health services on the one hand and the practices followed by people to restore health on the other, as the latter is perceived by the state as superstitious and threatening as well as non-rational. Realizing that other superstitious, irrational centers of relief such as healing shrines address a huge section of society and perhaps as an admission that 'blind beliefs' are rooted very strongly in a culture, a compromise formula, combining belief with medicines (allopathic) seems to be increasingly supported by organizations working in the field of mental health. This has led to interactions between healing shrines and psychiatric settings, wherein the beliefs of devotees are not challenged, yet these patients are given medical treatment! This includes as training healers to send 'severe' psychiatric patients to the psychiatrist or mental health clinic. In one interesting case, this has led to the setting up of a psychiatric ward inside a

Dargah[1] the aim of which is to encourage patients who come to the Dargah for healing to also meet the psychiatrist. Thus it promotes the idea that prayers and medicines work together. While such attempts are not overtly coercive to push in psychiatry inside non psychiatric settings and might in fact give a different interpretation, causation and treatment to the devotee (and now patient's) suffering, nonetheless if both drugs and prayers are an apt combination, one is tempted to ask whether in the same procedure, the healer could set up his healing practices within a psychiatric hospital. However, while the inclusion of psychiatry within a shrine has received reactions from many organizations, the latter has not even merited any consideration, thereby posing the question whether the two systems are truly equal or is it an instance of a dominant system trying to co opt other practices and perspectives.

This is however, not to say that the above-mentioned bills, facilities and acts are unnecessary or irrelevant. It is rather an attempt to raise the issue that what these bills, facilities and acts omit is as important as what they include. This chapter hence is an attempt to examine the contemporary legislations in the field of mental health and establishment of new patterns of providing psychiatric care. These interventions are based on politics of what is considered to be scientific knowledge and hence legitimate practices. The dominant discourse of psychiatric care as the aspired model is nothing short of hegemony, wherein the dominant discourse of psychiatry does not permit legitimacy or authenticity to any other perspective. Rather the very positioning and defining of these systems is in accordance with the dominant discourse. The chapter examines four recent developments- the proposed Maharashtra Eradication of Black Magic and Evil and Aghori Practices Act (2005), the proposed draft for modifying the National Mental Health Programme, a project by the Altruist in Gujarat which seeks to combine drugs and prayers by setting up a psychiatric ward in a healing shrine and the Human Rights issues for persons with mental illness which raises right to health as an important constituent of right to life. It is an attempt to conclude the dissertation with the questions that concern possession and trance at varied levels- from questions of science

1 The Mira Datar Dargah in Gujarat, -is known for its healing powers. There has been an introduction of a programme which combines psychiatry and healing. This is supported by -an organization Altruist in Gujarat

and rationality to questions concerning possession practices and finally an emphasis on constituting the term 'possession' itself.

Maharashtra Eradication of Black magic and Evil and Aghori Practices Act, 2005: Basis and implications.

a) The role of the Andhrashaddha Nirmoolan Samiti in Maharashtra.

In an attempt to curb what were seen as unscientific and harmful practices, the Maharashtra government proposed a bill to bring about 'social awakening'. This has met with varied responses. Organizations such as Hindu Janajagruti Samiti (" Oppose Black Magic Bill: A Draconian Law Targeting faith") have opposed this bill as they view it as curbing practices that are central to Hinduism. This bill has also come into highlight because of the definition of evil practices is very broad and hence viewed by many as ambiguous. This makes the act extendable to many practices and people who can be seen as quacks and conmen. In support of this bill is an important organization in Maharashtra, known as Andhashraddha Nirmoolan Samiti (ANS) which is believed to have a stake in formulating the act and specifically in formulating provisions which include organizations in the field of mental health to assist the government in implementation of the act, thereby making it possible for the ANS to actively and legally intervene in cases where evil practices exist. Hence before viewing the provisions of the act, it would be beneficial to view certain positions of the ANS, which would give a preview into the perspectives that were behind the framing of the act. The ANS ("Science on wheels") "believes that people who resort to black magic behave irrationally and are superstitious, because of their ignorance. The reason for this is simple; they do not have proper education. ...The so-called pundits in our country are in fact tall only because they are amongst dwarf masses". The ANS further believes that it is its duty to spread a spirit of inquiry and humanism. With regard to what it calls black magic or occult science, the ANS states that scientific studies indicate there is nothing like knowledge of black magic or occult science.

The above position of the ANS requires a closer examination. For science, black magic, and evil spirits do not exist. But for patients, a central concern as raised in this dissertation, is that of efficacy. In other words, patients resort to these practices because

they are seen as rendering meaning to the distress experienced by the patient. There is hence a need to shift from debating whether black magic exists to that of examining the options available to patients/ clients in order to raise their distress. A shift towards efficacy would also enable a closer understanding of how meanings of cure are closely related to availability. The choice of a treatment for cure is contagion upon the accessibility for cure that a community has. In other words well-being, cure and pain are all experienced by patients and hence how does one deal with patient narratives which emphasize benefits derived from such a therapy? a practice as pathology.

Resorting to possession practice for healing is not restricted to merely the for instance, we find people (clients/victims/devotees depending on the perspective) resorting to many forms of treatment simultaneously, in other words resorting to psychiatry and also to healing practices. In many cases, people who have not been healed in psychiatric care, take resort to healing shrines. Further, it is not only the underprivileged, rural population, which resorts to, such forms of treatment but such practices cut across different sections of society. In other words, the rural-urban, privileged-underprivileged, the folk and the classical, and similar other binaries need to be further examined. As Smith (2006) emphasizes, it is precisely to question assumptions such as that possession is essentially a folk phenomenon, that a textual view of possession is necessary. As Smith demonstrates Vedic literature (considered to be classical) has reference to possession in its varied usages in detail. However, in the analysis of possession practices there is hardly any reference to textual views on possession, relegating possession to the folk. The classical-folk binary can also be viewed as the contrast between the book view and the field view, written and oral, Brahmanical and non –Brahmanical practices. Questioning the classical- folk binary is also questioning the relation between the text and actual practice, (for instance, to what extent did the Brahmins practice Brahmanism) on the one hand and between experience and text on the other.

b) Maharashtra Eradication of Black magic and Evil and Aghori Practices Act, 2005: Brief overview and critique.

The problem of creation of binaries and creation of fixed notions which runs in the ANS view on black magic is also reflected in the proposed Maharashtra Eradication of

Black magic and Evil and Aghori Practices Act, 2005. The Preamble of this Act states that the bill aims to bring about social awakening and awareness in society. It further holds that there are an alarming number of incidents by conmen and quacks which are a threat to society as it exploits the people and harms innocent people physically, mentally and financially. Given these circumstances, the bill states that it has become necessary for the government to effectively contain such effects and practices. The aim of the bill is to *save the common people* from the harmful activities and to stop their refusal towards scientific remedies and cures. . Finally the bill holds that common people due to blind beliefs and ignorance take recourse to quacks, conmen and black magicians.

The Eradication of Black Magic and Evil and Aghori Practices Act (2005) however has not defined terms such as magic remedies or black magic. Rather it states that words and expressions not defined in this act shall have meanings as stated in the Drug and Magic Remedies (Objectionable Advertisements) Act, 1954 ("Drugs and Magic Remedies (Objectionable Advertisements) Act 1954"). A few important terms in the Drug and Magic Remedies (Objectionable Advertisements) Act, 1954 are the following. As quoted in the Act, the term drug' includes –

1. A medicine for the internal or external use of human beings or animals;
2. Any substance intended to be used for or in the diagnostic, cure, mitigation, treatment or prevention of disease in human beings or animals;
3. Any article, other than food, intended to affect or influence in any way the structure or any organic function of the body of human beings or animals;
4. Any article intended for use as a component of any medicine, substance or article, referred to in sub-clauses (i), (i) and (iii);

Similarly, the term 'magic remedy' includes ["Drugs and Magic Remedies (Objectionable Advertisements) Act 1954"], "a talisman, mantra, kavacha and any other charm of any kind which is alleged to possess miraculous powers for or in the diagnosis, cure, mitigation, treatment or prevention of any disease in human beings or animals or for affecting or influencing in any way the structure or any organic function of the body of human beings or animals." Thus any form of substance considered as possessing 'miraculous powers' might be seen as a magic remedy. Given the rather large ambit of the definition, it would involve a range of practices such as possession, to Reiki or Voodoo. The offences which are committed under this act would be cognizable and non

bailable. Any person who commits this Act himself or through another person can be held accountable for the provision under this act on and after the date of the act coming into force.

The act states that " nothing in this act shall apply to the acts involving religious rites and rituals which does not adversely affect any person mentally, physically or financially'. What does *adversely effect* mean however remains unqualified. The sections under the proposed act include (" The Black Magic Bill"):-

> a) using various methods of expelling ghosts and assaulting persons with chain, rope, beating, giving certain substances to eat, hanging to a roof, causing pain by placing heated object, forcing a person to perform sexual acts etc. b) It refers to displaying of miracles to fraud people. C) Practices causing danger to life or hurt in the view of receiving blessing of supernatural power. d) Any inhuman acts or human sacrifice in name of karni, bhanamati etc. (what these terms refer to however remains unspecified). e) To create an impression that a divine spirit has possessed an individual and create fear in minds of others, threatening of dire consequences. f) In the name of jaran-maran, karni, or witchcraft (chetuk) assaulting any person, parading him naked or put a ban on his daily activities. g) To crate panic in the mind of public in general by way of invoking ghost by mantras, or threaten to invoke ghost, putting up a false show to make a person free from poisonous infection by invoking mantras or similar things. H) Prohibiting and preventing a person from taking medical treatment in case of dog, snake or scorpion bite and instead giving him treatment like mantra-tantra, ganda-dora or such other things. i) To keep sexual relations with a woman who is unable to conceive assuring her of motherhood through supernatural power. j) To create an impression that a mentally retarded person is having super natural power and utilizing such person for business or occupation.

Removing magical belief from material substances (magical herbs for instance) is however much more complicated than what the proposed act prescribes. For one, varied practices are carried by individuals who profess to claim a certain expertise, such as acts to remove negative energies that surround a house. The margin separating acts of a healer from a priest (the latter presumably would not be covered under this act since it is 'religious' and not magical) is ambiguous. Further, various practices are carried out in daily life activities to ward off evil spirits or ghosts which do not involve any healer, magician or quack but nonetheless would be placed as belief practices. The act remains ambiguous about such practices. Thus expelling ghosts by wearing a talisman is magic, but would keeping an image of a mainstream deity to protect oneself at all times be considered magic? Similarly in many parts of India, people wear threads around their wrists for protection from danger, or from evil. Would this be considered to be religious

practice or would it be magical belief. In other words, the dominant 'religious' practices remain unchallenged, while those practices engaged with by the non-dominant sections are targeted as magic.

An important aspect missed by the act is that healing shrines cater to a large number of people, who have no other refuge. Closing down such practices might well be one aspect of proposed act. Nonetheless this act excludes those who choose to practice the system (whether it is due to socialization or any other reason) and does not include methods by which their concerns can be addressed. It does not consider the possibility that individuals might choose multiple modes of treatment at the same time. Even if the concerns of devotees/patients are 'blind belief', yet these concerns need to be addressed in terms of delivering care or offering treatment choices. In other words, though a practitioner might not share similar beliefs in spirits, nonetheless for the patient the effects of those spirits are real, this reality of the patient merits consideration because such neglect will lead to no practical outcome for either the patient or the practitioner.

Interface between psychiatry and religion: An experiment at Gujarat, India.

It is probably to resolve this deadlock that organizations in the field of mental health are reconsidering ways of including psychiatric care without challenging the worldview of the patient. An interesting programme which seeks to address the problem of religion versus psychiatry is run by an organization, Altruist in Gujarat. This programme seeks to combine prayers and drugs together. This has led to the establishment of a psychiatric ward within the premises of a Dargah (a healing shrine) at Mira Datar ("Health Department's prescription to remove shackles that bind mentally ill").Gujarat's Health Department tried a new way of involving medicine within religious settings. In short, this involved a psychiatrist who participated in the rituals of the shrine and while praising powers of the supernatural tried to intervene with 'modern scientific' prescriptions. Attempts were also made to engage the Mujawwars (roughly translated into shrine keepers) with the modern psychiatric care. Thus they were informed about different signs they should look out for and were told to send patients, in cases of severe psychoses to the psychiatrist. This was meant to be a cross referral system. None of this

was done however by openly challenging the powers of the Mujawars. In the case of patients, this resulted in some resorting to both medicines and the blessings of the baba at the Dargah. In order to be unobtrusive, the psychiatrists did not overtly dissuade patients at the shrine for believing in 'blind faith' but rather tried to use the setting for promoting their services in a more subtle manner. Aspects such as chaining, patients languishing in shrines for many years were reported to have reduced once this programme was started as these 'severe' cases were now referred to the psychiatrist. Practices such as chaining have led to healing shrines being viewed as dangerous, superstitious and inhuman. Thus for instance, a report that critiques the logic and seemingly unhygienic conditions of mira datar dargah states that (" Dargahs play Ghost-busters"), "a peek into `faith-healing' sanctums like the mira datar ka dargah, located in the grimy bylanes of reay road, makes it clear that in India, few people approach mental ailments with a scientific outlook. Instead, psychiatric problems are seen as ``manifestations of a great force" to be cured only by the ``intervention of an even greater force" an unfortunate phenomenon highlighted once again by the recent tragedy at erwadi". Contrary to the perceptions of the Maharashtra Eradication of black magic and evil and aghori practices act, this writing points out that the wealthy, urban population does not think twice before taking recourse to such 'cures'.

Human rights and rights of persons with mental illness

While aspects such as chaining and inhuman treatment, unhygienic conditions at *traditional* healing centres has often been critiqued, it is important to realize that the situations in the more scientific, mental health institutions also suffer from the above limitations. Hence banning healing centers on the above criteria would not result in much practical change for those suffering from mental illness. Given the abysmal nature of the mental health care, the National Human Rights Commission (NHRC) undertook an empirical study of mental hospitals in the country in 1999 and expressed serious concerns over the state health institutions. Outlaying the observations of the NHRC, Sharma (2008:270) explains:-

> The findings reveal that there are predominantly two types of hospitals. The first type does not deserve to be called hospitals or mental health centres. They are 'dumping grounds' for families to abandon their mentally ill member, for either economic reasons or a lack of understanding and awareness of mental illness. The living conditions in many of these settings are deplorable and violate an individual's right to be treated humanely and live a life of dignity. Despite all advances in treatment, the mentally ill in these hospitals are forced to live a life of incarceration. The second types of hospitals are those that provide basic living amenities. Their role is predominantly custodial... these hospitals are violating the rights of the mentally ill persons to appropriate treatment and rehabilitation and a right to community and family life.

In a more recent report (Gangadhar, nd:183) states that the Indian Psychiatric Society in 2007, enlists less than 3000 registered psychiatrists in this country. When equitably distributed this translates to one psychiatrist for every three lakh population. Further, a recent report proposed one psychiatrist for every hundred thousand population, which means that the number of psychiatrist must increase to three folds of what exists at present. Even more problematic is the unequal distribution of psychiatrists. Seventy five percent of psychiatrists are placed in urban areas and twenty five percent in rural areas, whereas the latter account for seventy five percent of the population. Consequently, the number of mental hospitals in a state is either just one or two. Further most of them had minimal basic living conditions. Thus for instance, the ratio of open wards to patients, cots to patients, sanitation, diet etc was deplorable. Post the Erwadi incident in 2001 in which mentally ill patients kept chained in a shed in dargah were charred to death in Tamil Nadu, many PILs were filed. For instance a PIL was filed, calling for a ban on the practice of physical restraint and administering unmodified or direct ECT (Electroconvulsive therapy), i.e. ECT without anesthesia.

The NHRC report further argues that the e right to life as mentioned in Article 12 of the Indian Constitution also means a right to health, inherent with physical and mental dignity. To provide health facilities is thus a constitutional obligation of state governments and hence any non-availability of basic facilities in government hospitals amounts to violation of article 21of the constitution. Ensuring human rights of the mentally ill are not violated has thus become an important concern especially in cases where the mentally ill face not only societal taboos and stigma but rather procedures for self care and living itself excludes the mentally ill from having a control over their life. For instance, the right of a person with mental illness to express himself or herself

remains contentious. Thus in legal situations, they are represented by another individual. Ironically, while those not diagnosed with mental illness have to provide an explanation if they need someone to represent them, those diagnosed with mental illness have to provide an explanation of their ability to represent themselves. Recognizing this problem, many international covenants such as the World Health Report, UDHR and the preamble of the ICCPR and ICESCR argue for basic rights such as right to life and freedom of speech and expression, explaining that "these rights derive from the inherent dignity of the human person". These covenants and article 21 of the Indian constitution mean that the mentally ill have a fundamental right/human right to receive equality in mental health care and to get human conditions. The rights of patients also means a right to know about admission and discharge procedures, a right to be treated with dignity (chaining and unmodified ECTs have been an issue of debate) and protection in cases of involuntary admissions in mental health hospitals. Institutionalization has also led to many other rights being suspended. For instance right to vote, right to enter a contract, right to marry and institutionalization has also effected social life and privacy of persons diagnosed with mental illness.

To take into accounts the rights of those diagnosed with mental illness, changes have been proposed to the Mental Health Act (1987). The draft of the proposed changes was made available on 23rd May 2010. This draft is an important step towards incorporating some of the changes suggested by different committees and organizations for the protection of the rights of those diagnosed with mental illness. Major changes include incorporation of psychiatric social work, counselors and clinical psychologists apart from the psychiatrist as important components in the health care delivery system. Much of the detailing in this report is also on extending community based interventions as effective tools towards enabling individuals diagnosed with mental illness. Apart from these, rehabilitation has been an important issue, as previous acts did not address this issue substantially.

Draft on changes to Mental Health Act, 1987: Changing perspectives and implications.

The draft on proposed changes to the Mental Health Act, 1987, suggests an alternative in use of terminology. Thus it suggests the term persons living with mental illness or persons suffering from mental illness instead of using the term mentally ill. The reason behind this was the observed link between language and stigma, wherein the use of the term mentally ill would stigmatize the individual. A further suggestion made by the draft committee involves adding the term 'rehabilitation' wherever the phrase 'treatment/care' alone is mentioned'. An important addition to the draft is the inclusion of access to care as a basic right. This would mean that all individuals shall have equal access to care. Presumably, it also seeks to make mental health care more affordable. It had been noted in many instances even if accessibility was improved, it did not guarantee affordability Hence, the draft suggests that the number of open wards in a public or private hospital needs to be examined. Emphasis is also on whether currently, in-patient facilities are provided free of cost or are they charged. The question of whether the government should subsidize treatments in private health hospitals has been placed for consideration (as comments to draft have been invited). The act expresses that since it aims to provide protection for the rights of people with mental illness and provide quality care and treatment, it does not propose to make a distinction between a government based healthcare and private healthcare system. Therefore, protection of rights and provision of quality services needs to be regulated in all sectors. Thus for instance, all health establishments independent of whether they are public or private have to register with the Registrar of Clinical Establishment. Currently, there is also discussion on the National Health Bill draft, which did not make a distinction between public and private health establishments and states that both inpatient and outpatient facilities should be covered under the term health care establishment. In the proposed amendments to the Mental Health Act however, there is a slight difference, wherein "mental health facility" includes all health facilities where inpatient care is provided. It does not include outpatient clinics, or day centres or other health facilities, where treatment is provided on an ambulatory basis and persons are not admitted to the facility.

With regards to the diagnostic terms used, the draft suggests that Mental illness should be defined not in terms of diagnostic categories but rather in terms of behaviors. This is also an international practice as diagnostic criteria change over years, for instance the Diagnostic and Statistical Manual for Mental Illness, the DSM -V is expected to be published in a few years. Hence if diagnostic categories were to be used, these changes would need to be accommodated, making the process more complicated. Another important reason for giving importance to behavioral practices over diagnostic criteria is that, diagnostic criteria are only used by psychiatrists and the law needs to be operationalized and be used by all the different stakeholders which include the patient, the family and other professionals such as legal professionals or administrative officers who might not be aware of diagnostic criteria such as the DSM or the ICD, nor are they qualified to make such a diagnosis. Following these changes, mental illness has been defined as (GOI, 2010:8), "Mental illness for the purpose of the Act means a substantial disorder of mood, thought, perception, orientation or memory which grossly impairs a person's behavior, judgment and ability to recognize reality or ability to meet demands of normal life and includes mental conditions flowing from the use or abuse of alcohol or drugs but excludes mental retardation". Thus, mental illness has been defined in behavioral terms rather than emphasizing diagnostic criteria. Hence, the term mental health professionals refer not only to psychiatrists but also extend to others such as psychiatric social workers and clinical psychologists.

Another contentious issue raised by the draft is that persons with mental illness should have a right to express their choice and make a decision for themselves and if they are not in a position to do so, all persons with mental illness are entitled to appoint a nominated representative. The nominated representative serves many purposes such as providing support to the person with mental illness when they have to deal with the mental health system, assisting the person with making choices. Secondly, the nominated representative by law is being recognized as someone who has the right to be involved in the care and treatment of the person with mental illness. This would mean that the nominated representative is now formally recognized as being involved in treatment and care. This would make it necessary for mental health professionals to include such representatives in decision-making. While the representative might be a family member,

it can also be another person that the person with mental illness chooses. This ensures that the representative is someone who is of his or her choice. In cases where the person suffering from mental illness is unable to make a choice then alternatives have to be specified. Importantly this serves as a safeguard against unilateral decisions made by doctors on the principle of 'best interest'. It is commonly held that the doctor in a given situation should use his discrepancy and choose the mode of treatment in the best interest of the patient. However this has many limitations. For one, the patient's right to make a free choice is violated. Secondly, the patient and doctor might prioritize differently on what is meant by 'best interest'. Given these among many other limitations of unilateral decision-making the UNCPRD suggests the need to move to a format of supported decision making. This takes into account different stakeholders and their decisions in a given situation. Hence the nominated representative is formally recognized in the amendments to the Act as a community based resource, to assist the person in making treatment decisions. Given that the majority of persons with mental illness need to be understood from the context in which they operate and that majority of care and support is provided by families and other non-professional individuals/groups, involving community decision making while choosing treatment choices plays an important role.

One of the main critiques of the previous mental health act is that national programmes are made by the Centre but health is a state subject. Hence the centre-state relations need to be readdressed. The draft suggests that similar to the initial act, facilities have to be given by State Mental Health Authority and this provision should remain. Since there is widespread variation in resources and types and intensity of mental health problems, it would not be viable to have a national programme. Further, incorporating changes at the state level is necessary as per changes in resources, forms of illness etc. Hence the draft suggests that it is more appropriate that the changes are brought through State Mental Health Authority Rules, rather than bringing it into the act.

While the draft amendments to the Act entail measures by which mental illness can be identified, and provisions for treatment and care, it provides little mention on how patient's perceptions and understandings of health itself might vary. Rather it suggests that these aspects should be discussed at state level meetings since it is not possible to have a singular conception. It does not suggest how alternate medical systems can

contribute or create problems for the psychiatric model of dealing with mental illness. Nonetheless the draft has important changes with regard to treatment and care of persons with mental illness and involving the community in health care. The NHRC in its report on mental health care (2008) had put forth certain suggestions in involving the community in supporting individuals with mental disorders and their families and allowing them to retain their environments. It also included capacity building of stakeholders. In other words it suggested the process of empowering communities so that they can take recourse to legal means to improve healthcare.

The impact of these amendments are yet to be seen. Nonetheless, it is important to note that these concerns are having an impact on practices in the field of mental health. Specifically in the field of possession practices, a process of sanitization is apparent, wherein practices considered as human rights violation are either removed or minimized. For instance, Kakar's work (1982) on Shamans, mystics and doctors mentions the case of possession in Rajasthan in India. The same site has been studied in by Dwyer in 2003. A reading of their works indicate that while the main practice of possession and the importance given to the deities/baba at the shrine remains, other practices have changed. For instance, less instances of chaining are reported or the area around the main shrine is described differently. Similarly, a book by Vijayakumari (1999as mentioned in ANS) states the act of removal of demons by Satya Sai baba, a well known 'baba' for his ability to produce miracles. The account describes the procedure of removal of demon by baba and continues to describe baba as saying, " It is not only a case of being possessed by a demon. Someone cast an evil spell on her. Black magic was used and a magician was hired to do all sorts of pujas to make her lose her wits there is no need for fear now.' On the question 'do demons really exist? ', he said, ' yes. Those who committed suicide, those killed in accidents, those who meet with an untimely death, all these will be roaming around like ghosts'. He drove away demons this way, physically only for one year. Later, He just used to give vibhuti prasadam and with that, send the demons away". This account is interesting in a context wherein new age spiritual babas/gurus/healers are seen to engage differently with the issue of trance. Further, what led to the decrease of this practice by Satya Sai Baba and how did the alternate practice 'work' remains unstated. This is important given that none of the recent books on Sai baba or the

recording of practices which takes place at his ashram indicate of overt driving away of demons. Perhaps the emphasis on negative energies instead of expelling demons is telling of a change in terms and procedures in an attempt to sound spiritual rather than superstitious or anti-rational.

Revisiting Debates on Possession and Trance: Exploring varied linkages and ambiguities.

The debates on questions of rationality and scientific procedures leads to some of the main concerns with regard to possession. Debates on possession are primarily rooted in the concepts of science, rationality, evidence, magic, belief and superstition. Current spiritual practices and the combining of religious activities with of medicine seem to overshadow the dichotomies and complexities of the debate on whether possession really works. On the other hand, debates also continue on whether possession should be considered to be a practice which is at best a ritual or in more scientific terms a c practice engaged in by common, gullible, uneducated people. Despite the attempts to merge religion and science, it is clear that there is a process of hegemony, where the psychiatric model is the dominant discourse, which excludes all other forms of knowledge and perspectives; yet, these other forms persist within the parameters defined by the dominant knowledge. This means that the process of defining the 'other' and its practices is through the lens of the dominant model.

It is hence not a mere co incidence that studies on possession have focused mainly on third world countries or amongst the marginalized, minorities or women in the case of developed country. At the risk of generalization, it is possible to posit the western, male, rational society as opposed to the non-western, female, marginalized, traditional society. This is demonstrated in a number of ways. Consider for instance, the notion of culture bound syndromes mentioned in the second chapter. The basic premise for such a category is non-western, hence pathological practices carried out by traditional people. Similarly, studies on gender and possession consistently mention about the lower status of women and the need for women to express themselves. It is extended to the argument that traditional societies as a whole need possession rituals in order to reinforce their kinship-based society and bring about social order. Other forms of denying

legitimacy to the theory/theories of possession which is offered by people who practice them, is through a process of applying theories convenient to a researcher to the practice of possession. Thus there are many theories which give psychological explanations of possession practices , wherein the explanations given for acts of possession is translated into psychological terms, categories and the psychological benefits derived from such practices. Thus it ignores the possibility that practices of possession might have theories on which they are constituted and on the basis of which they are practiced. For instance theories about the body, about personhood etc. Since theories which constitute and inform possession are ignored, there is a tendency to enforce scientific explanations to legitimize perceived non scientific practices. One of the important consequences is fixed representations of possession in texts. Thus practices are described as static, ignoring that practices themselves are subject to change. Hence one observes a gap between the text and the practice of possession. In the very act of limiting possession in the form of writing, there is a form of fixture that makes the act of possession monolithic and unilinear. The question also arises that in the process of describing the practice of possession, is there an attempt to move from practice to the theories or are theories formulated based on existing literature, conceptions etc which is then taken to the practice of possession. In other words does the practice of possession inform theories, or are practices merely a testing ground for analyzing whether theories work or not.

Conclusion: A case for efficacy of possession.

Analyzing whether possession works or not is dependent upon the perceived efficacy of possession. In other words, what matters to the patient is the outcome of varied treatment. Hence, unlike the scientist or the researcher for whom the main question is whether a practice is scientific, for the patient/devotee, the central concern is to address his/her distress. Analysis of the above bills and acts indicate the necessity to emphasize what constitutes efficacy from the perspective of the patient.

It is clear from the above discussions on linkages between theory and practice of possession, that not only the interpretation/ 'conclusions' that are the outcome of 'method' but that choosing certain texts, theories and arguments have a bearing upon the very object of inquiry in the way it is constituted, analyzed and the questions that it raises. Further, Smith (2006) states, given that studies were conducted by white men, on

non white men and women one of the problems that have emerged is that explanations have been Eurocentric and positivistic. The methodological problem which hence emerges is the tendency to use method to determine practices. Thus appropriate events, practices are selected and fitted into the constructed models, thereby legitimizing and validating the models. What is left unaddressed is the representation of the cultural context. Hence legitimacy is not given to the existence of spirits but rather they are viewed 'as if they exist'. This leads to a one-way discourse wherein possession as an ontological reality is not accepted.

The denial of any ontological reality to possession has led to a situation wherein on the one hand efforts are made to contain superstitious practices and beliefs while on the other, patients/devotees/victims (depending on the perspective that one views them) precisely seek for these very practices. In other words, the paradox lies in that while scientific fact making is a continuous endeavor of science and is supported by the pharmaceutical industry, what sells is 'magic'- in the forms of amulets, substances or non visible cures such as the effects of reiki or meditation. In the constant debate of knowledge versus belief and theory versus religion, visibility becomes an important aspect. Therefore, the debate on visibility emphasized the self-evident nature of the empirical world and was used by the biomedical approach. Questions of visibility gained prominence with regard to locating the disease in an organ or even in the form of treatment such as use of material substance. Further cure was also defined by parameters of visibility, in other words, there ought to be a change from the previous observable state after a treatment. For instance, a patient's narrative on experiencing cure will have limited significance if the measuring indicators such as scans or X rays do not indicate a change. Given the singular nature of cure, many other practices are then relegated to being quackery and the practitioners as quacks. One of the consequences of increasing emphasizes on scientific procedures has been a process of standardization, and this has led to mimicking of medical systems. Langford in a study of medical systems in India, (1999) states that each system has its own set of acceptable procedures and violating these procedures would lead to a practitioner being known as a quack. Given the increasing need for indigenous practices to validate and legitimize themselves, there is an increasing trend of one system of medicine attempting to mimic another to gain

legitimacy. Hence if folk medicine tends to mimic Ayurveda, Ayurvedic practice tends to mimic that of the professional sector, thereby offering a parallel medicine and a parallel science.

With increasing legislation on mental illness, there have been questions on integrating alternative paradigms and forms of healing. Possession (along with other practices like trance, witchcraft, which in many cases are not defined, but are used in as a term for practice which refers to or involves a 'ghost' or 'spirit') has been relegated to faith healing in many cases. Studies on possession report that patients visit the biomedical and other forms of treatment as much as they visit healers and shrines. This has led to the notion of complimentary and alternate medicine (CAM) to indicate the plurality of medical systems. Hence there is a move suggested towards a pluralistic health care system. However, the question of plurality is misplaced largely because these refer merely to plurality of treatments. Further the role of pharmaceutical industry and concerns of scientific procedure have led to standardization, making it necessary for systems to follow procedures of standardization to make their products accessible and safe. This also extends to terms such as testing, whose singular implication goes unquestioned. A major limitation in possession studies is the use of either anthropological or psychiatric approaches is that while the former views possession in terms of its symbolic, ritual, functional or cultural values, the latter views it with regard to pathology and disorders. Much of discussions on mental illness though have not found any significant importance in studies on possession. Notions of ability and functionality which are the emphases of both anthropology and psychiatry needs to be revisited. An important change proposed with regard to mental health is the inclusion of mental illness in the Persons with Disability Act. The understanding of 'disability' is closely linked with the notions of ' able bodiedness', 'productivity' and 'vitality'. It is in reference to these notions that the concept of normalcy is built and 'disability' is seen as a deviancy / departure from the normal. This step is crucial because the disability act also includes provisions towards a more inclusive society and to integrate disabled individuals within society.

Analyzing the impaction on possession practices in the light of these recent developments remains an important area of concern. In conclusion, debates on possession

practices have to acknowledge not only treatments and practices of possession but also theories and perspectives on possession. It is evident that possession practices are not restricted to only the uneducated, ignorant or gullible masses of marginalized populations, rather they occur across the world. That these should occur in 90% of the world and yet be constituted as being culturally bound or traditional raises questions on what basis are terms such as scientific or modern formulated. While it is true that many possession practices might be considered to be inhuman or violent, this is not exclusive to possession practices but as shown in this chapter is common amongst mental health institutions in India. The limitations of using a western perspective, language and terminology is blatantly evident. In the very constitution of the term possession lays the predominance of a particular discourse and that perhaps explains the inequality not only amongst people but an inadequate language to conceptualize and describe practices in their own terms.

References

Adams V A (1997) Dreams of a Final Sherpa. *American Anthropologist* 99 (1): 85-98.

Albanese CL (1999) The Subtle Energies of Spirit: Explorations in Metaphysical and New Age Spirituality. *Journal of the American Academy of Religion* 67 (2): 305-325.

American Psychiatric Association (2005) D*iagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision,* New Delhi: Jaypee Brothers.

Andaya B W (1997) Historicizing "Modernity" in South East Asia. *The Journal of the Economic and Social History of the Orient* 40 (4): 391-409.

Antze P (1992) Possession Trance and Multiple Personality: Psychiatric Disorders or Idioms of Distress? *Transcultural Psychiatry* 29 : 319-322.

Atkinson J (1987) The Effectiveness of Shamans in an Indonesian Ritual. *American Anthropologist, New Series* 89 (2): 342-355.

AvRuskin TL (1988) Neurophysiology and the Curative Possession Trance: The Chinese Case. *Medical Anthropology Quarterly, New Series* 2(3): 286-302.

Bacigalupo A (1998) The Exorcising Sounds of Warfare: The Performance of Shamanic Healing and the Struggle to Remain Mapuche. *Anthropology of Consciousness* 9(2-3): 1-16

Banyan Academy of Leadership in Mental Health, 2009, Report of Faith Healing in Mental Health Seminar (URL: www.balm.in/pdf/report'roleoffaithhealinginmentalhealthcare'.pdf *accessed on 1st June 2010).*

Bellamy C (2006) Smoking is Good For You: Absence, Presence, and the Ecumenical Appeal of Indian Islamic Healing Centers. *Hindu Studies* 10: 207-224.

Betty S (2005) The Growing Evidence for "Demonic Possession": What Should Psychiatry's Response be? *Journal of Religion and Health* 44 (1): 13-30

Bhui K and D Bhugra (2002). Explanatory models for mental distress: implications for clinical practice and research. *British Journal of Psychiatry* 181: 6-7.

Boddy J (1988) Spirits and Selves in Northern Sudan: The Cultural Therapeutics of Possession and Trance. *American Ethnologist* 15 (1): 4-27.

Boddy J (1994) Spirit Possession Revisited: Beyond Instrumentality. *Annual Review of Anthropology* 23: 407-434

Bolton J (1995) Medical Practice and Anthropological Bias. *Social Science and Medicine* 40 (2): 1655-1661.

Bourguignon E (1989) Multiple Personality, Possession Trance, and the Psychic Unity of Mankind. *Ethos* 17 (3): 371-384.

Bourguignon E (1992) The DSM-IV and Cultural Diversity. *Transcultural Psychiatry* 29:229-332.

Broch H (1985) "Crazy Women are Performing in Sombali": A Possession-Trance Ritual on Bonerate, Indonesia. *Ethos* 13(3): 262-282.

Brockman R (2000). Possession and Medicine in South Central India. *Journal of Applied Psychoanalytic Studies* 2(3): 299-312.

Campion J, Dinesh Bet al (1998) Religious and indigenous treatment of mental illness in South India- A descriptive study. *Mental Health, Religion and Culture* 1(1): 21-29.

Cardena E (1992) Trance and Possession as Dissociative Disorders. *Transcultural Psychiatry* 29: 287-300

Castillo R (1992) Cultural Considerations for Trance and Possession Disorder in DSM-IV. *Transcultural Psychiatry* 29: 332-337.

Chamberlain A G (1913) Demoniac Possession. *The Irish Church Quarterly* 6(22): 143-153.

Charles H L (1953) Drama in Shaman Exorcism. *The Journal of American Folklore* 66(260): 95-122.

Chatterjee P (1995) *The Nation and its Fragments:Colonial and Postcolonial Histories*, Delhi: Oxford University Press: 172-199

Csordas T (1988) Elements of Charismatic Persuasion and Healing. *Medical Anthropology Quarterly, New Series* 2(2): 121-142.

Csordas T (1990) Embodiment as a Paradigm for Anthropology. *Ethos*18 (1): 5-47.

Demetiro F R (1978) The Shaman as Psychologist in Asian Folklore Studies 37(1): 57-75.

Dow J (1986) Universal Aspects of Symbolic Healing: A theoretical synthesis. *American Anthropologist, New Series* 88(1): 56-69.

Dwyer G (2003) *The Divine and the Demonic: Supernatural Afflictions and its Treatment in North India.* London: Routledge.

Fabrega H Jr (2009) *History of Mental Illness in India: A Cultural Psychiatry Retrospective.* Delhi: Motilal Banarasidass Publishers,

Farida P et al (2007). " I will accept whatever is meant for us. I wait for that -day and night". The Search for healing at a Muslim shrine in Pakistan. *Mental Health, Religion and Culture* 11(4): 375-386.

Finkler K (1994). Sacred Healing and Biomedicine Compared. *Medical Anthropological Quarterly, New Series* 8(2): 178-197.

Foucault M (1990) *The History of Sexuality Vol.1.* London: Penguin.

Gell A (1980) The Gods at Play: Vertigo and Possession in Muria Religion. *Man, New Series* V 15(2): 219-248.

Gellner N D (1994) Priests, Healers, Mediums and Witches: The Context of Possession in the Kathmandu Valley, Nepal. *Man, New Series* 29(1): 27-48.

Gezon L L (1999) Of Shrimps and Spirit Possession: Toward a Political Ecology of Resource Management in Northern Madagascar. *American Anthropologist, New Series*, 10 (1): 58-67.

Government of India, Ministry of Health & Family Welfare, 2010, Ammendments to the Mental Health Act (1987), DRAFT, prepared by Pathare S and J Sagade, New Delhi. (URL: http://www.mohfw.nic.in/amendments%20MHA%201987%20final.pdf accessed on 5th July 2010)

Hale L (1997) preto velho: Resistance, Redemption, and Engendered Representations of Slavery in a Brazilian Possession-Trance Religion. *American Ethnologist* 24(2): 392-414

Halliburton M (2004). Finding a Fit: Psychiatric Pluralism in South India and its Implications for WHO Studies of Mental Disorder. *Transcultural Psychiatry* 41(1): 80-98.

Halliburton M (2009) *Mudpacks & Prozac: Experiencing Ayurvedic, Biomedical and Religious Healing.* California: Left Coast Press.

Hedges E and Beckford J A (2000) Holism, Healing and the New Age. In: Scutliffe and Bowman (eds), *Beyond New Age: Exploring Alternative Spirituality.* Edinburgh: Edinburgh University Press, 169-188.

Hervieu-Léger D (1990) Religion and Modernity in the French Context: For a New Approach to Secularization. *Sociological Analysis* 51:15-25

Hippler A (1973) Possession and Trance Cults: A Cross-Cultural Perspective by Arthur E Hippler. *Transcultural Psychiatry* 10:21

Hollan D (2000) Culture and Dissociation Toraja. *Transcultural Psychiatry* 37(4): 545–559

Hughes C C (1998) The Glossary of 'Culture-Bound Syndromes'. *DSM-IV: A Critique in Transcultural Psychiatry* 35(3): pp. 413-421

Hultkrantz A (1985) The Shaman and the Medicine Man. *Social Science and Medicine* 20 (5): 511-515.

Jadhav S (2000) The Cultural Construction of Western Depression. In: Skultans and Cox (ed) *Anthropological Approaches to Psychological Medicine.* England: Jessica Kingsley Publishers, 41-66.

Janes C (1995) The Transformations of Tibetan Medicine. *Medical Anthropology Quarterly* 9(1): 6-39.

Jonathan C et al (1998). Religious and indigenous treatment of mental illness in South India- A descriptive study. *Mental Health, Religion and Culture* 1(1): 21-29.

Jordan E (1922) Possession and Individuality. *The Philosophical Review* 31(4): 369-387.

Kakar S (1982) *Shamans, Mystics and Doctors: A Psychological Enquiry into India and its Healing Traditions*. Delhi: Oxford University Press.

Kapferer B (1979) Mind, Self, and Other in Demonic Illness: The Negation and Reconstruction of Self. *American Ethnologist* 6(1): 110-133.

Kapferer B (2002) Outside All Reason: Magic, Sorcery and Epistemology. *Anthropology in Social Analysis* 46(3):1-31.

Kar N (2008). Resort to faith-healing practices in the pathway to care for mental illness: a study on psychiatric inpatients in Orissa. *Mental Health, Religion and Culture* 11(7): 729-740.

Kelly E F and Locke R.G. (1985) A Preliminary Model for the Cross-Cultural Analysis of Altered States of Consciousness. *Ethos* 13(1): 3-55.

Kim K L (1992) Comment On Dsm-Iv Criteria for Trance and Possession. *Transcultural Psychiatry* 29: 341-342.

Kirmayer LJ (2007) Cultural Psychiatry in Historical Perspective. In: D Bhugra and K Bhui (eds) *Textbook of Cultural Psychiatry*. Cambridge: Cambridge University Press, 3-20.

Kleinman A (2006) Anthropology in the Clinic: The problem of cultural competency and how to fix it. *PLOS Medicine* 3(10): 1673-1676.

Kressing (2003) The Increase of Shamans in Contemporary Ladakh: Some preliminary observations. *Asian Folklore Studies* 62:1-23.

Lambek M (1980) Spirits and Spouses: Possession as a System of Communication among the Malagasy Speakers of Mayotte. *American Ethnologist* 7(2): 318-331

Langford J (1999) Medical Mimesis: Healing Signs of a Cosmopolitan Quack. *American Ethnologist* 26 (1):24-46.

Laubach M (2004) The Social Effects of Psychism: Spiritual Experience and the Construction of Privatized Religion. *Sociology of Religion* 65(3): 239-263.

Leavitt J (1993) Are Trance and Possession Disorders? *Transcultural Psychiatry* 30: 51-57.

Lee-Treeweek G (2000) Trust in complementary medicine: the case of cranial osteopathy. *The Editorial Board of The Sociological Review 2002*, Blackwell.

Lewis I M (1966) Spirit Possession and Deprivation Cults. *Man New Series* 1(3): 307-329.

Lewis-Fernandez R (1992) The Proposed DSM-IV Trance and Possession Disorder Category: Potential Benefits and Risks. *Transcultural Psychiatry* 29: 300-317.

Lewis-Fernandez R (1998) A Cultural Critique of the DSM-IV Dissociative Disorders Section. *Transcultural Psychiatry* 35 (3): 387-400.

Littlewood R (2000) Psychiatry's Culture. In: Skultans and Cox (ed) *Anthropological Approaches to Psychological Medicine*. England: Jessica Kingsley Publishers, 66-94.

Low M S (1988) The Medicalization of Healing Cults in Latin America. *American Ethnologist* 15(1): 136-154.

Mageo J (1996) Spirit Girls and Marines: Possession and Ethnopsychiatry as Historical Discourse in Samoa. *American Ethnologis.*. 23(1): 61-82.

McGuire M (1987) Ritual, Symbolism and Healing. *Social Compass* 34: 365-379.

Moore P E (1993) Gender, Power and Legal Pluralism: Rajasthan, India. *American Ethnologist* 20(3): 522-542.

Nabokov I (1997) Expel the Lover, Recover the Wife: Symbolic Analysis of a South Indian Exorcism. *The Journal of the Royal Anthropological Institute* 3(2): 297-316.

National Human Rights Commission and National Institute of Mental Health and Neuro Sciences, 2008, Mental Health Care and Human Rights, (ed), D Nagaraja and Pratima Murthy, Delhi, National Human Rights Comission. (URL : http://nhrc.nic.in/Publications/Mental_Health_Care_and_Human_Rights.pdf accessed on 7th July 2010)

Nishiyama T (2003) Demonology, Possession and the Question of Historical Transition. *Body and Society* 9(2): 115-120.

Nourse W J (1996) The Voice of Winds Versus the Masters of Cure: Contested Notions of Spirit Possession Among the Lauje of Sulawesi. *The Journal of the Royal Anthropological Institute* 2(3): 425-442.

Nuckolls W C (1991) Becoming a Possession-Medium in South India: A Psychocultural Account. *Medical Anthropology Quarterly, New Series* 5(1): 63-77.

Ong A (1988) The Production of Possession: Spirits and the Multinational Corporation in Malaysia. *American Ethnologist* 15(1): 28-42.

Patel S (2000) Modernity: Sociological Categories and Identities. *Current Sociology* 48(3): 1-5.

Perry C (1992) Are Trance and Possession Disorders Linked To High Hypnotizability? *Transcultural Psychiatry* 29: 347-358.

Peters L (1982) Trance, Initiation, and Psychotherapy in Tamang Shamanism. *American Ethnologist* 9(1): 21-46.

Pigg S L (1996) The Credible and the Credulous: The Question of "Villagers' Beliefs" in Nepal. *Cultural Anthropology* 11(2): 160-201

Pirani F and Rena Pet al (2007). " I will accept whatever is meant for us. I wait for that - day and night". The Search for healing at a Muslim shrine in Pakistan. *Mental Health, Religion and Culture* 11(4): 375-386.

Prince H R (1976) Psychotherapy as the Manipulation of Endogenous Healing Mechanisms: A Transcultural Survey. *Transcultural Psychiatry* 13: 115-133.

Prince H R(1974) The Problem of "Spirit Possession" as a Treatment for Psychiatric Disorders. *Ethos* 2(4): 315-333.

Raguram R et al (2002) Traditional community resources for mental health: a report of temple healing from India. *British Medical Journal* 325(7354): 38-40.

Ram R (2004) Untouchability in India with a Difference: Ad Dharm, Dalit Assertion, and Caste Conflicts in Punjab. *Asian Survey* 44(6): 895-912.

Rao A V (1978) Some Aspects of Psychiatry in India. *Transcultural Psychiatry* 15: 7-27.

Rountree K (2002) How Magic Works: New Zealand Feminist Witches Theories of Ritual Action. *Anthropology of Consciousness* 13 (1): 42-59.

Saniotis A(2009) Encounters with Religious Imagination and the Emergence of Creativity. *The Journal of General Evolution* 65 (7): 464-476.

Sax S W (2004) Healing Rituals: A critical performative approach. *Anthropology and Medicine* 11(3): 293-306.

Seligman R (2005) From Affliction to Affirmation: Narrative Transformation and the Therapeutics of Candomblé Mediumship. *Transcultural Psychiatry* 42(2): 272–294.

Sethi S and Bhargava S (2009) Mass Possession State in a Family Setting. *Transcultural Psychiatry* 46(2): 372–374.

Sharp L A (1995) Playboy Princely Spirits of Madagascar: Possession as Youthful Commentary and Social Critique. *Anthropological Quarterly* 68(2): 75-88.

Shields K N (1987) Healing Spirits of South Kanara. *Culture, Medicine and Psychiatry* 11: 417-435.

Shimoji A and Miyakawa T (2000) Culture-bound Syndrome and a Culturally Sensitive Approach: From a Viewpoint of Medical Anthropology. *Psychiatry and Clinical Neurosciences* 54: 461–466

Sinha V (2006) Problematizing Received Categories: Revisiting 'Folk Hinduism' and 'Sanskritization'. *Current Sociology* 54(1): 98-111

Skultans and Cox (2000) Introduction. In: Skultans and Cox (ed) *Anthropological Approaches to Psychological Medicine*. England: Jessica Kingsley Publishers, 7-41.

Skultans V (1987) The Management of Mental Illness Among Maharashtrian Families: A Case Study of a Mahanubhav Healing Temple. *Man, New Series*. 22(4): 661-679.

Smith F (2006) *The Self Possessed: Deity and Spirit Possession in South Asian Literature and Civilization,* New York, Columbia University Press.

Smith J H (2001) Of Spirit Possession and Structural Adjustment Programs: Government Downsizing, Education and Their Enchantments in Neo-Liberal Kenya. *Journal of Religion in Africa* 31(4): 427-456.

Spiro M A (2005) Najar or Bhut- Evil Eye or Ghost Affliction: Gujarati Views about Illness Causation. *Anthropology & Medicine* 12(1): 61-73.

Stewart K M (1946) Spirit Possession in Native America. *South Western Journal of Anthropology* 2(3): 323-339.

Stoller P (1992) Embodying Cultural Memory in Songhay Spirit Possession. *Archives de sciences sociales des religions*, 37e Année (79): 53-68.

Sutcliffe S (2000) 'Wandering Stars': Seekers and Gurus in the Modern World. In: Scutliffe and Bowman (eds) *Beyond New Age: Exploring Alternative Spirituality* Edinburgh: Edinburgh Univiersity Press, 17-37

Swanson G (1978) Trance and Possession: Studies of Charismatic Influence. *Review of Religious Research* 19(3): 253-278.

Turner V (1969) *Ritual Process: Structure and Anti Structure*, London, Routledge and Kegan Paul

Vecchiato L N (1993) Illness, Therapy and Change in Ethiopian Possession Cults. *Africa: Journal of the International African Institute* 63(2): 176-196.

Waldram B (2000) The Efficacy of Traditional Medicine: Current Theoretical and Methodological Issues. *Medical Anthropology Quarterly, New Series* 14(4): Theme Issue: Ritual Healing in Navajo Society (Dec. 2000), pp. 603-625.

Ward A C and M H Beaubrun (1980). The Psychodynamics of Demon Possession. *Journal for the Scientific Study of Religion* 19(2): 201-207.

Winkelman M J (1990) Shamans and Other "Magico-Religious" Healers: A Cross-Cultural Study of Their Origins, Nature, and Social Transformations. *Ethos* 18 (3): 308-352.

World Health Organization (2005) *WHO Resource Book on Mental Health, Human Rights and Legislation.* Switzerland: WHO, 1-40, 116-113

Website references

Anti-Superstition. Org, Science on wheels, (http://www.antisuperstition.org/index.php?option=com_content&view=article&id=49:science-on-wheels&catid=34:scientific-attitude&Itemid=78) accessed on 1st July 2010

Dargahs play Ghost-busters, (http://timesofindia.indiatimes.com/city/mumbai/Dargahs-play-ghost-busters/articleshow/1000190862.cms) accessed on 5th July 2010.

Diocese of Worcestor

(http://www.cofe-worcester.org.uk/news/news.php?y2010) accessed on 18th June 2010.

Drug and Magic Remedies (Objectionable Advertisements Act 1954), (http://www.fda-mah.com/MagicDrug.aspx) accessed on 1st July 2010.

Health Department's prescription to remove shackles that bind mentally ill, (http://cities.expressindia.com/fullstory.php?newsid=205149) accessed on 5th July 2010

The Black Magic Bill, (http://www.karmayog.org/govtactsschemes/govtactsschemes_3200.htm) accessed on 25th June 2010.