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Overview

Classification of serious mental illness according to Ayurveda

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Abstract. *Ayurveda is widely recognized as a Hindu system of medicine, but its formulation of mental illness is less well-known. This paper reviews concepts of mental illness with reference to principles of Ayurveda presented in the classical Sanskrit texts of the tradition. It discusses these concepts, their cultural contexts and relevance for cultural psychiatry. As a medical system with an elaborate theory, Ayurveda classifies mental disorders according to principles of an indigenous humoral pathophysiology, concerned with balance of* vāta *(wind),* pitta *(bile), and* kapha *(phlegm). Other categories of mental disorder acknowledged by the tradition refer to spirits (*bhūta *or* graha*) identified with particular personalities and patterns of behaviour. An account of the signs, symptoms and meaning of various forms of serious mental illness (termed* unmāda*), according to Ayurveda, provides a framework for examining the current influence of traditional cultural concepts and assessing cultural explanatory models of psychiatric illness. Doing so helps to explain how affected persons and others in their community understand and respond to this illness, including families, various practitioners who treat them and laypersons who collectively constitute the community context of mental illness. Recent attention to the value of a cultural formulation as an integral component of clinical assessment, which has been incorporated in the DSM-5, acknowledges the practical significance of clinicians' awareness of the formal traditions that may influence the experience and meaning of mental illness, and expectations of treatment. It enables them to better understand and help their patients.*

Keywords: Ayurveda; History of medicine; Classification of mental disorders; Humoral medicine; Cultural psychiatry; Cultural formulation; Cultural epidemiology.

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INTRODUCTION Ayurveda, the Hindu system of medicine that developed in the Indian subcontinent, remains widely practiced with some degree of influence in India and Sri Lanka. It has also been practiced in Southeast Asia and more recently has been introduced in Western countries as a combined result of the South Asian diaspora, appeal as an alternative to mainstream allopathic medicine, a feature of complementary health services and aggressive marketing. Deeply embedded in the Hindu culture of its origins, Ayurveda is both a reflection of that culture in areas of health and medicine, as well as a determinant of beliefs and practices affecting many other facets of life, especially diet, hygiene and lifestyle.

The medical tradition is notable for its systematic account of diseases and disorders, including concepts of mental illness, based on a coherent medical theory. Comparative and historical study of the relationship between mental disorder in Ayurveda and ideas about insanity in other Hindu cultural traditions — such as religion, philosophy, law, politics and literature — shows how culture, medicine and psychiatry interact (Weiss, 2010). Study of the approach to the classification of categories of

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unmāda, the term for serious mental disorder in Ayurveda, and how this classification relates to other features of the medical system and other Hindu cultural traditions indicates an approach guiding practitioners of Ayurveda for medical evaluation and treatment of their patients. Consideration of this approach clarifies cultural explanations of mental illness underlying its experience and meaning.

Although rooted in a classical tradition informed by textual sources in Sanskrit, Ayurveda is not just a matter of historical interest. It remains influential as a system of medical practice with a commercial pharmaceutical industry producing both curative medicines and products to promote health, and it delineates a cultural system that influences the way people think and behave. To practice effectively, mental health professionals need to understand their patients' ideas and experience of illness, and to communicate in terms that are comprehensible. An appreciation of the principles of Ayurveda helps practitioners of allopathy in India and elsewhere to understand the variety of illness experiences and to establish an effective therapeutic alliance with their patients. This paper presents the fundamental concepts of Ayurveda, and it considers their current influence based on recent research in India.

Historical framework and current priorities of cultural psychiatry

Interest in the cultural features and explanatory models of mental illness, and the relationship between professional and local conceptualizations of mental disorders, have been important motivations of cultural psychiatry from the outset. They were fundamental considerations motivating the proposition of a "new" cross-cultural psychiatry (Kleinman, 1977) and current interests in enhancing the cultural formulation of DSM-IV, developing it into a set of instruments for a cultural formulation in DSM-5 (Lewis-Fernandez, 2009). Field trials of the cultural formulation interview for the DSM-5 are currently underway, recognizing that aspirations of a global system require research that is not only international but also cross-cultural.

Without an adequate appreciation of how medical and psychiatric concepts are derived from and embedded in their culture and historical period, comparative analysis of ethnomedical concepts, including principles of Ayurveda, are likely to be simplistic. Our interest in the cultural concepts and their sources is not a matter of advocating their validity or promoting practice based on these concepts. Questions about the "truth" of Ayurvedic concepts and contemporary interpretation of the sources of the tradition are topics for empirical study and critical analysis for cultural and linguistic anthropology (Cohen, 1995; Wolfgram, 2010), especially as cultural traditions interact in a globalizing world. With regard to the interests of cultural psychiatry, the various formulations and manifestations of Ayurveda are important because they influence the experience, meaning and behaviour of people with mental illness, their families, communities and available sources of help. Recognition of the value of understanding, acknowledging and responding to these interests motivates development of the cultural formulation in clinical practice as a feature of the DSM-5, and research in cultural epidemiology to describe and explain the influence of cultural concepts of mental illness (Weiss, 2001).

CLASSICAL AYURVEDA

Sources of the tradition

The primary historical sources of Ayurveda are a collection of authoritative Sanskrit texts. Anthropological study identifies the context, experience and distinctive beliefs and practices identified with health and illness in the present day. Though recognizably consistent, they also diverge from the texts, reflecting patterns of continuity and change in the tradition over time. Research on Ayurveda has been undertaken by scholars and scientists working within and outside the system and across disciplines. Philologists, clinicians, health scientists, anthropologists, historians, political scientists and others have examined various aspects of Ayurveda (Leslie, 1976; Leslie & Young, 1992). Their interests include, for example, textual history of the medical system based on philological studies (Filliozat & Chanana, 1964; Jolly & Kashikar, 1977), social and cultural history (Basham, 1954), an implicit ecological and eco-social framework (Zimmermann, 1988), political manifestation and

motivation of Hindu revivalism (Kopf, 1969) and a cultural example of a sociological process of professionalizing medical traditions (Leslie, 1972).

Our consideration of the theory of serious mental illness focuses on the Sanskrit textual sources of that tradition. Scholars currently estimate that the earliest of these texts were written between 200 B.C.E. and 400 C.E., codifying a system of medical practice that had been evolving orally several centuries previously. The texts are difficult to date, in part because the present editions include piecemeal contributions over an extended period, reflecting a process of accretion and transformation. Wujastyk (1998) explains how scholars go about dating these texts, considering the example of *Caraka Saṃhitā*.

The treatises of Ayurveda themselves trace their origins without dates to divine sources, leading eventually to Dhanvantari, lord of medicine (according to the *Suśruta Saṃhitā*) or Bharadvāja (according to the *Caraka Saṃhitā*), and from them to the patriarchs of Ayurveda who produced each of the major texts. The three texts that are considered most authoritative, collectively known as "the great three" (*bṛhat trayī*), are those of Caraka and Suśruta, and the third, *Aṣṭhāṅgahṛḍaya Saṃhitā* of Vāgbhaṭa. Although the texts are identified with these names, internal references refer to a variety of sources. Similar to other Sanskrit traditions, the work of commentators elaborates an earlier treatise regarded as authoritative, thereby providing some indication of how medical concepts were elaborated and changed over time.

Each of the Ayurvedic texts acknowledges eight branches of medical knowledge (**Table 1**), and this association is so clearly identified with Ayurveda that a reference to "the eight branches (*aṣṭāṅga*)" is commonly understood as a synonym. None of these texts, however, are organized according to that framework. The treatise of Suśruta gives more attention to surgery, which is for the most part ignored by the others. Although there are references in the classical literature to texts on seven of the eight branches, none focus exclusively on problems associated with demons and spirits (*bhūtavidyā*); these refer primary to mental disorders, but also sudden-onset childhood fevers. Lack of such a reference to a dedicated treatise distinguishes this branch from the others (Majumdar, 1971).

Ayurveda is linked to classical systems of Hindu philosophy in a similar way that Western medicine (allopathy) is linked to philosophy, ethics and basic life sciences (viz., biochemistry, biology, anatomy and physiology). Among the six systems of classical Hindu philosophy, medicine is most closely associated with the traditions of *sāṃkhya* and *yoga.* Their vocabulary and concepts are points of reference for the theory of Ayurveda and mental illness (Obeyesekere, 1977).

Conceptualization of serious mental illness (*unmāda*)

Three basic components of an ethnomedical physiology are a hallmark of Ayurveda. Health requires their harmonious balance and illness results from their imbalance. Termed *doṣa,* and typically called humours in English, they are comparable with the historical concept of humours in Greek medicine (Filliozat & Chanana, 1964; Kutumbiah, 1974). The fundamental theory of Ayurveda refers to these three humours (*tridoṣa*)—namely, wind (*vāta*), bile (*pitta*) and phlegm (*kapha*). Clinical evaluation assesses features of their imbalance, the affected location in the body and affected tissue (*dhātu*) and a named disease (*vyādhi*).

Ayurveda acknowledges the importance of both mental and physical aspects of health; mind and body are each distinguishable determinants of diseases. Although lifestyle has acknowledged effects on peace of mind and illness, the balance of the humours is emphasized, and references to psychological and social determinants of serious mental disorder may be acknowledged, but they are less prominent in the framework for classification. Passages concerned with values of mental well-being are scattered throughout Ayurvedic texts, and typically of a general nature. The following passage is an example: "Diseases and pleasures are understood to reside in both body and spirit (*sattva*), which together in equal measure account for well-being." (Caraka 1.1.55). Such passages are typically cited in asserting the priority of an integrative and holistic perspective of Ayurveda.

Table 1 Eight Branches of Ayurveda (*Aṣṭāṅga*)

1.	**Kāyacikitsā**	**General medicine** Treatment of various general health problems, elaborating causes, diagnosis and treatment; serious mental disorders (*unmāda*) caused by a humoral (*doṣa*) imbalance are considered in this framework
2.	**Śalya tantra**	**Surgery** Surgical treatment, typically to remove foreign objects that enter the body (e.g., splinter, thorn, spear or arrow), but elaborated further in the Suśruta Saṃhitā
3.	**Śālākya tantra**	**Disorders of the eye and other sensory organs** Term refers to the sharp pointed instrument (*śalāka*) that is used to treat problems of the eye and other sensory organs; understood to apply to broader interests of health problems of the eye, ears and nose
4.	**Bhūtavidyā**	**Disorders associated with demons or possession** Term refers to demons or spirits and suggests problems identified with them, including mental illness, seizures and sudden onset childhood fevers
5.	**Kaumārabhṛtya**	**Care and upbringing of children** Diagnosis and treatment of health problems affecting children
6.	**Agada tantra**	**Medicines for relief of sickness, especially antidotes for poisoning** Term refers to relief of illness generally, but typically understood as antidotes (i.e., for poisons from foods, vegetation, animals and bites of snakes and insects)
7.	**Rasāyana tantra**	**Elixirs for general well-being** Refers to tonics that promote health, long life and general well-being, and that prevent ageing
8.	**Vājīkaraṇa tantra**	**Enhanced sexual functioning** Stimulants to ensure virility, promote sexual excitement and performance; aphrodisiacs

Explanations of mental illness refer either to endogenous causes, that is, the humoral imbalance, or external causes, that is, either caused by or associated with features of various classes of spirits, ranging from deities to ancestors and demons. Mental well-being, which benefits from appropriate diet and lifestyle, enhances resilience and reduces vulnerability to both internal and external threats. The concluding passage of the chapter on the therapeutics of *unmāda* in the *Caraka Saṃhitā* makes that point:

> One who avoids meat and intoxicating beverage,
> who desires what is wholesome and is pious and pure,
>
> This clear-headed one contracts neither
> endogenous (*nija*) nor exogenous (*āgantu*) mental illness (*unmāda*).
>
> *Caraka Saṃhitā* 6.9.96

Details of the social determinants and consequences of mental illness are not elaborated, and case histories are lacking. Like allopathic medical texts and clinical handbooks used by medical house

officers, they focus more on the signs and symptoms that a clinician needs to know to make a diagnosis with reference to the primary theory and to guide a plan of treatment accordingly.

Other areas of Sanskrit literature, apart from medicine, explain some of the cultural associations and social contexts. Stories refer to the maddening effects of romantic love — e.g., the madness of Purūravas in the absence of the beloved Urvaśī in a well-known legend recurring in Sanskrit literature; the tale of King Duṣyanta who became crazed with love of *Śakuntala* in a famous Sanskrit drama named for her; or the story of Unmādini, who was considered a threat to the kingdom because her intense beauty drove all men who saw her insane (*Kathāsaritsāgara* 15.65). These accounts, however, are literary rather than clinical. Legal texts reflecting additional related interests indicate responsibilities for protecting people with mental illness; they also refer to the danger of pollution from contact and interactions, and thereby appear to sanction and promote social exclusion that today would be regarded as stigma (Weiss, 2010).

Symptoms and an account of the categories of mental illness are presented in the texts of Ayurveda in chapters describing the pathology and treatment of *unmāda*. They identify two sets of broadly defined causes: foods that are spoiled or unclean, and the influence of various classes of spirits. The role of fear and terror is also acknowledged — emotions that engender chaotic mental turmoil and loss of clarity. Toxic impurities (*mala*) result from that, and they circulate to the mind and heart (termed *manas*, *buddhi* and *hṛdaya*; Caraka 6.9.4-7). Details of specific categories are presented with reference to two frameworks of classification: endogenous (*nija*) categories caused by the imbalance of one or more of the three humours, and exogenous, types associated with various classes of spirits (*āgantu* or *bhūtavidyā*), including deities, ancestors and demons. Categories of the endogenous types are distinguished by somatic signs and symptoms related to pathology of a particular humour in excess in various diseases, and features of the psychopathology (**Table 2**). Treatment typically involves efforts to cleanse the body and mind of the identified humour (one or more) that has accumulated in excess, using selected purgatives, emetics, sweat-inducing (sudorific) treatments and expectorants.

Table 2 Features of endogenous categories of mental illness (*nija unmāda*)

Type	Cause or Predisposition	Psychopathology	Somatic Symptoms
Wind *Vāta*	▪ Dry, cold, or insufficient food ▪ Purgation ▪ Decay of body elements ▪ Fasting	▪ Inappropriate laughing, smiling, dancing, etc ▪ Emaciated and ragged	▪ Reddish complexion ▪ Worse after eating
Bile *Pitta*	▪ Foods that are indigestible, bitter, sour, or hot	▪ Impatient, excited, threatening, agitated, angry ▪ Nudity ▪ Hallucinations	▪ Yellow complexion ▪ Feeling hot
Phlegm *Kapha*	▪ Fullness in the stomach	▪ Slowed speech and action ▪ Excessive sleeping ▪ Favours solitude, avoids wife	▪ Loss of appetite ▪ Nausea ▪ White fingernails ▪ Condition severe after eating

Data based on *Caraka Saṃhitā* 6.9.9-15

Accounts in the various major texts are for the most part similar, but Suśruta and Vāgbhaṭa include additional categories: one condition resulting from stress, loss or shock (*śokaja*), and another caused by poison (*viṣaja*). Suśruta also refers to a condition from bad blood (*rakta*). Another text, *Bhela Saṃhitā*, elaborates on the nature of stressors, referring to a condition caused by loss of wealth or bereavement. Although Caraka does not identify *unmāda* due to stress, loss or shock as a distinct category of endogenous disorder, the discussion of exogenous conditions refers to stressful periods when an individual is most vulnerable to the approach of spirits.

Categories of the exogenous conditions refer to distinctive features of disordered personality, symptoms and psychopathology that are readily identifiable with the character of culturally well-known classes of spirits and demons (**Table 3**). From the texts, it is not entirely clear whether these conditions refer to possession by spiritual entities, which is what most readers are likely to assume, or whether they refer to distinctive classes of spirits as a means of classifying particular forms of disturbed behaviours in a meaningful way, but without attributing the disorder to a spirit who takes possession of someone. A passage in Suśruta suggests the latter:

> They do not consort with men, nor do they ever take possession of men;
> and those who say that they do take possession are to be disregarded, since that kind of knowledge about the spirits (*bhūta*) is pure fantasy.
>
> *Suśruta Saṃhitā* 6.60.21

Other passages of Suśruta, however, describe an approach to treating the spirit-related conditions that suggests ideas about vulnerability and resistance to possession by them, rather than merely a descriptive account of symptoms and problems. These passages advise sacrifices at particular places for particular spirits—e.g., in the empty house of a Piśāca, at the river bank for the Pitṛs and in the fire at a temple for the Devas (*Suśruta Saṃhitā* 6.60.32-37).

The following passage from Caraka elaborates an approach to treatment for the exogenous form of mental illness that combines propitiation of the spirits with medicines:

> With food offerings, charms, oblations and
> use of medicinal herbs and drugs,
>
> With honesty, good conduct, austerities, wisdom,
> generosity, disciplines and vows.
>
> And by honouring gods, cows, Brahmans and teachers,
>
> The exogenous type attains tranquillity—
> also with supernormal powers, sacred formulas and
> medicinal herbs.
>
> *Caraka Saṃhitā* 6.9.93-94

This ambiguity about the effects of spirits as either causes or means of classifying mental illness may represent an accommodation of divergent views, but it probably also reflects inconsistent views among the various contributors. As explained above, these texts are accretions from various contributions over time, rather than works of a single author, who presented a unified coherent view and harmonized the overall text. If the idea of spirits seems at odds with the conceptualization of humours, it may be that it came from a divergent source. Reflecting on a process that would account for that, Chattopadhyaya (1986) explains, "The medical compilation [that] reaches us is full of alien propositions ... to be viewed as extrinsic to medicine, loosely inserted into the medical work" (v2 p424).

Some present-day practitioners of Ayurveda who advocate closer integration of Ayurveda and allopathy appear somewhat embarrassed by the proposition of a magico-religious basis of medical problems. Gaur (1992) argues that "spirits" should be understood as microorganisms. Although this assertion that the conceptualization of spirits may be reframed in a biomedical model has little cache, other efforts to integrate seemingly incongruous ideas in medical practice and theory have been widely influential. They are an important feature of medical and psychiatric pluralism in South Asia (Bhattacharyya, 1983; Leslie, 1980), and they provide a rationale for an integrated approach to treating mental illness. Evidence for that may be gleaned from ethnographic study of the practice of Ayurveda and popular cultural ideas about treatment of mental illness, which are discussed below.

Table 3 Features of exogenous categories of mental illness associated with spirits (*āgantu unmāda* or *bhūtavidyā*)

Type	Cultural association	Premorbid Features	Symptoms	Onset
Deva	Gods - divine and authoritative	▪ Pure, experienced in austerities and studious ▪ Moral ▪ Dressed in white	▪ Placid gaze, serious, dispassionate ▪ No desire for sleep or food ▪ Scant sweat, urine and faeces ▪ Lotus-blossom face	▪ Suspiciousness, delusion, hallucination
Guru, Vṛddha, etc	Teachers, elders, and respected persons	▪ Bathing, purity ▪ Solitude ▪ Versed in scriptures and poetry	▪ Behaviour, diet, and speech suggests a curse	▪ Auditory hallucination "by curse"
Pitṛ	Deceased ancestors	▪ Devoted to mother, father, teachers, elders	▪ Dull gaze, undiscerning ▪ Excessive sleeping ▪ Eats inedible substances ▪ Poor appetite and indigestion	▪ Visual hallucination
Gandharva	Celestial musicians associated with *soma*, love and gambling in Vedic literature	▪ Likes singing, music, someone else's wife, garlands, pleasant fragrances	▪ Passionate, impetuous, serious ▪ Fond of music ▪ Dance, food and drink ▪ Red clothes ▪ Derides ritual	▪ Touched (by Gandharva)
Yakṣa	May be divine or demonic; ruins offerings to Ancestors	▪ Intelligent, strong, handsome ▪ Likes humour, talks a lot	▪ Sleeping, crying, laughing ▪ Fond of dance	▪ Taken by Yakṣa ▪ Experience of being possessed
Brahma-rākṣasa	Ghost of unholy Brahman	▪ Dislikes scriptures, austerities, discipline ▪ Either a fallen Brahman or claiming high status ▪ Frolics in temple waters	▪ Dances and laughs loudly ▪ Hates gods, sages, and physicians ▪ May injure himself	▪ Unspecified
Rākṣasa	Evil demon with sharp teeth; ruins ancestral rites	▪ Lacking mental clarity ▪ Slanderous and lusting for women ▪ Deceitful and unpleasant ▪ Drinks and eats too much	▪ Disturbed sleep, averse to food ▪ Fond of knives, meat and blood ▪ Threatening	▪ Smell of raw flesh
Piśāca	Most evil and demonic; lurks in deserted houses, by waters, roads and trees	▪ Lacking mental clarity, slanderous ▪ Lusting for women ▪ Deceitful, a braggart, hurts others	▪ Abnormal thinking ▪ Behaves improperly ▪ Dancing, singing, laughing, chattering ▪ Sleeps in filth ▪ Nudity, running about aimlessly ▪ Memory loss	▪ Experience of being possessed: "They mount his back making him see"

Data based on *Caraka Saṃhitā* 6.9.20-21

ROLE OF AYURVEDA IN CURRENT CLINICAL PRACTICE AND CULTURE

The textual sources and conceptualization of serious mental illness in Ayurveda provide an account of the theory, which explains their meaning and has clinical implications. They do not indicate the extent or nature of its current influence, however, on clinical practice or how the theory affects the cultural concepts of illness among affected persons, their families and communities. Over the past several decades, ethnographic and cultural epidemiological studies show that people consult practitioners of Ayurveda less frequently for serious mental illness than they do for other medical problems. Serious mental illness, especially if the problem is identified with possession, is more likely to be treated by magico-religious healers than practitioners of Ayurveda. More than four decades ago in coastal Karnataka, Kapur (1979) found Ayurvedic doctors (*Vaid*) were least likely to be consulted first for mental health problems identified with possession (2 of 354 persons), and faith healers (*Mantarvadis* and *Patris*) were most likely to be consulted first (122 of 354 persons). Several decades later, studying pathways to care, Chadda and colleagues (2001) found that questions about first prior help seeking among psychiatric patients at a psychiatric hospital in Delhi identified only 1 of 44 patients who had gone to an Ayurvedic doctor and 23 who had gone to a traditional healer.

Bhattacharyya (1986) studied serious mental illness, termed *pāgalāmi*, in villages of West Bengal. In the course of her work she tried unsuccessfully to locate an actively practicing Ayurvedic psychiatric specialist in or around the region of Calcutta. Although several said that they would treat such patients, they explained that these patients did not come to them. She concluded that facilities and personnel for the Ayurvedic treatment of mental illness are almost non-existent. Even though spirits are acknowledged in the theory of mental illness presented in the texts, dealing with them is not an area of expertise associated in communities of West Bengal with practitioners of Ayurveda.

In Kerala, where the health system, media and popular culture are arguably more concerned with psychiatry and mental health than anywhere else in India, Ayurveda is not similarly detached from treatment of serious mental illness. The existence of a government-run Ayurveda mental hospital in Kottakkal itself makes the point. According to an informant in the ethnographic study of Halliburton (2005), the official approach to diagnosis in that hospital is based either on classification of the humour or the spirit. Like the position suggested by the passage of Suśruta (6.60.21) quoted above, identifying the spirit represents an effort to explain the behaviour of a mentally disordered patient, but it does not suggest that such persons and their problems result from possession by that spirit. Halliburton's informant who specialized in Ayurvedic treatment of mental health problems explained, "*Sarpa graha* diagnosis would be given to someone who acts like a snake, who hisses and pretends to slither like a snake. A person who thinks and acts as though he is a deity can be diagnosed as *deva graha*" (p 125).

Regarding the influence of humoural concepts of Ayurveda, it should also be noted that even though Bhattacharyya reported that Ayurvedic clinicians rarely treated patients for mental illness, when she studied patients coming for psychiatric treatment of serious mental illness (*pāgalāmi*), she found that Ayurvedic concepts nevertheless shaped many of their illness explanatory models (Bhattacharyya, 1986). Interviews with patients identified three dominant perceived causes of mental disorder: possession, sorcery and "bad head" (*māthāra golamāla*). The last of these was explained as a humoral imbalance, and some called it *unmāda*. Cultural epidemiological studies with EMIC interviews in Banaras, Mumbai and Bangalore have also demonstrated the significance of humoral concepts of mental illness in the explanatory models of patients seeking psychiatric treatment (Weiss *et al*, 1988).

Bhattacharyya noted some evidence of interdisciplinary cross-fertilization in the theory of mental illness reported by Ayurvedic physicians. They clearly had ideas about it even though they were not treating many patients. She noted that, "psychogenic factors which were ignored in Caraka and Suśruta are now emphasized and integrated into the *tridoṣa* theory" (Bhattacharyya, 1986). Halliburton (2005) also emphasized the importance of interdisciplinary and cross-cultural influences that were changing cultural concepts of mental illness in Kerala. He analysed interrelated ideas about spirit possession, psychiatry and appreciation of psychological and social determinants of mental illness. Accounts of spirit possession were becoming less elaborate, and the influence of alternative explanations, especially *tension*, were emphasized more.

Although tension is an English word, it has been incorporated in vernaculars throughout India to explain mental health problems. A study of cultural concepts of mental health problems in a Mumbai slum found that ideas about tension were ubiquitous. Parkar and colleagues (2003) explained that the taxonomy of tension is specified by its various sources: husband tension, children tension, financial tension, in-law tension, work tension, water tension, and so forth. Tension is the language through which people articulated the emotional impact of the environmental and the social experience of the slums.

Analysis of print media and films also highlights changes in cultural concepts of mental illness and efforts to reconstruct acceptable approaches to treatment. Noting a large following for psychological advice columns in popular magazines, which are often based on case data from clinical experience of the authors, Halliburton concludes that many of the cases "reveal a syncretic use of tropes of possession and psychological interpretation." The columns suggest that current practice merges "idioms of psychology and possession into a tangle that is impossible to identify as either 'modern', 'local', 'psychological' or 'religious/spiritual' " (Halliburton, 2005).

Consideration of an immensely popular Malayalam film in Kerala, *Manichitrathazhu* (The Ornate Lock, released in 1993), highlights the media portrayal of an ongoing debate in the popular culture concerned with competing ideologies of psychiatry and possession. Resolution of an intricate plot in the film involving a historical murder, revenge, possession and mental illness requires an effective alliance between a psychiatrist and a tantric faith healer. Its popularity might be regarded as a local phenomenon in a region preoccupied with psychiatry and mental health, but the theme has had wider appeal. The film has been remade with commercial success in other regional language versions, including Kannada (2004), Tamil (2005) and Hindi (2007). Success of these films suggests a felt need to resolve conflicts between possession and psychiatry as competing approaches in a globalizing India for addressing problems concerning the interests of mental health.

An additional report from Halliburton's field work is noteworthy for its consideration of cultural concepts, help-seeking options and the mental health of the population (Halliburton, 2004). Studying three forms of treatment for mental illness in Kerala — Ayurvedic psychiatry, allopathic psychiatry and religious healing — he found that each worked better for some patients but not as well for others. The research was motivated by the persisting question about why outcomes, first highlighted by the International Pilot Study of Schizophrenia, are better for people with schizophrenia in developing countries than in higher-income countries. He suggested that his findings may suggest an answer based on the benefits of medical pluralism. Perhaps the variety of available alternatives for help seeking enables a better fit between problems, preferences and the effectiveness of treatment.

IMPLICATIONS FOR CULTURAL PSYCHIATRY AND MENTAL HEALTH RESEARCH

The classical tradition and the ethnographic accounts of cultural concepts and treatment of mental illness, examined here through the lens of Ayurveda, are rich, complex and relevant for current interests of psychiatry and mental health. Recent consideration and efforts to enhance the cultural formulation, which was first introduced in Appendix I of DSM-IV, to make it a more integral feature of DSM-5 benefit from thoughtful consideration of illness explanatory models, and the relationship between both professional and lay explanations and approaches to dealing with mental illness (Kirmayer *et al*, 2008; Weiss & Somma, 2007). The ideas, frameworks and patterns of interacting cultural influences presented in this review influence expectations of patients and guide the practice of clinicians. A clinician does not need to be a practitioner of Ayurveda to benefit from an appreciation of how it affects illness-related experience, meaning and behaviour of patients.

Clarifying the framework of various explanatory models that may be relevant for a cultural group, as this review has done by presenting features of mental illness according to the classical theory of Ayurveda, addresses fundamental aims of cultural psychiatry. Consideration of the relationship of historical traditions and current practice highlights the influence and complexity of cultural experience

within a culture over time and changes in the framework and terms to describe or classify mental health problems. Although historical and ethnographic information is relevant for understanding and working in cultures, communities and practice settings, it has limitations as a generalized explanation for the experience, expectations and needs of a particular patient. Efforts to catalogue and examine the nature and implications of cultural contexts and explanatory models of patients and healers remain priorities for research in cultural psychiatry.

Clinical and research tasks are related. Development and use of a cultural formulation for clinical assessment and the recently developed cultural formulation interview for DSM-5 benefit from, and contribute to, the interplay of interdisciplinary research and clinical practice. Just as a psychiatric epidemiology is needed to assess priorities for health systems planning and effective treatment, a cultural epidemiology is also needed to guide culturally sensitive services and acceptable, effective clinical care. Concepts of mental illness mindful of historical accounts of the classification of serious mental illness according to Ayurveda presented here, and efforts to track the influence of traditional concepts on current priorities and practices, show how academic and practical interests of cultural psychiatry are linked in India. Cultural and historical studies elsewhere, where relevant sources are accessible, will also help to ensure that emerging mainstream interest and new tools for cultural psychiatry result in anticipated benefits for mental health.

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