International Journal of Innovative Research in Engineering
Volume 3, Issue 3 (May-June 2022), PP: 362-374.
www.theijire.com
ISSN No: 2582-8746

The Modernisation of Tradition: Thinking About Madness in Patna, India

SATHWIK REDDY GOPU[1], SAM KAMAL BODDU[2]
[1]*Acumen IITJEE & NEET College and Coaching Institute, Telangana, India.*
[2]*Shine Group of Institutions, Telangana, India.*

How to cite this paper:
SATHWIK REDDY GOPU[1], SAM KAMAL BODDU[2], "The Modernisation of Tradition: Thinking About Madness in Patna, India", IJIRE-V3I03-363-374.

Abstract: *Thirty-nine educated middle-class residents of Patna, India, were interviewed about vignette describing the behaviour of seemingly mad man or woman. The interview explored their representations of traditional healing methods and of Modern psychiatric notions. Besides explanations for mental illness and madness, the interviews also covered the reaction of families and neighbours to such phenomena. Respondents think causes depending on the context, ranging from frustrated desires, shock, and heredity to spirit possession. The majority's spontaneous preference for modern, psychiatric, treatment often co-exists with a faith in traditional healing. This faith is strengthened by their family's traditional preference. The resultsare discussed as example of process of modernisation of a common-sense in popularised scientific notions become anchored in the traditional setting of social structure and family life. The newly acquired knowledge forms a loosely organised social representation confronting a strongly objectified cultural representation of traditional thinking.*

THE MODERNISATION OF TRADITION FROM THE TRADITIONAL TO THE MODERN

Our first concern in this paper is to investigate contemporary urban North Indian socialrepresentations of madness. The cultural traditions of India themselves provide a rich and diverse source of beliefs about the causes and nature of madness, and also about appropriate forms of treatment embedded in diverse forms of social practice. Our question concerns the extent to which these traditions have absorbed "Western" or "modern" ideas based on contemporary medical and psychiatric knowledge. And do such "modern" ideas simply displacemore traditional Indian beliefs, or do Indian lay representations reconstruct these "modern" ideas in ways which allow them to co-exist with more traditional patterns of thought?

Framing the issues in this way itself raises a number of conceptual problems about the contrasting notion of tradition and modernity, which seem to imply narrative idea which has itself been criticsed for the way in which it constructs Western values as universal. As Pigg (1996) points out, however, modernity is an enigmatic concept in cultural analysis. Her analysis of the ways in which a discourse of modernity figures in the context of a Nepalese village shows how this idea is used to mobilise a number of key themes -including "notions of progress and development, of rationality and science" (p. 193)- which provide individuals with a social identity located within the dynamics of contemporary Nepalese culture. Pigg's approach,then, is not to avoid using what she acknowledges could be considered as the "tainted adjectives" of traditional and modern, but rather to emphasise that the contrast of these terms has become a part of contemporary Nepalese culture, and to suggest that the task for the culturalanalyst is to understand in what ways these terms are being used.

Pigg also notes that even within what can be called traditional patterns of belief there is considerable debate and argument generated for these villagers, as she puts it, by the "problems their ***unquestioned*** assumptions about healing, knowledge and illness pose for them" (p. 181). There is an echo here of a point made by Evans-Pritchard (1976) among others, that while to an outside observer traditional cultural systems may seem to be homogenous and static, there areneverthelessnontradictions within them (Archer, 1988; Gusfield, 1967) and a certain dynamic to the society (Bartlett,1928). Novelty introduced by innovation and modernisation has to operate within this context. As Bartlett recognised, the novel does'nt come into a cultural vacuum, but exert its influence within a context of already established meanings. He writes about culturalgroups having "preferred persistent tendencies" which express a general direction to the development of a group, and it is this general direction which determines their response to the novel and the new. Ideas and values which can be accommodated within this tendency are likelyto be accepted, while those which conflict with it are likely to be ignored. Within the contemporary Indian culture we are concerned with in this study, the motivation to embrace the new seems to be nourished by a general idea of progress. This is the context in which modern psychiatric ideas about mental illness are being re-worked into Indian common-sense.

Psychiatric notions and practices offer a more progressive account of these forms ofdisturbance and deviance than traditional theories and practices.

Framing our questions in this way also enables us to introduce our second concern whichrelates to issues about the dynamics of social representations themselves, and in particularly thisstudy addresses questions about the socio-genesis of representations[1]. Social representations can defined as:

"system(s) of values, ideas and practices with a twofold function: first, to establishan order which will enable individuals to orient themselves in their material and social world and to master it; and secondly to enable communication to take place among the members of a community by providing them with a code for social exchange and a code for naming and classifying unambiguously the various aspectsof their worlds and their individual and group history" (Moscovici, 1973, p. xiii).

In this sense social representations establish a universe of discourse within which meaningful talk can take place. As Moscovici, echoing Bartlett and MacDougall before him, hasemphasised the genesis of social representations is always concerned with rendering the

unfamiliar familiar. Research on processes of innovation in common-sense have described twoaspects to this process: anchoring and objectification (Duveen & Lloyd, 1990; Moscovici, 1981;Wagner et al, 1999). Anchoring refers to the process whereby the members of a group attempt to make sense of a new phenomenon by interpreting it in terms of pre-existing knowledge.
Objectification is the process through which the elaboration of ideas, interpretations and evaluations of an unfamiliar phenomenon results in a condensation of these elements into a simplified figure, icon or metaphor (Moscovici, 1976, 1988; Wagner, Elejabarrieta & Lahnsteiner, 1995). In a second phase of objectification, this image is projected so that reality isitself constituted in the terms of the representation (Wagner, 1998).

Most studies of social representations have been undertaken in Western cultures in conditions of modernity, and, as Moscovici (1981) suggests, the transition from the traditionalto the modern is also a transition from collective representations to social representations, from a relatively static order of unquestioned beliefs, to complex forms of different, even competing beliefs. Both historically as forms of collective thinking, and in the practical actuality of particular bodies of knowledge, social representations emerge out of tension and conflict whengaps or divisions appear within existing patterns of understanding. In short, when the taken-for-granted (Schütz's *fraglos gegeben*, 1972) can no longer be taken for granted, representational work is necessary to re-establish stability. In this sense, the socio-genesis of representations is an effort to restore or to gain collective, mental and cognitive stability (cf Duveen, forthcoming). When we talk of *social representations* we therefore always mean a *social representing system* which dynamically maintains a complex of meanings in a collectivity (Duveen & Lloyd, 1990).

In the present research we are concerned with two forms of instability. There is first of all madness itself, which, as Jodelet's (1991) study demonstrated so vividly, always presents a threat of instability in the ordinary business of living. Within the West, the categories employed to represent this disturbing and troubling phenomenon themselves have a history in which, as Foucault (1967) and others have pointed out, a notion of *mental illness* defined through analogyto physical disease and grounded in psychiatry as a scientific and medical practice has emerged in contrast to earlier notions of *madness* as a form of otherness. Contemporary representations in the West continue to incorporate both of these meanings. One continues to emphasise a sense of the radical otherness of the mad, while the other has sought to make this strange phenomenon accessible to the analytical framework of science by identifying causal factors inbiological or social processes.

The second form of instability we consider is concerned with the relatationship betweenthese different representations. In the West, at least, a certain stability has been achieved with the medical model of mental illness institutionalised in psychiatric practice, while popular social representations, even if they recognise the claims of science, nevertheless, as Rose (1996) has shown, continue also to hold on to a sense of the otherness of madness. De Rosa (1987) too found that the theme of madness continues to evoke archaic images of the mad as strange andbizarre among children and adolescents, as well as more modern, medicalised images. Both ofthese examples illustrate what Moscovici describes as a state of "cognitive polyphasia" (1976, p.286, see also Moscovici & Markova, 1998) which is characteristic of social representations in which different forms of understanding are able to co-exist. The continuing debates and arguments about these themes indicate a persistent potential for instability between representational systems.

A recognition of such polyphasia also serves as a reminder that Western representationsare not exclusively "modern", any more than Indian representations are exclusively "traditional".Indeed, this study is not presented as a comparative research. Rather, our concern is with the ways in which Indian representations are emerging. In common with most of the non-Westernworld, the institution of psychiatry is a more recent phenomenon in India than in the West, and traditional representations of madness persist not only as patterns of belief, but also through the practice of traditional healers. But they do so side by side with "modern" medical beliefs and psychiatric institutions. The dynamic established between these different threads of ideas suggests patterns of communication in which new forms of social representations are taking shape, and it is this which is our focus.

MADNESS, HEALING AND THE NOTION OF DESIRE IN INDIA

Although a wide variety of different healing traditions can be found in India, our respondents referred primarily to the cure of possession states and some aspects of the tantric

cult. In addition they also drew on ideas and principles of the medical system of ayurveda. Abrief explanation of these traditions will help to give the reader some orientation and background to this study.

Ayurveda. The complex and elaborate medical system of ayurveda builds on the idea that health and illness are determined by the balance of various elements, humours and qualitiesin the body. Besides the gross physical body, the person is conceived as consisting of two otherbodies, the subtle body (*linga sharira*) and the causal body (*linga karana*), of which only the subtle body is relevant with respect to mental illness. The subtle body consists of five principles: *buddhi* (intelligence), *indriyas* (the five potential sensory organs), *ahamkara* ("I- ness"), *tanmatras* (the five potentials of sound, touch, colour, smell and taste in the form of subtle matter) (Kakar, 1982, p. 239) and finally *manas*, which in psychological terms could bedescribed as responsible for

activation and direction of sensory and motor organs, self- regulation, reasoning and the combination of deliberation, judgement and discrimination (Kakar, 1982, p. 244). The balance of *manas* which constitutes mental health (*triguna samya*) is determined by the qualities (*gunas*) purity (*satva*), temperament (*rajas*), and inertia (*tamas*) andcan be disturbed by strong emotions such as fear (*bhaya*), grief (*soka*), lust (*moha*) anger (*krodha*), and - notably - by desires (*ichha*) and their counterpart repulsion (*dvesha*) (compare Kakar, 1982; Rosu, 1978; Srikantha Murthy, 1987).

In the diagnostic process, the practitioner of ayurveda (*vaidya*) generally aims to determine the specific nature of the imbalance within the bodily system in order to counteract this imbalance by prescribing herbal , dietary or mineral remedies. However, the ayurvedic medical system also acknowledges alternative explanations for illnesses. Among these, the concept of hereditary (*kulaja*) illnesses, which are referred to as *sukrasoniprakrti* or *adibala pravrtta*, and are recognised as having potential ill-effects on forthcoming generations (cf.Raina, 1990; Srikantha Murthy, 1987), is important in the present context.

Tantra. The term tantra in its literal sense simply denotes a specific genre of religious and ritualistic writing (Hardy, 1994). These writings generally consist of extensive compilationsof *mantras* and descriptions of ritual acts. However, the tantric material also provides its own theory of the human body and the physical processes involved in the pursuit of the ultimate aim of tantric mysticism, i.e. self-realisation (*moksa*). As with the ayurvedic system, tantra presupposes the existence of a subtle body, which in this case consists of thousands of *nadis* (conduits of energy or nerves) and six centres (*chakra*). The *chakras*, which are situated along the spinal cord, are connected by three major channels of energy, *shushumna* in the centre, themasculine *ida* to its left and the feminine *pingala* to its right (Kakar, 1982). Without meditational practice, the subtle energy only flows in *ida* and *pingala* without ever reaching *sahasrara*, the seat of "cosmic consciousness" (Kakar, 1982; p. 187), situated at the top of the skull. In order to achieve self-realisation, the energy has to be made to rise upwards through *shushumna* by means of meditation until it reaches *sahasrara*, thereby piercing the six *chakras*one after another (Kakar, 1982; p. 187). This simplified description of tantric ideas points to themajor reason for severe forms of mental illness as pictured in this tradition: that is the "unplanned and unprepared rising of energy through the central channel. Under severe bodily or mental strain, it is claimed, this energy may accidentally make contact with the *sahasrara* in the brain - with disastrous results" (Kakar, 1982; p. 188, italics in original).

Generally speaking, the accumulation of bad *karma* (i.e. indulging in "bad" thoughts or actions) leads to the malfunctioning of *chakras* and at a later stage to the generation of a malevolent spirit (*bhuta*). The therapeutic intervention for any kind of illness resulting from *chakra* malfunctioning primarily consists in the application of *mantras*, to conquer the afflicting*bhuta* or to restore the proper functioning of the affected *chakra*. Along with *mantras*, cannabis based drugs, hypnosis, massages, hot-water baths and various devotional rituals may be employed by the practitioner of tantra (*tantrika*) (Kakar, 1982, p. 189f). One last remark is important in connection to the *tantrika*: according to a widespread idea of *tantra* the practitioner of *tantra* is involved in quite extraordinary rituals which are said to take place on cremation grounds and may include sexual intercourse with women of low castes, along with the consumption of meat and alcohol. Because of such beliefs that are found among anglicised upper caste urban Indians as well as among poorly educated rural folks, the *tantrika* is assumedto have magic powers and the potential for black magic. Therefore he is often view with suspicion.

Bhuta-Vidya. *Bhuta-Vidya* can roughly be pictured as a form of exorcism although this Christian term implies not only the repulsion but also the destruction of an evil spirit possessing a human being. The Indian concept of *bhuta-vidya*, however, does not necessarily aim to destruct such a malevolent spirit but alternatively allows for pacification and/or reeducation of the possessing entity.

The Indian mythology differentiates between five classes of living beings, of which the various kinds of supernatural beings like demons and spirits make up one class (Hardy, 1994). These supernatural beings are meant to be able to interfere with human existence and well-beingby way of possession. The concept of illness caused by evil supernatural beings can be tracedback to one of the earliest Indian scriptures, the Atharvaveda (ca. 1500 BC). From there it foundits way into the classic ayurvedic literature (under the term of *pisacadi krta*), and in particular, in the book *Charaka samhita*, dating back to 100 AD. Although acknowledged by the ayurvedic medical system, illnesses and mental afflictions caused by spirits are not generally dealt with bythe *vaidya*. Instead, the practitioner of *bhuta-vidya* who is called *ojha* or *ojha-guni* is charged with taking care of these cases (called *bhut lagna* in lay terms).

The healing ritual employed by the *ojha* to expel the malevolent spirit is called *jhar-phook*and usually makes use of a broom (*jharna* = to sweep) or the wing of a bird and various ritualistic items such as sacred stones, the sacred ashes of burnt offerings to the gods and sacred water. As in the tantric tradition, *mantras* also play an eminent role in conquering the evil spirit. The use of a broom, however, can take two forms: either it is used in a rather 'symbolic' manner, to gently tickle the spirit, or it can be used in a more concrete manner, to literally beat the spirit out of the afflicted body by using the broomstick as a club. The latter way to make use of a broom is justified by the idea that only the spirit or demon can feel the pain, but nevertheless is a matter of concern and discussion, as many a story told in the interviews illustrates.

The notion of desire in Indian philosophical thought. The notion of desire plays an important role in traditional Indian folk-psychology (Bhattacharyya, 1984)which is distinct from Western indigenous psychological ideas. The preoccupation with desires in Indian religio- philosophical and notably in medical literature reaches back at least as far as the 5th century BC,

when the two most eminent religious traditions of ascetic renouncement, Buddhism and Jainism,were established (Hardy, 1994). The respective 'founders' of these traditions[2], Prince Siddhartaand Prince Vardhamana both taught that desires were the link filling the space between birth anddeath, while at the same time perpetuating the "fundamentally undesirable" (Hardy, 1994, p. 239) cycle of transmigration (*samsara*)[3]. Desires, here conceived of as the passionate attachment to any possible object including

life itself are seen as being responsible for human suffering, since even their fulfilment never yields lasting happiness. Only those who are awareof the profound truth of the interrelation between desires and suffering are able to escape the vicious circle of death and rebirth by way of detachment from all things, i.e. ascetic renouncement. Thus suffering here is also linked to ignorance of the principles behind *samsara*.

We can therefore understand the link established between desires, seen as the major obstacle to self-realisation (*moksa*), and desires seen as the source of sensory corruption whichmay, in turn, lead to insanity. The Bhagavadgita (ca. 500 BC), for instance, a philosophical treatise on the laws of *karma* (also well-known among lay people) links insanity to desires in the following way (Ch. 2, Verses 62-64) :

- When man dwells in his mind on the objects of sense, attachment to them isproduced. From attachment springs desire and from desire comes anger.
- From anger arises bafflement, from bewilderment loss of memory; andfrom loss of memory, the destruction of intelligence and from the destruction ofintelligence he perishes.
- But a man of cotrolled mind, who moves among the objects of sense, withthe senses under control and free from attachment and aversion, he attains purity ofspirit. (Radhakrishnan, 1993; pp. 125f.)

Ayurveda too has its own view on desire. While in general in *ayurveda* desire is thematised as an emotional force able to disrupt the balance of the *gunas*, thereby affecting the mind and causing mental disturbance, Kakar (1982) points out some passages in classic ayurvedic literature which partly contradict certain well-established metaphysical assumptions and codes of behaviour. Besides questioning transmigration and recommending a beef diet forcertain physical conditions, the *Caraka Samhita* also promotes worldly ambitions: "A person ofnormal mental faculty, intelligence and energy, desirous of his well-being pertaining to this world and the world beyond has to seek three basic desires, viz., desire to live, desire to earn and desire to perform virtuous acts" (Caraka Samhita, I.xi.3, cited in Kakar, 1982, p. 224).

The present study was conducted in Patna which is a developing city in North-East India.Patna's population could be expected to be sufficiently rooted in traditional ways of thinking aswell as open to new developments. The research aimed at discovering whether, and if so, how,respondents cope with seemingly contradictory representations of aetiology and healing of mental illness derived on the one hand from received common-sense and on the other hand from schooling and education.

METHOD

The setting: Patna, Bihar

Patna, a city of 1.5 Million, lies in the Northeast of India on the South-shore of the river Ganges. It is the capital and economic centre of Bihar, one of the least developed and most populated states. Despite the underdevelopment of the province at large, there is still a strongcontrast between the rural areas and Patna. In some rural areas more than half of the populationlive below the official level of poverty. Literacy is low in the country-side (20.2%, with women still lower at 6.4%) and reaches 52.2% in urban Patna (Indian Council of Social Science Research, 1983). There is a strong migration from the country-side into Patna. As a consequence, traditional values, caste-hierarchy and arranged marriages are common-place in the city.

Virtually everybody has potential access to TV, radio, the press and libraries in the city which also accommodates a university. There is a university clinic, several smaller hospitals anda fair number of private surgeries and psychiatrists' practices. A few years ago a psychiatric ambulance was added to the university hospital. The rural areas on the contrary, have much less well-developed medical institutions, with most villages devoid of surgeries. Equally, there is nopsychiatric hospital except in the city of Ranchi, 200 km south-east of Patna. Therefore healers are often the only sources of medical and psychiatric aid.

The sample

The sample consisted of 19 men and 20 women from the emerging educated urban middle-class in Patna. Each person had at least started university studies. They included 12 students, 9 teachers, 6 businessmen, 5 housewives, as well as a number of other professions and3 retired people. The sample covers the age-group from 20 to 55+ years. An overview is given in Table 1.TABLE 1

The Interview

There are strong cultural norms regulating contact between strangers especially of different sex. People who do not know each other must usually be introduced by a commonacquaintance. Therefore interviewees could not be contacted directly. The researchers had to rely on relatives, acquaintances and neighbours of students who could be contacted in the university setting. Sometimes the researchers had to present additional reference to be allowedan interview with a senior woman. Once an appointment was arranged, the interviewers met theinterviewees either in their home or in the hotel room of the researcher.

Interviews were conducted in Hindi by two local male graduate students of psychology,with a Hindi speaking Western researcher in attendance, who followed the discussion and made occasional interventions. Three women were interviewed in the presence of a chaperon, usually astudent colleague. Indian tradition also discourages an older person from being interviewed by a younger one. This was another reason for the interviewees being recruited amongst relatives andacquaintances, i.e. persons who knew each other at least by hear-say.

The interview was introduced as part of a study about mental illness, psychiatrists and traditional healers, and the researchers emphasised that they were not interested in factual or school knowledge, but in whatever the interviewee believed. The

interview was structured around a vignette which drew on situations and circumstances described by local people in some preliminary interviews (Verma, 1995). After the introduction the following vignette was read slowly and aloud to the interviewee:

A young woman/man in the neighbourhood is behaving in a striking way: one can always see her/him wandering around and talking to herself/himself. Sometimes she/he starts shouting for no apparent reason and sometimes she/he gets aggressivetowards people on the streets she/he does not even know. She/he may sometimeseven tear off her/his clothes. Other people who know this young woman/man saythat she/he is sometimes very much in fear of something or sad about her/his life orconfused and unable to care for herself/himself.

Occasionally the vignette was read a second time to ensure it was understood. For half thesample (ie half the men and half the women) the wording referred to a woman, while for the other half the protagonist was a man. The interviewer proceeded by asking the following questions:

- What is the problem with the person described here?
- Do you know such a person?
- What would you do if a member of your family behaved in this way?
- What would your neighbours think about your family?
- Would you take your family member to a traditional healer or to a psychiatrist?
- What would both, the traditional healer and the psychiatrist do?

The interview was of a semi-structured and focused type which allowed digression and variation according to the course of the conversation (Smith, 1995). Occasionally an intervieweeshowed signs of embarrassment after having been encouraged to answer a specific question. In this case the interviewer skipped it and proceeded to the next point. At the end each interviewee was offered a compensation of 60 Rupees (equivalent to US$ 2.2, the price of 6 liters milk or a simple meal in a popular restaurant at the time) which was sometimes rejected on the grounds that they had enjoyed being interviewed.

This vignette was the first part of a longer interview, and responses to it occupied about15-20 minutes. A series of local students assisted in transcribing and translating the interviewsinto English. Transcripts and translations were spot checked by the supervisor.

The conventions used in the transcript are the following: The interviews were conducted in Hindi. In India, however, many people, especially the more educated, often use English wordsand concepts. Any text in the transcripts written in normal style are translations from Hindi.
Capitalised WORDS were English in the original interview. Material in square brackets hasbeen added to the transcription to clarify the sense of a passage. Numbers in parantheses, eg. (34F) refer to the interviewee's reference number “34”, F (female) and M (male) indicate theinterviewee's sex.

EXPLANATIONS OF MENTAL ILLNESS IN VERNACULAR THINKING

Open responses to interview questions are always strongly influenced by their context. Inthe present case, although the interviews were essentially conducted by local students, the Western researcher was always present, and his presence seems to have tuned the responses to a "modern" frame of reference. With many interviewees it was only later in the interview, specifically in the context of healing, that responses became focused on more traditional explanatory conceptions.

Some interviewees differentiate between two stages of severity of mental affliction: a lesssevere state of mental illness and a "last stage" of madness. The term "mental illness" is used for afflictions which are usually treated within the family and do not require professional treatment. "Madness", on the other hand, not only requires professional intervention, but alsovery definitiely carries negative connotations. It gives rise to fears about what the neighboursand the public might think:

The kinds of explanations given by our respondents for these forms of conduct could be grouped into three themes: those where they refer to (a) family, norms and adjustment; (b) ideasof heredity and its moral threat to the family; (c) ideas of ghost or spirit possession. Each of these is discussed in turn in the following sections.

Family, norms and adjustment

Norms and adjustment. The tension between desires and social norms prohibiting fulfilment of desires is seen as the ultimate reason for the emergence of mental disturbances.Interviewees critically acknowledge the strict social organisation of Indian life expressed in itscaste system, marriage rules, sexual morality, as well as endemic poverty and unemployment ascrucial causes of mental illness.

I had a FRIEND who COMMITTED SUICIDE. He was suffering from an ACUTE DEPRESSION. He had an INTER-CAST MARRIAGE and there wasmuch PRESSURE from his home, from his WIFE, PSYCHOLOGICAL PRESSURE. And then the WIFE also used to disturb him. He was a COLLEAGUE of mine in the BANK, then at last HE COMMITTED SUICIDE.

It may be that this girl is very EMOTIONAL. Maybe this girl is very EMOTIONAL and LIKES someone very much. And due to reasons of social prestige she might not be in a position to take the desired step. Because it happensthat the FAMILY does not support such steps. The [head of the] FAMILY maybe used to say "If there will be such a girl in the FAMILY I will kill her." If the boy also LIKES her and the parents understand [what is going on], it might end in beating [of the children].They sometimes say that

the boy [she loves] can't be hers under any condition. If she is LIKING him very much, then she can go mad.

Respondent: (...) It is something related to caste also, as in my caste there is nopossibility of a second marriage. But at last we will see. Now we have modern times. Initially in our society there was no remarriage but now...
Interviewer: You are slightly deviating. When will this compromise come ? Respondent: The compromise will come. In her family she has been left due towhatever reason. Often it also happens for dowry and also there are many social incidents which occur between HUSBAND AND WIFE and between fathers-in-law and mothers-in-law.

Even resistance in less institutional activities like house work are bound to be seen as aserious violation of norms with the ensuing label of mental illness:

Today, I am a HOUSEWIFE, I am doing my housework. I am looking after my children, looking after my HUSBAND. I am handling the whole house. Today, if I would lie on bed for the whole day and say that I don't want to do any work. That I can't do any work. If I would have a NEGATIVE APPROACH to everything, then surely I would think... Maybe I do not think that, but others would think that she has some MENTAL ILLNESS. Otherwise a NORMAL person... If I have a stomach-ache daily or I have some problem, it is another thing. But without any reason if I say "No, I will not go anywhere, I will not see anybody, someone has to wake me up. I will not talk to anybody. I don't want to meet anybody. I don't want to talk to anyone. I am not SHOWING INTEREST in anything." This means that Iam MENTALLY ILL for sure.

The strict norms of everyday life require that people to adjust to them or risk the discriminating label of madness. To be "ADJUSTED in society, … ADJUSTED in family", even in cases of maltreatment, is normal life:

Interviewer: Do you know any such person?Respondent: Which is in TENSION?
Interviewer: Whose behaviour is like that which I DESCRIBED.

Respondent: Yes, but she has SHIFTED from our COLONY. She had not such behaviour but her HUSBAND treated her very badly. He used to beat her and didn't allow her to go anywhere. Her HUSBAND did such things, she did not havesuch behaviour.
Interviewer: What was her behaviour? What did she do?

Respondent: She too couldn't ADJUST. Some days... There were many DIFFERENCES between them. They were separated for many days, for at least ayear. And you know about our society. She has two children and her father's familytoo couldn't keep her with them. Then, at LAST she DECIDED to come back to herHUSBAND and today it is still the same. She gets beaten. He assaults her but shelives with him.
Interviewer: If any person in your family would start to behave like this, what wouldyou do?
Respondent: Any person in my family... It would take some TIME but I would ADJUST. But you know well that now the women are suppressed in our society. Itwould take TIME but I would ADJUST.

Note that the verb <to adjust> and its derivatives are nearly always given in English and not in Hindi. One may conjecture that this underlines the critical view many of the primarily middle-class respondents probably have towards adjustment to traditional norms in a societywhich is in swift economic development and in consequence exposed to Western cultural influences transported by films and other media. It seems that these interviewees perceive adjustment as a "modern" reaction to a conflict between a tradition enforced by the family andWestern modernity.

The moral threat of attributed heredity

It is in the context of the public and of what neighbours might think about a mentally illperson that interviewees come up with new explanations. The interviews create the impressionthat, for a family with a mentally ill person, the public and neighbours are a source of danger, attributing heredity and ghost possession to a family with a mentally ill member. Such attribution is seen as a serious moral threat for a family:

Interviewer: You were talking about the sick person. What would be the neighbours'opinion about your family?
Respondent: Most of them would think that there will occur more CASES of thatsickness in that family, that this CASE is hereditary. (17F)

Respondent: The BACKGROUND [impression] of my family would definitely become bad, if a girl from that family got this disease. After some time, the marriageof that girl would become a problem [she won't find a husband]. If anything LEAKS and people get to know it, they consider it bad. GENERALLY people think it is bad to go to the PSYCHIATRIST, they start to suspect whether she has become mad.
Interviewer: The position in society deteriorates if someone becomes mad?Respondent: Yes, people look at this maliciously. (23F)

In the INDIAN CONTEXT, if someone becomes mad in any family, people thinkthat it is a PROBLEM which is HEREDITARY. Even marriage becomes DIFFICULT in that house. People begin to think that it is a family of mad [persons]. They think that if

there is one person mad in the family, then certainly every person will be mad to some extent. Neighbours also think like this. (38M)

I know such families which have a mentally ill person [among them] and the behaviour of the villagers towards them [families] is not good. People say that he ismad. The second thing is that in villages there is a concept, if there is one who is

mentally ill in a family, the other members will also be mentally ill for sure, becausethere is a big contribution of the family in making a person mentally ill. (15M)

Within an Indian cultural context fear of neighbours and the attribution of heritability of amental affliction makes clear sense, since a juvenile woman or man from a stricken family, even if they are unaffected, lose much of their marriage value once a rumour starts. Moreover, such an attribution also endangers the family's social status.

Heritability in fact was already an acknowledged explanation of mental illness in the ayurvedic text *Caraka Samhita*, 300 BC, and in *Susruta Samhita*, 100 to 50 BC. Knowledge ofheritable (*kulaja*) diseases addressed as *sukrasoniprakriti* or *adibala pravrtta* lead to prohibitions of marriages between persons with certain degrees of affinity (Raina, 1990; Srikantha Murthy, 1987).[6]

The differential explanatory use of heritability and of the other causes of mental illness are reminiscent of "ethnocentric" attribution patterns which Pettigrew (1979) described as the "ultimate attribution bias". This is a tendency to attribute the negative behaviour of an out-groupmember internally and positive behaviour externally. Attributions to in-group members are reversed, so that positive behaviour is explained internally and negative behaviour externally (Hewstone & Ward, 1985). However, what is considered internal or external *to the individual* inthe original theory is internal or external *to the group* in the present case. On the one hand, attributions of unfulfilled desires, shock and depression, whatever their causes might be, are

clearly situational and refer to individual responsibility for reactions to social constraints. The attribution of heritability implies that it is a group, the more or less extended family, which bears responsibility.

REPRESENTATIONS OF HEALING AND TREATMENTTHE FAMILY AND THE REPRESENTATION OF THE PSYCHIATRIST

In the treatment of mental disturbance it is the family which is viewed as the primary resource, before psychiatric or traditional advice is sought. This may well have to do with the general fear of the public and neighbours getting to know about what has happened. Familialtreatment allows the case to be hidden for a while. Only later would a psychiatrist and—as a last resort—a traditional healer be consulted.

Treatment in the family is considered to consist of convincing the ill person that his or herperceptions and thoughts are unfounded, of finding the reasons for the affliction, of being particularly friendly and permissive, and of trying to fulfil the person's desires:

Respondent: A mentally ill person should always be happy. What they want theyshould be given to eat, to wear. But it is not possible for us [me] because they havebig dreams in their mind and we cannot do this. But we will try to convince him to live happily by what you [actually] have, it is enough. We will live happily by that. Interviewer: What will you do to make him happy? Respondent: To make him happy we have to live according to his wishes. Whatever he wants, clothes, food, vehicles, we will try to give him. And if we areunable to do so we should PREPARE him MENTALLY that we have [only] thismuch, and we will live happily by this. (7F)

The general attitude is that each such illness has causes and that the conditions leading tothese causes should—perhaps with the help of religion and gods—be changed. Even in the case of unemployment causing the mental disturbance, "the GUARDIAN has the duty to give him EMPLOYMENT" (30M).

When the problems are beyond one's own or the family's control, most interviewees consider consulting a doctor or psychiatrist. Only a few would immediately go to a traditionalhealer. Somewhat more interviewees would consider to consult a traditional healer if the psychiatrist is not successful.

No one gets mad all of a sudden. SYMPTOMS already start [before]. First it is aMENTAL ILLNESS, [being] mad is the last stage. As I told you in the CASE ofmy FATHER, as I am FEELING, I started doing what I should do, at my level, alittle affection, a little love, even though I have to realise that his condition is worsening, and [only when] it is beyond my control, then I will go to the DOCTOR, to the PSYCHIATRIST. (33F)

Living with her, I would try to remove the shock. It could happen that she is not able to think much if someone is living with her. When I would realise that it is beyond my capacity to keep her under control, I would consider it right to go to apsychiatrist . (17F)

So what is the knowledge the interviewees have about the psychiatrist's and the healer's treatment? The representation of the psychiatrist is relatively restricted: the psychiatrist will talkwith the patient and question them in order "to catch the patient's

tendency". A general feeling is that the psychiatrist will provide medicines (a few interviewees also mention electroshocks) tocure madness. The doctor will also treat the patient in a friendly and caring way, trying to make him or her happy. This psychiatric treatment will result in "removing a wrong idea", "make him or her understand the situation", increase the patient's voluntary control, and "remove a complex". Exception for the administration of medicines and electroshocks, this representationof the treatment given by psychiatrists is very similar to what family members would provide.

In fact, the strength of the popularity of the psychiatrist in the interviews stands in stark contrastto the weakness of the understanding of psychiatric treatment.

THE REPRESENTATION OF TRADITIONAL HEALING

Whereas many respondents hesitated to talk about psychiatric methods and only described them after having been asked repeatedly, virtually every interviewee, even those whofirmly denied believing in them, exhibited elaborate knowledge about some types and methods of traditional healing.

The interviewees primarily referred to ghost healers (*ojha* or *ojha-guni*). Other healersand their methods were mentioned *en passant*. Methods were often described in considerabledetail, such as *Jhar-Phook* (the "sweep and blow" method) employed by *ojha*, tantric methodslike magic and the application of mantras. Medicines, herbs and sedatives figured as methodswithin the realm of ayurveda.

A specific set of methods—pertaining to the tradition of *ojha*—mentioned by a fair fraction of interviewees is the use of physical force in treatment. It consists of beating, tortures,induction of fear and chaining the patient. According to popular beliefs this rough treatment is not felt by the possessed patient but only by the possessing ghost. As with Western notions ofexorcism, it is supposed to make the ghost leave the body.

Religious practices such as prayer, singing, sacrifice and the worship of specific gods, conversations and giving recommendations, as well as the mild methods of yoga complement the stock of traditional healing methods and were mentioned only by a minority.

This simple list of traditional methods does not reflect the intensity with which the interviewees talked about them. This engagement, even if its validity is often rejected in the presence of the Western researcher, gives vivid testimony to the continuing power and significance of traditional Indian knowledge even among the well educated middle-class population of Patna. In fact the rougher healing rituals can frequently be observed in public inthe streets of Patna, whereas ayurvedic healers practice privately in consulting rooms. This obtrusive visibility of the rougher methods in everyday life may in part be responsible for the representation of traditional healing as negative:

Interviewer: Do you think that the traditional healers are able to treat such diseases?Respondent: It is... As I told you, it happened with my aunt. But I think these things are nothing. Many people die, I have read that in books. Haven't you heard that one ojha killed somebody beating him to death? That man died. His story is finished. So I have some faith and at the same time I don't believe in them. (29F)

The ambivalence of choice between different methods of healing

Few respondents spontaneously subscribed to traditional healing procedures. While many acknowledged advantages of both, although only under certain conditions, the majority doubted the validity of traditional healing.

Respondent: What do they [traditional healers] have? Nothing! They would worship the Gods and Goddesses, make some promises [for offerings to the Gods]and after that they would say "I have treated you, it will be all right!" What do they have?
Interviewer: The healing ritual doesn't have the power to cure?
Respondent: What are they doing? There will not be a cure from that jhar-phook.

The decision in favour of the psychiatrist is based on a strong feeling of the superiority ofscientific method which ensures "100% success":

Interviewer: Do you think that there is a TECHNIQUE with traditional healers?Respondent: NO, I THINK NOT. If a TECHNIQUE would be with them thenSUCCESS must be there 100%. But they do not get SUCCESS anywhere, I THINK. (2M)

In popular thinking the scientific bases of their treatment are rarely if at all known.

Nevertheless they are believed to be successful:

These people [psychiatrists] are becoming more successful. They are doing research and they are improving everything. They improve their MEDICINES andtheir GENERAL SCIENCE.
It is possible that he [traditional healer] is not able to understand the BAD BEHAVIOUR [of the sick person] and it might increase the sickness. It is just possible that he [sick person] can turn mad or become aggressive [because the healer is treating him in a wrong way]. He [healer] might do it unknowingly. But aPSYCHOLOGIST would move in scientifically and would take ACTION continuously. He would always consider whether his ACTION is contributing towards cure or harming him [sick

person].

Faith in scientific or traditional treatment and a decision in favour of a psychiatrist or healer is not an individual's sole business but depends on the family and the patient. A majorityof family members opting for a traditional approach or access to a particularly powerful priestor *ojha* may well swing the respondent's opinion:

Look, I would not like to go to that jhar-phook, according to my [convictions], Iwould not like to go for that jhar-phook. But as I said, the decision of the familyDEPENDS on the TOTALITY. MY WISH WILL NOT PREVAIL IN ANY PARTICULAR CASE. Because [depending on whether] there are five boys or twogirls in my family, the TOTALITY of all people [will make different decisions]. If Isaid to go to the PSYCHIATRIST and some two or four people say that you haveno trouble in the jhar-phook so this should also be done. So it may be that my [wish] does not PREVAIL and the family PREVAILS much. But I PERSONALLY DON'T BELIEVE IN SUCH THINGS. (32M)

Because... Look, suppose in my family or maybe in the LONG RUN if it will happen to my child or my daughter-in-law or with me, then all the people who willcome will suggest to show him [the ill person] to that maulavi [Urdu word for ojha],

"in Patna there is a good maulavi. Take him to Biharsharif [a village near Patna] to the shrine." So all minds are of the same kind. Isn't it? So I do this even if I don't want to do it, but I won't get SUCCESSFUL [the patient won't be cured there]. ButI do it. And when I am not cured, I go to the DOCTOR at LAST and the DOCTOR does the treatment...

Individual desires must conform to the norms and beliefs and decisions must be agreed with thefamily. The weight of the collective also guides the interviewees' trust in psychiatry or traditional healing:

Respondent: I know about one incident. It happened in my family. There was one mahant-ji [priest]. He knew tantra-mantra. My brother was about to get married. He had terrible headache and 120˚ [Farenheit] fever. The ceremony of the sacred thread was to be held. The question was how should he wear the sacred thread [in his condition]? It happened in front of me. It is an incident of 1969/70. My brother went to the mahant-ji. He [the priest] touched my brother and his fever andheadache was gone.
Interviewer: What do you think? Only by touching the fever went away?Respondent: Yes, due to the mahant-ji and the tantra.
Interviewer: You believe in these things?
Respondent: Yes, I believe in that.
Interviewer: At one moment you believe that by mere touching a sickness is cured...
Respondent: Yes.
Interviewer...and in this case [mental] sickness you would not like to take [thepatient to a traditional healer]. Why?
Respondent: No, no. I would like to take him [to traditional healer]. The questionis if the traditional healer is of that sort that he can cure the sickness by touching. Then I would take him [patient] to him.

The relative tolerance expressed in these interviews complements Kapur's (1979) finding that in villages doctors are consulted alongside one or several traditional healers and temples (see also Wig et al., 1980). He found no effect of age, caste, financial well-being or educationalbackground. With our interviewess too, it may be more frequent than they admit: Firstly, the choice of healing strategy is not a single person's decision, and secondly it is the reputed success of either the psychiatrist or the healer which motivates a decision in favour of one or theother. This success can be experienced personally, as in the example given above, or it can be second-hand. A general belief in the superiority of any method, especially the psychiatrist's, iscertainly easily overridden by appeals to direct experience or affect or, last but not least, by a method's cultural foundation. The social context in and around Patna is strongly traditional and psychiatry is far from having been transformed into a social representation which can compete with the weight of local traditional thinking.

CULTURE AND SOCIAL REPRESENTATIONS

Situated representations

The visible richness of traditional accounts produced even by interviewees who repeatedly denied any belief in ghost possession contrasts with the poverty of ideas about psychiatry andpsychiatrists. As we might expect, there is little indication in our interviews that educated peoplein Patna have any understanding of psychiatry that would come close to the sophistication of their understanding of traditional healing. The local representation of traditional healing is well structured, detailed, and spontaneously produced. It is "proximal" knowledge, that is, knowledge which is affectively laden and close to the kind of informal knowledge familiar from personal observation or everyday conversations in the family or among friends. There is goodreason to call the interviewees' knowledge of psychiatry a social representation in the making and to distinguish it from their cultural representation of mental illness and healing, that is, a hegemonic structure of knowledge corresponding to what Durkheim (1974) described as a "collective representation".

Saito (1996) demonstrates the difference between cultural and social representations in astudy of Zen-Buddhism. She shows that the knowledge of Zen in Japan, even of people not practising it, differs notably from the knowledge of Zen found among believers in Britain. As in the present study, Japanese respondents produce a coherent, well-structured and proximal account of their local culture of Zen which is strongly connected to all walks of everyday life. British followers of the Zen movement produce a

fragmented image which is relatively isolatedfrom other practices.

The two varieties of knowledge about mental illness are located and used in different contexts. As we have seen, our respondents' beliefs mark a sharp distinction between mental illness in the private and the public spheres. In the private world of the family, mental illness arises as a consequence of frustrated desires, and its treatment is based on communication, talk and discussion which aims at reconciling the person to the exigencies of their life. Madness, bycontrast, is recognised by its resistance to such private forms of treatment, and is seen to be in need of some extra-familial treatment. In becoming public in this way, madness is a source ofshame and stigma for the family of the afflicted person. This traditional pattern of belief offers a matrix of ideas and values which enables psychiatric notions to be anchored in particular ways. The psychiatric notions which our respondents articulate most frequently are framed in terms which echo those of the traditional Indian representations of mental illness in the private sphere. Psychiatry too speaks in a language in which mental illness is a consequence of frustrated desires, of problems of adjustment, and offers forms of treatment based on talk anddiscussion. Just as Moscovici (1976, 1981) describes how, for the Catholic, the image of confession provides a point in which to anchor the unfamiliar idea of psychoanalysis, so too in this Indian context, the traditional patterns of belief about mental illness in the private sphere provide a context in which psychiatric ideas can be anchored.

Traditional representations of madness focus on the idea of spirit or ghost possession or heredity, which also marks a clear shift in the representation of the person. In the family context, where mental illness results from frustrated desires, it is the person's own thoughts and feelings which are responsible for their mental affliction, the person here is implied as a psychological agent of their own condition. In the traditional context, however, the person no longer *acts upon the situation*, but is *acted upon*. Agents and processes beyond the individual'scontrol take possession of the person's mind resulting in illness. In this context treatments like "brushing and blowing", beating and mantras are justified because they aim at an agent which isexternal to the mad person's mind and not at his or her own mind and sensitivity. This sharp distinction in traditional representations is less clearly marked in the emerging social representations of mental illness, where the forms of treatment offered by the psychiatrist continue to be described largely in terms of communicative processes which recognise the agency of the individual (although some of our respondents did remark on the use of drugs andelectro-shock therapy by psychiatrists, forms of treatment which do imply a denial of psychological agency). Indeed, the question of agency in the representation of the person provides an important point of contrast between contexts in terms of the relationship between traditional representations of mental illness and the emerging social representations. In the private context, a sense of agency is the thread of continuity which allows representations of modern psychiatry to be anchored in the familiar pattern of communicative processes within thefamily, enabling our respondents to elaborate their scanty knowledge of the psychiatrist with these more familiar images. However, in the public context, a sense of agency no longer provides this bridge between traditional healers and modern psychiatrists, and it is when our respondents were asked to face a dilemma in the public treatment of mental illness that they most openly spoke of conflict between traditional and emerging representations.

Our Indian respondents and the middle and upper classes as a whole are presently engaged in representational work to objectify psychiatric treatment and a new view of mental illness introduced by modern life and Western influence. This process can be seen at work in the mass media, particularly films and TV, and in the everyday conversations and experience ofpeople as they engage with these new phenomena. In the long run this process of objectification can be expected to produce a more elaborated image of psychiatry and madness. One can already see in the emerging social representations of the psychiatrist an emphasis on the effectiveness of their treatment of the mentally ill and the mad, contrasted with the ineffectivetreatment of the traditional healer, a contrast which again illustrates the influence of the values ofprogress. A mark of the shift in values is the belief our respondents expressed in the efficacy of scientific and medical practice. Such shifts do not imply that Indian representations of madness will simply adopt the perspective of scientific psychiatry. It is doubtful whether traditional ideas would be simply eradicated, anymore than in Europe, where in spite of the longer exposure to psychiatric medicine, popular representations of madness continue to draw on traditional themes and images (see De Rosa, 1987; Jodelet, 1991).

Innovation in common-sense: Contradiction or complementarity?

This study illustrates the way in which a particular reality is simultaneously constituted intwo fundamentally different ways. On the one hand there is the traditional way of thinking about indigenous healing procedures, while, on the other, there is the fashionable belief in modern science, of which psychiatry is an example. We have suggested that a new social representation of mental illness and its treatment is emerging as "progressive", Western ideas influence traditional cultural representations.

Although the theme of progress gives a certain dynamic to the relations between the traditional and the modern, this dynamic also has to accommodate the extent to which traditionalideas are embedded in established social practices. There is a point where ideational innovation meets the resistance of traditional cultural notions and of living social institutions. In the present case, Indian notions of desire with their emphasis on the renunciation of worldly pleasures in the name of spiritual growth served as the conceptual reference, and traditional patterns of marriage and family life provide the institutional matrix upon which attributions ofthe causes of mental illness are based. This is further enhanced by the importance of family status in relation to marriage, and implicit fears of gossip about the inheritance of mental instability. However, as many of our interviewees noted, when it comes to efficiency, the psychiatrist is preferred to the inefficient traditional healer.

Hence, when the modern hits the bedrock of traditional beliefs and institutions, it mustbuild upon it and cannot replace it. This is a rather flexible reaction to innovation, where traditional symbolic and institutional arrangements prove capable of absorbing what is new without losing their own identity. For the progressive, emerging middle classes of our sample,their sense of

the power of modern notions of psychiatry is circumscribed both by their sense of the limits within which older generations of their own families would accept these ideas, andtheir own ambivalence towards a tradition which they can simultaneously criticise while continuing to express some residual faith in it (producing a form of what Moscovici describes as "cognitive polyphasia", Moscovici, 1976, p. 286). As one of our female respondents said about traditional healers: "I have some faith and at the same time I don't believe in them" (29F).

We must also keep in mind that the present interviewees were all highly educated by Indian standards and as such represent but a small and probably atypical section of Indian society which might well be much more inclined towards cultural and technological modernisation than the general public. The picture is further complicated by the fact that some Indian psychiatrists have recently begun working on syncretic forms of psychiatry which unite Western and indigenous conceptualisations, though with mixed success (Pandey, 1988; Verma,1988).

What is clear from the present interviews is the complex interplay between the symbolic,the institutional and the technical aspects of representations in a context of change. Both the representations of modern psychiatry and of traditional healing may co-exist to a considerable degree and while most our interviewees have a sense of the contradictions between them, these contradictions are not generally experienced as logically exclusive, as a simple "either/or". Rather, any resolution of the conflicting claims of tradition and modernity has to recognise the wider practical context of institutions and relations. It is this context which determines how ourrespondents would deal with a case of mental illness in their own family.

The context for this co-existence in India, however, is rather different from that in the West. While notions of development, under-development or developing, have become problematic ways of offering broad and general characterisations of social formations (and not only in the West), within India, and especially urban India, the idea of the country as one in which socialand economic forms are developing towards a modern society remains a powerful belief. Thissense of a development towards a modernity is thematised around a notion of progress. Indeed, it is this idea of progress as the overcoming of tradition which provides an important context forthe emergence of contemporary social representations of madness, within which a view of madness associated with the scientific claims of the psychiatric profession can also claim to be aprogressive view, marked by its modernity in contrast to traditional representations of madness as forms of spirit possession. Further, the more humane forms of treatment of the mad personoffered by psychiatric medicine also resonate with other discourses about human rights, and may also contriubte towards the view that psychiatric models of madness are progressive.

CONCLUSIONS

In exploring aspects of culture change this study has focussed on the way that change is reflected in the representations people hold about about a specific field of knowledge. As newinfluences derived from psychiatric medicine are absorbed into the representations of these urban North-Indians, do they simply displace traditional ideas, or do both exist side by side? Based on the present study neither alternative seems to offer an adequate description of the process. On the one hand, in the interview many respondents flatly reject most of the traditional notions of ghost-possession and healing procedures as ineffective and "superstitious" and uncritically embrace psychiatric medical science. They do so even if their received wisdom about mental illness far exceeds their knowledge of psychiatry in detail and quantity. On the other hand, many of the respondents express a deep faith in traditional healing procedures which contradicts their simultanously expressed belief in scientific efficiency.

From the interviews it becomes clear that both representational systems, the system of traditional thinking and that of the novel, have their place in different contexts. Each of the tworepresentations is situated at different nodes of the respondents' social world. They are situatedrepresentations in the sense that in the context of public life (part of which was also the interview situation) discourse is oriented more towards the novel. In the context of private and family life talking in traditional ways is more appropriate. This aspect of their thinking was only expressed by our respondents after direct questioning and giving examples. There is littlesurprise in this, since in India (as indeed in the West) family organisation and family life remainone of the most traditional sectors of society. But it should serve as a reminder that the dynamic feature of social representations arises from the ways in which they are embedded inthe contexts of specific sets of social relations, as Moscovici (1976) and Jodelet (1991) have shown.

Finally, our study also questions the assumption that cultural and collective beliefs can beregarded as unflexible or fixed as to be non-negotiable. Where the pressures of development introduce instability and doubt, received wisdom can be questioned, as our respondents illustrated in their expressions of doubt about traditional ways of healing. The first signs of innovative change in culture are seen in the forms and pattern of public discourse, only in the longer run will innovation extend to areas of social life, such as the family, where tradition is most deeply entrenched. In this sense this urban North Indian society is as much a modern society as anything in Europe or the West, for all that it may be constructing a modernity in its own terms.

Table 1

Profession and age of respondents and sex of the character depicted in the vignette

- student 20 (male)
- 3 teachers 42(female)
- student 21 (male)
- teacher 36 (female)
- student 23 (male)
- student 23 (female)
- student 27 (male)
- lawyer 41 (male)
- student 23 (female)
- postoffice manager 57
- student 30 (male)
- businessman 55 (male)
- student 28 (female)
- businessman 45 (female)
- teacher 50 (female)
- retired 59 (male)
- businessman 51 (male)
- businessman 46 (female)
- no information 32 (male)
- businessman 28 (female)
- housewife 32 (female)
- nurse 45 (male)
- nurse 50 (female)
- housewife 32 (male)
- student 22 (female)
- student 21 (male)
- student 21 (male)
- housewife 27 (female)
- student 23 (male)
- teacher 41 (female)
- teacher 45 (female)
- teacher 35 (female)
- housewife 47 (female)
- teacher 32 (male)
- teacher 31 (female)
- retired 62 (male)
- employee 43 (female)
- judge 46 (female)
- teacher 47 (male)

Note: The first number in each row is the respondent's reference number, the second number isthe age, the words "male" and "female" in brackets refer to the sex of the character depicted in the vignette.

Table 2

Hindi terms rendered into English

m;nisk rogI	mansik rogi	mentally ill person
m;nisk ibm;rI	mansik bimari	mentally ill person
mnorogI	manorogi	mentally ill person
rog	rog	illness
m;nisk rog	mansik rog	mental illness
mnorog	manorog	mental illness
p;glpn	pagalpan	madness
p;gl	pagal	mad