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Mental Health in India: Cultural Narratives and Indigenous Representations

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Abstract

Mental health is not understood uniformly across cultures. In India, psychological well-being and mental distress are closely connected with philosophical beliefs, religious traditions, family relations, community life, local languages, and indigenous systems of healing. The present article examines the cultural narratives and indigenous representations through which mental health and mental illness are understood, expressed, and addressed in Indian society. It follows a qualitative narrative and thematic review design and draws upon psychological, anthropological, philosophical, psychiatric, literary, and policy-related sources published up to 2022. The literature was examined through repeated reading, classification, comparison, and thematic interpretation. Six interconnected themes emerged: indigenous explanatory models; culturally rooted idioms of distress; religious and philosophical representations; portrayals in cinema and folk traditions; indigenous and community-based healing practices; and the need for culturally responsive care. The analysis indicates that mental distress in India is often understood through overlapping frameworks involving karma, doshic imbalance, relational conflict, spiritual disruption, social stigma, and biomedical factors. Ayurveda, yoga, meditation, faith healing, family support, rituals, and psychiatric treatment may coexist within help-seeking. The article argues that cultural beliefs should neither be dismissed as irrational nor accepted without critical examination. A culturally responsive pluralistic framework is proposed to connect scientific treatment with cultural understanding, ethical safeguards, community participation, and human dignity.

Keywords: Mental health; Indian culture; indigenous healing; cultural psychiatry; idioms of distress; Ayurveda; faith healing

Introduction

Mental Health: A Comprehensive Perspective: Mental health is a complex concept that goes beyond the absence of mental illness (Keyes, 2002). It involves an individual's ability to cope with life's stresses, work productively, and contribute to their community (WHO, 2001). It emphasizes positive psychological functioning, emotional resilience, and social contribution, recognizing mental well-being as a continuum from optimal functioning to severe distress (Mishra & Verma, 2006; Jahoda,1958).

Mental health is a culturally and spiritually complex concept. In India, The Charaka Samhita, a foundational Ayurvedic text, describes mental health as "Prasanna atma indriya manah swastha iti abhidiyate" meaning mental health as a state of inner harmony (sattva) and balance among mind (Manas), body (Sharir), senses (Indriyas), soul (Atma), and environment (Samsara) (Charaka Samhita, Sutrasthana 1.41; Sharma, 1995). Bhakti and Sufism spiritual traditions view mental health as divine alignment, interpreting emotional states like grief as spiritual processes (Paranjpe, 1998; Dhand, 2002). Indigenous Indian healing often involves ayurveda, yoga, community rituals, storytelling, and music, reflecting a collective and symbolic approach to psychological restoration (Ranganathan, 2018; Kumar, 2010). This perspective is rooted in relational, spiritual, and socio-cultural contexts (Kakar, 1982; Mishra & Varma, 2006).

The present article explores how Indian communities interpret and respond to mental illness beyond an exclusively biomedical paradigm. It argues for culturally inclusive care that acknowledges indigenous belief systems and healing practices while retaining clinical, ethical, and human-rights safeguards.

Research Gap and Rationale

Existing scholarship has contributed significantly to the understanding of Ayurveda, yoga, cultural psychiatry, spirit possession, religious healing, mental-health stigma, and media representation in India. These domains, however, have frequently been examined separately. Studies of psychiatric pluralism often concentrate on movement between hospitals, shrines, healers, and community resources, while studies of cultural expression focus on idioms of distress, somatisation, religious metaphor, or cinema. A connected analysis is needed to show how these traditions collectively shape the recognition, interpretation, and treatment of mental distress.

A further gap concerns the relationship between cultural respect and clinical responsibility. Indigenous beliefs may provide meaning, reassurance, family support, and a socially acceptable language for suffering. Particular interpretations may also increase blame, strengthen stigma, or delay essential treatment. The relevant question is therefore not whether indigenous and biomedical systems should be accepted in isolation, but how their interaction can be understood critically and ethically. This article addresses that gap by examining philosophical ideas, local expressions, media narratives, ethnographic observations, and healing traditions within a common framework.

Aim, Objectives and Research Questions

The study aims to examine the cultural narratives, indigenous explanatory models, symbolic representations, and healing practices through which mental health and mental illness are understood and addressed in Indian society.

The specific objectives are to examine indigenous, philosophical, religious, and community explanations of mental distress; identify culturally rooted idioms and metaphors; analyse representation in cinema, folk traditions, and digital culture; examine pluralistic help-seeking; and propose an ethically grounded framework for culturally responsive care.

The study asks: What cultural explanatory models are used to understand mental distress in India? How is suffering expressed through local idioms, religious metaphors, folk narratives, and popular media? What role do indigenous and community-based practices play in help-seeking? How can culturally rooted knowledge be incorporated into contemporary care without compromising scientific standards, dignity, and human rights?

Methodology

Research Design and Sources

The study follows a qualitative narrative and thematic review design. This design was appropriate because the purpose was not to estimate prevalence or test a single intervention, but to interpret how mental health and suffering have been represented across psychology, psychiatry, anthropology, philosophy, religion, literature, cinema, public policy, and indigenous healing. It used published peer-reviewed articles, scholarly books, book chapters, ethnographic studies, recognised translations of classical texts, and government documents. Only sources published up to 2022 were considered.

Selection and Analysis

Sources were included when they examined mental health within an Indian cultural context; discussed indigenous or religious explanations; described local idioms or culturally shaped help-seeking; analysed Ayurveda, yoga, meditation, faith healing, cinema, or folk traditions; or addressed the relationship between cultural knowledge and professional services. Sources without a clear cultural or conceptual connection were not central to the analysis. The literature was read repeatedly and organised under causes of illness, expressions of distress, religious meanings, stigma, healing practices, family participation, media portrayal, and professional care. Related categories were compared and brought together as broader themes. Attention was given to tensions within the literature because a belief may provide meaning and support in one setting but contribute to stigma or delayed care in another.

Trustworthiness and Ethical Position

Interpretive credibility was strengthened through comparison of sources from different disciplines. Community beliefs were distinguished from established clinical explanations, and philosophical concepts were not treated as substitutes for psychiatric diagnosis. India is culturally, religiously, linguistically, and regionally diverse; therefore, the findings represent major patterns in the selected literature rather than a fixed account of all communities. The study used published secondary sources and did not involve human participants. It also avoids endorsing coercion, restraint, humiliation, abandonment of necessary treatment, or any practice that violates dignity.

Findings and Thematic Analysis

The literature shows that mental health in India is understood through interacting psychological, social, bodily, spiritual, moral, and relational meanings. Indigenous explanations do not always function as alternatives to biomedical knowledge. Families may accept psychiatric, religious, and

social accounts at the same time and move between hospitals, shrines, traditional healers, yoga centres, and community networks. Six themes organise the findings.

Theme I: Indigenous Explanatory Models of Mental Illness

Indigenous Explanatory Models of Mental Illness: Indian religious traditions, including Buddhism, Jainism, and Hinduism, use Punarjanma and karma to understand human suffering, including mental illness (Singh, 2022). These traditions believe that deliberate actions accumulate over a lifetime, affecting one's psychological and emotional states (Kumar & Kumari, 2021). Mental anguish is often seen as a result of past karmic residue (Rao & Paranjpe, 2016).

Hindu philosophy: In Hindu philosophy, such ideas are well-articulated in the Bhagavad Gita "देहिनोऽस्मिन्यथा देहे कौमारं यौवनं जरा। तथा देहान्तरप्राप्तिर्धीरस्तत्र न मुह्यति॥" (2.13), which describes the soul's journey through successive stages of embodiment and rebirth, thereby establishing a metaphysical continuity that legitimizes current suffering as an outcome of past actions.

Vedanta Darshan(ṣaḍ-darśana), an Indian philosophy school, offers a non-dualistic framework for understanding mental health based on Upanishads. It posits that pure consciousness (Brahman) is the ultimate reality, and suffering arises from ignorance of this true self (Kumar, 2011). Mental health disorders (Manasika dukkha) arise from identifying with the body-mind complex instead of the timeless, unalterable self (Atma) and spiritual disconnection. Therefore, Jnana yoga (Path of knowledge), self-inquiry (ātma-vichāra), detachment (vairāgya), and disciplined living are practices for mental well-being, aiming to dissolve the ego and realize self-unity with Brahman (Sharma, 1996).

The Buddhist perspective posits that psychological distress arises from karmic actions driven by unwholesome mental factors, known as unskilful mental states (Akusala cittas). Emotional and cognitive disturbances such as aversion (Dosa), delusion (Moha), and attachment (Lobha), are considered basic mental defilements (Kleshas) that hinder wisdom and perpetuate suffering (Dukkha) (Harvey, 2013). The development of wholesome mental qualities (Kusala cittas), is crucial for liberation (Nirvana), as suffering results from a corrupt mindset. All mental states follow the mind. Wallace and Shapiro (2006) emphasize mindfulness (sati), concentration (samādhi), and wisdom (paññā) as essential tools for altering consciousness, fostering clarity, and achieving emotional equilibrium, highlighting mental health as a moral and existential metamorphosis rather than just emotional stability (Dhammapada Verse 1).

Jainism perspective: The Jain philosophical framework posits mental health as a result of karma, a subtle material substance(Pudgala) binds to the soul (Jiva) through passions like anger, pride, deceit, and greed (Jain, 2021). Jainism views mental illness as manifestations of karmic accumulation and spiritual imbalance, with karmas like mohaniya (Deluding Karma), vedaniya (Feeling-producing Karma), determine the emotional experiences and gotra (Status-determining karma), which affects self-concept and esteem, directly implicated in psychological suffering (Kachhara, 2018)

Karmic explanations remain relevant in modern Indian society, especially in rural and non-Western contexts, as evidenced by Kakar's 1982 psychoanalytic and anthropological analysis of Indian healing traditions, where patients often prefer karmic narratives to explain psychological distress without personal failure or stigma. Nichter's 1981 study on "idioms of distress" revealed that South Indian

communities frequently utilized karmic reasoning to explain chronic illnesses, particularly in cases where conventional treatments failed. Sujeetha and Gopalan's (2020) study on carers of schizophrenia in Tamil Nadu revealed that many seek help from religious and spiritual practitioners alongside psychiatric professionals due to their belief that the illness is caused by past transgressions. These belief systems have a significant psychosocial purpose, offering victims and their loved ones a spiritual and moral perspective on hardship, potentially reducing stigma, shame, and guilt (Ranganathan, 2018).

Spirit Possession and Supernatural Causes: In India, mental illness is often viewed through the lens of spirit possession (Atma ka Prokop), black magic (Kala Jadu), and the evil eye (Nazar lagana), which are seen as supernatural forces disrupting psychological and emotional balance (Majumdar 1996). These beliefs provide a spiritual or moral causality to symptoms like hallucinations, dissociation, mutism, erratic behavior, and withdrawal, which might otherwise be classified as psychiatric conditions. Spirit possession is often seen as a literal invasion of an individual's body or consciousness (Boddy, 1994).

Obeyesekere's (1981) study of Sri Lanka and India found spirit possession as a socially acceptable expression of distress, especially for women in patriarchal homes. Kakar's research showed that families of patients with psychosis in North India often consult Tantriks, Ojhas, or faith healers before seeking psychiatrists due to the belief that the behavior is caused by Aatma ka prabhav or curses invoked through sorcery. Sorcerers often use black magic rituals to send negative energies into the target's body, causing sleep disturbances, fear, personality changes, and suicidal thoughts. The evil eye (Nazar Lagna), a harmful gaze driven by envy, is believed to cause sudden illness, fatigue, crying in children, and loss of mental clarity. Rituals like lemon-chili offerings, smoke purification, and casting off the evil eye are used as first-line responses to these affliction

Doshas and Imbalances: Classical Ayurvedic texts provide extensive typologies of mental illness based on doshic pathology. The Charaka Samhita, one of the foundational texts of Ayurveda, outlines various mental disorders under the category of Unmada (insanity) and Apasmara (epilepsy and seizures), emphasizing the role of doshic disturbances in their etiology (Charaka Samhita, Nidana Sthana, Chapter 7). The Sushruta Samhita also identifies mental illness as the result of impaired interaction between the doshas and manas (mind), often caused by emotional excesses or improper diet and lifestyle (Sushruta Samhita, Chikitsa Sthana). In addition to physiological explanations, Ayurvedic psychology integrates the Triguna theory Sattva (purity), Rajas (activity), and Tamas (inertia) which further elucidates personality types and predispositions to mental imbalance. A dominance of Tamas, for example, is associated with delusion, depression, and inertia, while excessive Rajas is linked to agitation, impulsivity, and restlessness (Akter & Nahar, 2022).

Theme II: Local Idioms and Embodied Expressions of Distress

Local Idioms of Distress: People may use terms like Paagalpan (madness), Dimag kharaab (disturbed mind), or Dimaagi rog (mental illness) to describe a variety of emotional states. These idioms reflect not only the symptomatology but also social meaning. In Indian linguistic and cultural traditions, particularly in Hindi-speaking communities, Muhāvare (idioms) serve as powerful cultural tools for expressing mental distress in socially meaningful ways.

These idiomatic expressions often encapsulate complex psychological states ranging from anxiety and grief to emotional trauma without invoking clinical or stigmatizing terms. For instance, phrases like "Dimāg ghoom gayā hai" (the mind has spun) and "Dimāg kharāb ho gayā hai" (the brain has gone bad) are commonly used to denote states of emotional disorientation, extreme anger, or erratic behavior. While these may be employed casually, they often signal underlying cognitive or affective disturbances. Similarly, "Sar par bhūt sawār ho gayā hai" (a ghost has mounted the head) is a supernatural idiom used to describe someone under the influence of an overpowering obsession, compulsion, or altered state pointing toward culturally embedded beliefs in spirit possession, which intersect with psychiatric phenomena such as dissociation or psychosis (Kakar, 1991; Kleinman, 1980).

Other idioms express the emotional toll of distress more subtly. "Dil toot gayā hai" (the heart is broken) and "Andar se toot chukā hoon" (I am broken from within) reflect experiences of deep sorrow, despair, or depressive symptoms following interpersonal loss or emotional betrayal. These phrases parallel Western expressions of depression, but are often more acceptable in collectivist societies where open discussion of psychological vulnerability is constrained by stigma (Weiss et al., 2001). Similarly, idioms such as "Mann udās hai" (the heart/mind is sad) and "Duniya andheri lagti hai" (the world feels dark) are indicative of melancholy or hopelessness, often used to describe the affective quality of prolonged emotional suffering. Physical idioms are also prevalent; for instance, "Seene mein ghutan mahsoos hoti hai" (there is a suffocating feeling in the chest) and Sar mein dard hi dard hai" (there is only pain in the head) are somatised expressions of anxiety and tension, aligning with research showing the prominence of somatic complaints in South Asian idioms of distress (Nichter, 1981; Raguram et al., 2001).

These idioms not only convey individual suffering but also reflect shared cultural narratives of mental and emotional experiences. For example, "Hoś hawās khona" (losing one's senses) is frequently used to describe overwhelming shock, grief, or trauma, and "Gusse ka dimāg par asar ho gayā hai" and "Garmi dimag pe chadh gayee hai" (anger has affected the mind) highlights the perceived connection between emotion and mental imbalance. Such expressions function as socially acceptable ways of voicing distress, especially in contexts where psychiatric labels such as "depression" or "anxiety" may be inaccessible or stigmatized. According to Kirmayer and Young (1998) and Kleinman (1980), these idioms serve as culturally resonant "idioms of distress," which not only reflect personal suffering but also mediate social responses, determine help-seeking behavior, and influence whether individuals turn to faith healers, family support, or mental health professionals.

Theme III: Mental Health in Cinema and Cultural Media

Representations in Cultural Media: Bollywood films significantly influence Indian society's perception of mental illness, emotional distress, and treatment, shaping social stigma, popular discourse, and behavior towards seeking help (Malik et al., 2011). Traditionally, these films use melodramatic and sensationalist tropes to portray characters as pathetic or irrational. Early films like Khilona (1970), Raat Aur Din (1967), and Kyon Ki (2005) portrayed mental illness as madness and normalcy, fostered public misconceptions about mental illness as incurable or dangerous, leading to widespread stigma and social exclusion (Nair & Jadhav, 2020; Pathak & Biswal, 2021).

Recent films have shown a shift in mental health portrayals, focusing on humanizing experiences and encouraging dialogue. Aamir Khan's Taare Zameen Par (2007) highlighted dyslexia, emphasizing early diagnosis, emotional support, and creative pedagogy. Aparna Sen's 15 Park Avenue (2005) explored schizophrenia, raising critical questions about familial caregiving, imagination, and psychiatric treatment limits. These films reflect an evolving consciousness about the subjective interiority of mental illness, a concept rarely acknowledged in earlier cinema.

Dear Zindagi (2016) normalizes therapy-seeking behavior among young adults by de-stigmatizing emotional vulnerability and reframes therapy as a journey towards self-awareness. The film challenges stereotypes of mental illness and promotes mental wellness discourse (Raghuram, 2011; Das, 2014). Similar films like Chhichhore (2019), Judgementall Hai Kya (2019), and Atrangi Re (2021) explore themes of suicidality, trauma, and bipolar disorder with varying accuracy and sensitivity. On the other hand, Bollywood films often trivialize mental illness, using it for comedic effect (Nair & Heath, 2008) or horror narratives. For instance, Bhool Bhulaiyaa (2007) blurs the lines between possession and psychosis, while Judgementall Hai Kya's portrayal of the female lead can perpetuate misunderstanding. This contributes to public fear and dismissal of mental health issues (Chatterjee, 2015).

We can say that cinematic narratives shape public attitudes towards mental illness, especially in stigmatized contexts. Misrepresentations can deter seeking help, while accurate portrayals can educate and reduce stigma (Pathak & Biswai, 2021). With OTT platforms and web series like Delhi Crime, Made in Heaven, and Gehraiyaan, Indian media is embracing complex depictions of mental health, trauma, and therapy, particularly among urban middle-class youth.

The Indian government and civil society also recognize media's role in mental health promotion, encouraging sensitive reporting on mental health and suicide. Campaigns like #MentalHealthForAll and “The Live Love Laugh Foundation” founded by actress Deepika Padukone collaborate with content creators to promote responsible storytelling (Jain et al, 2017). Cultural media, particularly film and digital storytelling, remains central to shaping India's collective mental health awareness (Mehta & Sharma, 2022).

Theme IV: Folk, Religious and Philosophical Representations

Folk Narratives: These including village performances, ritual dramas, oral epics, and devotional songs provide rich cultural frameworks for understanding mental illness, often interpreting psychological disturbances not as medical pathologies but as manifestations of divine will, moral transgression, or spiritual awakening (Kumar, 2010). These narratives function as culturally sanctioned idioms of distress, allowing individuals to express suffering in socially acceptable ways. For example, in Bengal’s Baul tradition, the pagol baul (mad mystic) is revered rather than pitied his erratic behaviour, detachment from material life, and emotional ecstasies are seen as signs of spiritual enlightenment, not insanity (Kakar, 1982). In Theru Koothu, a Tamil folk theatre, characters who behave irrationally are often depicted as suffering due to a deviation from dharma (moral order) (Blackburn, 1981), and their journey back to societal norms is staged as both moral and psychological healing (Beck, 1981). In the Central Himalayan rituals studied by Sax (2009), individuals believed to be possessed by local deities or spirits often women are taken to temples or public ceremonies, where their distress is interpreted through a spiritual lens. Rather than being marginalized, these individuals

are temporarily elevated within the community, and the ritual context provides a collective healing process that integrates spiritual, emotional, and social dimensions. Similarly, bhakti poetry and folk songs from regions like Rajasthan and Maharashtra often narrate stories of saints or devotees who suffer hallucinations, visions, or periods of madness as part of their devotional trials or divine tests, such as in the legends of Meerabai or Chokhamela. Stories in India serve both moral and therapeutic purposes, validating suffering and offering symbolic resolution through ritual, music, and communal storytelling. These representations challenge Western diagnostic models and emphasize the need for culturally sensitive and contextually grounded approaches to mental health, as folk epistemologies continue to shape popular and clinical understandings. (Misra, 2011; Kakar, 1982; Sax, 2009; Beck, 1981).

Religious Metaphors: In both Bhakti and Sufi poetic traditions, madness is frequently used as a metaphor for divine love, longing, and transcendence, reflecting the spiritual seeker's intense emotional and existential journey toward union with the Divine. This madness (pagalpan, junoon, unmaad) is not a symbol of illness or irrationality, but a celebrated form of divine intoxication a state where worldly attachments dissolve in the fire of spiritual yearning. In Bhakti poetry, saints like Meerabai, Tukaram, and Kabir are often portrayed as "mad" in love with God. Meerabai's defiance of social norms, singing and dancing in public in ecstasy for Lord Krishna, is interpreted as unmaad bhakti (divine madness) and not psychological disturbance. Scholars argued that her spiritual madness symbolized mystical devotion and feminist resistance, allowing women to transcend patriarchal control through religious expression. Similarly, Tukaram's abhangas (devotional verses) describe episodes of weeping, dancing, and emotional collapse as moments of sacred transformation, not weakness.

In Sufi traditions, poets like Rumi, Bulleh Shah, and Qalandar use the metaphor of junoon (passionate madness) to describe the soul's love for the Divine. Schimmel (1975) and Ernst (1997) have noted that for Sufi mystics, madness reflects the loss of ego (nafs) and the annihilation of the self (fana) in God's presence. For instance, Rumi writes, "I have gone mad with longing for my Beloved/Only the mad understand this fire." The figure of the mast (spiritually intoxicated wanderer) in South Asian Sufism often seen as erratic, laughing, or muttering is culturally revered, not pathologized. Sufi shrines in India and Pakistan show how communities view such individuals as divine lovers, offering blessings rather than being seen as mentally ill. These metaphors serve not only literary or religious purposes, but also create space for alternative understandings of psychological intensity, where overwhelming emotion becomes a form of spiritual enlightenment rather than disorder (Kirmayer, 1993).

Theme V: Ethnographic Insights and Field Narratives

Ethnographic Insights and Field Narratives: Ethnographic research offers valuable insights into mental illness experiences, focusing on local narratives, explanatory models, and cultural idioms that shape illness meaning and healing (Mishra & Verma, 2006). In India, studies have shown that mental distress is understood not only in medical terms but also in terms of moral, spiritual, and social life, highlighting the importance of ethnographic research in understanding mental health (Raguram et al., 2002).

Obeyesekere, Kleinman, and Frank explore how spirit possession and psychological suffering are socially sanctioned expressions of conflict, particularly among women in patriarchal societies, and how illness narratives articulate emotional pain. Ethnographers have discovered alternative healing methods in Indian field settings, such as ritual healing, spiritual possession, and temple therapies. For instance, at the Dargah of Mira Datar in Gujarat (Jadhav et al., 2001), people with severe mental illness engage in Sufi rituals for better health. These faith-based interventions offer spiritual relief, community, dignity, and cultural legitimacy, which psychiatric hospitals often lack.

Ethnographic studies also revealed that how gender, caste, and poverty mediate mental health experiences. In her work on Dalit women in Uttar Pradesh, Das (2007) shows how suffering is not always verbalized in psychiatric terms but lived through the body via fatigue, pain, or silence. These forms of suffering are not simply medical symptoms but embodied expressions of structural violence, social exclusion, and existential despair. Likewise, Singh's (2015) ethnography of mental illness in rural Rajasthan explores the blurred boundaries between spiritual ecstasy and psychosis, arguing that Indian experiences of mental states must be understood through culturally specific ontologies of the self. These accounts challenge the universality of Western psychiatric categories and call for context-sensitive mental health paradigms that engage with lived realities, not just diagnostic criteria.

In contrast, urban fieldwork in Mumbai has documented the dilemmas of middle-class families, who often oscillate between psychiatric consultations and astrological guidance when facing psychological distress within the household. This reflects the healthcare pluralism characteristic of Indian society, where medical rationality coexists with deeply embedded beliefs in karma, planetary influences, and ancestral curses. For example, parents might seek a clinical diagnosis for a child's behavioral issues, while simultaneously consulting a jyotishi (astrologer) to perform remedial rituals for graha dosha (planetary misalignment) or bad karmic influence. These families do not necessarily see these approaches as contradictory but as complementary systems that address different dimensions of the problem material, moral, and metaphysical (Banerjee & Rao, 2020; Das & Addlakha, 2001). Such ethnographic narratives underscore that mental illness is never experienced in isolation from cultural meaning, social expectations, and interpersonal dynamics.

Across these varied settings, what becomes clear is that the experience and treatment of mental illness in India are shaped not only by symptoms or diagnoses, but also by social roles, moral economies, gender norms, religious cosmologies, and the availability of care networks. Ethnographic fieldwork challenges the universality of psychiatric categories and reminds us of the need for culturally competent and contextually grounded mental health approaches. As scholars such as Kleinman (1980) and Das (2007) argue, to understand suffering is not only to classify it but to listen to how it is lived, spoken, concealed, and healed in everyday life.

Theme VI: Indigenous and Pluralistic Healing Practices

Ayurveda as an alternative treatment of Psychopathologies: Ayurveda, India's ancient medical tradition dating back over 5,000 years, provides a holistic biopsychosocial-spiritual model of mental health that is increasingly gaining global recognition for its integrative approach to psychopathologies (Prathikanti, 2007). As we discussed earlier, In Ayurvedic nosology, mental illnesses (Manasika Vyadhis) are understood as arising from an imbalance of Tridoshas (Vata, Pitta, and Kapha) and mental

Gunas particularly the overactivity of Rajas and Tamas, and the depletion of Sattva. This conceptualization parallels modern neurobiological insights into stress, neuroendocrine dysfunction, and affect regulation (Obeyesekere, 1992). Ayurvedic psychiatry (Bhutavidya), one of the eight classical branches of Ayurveda, outlines various therapeutic modalities including medhya rasayana (rejuvenative and nootropic herbs), sattvavajaya chikitsa (psychotherapy), daivavyapashraya chikitsa (spiritual healing), and yuktivyapashraya chikitsa (rational pharmacological and behavioral treatments) (Sahoo et al, 2015).

Recent studies have provided empirical support for the efficacy of Ayurvedic treatments in managing psychiatric disorders. A double-blind, randomized, placebo-controlled trial conducted by Chandrasekhar et al. (2012) found that Withania somnifera (Ashwagandha) significantly reduced symptoms of anxiety and stress, with reductions in serum cortisol levels (Andrade et al 2000). Similarly, Brahmi (Bacopa monnieri) has been studied for its cognitive-enhancing and anxiolytic effects; a meta-analysis by Stough et al. (2008) confirmed its role in improving working memory and cognitive processing in individuals with attention and mood disorders. Shankhpushpi (Convolvulus pluricaulis) and Jatamansi (Nardostachys jatamansi) have demonstrated significant neuroprotective and antidepressant properties in rodent models and preliminary clinical trials (Singh et al., 2015; Sharma et al., 2016). Moreover, Panchakarma therapies particularly Shirodhara and Nasya have been shown to modulate the hypothalamic-pituitary-adrenal (HPA) axis and improve symptoms of insomnia, depression, and psychosomatic distress (Rao et al., 2017; Kessler et al., 2008).

From a psychological perspective, Sattvavajaya chikitsa, often described as the Ayurvedic parallel to modern psychotherapy, focuses on cultivating positive cognition, ethical conduct (dharma), self-regulation (niyama), and meditative practices (dhyana) to restore mental harmony. This aligns with cognitive-behavioral principles and mindfulness-based interventions. Additionally, Ayurveda emphasizes dietary regulation (Ahara) and lifestyle modification (Vihara), which are now supported by contemporary research on the gut-brain axis and circadian psychiatry (Sarkar et al., 2016).

While large-scale, multi-centered randomized controlled trials are still limited, there is growing scientific interest and funding in India (AYUSH Ministry) and globally to systematically evaluate Ayurvedic approaches to mental health. Integrative care models that combine Ayurveda with conventional psychiatry are emerging in institutions such as NIMHANS, AYUSH Research Councils, and All India Institute of Ayurveda, demonstrating promising outcomes for treatment-resistant depression, generalized anxiety disorder, somatization, and mild neurocognitive disorders. Thus, Ayurveda offers a rich, multidimensional, and evidence-informed framework for the treatment of psychopathologies, which can serve as a culturally congruent and complementary approach in mental health care in India and beyond (Rhoda, 2014).

Yoga as a Treatment for Mental Illness: Yoga, a spiritual discipline and therapeutic practice, has become a powerful adjunctive treatment for mental illnesses (Kishan, 2020). Rooted in Patanjali's Yoga Sutras, yoga is conceptualized as the cessation of mental fluctuations (chitta vritti nirodhah), yoga aims to restore internal balance through a combination of ethical conduct (yama-niyama), physical postures (asana), breath regulation (pranayama), sensory withdrawal (pratyahara), concentration (dharana), meditation (dhyana), and transcendence (samadhi). It is practiced globally, including India. Yoga's synergistic components reduce stress, enhance emotional regulation, and

promote self-awareness and cognitive clarity, with clinical and neurobiological studies supporting its psychiatric benefits when combined with pharmacological and psychotherapeutic interventions (Cramer et al., 2017).

In the Indian context, institutions like NIMHANS, SVYASA, and the Central Council for Research in Yoga and Naturopathy (CCRYN) have pioneered the integration of yoga into clinical mental health services. Government initiatives such as AYUSH and Tele-Yoga programs further reflect its growing acceptance in mainstream psychiatry. While yoga is not a standalone cure, it serves as a cost-effective, culturally congruent, and evidence-informed adjunctive treatment that enhances psychological resilience, emotional regulation, and overall well-being in individuals with mental illness (Varambolly & Gangadhar, 2020).

Buddhism treatment of mental illness: It offers a holistic framework for treating mental illness (Harvey, 2013) involves ethical conduct, mindfulness (sati), concentration (samādhi), and insight (paññā), as outlined in the Noble Eightfold Path (Gethin, 1998). Practices like Vipassana meditation, popularized in India by Goenka, reduce anxiety and promote emotional balance (Kumar et al., 2013). Mindfulness-Based Cognitive Therapy (MBCT), derived from Buddhist principles, is clinically effective for depression and anxiety (Segal et al., 2002). Indian studies also show positive outcomes from meditation retreats on well-being and stress reduction (Dwivedi & Choubey, 2020). Unlike Western psychiatry, Buddhism frames healing as a moral and spiritual transformation aimed at liberation (nirvana) rather than mere symptom relief (Wallace & Shapiro, 2006).

Faith Healing: Faith healing in India is a deeply culturally legitimate system that addresses mental distress through rituals, prayers, and offerings at Sufi shrines, dargahs, and temples. Symptoms like hallucinations, disorganized behaviour, depression, and perceived spirit possession often lead individuals to seek spiritual healing in these places, where the cause of their suffering is interpreted as a moral, spiritual, or supernatural imbalance (Kumar et al.

Healing spaces, such as the Mira Datar Dargah in Unava, Gujarat, are not just religious institutions but also social and therapeutic sites that offer structured rituals, collective participation, and a shared cultural vocabulary for understanding suffering. These spaces help patients and families seek relief from mental illnesses interpreted as jinn possession, evil eye, or black magic. Rituals include recitation of Qur'anic verses, fumigation with incense, and collective supplication (Jadhav et al., 2001). Healing practices are distinguished by their relational and moral dimension, where patients are not isolated but are accompanied by families and communities in the healing process.

Hindu temples like Balaji Temple in Mehandipur and Chottanikkara Temple in Kerala are known for ritual healing, exorcism, and spirit removal. In Mehandipur, individuals with schizophrenia, dissociative disorders, or depression often experience trances, interpreted as demonic possession or karmic retribution. Rituals involve fire offerings (Havan), chanting of Hanuman Chalisa, beating drums, and symbolic sacrifices to drive away evil entities. Healing is a public and performative act, reinforcing the visibility and legitimacy of distress in a stigmatized psychiatry context (Koileri, 2022).

Ethnographic accounts (Kakar, 1982; Béteille, 1996; Singh, 2015) suggest that Rituals help sufferers externalize their suffering, shifting blame to external forces, reducing self-stigma and enabling social reintegration. These healing experiences provide catharsis, symbolic reparation, and

moral reintegration, often absent in clinical settings focused on symptom management. Faith healing sites serve as community-based institutions of care, offering ritual repetition, affective engagement, and ontological validation. Unlike modern psychiatric settings, anthropological and transcultural literature emphasizes dialogical engagement, recognizing the epistemological validity, emotional efficacy, and social embeddedness of these healing systems (Raguram et al., 2002; Littlewood & Dein, 2000). The World Health Organization (WHO, 2001) acknowledges that spiritual and cultural models of care often fill the treatment gap in low-resource settings. Faith healing in India is an active, adaptive, and meaningful response to psychological suffering, requiring careful academic study and culturally sensitive policy consideration (Raguram et al., 2002).

Community Healing Rituals-Music, Dance, and Trance in Indigenous Mental Health Practices: In Indian communities, particularly rural and tribal areas, mental distress is addressed through community-based healing rituals led by local spiritual healers, shamans, or ojhas (Kigunda, 2007). These rituals, which often involve music, rhythmic dance, chanting, and trance states, are believed to expel harmful spirits, restore spiritual balance, and realign individual energies, transforming mental suffering into a shared cultural event.

For example, in Tamil Nadu's Mariamman festivals, women experiencing emotional distress or possession states often enter trance during processions or ritual dances (Kavadi Attam), interpreted as the goddess expressing herself through their bodies (Beck, 1981). In Uttarakhand's Jagar rituals, studied by Sax (2009), spirits believed to be causing illness or imbalance are summoned, negotiated with, and ritually appeased through collective singing, drumming, and possession episodes. These healing ceremonies enable the sufferer to give symbolic expression to suppressed conflict, grief, or trauma, while also providing a structured, culturally meaningful path to reintegration within the community.

Anthropological and psychological studies suggest that these rituals have therapeutic effects, not only by offering catharsis and social validation, but also by restoring a sense of identity and belonging. Kakar (1982) argues that such indigenous healing systems often address relational and existential dimensions of suffering, which biomedical psychiatry may overlook. Furthermore, Raguram et al. (2002), in their study at NIMHANS, found that many individuals moved between faith-based healing and psychiatric services, illustrating the enduring cultural significance of ritual healing. Rather than being irrational or outdated, these practices reflect a holistic and culturally embedded approach to mental health, where the body, mind, spirit, and society are seen as interconnected realms of healing.

Discussion

The findings demonstrate that mental health in India cannot be adequately understood through a single explanatory system. Biomedical psychiatry provides essential knowledge regarding symptoms, diagnosis, risk, medication, psychological intervention, and rehabilitation. Individuals, however, do not experience distress only as a medical condition. It may also be understood as a disruption in family relationships, moral responsibility, social position, bodily balance, spiritual life, or personal meaning. Kleinman (1980, 1988) argued that illness experiences are shaped by explanatory models, and the present analysis supports this position in the Indian context.

The coexistence of several explanatory models is a central finding. A family may attribute unusual behaviour to stress, karma, spirit influence, conflict, bodily weakness, and mental illness at the same time. It may seek psychiatric help while continuing prayer, ritual observance, yoga, or Ayurvedic treatment. Halliburton (2004) described such patterns as psychiatric pluralism. They may represent an effort to address biological, emotional, relational, and spiritual dimensions together rather than a simple rejection of modern medicine.

Cultural narratives may have supportive as well as harmful consequences. Beliefs in karma, divine testing, or spiritual imbalance may give meaning to otherwise incomprehensible experiences. Rituals and collective worship may provide expression, social recognition, and community support. The same beliefs may become harmful when illness is attributed to moral failure, impurity, possession, or defective family conduct. They may increase shame, expose individuals to coercive practices, or delay emergency treatment. Cultural sensitivity therefore requires respectful listening together with critical ethical judgment.

Idioms of distress show that suffering is not always communicated through standard psychiatric terminology. Expressions such as mann udas hai, dil toot gaya hai, dimag kharab hai, seene mein ghutan hai, or andar se toot chuka hoon may communicate sadness, anxiety, grief, trauma, anger, helplessness, or bodily discomfort. Professionals who overlook these expressions may underestimate distress. In the same way, spiritual ideas should not be mechanically converted into diagnoses or universal prescriptions. Their value depends upon the person's beliefs, circumstances, interpretation, and freedom of choice.

The findings suggest that culturally responsive care should begin with listening rather than immediate correction. Professionals should ask what the person calls the problem, what they believe caused it, how the family interprets it, whom they have consulted, and what kind of recovery they expect. Understanding a belief does not require accepting it as scientific fact; it clarifies how that belief shapes fear, stigma, adherence, family participation, and hope.

A Culturally Responsive Pluralistic Mental-Health Framework

On the basis of the findings, the article proposes a framework containing six connected levels. The first is the individual psychological experience, including emotions, thoughts, behaviour, bodily sensations, history, coping, and personal meaning. The second is the family and relational context because family members often recognise symptoms, select services, support treatment, and influence recovery. Family participation should nevertheless respect the consent and dignity of the person receiving care.

The third level concerns cultural narratives and idioms through which suffering is communicated. The fourth includes voluntary spiritual and philosophical resources such as prayer, meditation, devotion, compassion, forgiveness, and ethical reflection. The fifth consists of safe indigenous and community resources, including yoga, selected Ayurvedic practices, community support, religious leaders, and traditional healers. Their involvement requires defined boundaries, informed consent, and referral in situations requiring medical or psychiatric intervention.

The sixth level is evidence-based psychological and psychiatric care, including assessment, counselling, psychotherapy, medication, crisis intervention, suicide prevention, rehabilitation, and follow-up. All levels are governed by human-rights safeguards protecting autonomy, confidentiality, consent, physical safety, equality, and dignity. Cultural understanding is therefore used to improve professional care, not to replace necessary treatment.

Implications for Practice, Education and Policy

Mental-health assessment should include culturally relevant questions about the person's understanding of the problem, family interpretations, spiritual concerns, earlier help-seeking, and expectations from treatment. Training for psychiatrists, psychologists, counsellors, teachers, and social workers should include cultural psychiatry, Indian psychology, local idioms, religious diversity, and ethical engagement with indigenous systems. Cultural competence is not a fixed list of customs; it is the ability to listen, examine assumptions, recognise differences in power, and negotiate care collaboratively.

Schools and higher-education institutions should train teachers and counsellors to recognise culturally expressed distress. Students may report headaches, fatigue, fear, loss of concentration, family pressure, spiritual anxiety, or a feeling of inner collapse rather than use diagnostic terms. Community programmes may work with local organisations and religious leaders while training them to recognise suicidal intent, acute psychosis, severe self-neglect, prolonged sleeplessness, substance dependence, and other warning signs requiring referral. Such collaboration must remain consistent with the dignity and rights emphasised by the Mental Healthcare Act, 2017.

Limitations and Directions for Future Research

The study is based on secondary literature and does not include direct interviews with people experiencing distress, caregivers, clinicians, or traditional healers. India's regional, linguistic, religious, caste, class, gender, and tribal diversity cannot be fully represented by a narrative review. English-language scholarship and recognised translations may also underrepresent knowledge available in regional languages and oral traditions. Some indigenous practices have not received sufficient empirical evaluation.

Future studies should include regionally grounded interviews and comparative work across rural and urban communities, age groups, linguistic regions, and religious traditions. Longitudinal research is needed to understand movement between healing systems and its effect on continuity of care. Carefully designed studies may also examine culturally adapted counselling, family-based care, yoga, mindfulness, community referral, and ethical collaboration with traditional healers.

Conclusion

Mental health in India cannot be separated from the cultural, spiritual, familial, and social worlds in which people live. Distress is communicated not only through clinical symptoms but also through bodily complaints, local idioms, religious metaphors, family conflicts, folk narratives, and media representations. These forms influence recognition of a problem, choice of assistance, and expectations of recovery.

Indigenous and biomedical understandings often coexist. This pluralism is not simply a conflict between tradition and modernity; it reflects an effort to respond to biological, emotional, social, relational, and existential dimensions of suffering. Cultural practices that provide meaning, belonging, expression, or support may contribute to recovery, whereas practices that delay essential care, strengthen stigma, or violate dignity require correction. A culturally responsive system is therefore neither a rejection of biomedical science nor an uncritical return to tradition. It combines scientific knowledge, cultural understanding, ethical safeguards, and respectful dialogue to make mental-health care more humane and relevant to India's diversity.

Declarations

Ethical approval and informed consent: The study was based exclusively on published secondary sources and did not involve human participants; therefore, institutional ethical approval and informed consent were not applicable.

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