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“What do I know?” Scholastic fallacies and pragmatic religiosity in mental health-seeking behaviour in India

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This paper draws on ethnographic fieldwork on psychiatrists and their patients (their care-givers and their communities) in North India. It addresses the questions as to when and why people approach psychiatrists and religious healers by arguing that approaches assessing “explanatory models” and other knowledge structures relevant to the people’s health-seeking behaviour should place more emphasis on the people’s strong desire to get well, in any way possible. Secondly, the difference between beliefs rooted in the patients’ life-worlds and explanations suggested to them by experts has to be acknowledged. These insights motivate a shift away from the concept “religion” towards the differentiation between pragmatic and scholastic religiosities. This argument relates back to the Greek meaning of “pragma” understood by Hans-Georg Gadamer as “that within which we are entangled in the praxis of living”.

Keywords: mental health; health-seeking behaviour; India; psychiatry; religion; religiosity; explanatory model

Introduction: uncertainty in health-seeking behaviour

Very early on in the ethnographic fieldwork in the psychiatrist wing of a general hospital in North India upon which this article is based, Mrs Raturi, an elderly woman from Chamoli district in Uttarakhand, entered the out-patient department (OPD) of the psychiatrist Dr Kumar (all names are pseudonyms).¹ Mrs Raturi complained that her whole body felt like “it was shrinking”. She sometimes felt it in her chest, at other times elsewhere in her body. She sometimes felt “as if her throat was closed”. As a result, she said that she was unable to do any kind of work. She also reported that at times, when sitting at home, voices would tell her: “Get up! What are you doing inside? Get up”. The voices also said: “Shut up, get up, go to your natal home” (March 22, 2010).

In an interview that took place after the OPD session, and was conducted by the author with the help of the resident doctor Mr Gupta, Mrs Raturi was asked where she thought her problem came from. She had to reflect on his question for some time. On the one hand, she had been told that it could be “black magic” because “there was something going on in my stomach; my stomach felt as if something was put inside it by someone”. She also spoke of a kind of “spirit possession” that resonates with what the anthropologist

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William Sax describes as a “paradigmatic affliction” in this part of India (2008, p. 84). When a woman is grabbed by a *chhal* (in this context a “crafty demon”) the standard treatment consists of a specific ritual, a *chhal puja*, during which the woman and her husband visit her natal home (*mait*) to exorcise the demon. Following such advice, Mrs Raturi had visited her *mait* and had the respective *puja* performed. When the resident doctor asked her whether she thought that her condition had changed due to the rituals, she said that it had gotten worse. She complained that she had made “many offerings” but that “out of all this, ashes were the only thing left for me”. At the same time, she had visited various doctors and tried different kinds of medicine and was not satisfied with their efficacy either. Her final verdict was undecided: On the question as to her feelings on what or who was inside her, she said: “What do I know? It could be that God (*bhagvān*) is inside me, it could (also) just be my own mind (*dimāg*), or my own obscenity (*gāli*). What do I know?” This quote exemplifies Mrs Raturi’s ambivalence with respect to her assessment of the reasons that led her to seek the help of a psychiatrist. It invites the interpretation that she tried to decide whether it was a religious or a psychological problem that she had, and therefore whether she should consult a religious specialist rather than a psychiatrist. In this article it will be argued that this question is often of greater concern to social scientists interested in patterns of health-seeking behaviour than to people in search of help. In some cases the opposition between medicine and religion is even misleading since it suggests that people take their decisions on the basis of such a clear-cut, ideological separation. Instead it is argued here that some people have a pragmatic religiosity with respect to their health-seeking behaviour within which the strong desire to get well is coupled with every-day life concerns and experiences. Illness explanations concerning the realms of medicine and religion are often to be understood as “quotes” that defer to the assessment of the respective experts consulted, whom the patients and their care-givers have to trust in these matters.

The psychiatrist in this hospital, Dr Kumar, took Mrs Raturi’s statements to be an indication of a psychological problem, independent of her own interpretations. She was diagnosed with paranoid schizophrenia and he prescribed her the antipsychotics Olanzapine and Trifluoperazine as well as some analgesic drugs (“painkillers”). Mental health professionals and policymakers in India generally have a narrow conceptualisation of mental healthcare which excludes the religious and focuses only on the biomedicine medical realm (Quack, in press). The mental health professionals interviewed during the fieldwork thought of the various religious therapies as business competitors, with largely harmful outcomes for the patients.² During their diagnostic sessions, they did not concern themselves with the patients’ religiosity due to time constraints, and because they assumed that it did not interfere with their treatment in any significant way. This stands in contrast to anthropologists and other social scientists working in this field who generally propose a broader conceptualisation of the realm of mental healthcare. In India, this includes psychiatry and psychology (as part of cosmopolitan- or bio-medicine, also called allopathy, modern, English or Western medicine in India), the learned or codified medical traditions recognised and supported largely by the Indian state alongside bio-medicine (Ayurveda, Yoga, Unani, Siddha, and Homeopathy – AYUSH), as well as the heterogeneous realm of religious or “folk” therapies (faith, local, symbolic, ritual healing practices).³ Hence “folk healing” is a residual category along with the term “healer” as it is used here. The realm of psychiatry is thereby considered to be secular, separate from religious ways to deal with mental health problems as can be found in temples, mosques, churches, and as addressed by religious experts such as Hindu pundits, Muslim maulvis, Christian priests as well as babas, tantrics, astrologers, gurus, and other kinds of religious

specialists.⁴ Accordingly, scholars are very interested in health-seeking behaviour patterns in this medical pluralism. They ask when and why people approach psychiatrists or psychologists, representatives of AYUSH, or religious healers, or several of them at the same time (see Fabrega, 2009, pp. 662–663; Halliburton, 2009, pp. 42, 118; Sébastia, 2009, pp. 7–20).⁵

Most studies researching peoples' health-seeking behaviour concentrate on the importance of belief systems, health beliefs, related conceptual categories and "illness explanatory models" as conceptualised, for example, by Arthur Kleinman and operationalised in the Explanatory Model Interview Catalogue (Weiss et al., 1992).⁶ The focus on explanatory models was critically discussed from early on (see Blumhagen, 1981; Kleinman, 1980; Young, 1981). Young argued, for instance, that many patients think "prototypically" about their problems; the elements of their experiences and interpretations are not organised into functional systems or locked into nesting hierarchies of verbal classifications. In the last 30 years this focus became more and more established despite continuous criticism (see for an overview Alex, 2010). Particularly relevant for the argument advanced here is Simon Dein's criticism of approaches assessing health beliefs and explanatory models as "overinterpretation" and "oversystematization" (2007). As a result of these debates, more refined methodological directions were explored in attempts to complement the focus on explanatory models with a focus on other kinds of knowledge structures (Groleau, Young & Kirmayer, 2006; Stern & Kirmayer, 2004). With respect to India this discussion was further supplemented with a study that focused particularly on the role of aesthetics and pleasant procedures in the decision-making process for different forms of mental health care (Halliburton, 2009). Brigit Sébastia nicely summarises the important factors helpful in explaining the recourse of people to folk remedies and religious therapies including, amongst other things, the peoples' "belief system" about causation of mental disorder and the strong role of the "social network" in promoting religious alternatives (2009, pp. 12–13). However, none of these accounts discuss the ways in which patients and care-givers can also be undecided, unsure, and doubtful about the problems at stake and the fact that their desire to get well may override cognitive and ideological issues. Nor do they address how much the patients' and care-givers' apparent beliefs and knowledge structures are based on deference to kin, friends and experts and how important the notion of trust is in this respect. This is the case despite the fact that empirical data clearly raise questions in these respects, questions that have so far been left unaddressed. Campion and Bhugra, for example, found that in cases where relatives saw the cause of the patients' illness as psychiatric, psychological, or physical, roughly half of the patients were nevertheless taken to see a religious healer by them. And, conversely, they stated that roughly one-third of those who considered the problem to be "supernatural" went to see a psychiatrist (Campion & Bhugra, 1997, p. 217). Similar results are reached by Banerjee and Banerjee (1995, p. 221) and in the study on which this article is based. To explain why a large group of patients and their care-givers seems to act in opposition to the illness explanatory models ascribed to them, one has to complement existing studies with a reconceptualisation of the patients' beliefs and desires in their decision-making.

Firstly, many of the beliefs ascribed to people as guiding their health-seeking behaviour on the basis of standard assessments tools turn out to be rationalisations *ex post facto* ("from after the action"), that is, explanations are provided by the people often after they had taken decisions based on more pragmatic concerns and they thereby often retroactively reformulated the diagnosis given by others as a reason for their actions. Secondly, following on from Young's argument on the social science privilege of a

hypothetical “Rational Man” rather than real people (Young, 1981), this paper tries to further problematise any straightforward inferences from what people say in an interview or a questionnaire to what they think, know, and feel as well as to highlight the non-cognitive determinants of their decision-making. In addition to Young and others, it is argued that the threat of imposing false coherence is not only due to the various types of reasoning at play (Stern & Kirmayer, 2004) but also due to the fact that the emotional and pragmatic aspects of the decision-making, the “logic of praxis” in Bourdieu’s terms, and the pragmatic religiosity, as outlined here, are ignored. In order to supplement the aforementioned studies and discussions, this paper proceeds with an analysis of the beliefs and desires that lie behind the people’s choices without committing what Bourdieu called a “scholastic fallacy”, that is, the danger is that the *sujet savant* (knowing subject) slips their imaginary projection onto the *sujet agissant* (action subject) (Bourdieu & Wacquant, 1992, p. 123). Here it is important to differentiate between whether factors in peoples’ decision-making are the reasons which lead people to take certain actions, or whether they are secondary rationalisations made by others, such as the experts consulted or the anthropologists. The importance of this differentiation became explicit in the “rationality debate” (Lukes & Hollis, 1985; Wilson, 1974) with respect to the following two questions: Why do people perform religious and magical acts? Why do people have religious and magical beliefs? Intellectualists and literalists, on the one hand, answered that such acts are performed because they are believed to be means to ends they desire to achieve and that people have these beliefs because they are socialised into them. Durkheimians and the broader school of symbolists, on the other hand, run the two questions together, and respond to them with the answer to the second; the religious and magical acts are performed by people, and the cosmological ideas that give them their point are held by the people, because they were socialised into a setting that inculcates both.⁷ In the latter approach the actual beliefs and desires of the people are secondary to the symbolical or cosmological explanations provided by the researcher. Durkheim wrote that

the real function of a rite does not consist in the particular and definite effects which it seems to aim at and by which it is ordinarily characterized (...) the real function of the cult is to awaken within the worshippers a certain state of soul. (Durkheim, 1965, p. 431)

In this line of theorising, the choice to perform a given healing ritual is not explained by the actors’ aim to achieve practical results on the basis of their beliefs and desires, but by the “symbolic”, “expressive”, or – more fashionable – the “performative” aspects of their actions (Quack & Töbelman, 2010). Against this background, this article proposes a literalist approach that tries to focus on the actual nature and role of beliefs and desires behind the peoples’ healthcare decisions in order to learn more about the role of religion in mental healthcare from their perspective. Academic debates have moved on from the rationality debate (despite many unresolved issues) and this paper therefore draws on the more recent work of one of its early contributors, the anthropologist Dan Sperber. It will be argued that the beliefs underlying peoples’ healthcare seeking are in some cases not to be conceptualised as belief systems or explanatory models of illness, but as an ambivalent amalgam of propositional attitudes and representations that are accepted without them being fully understood. Yet, by engaging with the philosopher Francois Recanati’s criticism of Dan Sperber’s position, half-understood beliefs, also called semi-propositional beliefs by Sperber, are conceptualised here as quantitatively and not qualitatively different from fully understood beliefs. On this basis, it is argued that a focus on types of reasoning has to be supplemented with an account of the importance of trust. The important role of the peoples’ desires is to be highlighted because it is often ignored in the literature. The

underlying suffering and strong desire for any improvements in the situation might be taken for granted in other accounts, but any omission of its central role in decision-making leads to a misrepresentation of the patients' concerns. Finally, this discussion of the patient's beliefs and desires provides the basis for the delineation of a pragmatic religiosity in the patient's health-seeking behaviour. It thereby contributes also to what Woodhead called "religion as quotidian practice" and others called "lived religion" or "everyday religion" (Woodhead, 2011, p. 133).

The following argument, however, applies to varying degrees to the patients and caregivers met during the time of the fieldwork. For the sake of clarity the paper begins by opposing two groups of patients in an ideal-typical manner. One group of patients held a perspective which was more or less similar to that of the psychiatrists' as briefly indicated above. They distanced themselves from religious healing in general, and often also from specific practices that they considered to be backward and superstitious. With respect to the problems that brought them to the psychiatrists, they were convinced that it was an illness (*bimāri*) rather than anything religious. The other, larger group of patients was, however, not so sure about how to assess or explain their problems. This group of patients followed a "trial and error" approach as part of which they were looking for help from more or less any kind of expert available, affordable and endowed with a certain reputation in the respective communities, as well as on the basis of experienced outcome of the treatment. The next part of this paper attempts to differentiate and substantiate this claim on the basis of an exemplary case study.

Trial and error: the desire to get better, no matter how

Mrs Rawat, a 37-year-old Hindu woman from one of the poorer outskirts of the state's capital, came to the hospital with her father (April 8, 2010). She had attended school until the 12th standard but had not worked in years; she was unmarried as a result of her problems. During the OPD session with Dr Kumar and the interview with the anthropologist and Dr Gupta, she hardly answered a question. Her mouth remained open for most of the time. She wore a slight smile and her eyes were fixed to some point, usually her father's head. She gave the impression of living in her own world, constantly thinking of something else. As a result, practically all answers to our questions were given by her father, Mr Rawat. He initially stated that his daughter was "mentally retarded", referring to one of the many different diagnoses he received from psychiatrists that they had visited over the last few years. Dr Kumar was unsure of his diagnosis, but noted "schizophrenia" and prescribed the anti-depressive Flunarizine (trade names: Prozac, Sarafem), the atypical (or "second generation") antipsychotic Olanzapine, the benzodiazepine Lorazepam and Pacitane (Trihexyphenidyl, usually used against Parkinson's disease).

During the subsequent interview, Mr Rawat told us that her problems had started in 1995 when, all of a sudden, she experienced strong fits (*daure*) while preparing food in the kitchen. Later on in the conversation, the father narrated different interpretations prevalent in their family and community. The first suggestion was that she had been taken over by a ghost (*bhut pret lag gayā*), but after the respective rituals failed to bring any relief, many further interpretations were put forward. On the question what they had done the father answered:

We had everything done. Those who "dust" (*jhārne vāle*),⁸ we took her to them. What they gave, the *mantra* they gave, we did that. Secondly we also used to do a little bit on our own.

We've known it since childhood. In our house we watched and learnt from our mother and father. [...] "Black-magic" (*jādu-tonā*), (also) for that we got the treatment done. But due to this there was relief, just for a few days, a little bit, for two or three months, then not, always only a little bit.

This quote is only indicative of Mrs Rawat's long history of health-seeking behaviour and the various explanations given and remedies tried. Of crucial importance is the sentence: "We had everything done". Initially they had tried to figure out what kind of problem it might be by asking family members, friends and neighbours. The first expert approached was the one most accessible and affordable (in this case a man in their village "knowledgeable in these matters"). The first diagnosis was of ghost possession and the respective rituals were performed without any signs of lasting improvement. Accordingly, they consulted other religious experts and received other diagnoses. They also tried the therapies, remedies and rituals orally transmitted in their family. At one point the consultations of various healers were supplemented by the first visit to a psychiatrist. The medicine prescribed by him was expensive and had strong side-effects; the treatment was soon discontinued. Further visits to biomedical, AYUSH and folk healers followed and the assessment of the problem became more and more diverse and confusing to the family members. The long and short of the story is that over a span of 15 years all kinds of experts had been consulted, a great variety of approaches, medicines, rituals, and remedies tried, and although no lasting positive effects were experienced, the family did not give up hope.

Important for the argument advanced here is the observation that the narrative of the father simply listed where they had to travel to, how much they were charged, the ways in which the situation improved and the painful relapses. The way in which the narration was structured indicates that the aforementioned differences between science and religion were insignificant for their health-seeking behaviour. The father mentioned the names, places, prices and outcomes of the people they had visited, without specifying what kind of therapy they received (religious or medical). From their perspective, they approached different experts, and only upon inquiry did the father add specifications as to the kind of treatments they received. The underlying pattern – representative for this group of patients – was clearly one of trial and error. What was important to them was not an ideological classification of experts, illness causation or kinds of therapy – but primarily time, money, and, of course, outcome.⁹

A focus on the peoples' belief system and explanatory models easily elides the fact that patients like Mr Rawat and his daughter simply had everything available and affordable to them done.¹⁰ Their desire is to get better, in any way possible. Similar findings were made as early as 1977 by Charles Leslie who argued that throughout Indian society

laymen... utilize whatever forms of medical knowledge and practice are available to them. They are less concerned with whether the therapy is indigenous or foreign, traditional or modern, than with how much it will cost, whether or not it will work, how long it will take, and whether the physician will treat them in a sympathetic manner. (Leslie, 1977, p. 517, cited after Ram, 2010, p. 202)

More recently, Banerjee and Roy stated that in their study "the families went to the nearest healer or the best known amongst them in the locality. The method of treatment was not a criterion of choice" (1998, p. 210). Despite such findings there were no further methodological or conceptual conclusions drawn in this respect. The same can be said with respect to the importance of trust in health-seeking behaviour, as will be outlined in the next section.

“What do I know”: the importance of trust

Ideological differentiations, questions concerning belief systems and explanatory models were also discussed in the study upon which this article is based, but they primarily appeared to be of relevance when the patients were asked to reflect on their problems, as, for example, during the interviews and less during informal conversations on the same issues. Mrs Raturi, Mrs Rawat and her father thereby showed, as did all other patients with comparable un-ideological trial and error approaches, great ambivalence in answering questions about their perspectives on different kinds of therapeutic offers. When talking, for example, about the relationship between *dava aur dua* (medicine and prayer) the large majority of them just said that both are important, that both should go together. But when asked to assess their problems along these lines they hesitated to respond, gave vague, contradictory, or ambivalent answers; in most cases they referred implicitly or explicitly to the expertise of the respective doctors and healers. Two women, the daughter and granddaughter of an old female patient (April 27, 2010), told me, for example, that they were in the predicament that various kinds of treatment were suggested to them at the same time. Since they did not know whom to believe and what to do they just did everything possible. The grand-daughter said that they approached various healers and she added: “We showed her to the doctors too, we did private treatment as well, every type of doctor, but I do not remember their names”. The daughter added with reference to the *dava aur dua* question: “We did the doctors treatment regularly and along with it we ran both the things together so that she would get well from whichever gave relief...” When asked about their personal assessments, they were not sure what to say; they simply answered that they were not sure what to do. Despite several such cases, I did not come across discussions of unexplained cases in the literature with the exception of the work of Gilbert Lewis, who notes the important difference between explained and unexplained illnesses in his ethnographic research in Papua New Guinea (1975, 2007).

Mrs Raturi summarised her position in one sentence: “What do I know?”¹¹ She did not know whether it was God inside her, or some demon, whether she was the victim of black magic, or of her own “obscurity”, or whether she had schizophrenia. She was not sure how to assess any of the options that were suggested to her by others. She did not care so much about which interpretation was correct. Rather, she cared about which of the experts was actually improving her situation. Likewise, Mr Rawat was not sure whether his daughter was mentally retarded, schizophrenic, possessed by a ghost, or the victim of black magic. Having consulted so many different experts, he was concerned with how much longer they could afford to approach people for help, since none of the therapies tried thus far had led to lasting improvement.

As a general pattern, most patients initially repeated what the last doctor they had visited had said to them. In further conversations further explanatory options were added, but often without a strong commitment to apply any of these. A straightforward analysis of such answers would lead to the assessment that they held several, apparently conflicting beliefs and explanations for the problems at stake at the same time (see also Charles, Manoranjitham, & Jacob, 2007, p. 330). It is of course a common characteristic of humans to hold many contradictory beliefs without giving them a second thought. Nevertheless, many scholars and methodological tools seem to elide this fact, especially those addressing the relationship between religious and medical beliefs and explanatory models in health-seeking behaviour. Nilamadhab Kar, for example, notes that the majority of patients and families in his study continued to believe in supernatural causation despite and while taking medicinal treatment. Many patients follow folk-healing suggestions and treatments

while under treatment in a hospital – findings consistent with the work of Callan and Littlewood (1998), Dein (2001), Saravanan et al. (2008), and this study. Kar concludes that it “was evident that belief in a particular explanatory model of illness and resort to different models of treatment may co-exist without major dissonance” (2008, p. 736). In other words, particular explanatory models of illness deduced from questionnaires have little to say about the actual choice of different models of treatment; they co-exist without major dissonance. If this is the case, why then attribute so much explanatory force to explanatory models of illness?

An analysis of the ways in which these apparently contradictory beliefs are held in the cases presented here further undermines the exclusive focus on belief systems or illness explanatory models and its implicit differentiation between medicine and religion. The group of patients this paper is concerned with often explained their decision to approach any kind of expert by deferring to the people they trust, such as kin, neighbours or religious experts and doctors. This and their own experiences of successful therapeutic interventions form, in the words of the anthropologist Dan Sperber, the “validating context” for their beliefs. Sperber argues that humans basically have two modes of evaluating their beliefs corresponding to two ways in which these are stored in our minds. In one case, arguably the one most people would consider to be the standard case, in “ordinary beliefs”, interpretation precedes truth-evaluation. In other cases we hold propositions to be true although we are not really able to interpret them ourselves, usually because we trust the respective authorities. If we are taught by a reliable mathematician that in non-Euclidian geometry two parallels meet in infinity we might consider this to be true without fully understanding why and how. According to Sperber in this case we do not believe but “quasi-believe” that two parallels meet in infinity because this belief cannot be fully interpreted within our mental idiolect. We can reach a point such that we can think *about* such beliefs without being able to think *with* them (1997). In other words, we think *with* “propositional” belief contents given that they are understood well enough for ordinary purposes. But we can merely think *about* beliefs that Sperber calls “semi-propositional”, they are only half-understood as long as we have limited commitments as to what it presupposes and entails in our everyday lives.

Sperber’s position was criticised by the philosopher Francois Recanati who argued against the clear separation between propositional beliefs and “quasi” or “semi-propositional” beliefs. Recanati agrees with Sperber that some beliefs are less determinate than others. For the quasi-believer the statement that in non-Euclidian geometry two parallels meet in infinity is epistemically indeterminate since the quasi-believer does not know which proposition the deferential sentence she accepts expresses (see Recanati, 1997, p. 93). But there are degrees of understanding, the more you learn about non-Euclidean geometry the more you understand what the mathematician is talking about. The point is that we still can differentiate between “species of belief”: on the one hand there are deferential representations (Sperber’s quasi-beliefs) and there are ordinary beliefs on the other. The rule of thumb question concerning deference is whether the people see themselves to be in a position to judge what the reasons for their problems might be. A large group of patients spoken to during the fieldwork would not claim firm grounds (not to speak of expertise) for any of the religious and medical explanations they gave of their problems. Rather, the analysis of their statements in the larger context of their narratives and reported behaviour showed that they would make pragmatic decisions connected to time and money or drift with the flow of events facilitated through the judgements of others and – if asked – they would repeat what others suggested to them and – if asked further – they would refer to their authority. In some cases people stated that they did not

know and deferred to the assessment of others without previous inquiry. A Muslim father of a young girl refrained from making an assessment on his own but said (May 13, 2010): “The people used to say that (supernatural) wind strikes her (*havā kā jhatkā lagtā*); we told this to the doctor, and the doctor used to tell us to take her to a brain specialist (*dimāg vāle*)”.

In the assessment of such instances, this paper follows Recanati’s argument against Sperber that deferential representations and beliefs are not sharply demarcated from ordinary beliefs, rather they posit a continuum of cases. If we apply these insights to the various beliefs patients hold about their problems and the ways in which they defer to the authorities they have consulted, it turns out that beliefs about possession and beliefs about schizophrenia are often more like deferential beliefs and less like ordinary beliefs. In these cases neither explanation, not possession or schizophrenia, can be fully interpreted by the people within their mental idiolect, people do have problems integrating these beliefs into their everyday lives. However, while this is the case to varying degrees, it is arguably religious explanations which are less deferential in many cases. This point is well illustrated with the help of the case studies introduced above. Mr Rawat knows well enough what his belief, that he will neither be able to find a husband nor a job for his daughter due to her problems, presupposes and entails in the families day-to-day life, but this is not the case with respect to the diagnosis of schizophrenia. He and most other patients trust the doctor’s assessment to a certain degree and have discussions about it with kin and friends, but the underlying belief is, in Sperber’s terminology, only half-understood since most patients cannot think *with* the diagnoses they receive the way the doctor can.¹² This is usually also the case with respect to most of the religious diagnoses they receive, albeit to a lesser extent. With respect to religious explanations, it has been argued that these are often to be understood less in causal and more in moral terms. In other words, they address the question *why* rather than *how*. As Dein points out: “If the ancestors make someone ill, they have only the faintest notion of how they do it” (2007, p. 42). In other words, most patients have no idea as to the basis on which they could challenge or endorse either a diagnosis of possession or schizophrenia. Mr Rawat stated that they had used home remedies and that they had learned “such things” in their childhood, but he also made clear that this familiarity is not comparable to the extra-ordinary knowledge and power of the oracles and gurus. When they visit an oracle, a *puchhwari*, the oracle is likely to “play the rice” on a *thali* (metal platter) by tossing a handful of rice up and down as if it were a winnowing pan. During this procedure the oracle falls into a trance and is possessed by a deity. The deity speaking through the oracle asks all manner of questions, interprets the constellation of the rice on the *thali*, and finally explains the cause of the problem (Sax, 2009, p. 55). When patients visit a doctor, he (both oracles and doctors are usually men) also interrogates the patients with questions that are often as strange as those of the oracle, at times the doctor consults his books and finally he comes up with a diagnosis in unfamiliar terms. When asked about either diagnosis, the patients usually show ambivalence in making sense of it, of being overwhelmed, overburdened or disaffected with any ideological assessment.¹³ In other words, depending on the patients’ or caregivers’ level of acquaintance with the respective religious or medical concepts, there are different degrees of understanding but in many cases they simply defer to the respective experts when asked about the meaning of these explanations.

Against this interpretation an important objection can be raised concerning the reliability of the data. Some people, it could be argued, probably held the pragmatic view of not wanting to elaborate at length on their own perspectives in front of a stranger. Further, one could raise the question as to whether sentences like “What do I know” are

less indicative of indetermination and nescience and more of power-relations implicit in the research situation. This is all the more the case since the examples quoted here were of interviews in the hospital context, where people often are more reluctant to talk as they would amongst their kin and friends. Here, indeed, some people were initially quite reserved or humble in front of a foreign researcher, and to some degree they refrained from taking positions and instead delegated expertise to him, as done in the presence of medical, religious and other authorities. In the end it cannot be known to what degree there existed a “hidden transcript” (Scott, 1990) and peoples’ true convictions were reserved for the offstage invisible to the researcher, to what degree they withheld judgement as a (habitual) way of getting by in asymmetrical power relations. Yet, every attempt was made to break this constellation and long personal narratives indicate a certain degree of success in this respect. There are enough examples where people elaborated upon their personal views in great detail and some conversations continued outside the hospital realm, at the homes of the patients and elsewhere. On this basis, the argument that methodologies and conceptualisations of health-seeking behaviour should acknowledge the desire to get well and provide room for uncertainty, indetermination and nescience on the side of the people nevertheless holds.

Further, the argument presented here does not imply that patients do not differentiate between religious and medical explanations in other spheres of life. The argument is rather that there is no categorical difference between the kinds of beliefs that lead people to approach one expert or the other. Concepts like that of religion can be misleading in this respect since the discourse on religion is often intellectualistic in the sense that it implicitly reproduces theological distinctions. This is particularly the case in the realm of health-seeking behaviour where theological differences become irrelevant, even if they are otherwise of great importance to the people concerned. The anthropologist David Mandelbaum observed – with reference to the similar observations by Beals (1962, pp. 47–48) and Bhowmick (1965) – that a “Hindu villager who would never join in congregational prayers at a mosque will quite readily make an offering at the tomb of a local Muslim saint and ask the spirit to cure him or his child” (1966, p. 1178). This is, however, not the case with respect to all health problems. Most people with a broken leg would not approach a Hindu *pundit* or Muslim *maulvis*. The role of religion within health-seeking behaviour is to be re-conceptualised where sharp distinctions between religion and medicine and between various doctrines of Hindu religion(s) become less important. In India this is often the case with respect to particular epidemic illnesses, such as smallpox, issues such as infertility or chronic illnesses, as well as “those odd symptoms which provoke a rupture within normal social behaviour” (Sébastien, 2009, p. 11). In the final section of this article it will therefore be argued that the role of religion within some patients’ mental health-seeking behaviour is better described and analysed by their pragmatic religiosity.

Pragmatic and scholastic modes of religiosity

Alan Young argued that attempts to elicit illness explanatory models are often “tailored to fit an hypothetical Rational Man rather than real people” (1981, p. 317). What Young argues with respect to explanatory models of sickness should also be considered by those interested in the role of religion within Indian mental healthcare. In public discourse as well as in academia religion is generally understood as a universal and generic concept that describes a distinct social realm (independent of other social realms such as science, art, and politics), as consisting of various distinct religions (Christianity, Islam, Hinduism,

etc.), and with a belief in spiritual beings (non-human agencies, supernatural entities or the like) at its core. Such an intellectualist perspective was described by Linda Woodhead as a “distinctively modern one, with a bias towards modern Christian, especially Protestant, forms of religion” (2011, p. 121). Here it is suggested to shift attention to what Woodhead calls “religion as quotidian practice” and what others call “lived religion” or “everyday religion” (2011, p. 133), by discussing different “modes of religiosity”. The anthropologist Harvey Whitehouse introduced probably the most famous approach to differentiate modes of religiosity in academia (2004). This paper, however, builds on the ways in which the German historian of religion, Ulrich Berner, differentiated between modes of religiosity. Berner observed that most academic studies of religion(s) are overly oriented towards the use of religious language and the respective classificatory schemes. Such studies inherited the self-designations of religions as well as the very concept of religion as identification of their objects of inquiry, this despite the fact that the inherent difficulties of such tendencies have been raised since the 1960s (Berner, 2009). In line with Berner’s argument, this paper proposes differentiating between modes of religiosity that run transversely to the prevailing ways of ordering the religious field. In his attempt to find organising principles independent of theological categories, Berner differentiated between sceptic, fideistic, dogmatic and fundamentalist modes of religiosity. While it is not intended to provide an all-embracing typology of different modes of religiosity, Berner’s observations are complemented here by outlining the non-hierarchical differentiations between a pragmatic and, for the sake of having a contrasting position, a scholastic mode of religiosity. In light of what has been said above, it is important to highlight that this differentiation is neither necessarily connected to peoples’ social status nor is it meant to describe people’s religiosity in general, but to help in assessing their health-seeking behaviour.¹⁴

The scholastic mode of religiosity – that is, the mode of religiosity of some patients and basically all representatives of psychiatric establishment – is characterised by ideological oppositions between secular medicine and religious beliefs and practices as well as differentiations between orthodoxies and orthopraxis within a religious framework that is separated from illegitimate and superstitious practices. These patients and the psychiatrists frequently made value judgements on the rationality and irrationality of certain religious traditions, and privileged “High Hinduism” over “folk religiosity”. Patients with a scholastic mode of religiosity decided what kind of expert to approach for help along these lines. This mode of religiosity owes its name to the sociologist Pierre Bourdieu, who cautioned his colleagues against the “scholastic fallacy” assuming that *all* people interpret the world along the lines of social scientists and theologians (1990, p. 384). This does not mean, however, that members of this group of patients are scholars themselves, nor do they necessarily share the social, cultural and symbolic capital of scholars. This label rather indicates that the role of their religiosity within their health-seeking behaviour happens to match the ways in which religion is often conceptualised by academics. Yet, what might be the case with respect to one group of patients can be misleading with respect those patients this article focuses on.

In contrast to the scholastic mode of religiosity, the mode of religiosity of the other group of patients can be called pragmatic. The Greek word “pragma” is translated by the philosopher Hans-Georg Gadamer – in a way that resonates with the insights of Bourdieu and Young – as “that wherein we are entangled in the praxis of living, [...] that within which we are moving and with which we have to do”. Gadamer adds that “this is an orientation that has been marginalized by the modern ways of usurping the world, structured by the sciences and based on technology”.¹⁵ In such a perspective, religious

actions are not primarily geared to orthodoxies and orthopraxis, but to beliefs and desires rooted in everyday life. Against the perspective of academics and psychiatrists, many patients (family members and friends) are usually less concerned about separations between the different realms of mental health-care. The oppositions between secular and religious treatments or between different representatives of established religions are subordinate factors in their decision-making. The realm of religion is not categorically different from mundane medicine. Religious specialists are approached to perform specific practices for short-term, immediate, empirical, instrumental and largely individual goals independent of divisions between different religious denominations or the opposition between religious and scientific interventions. If one focuses on the beliefs patients have, one finds that Mrs Raturi performed several religious rituals for the same reasons that she took the medicine prescribed by several psychiatrists: she trusted the respective experts in as far as they could help her to find relief from her problems even if she did not fully understand their explanations. The reasons for approaching the doctor are, for people like Mr Rawat and her daughter, the same as those for approaching the religious specialists. Religious healers are seen as experts just as doctors are; both have reputations and experience in initiating and executing (manipulative or coercive) healing powers. A focus on explanatory models or belief systems that draws on the ideological differentiation between medical and various religious approaches easily ignores the most crucial factors in peoples' health-seeking behaviour. These include affordability and accessibility on the one hand, and reputation, trust and perceived outcome on the other. The common factor in all cases is that these decisions are primarily driven by the desire to get well by any means available.

The fact that many studies of health-seeking behaviour fail to adequately address the issues of desire, trust and pragmatic religiosities can be explained by the pervasiveness of scholastic fallacies in academia. Bourdieu outlines how scholars are raised in a life-world of studious leisure and freedom from urgency that leads to presuppositions inscribed in the methodologies and conceptualisations that bracket the things like temporal emergency or economic necessity (1990, p. 382).¹⁶ For people like Mrs Raturi and Mr Rawat it is no problem to visit different therapeutic settings consecutively or at the same time. Their logic of practice is oriented towards practical ends, that is, the actualisation of wishes and desires prevalent in their everyday life (Bourdieu, 1990, p. 384).¹⁷ The apparent contradictions that pervade the peoples' decision-making are only surprising from a scholastic perspective; within Bourdieu's logic of practice they do in fact account for the flexibility and openness of their pragmatic stance. On the basis of this observation, it is a fallacy to ascribe to the people the dispositions and cognitive structures that we tacitly or explicitly inscribe in notions such as religion. Bourdieu rather asks us to "uncover the intellectualist bias that is inscribed in the most ordinary instruments of intellectual work" (1990, p. 385). This fallacy often underlies the assessment of the role of religion in mental healthcare, the explanation of the people's actions as guided by belief systems and the focus on explanatory models as outlined by Young.

Conclusion

While many people apply theological differentiations in various parts of their life it has been argued that within explanations of mental health-seeking behaviour the concept pragmatic religiosity should complement that of religion because of the latter's intellectualist implications and connotations. Along these lines the desire of some people

to get well in any way possible must be acknowledged and implemented in scholarly explanations of peoples health care choices. Mr Rawat and his daughter exemplified the pragmatic stance to try every therapeutic offer available and affordable to them. Furthermore, the answers provided by Mrs Rawat illustrated the necessity to distinguish between beliefs and practices rooted in the everyday-life of people and those based on deference and trust in experts. The different explanations mentioned by her (God, mind, and obscenity) turned out to be suggestions that have been made to her by others. On the one hand she trusted the assessment of healing experts and kin; on the other hand she was very unsure as to what she should make of suggestions. In assessing her health-seeking behaviour, we have to acknowledge how she summarised her position by simply asking: "What do I know?"

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Notes

1. This article primarily draws on an ethnographic study conducted over nine months in the psychiatric wing of an urban hospital in North India in 2010. The overall question underlying the research concerns the role of religion within mental healthcare in India, as perceived by psychiatrists, patients, and care-givers. Besides participant observation, 93 self-designed questionnaires were jointly filled with the patients and 68 semi-structured narrative interviews were conducted in Hindi by the author (in many cases accompanied by a resident doctor). In all cases written informed consent was given.
The author further draws on research on traditional as well as institutionalised mental healthcare in India since 2005. This includes visits to different mental healthcare sites such as Balaji Temple (Mehandipur), the Vineyard Workers' Church (Pune), the Mirawali Dargah (Ahmednagar), Mahanubhav Temple (Phaltan), Farshiwale Baba (Nasik), and Mira Datar Dargah (Palanur), interviews of patients, healers, psychiatrists, mental-health activists, representatives of NGOs and self-help groups in Maharashtra and Delhi, as well as extensive research on the criticism of religious healing practices in public discourse.
2. Since the fieldwork was based primarily in a hospital the people are referred to as "patients".
3. "Folk" is thereby used as an umbrella term for a set of quite heterogeneous practices. The places where they are applied are often referred to in the literature as Traditional Healing Centres (THCs), a term which includes private homes as well as the public treatment centres of healers, astrologers, tantriks, and oracles; or religious specialists practicing at Hindu temples, Muslim dargahs, and Christian churches. The notion "folk" in this respect was made popular by the work of Kleinman. He differentiates between three overlapping parts within a (local) health care system: the popular, the professional and folk sector. The folk sector consists, in his scheme, of non-professional, non-bureaucratic specialists whose knowledge is usually passed down orally from healer to healer often through family tradition (see Kleinman, 1980, p. 59).

4. The borders between these realms are fuzzy given that there are practitioners who combine and fuse different therapeutic approaches (see Connor & Samuel, 2001). The crucial role of the families providing the large majority of daily care is unfortunately widely ignored.
5. It is important to add that the concept of mental health is not regularly applied in the folk sector. Representatives of the folk sector also deal with financial problems, runaway children, runs of bad luck, family problems, and so forth. Elsewhere it has been argued that it would be as wrong to reduce all the practices within the folk sector to mental healthcare, as it would be to ignore their important contributions to mental healthcare in India (Quack, in press).
6. Furthermore, there are the Short Explanatory Model Interview (Lloyd et al., 1998), the Mental Distress Explanatory Model Questionnaire (Eisenbruch, 1990), and the Barts Explanatory Model Inventory (Bhui, Rüdell, & Priebe 2006). For applications of these research tools in India see Banerjee & Banerjee, 1995, p. 219; see also Campion & Bhugra, 1997; Banerjee & Roy, 1998; Nieuwsma, Pepper, Maack, & Birginheir, 2011; Paralikar et al., 2011. Religious explanations might refer to Karma; bad or prior deeds or parent's deeds; the will of God(s); fate; deities and demons; the evil eye; astrological factors; spiritual deficits; sorcery; or other supernatural factors (see Nieuwsma et al., 2011, p. 549).
7. For the most thorough analysis to date see Skorupski (1976).
8. "Dusting" (*jhārna* or *jhār-fuk*) refers to a practice where an affliction is swept out of the body with a broom; it is often used as an umbrella-term for all kinds of healing rituals.
9. Further factors to be listed are approachability and reputation of the expert, social norms and social relationships, potential social consequences and stigma, and further behavioural patterns and habits prevalent in the respective community. The way in which experts interacted with the patients was also crucial. If one doctor was considered to be incompetent (e.g. because he adjusted the medicine too often, or if the prescribed medicine was considered too expensive) patients would consider stopping the medication and/or going somewhere else.
10. It can be hypothesised that different kinds and degrees of desire are connected to the length and severity of the problems. In the case of Mrs Rawat and her father, after 15 years in search of help, their desire for improvement oscillated between hope and despair.
11. Statements like "What do I know" are often rhetorical parentheses with no further meaning. But in the cases presented here the point was clearly to express indetermination and nescience on the one side and a description of the scope of the health-seeking attempts on the other.
12. Talking about half understood-beliefs might sound problematic to those acquainted with the criticisms of the use of the notion "belief" in anthropology in general, and medical anthropology in particular (Good, 2001, pp. 20–21). The apparently knowing anthropologist ascribes half-understood beliefs to the believing object. But Sperber's point is quite the opposite. First, his paradigmatic example of half-understood reflective beliefs is taken from Christianity: the dogma of the Holy Trinity. Second, his argument necessarily implies that many (reflective) beliefs in the realm of science are only partially understood by scientists themselves. The author, for example, believes that nuclear fission is a way to generate a tremendous amount of energy, but definitely does not have a full grasp of the way it works. He cannot think *with* atoms, neutrons and photons the way the experts can. Nevertheless, he thinks *about* nuclear fission a lot. He even protests against nuclear reactors, because he considers those experts who consider this method of generating energy as dangerous to be more trustworthy, compared to those who do endorse nuclear energy.
13. In a comparable context Kalpana Ram speaks of "pre-familiarity" with respect to Siddha and Ayurvedic paradigms, that does "not depend on the capacity of villagers to exhibit the same kind of knowledge as the intellectual specialists of Siddha or Ayurvedic medicine" (2010, p. 203).
14. The mode of religiosity can hereby change over time. One father was initially indifferent to diverse ways of explaining and treating his son's problems, but the great the number of experts they had consulted without success over the years, the more convinced he became that the problem was such that it exceeded the limited reach of doctors.
15. "[D]as, worin man in der Praxis des Lebens verwickelt ist, [...] worin man sich bewegt und womit man es zu tun hat. Das ist eine Orientierung, die in der modernen, durch die Wissenschaften strukturierten Weltbemächtigungen und in der auf sie gegründeten Technik an den Rand gedrängt ist" (Gadamer, 1985, p. 6).
16. To paraphrase a section from Bourdieu by replacing the word "school" with "mental health": The sociologist can easily forget the gap that separates the interest that he may have in

the mental health [school] system as a scholar who simply wants to understand and to explain, and that consequently leads him to set a 'pure' gaze on the functioning of the mechanisms of differential elimination according to cultural capital, and the interest that he has in this same system when he acts as a father concerned with the future of his children (1990, p. 383).

17. Ram criticises a focus on pragmatism that suggests that the lay subject has available, as if displayed in front of her, all the branches and varieties of medicine from which to choose. "Informed by a strategic consciousness, and with perfect awareness, the lay subject proceeds to put together a package of curative possibilities" (2010, p. 202). Obviously, neither the notion of pragmatic religiosity nor Bourdieu's logic of practice implies such an idea.

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