# Chapter 4
# Social Psychiatry in India-Heralding a Paradigm Shift

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**Abstract** Social psychiatry in India is heralding a paradigm shift in mental healthcare. The traditional Western-based model has become unavailable, unaffordable and inaccessible to large sections of the population—especially the marginalized, in India and many of the Low and Middle Income (LAMI) countries. This calls for a paradigm shift in our approach to medicine and psychiatry with greater focus on social factors and social determinants of health. Mental health is of low priority in most countries with poor investment, poor infrastructure and inadequate personnel. Social psychiatry has started receiving greater attention in India and the world heralding a new approach to mental healthcare, which is inclusive of all. This paper discusses the roots of social psychiatry in India, its history and relevance, the contributions to the Indian Association for Social Psychiatry, milestone studies, stigma, suicides, the role of spirituality and religion and other related social psychiatry topics from India, which is relevant to Asia and the rest of the world.

**Keywords** Social Psychiatry · India · History · Studies · Stigma · Suicides · Spirituality paradigm shift

## 1 Introduction

Modern medical care in India has often tried to imitate the Western model with an emphasis on sophisticated technology, advances in pharmacological treatment and high-tech hospitals. However, the large majority of the population remains left behind, especially those who cannot afford costly medical treatments and those without medical insurance. This calls for a paradigm shift in our approach to medicine and psychiatry with a greater focus on social factors and social determinants of health.

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Mental health has long been neglected in India and most of the Low and Middle Income (LAMI) countries. Psychiatry and mental health have remained out of the focus of governments, policymakers and administrators for far too long. At the same time, the burden of disease due to mental illness in these countries, as everywhere else, has been huge. Social psychiatry must receive greater attention in India and the world, heralding a new approach to mental healthcare which is inclusive of all.

## *1.1 Roots of Social Psychiatry in India*

Social psychiatry is a discipline that focuses on the social dimension of mental health, mental illness and mental healthcare. Social psychiatry uses concepts and methods of social sciences, including psychology and anthropology, to investigate social factors in influencing and relevant to the occurrence, expression, course and care of mental disorders. The roots of social medicine can be found in the ancient Indian civilizations. The earliest roots of social medicine can be found in the ancient texts of Ayurveda. The focus of the physician in Ayurveda is on the patient's health rather than the disease. There is often a stipulated harmonious framework for health and life. There is a greater emphasis on quality of life rather than just the curative aspect of disease. The treatment approach in Ayurveda is person-centred and often takes into consideration the person as a whole. The same would apply to ancient Greek philosophy. Socrates, Plato, Aristotle and Hippocrates talked about the importance of the social paradigm of health. The concept is summarized in Socrates's quote, "If the whole is not well, it is impossible for the part to be well" (Mezzich, 2007).

In India, Hinduism encourages people to achieve a certain life purpose, often closely tied to fulfilment in the afterlife. The objective of earthly life is to respect the laws of Dharma and gain benefit from the cycle of life and reincarnation. In the same fashion, religious rites give expression to communal beliefs, and everyone's self-perceived role becomes a physical manifestation of these beliefs.

## *1.2 History of Social Psychiatry in India*

The Indian Association for Social Psychiatry (IASP) completed its 40th year of existence in 2024. The Association was registered on 6 June 1984 (Regn. No. 1178/84) under the Societies Act of India. It has a membership of more than 1000. Members include mental health professionals from different fields, including psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses.

The association supports continued medical education through its yearly national conference—The National Conference of Indian Association for Social Psychiatry (NCIASP), along with multiple other CME and international conferences. IASP promotes excellence in research in young scholars and honours the lifetime achievements of senior professionals by providing yearly national awards in the field of

psychiatry and mental health during the annual national conference. The website of the association www.iasp.org.in was launched in 2008.

The Association came into being following certain fortuitous circumstances. During the transcultural psychiatry meet held in Madurai in August 1981 under the chairmanship of Professor A. Venkoba Rao, a group of behavioural scientists concerned with the relative neglect accorded to the study of social factors in mental illness in India decided to constitute an organization specifically devoted to further this cause. At that meeting it was generally felt by many professionals that there was a great need in the country to have a separate professional organization for social and/or transcultural psychiatry. Such an organization could also examine the interface between culture and personality and be conducive to the scientific study of the social issues relevant to the country and the society, in addition to examining the social and transcultural factors in the phenomenology, course, outcome and treatment of psychiatric disorders. The organization would primarily attempt academic and intellectual exercises and bring a multidisciplinary approach to bear on these issues. As a result in January 1982 in Madurai, an ad hoc committee was formed with Dr. V.K. Varma as the convener and Dr. Kirpal Singh as the chairman. This committee met at different places and discussed various aspects and organizational matters. Finally, The Indian Association for Social Psychiatry was formed on 14 January 1984 at Ranchi. Its constitution and by-laws were adopted, and the office-bearers were elected. Dr. A. Venkoba Rao was the first President and served in that capacity between 1984 and 1986. The Association is committed to studying the influence of culture in the causation, treatment and prevention of behavioural disorders; to promoting national and international collaborations among professionals related to social psychiatry, and making the knowledge and practice of social psychiatry available to other sciences and to advance the physical, social and psychological well-being of mankind.

The Association has been holding regular conferences, which have been held in various cities representing different parts of the country. Each conference was held with a socially relevant theme and included symposia, free papers and a number of guest lectures and popular lectures. The first annual conference was held in Kodaikanal in February 1985 under the chairmanship of Dr. A. Venkoba Rao and the second in Chandigarh. Prof. Shridhar Sharma was the founder member and President-Elect of IASP along with Prof. A. Venkoba Rao. Since then, the Indian Association has grown much stronger and is playing a bigger role in the growth of the World Association for Social Psychiatry (WASP) (https://iasp.org.in/about-iasp/). The Indian Association for Social Psychiatry (IASP) became formally affiliated to the WASP in October 1985 held the Regional Symposium of WASP in New Delhi in February 1989 and hosted the XIII WASP Congress in New Delhi in November 1992. The IASP hosted the Regional Symposium of the Transcultural Psychiatry Section of WPA in March 1995. It became a member society of the World Psychiatric Association (WPA) in June, 1993. IASP is one of the most active members of the WPA. Through its own activities and through the activities of its members, the IASP received greater recognition and visibility at the global level and at the level of the WPA and WASP. Professor S.D. Sharma, a past President of IASP has also served as the President of the World Association for Social Psychiatry. Prof Roy Abraham Kallivayalil, the past

President of IASP and Secretary General of WPA and President of WASP, contributed to a great extent to the development of social psychiatry in India.

The 20th World Congress of Social Psychiatry, in 2010, was organized under the leadership of Driss Moussaoui. The theme was "Promoting Integral of Health and Mental Health." The General Assembly elected Driss Moussaoui as President, Tom Craig as President-elect, and Roy Abraham Kallivayalil from India as secretary-general and resolved to revise the statutes. The event was a grand success with about 700 delegates participating.

The 21st Congress, Lisbon, was held in 2013. The theme was "The Biopsychosocial Model: The Future of Psychiatry." Organized by Maria Luisa Figueira. Tom Craig was elected as President, and Roy Abraham Kallivayalil as President-Elect.

The 22nd WASP Congress was held in New Delhi from November 30 to December 4, 2016, under the chairmanship of Prof R K Chadda, past President of IASP. More than 1100 delegates from 50 countries participated. The Congress theme was "Social Psychiatry in a Rapidly Changing World." With more than 1,000 delegates attending, it was one of the most successful WASP Congresses to date. The General Assembly elected Roy Kallivayalil as the President, Rachid Bennegadi as President-Elect, Fernando Lolas as secretary-general and Marianne Kastrup as treasurer.

The 23rd WASP Congress, Bucharest, was held from October 25 to 28, 2019. The theme was "Social Determinants of Health/Mental Health and Access to Care." Nearly 700 delegates from 66 countries participated. Roy Abraham Kallivayalil was the Congress President and it was organized under the dynamic leadership of Doina Cozman and Alexander Paziuc. The inauguration and release of the first issue of the World Journal of Social Psychiatry was one of the highlights of the Congress. Debasish Basu (Chandigarh, India) is the founding editor. The General Assembly elected Rachid Bennegadi as President, Vincenzo Di Nicola as President-Elect, Rakesh Chadda as secretary-general and Andrew Molodynski as treasurer. IASP has organized three World Congresses of Social Psychiatry and has given two Presidents to the WASP. India has also made an impressive contribution to the cause of the WASP (https://www.worldsocpsychiatry.org).

## *1.3 Indian Journal of Social Psychiatry*

The first issue of the Indian Journal of Social Psychiatry was published in 1986 under the editorship of Dr B.B. Sethi. Indian Journal of Social Psychiatry, a peer-reviewed online journal with a quarterly print compilation of issues. The journal focuses on issues related to health, ethical and social factors in the field of social and community psychiatry and is highly acclaimed by the mental health academia. The journal is open-access and is indexed by Baidu Scholar, CNKI (China National Knowledge Infrastructure), EBSCO Publishing's Electronic Databases, Exlibris—Primo Central, Google Scholar, Hinari, Infotrieve, National Science Library, ProQuest, TdNet and Kudos.

## 1.4 World Association of Social Psychiatry Congresses in India

XIII New Delhi, India 1992
XVII Agra, India 2001
XXII Delhi, India 2016

## 1.5 Presidents of the World Association of Social Psychiatry from India

2001–2004: Shridhar Sharma, India
2016–2019: Roy Abraham Kallivayalil, India
2025–2028: Rakesh K Chadda, India

## 1.6 WASP Member Societies

The organization of Member Societies within WASP is a relatively new development. Julio Arboleda-Flórez, President at the time, constituted the New Member Societies Committee in 2010, considering the importance of creating interest in new countries to develop their national Social Psychiatry Societies. Roy Abraham Kallivayalil, India, was the chair of this committee (Kallivayalil R. Notes from WASP President's desk, 2021).

A workshop on "National Social Psychiatric Societies: Best Practices & Lessons Learned" was held during the WASP Congress in Marrakech, October 2010, in which the following presentations were made:

1. Roy Abraham Kallivayalil (India): "Cultural Perspectives and Networking among National Social Psychiatry Societies."
2. J. K. Trivedi (India): "Indian Association for Social Psychiatry."

This was the beginning of the organization of WASP into Member Societies. The 2016–2019 WASP-EC, under the leadership of President Roy Kallivayalil, considered membership development as a priority item, and by the 2019 General Assembly, eight more Member Societies were added, taking the strength from 19 to 27. This was a significant leap forward in spreading the WASP movement to all parts of the globe (Kallivayalil, 2021).

## *1.7 Relevance of Social Psychiatry in India*

The study of social factors in mental disorders has been at the forefront of psychiatric literature in the West. In India, though not totally absent, it has failed to be expressed in a coherent fashion. Epidemiological studies from India indicate the possible implications of factors like, social class, marital status, caste considerations, sibling position and family structure in relation to certain psychiatric disorders.

It has also been pointed out that the industrialization and modernization of India is changing the face of India from a predominantly rural and agrarian society to an urbanized one—the most telling impact of which is on the core of our society, i.e. the family which seems to be undergoing a transition from traditionally a joint pattern to a nuclear one. This phenomenon may be related to the increased frequency of mental disorders. At a clinical level, too, it has been emphasized that our patients express their mental problems in a pattern that is socio-culturally determined. Consequently, one hears of a need for therapies (e.g. psychotherapy) that are socially and culturally relevant. At this juncture however, it would be appropriate only to underline the fact that even though indirect evidence exists to link social factors to mental disorders in India, yet the attention paid has not been of a very high order. India is an excellent place for the study of the social and cultural processes as they relate to behaviour and more so now since the change from a conservative to a modern India is occurring at an unprecedented rate (Trivedi, & Kailash, 2012).

Much of the professional output of psychiatrists, psychologists and other mental health professionals in India can be subsumed under the rubric of social psychiatry. Previously, most Indian psychiatrists cut their psychiatric teeth either in the West or on the Western model. On returning to their home country, they often encountered significant difficulties in applying the Western model to the ground realities in India. "One major concern of the Indian psychiatrists was to translate modern psychiatry as it has evolved in the West to the Indian setting. This exercise has covered topics such as the epidemiology, types, manifestations, course and outcome of mental illness. Comparing the Indian situation to the Western textbooks has been a prime concern, particularly of the Indian psychiatrists trained in the West, and to a lesser extent all psychiatrists, as the Western frame of reference continues in their training and education."

Varma, in his write-ups of the souvenirs of the first (1985), the second (1986) and the fifth (1989) annual conferences of the IASP, has drawn attention to the social issues and problems of particular relevance to India. "The great diversity of the Indian culture both in temporal and spatial contexts" has been pointed out, particularly in view of the problem of national integration. In the national context, "problems of poverty and economic deprivation, technological backwardness, social and economic inequalities, urbanization, industrialization and social change, population control, cultural diversity and national integration and intra societal conflict and violence have been particularly identified as social problems. Increasingly, attention has also been drawn to crimes against women, including dowry death and rape and to the legal situation regarding attempted suicide and drug abuse" (Varma, 2012).

In India, the role of socio-cultural factors in mental health is indispensable. Rapid urbanization and growing technology have cut across national boundaries and are continuously testing the ability of people to adapt to this modernization. Disappearance of the joint family and the support system that comes along with it is resulting in the depletion of one of India's most valued resources. Stigma, problems of the deprived and socio-cultural issues specific to women are areas of interest in developing countries like India but also in developed countries. Family care and burden, disability, suicide including farmers suicide, religion, spirituality, help-seeking behaviour, pathway of care and preventive psychiatry are areas of specific interest in India and a great deal of work still needs to be done in these areas (Trivedi & Kailash, 2012).

## *1.8 Milestone Studies Related to Social Psychiatry in India*

In India, more than 90% of the severely and chronically mentally ill reside with their families (Thara et al., 1994). Family members are the key persons involved in the decision-making process regarding treatment and are primarily responsible for continued care and for ensuring adherence to treatment. In this area, one of the earliest studies was the measurement of expressed emotion (EE) in an Indian sample in comparison with the West as part of the WHO Determinants of Outcome project. It was found that in Indian families, EE was lower than in London families, and this may account for better outcomes for schizophrenia often observed in India (Wig et al., 1987).

Several scales on attitudes and burdens have been developed in India. Some of them are the Family Burden Scale by Pai and Kapur (Pai & Kapur, 1981) and the Burden Assessment Scale (BAS) developed by the Schizophrenia Research Foundation (SCARF) (Thara, Padmavati, et al., 1998). Attempts have been made to correlate the burden with the functioning of patients as well. Loganathan and Murthy, in 2008, assessed functioning in 100 patients with schizophrenia and the burden and methods of coping of their primary caregivers (Loganathan & Murthy, 2008). Fatalism and problem-solving were the two most preferred ways of coping. Problem-focused coping, i.e. problem-solving and expressive action, decreased the burden of caregivers, while emotion-focused coping, i.e. fatalism and passivity, increased it.

Rammohan et al. found that families of persons with schizophrenia used denial and problem-solving strategies (Rammohan et al., 2002). The strength of religious belief and perceived burden were significant predictors of the well-being of carers. The authors emphasized the need to reinforce religious coping methods as a component of family intervention programmes in India.

Murthy et al. showed reduction of burden on the family and better functioning of the patients with the onset of regular treatment in untreated or irregularly treated patients in a rural community (Murthy et al., 2005). In India, family burden is also reported by carers of persons with dysthymia, obsessive–compulsive disorder (OCD) and bipolar disorder (Chakrabarti et al., 1993). In the WHO Collaborative Study on

Strategies for Extending Mental Health Care in four developing countries (Colombia, India, Sudan and Philippines) for the social burden caused by mental illness in a family member, the social burden was found to be greatest in urban areas (Harding et al., 1983).

With the breaking up of joint families and the emergence of nuclear families and working women, families started seeking professional help to cope with mentally ill members of the family. Kulhara et al., in a randomized controlled trial of family psychoeducation, found that it was significantly better than routine outpatient care (Kulhara et al., 2008). The psychoeducational intervention package used was a simple, feasible and inexpensive viable facet of intervention for schizophrenia in India.

Family involvement in the process of care in India has led to the formation of family support groups in the last decade. They consider themselves as micro-organizations demonstrating the virtues of "small is powerful" and advocating family empowerment as the core of emotional strength and support to those with a disorder (Srinivasan, 2003).

## 2 Disability

Although the disability associated with mental illness was placed on a par with other disabilities in the Western world, and though we had an act for Persons with Disabilities since 1996, very little emphasis was given to India. Certification of disability of mental disorders was not regularly carried out, and as a result, many disabled persons did not get the benefits despite their eligibility.

The Indian Disability Evaluation and Assessment Scale (IDEAS) developed by the Indian Psychiatric Society was a significant leap in this regard (Thara, Rajkumar, & Valecha, 1988). Chaudhury et al. compared the disability of seven conditions using IDEAS in the north-Western state of Assam and found that while schizophrenia was most disabling, it was closely followed by alcohol abuse and OCD (Chaudhury et al., 2006). Disability in the occupational sphere was the most important concern since job not only provides self-respect and self-esteem but also a means of family income. Many rehabilitation programmes in India are therefore started towards increasing work-related skills and job placement efforts.

## 3 Stigma of Mental Disorders

The stigma of mental illness is as old as the disorder itself and its negative consequences seem to play a role in the outcome of many disorders. In India, caregivers and family members are subject to as much stigma as the patients. The nature and degree of stigma experienced by persons with schizophrenia was studied in Chennai (Srinivasan & Thara, 2001). Marriage, fear that neighbours would treat them differently

and the extra efforts they had to make to hide the fact of mental illness from others were the predominant concerns. While 90% of marriages in India are "arranged" by the families, caregivers and family members are subject to greater stigma than the patients. If the fact of mental illness in a family is known to others, it could also jeopardize the chances of other members of the family getting married. In this study, stigma was higher if the patient was female and women carers perceived more stigma.

Another study on women with schizophrenia whose marriages had been broken revealed that families perceived this as a "dual tragedy" and felt very stigmatized (Thara et al., 2003a, b). Very few of these women received any support from their husbands after the onset of illness, and many were sent back to their parental families. Many women considered the break-in marriage more stigmatizing than schizophrenia since they felt socially ostracized because of the failure of their marriage. Many hoped that someday the husband would take them back.

## *3.1 Stigma in Urban/Rural Areas*

Stigma is not confined to urban areas. An interesting ethnographic piece of work by Jadhav et al. showed significantly higher stigma among rural Indians, especially those with a manual occupation, and many appeared to deploy a punitive model towards the severely mentally ill (Jadhav et al., 2007). The urban group, in contrast, expressed a more liberal view of severe mental illness. Loganathan and Murthy also report the stigma of mental illness in rural areas (Loganathan & Murthy, 2008). While urban respondents of Karnataka (in southern India) felt the need to hide their illness and avoided illness histories in job applications, rural respondents experienced more ridicule, shame and discrimination.

## *3.2 Stigma Related to the Causation of Illness*

Beliefs about the causation of mental illness can clearly influence the attitudes that families adopt towards patients and their help-seeking behaviour. Indian families have been typically described as often believing in causes like supernatural forces and therefore seeking help from magico-religious healers. In the changing mental health scenario in India, this impression was tested by Thara and Srinivasan by interviewing the key relatives of 254 chronic schizophrenia patients and asking them to name the causes they believed were responsible for the illness in their family members (Thara & Srinivasan, 2000). A supernatural cause was named by only 12% of families and as the only cause by 5%. Psychosocial stress was the most commonly cited cause, followed by personality defects and heredity. Urban families of patients rarely subscribe to the idea of supernatural causation of the illness. Rather, their causal attributions tend to be more biological and psychological.

Charles et al. in their study in Vellore in Tamil Nadu state observed that patients and families simultaneously held multiple and contradictory beliefs about the causation of illness and its treatment (Charles et al., 2007). A majority of respondents had approached at least two systems of healing, which included allopathic and traditional/magico-religious/religious modes. Stigma scores of patients were associated with a belief in disease models, as well as karma and evil spirits as a cause of illness. The authors argue that while planning mental health services, it should be kept in mind that beliefs regarding attributions, explanatory models and stigma play no small role in the help-seeking pattern of patients with mental disorders.

## *3.3 Suicide in India*

Suicidal behaviour with consequent fatal outcomes has become an important public health problem in India. On average, 100,000 people per year commit suicide in India. Attempted and completed suicide was held to be a crime by an antiquated Indian law. India ranks 43rd in descending order of rates of suicide with a rate of 10.6/100,000 (Lee & Ortiz, 2015). A recent survey conducted by NIMHANS in 12 states of India on a random sample of 40,000 people shows that 1 million Indians are at high risk of suicide, and more women are found to be harbouring thoughts of suicide (NIMHANS: One crore Indians at high risk of suicide. The New Indian Express 10th September 2017).

## *3.4 Risk Factors for Suicide*

Multiple factors impinge on the risk of suicide. In India, the causes that are reported for suicide differ in police records and in clinical experience. Maladjustment with significant family members, financial problems and domestic strife have been cited as the most important causes of suicide attempts in India (Kumar et al., 1997).

Marital conflict is the most common cause of suicide among women, while interpersonal conflict is the most common cause among men (Banerjee et al., 1990). In Ponnudurai and Jayakar's study 12.5% females have committed suicide due to maladjustment with alcohol and drug abusing husbands (Ponnudurai & Jayakar, 1980).

An interesting finding, rarely seen in the West, is the high rate of suicide associated with sexual abuse (80 cases) and illegitimate pregnancy (49 cases) in India (Accidental Deaths & Suicides in India, 2019. New Delhi: Ministry of Home Affairs, Government of India; 2021. National Crime Records Bureau). This may be a reflection of cultural taboos related to sexuality in India. Chronic pain and illness are featured as a common reason in some studies (Srivastava et al., 2004).

A similar trend is seen for attempted suicide with interpersonal conflict, financial stressors, and educational burden being the most common triggers (Mohanty et al., 2007).

## 3.5 Mental Disorders and Suicide

In India, the relationship between suicidal behaviour and psychiatric diagnosis has always been a matter of debate. Western literature reports that about 90% of all those who commit suicide suffer from a psychiatric disorder (Bretolete & Fleischmann, 2002).

Studies in India show varying results with rates of psychiatric disorders ranging from 9.5 to 24.9% (Manoranjitham et al., 2010). Unfortunately, no reliable data are available from India on psychiatric diagnoses of suicide victims. In a series of studies on suicide attempters by the author, the predominant psychiatric problem was major depression closely followed by adjustment disorder and alcohol abuse/dependence. Several of these attempts were of impulsive type and were done within hours of some triggering factor (Kumar, 2013).

## 3.6 Farmer Suicides

Suicides in the farming industry continued to increase in 2022. According to the latest report of the National Crime Records Bureau (NCRB), 11,290 suicide cases were reported across the country last year. This is an increase of 3.7 per cent from 2021, when 10,281 deaths were reported. It is an increase of 5.7 per cent when compared with 2020 figures (National Crime Reports Bureau, ADSI Report Annual—2023, Government of India). The actual numbers may be larger, partly because the NCRB defines "farmers" as men (but not women) who work in agriculture.

In a study on farmer suicides in the Vidarbha region, Behere and Behere employed the psychological autopsy method to understand the phenomenon and identified the following reasons for farmer suicide (1) chronic indebtedness and inability to pay debts accumulated over the years, (2) economic decline that leads to complications, family disputes, depression, alcoholism, etc., (3) compensation following suicide helps the family repay debts, (4) grain drain and (5) rising costs of agricultural inputs and falling prices of agricultural produce (Behere & Behere, 2008).

In a psychological autopsy study conducted in Wayanad, an agrarian district of Kerala, factors contributing to the high rate of suicide in this vulnerable population were economic adversity, exclusive dependence on rainfall for agriculture, alcohol abuse, depression and possible monetary compensation to the family following suicide (Kumar, 2011).

## 3.7 Religion, Spirituality and Suicide

Religion seems to be a protective factor both at the individual and societal levels. The psychological autopsy study in Chennai by Vijaykumar and Rajkumar found that the lack of belief in God was over six times more common in completed suicides than in controls (Vijayakumar & Rajkumar, 1999). Victims had less belief in God, changed their religious affiliation and rarely visited places of worship. Eleven per cent had lost their faith in the three months prior to suicide (Vijayakumar, 2002). This finding was replicated by Gururaj et al. in their psychological autopsy study in Bangalore (Gururaj et al., 2004).

Altruistic suicide has a long history in India, even being noted in the Dharmashastras, an ancient religious text. In ancient India, two forms of altruistic suicide were practiced. One was Jauhar, a kind of mass suicide by women of a community when their menfolk suffered defeat in battle; the other was Sati, the suicide of a widow on the funeral pyre of her husband. The practice of Jauhar ended with the fall of the Muslim rule and the practice of Sati is against the law, although stray cases are still reported. The act of Sati is now seen as suicide, not as an altruistic act, and there are laws against abetment and glorification (Thara & Padmavati, 2010).

## 3.8 Mental Health, Religion and Help-Seeking

Religion and religious practices play a very important role in every aspect of life in India. Seeking help from a religious setting or faith healers is a common behaviour pattern among those suffering from mental illness (Campion & Brugha, 1997) (Sharma et al., 2007). The variety and diversity of traditional healthcare practices are an indication of the great influence that socio-cultural practices have on healing systems. The several sources of traditional and religious help available range from places of worship like temples, dargahs and churches to the ubiquitous roadside indigenous faith healer.

In a methodologically rigorous study in a rural population in south India, Thara et al. found that the explanations offered for psychoses, depression and hysteria were possessions by evil spirits, devils or a curse of God, warranting a religious or traditional mode of treatment (Thara et al., 1998). On the other hand, epilepsy and mental retardation were understood as having an organic basis. Another general population study, conducted in a rural area in northern India, found that magico-religious systems were utilized by a substantial number of persons who attributed the illness to supernatural causes (Sharma et al., 2007).

The coexistence of several kinds of healers treating mental illness has been well documented in India (Sharma et al., 2007) (Kapur, 1979). Healing methods included penance, visits to a shrine, astrology and spirit possession to negotiate with the evil spirit. The choice of a particular healer is often made because of the perceived effectiveness of the healers in dealing with mental illness. This choice may be independent

of the level of education or the patient's belief in the cause of illness (Jiloha & Jugal, 1997).

The effectiveness of healing sites has been described in ethnographic studies. Raghuram et al. used standardized clinical assessments of psychopathology in a temple in south India (Raghuram et al., 2002). A near 20% reduction in observed psychopathology scores was noted. Family care givers also thought that most of the subjects had improved during their stay in the temple. The cultural power of residency in the temple, known for its healing potency, may have played a part in reducing the severe psychotic symptoms of the subjects. In another study, several ritualistic practices employed at various centres were documented (Padmavati, 2005). These included making offerings (money, in kind), engaging in physical acts like going around the place of worship, fasting, eating raw fruits like lime or letting oneself be chained. These rituals were viewed as necessary for recovery. These ritualistic practices appear to have a wide framework, incorporating social, religious and mythical domains, allowing the patients to express and resolve social and psychic suffering (Pfleiderer, 1988).

The pattern of utilization of traditional and indigenous systems has prompted the initiative of a formal collaboration between religious systems and the formal psychiatric care system. A rehabilitation centre was established in a place called Gunaseelam in south India, within the premises of a Hindu temple known for its religious healing of the mentally ill for over 200 years. A quasi-experimental integrated intervention programme was designed incorporating pharmacotherapy, rehabilitation strategies and spiritual (ritualistic) strategies (which have been followed as part of the temple's healing practices). Assessments of psychopathology, family burden and quality of life of caregivers indicated an improvement after the interventions. The authors hypothesized that the improvement may have been the result of a combination of psychiatric interventions with the existing spiritual and ritualistic strategies (Stanley & Shwetha, 2006).

## *3.9 A Brief Overview of Epidemiology of Mental Illness in India*

Epidemiological studies report prevalence rates for psychiatric disorders varying from 9.5 to 370/1000 population in India. These varying prevalence rates of mental disorders are not only specific to Indian studies but are also seen in international studies (Math & Srinivasaraju, 2010). In National Mental Health Survey the overall weighted prevalence for any mental morbidity was 13.7% lifetime and 10.6% current (National Mental Health Survey (India)[56]

According the National Survey on Extent and Pattern of Substance Use in India, alcohol is the most common psychoactive substance used by Indians (14.6% of the population between 10 and 75 years of age uses alcohol). After Alcohol, Cannabis (2.8% of the population) and Opioids (2.1% of the country's population) are the

next commonly used substances in India. About 1.08% of 10–75 year old Indians (approximately 1.18 crore people) are current users of sedatives (non-medical, non-prescription use). Other categories of drugs such as Cocaine (0.10%) Amphetamine Type Stimulants (0.18%) and Hallucinogens (0.12%) are used by a small proportion of country's population (National Survey on Extent and Pattern of Substance Use in India' 2019) (Magnitude of Substance Use in India, 2019).

The treatment gap for mental health in India is high, with 70–92% of people with mental disorders not receiving treatment. This is due to a lack of awareness, stigma and a shortage of mental health professionals (Singh, 2018).

**Indian contributions to social psychiatry**: There are many Indians who have made outstanding contributions to social psychiatry. Some of them are:

R L Kapur (1938–2006): He was a colossus in Indian Psychiatry, an original thinker and a great scientist. After his training in psychiatry in India, he went over to UK, had further training and research there, came back to India and worked in psychiatric settings in a medical school and a neuroscience hospital. Afterwards, he took keen interest in social science research apart from psychiatry. He is considered as one of the great beacons of social psychiatry in the world and especially from Asia (Kallivayalil et al., 2025). His contributions to psychiatric epidemiology, social and community psychiatry, postgraduate training and qualitative research on diverse social issues including violence and terrorism makes him an outstanding luminary in social psychiatry (Bibleau & Corin, 2010) (Bhide, 2006). His notable publications are: The Great Universe of Kota (1976) (Carstairs & Kapur, 1976), Indian Psychiatric Interview Schedule (1974), Indian Psychiatric Survey Schedule (1974), The role of traditional healers in mental healthcare in rural India (1979), Community involvement in mental healthcare (1994), Violence in India: A psychological perspective (1994), Qualitative methods in mental health research (1999) and Another Way to Live (2009).

Vidya Sagar (1909–1978) is a legendary figure in Indian Psychiatry who had dedicated his life to the service of the people first in the state of undivided Panjab and later in Haryana, India (Malhotra & Kallivayalil, 2025). Community psychiatry has come a long way in India and the building blocks were laid by Vidya Sagar, in 1950, by constructing tents and involving family members in the treatment of persons with mental illness in Amritsar. During the horrific times of partition of India, when a huge number of patients with mental illness were sent to Amritsar and kept in army barracks, he displayed phenomenal devotion to their care (Sethi & Batra, 2010). Vidya Sagar was the most renowned social psychiatrist of his times, a humanist, full of compassion for the mentally ill and their families, a self-less man, revered by his patients. He was ahead of his times in propagating family psychiatry, community psychiatry, psychoeducation and mass psychotherapy, in times when psychiatry was primarily practiced in mental hospitals.

A Venkoba Rao (1927–2005): A great teacher and an inspiring speaker, he was Chairman of the Institute of Psychiatry, Madurai Medical College for 23 years. He had many books authored or edited by him including *Psychiatry of Old Age in India*, *Depression and Suicide Behavior*, *Textbook of Psychiatry*, *Culture, Philosophy, Mental Health* and *Mind: Turbulent and Tranquil*. He was the founder President of the

Indian Association for Social Psychiatry and evolved a model of healthcare delivery to the rural aged in India. He also pioneered Geriatric Psychiatry research in India. He also interpreted and incorporated India's scriptures and ancient philosophies into contemporary mental health concepts. He was well known for his lectures and writings on the Bhagvad Gita and its implications for psychiatry (Kallivayalil, 2025).

N. N. Wig (1930–2018): had made seminal contributions to research in the area of nosology, culture-bound syndromes, course and outcome of psychoses, psychotherapy and social psychiatry. Apart from his role as a regional advisor for mental health of the EMRO—WHO, he had worked tirelessly to reduce stigma and discrimination due to mental illness (Avasthi & Chakrabarti, 2018).

J K Trivedi (1952–2013): was one of the most eminent social psychiatrists of India. He was an academician, researcher, teacher and leader of rare abilities. He was one of the foremost researchers in Psychiatry in India and conducted researches in collaboration with National Institute of Mental Health, USA; John Hopkins Institute, USA; Indian Council of Medical Research, etc., (Kallivayalil & Dalal, 2013).

**Culture-bound syndrome in India**: Among them, commonest are Possession Syndrome, Dhat Syndrome, Koro, Bhanmati, Gilhari syndrome, Compulsive spitting, Suchibai syndrome, culture-bound suicide (sati, santhra), Jhinjhinia, ascetic syndrome, etc., (Kapoor et al., 2018).

**Guru-Chela relationship**: meaning master-disciple or teacher-trainee, is a traditional Indian concept, particularly in Eastern traditions like Hinduism and Buddhism, where the guru guides the chela towards spiritual or practical knowledge and enlightenment through teachings and practice. As a therapeutic paradigm, the guru-chela relationship appears most suited to cultures valuing self-discipline rather than self-expression and creative harmony between individual and society (Neki, 1974).

**Hanuman complex**: in the context of Indian mythology and psychotherapy, refers to Hanuman's forgotten powers being restored by Jambavan during a crucial mission to rescue Queen Sita, illustrating a concept of regaining potential. Wig has often used this story in helping patients in psychotherapy as well as in teaching medical doctors and trainees in psychiatry. He had made a plea for wider use of stories from Indian mythology in psychiatric practice (Wig, 2004).

**Marriage and mental illness**: In India, marriage is regarded as an important and sacrosanct event in an individual's life, and everyone is supposed to get married and have a family so that he can continue his progeny. Marriage is essential not only for begetting a son to discharge his debt to the ancestors but also for the performance of other religious and spiritual duties, according to Hindu beliefs. Major mental disorders are listed both as preconditions of marriage and as grounds for divorce. Under the Hindu Marriage Act of 1955, conditions with respect to mental disorders have been included (Narayan et al., 2015).The Hindu Marriage Act (HMA) and the Special Marriage Act (SMA) address mental illness, with provisions for annulment or divorce based on "unsoundness of mind" or mental disorder, but these laws are often complicated by societal stigma and patriarchal attitudes.

**Stigma in India**: Stigma is an important issue here and needs to be addressed as a priority. It is one of the key reasons for people to shy away from seeking mental healthcare. Anti-stigma measures help to improve the quality of mental health

services and even enhance the self-esteem of psychiatry and give mental health rich dividends (Kallivayalil & Enara, 2016).

**Social support systems in India**: It is heavily dependent on family and community networks. Families take up a dominant role and usually consider it their responsibility to care for the mentally ill. The problem occurs when the families themselves are poor and deprived. India needs a holistic approach in treatment which involves patients, their environment and other stakeholders. Non-governmental Organisations (NGOs) in India give a great opportunity to work collaboratively with all stakeholders, enabling the fight against stigma and discrimination (Kallivayalil, 2023a, b).

## 4 Conclusion

Social psychiatry is against biological reductionism and strongly advocates attention to the social paradigm in health and disease (Kallivayalil, 2020). The renewed interest in social psychiatry has led to the emergence of WASP as a powerful and influential organization. Social psychiatry's relevance to clinical practice is underlined in the recently published WASP Textbook on social psychiatry, a comprehensive book with editorial contributions from India (Kallivayalil, 2023a, b). Social psychiatry is inclusive, as in ancient India, and also uses the concepts of social sciences like psychology, sociology and anthropology (Kallivayalil, 2023a, b). Psychosocial issues and social approaches to care are paramount in India (Chadda & Kallivayalil, 2023) and many other countries.

We have provided a brief overview of the roots of social psychiatry in India, the formation of IASP and significant contributions by stalwarts from the country. We have also outlined key studies related to social psychiatry in India, focusing on the role of families, disabilities, stigma, the specific problem of suicide and farmer's suicide, spirituality and the plurality of help-seeking responses and resources. The findings of these studies pose specific challenges in the Indian context. Understanding and meeting these challenges requires a social psychiatry perspective, both in research and in the delivery of care to those with a mental illness and their families—a paradigm shift in our thinking. This should happen now!

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