De-medicalisation of Mental Health and Alternate Healing System: A Case Study

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Abstract

Cultural and religious teachings frequently shape beliefs about the causes and nature of mental illness, as well as attitudes toward those who are mentally ill. Social practices go beyond mere attitudes and beliefs. Knowing individual and cultural beliefs about mental illness is indeed critical for implementing effective approaches to mental health care. Although each person's experience with mental illness is unique, the studies listed below provide a sampling of cultural perspectives on mental illness. With the advancement of medical knowledge, the state plays a pivotal role in isolating and monitoring 'persons with intellectual disabilities in secluded places. Here knowledge production in general and medical expertise played a critical role. In this context, this paper is trying to address the following questions. Firstly, how the body of 'persons with disabilities are subject to govern by the 'regulatory norms and values of society? This question will help us understand the reciprocal relationship between disability and cultural practices. Further, it will help to understand the question of how gendered differences played an essential role in the sequelae of violence.

Keywords: Violence; Disability; Governmentality; Intellectual disability

Introduction

What do you believe is the root cause of mental disorder? Hardly anyone understands what specifically causes mental health problems, but different people have different theories. Generally it is regarded that the loss of family, friends, financial stress, and general stress or worry as more likely causes of mental illness. Nobody gives a definite answer but they are right in the sense the way they see the issue at hand. For example, a person from medical knowledge will see it from medical science perspective and argue for medical intervention. At the same time some people will go and argue that mental illness is socio-cultural construction about certain human behaviour that does not fit into the collective. Individuals, families, ethnicities, cultures, and countries all have different attitudes toward mental illness. Cultural and religious teachings frequently shape beliefs about the causes and nature of mental illness, as well as attitudes toward those who are mentally ill. Beliefs about mental illness can affect patients' readiness and willingness to seek and adhere to treatment, as well as whether they experience social stigma. Knowing individual and cultural beliefs about mental illness is indeed critical for implementing effective approaches to mental health care. Although each person's experience with mental illness is unique, the studies listed below provide a sampling of cultural perspectives on mental illness [1].

In this sense, a common misconception, stereotypes, and unconscious unexamined prejudice concerning the person with disabilities can lead to the development or construction of systems/ institutions that focus on control, protection, and isolation instead of empowerment and full integration of persons with disabilities into the more significant societal life [2]. Social practices go beyond mere attitudes and beliefs. For example, it has been witnessed time and often that even the court of law refused to testify about the abuse and experiences faced by 'people with intellectual disabilities.' Further, with the advancement of medical knowledge, the state plays a pivotal role in isolating and monitoring persons with intellectual disabilities in secluded places. Here knowledge production in general and medical knowledge, in particular, played a critical role. In this context, this paper has attempted to answer specific questions [3].

In this rubric, the is divided into three sections. Each section has addressed a specific question(s). This essay's first section discusses the historical context in which "intellectual disability" knowledge has been generated. This section will focus on how the body of persons with disabilities is subject to be governed by the 'regulatory norms and values of society'. This question will help us understand the reciprocal relationship between disability and violence [4]. The second section of this essay attempts to delve into the case study, which is the core of the investigation. This section deals with how gendered differences played an essential role in the sequelae of violence. The final part of the essay is giving an overview of the alternative healing system that prevailing in rural India. This section helped us understand our cultural embeddedness in symbols, folk models, and ritual practices that contribute to resisting and healing the trauma, or further, double the violence. The case study approach was used to build this paper's methodology [5].

Another key point to clarify before the conversation resumes is the usage of language. To preserve their historical significance, terms such as disability, mental disease, intellectual impairment, feeble-mindedness, and so on have been used interchangeably. The history of these terms is significant because, through time, they have evolved and new phrase(s) have been employed instead of the old ones. As a

result, whenever language has been employed to refer to that specific historical juncture. Furthermore, as a topic, these terms function as a weapon for symbolic aggression by the person with an intellectual disability [6].

Literature Review

The historicity of the terminology

Since human civilization has evolved language as a medium of communication, they have invented many terminologies to describe many 'social group(s)' within and outside the community. One such group or category is 'people with low intellectual ability' compared to others in a given society. One such term is 'idiot.' The word 'idiot' has been used as a main scientific word in the English-speaking world for ages. However, Howe subdivided it into four degrees and used four different terms to connote 'idiocy,' *i.e.,* pure idiot, fools, simpletons, and imbeciles. With time, simpletons were replaced by 'feeble minded,' and 'feebleminded' was replaced by 'mental deficiency.' It was the first time the British Parliament used different terms in the Mental Deficiency Act of 1913. They used the term "idiots" along with other terms like "imbeciles," "feeble-minded persons," and "morally defectives" into law. At the same time as the British Parliament, Tredgold proposed using the term "amentia." The term is mixed up of two words, *i.e.,* a synonym without and men equal to mind. So, he proposed to use without a mind to denote those whose minds had never attained normal development. H. H. Goddard, an American psychologist, has added another word for them, *i.e.,* "moron," to the litany of words used to describe those considered "dull." The first time, Ayres used the word "retarded" to connote those children who failed to progress in school. With the campaign against the deeming terminology by parents and 'person with mental deficiency,' in the USA, the terminology was replaced by 'intellectual disability in the 1980's. Around the same time, the term 'learning disability' in the UK replaced the former. Importantly the meaning of learning disability is quite different in UK and USA [7].

The definition of intellectual disability mostly depends on medical proficiency. In the UK, according to the Mental Deficiency Act of 1913. In the contemporary period, intellectual disability is based on the American Association of Intellectual and Developmental Disabilities (AAIDD) definition. The AAIDD manual defines intellectual disability as, significant limitations characterize intellectual disabilities in intellectual functioning and adaptive behavior as expressed in conceptual, social, and practical adaptive skills. The disability originates before age 18 [8].

This definition is meant for high Western society in terms of literacy rate. So, they can identify and label people who are failing their fixed IQ match. However, this definition can pose an in-deficiency in those societies that do not feel fortunate to have a high literacy rate. Historically, there was a terminology change before the connotation of intellectual disability [9]. Each term reflects its historical era because one's own world experience depends on his/her genetic structure, *i.e.,* biology and physics, along with the family, culture, and society where s/he is living. In this regard, Berkson argued that the terminology describing what we now call developmental disabilities or intellectual disabilities has typically changed once or twice in each generation. Times change, and so does language in ways that can be critical to categorizing and labeling people.

The process of 'labeling' or the term 'label' suggested by Memert and Becker refers to 'deviant' from others. The process also generalized and created others. Putting it in the words of Goffman, "the processes by which humans label all kinds of concepts and people, labels applied to such groups as "retardates" connote generalizations about the people to whom we apply the labels" [10].

For Manion and Bersani, it is because of society's pre-defined notion of 'normal' that creates the 'otherness' for those who differ; as a result, 'people with an intellectual disability acquire the label of 'abnormal.' Castles argued that many times researcher undermined the fact that, people with disabilities are also human being with all feelings, emotions, thought and complexities of experiences, and instead view them as 'object' of study [11].

In the contemporary period also, there is a debate on the usage of language in terms of whether the individual should come first or last, *i.e.,* "people with disabilities" or "disabled people". Nevertheless, in this paper, I tend to go with "people first," keeping in mind the recent social movements and their focus on what all humans have in common, first, rather than what divides us. The construction of 'intellectual disability' before the thirteenth century, as argued by Neugebauer and Stainton, is different from the generic idea of mental illness, although centuries later still, there was the same asylum for both 'idiots' and 'lunatics' [12]. The attitude of society towards persons with an intellectual disability is very alarming though it is changing with the passage. Initially, Institutions/Asylums were set up to educate feebleminded and eventually retire them to the community. However, in the latter part of the nineteenth and early part of the twentieth centuries, 'feebleminded' were seen as a burden to society, and the process of alienating them from the rest of society started. Putting it in the words of Noll and Trent by the time, it was felt that there was no point in educating the 'feebleminded'; instead, they felt that the 'feebleminded' could not learn in whatever, but all means and it is better to keep them segregated from the rest. It reflects on official attitude, popular literature, fiction, etc. [13].

There is a desire to order things similar to each other into groups, a natural tendency across the globe. Even if there is a gradual difference between humans and objects, order happens. This ordering helps to categorize, though the categorization depends on a given culture and the time and space in which it has been categorised. The consequence of categorization is that people think that each group member is similar and equivalent to other members and tend to differ from non-members. Further, this adds other baggage stigma and other forms of stereotypes. Classification is obligatory for the ordering of things, and there are two different forms of classification, *i.e.,* taxonomic and thematic, for Western and Eastern cultures. The former has been classified under the 'taxonomic group' whereas the latter under the 'thematic group.' In addition to this, to help our judgments of people, 'cultural background' and 'immediate context' played a foundational role. In the words of Kim et al., in the low-context setting, the focus is on the individual; in the high-context culture, the focus is on connection to the group.

People with intellectual disabilities have similarly experienced stereotyping, and the list of labels they have worn is lengthy (e.g., childlike, defective, incompetent, dumb, immature; Beirne, Smith, Patton, and Ittenbach). When people are labelled, others, of course, view them differently, and the effects of the labels can be powerfully stigmatizing (e.g., Page) taking on a life of their own (Rosenhan). According to one person receiving such a label, the result may be devastating; putting it in perspective, the problem of getting a label is

something; after that, you are not a person. It is like a sty in your eye; it is noticeable. Like that teacher and the way, she looked at me. In the fifth grade, my classmates thought I was different, and my teacher also knew I was different,

As Bogdan and Taylor noted, the labels we construct divide humanity into two groups: The "normal" and the "retarded" or "disabled." Often, the latter was considered "abnormal" or "pathology" and dangerous for society. Beart, Hardy, and Buchan concluded that the label "intellectual disabilities" is powerful and dominant, overriding such other identities as gender. It is this construction that played an essential role in the emergence and development of many regulatory institutions that take custody of "abnormal" "retarded" or "pathologists."

Institutionalization for intellectual disability

The development of an institution needs to be looked at whether it was an institutional model of caregiving institution or a governing mechanism for those who have been declared unfit or a threat to 'mainstream society.' In this context, Wolfensberger detailed how perceptions of individuals with disabilities served historically to determine institutional models of care. These perceptions (and their accompanying labels) included the developmentally disabled person as "sick," "subhuman," "menace," "object of pity," "burden of charity," "holy innocent," and "developing individual". From its beginning, the primary professional organization concerning intellectual disability was responding to intellectual disability as a disease or illness label that persisted well past the middle of the twentieth century (e.g., American Medical Association). As Wolfensberger noted, facilities responding to individuals as a medical ethos marked sick, as evidenced by the pervasive use of medical language (e.g., "hospital," "infirmary," "nursing care," "patients," "disease," "diagnosis," "patient charts") and procedures (medical-style staff uniforms, hierarchical relations between types of staff, physicians as decision-makers, medically related disciplines and treatments taking priority over non-medical approaches).

The mid-nineteenth century marked the dawn of time, both exciting and troubling in the history of Americans with intellectual disabilities. Beginning with the establishment of the first public institution in 1848 in the state of Massachusetts (Wolfensberger), people with intellectual disabilities found themselves travellers on a strange, convoluted odyssey that involved a variety of forms of treatment, at least as many kinds of mistreatment and abuse, public display and ridicule, and a veritable building boom in public facilities devoted to their care and confinement.

The exact timing of the development of intuitions made for 'less intellect' people differs in time and space. For instance, it is stressed in the late sixteenth and early seventeenth centuries in the UK. Little late, the Britishers started developing these institutions in British India as well. In the early period, it is said that these institutions were for educating them, but with time, everything changed. The 'person with intellectual disabilities' considers pity and needs protection. Now they became 'objects,' and institutions became their 'colonies' with elaborate plans, development, and maintenance of intellectual disabilities. The era of colonies thinks that it was a village where people with intellectual disabilities could live peacefully and relatively short-lived. Mastin argued that "every 'feeble-minded women' gave birth to approximately two feeble-minded children each, thus multiplying themselves by two as their contribution to the burden of pauperism in the coming generation has grown up (ibid)."

Hence, people developed a belief that there is an urgent need to protect themselves and the country from the crime committed by imbecility. Putting it in perspective, people started believing in protecting non-deviant from the deviant, of ordinary from the abnormal one.

Cultural believes and mental illness: In understanding, cultural influence on shaping the idea of mental illness researchers are yet to unravel the sociocultural factors that determined the therapy people adopt. The field is still dominated by the "western medical framework" that sees mental disorders as diseases and tries to find out a solution. They continued to ignore sociocultural factors despite having sufficient data on them. From medicalised perspective, regardless of the cultural context in, which they occur, mental diseases are believed to be generated by universal processes that result in discrete and recognisable symptoms.

Extensive data from cross-cultural studies have been used to refute the disease model's validity adopted by modern psychiatry. They argued that human behaviours are culturally influenced and mental disorders and therapies are culture-specific. They argued that it is individual interaction with his/her environment that manifests a certain form of behavior. This manifested behavior thought by 'certain people that are not in order with socially approved behavioural pattern and declare the person in question as having a mental disorder. White and Marsella show that the concept of mental problems only has personal meaning and societal relevance within the cultural context of "mental disease" as a distinct realm of illness stems from a certain (Western) culture and history. They have established that sociocultural variables play an important role in the conceptualisation of 'person,' 'mental disorder,' and 'indigenous therapies.' The medical experts argued that the idea of a "cultural conception of mental health" refers to a "common sensical" understanding (ibid). They ignore that this understanding shape people's medical experiences and their views on mental disorder. A substantial amount of psychiatric and cultural research demonstrates that the experience of sickness is an interpretive effort that is built in social contexts by cultural "theories" about illness and social etiquette in general. There is a long history of cross-cultural research that has described cultural practices and beliefs related to mental illness.

Discussion

This paper has a build-up with a case study of six persons with some or other form of intellectual disabilities in their lives. Let's have a look at data that has been collected through a triangulation method. For ethical reasons and privacy issues, a proxy name has been used for a clear understanding. The name connotes to male cases are capitals W, X, Y, and Z while for female connotation the capital A, B, and C are used. Three of them are female, and four are male.

A male with an intellectual disability is from the same village, whereas in the case of a "female with an intellectual disability," they are from a different village. However, all the villages are nearby to each other. One thing common in them is that locals, as well as their nearby people, called them 'Pagal,' which in English is known as 'mad.' Though there is a vast difference in terms of the degree of their 'impairment.' Few are severely affected, whereas the rest of them well recover after the intervention by an alternate healing system. Those who recover from their early 'mental disorder' are male-only, and now they are pretty well coped with the outside society.

Causes of their illness

Two of them namely, 'X' and 'Y' believe that it was their ancestor deities who causes the illness because of their improper and irregularities in devotion to them. It is mainly because their family entrusted them to serve as "pujhari and dihari" to the deities. Pujhari refers to the person who performs the ritual activities while dihari connotes the person to whom deities possessed on the day of devotion. In 'W' case, he got a sudden psychic shock when his father was killed by his relatives and didn't recover. It is also believed by his mother and sisters that, their relatives have witchcraft the only male person in the family to capture the property. But the case of 'Z' is different from the other three. Before his mental breakdown, he was overwhelmed by sexual impulsive and failed to fulfil the desires that led to his disorder. His family's inability to get him married was also one of the contributing factors to the unfulfillment of his desire and subsequent disorder. Later on with intervention from a 'medical expert' he recovered and lived a married life. While, 'X' and 'Y' went for an alternate healing system, in this case, they return to worshipping their deities without failing and living a stable life. In their early therapy, they were also inclined to medical intervention but their strong cultural belief led them to alternate therapy. 'W' has no one to take care of him and lives with society's prey.

In female cases, 'A' victim of sudden psychic shock like the case of 'W'. Her entire family were killed by relatives for personal enmity. She was left with no one to fill a caregiving role. The relatives of 'B' didn't try to understand the reason behind her disorder. Though some indigenous therapies were offered to her she didn't respond to any of the therapies. 'C' is also a victim of provocative relatives as her husband is also mental disorder person.

This case study shows that the case of women is more important than the men, not because of the gender binary, but instead of the readily available medical remedy for later and subject to 'violence, negligible and other exclusionary practice' of former. On the one hand, among the male cases, one was exposed to the severe violent nature of society, and two others were subject to various care systems and intervention by various healing systems. On the other, the case of women is very pathetic; their families abandoned them, and they are neither subject to any form of institutionalized care system nor any healing system. Another distinct feature between males and females is that the behavioural pattern of the male was very violent whereas females resorted to violence only after provocation by others.

Deinstitutionalization and alternate healing system

There are some alternative healing systems entirely outside the realm of medicalization. Many stakeholders play a crucial role in availing of these systems. Consultation with a particular healer is governed by a set of socio-cultural beliefs, the background of the patients, and the family members, which has also been followed through the accessibility and availability of such healers.

Belief is a powerful tool or mechanism that highly affects the health care system. Often, blind beliefs in the 'supernatural aetiology of mental illness are highly prevalent among a significant chunk of the population, predominantly rural and tribal areas that constitute highly lower caste and lower-class people. These irrational beliefs centre around spirit possession, witchcraft, breaking of religious taboos, divine retribution, the capture of the soul by spirit, etc. In India, traditional healers and their healing systems constitute a vital role in the health care system, particularly in the case of mental illness. More than two-thirds of the people with mental illness and their family members strongly believe in the supernatural causation of mental illness, and this belief forces them to consult traditional healers before turning to the modern healthcare system.

As Hunter and Whitten put it, human beliefs are "thoughts that are based on the uncritical acceptance of the inherent truth or correctness of the cognitive categories of one's culture." Cultural beliefs highly influence health related behaviors and are also reflected in a society's healthcare system. This belief system affects nearly all aspects of mental illness, including assessment and diagnosis, and illness behavior, and helps to seek mutual expectations of interaction between patients and practitioners.

Glick hypothesized that "knowing a culture's chief sources of power, *i.e.,* social, political, mythological, religious, technological, etc., allows one to predict its beliefs about illness and how to treat it." Aruther Kleinman, an eminent American psychiatrist, gave a theoretical framework for the local healthcare system consisting of three categories, *i.e.*, popular, professional, and folk. The framework remains useable beyond cultural boundaries while content inside the categories differs with time and space. The first one is based on laypeople, nonprofessional as spread across many levels like the individual, family, social network, community belief systems, etc. With the consultation with people from the first category, they move to the second type of healing system, *i.e.,* a professional expert on the matter or they opt for medical intervention. The last one is folk categories mainly consist of nonprofessional only. In this category, people primarily sought what is known as devta, Gunia, bait, etc.

To get relief from their illness, people are consulting multiple healers. It is mainly because one healer's failure or unsatisfying outcome forces them to consult the other. Some of the factors that determine the choices of the healer(s) as well as healing systems are,

- The strong belief of decision-maker, family members, relatives, peer groups, and community members, in faith healing.
- Readily available or approachable.
- Social stigma associated with psychiatric consultation.
- The belief about the causation of mental illness.
- Lack of awareness among common public.
- Deficiency in existing mental health services.

In Indian villages, different healers practice treating mental illness. Weise et al., argued that there are four types of healers: Folk healers, healers in temples, practitioners of Ayurveda, and psychiatry or allopathic healers. The first three categories come under the traditional healthcare practice system. Predominantly in villages, most people's first choice for mental illness is the traditional healing system. This tendency shows in the above-taken cases as well.

Conclusion

Historically people with 'mental illness or 'intellectual disability' are on receiving end; the way knowledge has been produced so far about them. Whether in the realm of modern scientific knowledge or traditionally developed understanding, people with intellectual disabilities seem to be a pity and threat to society. In many cases, they are subject to abandonment by their family members and live as society's prey. In society also, they are not getting any form of sympathy or what so ever; instead, they are subject to mob stone pelting, etc.

Nevertheless, those who have been taken care of prefer to go for the traditional healing system first. It is after that that they opt for the modern health care system. All the health care services have been taken together to form a model for mental health care called an "Eclectic Healing Model (EHM) for people with mental illness.

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