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# Decoding the Superstitious: Spirit Possession and Ritual Healing as an Indigenous Knowledge Framework for Mental Health

**Sristi Swayansha Swain**[1]

[1]Masters Student at Department of Political Science, University of Delhi, New Delhi

## Abstract

Mental health has become an increasingly global public policy concern, particularly through the rise of the Global Mental Health Movement and its emphasis on the biomedical and evidence-based psychiatric treatment. However, the universalisation of the Western psychiatric frameworks often overlooks culturally embedded ways of understanding and responding to mental afflictions. This paper examines spirit possession and ritual healing in India as an indigenous framework for addressing mental illness that challenges the dominant biomedical paradigm. Drawing on anthropological, psychological, and historical scholarship, the study dissects how practices such as exorcism, trance, and ritual healing, particularly in sites like the Mehendipur Balaji temple, operate as socially embedded therapeutic systems. These practices externalise psychological distress through culturally meaningful narratives of possession, mobilise performative emotions through rituals, and integrate family and community participation in the healing process. The paper further situates these practices within broader debates about the politics of knowledge, showing how colonial and post-colonial psychiatric institutions have historically marginalised indigenous healing systems by labelling them as superstition. Through an examination of the state responses, the Ervadi tragedy, and collaborative initiatives such as Dava and Dua programme, the study argues that dismissing ritual healing as irrational overlooks its social and psychological functions. Instead, the paper advocates for a pluralistic approach to mental health care that recognises the coexistence of biomedical psychiatry and culturally grounded healing practices. Such an approach is essential for addressing the treatment gap in countries like India while also contributing to broader efforts to decolonise psychological knowledge.

**Keywords:** spirit possession, ritual healing, global mental health, Indian psychology, medical pluralism, faith healing, mental health policy

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**Corresponding Author:** Sristi Swayansha Swain (ORCID: 0009-0005-3715-0808) | **Email:** sristiswayanshaswain@gmail.com

## Introduction: mental health as a political priority

Mental health as a topic of discussion has long been attributed quite a privatised characteristic. In the current world order, seeking therapy has largely been a hushed matter, not something that can transgress the private enclosures of the family. And a historical impression associated with "madness" can be held to be partially responsible for the stance that we are currently maintaining towards mental health issues. But the very labels that contingently made mental health a very personal part of one's story, also seem to have historically played a massive role in institutionalising the system that dealt with mental health as a matter of social concern. "Over the course of the nineteenth century, care for mentally ill individuals, then known as 'lunatics' or 'distracted persons,' increasingly became a public concern as the social disruption brought about by rapid population growth, urbanisation, and a changing economic system increased the visibility of and public attention to mental health issues (65)" (Purtle et.al. 2020). This period marked concerted efforts at the establishment of "a disparate system of local and state-run asylums that would care for, through much of the twentieth century a significant number of Americans in need of mental health services" (ibid).

Institutionalising mental health connotes two underlying observations. One, the state has a direct role to play in deciding the course of the mental health management system. Secondly, it puts forth the question, why should mental health disorders be prioritised at the political level? The Global Burden of Disease Collaborative Network, 2020, has reported that "mental disorders represent the leading cause of disability worldwide and the third leading cause of global burden of disease after cardiovascular diseases and cancer. And most of the burden is in low- and middle-income countries where 81% of people with mental disorders live." Global Burden of Disease Collaborative Network. 2020. Another reason why it should be prioritised is the way it directly contributes to the social exclusion of people suffering from such conditions and the brutal treatment methods inflicted upon them as a means for their restitution, which concerns the violation of human rights. "People with mental illness were relative latecomers to civil and disability rights activism. They were left out of these movements because they were still institutionalised when this movement was gathering steam, and partly because of the stigmatised views from within the movement that individuals with psychotic disorders were too violent, volatile or irrational and unable to meaningfully participate in empowerment" (Mezzina et.al. 2018).

However, while tracing the origins as well as the eventual socio-historical trajectory and perceptibility of mental health as an issue with political implications, we observe that the narrative is replete with a fundamentally "Western" way of understanding the "individual". While we speak of deinstitutionalisation as an alternative, it excludes a particular culturally relative way of understanding men-

tal wellbeing. Ethan Watters objects to it by stating, "Americans have been industriously exploring their ideas about mental illness…they have failed to foresee the full impact of these efforts. It turns out that how people in a culture think about mental illnesses, how they categorise and prioritise the symptoms, attempt to heal them, and set expectations for their course and outcome, influences the diseases themselves. In teaching the rest of the world to think, they have been, for better and worse, homogenising the way the world goes mad" (Watters 2011).

## Navigating through the differences: ecology of the Indian version of psychotherapy

There are some features that have been uniquely an asset for understanding mental health within the framework of Indian psychology. The way Indian psychology grapples with consciousness is vastly distinct from the ways Western models deal with these concepts. In "*Decolonizing Psychology: Reclaiming the Indian Psychology of Wellbeing*" (2023), Shilpa Ashok Pandit, for instance, points out how hierarchized consciousness in the Indian mindset can yield both positive and negative definitions of the same concept. "For example, emotions, when tied to the body, yield a negative definition, while when tied to spirituality, yield a positive definition. In flat conceptualisations of mainstream Euro-American psychology, this looks like a contradiction" (Pandit 2023).

### *2.1 Psychic disorders with a religious dimension*

The role played by Ayurveda, Tantric systems of healing, and the way the Indian knowledge system conceptualises the notion of self and suffering, helps us conclude that psychic disorders in India do not merely have a clinical dimension but also a religious, spiritual and faith-oriented one. "Faith healing may be an old tradition whose historical roots still need to be traced, but it is also a new problematic that derives from, as well as challenges, established critical theory in general and critical psychology in particular" (Siddiqui 2016). "Unlike psychoanalysis, which developed from clinical encounters with neurotic suffering in the consulting room, IKS traditions arose from sustained quests for spiritual realisation and ultimate liberation. The fundamental aim was transcendence—freedom from ignorance (avidyā) and liberation from the endless cycle of birth and death (mokṣa)" (Sharma 2011). While psychoanalysis in Western terms is driven by the "goal of bringing unconscious conflicts to light, relieving the symptom and enabling greater ego integration, the Indian methods underscore a shared belief: transformation requires dedicated practice, not just verbal interpretation" (Mallick and Mallick 2025).

### *2.2 Spiritual explanations behind madness*

Unequivocally pertinent to the differences is the way there exists a cultural variance to the notion of

"madness" in the Indian and Western context, and how that goes on to influence the whole direction of healing. While "Western mental health services tend to conceptualise mental illness using the bio-psychosocial model, which advocates that stress interacts with one's overall level of bio-psycho-social vulnerability to give rise to mental health difficulties, cross-cultural studies have shown that Asian cultural groups attributed psychosis to religious-spiritual explanations characterised by beliefs in spiritual possession. (Ghanem et.al. 2023)" And this alters the belief models for the healing of such diseases as well.

Saravanan B, in an exploration of the "Belief Models in First Episode Schizophrenia in South India", examined the cases and concluded that "patients with schizophrenia in this region of India hold a variety of non-medical belief models, which influence patterns of health seeking and are likely to be rated as having less insight." (Gautam and Jain 2010). A plunge into how the cultural differences also influence the expression of the affective dimensions related to disorders has revealed that "guilt as experienced by the Indian patients is of an impersonal nature: the present suffering is attributed to possible bad deeds of the previous life (consequence of "karma") rather than due to self-failure as in the West" (Viswanath and Chaturvedi 2012). Even the way we process emotions and express them out show a considerable cultural variance, insofar as they embody an outlook on afflictions that have an association with lives that transcend the linearity of existence.

### *2.3 Doctor and patient beyond the professional relationship*

Yet another way through which differences emerge is the way we look at the doctor-patient relationship. The Western notions of psychotherapy embody a contractual relationship. The western model embodies a "doctor-patient relationship that is purely professional and thus, formal. There exists a significant social distance between them. All that transpires remains a secret between the therapist and the patient" (Varma and Gupta 2009). In sharp contrast to this model was the Indian model that did not follow an insular course to heal people. "The Indian model has not been meant only as a method of treatment of sick people. Psychotherapy was considered as one of the several mechanisms to guide people into the right path" (ibid). There was a predominant form of filial relationship that was conjoined with the professional relationship. While Western society places an unwarranted emphasis on individual autonomy and is mostly guided by the aim of reaching this end through the dialectical nature of psychotherapy, we observe that "in traditional societies like India, a child grows up in a family where coexistence and co-dependence of functioning is the norm" (ibid). Such a sociotropic individual emphasises inter-personal interactions involving relatedness, intimacy, empathy, approval, affection, protection, guidance and help. This meant that there was a milder confidential layer surrounding the treatment and a greater involvement of "significant others" in the whole lot of the

healing process. This also corresponded to the understanding that the roles were not concretised and strictly compartmentalised. They were fluid and also allowed space for emotional informality.

In a study conducted to analyse the "help-seeking behaviour of psychiatric patients before seeking care at a mental hospital", Chadda, by looking into the case of faith healers and religious healers, concluded that a "substantial number of patients suffering from severe mental disorders seek non-professional care. Trust, easy availability and accessibility, recommendations by the significant other and belief in supernatural causation of illness were the important reasons for choosing a particular facility" (Chadda et.al. 2001).

Ranganathan (2018), in an anthropological study of women seeking healing in Mahanubhav temples in Maharashtra, argued that the conceptual differentiation between biomedical and indigenous healing systems is, in fact, at odds with people's everyday lived experiences of healing. Women's complicated healing pathways reflected a fluidity that was facilitated by the temple discourses of healing, thereby maintaining a greater efficacy of these temples compared to biomedical treatment for spiritual afflictions. With this, we enter probably the most contested terrain within, the "superstition of possession" and the multiple ways of healing as embodied in ritual healing.

**Spirit possession and ritual healing: an Indian way of addressing mental afflictions**

Possession in Hinduism has long been a subject of rigorous debate and contestation. An individual is often identified as possessed by a spirit when "his or her behaviour is sharply altered, suggesting that the individual is manifesting a new or different identity and that agency has shifted away from the otherwise identifiable person. (Smith 2022). Out of the different kinds of possessions, negative possession is "mentally and physically debilitating", often requiring exorcism (ibid). Ayurveda discusses negative possession at length. In these texts, "one of the major categories of illness is *unmada*, 'madness', having two sub-categories: *nija unmada*, indicating natural cause, and *agantuka unmada*, an unnatural condition in which the affliction has no identifiable external cause" (Smith 2006). Positive possession, "on the other hand, is virtually always ritually constituted, oracular and invited. It is not often possession by deities or any one of a number of identified ethereal beings" (Smith 2011). An example of positive possession from antiquity is drawn from the *Brhadaranyaka Upanisad* of approximately the seventh century BCE, in which the wife and daughter of a learned ritualist are said to be possessed by a Gandharva or celestial musician" (ibid).

Out of the different categories of possession, a psycho-anthropological study on spirit possession in a variety of cultures has also suggested that there are two other forms of possession, each correspond-

ing to a fragile balance between social sanctions and individual conflict. Ward (1980) observes that while ritual possession conducted in the ceremonial context reinforces cultural morality, peripheral possession functions as an indirect form of social protest and pathological reaction to individual conflict. Thus, in both instances, we observe how the agency of the individual is not just confined to him, but also extends a dependence on the social mechanisms to help ease a sanctioned psychological defence mechanism.

### *3.1 Nuances of the healing method at Mehendipur Balaji and recasting it into the psychoanalytic paradigm*

"The concept of illness caused by evil supernatural spirits can be traced back to one of the earliest Indian scriptures, the Atharvaveda" (Wagner et.al. 1999). The healing ritual "employed by the *ojha-guni* to expel the malevolent spirit is called '*jhar-phook*' and usually makes use of a broom and various other sacred ritualistic items such as sacred stones, sacred water, etc" (ibid). In colloquial terms, the most common usage "for spirit illness is '*sankat*', meaning misfortune in Hindi. The term *sankat* is used in Balaji to refer both to the personification of a troubling spirit and as a synonym of 'spirit illness' (Sood 2013). In the traditional Indian concepts, the *bhuts* that cause the mental afflictions "are unhappy spirits of the deceased people who have not found fulfilment of their life due to untimely death caused by illness, accident, violence or sometimes because of non-performance of the last funeral rites. They are still hungry for life and roam around looking for a human body into which they could enter in order to enjoy life once more" (Pakaslahti 1998).

"In Mehandipur, the treatment of *peshi* is carried out through the divine intervention of the deities and the saints through the mediumship of priests and mystics, usually accompanied by the full-hearted participation of the family of the possessed person as well as all those who gather to witness and participate in the event that demonstrates the power of this process, which is called *sankat-mochan"* (Siddiqui 2016). Quack (2014) has succinctly highlighted one of the primary reasons why such individuals believe they have been possessed and are more inclined to seek treatment in such set-ups. Drawing from the understanding extended by Saba Mahmood, he describes how, in India, there are certain subjectivities that "do not categorically differentiate in a Cartesian fashion between mind and body, or between humans and things, material and moral, signifier and signified. Their respective religiosity is not based on a set of propositions that one has personal reasons to believe or not. Rather, the particular mode of religiosity consisting of embodied morality and piety cultivated through rituals and liturgy, and is based on codes of conduct" (Quack 2014)

#### *3.1.1 Externalising the sense of agency*

A major shift occurs in setting the pre-healing perceptibility of the patient to the healing methods. Unlike Western methods that focus on reclaiming the sense of agency of the patient, "traditional representations of madness focus on the idea of spirit or ghost possession, which marks a clear shift in the representation of the person. Here, the person no longer acts upon the situation but is acted upon. Agents and processes beyond the individual's control take possession of the person's mind, resulting in the illness" (Wagner et.al. 1999). "The peshi ritual at Balaji attempts to transform the patient's belief into a conviction that his bad traits and impulses are not within but without; that they are not his own but belong to the *bhuta"* (Kakar 1991).

Sudhir Kakar, in an extensive analysis of traditional methods of healing, has noted that the Western psychoanalytic paradigm concentrates on the "text of the mental illness "- its understanding, translation and genesis. But the healing rituals at Balaji are concerned more with the context of the illness. The special idioms are left at the symbolic level without any attempt at translation" (Kakar 1991). What is accounted for, directly or indirectly, in the analysis of the supernatural affliction is the life events that precede the possession, the causes usually being derived from "family tensions, loss of profits in business enterprise, failure to gain employment or to find a suitable marriage partner, are ascribed to supernatural agency" (Dwyer 2003).

*3.1.2 The role of peshi, trance and the evocation of performative emotions*

"According to Bourguignon (1973), over 90% of human societies engage in one or more types of altered states of consciousness (ASCs), of which 57% are possession trances (Oohashi et al. 2002; Flor-Henry et al. 2017)." (Saniotis et.al. 2025). The word 'trance' denotes a psychological transition between states of consciousness. It is a "state often associated with hyperbolic or intense emotions and may include several types of altered states of consciousness such as euphoria, frenzy, excessive grief, rapture, hypnosis, mental absorption, 'possession', and madness" (ibid). What is specifically powerful to trance is the way it transgresses the normal conduct of emotions in our everyday lives. Bercovitch (1989) has stated about the "invisible realm of religion which represents domains of subliminal consciousness that are sovereign from conscious awareness." This closely corresponds to Freud's thesis of the overwhelming power of religion over reason, whereby the former contains primaeval impulses that are manipulated via ritual behaviour" (Freud 1939)

Via the performative acts that are a part of the healing process at Balaji, patients are given the outlet to come in touch with the expressive side of the emotions that had been suppressed for too long to ultimately slip into the unconscious and resurface only through symptoms. Dwyer (1999) through an analysis of Kapferer's work takes note of an observation that, "while it is true that emotions are gener-

ated in trance which is thought to facilitate cure due to its avowed transformative power, nonetheless, because it is thought to be present in the healing and because exorcism is seen as being emotionally charged and explicitly aims to activate the emotions, Kapferer's argument that emotions are actually produced is also plausible." The patients who were frequently drawn into a state of trance report the ways they were affected during exorcism. "In addition to unpleasant physical sensations, many of them maintained that they were conscious of losing all control over the body. Participants not only frequently say that they experience a feeling of tension (*tanav*) during trance, but also many of them claim to feel anger (*gussa*)" (Dwyer 1999). Therefore, emotions do play a critical role in the curing process, insofar as "it enables patients to de-identify with negative states of being and to re-identify body and mind or the self in accordance with positive feelings" (ibid).

*3.1.3 The role of family and community-based healing*

The social attitudes and family reactions largely decide the time that can be taken for recovery. In Balaji, healing takes place within the social context of religious devotion and pilgrimage. "Since not even the seriously ill are excluded from the pulsating activity of the temple and its devotional services, the patients are not isolated from the other people. On the contrary, in the therapeutic milieu, they are reintegrated into the social and cultural fabric of traditional life and its values. Peer-group support, the discovery of commonalities, camaraderie, encouragement and advice from cured patients create a hopeful atmosphere" (Pakaslahti 1998). In the temple, it is the family that is specifically enjoined by the temple rules to take care of their ill members. As Kakar (1991) has already stressed the context of the illness that is central to the healing processes found in Balaji, the ensuing social life is definitely one such context that cannot be overlooked in the course of healing. "Accompanying the patient from morning till late in the evening through the various healing rituals and living in an environment where sankat (and its vicissitudes) is the central theme of community life, the distinction between a 'sick' and a 'normal' member of the family is gradually eroded" (Kakar 1991). The distinction between sane and insane becoming porous helps the patient to overcome his feelings of isolation and moral worthlessness.

The notion of 'treatment gap' as we understand it in the vocabulary of Global Mental Health often focuses only upon access to professionalised biomedical and psychosocial care but completely overlooks informal sources of care, such as traditional healers, non-registered medical practitioners, community and family support. "We found people's help-seeking practices lead to an informal integration of the available social, biomedical, and psychological resources. These diverse and informally integrated care systems provide access to different yet complementary forms of care that support well-being. Many traditional healing spaces may enable people with psychosocial disabilities to

live well with a long-term mental health problem, and with family support, may facilitate positive social outcomes such as increased social participation and inclusion" (Mathias et.al. 2020). While medicines can cure a person for once, continued support provided by the family extends beyond the stipulated span of therapy and lends the necessary coping mechanisms to heal after medicines have covered their biomedical course of healing. Viswanath and Chaturvedi (2012), in a study of the cultural aspects of major mental disorders, concluded that "while coping with severe mental illnesses, the degree of perceived stress was lower among Indian patients, due to better family support".

**How does the state view such notions of healing**

Siddiqui (2016) observes that religion today has been operating as a resource for alternative conceptions of treatment, but then it also shows how the space is being hemmed in and colonised by the state. Despite the widespread popularity of unorthodox treatment, their use as suitable modes of mental health care has become a serious point of contention for those structuring the country's mental health structure. Sood (2016) notes, "while archaic images of bodies possessed or constrained in divine chains in healing temples and dargahs have always been unappetizing for the postcolonial Indian state in pursuit of modernity and development (Davar, 2014), in recent years the rising tenor of the Global Mental Health (GMH) movement has given a more serious direction to the state's ire against these practices. What had once been benign disapproval of superstitious beliefs is now becoming a consolidated policy stance of the Indian state against the continuation of folk healing".

***4.1 Lessons from the Ervadi Dargah tragedy***

In 2001, a tragic fire at the Ervadi dargah of the Ramanathapuram district of southern Tamil Nadu shook the entire nation and brought to the notice of the wider public the importance of sensibly looking after patients with mental illnesses. Before going into the details of why the people preferred to get treatment in a holy shrine instead of opting for a concerted biomedical healing in mental hospitals, we need to take a look at the dire conditions in which the mental asylums operate in India today. The NHRC in 1998 released a report illuminating the gross ways in which the human rights of people with mental disorders were being violated at such places. "38% of the hospitals still retain the jail-like structure that they had at the time of inception. Most of them have a custodial type of architecture with high walls. Overcrowding was largely evident in such places. Leaking roofs, overflowing toilets, eroded floors, broken doors and windows are common sights" (NHRC 1999).

In subsequent cases, we get to observe the ambivalent nature of the state institutions' approach to the issue of mental illnesses. The state, while having addressed the egregious conditions under which

these people receive treatment in the mental hospitals, taking their human rights seriously, also denied acknowledging the traditional ritual healing practices and chose to deem them as superstitious and non-yielding. It was noted that "The court in seeking information on a State's enforcement of the Mental Health Act in the aftermath of the Ervadi tragedy was perhaps trying to underscore the fact that if the State had fulfilled its obligations under the Act, the tragedy could have been averted. Similarly, the other queries were aimed to underscore that if adequate services were available within the State, people would not feel impelled to visit religious and other faith healing places" (Dhanda 2005). Thus, one observation is clearly registered. While the state is willing to make efforts to improve the institutional setup for biomedical treatment of patients with mental afflictions, it is not willing to accept people's propensity towards traditional methods of healing as anything more than a lack of proper institutional mechanisms and facilities.

In Pune, the Bapu Trust for Mind and Discourse took this occasion to conduct a study on the "Health and Healing in Western Maharashtra: The Role of Traditional Healing Centres in Mental Health Service Delivery" between 2003 and 2006. They found out that "users are inclined to access places where they can express their problem as they experience it, where they sense a match between their causal models prevalent in the healing space; places where they will not be forced to directly confront their problems at the individualistic level, as a disorder, but can depend on divine or collective medication." The strict rationality of science thus doesn't seem to be appealing to the South Asian contexts, and that's where the state needs to productively intervene and facilitate the healing of that section of the population that cannot be seamlessly integrated into the psychiatric model of healing.

### *4.2 An analysis of the nature of state policies adopted for mental health and the underlying reasons*

A review of the existing policies of the state towards medical pluralism reveals that it follows quite an incoherent trajectory. "The global science of biomedicine defines the contours of its temper. Yet at the same time, considering the popular appeal of indigenous practitioners, and the elite character of the biomedical services, the state has had to turn its attention to traditional medicine whenever its legitimacy is weakened" (Mishra et.al. 2018). Whenever the state has collaborated with faith-based healers, the partnership has expressed covert reluctance and a very utilitarian approach. Quack (2012) has pointed out how the state's collaboration with such healers has meant the utilisation of these healers, rather than appreciating the positive elements of this body of knowledge and practice.

Another dimension that is often overlooked while investigating why the state would prefer to prioritise drug-based treatment over faith-based one is the peculiar "political-economic" nature of mental health in India. Dhar (2013) has placed into perspective the way suffering is attributed a biological

nature. Accordingly, the medical and even non-medical models locate the problems in the individual, particularly in the biology of the individual as understood by the pharmaceutical psychiatry. Thus, mental health in India has not managed to attend to the social as cause of suffering. "Sites of faith healing remain to this day the only option available to the mentally diseased from poor rural backgrounds. The Indian mental health system is thus primarily urban-centred and is strictly individualistic (even family circumstances or dynamics are not considered). The pharmaceutical industry focuses on only the individual sufferer; the perspective of the social is ignored. It has to be ignored for the mass production and consumption of long-term psychiatric drugs to continue unabated" (Dhar et.al. 2013).

### *4.3 The dava-dua programme as a flickering hope of orientational change in the state*

The Dava and Dua project was "developed by the Hospital for Mental Health in Ahmedabad to establish a relationship between traditional healers at the Mira Datar Dargah and community mental health care professionals. The project aims to reduce potentially harmful methods of traditional healing, provide mental health care training to traditional healers, create awareness of mental illness in the community, and protect the rights of the patients. The project has been successful in securing psychiatric care for several Mira Datar patients with severe mental illness and appears to have effectively cultivated relationships between traditional healers and psychiatrists" (Schoonover et.al. 2014).

Saha (2021), using a multi-method approach, conducted research to understand the implications of the *dava-dua* programme. He stated, "attempting to understand the religioncultural and scientific causes of mental illness, engaging patient perspectives, going beyond the traditional biomedical model of treatment and negotiate a shared plan for treatment are serious challenges for universal access to mental health services. Dava-Dua intervention addresses these challenges by appreciating the patient's reality and negotiating a shared plan of treatment." Somehow, the programme, as is monitored by the NGO "Altruist", has become a medium through which even the dangerous aspects associated with faith-based healing are undergoing manageable corrections through the collaborative framework. The founder and director, Hamlai, noted that "psychiatrists Bakre and Chauhan were of the opinion that mere talk with the healers at the shrine would not bring a solution to the problem, and therefore they came up with the idea of situating psychiatric and psychological treatment alongside faith-based healing practices in Unava. This would protect the livelihood of the *mujawars*, and at the same time, the state could be reassured that it was attending to the patients suffering from mental illnesses, who have the right to healthcare under the Indian constitution, but for reasons of their own, take recourse to sites of faith-based healing" (Siddiqui 2016).

**Conclusion: How is this indigenous system of healing associated with the politics of knowledge?**

With the growing popularity of the Global Mental Health Movement, evidence-based treatment, with scientific rigour, has been dominating as the ultimate framework for assessing the effectiveness of a healing procedure. However, research shows that "evidence-based, as well as other criteria for examining folk healing within the GMH framework, are embedded in Western epistemological assumptions, and disregard a whole range of culturally diverse ways of knowing and healing (Kirmayer, 2012a). The GMH movement's emphasis on locating mental illnesses primarily in individual biology, and on protecting the human rights of mentally ill persons, conceived as autonomous from their communities of belonging (Campbell & Burgess, 2012), for instance, draws upon Euro-American constructions of personhood that are starkly different from those of cultures where persons, health, and rights are conceived in relational and collectivist terms (Kirmayer, 2012b)" (Sood 2016).

The primary reason for investigating the questions of politics of knowledge arising from such an analysis is that "the modern Euro-American-based psychology produces research that is based on 5% of the population of the world; yet these findings are posited as having universal applicability and relevance for 95% of the world" (Amett 2008). Bhatia and Priya (2021) have made a case using the decolonising framework to evaluate how psychology continues to play a role in globalising the neoliberal self and subjecthood in several parts of the global south. In a stark description of how social suffering has been medicalised, they note: "With many tribals living in abject poverty and squalor, the mental health professionals interact briefly for four to five minutes with pointed questions to examine their 'mental status' in order to fit them neatly into a specific diagnostic criterion. A patient, when asked if his mind was peaceful, responded by saying that he is worried about getting food since he has been unemployed for almost four years. The mental health professional prescribed medicines to treat 'bipolar disorder' for this patient". This clearly shows how Western psychotherapy can reduce the suffering of a marginalised group to a matter of individualised psychopathology, subjecting them to a second round of victimisation. Most of such approaches are completely stripped of the social and cultural context that plays an equally important role in contributing to mental health problems.

As we observe, with the burgeoning influence of biomedical psychiatry, the state has been recurrently using "moral imperative to protect the human rights of mentally ill by shunning traditional healing sites and expanding biomedical psychiatric interventions" (Sood 2016). This new wave has manifested its impact on the healing practices in Balaji as well, whereby the "administration of the temple is devotedly upholding the state directives and planning to attract a larger pool of general Hindu devotees to the temple, instead of those seeking healing" (ibid). The *sankatwallas*, however, do not seem quite encouraged by the introduction of the new rules, which dissuade such healing practices. Most

of them "supported the disappearance of the traditional healing practices and many of them voiced their concern that something of the healing powers of the temple had been lost since these practices had disappeared" (ibid). Such a situation calls for a change in outlook, one that integrates medical pluralism, and that is clearly not possible without deconstructing the way we view the universal as an overarching brand that reigns supreme. Therefore, decolonising psychology includes an active effort towards embracing the marginalised techniques that in due course came to be dismissed on grounds of being "unscientific". Ignacio Martin Baro, in an attempt to fortify liberation psychology, which emerged in Latin America as a theoretical framework "to decolonise the intellectual traditions by strengthening critical thinking, collective memories and creative transformation, proposed three essential pre-requisites to achieve this objective: psychology needs a new goal, a new epistemology and a new praxis" (Singh 2021). Adams (2015), in the recent past, has rearticulated the pre-requisites as de-ideologising everyday realities, recovering historical memory, and privileging marginalised perspectives.

Therefore, as Halliburton (2020) rightly observes, "Biomedical psychiatry does have an important role in mental health services, not through displacing other systems of healing, but as a contributor to a pluralistic healthcare system. Any scaling up of psychiatry should aim to improve the psychiatric offerings that already exist rather than push aside other systems".

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