UDĀS
AN INQUIRY INTO A SOUTH ASIAN STATE OF MIND

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It is almost as if 'seeing the sign in this context' were an echo of a thought. "The echo of a thought in sight" – one would like to say....

Now it is easy to recognize cases in which we are interpreting. When we *interpret* we form hypotheses, which may prove false. – "I am seeing this figure as ....." can be verified as (not in the same sense as) "I am seeing red'. So there is a similarity in the use of "seeing" in the two contexts. Only do not think you knew in advance what the "*state* of seeing" means here! Let the use *teach* you the meaning (Wittgenstein).[1]

ABSTRACT

A state of the mind known as udās is widespread in Rajasthan, India. Although accurate statistical information regarding its distribution is hard to obtain, linguistic data indicate its prevalence throughout the South Asian cultural area from ancient times. In Rajasthan, in the central regions around Jaipur, Bikaner, and Jodhpur, in the region known as Marwar where I conducted my field research, this is a well-known phenomenon. Adults of every age seem to experience this condition of being.

Field data show, and lexicographic research confirms, that there is a common definition for this state of mind. According to the common definition, udās refers to a heart heavy with sadness, dissatisfaction one feels about one's lot in life, and disquiet about the nature of the world and how people live in it.

What are the characteristics of individuals who experience udās? How do the Jains identify, classify, and evaluate them? What methods are available in the local culture to deal with this condition? What methodological and philosophical issues render the Jain cultural constructions about this mental state incommensurable with the psychiatric constructions about it? I address these issues in my essay.

THE PLACE

In 1982 and 1983 I conducted a field research on Jain monasticism in Rajasthan, India. I did most of my work in a town, which I shall call Muktipur,[2] where approximately 1/3 of the population were members of the Jain sect Dharmapujaka. The town had a complex monastic establishment belonging to this sect where about eight male and about ninety female ascetics were in residence. I stayed there, and had frequent contacts with both the monastic and lay components of the community.[3]

During my conversations with the Jains of Muktipur I found that they frequently referred to a state of mind called *udās*. In Marwari, the Rajasthani dialect of Hindi that my Jain friends of Muktipur considered as their mother tongue, *udās* meant a complex of emotions, attitudes, and behaviors.

THE MINDSET[4]

Udās in the nominative case means the condition of being with a sorrowful heart, a frame of mind that makes a person feel lonely, solitary, forlorn, dull, and indifferent to the world around, withdraw into a corner, and brood. In music, which the Jains very often indulged in, it refers to the bass note. In the adjectival case, the word is *udāsin* or *udāsi* and refers to a dejected, solitary, sad person with an unsettled mind. The term is found in Hindi literature as well.[5]

South Asians everywhere have experienced this mindset because all major languages have the same or a derivative term. To cite a few, the Bengalis call it *udās*, the afflicted individual *udāsi*, and the existential condition resulting from the state of mind *udāsin*.[6] The Nepalis have experienced *udās* and witnessed *udāsi, udāsilo, udāsin*, and *udāse*.[7] In Telingu of Andhra, *udāsinamu* refers to the acts of bullying, rejecting and disregarding of others and of using abusive language. This is the conduct of an *udāsinudu*, a stranger, who is indifferent towards others. An *udāsinudu* is an unconcerned spectator of the world around her.[8] In Kannada of Karnataka, this frame of mind and the associated phenomena are called *udāsha, udāsa*, and *udāsu*. Individuals who experience these states of mind and of existence compel her to neglect her social obligations and treat them with contempt, indifference and listlessness. They condemn, despise, loathe or disgrace others using foul or abusive language. This pattern of behavior also brings social contempt towards them.[9] The Tamils have also conceptualized the syndrome bivalently. *Udāsinam* means *udās* as well as disgrace, and *udās* may cause or be the effect of *udāsinam*.[10] In Sinhala, the term is *udāsina*. It is generally used in the adjectival case to indicate indifference and apathy.[11] This term is found in Pali, Prakrit, and Sanskrit as well.[12] In fact, the current terminology descends from the ancient terminology found in these classical languages.

The distribution of *udās* in the population is hard to measure. I had neither the time nor the resources to conduct a large-scale survey. However, looking at the linguistic materials in hand and considering my field experience, I can say that it is widespread throughout the indigenous South Asian population, geographically and temporally. As the preceding discussion shows, the term occurs in all the major Indian languages. Its existence in languages from Nepal to Sri Lanka and from Bengal to Rajasthan gives an idea of the geographical distribution of the syndrome. *Udās* has existed for millennia. The occurrence of the term in Pali, Prakrit, and Sanskrit shows its temporal distribution. The distribution on these spatial and temporal axes shows that *udās* is a term used in South Asian languages to define a regional psychological phenomenon that has a long history. Is it peculiar to South Asia? Perhaps, and I shall return to this issue later. For now, let me focus on its manifestation in Muktipur, Rajasthan.

The above linguistic information provides a common definition of *udās*. An individual may not use all of the above shades of meaning to define his/her condition on a given occasion. The frame of mind varies from day to day and the average individual does not feel

udās everyday. Some days, she wakes up feeling *udās*. Other days, a social situation might make her feel *udās*. Sometimes, it is a temporary feeling. At other times, it might ruin her whole day. It is known to persist for weeks. Every time she feels *udās* she may give it a different shade of meaning, depending on the specificity of the her state of mind on that particular day, at that particular time. Usually, individuals tailor the common definition to describe each one's particular experiences of *udās*. Notice also that its severity or its significance is culturally variable within South Asia. Different languages give different degrees of emphasis to the term indicating the differential significance of the syndrome in the cultures to which the languages belong. For example, in the linguistic information given above, it is clear that the Kannadigas, Telugus, and Tamils evaluate the conduct of a person experiencing *udās* in stronger terms than the Rajasthanis, Bengalis and Nepalis. The Sinhalas have hardly developed the term *udāsina* by which they refer to inaction. However, they do experience this state of mind and call it *kalakirīma*.[13]

Further, there are different kinds and degrees of *udās* within the same culture to indicate a person's mindset at a given time. In Muktipur, if someone says, "I feel *udās*," we should not use the common definition to understand his condition. We must probe further until he talks about what he feels at that time. However, his description is hardly precise, because *udās* is always layered and complex. Furthermore, in my experience, not all have the same verbal capacity to express themselves accurately.

As said before, there are varying degrees of *udās*. It can be temporary, might last the whole day, extend for a week, or become a permanent state of mind. Thus, it exists in a continuum between a temporary state of mind and a permanent condition of the mind. Exactly where an individual's *udās* lies on this continuum depends on what triggers it.

How do the Jains explain the causes of *udās*? The local explanation is multi-polar and complex. The mildest level of *udās* might occur because of lack of sleep, physical exhaustion, inappropriate food, lack of food, or as a symptom of a cold, flu or some other common illness. It can occur as the mental dimension of menstruation, pregnancy and bodily conditions immediately prior and subsequent to parturition etc. Mild *udās* might also be the result of worrisome social experiences such as bad company, unpleasant situations, debt, experience of ingratitude and rudeness, insults and the like. Those afflicted with this frame of mind said they felt sad, confused, impatient, angry, and wanted to be left alone. This level of *udās* usually wears out once the physical conditions are changed and time heals the social wounds. Then the afflicted individual returns to normal social functioning. When *udās* has social origins, Jains have other means of coping. I shall discuss these later.

The next noticeable level is longer lasting and somewhat debilitating. There may exist biological explanations for this degree of *udās* as well. I have no data on this aspect and had no competence to formulate a strategy to collect such data. However, there was ample social information to explain the occurrence of this kind of *udās*. Bereavement on account of the loss of spouse, parent, child, sibling or close friend due to death, marriage, or some kind of permanent separation is a common cause. The jilted lover, the businessman who went bankrupt, the parent who is worried about a child's incurable sickness, the childless person, individuals in bad marriages, all suffer from longer lasting *udās*. They find the normal activities of day to day existence bothersome and ignore them. They notice loathsome greed and avarice in ordinary acquisitiveness, contemptible vulgarity in mirth and laughter, and

condemn others for being what they are, often using abusive language. They might feel completely listless, become clueless about the world, withdraw from it and wallow in whatever that they are obsessed with.

At the other end of the continuum, the withdrawal is complete and *udās* is a permanent state of mind. In Rajasthan, this mental condition is known as *vairagya bhavana*. Literally, the term means meditation (*bhavana*) on the lack of desire (*vairagya*). Certain social types seem to be especially susceptible to this extreme form of *udās*. They include individuals of marriageable age, widowed persons, those caught up in seemingly interminable bereavement, persons who have become completely discouraged about the future because of the conduct and or experience of others. In *vairagya bhavana*, the individual loses all desire to remain in the household, finds no meaning in anything that a householder values, develops contempt and loathing for everyday household activities, and becomes socially, therefore economically, non-functional. She enters a religious path to become a wandering ascetic or, more usually, a monastic. Monks, nuns, and monastic aspirants who claimed to experience this state of mind said that once *vairagya bhavana* occurred they could no longer stay in the household. The household life, the *grhastha jivan*, became too painful to bear. Their minds were full of sorrowful thoughts about the meaninglessness, even perilousness, of life in the household. Thus they renounced it and became mendicant monastics.

The Hindus also do the same. Some follow the ancient path of the *sanyasi*, the wandering anchorite. Others join Hindu monastic orders. Whichever the path they take, they claimed to experience *shanti* after their renunciation of the *grhastha jivan*. The *vairagya bhavana* remained an auspicious condition that pointed to them the perils of the *grhastha jivan* and why people suffer *dukh* in the *sansar*, the Hindu and indigenous South Asian sense of existence in the world.

However, when asked whether they experienced *udās* even after their renunciation, the Jain ascetics of Mukthipur said they did occasionally experienced some *udās*. They said they were not perfect but only trying to be perfect. As such, they were subjects of the ordinary pressures of life. They try to be disciplined, and retain the *shanti* that they feel through *vairagya bhavana* and activities that they perform to purify their souls. However, the infirmities and vagaries of the body and the soul, the fruition of karma, and temptation from the household continually pull them back into the world of the *sansar*. Then they experience *udās*.

I must stress that the distribution of *udās* from one end to the other in the continuum is gradual and not clustered as I have presented it for convenience. There are many stages between these rather crudely constructed types. Most individuals can be classified as members of one or more of these categories. However, in a hypothetical statistical model, the modal type would be constituted of individuals who suffer the mildest form of *udās*. This is because the majority of Jains experience disappointments, become tired, and feel bad when they are sad, angry or hungry.

How do others in society perceive an individual with *udās*? The social perception of the sufferer depends on the severity of her *udās*. Ordinary *udās* that practically everyone occasionally experiences is seen as a pitiable condition which others must accept with sympathy and kindness. Therefore, others leave the *udāsi* alone, hoping that she would

recover after a good meal or a good night's rest. Ordinarily, others hardly notice this mild form of *udās* because the sufferers cleverly, and as a matter of etiquette, conceal their suffering.

As the severity of *udās* increases, the sufferer fails to hide her condition. When she behaves in ways described earlier, the social perceptions of and responses to the *udāsi* change. People try to comfort her by talking to her and by offering advice. Close friends who understand the issues underlying her *udās* attempt to help her find solutions. One of the solutions is to visit the nearest monastery or the nunnery and *see* the ascetics.

THE RITUAL

Among the Jains, visiting the monastics is a principal method of dealing with stressful situations. The normal hours of visiting are at the end of the working day, when most people are free. After sunset, while the twilight is still quite bright, before they eat dinner, individuals and families come to the monastery. At this time, the ascetics are also ready to receive them. In fact, they expect the lay people to come by. The interaction between the monastics and the laity is institutionalized as *Darśan*.

Darśan means to view, to gaze at and contemplate the models of perfection. In the Hindu model, this is to see and contemplate the nature of the devotee's favorite god. This usually takes place in the form of ritualized viewing of an icon of this god. Thus I have seen at Nathadwara, a famous Krishna temple in Southern Rajasthan, devotees anxiously await the daily presentations or exhibitions of a picture of Krishna. When the priests brought the icon from the inner sanctum of the temple and showed it to them, the devotees cried out "*haré Krishna! haré Ram!*" in unison, loudly, and frenziedly, in tremendous excitement at the sight of this Vaishnavite Hindu model of perfection.[14]

The Jain practice is sedate, unhurried, quiet, and contemplative. The monastics sit or stand wherever they please. Monks usually choose a spot in the verandah or a corridor of the monastery. Nuns sit inside the building. The ascetics sit alone or together, cross-legged in a comfortable posture. The lay people come and sit in the yard. If an ascetic sits alone, those of the ascetic's sex who find him/her particularly likeable and friendly go to that ascetic. Laymen sit about ten feet away from the ascetics, whispering various *gathas*,[15] such as the *namokar mantra* that focuses on the four sacred statuses in the Jain religious world: the *arihants*, the *siddhas*, the *gurus*, and the *sadhus*.[16] These are the Jain models of perfection. The last two categories reflect the glory of the first two that are not found in the world any more. After contemplating the models of perfection, lay people whisper other *gathas*. Throughout, they gaze at the ascetics. After about fifteen minutes of this formal encounter, they approach the ascetics.

I do not presume that all in the gathering dutifully contemplate the ideals of Jainism and perform all the ritual steps with equal dedication and mental focus. However, I have noticed that most of those who came to perform *darśan* seemed to be actually motivated. Since there is no compulsion for everyone to attend, individuals do not visit the monastery unless motivated by some reason. Many of my younger friends in Muktipur hardly visited the ascetics. Therefore, I believe that the regular participants habitually visited the monastery at this hour as a part of their religious training, while the occasional participants did so

purposefully. One of these purposes is to find relief from *udās*.

The *udāsi*, and there might be more than one in a given evening, might sit amid a group or alone. He would begin his participation in the rituals by paying respect to the ascetics. Then he would sit cross-legged in front of them and chant the *namokar mantra* while gazing at the ascetics and contemplating the Jain ideal statuses. The ascetics speak to every lay person in the audience and inquire about their health, and so on. The ascetics' attention is highly gratifying to the lay person. These informal conversations go on for a while, and some, particularly those who came with their families, decide to leave. They approach the ascetics, pay obeisance to them, and return home.

The *udāsi* lingers on until he gets a chance to have a private audience with his favorite ascetic. The ascetic talks to him in a very friendly manner. He asks about the *udāsi*'s family and how the *udāsi* is doing in the world, offers advise in spiritual matters, cracks a few jokes, and shows that he cares. Then the *udāsi* also leaves.

THE PEOPLE

Munim Jee

As far as I could ascertain, this social drama is quite effective, particularly for those who are afflicted with mild *udās*. Some days, my friend Manikka Chand Maloo, the Munim Jee or the accountant of the pilgrims' rest, a bachelor about seventy years old, would experience temporary *udās* for unspecific reasons. He would tell me that he felt *udās*, that he felt he had no one in the world, that the world was full of strangers. Then his heart would become 'heavy' and he would feel sorrow. Munim Jee would often listen to *gazals*, a variety of semi-classical songs of lamentation in *Urdu*. As he explained to me, unlike the usual laments that focus on the lost love between a lover and the beloved, the *gazals* speak of a loner who is forever looking forward to meet his ideal friend, his *sahrda*. The *gazal* singer is sad because he has not yet met this *sahrda*. His *sahrda* is nowhere to be seen. He worries because this person might not even exist. Yet, he keeps hoping, but he knows that his hopes are in vain. I have seen Munim Jee quietly weep as he listened to *gazals*.

He would often go to see the ascetics with me. When the socializing with the ascetics was over, he would leave the monastery feeling better. He would return to the pilgrim' rest in a jolly mood, humming *Raga Durga*. Munim Jee's *udās* was gone. This sort of *udāsi* goes in and returns without his *udās*, having recovered his emotional equilibrium.[17]

The *udāsi* must do more to overcome more severe and long-term *udās*. Such an *udāsi* would stay in the pilgrims' rest for a couple of weeks performing *sadhana*.

Dr. Jain

Dr. Jain, an allopathic general practitioner, came to Muktipur to practice *sadhana* in this manner and stayed in the *athithi bhavan*, the pilgrims' rest, where I too stayed, in the room next to mine. At first, he was socially reticent. He seemed lost in thought and his face hardly had a smile. I made numerous overtures to begin a conversation but he maintained a taciturn attitude. He would sit in his room or in the verandah, sitting cross-legged on a cloth mat. Was he meditating? Was he simply engrossed in thoughts about his family? I could never know. I speculated that he might be performing *samayik*, a special meditation practice among many

Dharmapujaka Jains.[18] I have seen him in the company of the ascetics. He would sit cross-legged near them. Occasionally, he would engage in conversation with them about various doctrinal matters in Jainism. He would be invariably present in the monastery during *darśan*, and sit alone. I gathered from Munim Jee and from our cook Ghisu Jee that Dr. Jain regularly skipped breakfast and dinner and every now and then would fast for a day or two.

After about a week of these practices, Dr. Jain would become more sociable, communicative, and in about ten days he would shrug off his reserve and join the rest of us, and eat with us all three meals. Under these conditions, he and I had many conversations about each other. He said his heart was often heavy with worries. He had a son who was a polio victim. He worried about this child's future. The child was a burden too. His wife was constantly working, looking after other children while taking care of this one, and running the household. There was nothing he could do to alleviate the burden on his wife. He always felt responsible for the child's predicament although he did not cause the his suffering. There was nothing he could do to change any of this. In spite of this situation, he and his wife had a normal family life. However, occasionally, problems would accumulate and make him feel *udās* that would persist for days. Under such circumstances, he would come to Muktipur, like he did this time.

Although he was an allopathic practitioner, Dr. Jain had not given up the traditional Jain faith and practices that he inherited from his family. From his point of view, science was very useful to find quick solutions to problems. Nevertheless, there was much in life that science did not address. However, religion addressed these issues. As far as he was concerned, religion gave him a perspective on his situation. This was particularly effective when he was in the company of the ascetics. His place of choice where he would meet the ascetics was Muktipur, the birth- place of the then incumbent head of the sect. The ascetics in Muktipur would posit his problems in the larger scheme of the world found in Jain cosmology, and he would then realize that his worries were insignificant matters, even necessary and instructive steps as he advanced in his journey in the *sansar* towards *moksh*.

Dr. Jain would stay in Muktipur for a fortnight or so. By the end of his visit, he was friendly with others in the monastic complex and, as he appeared to me, at ease with himself. He seemed to have recovered from his *udās*.

Pramila Bhootoria

Pramila Bhootoria was different from Dr. Jain, not because of gender, but because her indifference towards the world at large was a permanent state of her mind. Bhootoria was about nineteen years old when I met her. She was a monastic aspirant living in a special educational institution known as the *Paramarthik Sikshan Sanstha*.

Bhootoria hailed from a middle class family. Her father was a clerk in a Marwari firm doing business in Calcutta but the family lived in Muktipur. Bhootoria was the eldest in a family of five children four of whom were girls. Her father came home from Calcutta only three or four times a year.

She experienced various hardships from her childhood. She had to look after her younger siblings from a very tender age. Her mother constantly nagged her for the slightest reason. If her brother wetted the floor, a sister cried too often, or spilled food from her plate,

her mother blamed her for all that. Her mother often scolded her and never hesitated to beat her up. When her father returned from Calcutta, her mother would constantly complain about her to the father who would often vent his anger by thrashing her.

Bhootoria very rarely had the opportunity to get out of the house and play with her cousins in the neighborhood. When she did, she was always embarrassed about her clothes. They were cheaper and older than the clothes her cousins wore. Her toys were soiled and old. She hardly had any pocket money. This embarrassment became worse when she started to go to school. Further, she was always unprepared for her classes because of all the household work that she had to do. Pramila Bhootoria was an unhappy little girl.

As she was becoming an adolescent her lack of self-confidence and happiness worsened. Pramila Bhootoria was a plain looking girl whom the boys did not much care for. However, that was a minor matter. What mattered more was that she did not even have very many girl friends. When the girls got together, they would often talk about marriage and she was terrified by what she heard. Indian brides have to go through many hardships as they try to adjust to living in the *sasural*, the mother-in-law's house. The girls would talk about terrible things that happened to certain brides. For middle class families, the dowry is a major concern. Perhaps, the parents were harsh on her because of the large number of daughters they had. Finding dowries for all the girls was a great challenge to this family with a very modest income. Her mother's obnoxious attitude towards her became worse as she grew older.

Thus, Pramila became a lonesome person. At night, in bed, she wept silently and bitterly. She thought the whole world was a miserable place and everyone in it, including herself, was a miserable person caught up in endless suffering. Her emotions had to be bottled up for there was no one to share them with. In order to get out of her loneliness she began to visit the nearby nunnery. Now that her siblings were older, her mother did not object to her visits to the nunnery. The nuns helped her with her studies, but she was already beginning to be indifferent to all this bookwork. More than anything else, she was comfortable in their company. Her clothes, modest physical appearance, and lack of money did not bother the nuns. If she made mistakes, or did not study, the nuns never scolded her. Instead, they showed her warmth and kindness that she had never known before. They listened to her and she could talk to them about her sadness, her harsh family, her loneliness and fears about the future, without inhibitions. She knew they would not gossip about her or laugh at her.

Gradually, she found being among the nuns a relief from the agonies at home. She has also begun to see the world from a completely religious viewpoint. At the time I met her, Pramila had not yet grasped all the finer points in Jain metaphysics. However, she was informed and convinced enough to be able to give reasonable interpretations of the events of the household from a doctrinal angle.

One day, Pramila's mother saw her talking to a male friend. Her mother scolded her using bad language, and accused her of wanting to be with men. Pramila found this accusation insulting. She was merely talking to an old friend with whom she grew up. She treated him as a brother. The boy was well known to her family from his childhood. How could her mother insult her in this manner, as if she had a bad reputation regarding boys?

That incident changed her mind about her family forever, and she decided to leave.

When she informed the nuns that she would leave home permanently, they accepted her warmly and, through consultations with the guru of the sect, arranged her a place in the training institute where she would live and study further under their supervision until she became qualified to join them. Her *udās* had advanced to *vairagya bhavana*, an entirely auspicious condition for monasticism.

Pramila said she still felt *udās*, felt anger towards her family, particularly towards her abusive mother. However, she saw her anger as a sign of her own spiritual inadequacy. The karmas were blocking her perspective. She needed to know more and do more by way of ascetic practices and meditation to get rid of these karmas so that she could "see," become free from her bad moods, and feel shanti as a permanent state of mind.

DIVERGENCES IN ANALYSIS

What can we say about this continuum of a state of mind? Is it a mood disorder as in the Diagnostic and Statistical Manual (DSM) nosology, the various characteristics of *udās* constituting a symptomatology of clinical depression? Many of the characteristics, practically all necessary for a diagnosis given in the DSM, are found in *udās* but are we to consider *udās* as depression? The answers to these questions had to come from the Jains themselves. None saw it as depression. None saw even *vairagya bhavana* as depression. None saw any of this as a mood disorder. Disorder is an abnormal condition, a pathological situation. But no Jain ever considered an *udāsi* of any degree as someone suffering from an illness.

Thus, from a cultural perspective, *udās* and its many degrees of manifestations do not constitute a psychopathological condition. The Jains share with other South Asians an indigenous symptomatology of mental illness. They do not bring *udās* under this symptomatology. However, does this mean the DSM categories are entirely inapplicable? To answer this question it is necessary to take a quick, though hurried and incomplete, look at some aspects of the intellectual history of the last century of which the DSM series is a part.

The applicability of the DSM nosology and symptomatology to identify, classify, and explain *udās* as a mental illness is fraught with challenges from sociology and anthropology. The DSM attempts to develop a culture-free, pan human set of diagnostic criteria based on a symptomatology and a nosology that would classify the mental states that conforms to the symptomatology under a larger class of mental illness, and then under specific illnesses such as depression and mood disorders. Here, the assumption is that these are valid, as other classifications under the Linnaean paradigm, for all *homo sapiens* irrespective of their social and cultural differences. Underlying this assumption is the premise axiomatic to it, that mental illness is a purely biologically determined mental condition. This way, it attempts to be a culture free scientific psychiatric instrument.

The intentions for the development of such an instrument is the lack of uniformity in symptomatologies and nosologies that the non-biological paradigms produced. The biological reasoning of human nature, including mental illness, had to compete with a variety of other approaches that emphasized the cultural and social uniqueness of the different societies and the impact of these on the final outcome of human nature. The famous nature/nurture debate that occurred early last century was a culmination of this conflict of biological explanation of human nature with the cultural explanations of human nature.

In this battle, the sociocultural approach gained supremacy by the second quarter of the century. Together with this, the psychoanalytic interpretation of culture became a significant school of thought that also became the forerunner to psychological anthropology. As Good (1992) explains, the early models of psychoanalytically oriented psychiatric diagnostic procedures, as in the DSM II series, that attempted to develop a universally valid nosology and symptomatology, were soon found to be inadequate because the psychiatric practitioners could not agree upon the uses of the taxonomy and the diagnostic criteria. Perhaps, the very cost of psychoanalytic treatment became another problem. Further, the psychoanalytic model of the mind itself was brought under scrutiny and was found to possess questionable scientific validity since its basic concepts were not amenable to direct observation and experimental verification.

Nevertheless, as Worthman (1992) discusses, the sociocultural model continued to be in use, particularly in anthropology. However, already in the late 1950s, the application of Western constructed grand theories of society, culture, and human nature to examine even the Western societies was questioned in sociology (Mills:1959) and this was further advanced from a phenomenological perspective by Berger and Luckmann(1966). The raw application of these systems theories and finding data to further illustrate their validity soon became an exhausted paradigm. Instead, local realities and everyday life were taken as the appropriate themes of study and the discovery of theories from local contexts as individuals in these contexts developed them became the appropriate methodological stance. Non-Western cultures were seen as unique entities with their own sense of reality that varied widely from the Western notions of reality. Geertz(1973) argued that instead of the systems theories which arrogated to themselves intellectual correctness, it was necessary to examine the non-Western cultures and their sense of reality on their own grounds and then to interpret these using Western schemas so that Western intellectuals could understand the other senses of reality possible in human experience and existence. Rather than the application of formulae derived from grand theories, a phenomenologically oriented hermeneutical method to develop thick descriptions of these cultures thus came into vogue.

By then, psychological anthropology with a heavy emphasis on psychoanalysis has become the main paradigm for explanation of alien mental states. However, under the above criticisms of using grand theories and the new emphases on the local theories, even psychoanalytic anthropology was in distress. Nevertheless, the anthropological rejection of the "nature" side of the dichotomy persisted and, although hinged on a grand theory, even psychological anthropology marched on highlighting the sociocultural origins of mental states. When Geertz(1980) and others discussed how even the primary emotions were culturally constructed, the use of psychoanalytic categories also, now seen as essentially Victorian European cultural constructs, to explain primary affects and the reality behind seemingly absurd non-Western cultural constructs, came under critical scrutiny.

In India, psychoanalyst Kakar published a psychoanalytic interpretation of Indian psychological complexes in 1978. This work was much admired in the psychological anthropological circles. However by 1982, Kakar was applying not only phenomenological theories but also the discourse analysis of Foucault to declare,

"Foucault, for instance, has pointed out that each age of civilization, from the

medieval period to modern times, has had its own view of madness which closely reflects the general social and logical preoccupation of the time. Psychopathology is not independent of social history, for each age draws the split between madness and reason at a different point and in a different fashion. Many anthropologists have complemented Foucault's account of the historical relativity of mental illness by drawing attention to the cultural relativity of psychiatric concepts"(ibid:6).

He went on to elaborate that the purpose of his work was an exploration of Indian "cultural psychology"(ibid.) and commented, "...it is rarely recognized how much a certain kind of introspection – a sine qua non for psychoanalysis – is a peculiarly Western trait, deeply rooted in Western Culture" (ibid:7).

Obeyesekere (1981:1990), working in the Sinhala Buddhist community in Sri Lanka, found that what the Western psychiatry considers as symptoms cannot be treated as such when found in Sri Lankan contexts. Sri Lankan culture provides frameworks to translate symptoms into symbols that have no medical meanings but religious meanings. This work of culture is not available to Western individuals who exhibit similar symptoms because of the rationalization of the life world and demystification of religion. Obeyesekere (1985) addressed the theme of depression, and found that the uncritical application of diagnostic instruments such as the DSM to identify symptoms of pathology erroneous when applied in non-Western societies. Obeyesekere writes:

"My contention is that what is called depression in the West is a painful series of affects pertaining to sorrow and is caused by a variety of antecedent conditions – genetic, sociocultural, and psychological. These affects exist in Western society in a relatively free-floating manner: they are not anchored to an ideology and are therefore identifiable and conducive to labeling as illness. However, this need not be the case in other societies where these affects do not exist free-floating but instead are intrinsically locked into larger cultural and philosophical issues of existence and problems of meaning" (1985:134-135).

Discussing the application of psychiatric symptomatology as in the DSM and similar instruments for diagnosis of mental illness in non-Western cultures, Obeyesekere found grounds for disagreement. Carstairs and Kapur (1976) employed a comparable methodology to isolate psychiatric symptoms in an Indian sample. Their intention was to use a set of symptoms to find what percentage of members in their sample would exhibit how many symptoms and to relate the symptoms to psychiatric need for help on a need scale ranging from 0-5. If the need score was 5, the individual was classified as psychotic, urgently needing psychiatric help.

As Obeyesekere shows, this scaling is erroneous because the quality and intensity, not the quantity, of symptoms determine the need for psychiatric care. For example, an individual with one extremely intense symptom that may be qualitatively highly significant may require immediate care while another showing five low intensity and low quality symptoms may not need care at all.

To complicate matters further, Carstairs and Kapur found that, in certain instances, individuals with symptoms and without symptoms showed no difference in their social

functioning scores. In that case, what is the significance of this symptomatology? Carstairs and Kapur failed to address this issue. If symptoms do not impair social functioning then there must already exist ways of dealing with illnesses that they signified. And this is where Obeyesekere's thesis on the work of culture kicks in. The culture of the Indians under investigation had facilitated canalization of the affects that lead to symptoms into cultural symbols that are personally and collectively meaningful. However, when individual mental states are isolated from the culture, as the instrument used by Carstairs and Kapur and other comparable instruments such as the DSM do, there is no way to figure how individuals socially function while theoretically exhibiting symptoms of acute illness.

While the efficacy of Western symptomatology and nosology to identify non-Western psychiatric symptoms was thus caste in doubt, other researchers took even more relativistic positions by rejecting Western ontology altogether. Schweder (1984), Lutz (1985), and Harré (1983 & 1986) expressed doubt on all Western psychological globalizing theories and adopted a cultural relativism that considered only the variables defined by the local cultures. Rosaldo(1984) agreed with Geertz (1980) in the latter's contention that primary affects, feelings, and thought are culturally constructed. Schweder (1990) went on to develop a cultural psychology by stressing a dialectic between intentional worlds (cultures) and intentional persons (mind).[19] During this rush of ideas and perspectives, a word of caution was heard from mainstream psychological anthropology. Spiro (1986) pointed out the need to pay closer attention to the common ground of human physical existence irrespective of cultural variability and the relevance of comparative research.

Although some researchers in psychological anthropology adopted cultural relativism, others show a renewed interest in biology and reorganization of globally applicable diagnostic criteria that would also be culturally sensitive (Worthman :1992 and Good :1992). The latter discusses how psychiatry has taken an increasingly biological orientation during the last three decades and the sociological, economic, and political factors in the background of these orientations. Before I engage in an examination of these let me first clarify a few points.

The discussion so far attempted to show the two paths taken by the researchers. On the one hand, the biologically oriented psychiatry and related anthropological schools take only the "nature" side of the famous dichotomy ignoring the sociocultural factors in the background of mental distress. On the other hand, the phenomenologically oriented psychologists and social scientists ignore the species specific biological characteristics that all humans share. The issues here are conceptual, ethical and technical.

Conceptually, the psychiatric nosology hinges on a biological and genetic model of the mind. Mental states are perceived as genetically inherited and or the products of various physiological, neurological, endocrinal and other biological processes. This is because of the natural science orientation of modern psychiatry and psychology. The epistemology of the natural sciences requires that the phenomena under investigation have an existence within the purview of the five senses. Ontologically, these phenomena must be amenable to experimental method. Teleologically, they are physical and functional, and exist in order for the organism to survive in a given environment. Thus, mental states are also taken as products of the biology of a person. These mental states function to facilitate an individual's existence in a given environment. The biological bases of these mental states are manipulable by experimental means. When mental states that are harmful to the existence of the individual

arise, they can be removed by altering the biological conditions that produce them. The theory of the psychiatric symptomatology and nosology chooses not to discuss the etiology of mental states, and proceeds to manipulate the physical organism by pharmacological means in order to change mental states that are deemed abnormal, pathological, and destructive so that the individual can recover normalcy and health. Teleologically, it assumes that it is necessary to remove such mental states for the individual to survive in her environment. It does not deal with the cultural contexts of mental distress.

The psychiatric diagnostic instruments, while assuming that a normal mind is necessary to survive in a given environment, are blind to the possible effects of the environment on the individual that might engender the unhealthy states of the mind. They are constructed on the assumption that individuals exist in a perfect environment and that this environment is unchangeable, and assume further the existence of a unidirectional unilinear relationship between the individual and this environment.

Ethically, the historical reasons for emphasizing fast diagnosis and fast therapy are rooted in the history of mental illness itself. Foucault (1965) and Jackson (1976) have discussed the enlightenment reaction to the confinement of the mentally disturbed along with the criminal elements and epileptics. Since Pinel introduced an alternative way of dealing with individuals affected with mental suffering, the move to eliminate confinement became both morally and economically relevant. Morally, confinement went against the Enlightenment concept of humanism. Economically, the maintenance of mental hospitals to keep the mad men, or whoever the society deemed psychologically unfit, in confinement became too much of a burden on the State. However, there appears to exist more systemic reasons as to why certain states of mind, not only psychosis or schizophrenia but even conditions such as deviations from ordinary psychological norms of culturally defined sense of normalcy, be considered pathological.

Technically, Western cultures do not tolerate deviations from psychological norms.[20] Perhaps, there is a relationship among the nature of religion, the mode of production, as Max Weber discussed early in the last century, and social tolerance of deviations from the normative psychological conduct. Modern capitalist societies are mostly Protestant. These schools of Christianity have no elaborate rituals or saints as in Catholicism to offer psychological relief. Rather, Protestantism emphasizes individual responsibility and prayer. Weber pointed out that this sense of personal responsibility led to the growth of the spirit of modern capitalism but at the cost of loneliness. In these societies, religion became rationalized, demystified, and meaningless in the emotional lives of individuals. Consequently, as Obeyesekere (1985) discusses, the mental states that the earlier religious notions dealt with became free-floating phenomena not anchored in the culture. The individuals who had such states of mind had no cultural ways to deal with them.

These societies emphasize economic, religious, and political individualism and exhibit a relatively much lower degree of tolerance for psychological individualism or deviations from the psychological norms. Conformity with the psychological norms is a prerequisite for the systematic, economy-oriented, capitalist or socialist modes of production. Talcott Parson's social systems theory is an elegant exposition of the systematic nature of this type of societies.[21] The personality, culture, economy, society are all, in terms of his American experiences, synchronically interrelated to produce the social system. In my experience, the

American (Western, in general) society is very systematically organized and all individuals have well-defined places and functions in it. Of course, sometimes, certain areas of activity become temporarily disorganized but order is quickly and efficiently restored.[22] Ordinarily, every individual must, irrespective of her personal problems, hold her status and play her roles efficiently and effectively so that the system functions undisturbed.

An individual's deviation from the psychological norm introduces an unexpected and unwanted glitch, and this glitch must be dealt with promptly so that the system can function dependably and efficiently. Therefore, among other states of mind, certain moods and attitudes are identified as troublesome and brought under psychiatric manipulation in order to restore individual and systemic normalcy. In this context, any reasons as to why that individual does not fit in is not seen dialectically. Rather, the system is taken as a constant, perfect in itself, unchangeable and monolithic. The individual must work with this system in order to survive. The individual must change, but not the system. Hence the need for fast diagnosis, in terms of nosologies and symptomalologies such as the DSM, and fast therapy. In the process, conditions of the mind that are considered as normal in South Asia end up becoming pathological under the Western diagnostic criteria.[23]

At this point, a hint from Good (ibid.) is also relevent. He suggests that the power of the pharmaceuticals industry and the involvement of third party reimbursement schemes are relevant to understand the sociology of the biological orientation in psychiatry. Pharmaceutical industries have heavily invested in, and have a stake in the direction of psychiatric research. Research grants, laboratory facilities, and other requirements of researchers are, to a significant degree, controlled by the pharmaceuticals industry. On the other hand, third party reimbursement schemes that compensate the healthcare industry for mental healthcare delivery involve the health insurance industry. The latter demands fast and inexpensive therapeutic programs for its profit margins depend on least expenditure on reimbursement on healthcare delivery. Pharmacological therapies, based on biologically oriented psychiatry, involve such low cost treatment programs that often require only outpatient facilities. In contrast, the therapeutic programs involving psychotherapy require hospitalization for extended periods of time, which is expensive.

Conceptually, South Asian religion does not restrict its epistemology to sense perception. The mind is also considered as an organ of perception (*manendriya*). This allows the ascetics and the sufferers of *udās* to establish a mode of knowing, cultural knowing, as it were, and communicating. They use their capacities for empathy to understand each other. Since there are no issues of experimental verification or falsification as in science, this mode of knowing is confidently used. In fact, verification of the effectiveness of communication between the ascetics and the *udāsi* exists at a personal level. If an ascetic is insensitive or has the wrong attitude in such a manner that there is no communication between him and an *udāsi*, the latter goes to another ascetic.

Ontologically, South Asian religions posit every conceivable phenomenon of the world within an overarching sense of reality conceived as the *sansar*. Within this reality illness as well as well being, madness as well as sanity, is given the same treatment. They all are conceived as the results of karma, a bridge concept that ties existential situations with cosmic themes.[24]

Teleologically, an individual's suffering is conceived as functional in that such suffering could, with due diligence on the part of the sufferer and care on the part of the surrounding community, expose the reality as religion conceives it. Here, unlike in the scientific teleology, not to suffer is not to know and therefore to be ignorant and unfit for redemption.

Further, the South Asian societies are not so tightly systematized by means of technological, technocratic, and bureaucratic organizations. Nor are they as individual centered and as economically productive and prosperous.[25] This relative looseness in the organization and lower expectations from individuals regarding their conformity to psychological norms and economic productivity give the individuals greater leeway with regard to deviations from psychological norms. The lower expectations in this area of life coexist with greater tolerance.[26] Thus, there is no need to conceive of these as medical conditions.[27] South Asians do recognize mental illness[28]. However, the conditions of the mind in the *udās* continuum are not among such illnesses.

Ethically, there are no quarrels with the society as a system since there are no, and has never existed, modes of confinement of the 'mad.' On the other hand, there has been no economic or technological/bureaucratic urgency to compel individuals to fit in either. To be sure, the South Asian societies place a heavy burden on individuals to socially conform to the dictates of caste, religion, and other aspects of culture as defined in the *Manusmriti*.[29] These undoubtedly cause serious frustrations and disappointments that lead to psychological agony. Many religions, including Jainism and Buddhism and other schools of *sramana* religions, have sprung up denouncing this code and sociocultural confinement that it engenders. The Hindu tradition that up holds the *Manusmriti*, as well as the *sramana* religious orders, have developed ethical and conceptual schemes to accommodate the frustrations and concomitant mental states.

Technically, these schemes offer alternative conceptions of reality and life styles that fit into these alternatives. Even the Hindu tradition, while formally accepting the *Manusmrti*, also denounces it considering the world according to the values of the household based on Manu as *maya*, and provides lines of action comparable to the Jain and Buddhist programs to accommodate the mental states emerging from conformity or non-conformity with Manu. They utilize the mental states, the *udās* and *vairagya bhavana* that result from frustrations in this world, to push the limits of reality of everyday world and its values, and the limits of psychological tolerance of denial, opprobrium, guilt, and shame, in order to find relief from suffering.

THE LOCAL MODEL

Darśan, discussed above, meditation, and asceticism are among the techniques so developed. The Jains, as other indigenous South Asians do, give these mental states a religious definition. For the Jains, it is the indication of the defiled soul finding a window of opportunity to perceive the reality without the mundane interferences. Not all Jains consider this situation salubrious. Many people want to live a lay life, be happy at all times, and do not want to renounce the world although they formally declare that world renunciation is their ultimate goal. They do not want to see their nearest and dearest relatives and friends go begging for food in the streets or practice severe asceticism. They make serious attempts to prevent the *vairagin* from renouncing the household although these attempts do not include psychiatry and psychotherapy. But, for the *udāsi*, there is a great need to find relief from his *udās*. For him, his state of being is a double-edged sword. He would like to get out of his gloomy mood but also use it to cultivate a few understandings about the world and about himself. Both these could be achieved during *darśan*.

Darśan allows the *udāsi* to use his condition as a vantage-point to contemplate perfection. Given his loneliness and his yearning for perfect company, *darśan* is an ideal opportunity to engage in such contemplation. The culture provides him with a theater in which he encounters other players in a set choreography. As a member of the culture, he knows exactly what to do when he has this state of mind. He goes to the monastery and contemplates the sacred categories while the ascetics sit there representing these eternal categories, although in mortal form.

The aesthetic that transpires from this encounter leads to a dialectical cognitive process. It helps him encounter, through his *udās* mindset, the most sublime. This encounter rearranges his cognitive system, eliminates *udās*, and brings him back to the mainstream life, now renewed and invigorated. Here, the *udāsi* participates in the act of creation of the sublime that the culture has established through the institution of *darśan*. He, by gazing at the images of perfection, finds a glimpse of perfection, the perfect companion that his heart longed for. This discovery leads to the recovery of his equilibrium, which the *sansar* will undoubtedly upset once more as he faces the ebb and flow of life. Then it will be time to perform *darśan* again to recapture the lost companionship with perfection.

This procedure, however, is adequate for mild *udās*. More serious *udās*, as stated above, requires augmentation of other meditation techniques and ascetic practices and a prolonged stay in a monastic environment. But, for *vairagya bhavana*, *darśan* alone is inadequate for two reasons. On the one hand, being at the other extreme of the continuum, periodically performed *darśan* is insufficient. On the other hand, the ascetics detect potential for monastic recruitment when they detect the presence of, at least the individual's claims of, *vairagya*. The condition of *vairagya* or complete loss of interest in the household is the fundamental characteristic of a monastic. The ascetics pay special attention to those who have this state of mind. What is significant here is how the ascetics understand and evaluate the condition of such individuals. There is no diagnosis as such but an understanding of a condition using personal experience and cultural knowledge. The technique is dialogical and hermeneutical with the ascetic comparing his and other ascetics' personal and collective experience with that of the *vairagin*. The conclusion arrived at after detecting *vairagya bhavana* is that the individual has inherited this frame of mind from her previous births, as a result of her good

karma or *punya*, the result of her ascetic practices in those births. All Jains believe that ascetic motivation through *vairagya bhavana* indicates that the individual was an ascetic in her previous births as well.[30]

The Jains, however, refer to the need for medical treatment when they realize that an individual's state of mind is not related to religion. The condition of mind, then, is neither *udās* nor *vairagya bhavana* but one of mere anger, disgust, contempt, inability to get along with others, abusive language and so on. Such individuals are not seen as potential religious virtuosi but medical cases. In Muktipur, the monastic compound also had an ayurvedic treatment center for individuals with such problems. These individuals, who suffer from mood disorders without a religious orientation, are not recruited to monasticism.

DILEMMAS

Would the Jains agree with the Western theories about the characteristics of *udās*? My interviews with them revealed that, technically, the Jains accept all possible and conceivable explanations. According to their system of logic, the *sayadvada*, there are numerous ways to arrive at the truth. The Western style symptomatologies, nosologies, etiologies and other diagnoses are some among many possible methods to discourse on *udās*. The ascetics and their lay followers of Muktipur contended that whatever the nature of the condition, it is still a product of one's karma. Jains do not recognize a pathological condition in *udās* but a karmic predisposition to have a particular view of and attitude towards the world. *Udās*, without this predisposition, may be pathological, an illness of the mind. But *udās* with the correct religious foundation is an access to reality and a perspective on the pathology of the world. The differences in the attitude in the evaluation of *udās* make all the difference between the pathology of the individual and the pathology of the world. The difference between the *udās* of the mild kind and *vairagya bhavana* is that the ordinary *udāsi* uses this mindset to develop a perspective on the pathology of the world to which he must return wheras the *vairagin*, once she discovers the pathology of the world, rejects it altogether. In the Jain cultural hermeneutics of *udās*, the world according to Manu engenders it while the Jain path of soul purification eliminates it.

Obeyesekere (1981, 1985, 1990) considers the Sri Lankan Buddhist conceptualization of certain states of mind that psychiatry considers as symptoms of pathology as the work of culture. The culture intervenes between the individual and the society and helps the individual to canalize her affects through cultural symbols so that her affects become socially meaningful. Here, psychiatric symptom becomes a cultural and personal symbol.

In the Jain case, *udās* and *vairagya* are not symbols that represent something other than themselves but signs that point to other phenomena while being literally meaningful. They are signs of distress at the level of *parole*, and signs of ascetic predestination due to the *punya* or merit accrued from previous lives at the level of *langue*, as in Saussurian semiotics. Thus, at the deeper levels of meaning, *udās* is a sign of spiritual capacity and *vairagya* is a sign of spiritual awakening leading to monastic asceticism.

Thus, in the contexts of the South Asian religious world, there is a procedural issue in the application of psychiatric categories. They are employed in a matter-of-fact fashion as if a quick look at the individual could reveal a complex problem that she deals with. The

psychiatric symptomatologies such as the DSM view the mind in the same way a laboratory scientist looks at a thing, but not as a perceiving, cognizing, thinking, analyzing, classifying, and feeling being, in short an intellectual life form, whose life history as she recollects, and as she can never recollect, has a foundational impact on her existence.[31] What is alarming here is that with the current trends of globalization of the local economies, medical practices are also becoming globalized. In the fast paced life styles of many South Asian cities more and more individuals are employed in Western type organizations where the individual to group relationships are expected to function in the same way they do in the Western societies in order to maximize work output and resultant profits. As the local belief systems become "demystified" through superficial education in the natural sciences and even more superficial adherence to political ideologies such as garbled Marxism, urbanized people steadily lose interest in religion, and lose their bearings within their own cultures although they still adhere to many other aspects these cultures. Add to this the steady deterioration of the respectability of religious authorities who, too, have become victims of the market place. Consequently, when the competition for profits, and for resources for existence, increases more and more quick fixes for psychological stress are being sought. The outcome is the need for adoption of diagnostic criteria similar to the DSM type. What is even more alarming is the fact that Western educated South Asians are becoming less and less tolerant of psychological variance from the norm, leading the way for condemnation of more and more South Asians as mental patients. These types of nosologies and symptomatologies invent psychopathology when applied in traditional South Asian contexts whereas none exists when seen from the native cultural point of view. These inventions do not remain in the clinical domain for too long. They quickly trickle down to common usage and enter the everyday language and everyday social discourses. At that level, and in the heads of irresponsible popular psychologists, they become free-floating schemas for cognition of formerly normal behaviors as pathological. Now that is a cause of *udās*.

POSSIBILITIES FOR CONVERGENCE

The way out of this dilemma is to develop a compromise position. The discourses available to understand *udās* oscillate between biology and culture. If we recognize the significance of biology without getting caught in the recalcitrant dichotomization of the mind and the body, and give the due recognition to the socioculturally constructed nature of our views of the mind, it may be possible to develop a matrix of possibilities within which *udās* could be meaningfully discussed.

First, the biological aspects of the mind do play a role in engendering various moods and motivations. These may be due to genetic reasons, or due to pre- and post natal deformities arising from accidents, poor maternal health because of drug addiction, alcoholism, malnutrition or illnesses that damage the central nervous system. Further, the endocrinal system, other hormonal factors arising in the contexts of menstruation, pregnancy, menopause, senility, and other such bodily functions have an effect on the way we perceive, cognize, cathect, and discharge emotions. Here, we have a situation where there is nothing wrong with the world, but in the way the individual responds to it. Here, the DSM type nosologies and symptomatologies and pharmacological therapies might be the best approach to deliver psychological relief.

The second possibility is that while the biological organism is capable of functioning

optimally, certain sociological factors may interfere with it, causing mood disorders and depression. Politics (warfare, terrorism etc. that cause tremendous harm to physical and mental functioning), economics (poverty, malnutrition, unhygienic living conditions), family relationships (incest and resultant psychological traumas), drug addiction and or alcoholism (both caused by the vulnerability of the individual and the availability of these substances), and a host of other such extra-biological and purely sociological phenomena may inhibit physical growth or damage the body causing psychological disorders. At this level, a biological etiology might not be adequate to explain the causes of mental distress, for large sociological themes are at play underneath the biological factors. Thus, a nosology and a symptomatology such as the DSM that does not provide an etiology might misdiagnose the actual causes and overdiagnose the bialogical factors. At this level, biology and sociology must and do overlap. Programs of social medicine and psychiatry need to look at these larger themes to deliver lasting relief, and psychological relief goes beyond psychiatry towards social policy and the law. The latest edition of the DSM attempts to account for some of these factors.

Third, with biology remaining constant, sociological conditions may engender non-biological psychological disorders. Psychological abuse in interpersonal relationships in the family[32] and in other institutions such as schools, hospitals, prisons, concentration camps, war and terrorism, and refugee camps can lead to traumas and post-traumatic stress disorders for which pharmacology can provide only temporary relief entailing with it the dangers of drug dependency. Lasting solutions have to come through the law and social care giving. For example, mental harm from familial child abuse can be avoided through legal intervention that facilitates removal of children from abusive families, as in California, U.S.A. In any event, the only credible response has to be the removal of the social conditions that cause psychological stress. And here, symptomatologies of the DSM type that are founded on a biological model are irrelevant.

The fourth situation arises when the culture and the individual find something good in the mental distress. Here, the culture has institutionalized ways of conceptualizing the mental state irrespective of its causes. The only requirement is the possession of minimal intellectual capacities to learn to use the cultural schemas[33] to perceive, cognize, and conceptualize one's state of mind. The society provides experts who advise and provide support to develop such capacities. Once these schemas are grasped, the individual changes her perspective on and attitudes towards the issues that caused her frame of mind and rearranges her concepts about her situation. This is what happens in the Jain case. Having developed religious schemas, she follows the lines of action that the culture teaches her as a strategy for obtaining relief, not from a mere state of mind but from what is culturally perceived as the ground of all suffering, the *sansar*.

The community also grasps the cultural schemas and begins to treat her accordingly. By the term community, I refer to the individual's immediate group affiliations that are closely related to her psychological existence. How this community perceives the individual is just as important in determining whether she is sickly or saintly because her reality is a social construct whose nature is determined by the poles of her existence: the domestic and monastic communities. In order to generate a shared definition of the state of the individual, these two communities must share the cognitive schemas with the individual. And, in order to understand how this sharing occurs, sociology, anthropology, and psychiatry need to grasp

cultural semiotics in non-Western societies and do away with the medical semiotics of the symptomatologies.

Thus, discussions of *udās* and other comparable mental states can take into account both scientific and cultural notions without compromising objectivity. Religion, as Jainism does, is capable of absorbing a rigorous biology of states of mind without compromising its integrity. The challenge for science is to be flexible enough to accommodate a phenomenology of religion.

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NOTES

[1] *Wittgenstein, Ludwig, 212 Philosophical Investigations, tr. G.E.M.Anscombe. Oxford(UK) and Malden(MA, USA), Blackwell Publishers Ltd.*

[2] *I have changed place, institutional and personal names wherever I thought was necessary to protect the privacy and identities of individuals and institutions.*

[3] *During this period the total Jain population in India was roughly 4.5 million. This amounted to about .5% of the Indian population. The Jain community exists as two main sects, Digambar and Swetambar. Digambars are concentrated mainly in Karnataka, Maharashtra and Delhi whereas the Swetambars are found mostly in Rajasthan and Gujarath. Sizeable Swetambar concentrations exist in Delhi and Maharastra as well. Both*

Digambars and Swetambars are internally segmented into a number of subsects. Swetambars are segmented into Murtipujaka, Sthanakavasi, and Terapantha subsects. What I refer to as Dharmapujaka is one of these. The Dharmapujaka sect had a monastic pupulation of about 770 ascetics of which roughly 65% were female. Of this, 60-65% were widows. This sex distribution appeared to be shared by the other two subsects. Digambar statistics of sex distribution must be quite different because they do not initiate females into monasticism. Instead, they have the institution of aryika to accommodate women's aspirations to a life dedicated to religion. Unlike the Swetambar sadhvis, the aryikas are not nuns.

[4] *Throughout this essay I shall use terms such as mood, affect, feeling, emotion etc. to define udās. The psychiatric terminology also uses these words of English language to denote states of mind. My usage involves only the literary meanings of these words whereas the psychiatric usage attributes to them a medical character suggesting illness. Except where I refer to specific psychiatric and medical contexts, I use these terms in their literary senses.*

[5] *Bate, J.D. (1875).*

[6] *Haughton, Graves .C (1833).*

[7] *Turner, Ralph Lilley, (1931).*

[8] *Brown, Charles Philip, (1903).*

[9] *Reeve, W., (1858:1980).*

[10] *Peiris, K.N.D. (ed.),(1994).*

[11] *Although the term is available in Sinhala it is not used in everyday language and is restricted to literary Sinhala. Even there, its meaning is not as specific as in other South Asian languages. However, regarding the constellation of moods and attitudes, Obeyesekere (1985) examined a comparable phenomenon in Sri Lanka. As he discusses, terms such as sōkaya (sadness), tanikama (loneliness) and so on are used to define this state of the mind instead of the term udāsina. In effect, though, the state of mind among the Sinhala people is identical to udās. The Jain vairagya bhavana is comparable to the Buddhist pilikul bhavana and asubha bhavana that Obeyesekere discusses. However, pilikul bhavana and asubha bhavana are ritually and purposefully constructed mental states. Vairagya bhavana occurs in daily life without a ritual context. Everyday experiences engender it.*

[12] *Rhys Davids, T.W. and William Steed, (1922:1952), Buddhadatta, A.P.,(1950:1960), Monier-Williams, Monier, (1899:1979).*

[13] *See Obeyesekere (1985) for an analysis of this term. Obeyesekere finds a semantic connection with the term kālakriya, meaning death. Other semantic variants are sōkaya (sadness and sorrow), kampanaya or kampāva (shock of loss), sanvēgaya (pain of mind). Obeyesekere writes:*

"One of the most common terms in the lexicon of sorrow is kalakirima, a sense of hopelessness,, or despair with life. Etymologically, kalakirīma is derived from the words kāla and kriyā, 'termination of time,' that is, death. When the word is used in its formal etymological sense as kālakriyā, it refers euphemistically to 'death.' However, in its popular form as kalakirīma, it refers to a sense of hopelessness, but not a free-floating one: it is a reaction against life itself. Specific emotional words for sorrow and loss -- such as kampāva, sanvēgaya - are easily assimilated into more general terms that express an attitude to life in general, such as dukkha and kalakirīma. This is reflective of the Buddhist orientation of this culture"(144).
Also see n.11 supra.

[14] *See Eck (1981) for the Hindu doctrine and rituals of Darśan. Structurally this is quite similar to the Jain Darśan.*

[15] *Gathas are religious verses composed on various aspects of the religious ideology. More usually, they are in praise of the sacred statuses. Similar gathas exist in the Buddhist culture as well.*

[16] *Arihants are the onmiscient ascetics who have achieved complete spiritual liberation from sansar. After death they become siddhas, bodiless residents in moksh or moksha. The gurus are the heads of the various schools of*

ascetics known as gana, gachcha or pantha. They are also known as acharya. Sadhus refer to both sadhus and sadhvis - monks and nuns respectively. The Jain sasana or the community, consists of four groups: sadhus, sadhvis, sravakas (laymen) and sravikas (laywomen). For details see Sangave (1980), Deo (1960), Cailat (1975), Jain (1975), Jaini (1979), Tatia and Mahendra Kumar (1981), Goonasekera (1986), Carrithers and Humphrey (1991), Jaini (1991), Granoff and Shinohara (1992), Dundas (1992), and Cort (1998).

[17] *This process is comparable to the Sri Lankan Buddhist's visit to a monastery. He would first go, worship, andthen go by the monastery to see the monks. Usually, most Sri Lankan villagers have their favorite monks, and the udāsina (kalakirunu) individual would visit them, chat in much the same way as the Jains do and return home feeling a lot better. See ns.11 and 13 supra.*

[18] *Samayik involves the contemplation of the sacred categories addressed in the namokar mantra, discussed above, for forty-two minutes. See Goonasekera (ibid.) for details.*

[19] *SeeWorthman (1992) for a full treatment of this subject.*

[20] *Perhaps, the use of the term Western is inappropriate because in many Western societies, particularly in Catholic societies, there is a high degree of tolerance. The many religious rituals ranging from confession to self-mortification prevalent in Catholic societies indicate the use of religious techniques for coping with psychological stress and the social tolerance of deviation from psychological norm. The Protestants have a relatively narrow choice of means to cope with psychological stress. These are based on prayer.*

Another reason why the term is inappropriate is the existence of native American communities in the Western hemisphere. Further, the careless use of the term is pejorative. In my usage I do not involve it in a cultural blame-game. I am only making a comparative analysis.

In any case, I use the term Western to indicate the European and derivative societies such as the North American, Australian, and New Zealand societies where institutionalized science, modern medicine, psychiatry and other aspects of modernity originated. Under the same rubric I include the Westernized segments of the non-Western societies that have, for all practical purposes, adopted the materialist world view of the natural sciences.

[21] *Parsons(1951).*

[22] *The systematic character of the Western social organization becomes apparent particularly when compared to the modern aspects of South Asian societies. Today, at least in Sri Lanka, the elements of systematic social and institutional organizations that the colonial governments left behind are in almost total disarray. I use the term "modern" to identify them. However, the "traditional" aspects of the Sri Lankan and South Asian community retain a relatively higher degree of systematic character and internal coherence.*

[23] *In this context, Michel Foucault's diagnosis of the Western conceptualizations of mental disorders is relevant. By means of positivist and empiricist formulations of mental disorders, of which the Diagnostic and Statistical Manual of all editions is a most vivid example, Western cultures view states of the mind from the point of view of existing economic and bureaucratic needs. This tendency that, according to Foucault, emerged from 18th century coincides with the emergence of the spirit of modern capitalism that Weber discusses. What Weber has in mind is not capitalism or Protestantism itself but the process of rationalization that produced the bureaucratic social organization of which technological reasoning, technocratic planning, and capitalism for the sake of increasing capital are integral aspects. The objectification of the individual led to the demystification of the cultural expressions of mental distress in terms of clinical categories. In this, the power of the system over the individual is evident for the clinician who "objectifies" and "demystifies" the beliefs of another individual exercises the power of the system of which he is an agent and an employee.*

[24] *In the contexts of Sri Lankan rituals associated with the goddess Pattini, Obeyesekere presents a classification of dōsas or faults. There is a humoral theory of dōsa to explain the illnesses arising out of imbalances of the three humors (tri dōsa) and a nosology that classifies the various illnesses resulting from the different combinations of humoral conditions. Additionally, there are theories of "faults" arising out of the wrath of the gods (deviyanne dōsa), of other spirits (amanusya dōsa) etc. These explain both physical and mental illnesses. An overarching theory is that of the graha dōsa, faults related to bad planatory positions and combinations. But*

the karma theory gives the metatheory of all illnesses subsuming all suffering under an individual's bad karma that she accumulated from her previous births. These are called karma dōsa. See Obeyesekere (1987: 40-49) for an elaborate discussion of the dōsa theory.

The dōsa theory is adopted from the Sanskrit ayurveda and is known to the Jains and Hindus as well. However, the karma involved here is bad karma since it is used to explain faults and misfortune. One might compare this with pāpa karma, the karma resulting from bad actions. On the other hand, punya karma brings about good fortune and lasting happiness. The Jains would place vairagya bhavana under the results of punya karma.

[25] *This is not to say that they are not selfish or self-centered. On the contrary, egoism, selfishness and self-centeredness are conceptualized as real world phenomena that are, nevertheless, devalued. All indigenous religions of South Asia focus on these characteristics of human beings. The Buddhist concepts of tanhā and lōbha and the Jain concept of parigraha are examples. See Jaini (1979), Goonasekera (1986), and Dundas (1992) for details. In fact, the South Asian notion of nishkramana (often translated as "renunciation") hinges on these concepts.*

[26] *To be sure, South Asians are thoroughly norm-bound in other areas of life. Despite the recent acquisitions of some characteristics of Western social organization, science, technology, and the law through colonialism and acculturation, religion, caste, class, and gender ideologies still show little or no tolerance for the slightest deviations from the norms. Consequently, South Asians endure much personal suffering. In this regard, the Western societies are extraordinarily liberal and exhibit a high degree of tolerance for individual deviations from these norms.*

[27] *The South Asian mode of repression is social. The social investigations by "social clinicians," the elderly, the ubiquitous busy bodies, and the local gossip mongers who keep an eye on everybody's conduct, detect deviations from social norms, castigate individuals for deviations from these norms, and bring about marginalization of the offenders. In the worst case scenario, the culprits are ostracized. This occurs with extraordinary rapidity. Instead of confinement that Foucault discusses, South Asians use expulsion from the group as the technique of repression. The difference between the South Asian and Western ways of exercising social power over individuals is a matter of emphasis. The West emphasizes individual productivity whereas South Asia emphasizes social purity. The manner of castigation follows accordingly.*

[28] *Charaka Samhita provides elaborate diagnostic criteria and therapeutic procedures for what is locally perceived as mental illness.*

[29] *The Laws of Manu (1991).*

[30] *If this is the case, then how does an individual experience vairagya bhavana for the first time? I put this issue before monastics as well as lay people. One of the responses was that when an individual understands the dharma well, and begins to practice self-mortification and other activities directed towards soul purification, punya accumulates in a cosmic "account" and in the next birth this punya contributes to the creation of conditions necessary for the development of vairagya bhavana. The cosmology and the metaphysics of this explanation are too detailed to outline here. Suffice it to state that vairagya bhavana is always considered as the result of good karma.*

[31] *Fortunately, there is much debating on these issues as Good (ibid.) reports.The re-evaluation of a pure science model as in the DSM series mentioned above appeared in the fourth edition of the DSM. The discourses mentioned earlier are already reflected in the new approaches to viewing non-Western societies, as in Ingham (1996). Relevant debates have been published in journals Social Science and Medicine as well as in Culture, Medicine, Psychiatry. In the field of psychiatry, the ethics of using nosologies and symptomatologies such as the DSM are increasingly under attack. Psychopathology,32:3:1999 carries a series of articles by clinicians Mezzich, Schmolke, Frommer, Kilian and Angermeyer, Lothane , and Kick. To the best of my knowledge, these journals are not available in Sri Lanka. But the abstracts of Psychopathology, available on the Worldwide Web, appear to be directly relevant to this discussion.*

[32] *At this point, psychoanalysis offers an effective non-biological scheme to interpret the etiology.*

[33] *Here I refer to Roy D'Andrade's (1992) work on cognitive schemas.*

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