

A review of *Depression in Kerala* by Claudia Lang

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I. Research localities

Depression in Kerala is an excellent study about the glocalization (vernacularization) of depression in Kerala, a south Indian state known for its (mental health) literacy and a relatively flourishing Ayurvedic sector. The study is based on seventeen months of anthropological fieldwork in the period 2009–2014. Research was mainly conducted at three sites: the Government Ayurveda Mental Hospital (GAMH)¹ and the *manisika* (“psychiatric”) OPD of the P.S. Varier Ayurveda College; a private Ayurvedic psychiatric clinic in the vicinity of Ernakulum; and in two multi-speciality biomedical hospitals with a psychiatric section located in central Kerala. GAMH and the P.S. Varier Ayurveda College are situated in Kottakkal, a provincial town in the north of Kerala known for the Arya Vaidya Sala, a prestigious Ayurvedic manufacturer that runs a highly popular Ayurvedic hospital, an Ayurvedic college, a chain of clinics all over India and abroad, a publication department, and a cultural centre. The Ayurvedic college in Kottakkal is named after P.S. Varier, who as a well-known modernizer of Indian medicine established the Arya Vaidya Sala in 1902. GAMH is heavily understaffed with just four Ayurvedic psychiatrists while the *manisika* department of the Ayurvedic college only admits six students pro year. Both the hospital and the college exclude spiritual treatment from Ayurvedic psychiatry and criticize Ayurvedic colleagues who apply *daivavyapasraya chikitsa* (“spiritual therapy”) in their practice. The Government Ayurveda Mental Hospital and

¹ See Giguère 2009 on the history of and medical practices at GMAH.

the P.S. Varier Ayurveda College limit Ayurvedic psychiatry to secular treatments such as *yukti-vyapasraya chikitsa* (“rational therapy”, i.e. treatment with medicines and diets) and *sattvavajaya chikitsa* (“psychotherapy”, i.e. controlling and disciplining the mind).² Not that religious healing does not have its place in Ayurveda’s classical corpus. After all, the *carakasamhitā* discusses *bhūt vidyā* (“demonology”) as a valid Ayurvedic treatment for mental distress (see Smith 2006, 2010, 2011; see also Halliburton 2003, p. 176). However, Ayurvedic psychiatry as it is practised, taught and advocated in GAMH and the *manisika* section of the P.S. Varier Ayurveda College, treats depression as a biological and a moral problem, not as a spiritual one. Though officially the Ayurvedic psychiatrists from Kottakkal exclude spiritual treatments they do not discourage their patients from visiting folk healers and religious experts. But to make demonology part of Ayurvedic psychiatry would invite severe criticism from the Ministry of AYUSH and from many of their Ayurvedic colleagues, because this would be seen as undermining modern Ayurveda’s policy of secularisation and biomedicalization going back to the end of the ninetieth century (Leslie 1976, Berger 2013).

II. Depression and its constructions

Depression in Kerala discusses two related topics: The indigenisation of the biomedical notion “depression” in twenty-first century Kerala and the making of Ayurvedic psychiatry as an alternative for biomedical psychiatry. In Lang’s “ethnographic ontological approach” “depression” has no fixed identity and is enacted differently in various localities. Knowledge is seen as contingent upon knowledge communities and their divergent logics as there is no model-independent understanding of reality. Depression as understood in contemporary Kerala did arise out of a network of conceptual, institutional and material transformations taking off in the 1980s. The concept “glocalization” theorizes the articulation of global biological psychiatry with local practices and notions. For example, biological psychiatry fell on fertile ground as its logic dovetails with the somatisation of mental distress which is current in Kerala and all over Asia (see, for example, Kleinman 1982, Obeyesekere 1985, Raguram et al. 1996). Lang shows that in Kerala depression is constructed on three interrelated levels. Firstly, as a disease entity depression was given thing-like qualities. Secondly,

² According to Smith 2011 the term “psychotherapy” does not cover the notion *sattvavajaya chikitsa* as mentioned in the *sūtrasthāna* of the *carakasamhitā*. He argues that the term should be translated as “the repeated restraining of the mind from harmful objects.”

depression formerly considered a mental disease in need of hospitalisation is now framed as a common disease from which many Keralites are said to suffer. Thirdly, the promotion and wide availability of cheap anti-depressants such as SSRI's, SRNI's and benzos, has further added to depression's biomedicalization.

The biological psychiatric logic that links depression to neurochemical imbalance and faulty brain chemistry has made strong inroads in Keralean professional and popular discourse. Ayurvedic psychiatrists do not challenge this view when they map biomedical psychiatric concepts on Ayurvedic notions and practices. Mental distress gets momentarily stabilized as "depression" when it is enacted in, for example, research projects, clinics and popular writings. Depression's malleability is hardly surprising as "depression" is not a natural kind (category).³ In other words, as a category depression is historically, socially, institutionally, ontologically and epistemologically contingent (see Karter and Kamens 2019).

III. Ayurvedic gatekeepers and the denial of everyday reality

In Chapter 4, "Appropriating Depression in Institutionalized Ayurvedic Psychiatry", the focus is on India's only government Ayurvedic mental hospital (GAMH) and the P.S. Varier Ayurveda College, one of the few Ayurvedic colleges offering training in the treatment of mental distress.⁴ Both institutions work towards an Ayurvedic psychiatry as a viable and equally scientific alterity to biomedical psychiatry. The Ayurvedic physicians and professors of the Ayurvedic mental hospital and the related *manisika* college pose themselves as gatekeepers of Ayurvedic psychiatry. Their policing of the borders of Ayurvedic psychiatry is well illustrated by the condemnation of the private Ayurvedic psychiatric practice of Joseph John, an Ayurvedic physician with a Bachelor's degree in Ayurveda (BAMS) and some training in counselling and biomedical psychiatry. His practice in the nearby Ernakulum area is thoroughly discussed in Chapter 5, "Possession to Depression and Back: Ayurvedic Psychiatry from the Margins." John collaborates with a Catholic priest who uses exorcism in his

³ In analytic philosophy the term "natural kind" refers to a grouping of entities sharing characteristics (qualities) which are not conditioned by human knowledge of these entities. From this perspective depression is not a natural entity in contrast to, for example, "lions" as a zoological category.

⁴ The two other Ayurvedic colleges offering a post graduate course in Ayurvedic psychiatry are the Ayurveda college in Hassan (Karnataka) and Banaras Hindu University (Uttar Pradesh).

treatments of patients suffering from mental distress. Lang's informants from Kottakkal criticize John's inclusion of *daivavyapasraya chikitsa* ("spiritual therapy") in his Ayurvedic psychiatric practice. As self-imposed gate keepers of modern Ayurveda they have no choice other than to exclude metaphysics from Ayurvedic psychiatry as its inclusion would certainly hinder the acceptance of Ayurvedic psychiatry by the Indian health authorities and by many of their Ayurvedic colleagues. However, this did not result in opposing their patients from wearing amulets, reciting mantras and offering to deities. This is hardly surprising as spiritual treatments to combat mental distress performed in temples, mosques and churches, as well as by folk healers, astrologists and *tantrics*, are highly popular.⁵

IV. Depression as common ailment

Chapter 3, "Glocalizing Depression and its Treatment in Kerala", examines how in the twenty-first century depression became an epidemic of which thirty per cent of the Keralean population is said to suffer. In this chapter Lang analyses what happens to "the globally circulating concept of depression" when it intermingles with the social-cultural and institutional actualities of contemporary Kerala. As mentioned earlier, the wide availability of cheap anti-depressants, a policy turn towards community psychiatry and the framing of depression as a common ailment, shape depression as a category in twenty-first century Kerala. In this chapter, as well as in the excellent introduction, Lang philosophically situates her "ethnographic ontological approach." Empirical data come from observations, interviews and discussions with mental health professionals, Ayurvedic researchers, professors, office bearers, policymakers and bureaucrats as well as from Keralean scientific and popular publications on depression. As a hybrid assemblage the category depression gets domesticated and stabilized in dissimilar though often related ways. Blueprints for understanding mental distress as "depression" feed into experiences and practices of therapists, patients and the general public.⁶ In some of the clinical practices studied by Lang the biomedical notion that sees mental distress as conditioned by faulty brain chemistry sits together with Ayurvedic and spiritual aetiologies. However, ethnographic research suggests that biomedical logic is getting the upper hand and

⁵ Demarcations between these treatments are certainly not clear-cut (see Connor and Samuel 2001, Barret 2008, Quack 2013).

⁶ This mechanism is known as "the looping effects of human kinds" (Hacking 1999; see also Kirmayer 2018, p. 3).

that terms such as “depression” and “tension” are on the advance at the expense of metaphysical framings of mental distress (Halliburton 2005, 2009).

V. Pills swallowing policy

In Chapter 2, “Kerala: a Society in Distress”, Lang discusses professional and popular discourses on the high incidence of depression and suicides in Kerala. Work migration to the Gulf states, unrealistic social-economic ambitions, rising divorce rates, the breaking up of joint families, loneliness, “love failures” – love affairs that are not sanctioned by parents and community – are seen as the signs and the consequences of Kerala’s hampering development trajectory. To advance their case for Ayurvedic psychiatry Ayurvedic professionals align themselves with these discourses on Kerala’s “defected modernization” – a short hand for the pathological effects of rapid social-economic and cultural transformations.

Over the last decades the disease category depression has been expanded from a rare and severe psychiatric disorder that needs hospitalization in an asylum to a common disease from which many are said to suffer in present-day Kerala. However, up to the ninety-seventies Indian psychiatrists and biomedical physicians diagnosed mentally distressed patients as schizophrenic, epileptic or suffering from bipolar disorder, and in need of hospitalization in a psychiatric asylum (Ernst 2013). This started to change with the National Mental Health Programme of 1982, the Mental Health Act of 1986 replacing the Lunacy Act dating from the British colonial period, and later on with the District Mental Health Program Movement of 1996 which advocated a community based approach to mental health care and the provision of psychiatric treatment in primary health care centres.⁷ Though the term “community” suggests a social ecological approach to mental distress its causes were located in the psyche of patients and the cultures of their families. Good intentions and lip service notwithstanding the new policies – the latest example is “New Pathways, New Hopes” from 2014 – mainly boiled down to distributing biomedical psychotropic drugs. Social psychiatry, appreciation for popular idioms of mental distress and their related therapeutics, took a back seat (see Kapur 1979, Bibeau and Corin 2010, Quack 2012). “Pills swallowing policy” is how two authorities on psychiatry in India typify this pharmaceuticalization of mental illness in contemporary India (Jain and Jadhav 2009). The aggressive marketing of cheap anti-depressants such as SSRIs by the Indian pharmaceutical industry also contributes to the biologiza-

⁷ For excellent overviews of this policy change and its rhetoric see Quack 2012 and Sood 2016.

tion of mental distress in present-day Kerala and in India at large.

Psychiatry in India is treated step motherly as the number of 3600 psychiatrists in 2018 testifies. The discipline also holds limited prestige compared to other biomedical specialisms. But allopathic psychiatry still carries much more prestige than Ayurvedic psychiatry which is not mentioned at all in policy documents. However, the practice of Ayurvedic psychiatry is not curtailed like the treatment of mentally depressed patients in religious establishments. The Erwadi tragedy of 2001 in which twenty-nine distressed patients who were treated in a healing dargah in Tamil Nadu lost their lives due to a fire that broke out in this Sufi shrine, led to the curtailment of spiritual treatments by the Indian Mental Health Authority. This does not seem to be a wise policy because around eighty percent of severe mental distressed patients are treated by the informal sector (see Davar and Lohokare 2012, Quack 2012). Its popularity together with the paucity of psychiatrists and other formally sanctioned mental health care providers makes the banning of the informal sector unrealistic, unproductive and even dangerous. This exclusion echoes colonial times as “(...) the postcolonial Indian state has historically considered the popularity of these indigenous [psychiatric] treatments regressive, and claimed Western psychiatry as the only mental health system befitting the country’s aspiration as a modern nation state (Sood 2016, p. 766).”

Halliburton (2004, p. 80) argues that the coexistence of allopathic, Ayurvedic and spiritual treatments for mental distress in Kerala might explain the comparatively better prognosis for mental disease in India compared to the West. However, the popularity of medical plurality among anthropologists like Halliburton also raises questions. Though I share this love for diversity it imposes the question if a potpourri of explanations might not be confusing to mentally disturbed patients who already find it difficult to carve out an identity. As in Lang’s monograph this question is usually ignored. This certainly does not mean that Lang is insensitive to the situation patients and their close relatives find themselves in. On the contrary, Lang shows great sensitivity towards the often dramatic happenings in the lives of patients and their families. By reading her monograph we get intimate with their sufferings, their quests for relief, and their worries and hopes. What Lang makes clear is that the diagnosis depression is often a misnomer, or at most a simplification, for the severe mental and social problems of the patients who feature in her monograph. *Depression in Kerala* once more makes it clear that attributing mental distress to faulted brain chemistry unduly ignores its economic and social-cultural determinants.⁸

⁸ Compare Catherine Boo’s moving documentary-novel on the people of Annawadi, a slum next to Mumbai international airport.

VI. Heart breaking narratives of patients

The ethnography *Depression in Kerala. Ayurveda and Mental Health Care in 21st Century India* contains elaborate descriptions of Lang's encounters with people involved in (Ayurvedic) psychiatry in Kerala. Data come from dozens of interviews she and her research assistants conducted with biomedical and Ayurvedic psychiatrists, superintendents of hospitals and colleges, Ayurvedic MA and PhD students, psychologists, social workers, bureaucrats, office bearers and authors of scholarly and popular works on Ayurveda. Lang also closely observed the practices in Ayurvedic and allopathic psychiatric facilities, the *manisika* section of the P.S. Varier Ayurveda college, as well as exchanges at meetings and press conferences of organizations such as the Association of Ayurveda Psychiatrists (AAP) and the Ayurvedic Medical Association India (AMAI). Patient files, college syllabi, Ayurvedic thesis, government reports on mental health, articles on Ayurvedic psychiatry and mental suffering, as well as advertisements for Ayurvedic antidepressants, etc., were also thoroughly analysed.

Readers acquaint themselves with the experiences, opinions, doubts and hopes of those who work at the Government Ayurvedic Mental Hospital and the *manasika* section of the P.S. Varier Ayurvedic college. Especially Lang's narrations of the lives and treatment trajectories of patients and their relatives are at times heart breaking. Case descriptions are extremely thorough and can take up more than twenty pages. An example is the story of Anita, a sensitive and well educated young woman with a history of suicide attempts, who's disease trajectory is thoroughly discussed in Chapter 5. The case descriptions of six other patients – Subhash (Preface, Chapter 3), Nura (Preface, Chapter 5), Reetamol (Chapter 3), Chandra and her mother Parvathi (Chapter 3), Pradeep (Chapter 4) and Madhavan (Chapter 4) – are also thorough and emotionally moving. What these patients have in common is that they all consulted a wide range of mental health care specialists among them there are psychiatrists, psychologists, astrologists, faith healers, acupuncturists, magnet therapists, hypnotherapists, as well as others.

In the book's preface Lang introduces two patients and their close kin. We encounter Subhas and his highly educated mother, who Lang meets for the first time at the Government Ayurvedic Mental Hospital (GAMH). Subhas is an ambitious and highly educated young man who graduated from the Indian Institute of Technology and worked as an electric engineer in India and Italy, but whose mental state eventually made him unable to practice his profession. Subhas is very critical towards the many treatments he underwent and sees his stay at GAMH, where he is diagnosed with major depressive disorder framed

as a *vata-kapha* problem, as his last chance. Earlier on in his help seeking trajectory Subhas was diagnosed with Obsessive Compulsive Disorder, Anxiety Disorder, Somatoform Disorder and Hypochondriacs, for which he was given benzos and SSRIs. He also consulted spiritual healers and astrologists who prescribed mantras and healing ceremonies to appease spirits and unfavourable planets (*grahas*). Though Subhas was hopeful when he came to GAMH he left before the completion of the thirty day treatment schedule. The second patient Lang introduces in the preface is Nura, a young married woman suffering from post-natal depression, serious somatic complaints and extreme mental distress to the extent she at times stopped talking all together. Apart from allopathic and Ayurvedic specialists she and her husband consulted Muslim priests who advised her to recite “mantras” from the Quran. When she had diagnosed herself with depression Nura consulted a private Ayurvedic psychiatrist who gave a spiritual explanation for her distress and told her that she suffered from *adhijonmāda* (“exogenous depression”) evolving into its more severe *kaphaja* variant (“endogenous depression”).

It is however Anita – like Nura also a patient of the private Ayurvedic psychiatrists Joseph John – with whom Lang emotionally involved herself the most. Anita, a young well educated woman from a Syrian Catholic family, suffered from breathing problems, extreme mood changes and attempted a few times to end her own life. She also had to deal with a repressive, alcoholic and at times violent father. Joseph John ascribed Anita’s severe mental distress to bad family karma that had turned her father into an alcoholic and liquor retailer. He told Anita to submit herself to devil expulsion sessions of a local Catholic priest with whom he collaborated. To prepare her for these deliverance sessions and to mitigate their side-effects John applied the Ayurvedic treatments *yuk-tivyapasraya* and *sattvajaya*. As the expulsion of unwholesome “materials” is central to both Ayurveda and exorcism there seems to be no logical contradiction between the two. This is supported by the Ayurvedic term for depression *vishada rogam* (lit. “poison disease) referring to eviction as the way for treating depression. Before Anita came to John’s clinic a biomedical psychiatrist had diagnosed her with bipolar disorder and major depressive disorder and put her on lithium carbonate, antidepressants, neuroleptics and anxiolytics. Lang argues that John’s depression diagnosis was crafted on the earlier judgement of the biomedical psychiatrist.

Joseph John’s framing and handling of Anita’s distress made me doubt the validity of his approach. John counsels Anita on how to help her alcoholic father who has a history of violence against Anita and her mother. This seems controversial. The more so because Anita has a symbiotic as well as an antagonistic relation with her mother whom she calls her best friend but also accuses of

having tried to abort her when she was a fetus. It seems doubtful if Anita is the right person to help her father overcoming his addiction. Then there is the issue of John's potpourri of aetiologies: occult violence, neurochemical imbalance, personality disorder and *doṣic* inequity. Does John's multi-vocality not add to Anita's disorientation? However, there seems to be a happy ending when Anita finally marries – her parents wanted to get her treated before marrying her off – and moves with her husband to the Gulf. Contrary to forms of psychotherapy practiced in the West that encourage patients to explore their inner feelings, individual ambitions and intrapersonal conflicts, treating mental distress in India often means that patients are encouraged to adapt to social norms. Ayurvedic practitioners employ *sattvajaya* (“controlling and disciplining the mind”) to align patients with the expectations of family and society (Lang 2018, p. 227).

Though modern Ayurveda has a nonviolent image (Zimmerman 1992, Halliburton 2003), Ayurvedic treatment can be quite violent. For example, at GAMH and in the private practice of Joseph John treatments can be relatively vicious when patients have to undergo *virecana* (“purgation”), *vamana* (“vomiting”) and *snehapanam* (“the consumption of large quantities of medicated ghee”) as part of a *shodana* (“purification”) regimen. As we have seen detoxification (expulsing toxins) is a widely applied treatment strategy in modern Ayurveda. This has replaced the canonical notion of “*prajñāparādha* (“violation of good judgement”) as the most fundamental idea of disease causation (see Wujastyk 1998, p. 69, note 24).⁹

VII. The legitimacy of the gatekeepers of Ayurvedic psychiatry

We saw that the inclusion of *daivavyapasraya chikitsa* in Ayurvedic psychiatry is frowned upon by the Government Ayurveda Mental Hospital (GAMH) and the *manasika* college department of the P.S. Varier Ayurveda College. But the modest seize of these Ayurvedic psychiatric ventures makes their Ayurvedic psychiatry boundary surveillance ambitions a bit out of place. With just four Ayurvedic psychiatrists GAMH is heavily understaffed. At the time of Lang's research the hospital was lobbying for funds to start its own research unit; not a luxury as there are hardly any data on the practices and effectiveness of Ayurvedic psychiatric treatments. The *manasika* college department is housed by the Department of Kayachikitsa because it lacks a building of its own. The modest

⁹ In modern Ayurvedic discourse the notion of toxins can refer to various things such as incompatible food and drink, unintegrated psychological experiences, residues from allopathic medications, etc.

intake of six students per year further illustrates its marginality. In 2014 all together sixty Ayurvedic physicians had graduated from the *manisika* department with a master's degree in Ayurveda psychiatry. However, not all these sixty graduates practice Ayurvedic psychiatry and they are certainly not the only Ayurvedic physicians who treat mental problems as in modern Ayurveda mental problems are usually treated by Ayurvedic physicians who have specialised in *kayachikitsa* ("internal medicine").

Nevertheless, Lang's Kottakkal informants pose themselves as gatekeepers of Ayurvedic psychiatry. This is well illustrated by their critical stand towards the private Ayurvedic psychiatric clinic of Joseph John in the nearby Ernakulum region. John's psychiatric practices are condemned because he uses exorcism in his treatment of mental patients. As the GAMH and the *maniska* department have to answer to the Ministry of AYUSH they are in no position to support metaphysical explanations and practices. However, Lang does not problematize the reach, authority and mandate of these two establishments. We also lack data on how widespread the treatment of mental distress by Ayurvedic graduates actually is. We are in need of a quantitative and qualitative survey to map the terrain of Ayurvedic psychiatry.

VIII. A plea for Ayurvedic psychiatry

Ayurvedic psychiatry could be a worthwhile alternative and compliment to biomedical psychiatry. This is certainly true for India with its lack of psychiatric facilities. Ayurvedic psychiatry has the advantage that it is congruent with Indian popular practices and notions, such as ascribing healing power to herbs and spices, the crucial role of proper digestion for the conservation of health, and the view that disease comes from the violation of a "natural life-style."¹⁰ Taking local phenomenologies and social-cultural realities into account can make medical treatments more successful (see Carstairs and Kapur 1976, Nichter and Nordstrom 1989, Samuel 2010). An example hereof is the treatment of a roller of *bidis* (local cigarettes) of marriable age. The local *vaidya* (Ayurvedic practitioner) initiated the negotiation process between the young woman and her close kin by posing:

"(...) rhetorical questions about somatic and affective states and structured by a conceptual framework which relegates such states to humoral inter-

¹⁰ Another argument for Ayurvedic psychiatry is the comparatively more personal and extended character of the Ayurvedic clinical encounter.

relationships. By establishing a humoral explanatory model for an illness episode or affective state which takes into account environmental and constitutional factors over which one has little control, responsibility is mollified and dialogue about personal problems eased.” (Nichter 1981, p. 5)

Nichter (1981, 1982) argues that Ayurvedic therapy can have socially integrative and adaptive consequences for a number of illnesses associated with the somatization of psychosocial stress. He shows that the *vaidya* made use of indigenous concepts when he mediated between the patient, who detested that she could not prepare for marriage because her parents claimed all her earnings, and her close kin. Nichter argues that the handling of humoral notions was not only helpful in alleviating the young woman’s feelings of guilt and responsibility but also lessened her back pain, menstrual distress and general weakness. A phenomenological and cultural sensitive approach can activate the agency and coping responses of patients. Not a small matter when it comes to the treatment of psychiatric and chronic ailments (see Kapur 1979, Weiss et al. 1988, Sax 2014, Kirmayer 2018).

The efficacy of Ayurveda and other Asian medical traditions is a much disputed and polarized topic. Though the advantages of Randomized Controlled Trials are not to be ignored, doing away with psycho-social healing factors denies the positive effects on somatic and mental wellbeing of meaningful, activating and emancipatory medical practices (see, for example, Sujatha 2009, Bode and Payyappallimana 2013, Thirthalli et al. 2016). Ayurvedic psychiatry can certainly benefit from research on the healing potential of the “meaning response” – a notion that challenges the idea that the placebo effect translates as empty treatment (see, for example, Kaptchuk 1998, Moerman 2002, Kirmayer 2004, Thompson, Ritenbaugh and Nichter 2009). Ayurveda as a well-argued philosophy of systematic correspondences between different spheres of life has its own ways of framing the vagaries of body-minds. Besides, the scientific standing of biomedical psychiatry is modest in terms of robustness of disease categories and treatment efficacy. In India, the effectiveness of biomedical psychiatry also suffers from the social-cultural distance between physicians and patients (see Priya 1995, Ram 2010) and from the stigmatizing effects of psychiatric ailments (Bodeker and Burford 2007).

IX. Concluding remarks

Lang’s monograph is an important contribution to our knowledge of mental suffering in Kerala and the making of Ayurvedic psychiatry as an alternative

to biomedical psychiatry and spiritual treatment. Ayurvedic psychiatry as practiced and taught in Kottakkal presents itself to the biomedical sector, the health authorities and the public as a parallel and scientifically valid approach to mental distress. At the government sanctioned Ayurvedic mental hospital and the *manisika* Ayurvedic college section in Kottakkal where Lang did many of her observations and interviews, severe mental distress is treated with herbal-mineral drugs, diets, purification procedures and a directive form of counseling. Though *daiva-vyapasraya chikitsa* is mentioned in the *sūtrasthāna* of the *carakasamhitā* as a valid therapeutic strategy the condemnation of spiritual healing by both establishments in Kottakkal is in line with the secularization strategy of modern Ayurveda.

Biomedical psychiatry has a modest record in terms of theoretical standing and practice effectiveness.¹¹ At least in India indigenous treatments might offer a welcome alternative. Their mobilization of cultural metaphors and experience-near notions gives them an advantage over biomedical psychiatry which heavily leans on the aetiology of faulty brain chemistry and psychopharmaceutical treatment. Indigenous psychiatry can also be instrumental in diminishing guilt feelings of patients and prevent their stigmatization.¹² Ayurvedic psychiatry could take advantage of this by integrating local logics and practices. This asks for a critical stand towards the scientization and secularization policy of modern Ayurveda. Already in the 1970s the Indian psychiatrist Ravi Kapur criticised the top-down approach of Indian psychiatry when he and his colleagues pleaded for a phenomenologically oriented psychiatry that opens up to local realities, practices and notions (Kapur 1979; see also Bibeau and Corin 2010, Quack 2012).¹³

Depression in Kerala comes timely as in 2014 for the first time an Indian medical health policy was formulated by the Ministry of Health and Family Welfare. Lang's well written and highly interesting monograph convincingly argues that it is a miss not taking the Ayurvedic approach to mental distress into account. Drawing on extensive fieldwork, this book will be of interest to social scientists and medical historians who study Ayurveda's trajectory in modern India. It also has something to say to policy makers and medical practitioners,

¹¹ For a overview and an assessment of these critiques see Kartner and Kamens 2019.

¹² See Barrett 2008 for a discussion of indigenous treatments of infamous diseases such as leukoderma and leprosy. On the stigmatization of mental disease in India see Bodeker and Burford 2007.

¹³ According to Carstairs and Kapur (1976) treatment of mental distress is more successful when local discourses on mental suffering – nosology, aetiology and therapy – are taken into account.

especially to those interested in traditional, alternative and integrative medicine. The monograph also provides insights in how mental distress is framed and treated in present-day Kerala and therefore contributes to studies on the health hazards ascribed to modernization.

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