Framing Experiences

Diagnosing and Explaining Dissociative Phenomena in Indian and Brazilian Mental Health-Care Institutions

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A clinical narrative from India

> Case 3. Ms. E, a 15-year-old student in Delhi who was the youngest of five children, was brought to the walk-in clinic because on the previous morning she had claimed that she was Ms. F, an illiterate girl who had never attended school. She denied knowing any of her family members, spoke in an authoritative manner, and was very assertive and demanding. She claimed that she lived with her mother and brother at a different place in the same city and demanded to go and join them. On being permitted to go, she went to a friend's house and claimed that her friend's mother was her (the patient's) mother. She identified her friend and the friend's sister as her mother's servants. She stayed there for a full day, wore her friend's clothes, and had food of her own choice. As Ms. F she was very active, authoritative, and cheerful although she clung to her friend's mother.
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> The next day Ms. E was hospitalized. Her behavior as Ms. F was observed and documented in the ward. She reverted back to her normal self and had amnesia for the secondary personality. However, she insisted that she was illiterate and pretended to learn the alphabet from the student nurses. Ms. E had had conversion symptoms four times in the past year. Each time she had developed "blindness" before taking tests in school. Her scholastic difficulties were related to a change in the language of instruction from Hindi to English that year. The current illness was temporally associated with her final examinations. Her premorbid status was described as sociable, highly ambitious, and attention seeking. (Adityanjee *et al.* 1989: 1608)

An ethnographic narrative from Brazil

Elisângela is a 44-year old unmarried and childless teacher and has been suffering from melancholy and sadness since the age of nineteen after the death of two friends. In October 2015, she was admitted for the second time to HEM (Hospital Espírita de Marilia, a Kardecist psychiatry) and diagnosed with a bipolar affective disorder. When asked why she is here, she responds:

> Look, from my point of view, I am here because I am not able to defend myself against the people who curse and harass me. You know, they tell me to fuck off, and I cry. […] As they harassed me repeatedly, I started not liking myself. People would not accept me as I am. Therefore, I started to criticize myself, too. […] I did not like myself because so many people cursed and harassed me.

When asked who harassed her, she answers:

> I cannot reveal! I came here to overcome my […] pain…physical pain and pain of the soul…as I said already in the meetings.

The meetings Elisângela refers to are the lectures provided by volunteers like the medium Regina (see below). At one of these sessions, Elisângela reveals that her harassers are both living family members, but especially obsessing spirits, which she cannot rid herself off. She feels responsible for the death of her two friends, as she stresses that in both cases she foresaw their death but did not warn them. Elisângela thus now believes that she is a medium because she sees things, and then they happen. She thinks that she has to frequent a Spiritist center, developing her mediumship, and thus being able to help herself and others at the same time. She suffers a lot from being stigmatized as "crazy." (Kurz 2015, Fieldnotes)

Introduction

Above we displayed two different modes of framing of what one may term as "dissociative experiences" in transcultural psychiatry (*cf.* Seligman & Kirmayer 2008): a clinical narrative published by Indian psychiatrists in the American Journal for Psychiatry in 1989 and an ethnographic narrative from field research in Brazil by Helmar Kurz

in 2015, one of the authors of this article. As representatives of the research focus of Trans-/Cultural Psychiatry at the Institute of Social Anthropology in Münster, Germany, and emphasizing our longstanding cooperation with Ekkehard Schroeder we want to contribute in his honor concerning the question how the clinical view on experiences of dissociation phenomena varies and develops in the (psycho-)therapeutic nexus. Helmar Kurz works on the diversification of mental health within a globally increasing medical pluralism. He researched in Spiritist institutions in Brazil (in the states of Bahia and São Paulo) and Germany. He focuses on dynamics of healing cooperation between psychiatric and religious-spiritual actors and related aesthetic modalities of healing.

Annika Strauss researched in different psychiatric settings in and around the mega-city Mumbai (India). She is concerned with questions regarding biomedical practices, narratives, and discourses in Western and Non-western contexts. In our contribution, we aim at contrasting the different explanatory models and diagnostic categories regarding mental health and well-being the two narratives above draw on.

Explanatory models refer to ideas on causes, diagnostic categories, and treatment options of illness experiences. They are developed by various persons actively or passively involved in the therapy process: patients, healers, community members, and religious experts alike. Explanatory models regarding mental distress reflect social relations and the dynamics of stigmatization and (re-)integration of afflicted individuals, as well as alleged causes, effects, and consequences of the illness experience. Accordingly, individual experience (illness), professional diagnosis (disease), and social aspects (sickness) of "mental distress" correlate with culturally or socially defined frames (Kleinman 1988a). However, Kleinman (1988b) stresses the importance of individual narratives for the interpretation of practices, experiences, and meanings of illness and therapy. Thus, an investigation of explanatory models and the related diagnostic systems should include social and cultural frameworks and at the same time individual experiences and resources (*cf.* Kurz 2018b).

Religion and spirituality are such personal resources which influence illness experience and explanatory models regarding mental, emotional, and spiritual distress and thus interact, intersect, and sometimes compete with the scientific discipline of psychiatry (*cf.* Basu *et al.* 2017). Nichter (1981) has shown how individual experiences reflect certain social contexts in terms of culturally provided "idioms of distress" which themselves provide culturally accepted diagnostic categories. He points out that the particular manifestations of distress always should be analyzed in relation to personal and cultural meaning complexes as well as the availability and social implications of coexisting idioms of expression. However, three decades later when reviewing his classical article, Nichter (2010) stresses the importance of individual experience which shapes socio-cultural diagnostic practices, and not vice versa.

The two narratives above reflect different modes of interpretation. Depending on the socio-cultural frame the illness narratives and experiences are embedded in, they are labeled as possession, mediumship, spiritual obsession, or dissociative disorder respectively.

The ***first example*** focuses on diagnostic categories that refer to a particular knowledge system in the ethnomedical context of Indian psychiatry. Psychiatric diagnosis as a social practice relates to culturally generated explanatory models and narratives concerning individual experiences (Jutel 2011). As Kleinman (1988b: 16) states "[a] corollary to the meaning of symptoms is the semiotics of diagnosis." The discussion of the emergence of Multiple Personality Disorder (MPD) in Indian Psychiatry focuses on the perspective of the "healer," namely mental health professionals and the relation between "imported" Western diagnostic categories (MPD) and local diagnostic categories (possession). The discussion of the Indian example indicates that neither psychiatric diagnosis as a knowledge system nor the illness experiences it tries to frame and describe remain stable over time. Instead, they change, shift and transform and dynamically react to diverse socio-cultural influences and global developments.

The ***second example*** from Brazil is more concerned with the question of how explanatory models relate towards possession experiences from the perspectives of patients. It nonetheless also touches on the relation between local diagnostic categories (spiritual obsession and mediumship) and psychiatric diagnostic categories (depression,

bipolarity, anxiety). Thus it relates to current discourses in medical anthropology on the diversification of mental health practices (Kurz 2017) and their relation in terms of establishment or refusal of healing cooperation of medical/psychiatric and religiously/spiritually informed practices (Kurz 2018a). It corresponds to a development of scientific discourses on spirit possession/obsession from psychopathology towards a resource of transformational healing, agency, and de-stigmatization (*cf.* Schmidt 2016).

Our final discussion compares the two culturally divergent examples of diagnostic practices related to dissociative experiences in terms of the variation and development of clinical views in the context of encounters between Western psychiatric and local, spiritually informed diagnostic practices. We want to shed light on how experiences, narratives and diagnostic practices as interconnected components of explanatory models regarding mental health relate to each other. Doing this, we do not only draw on the different socio-cultural contexts the two examples are embedded in, but also consider spatiotemporal dimensions. In other words, we will address the question of how illness narratives and explanatory models are related to time and environment. We dedicate this contribution to Ekkehardt Schröder who can be considered as a medium of interdisciplinary communication and exchange himself. Not at least through his longstanding work for *Curare: Journal of Medical Anthropology* Ekkehard contributed towards an understanding of explanatory models, diagnostic categories, illness narratives and experiences throughout time and space for the last forty years.

"The Emergence of MPD"—Multiple Personality Disorder vs. Possession Syndrome as a Diagnosis in Indian Psychiatry

Adityanjee *et al.* (1989) discuss the case above in relation to two more cases of Multiple Personality Disorder, which they encountered over a period of three years in an outpatient clinic in New Delhi. All, one boy and two girls, are adolescents (around 15 years old) and all students with a middle-class background. The authors note that "multiple personality disorder is still a clinical rarity in India" (*ibid.* 1608). Comparing the three cases with clinical presentations from the West where persons often had ten or more personalities, they observe that the "number of distinct alternate personalities in these cases is relatively small" (*ibid.*). Furthermore, in all three cases, the transition from one personality to another was mediated by overnight sleep: "Such a transition may be peculiar to the Indian situation, as the Hindi cinema has glamorized dramatic changes in behavior and personality brought about by events such as sleep or automobile accidents" (*ibid.*).

The authors identify two lines of internal conflict which they deem as typical for the age of the teens and the socio-cultural context. Firstly, all three of the young people had been undergone psycho-social stress, because they were involved in a love affair that was not approved on by their families as premarital sexual relationships are considered as unacceptable. Secondly, the secondary personality represented the diametric opposite of the perceived self-image. In the case above, the secondary personality reflected the difficulties faced in school by the patient: "In Indian society a good education is the only way for upward social mobility; children and adolescents face considerable pressure from their parents to perform well in their studies" (*ibid.*). Interestingly, in the other two cases, the secondary personalities impersonated an idealized self-image that was Westernized and e.g. spoke English rather than Hindi.

There are several points I want to make and illustrate here with this psychiatric article at hand. One concerns how the Diagnostic Statistical Manual on Mental Disorders (DSM) published by the American Psychiatric Association and Western diagnostic categories serve as a catalyzer for the discovery of new diseases and in "making up people" (Hacking 1986). We could understand the application of the diagnosis of MPD as a case of a "category fallacy" as pointed out by Kleinman (1977). And indeed the authors note the similarity of the cases to another dissociative disorder far more common in India, namely possession phenomena, when an afflicted person after a usually sudden onset behaves "as if a religious deity or the spirit of a dead relative has taken over his or her mind and body" (Adityanjee *et al.* 1989: 1609).

It mostly affects women of lower socioeconomic classes and lower levels of literacy. The possessing spirit usually "makes various demands on the

surroundings, usually on close relatives who humbly comply with them" (*ibid.*). While the authors in this article do not discuss possession as a differential diagnosis, an article published fifteen years later by Gupta & Kumar (2005) does elaborate in more detail on the diagnostic differences.

It discusses the case of a fourteen-year-old girl from Delhi with an alternate male personality that she apparently developed as a reaction to the separation from her sister when her father left her mother on the issue of not having a son. Her mother reported a change in her behavior, that she became stubborn, confident, outgoing and demanding in contrast to her earlier behavior. She further developed an interest in drawing and painting and demanded different types of fast food, dresses, and articles. Her mother readily fulfilled all her demands. The girl stopped going to school as well. She suffered from "fainting episodes" for one year, before she was found one morning after such an episode in the altered state of her male identity. She acquired this state recurrently for around ten to fifteen days before she returned to her original state for one to two days. The demanding attitude of the alternate personality, the sudden onset in connection with a fainting episode and the embodiment of a character that was not appropriate of the girl's original, female character resembles symptoms of possession.

But this diagnosis is ruled out by the authors because the girl "was not aware of her immediate surrounding and her true identity during these attacks and did not remember about these episodes in normal periods" (*ibid.* 99). Additionally, they claim that the "personality assumed is always that of a concrete known person or a deity whose characteristics are socially agreed upon" (*ibid.*). The discussion, if the girl's symptoms could be described rather as possession or MPD, illustrates that effective classification is based on the recognition of difference as well as similarity between categories (*cf.* Jutel 2011: 15). Nevertheless, the boundaries that are drawn in classification systems of disease are not necessarily reasoned logically, but rather reflect pragmatism and the context of their socio-cultural origin. This ambivalence is remarkably reflected in the article by Adityanjee *et al.* (1989) when they comment:

> The cross-cultural differences may also be explained on the basis of divergent diagnostic practices. Traditionally, the diagnostic category of possession syndrome has not been available to psychiatrists in the West. Most of these cases might have been lumped together with multiple personality disorder. Such a tendency is reflected in DSM-III-R, which explicitly states that 'the belief that one is possessed by another person, spirit, or entity may occur as a symptom of Multiple Personality Disorder. In such cases the complaint of being "possessed" is actually the experience of the alternate personality's influence on the person's behavior and mood. Alternatively, the historical bias in North America toward overdiagnosis of schizophrenia may have resulted in interpreting the feeling that one is possessed as a delusion in a psychotic disorder such as schizophrenia (...). On the other hand, it is possible that most of the cases of multiple personality disorder in India have been diagnosed as possession syndrome, a nosologic entity with fairly good evidence of face and descriptive validity (*ibid.* 1609).

We rarely find such a reflexive approach to how diagnostic practices are shaped by their sociocultural context and available classification systems in Western psychiatric articles, where it is assumed that the psychiatric approach is scientifically "neutral" in its empirical orientation.

The attitude reflected in the article represents a comparative approach that Annika Strauss generally encountered in clinical practice and in interviews with psychiatrists, who often explained how psychiatry works in India by juxtaposing it to "Western" psychiatry or "Western" diagnoses. This insight may hint to how Indian psychiatric practice conceptualizes itself comparatively, as a "variant" of Western psychiatry. Ironically that is even reflected in the cases of the presented multiple personalities, where the alternate personality in two cases represents an "idealized, westernized self-image." In contrast, Western psychiatry at that time mainly perceived itself as "culture-neutral" and tended to discover "cultural bound syndromes" in other cultures rather than recognizing how culture-bound its own approaches were (Jadhav 2004). However, Adityanjee *et al.* conceptualize the—for India—common possession syndrome and multiple personality disorder as "parallel dissociative disorders with similar etiologies despite some major differences in clinical profiles" (*ibid.* 1989: 1610).

Interestingly, the reflexive and causality ori-

ented approach is not reflected in the article by Gupta and Kumar, who focus exclusively on the clinical and formal features of their case. It may be a consequence of the global development of psychiatry towards a more symptom and bio-genetic oriented practice, which is less concerned with the contexts and psycho-social dynamics of mental illness. In the late 1980s Adityanjee *et al.* expected the rate of possession syndrome to be likely to fall, because of "the increasing Westernization of Indian society" and "increased awareness among Indian psychiatrists of multiple personality disorder as a nosologic entity" (*ibid.* 1989: 1610). What happened instead was that MPD was renamed to "Dissociative Identity Disorder" (DID) in the DSM-IV that was published in 2000. Gupta & Kumar nevertheless still make use of the diagnostic category "MPD" when their article was published in 2005. In the DSM-V eventually, the definition of DID acknowledges that "experiences of pathological possession in some cultures are included in the description of identity disruption" (American Psychiatric Association 2013: 10).

What does the case of MPD in India tell us about diagnostic categories and "making up people?" Clearly, on the one hand, we can see the application of MPD in India as a "category fallacy" because the diagnosis was not developed and validated in this cultural context. On the other hand, it illustrates how people suffering MPD are made up by professional psychiatric knowledge entering the Indian Mental Health context. One driving force is the expert knowledge, *e. g.* by psychiatrists learning about the existence and symptoms of MPD. Another important impact has the popular knowledge spread by *e. g.* Indian cinema, as it is also mentioned in the article by Adityanjee *et al.* Movies, in particular Bollywood Movies, serve as an important catalyzer in shaping peoples images of mental illness and mentally ill persons since the 1950s (*cf.* Bhugra 2006).

Of the several Bollywood movies that portrait MPD and its symptoms two recent examples are worth mentioning. The first is the movie *Bhool Bhulaiya* (Priyadarshan 2007): A female main protagonist, who later on will be diagnosed as suffering from MPD by an American Indian psychiatrist, displays symptoms very similar to spirit possession and is finally healed by an exorcism ritual (*cf.* Basu 2011: 79). The second movie *Karthik calling Karthik* (Lalwani 2010), portraits an introvert main character who lacks confidence and feels trapped in his average job at a construction company. He develops an alter-ego that is more assertive and regularly calls him anonymously to advise him on how to live life. His diagnosis nevertheless turns out not to be MPD, but schizophrenia—obviously influenced by the stereotype that schizophrenic people suffer from a "split mind." As Basu (2011: 74) points out, the representation of psychiatry and psychiatric diagnosis in popular culture cannot be understood as a portrait of clinical reality or scientific insights, but the stories and narratives transform their image and creatively integrate them in local contexts, traditional explanation models of madness and its treatment.

The reports discussed above by Adityanjee *et al.* and Gupta & Kumar present an "Indianized" version of MPD, encompassing a concept of person and self present in the "westernized" and "educated" Indian middle class, that often condemns the belief in spirits as "backward" (Quack 2012): On the one hand, the "symptoms" described in the articles are similar to the ones that often can be observed in the context of possession phenomena (*e. g.* only one alternate personality, inappropriate and demanding behavior for the person's gender). On the other hand the "alternate personality" is no spirit or ancestor with certain social meanings or characteristics that "possesses" the person, but instead an idealized version of the self. The "idioms of distress" (*cf.* Nichter 1981) seem to have shifted in accordance with a change in socio-cultural lifestyle and values in the urban centers. What we do not come to know through the articles though, is how the patients themselves and their relatives explain and experience these alternate states of being.

Spiritual Obsession and Mediumship as Explanatory Models and Diagnostic Categories within Spiritist Psychiatry and Spiritist Centers in Brazil

In Brazil, diagnostic categories of "mediumship" and "spiritual obsession" serve as explanatory models regarding experiences of mental distress as spiritual (external) influence. They serve to escape stigmatization, to develop a new social role, and especially to cope with one's personal expe-

rience in terms of activating individual resources. This aspect is especially true for healing practices within Kardecism, a highly institutionalized movement within the Brazilian Spiritist continuum. Kardecists developed different kinds of healing cooperation with the official Brazilian healthcare sector and established a network of Spiritist psychiatric hospitals throughout the country (*cf.* Kurz 2018a).

Kardecist explanatory models link spiritual ontologies to psychiatric issues and stress the human spirit's experiences throughout current and past lives. Besides social, biological or psychological reasons for mental distress, it is assumed that the spirit of a patient would reincarnate to morally develop and to rectify past mistakes. Obsessive processes are explained as dynamics to inflict self-punishment on the patient's spirit for bad deeds in past lives, or as a process where spirit obsessors would seek revenge for those. Spiritual obsession thus is understood as a psychiatric-spiritual problem. The suggested therapeutic intervention involves mental hygiene, cultivating Christian discipline and charity as resources for self-examination, self-control, self-development and self-empowerment through the study of Spiritist literature, prayers and practices of fraternal attention. Bio-energetic fluid therapy related to Mesmer's animal magnetism and disobsession practices as "mild exorcisms" are considered as further contributions. Within the Hospital Espírita de Marília (HEM) in the Brazilian state of São Paulo, healing cooperation between psychiatrists and Kardecists has been established with the support of volunteers from the local Spiritist network to fulfill HEM's promise to "treat people with love." They provide to the patients lectures and study groups of Spiritist doctrine and laying-on hands as bio-energetic fluid therapy. They also meet for mediumistic sessions of disobsession without the participation of patients to deal with disturbing spirits and have them treated in a hospital on the spiritual level. (Kurz 2017; 2018a, b)

Above, I already briefly introduced the narrative of Elisângela (name changed), who is a psychiatric patient in HEM. Now, the interrelated case study of Regina will be presented to demonstrate the impact of Spiritist explanatory models of spiritual obsession and mediumship on the narratives and social experience of patients and on their relation to psychiatric diagnostic categories. Regina is a medium who participates in disobsession meetings. She also is part of the Spiritist council of HEM, and she is one of the volunteers who lecture and discuss Spiritist literature with patients like Elisângela. She is about 75 years old, widow, mother of five, and a retired teacher. She was a single child and talks about her father with intense affection. She grew up with a fear of spirits and the dark, and she believes that she has been a medium since the age of twelve when she began "sensing things," suffering from insomnia and feeling sad. After Regina married and her first daughter turned six months old, her father died young of a heart attack. Shortly after, when she was pregnant with her second child, her disturbing experiences started:

> I stayed fatigued, as it is normal for a woman after the second month. So every night at eight o'clock, I was ready to go to sleep. My husband would have to go to bed early with me, or I had to sleep in the living room on the couch, crashing in front of the TV, because I was afraid to stay on my own in the bedroom, once this phenomenon only happened when I was on my own […]. I would hear a voice right in my ear, like an echo of these microphones turned on too loud, and it says: 'My daughter, I love you … I love you a lot, my daughter.' […] And this left me with fear … freaking out … scared. […] And this phenomenon would repeat several times. […] It could not go on like this … so what should we do? And I tell you, the only way was to turn to Kardecism […].

She participated in a mediumistic session where the spirit of her father was directed to the before mentioned hospital on the spiritual level to find support there. She was told that she is a medium and would have to start to frequent a Spiritist center and to participate in study groups, which she did whenever possible. She never had any more comparable experiences until her husband died some ten years later. Again, she would hear his voice at night, even though in a much more peaceful way than was the case with her father. Regina declares that with the death of her husband and with all the problems that come with being a single mother, she owes her balance to Kardecism. Especially after retiring, she spent a lot of time there to develop her mediumship in special training groups. She started to participate in weekly

disobsession meetings as a medium who incorporates spirits of deceased people. It helps her in a threefold way: 1) She is able to help obsessive spirits and their victims (the psychiatric patients), 2) she is able to release disturbing sensations which accompany her during the week, and 3) her experiences are valued as mediumship instead of being pathologized in psychiatric terms.

Elisângela's and Regina's narratives reveal how the explanatory models of spirit obsession and mediumship are interrelated and dealt with in practice. Spirit obsessors are identified as external causes of mental illness. It is not so much a way of legitimizing abnormal behavior but an approach of making sense to experiences in terms of the Spiritist doctrine. Interpreting experience as mediumship substitutes a psychiatric diagnosis and provides a transformation towards agency regarding care and self-care. Regina is exemplary in this regard: she hears voices but turns to Spiritism where her experiences are held in high esteem. She interacts with a social peer group who perceives her experience as a gift and interprets it as mediumship and the ability to deal with spiritual obsessors. From a psychiatric point of view, one could argue that she is showing specific symptoms ('hearing voices'). However, her spiritual involvement and the related explanatory models of spiritual obsession and mediumship keep her off severe suffering and psychiatric treatment. Elisângela has similar experiences (clairvoyance) but lacks comparable social support. However, evangelization treatment by volunteers like Regina in HEM is helping her to get back on track, and, like Regina, she wants to use her experience to help others, thus transforming her experience of spiritual obsession into a practice of mediumship.

This chapter does not aim to discuss causes, effects, or the reality of possession/obsession experiences, but seeks to understand diagnostic categories related to explanatory models and individual narratives as postulated by Kleinman (1988b). A particular pattern shapes the experience of persons who allege that they are mediums and/or victims of spirit obsession, namely a gradual transformative process from "patiency" to "agency." Afflicted persons develop practices and habits which do not deny but integrate experiences normally stigmatized as "madness." At the psychiatric Hospital Espírita de Marília (HEM), concepts of mediumship and obsession are integrated into explanatory models for mental, emotional, or spiritual distress. They do not contest psychiatric diagnostic categories but offer a complementary approach to the interpretation of human suffering and are supported by most health professionals. The case studies reveal the dynamics of how these explanatory models within Kardecist mental health-care address the self-responsibility of patients. Far from stigmatizing individual experience as "madness" (*cf.* Leibing 1995), they offer explanations in terms of making sense and as strategies to deal with it. Regina's case is exemplary from an etiological point of view, too. Like Elisângela, she has a disposition for an affective disorder related to the loss of her deceased beloveds and experiences extraordinary sensory phenomena (Regina "hears" and Elisângela "sees"). Both are of comparable social background (urban middle class, teachers) and have to deal with unsatisfying life situations (Elisângela wants children but has none; Regina at some point is left alone with five children). However, Regina never became a psychiatric patient. Her experience is interpreted as mediumship and the influence of spiritual obsessors (though in her case of benevolent ones). She experiences how people make sense of her experience and help her to resolve it in the Kardecist context. She starts to study Kardecist doctrine and actively integrates related discourses and practices as dispositions of a new (Kardecist) habitus of spiritual development, charity, and support of others.

Elisângela has not been so lucky, as she has been admitted twice as a psychiatric patient. She suffers from feelings of guilt and has been treated even by family members as "mad" when she started to communicate her experiences. However, the concepts of mediumship and spirit obsession offer an explanation to her which she can actively work with and which provides a future perspective to her. These approaches are integrated into the treatment of psychiatric patients, and many start to frequent Spiritist centers after they have been released. In general, it seems to be more socially acceptable in Brazil to talk about spiritual issues than of psychiatric ones.

Framing Experiences—The Emergence of New Explanatory Models and Diagnostic Categories

The above examples from Indian and Brazilian psychiatry indicate the impact of changing socio-cultural discourses and contexts on forging new 'disorders' and the provision of alternative diagnostic categories. A classic medical anthropological example for this phenomenon is Nichter's (1981) description of certain "idioms" by which South Kanarese Havic Brahmin women communicate mental distress. During his study in the 1970s, he observes that some decades ago, possession was a common experience for Havic women, particularly

> during that period of their lives when they maintained a low or ambiguous status in the family, *i. e.*, when they were mature but unmarried, newly married, married but childless, or widowed. (*ibid.* 396)

Subsequently, though, cases of possession declined, and an increasing number of women found refuge in devotional (bhakti) movements. Nichter explains this development connected to specific Brahmin values, norms, and stereotypes. If a possession case occurs, it carries with it a certain degree of social stigma if not an embarrassment for the family because spirit possession is implicitly associated with impurity. Brahmins, who are in a state of purity, are thought of being—compared to other, impurer casts—less vulnerable to attacks by malevolent spirits. Nevertheless, the continued decline of possession cases among Brahmin women during the 1970s is related—according to Nichter—to concomitant social factors including increased economic status, education, modernization, and prestige consciousness. These social developments led to a situation, in which possession is viewed as an even more marginal state than it has already been in the past (*ibid.* 393).

Mental health-related diagnostic categories and explanatory models change and develop over time according to social, cultural, economic, political factors and last but not least they are embedded in the dynamics of scientific progress. These developments are not restricted to non-Western cultures, as Shorter (1998) shows in his "History of Psychiatry" for the European context (*cf.* Gaines 1992). However, trends and dynamics of these developments extremely vary from place to place: the allegedly universalist approaches of psychiatric diagnostic categories as presented in the DSM and International Classification of Disease (ICD) published by the World Health Organization (WHO) are locally implemented in different ways and provide new spaces of interaction, cooperation, and contestation (*cf.* Bhabha 1994).

How and in which socio-cultural contexts explanatory models—in the shape of diagnostic categories and clinical narratives—relate to personal experiences of dissociative states, fundamentally depends on their inclusion of local concepts of person, self, body and consciousness. Take as an example the psychiatric symptom of "auditory hallucination" or "hearing voices:" Tanya Luhrmann shows how the experience and awareness of "inner voices" or "voices of other persons in the head," but also "praying" as a dialogue with God differs cross-culturally and depends on an "inner sense cultivation" (Luhrmann *et al.* 2015, Luhrmann & Morgain 2012). This idea of "inner sense cultivation" also hints at Brazilian Spiritist diagnostic categories and healing practices, especially when relating to experiences of spiritual obsession and mediumship training (*cf.* Kurz 2017).

For the 1980s and 1990s, Leibing (1995) shows that individual experience, psychosocial aspects, and cultural idioms of distress have been widely ignored within conventional Brazilian psychiatry. Therapy was mainly reduced to medical treatment and group therapy. This, though, has been progress compared to previous practices when psychiatric patients were locked away in working camps under miserable conditions (*cf.* Theissen 2009). A psychiatric diagnosis is extremely stigmatized in Brazil until today, and patients often become socially excluded (*cf.* Leibing 1995, Theissen 2009). Accordingly, the Brazilian psychiatry reform since the early 2000s pursues a de-hospitalization strategy and aims at the social reintegration of patients in their communities with minimal medical treatment but support by local psycho-social attention centers (CAPS). However, sufficient capacities and resources are lacking, and many patients are left alone without treatment, turning themselves towards religious institutions like Spiritist centers. Some seek support in one of the few remaining psychiatric hospitals, which are mainly maintained by Kardecist associations trying to resist

the efforts of the official health-care system (SUS) to shut them down (*cf.* Kurz 2017, 2018a). Not only do patients find social support and psycho-therapeutic treatment there, but their narratives are interpreted in terms of experiences of spiritual obsession and mediumship, thus providing additional diagnostic categories which are less stigmatizing and even valued as capacities to help others. Thus, a transformation of the patient is induced which leads from patiency to agency by the cultivation of mediumship practices and a Spiritist habitus which includes the study of Spiritist literature, mediumship development, and charity (*cf.* Kurz 2017).

Juxtaposing the examples of India and Brazil, we observe contradictory strategies of framing dissociative experiences in two so-called "emerging countries" in terms of relation, cooperation, and contestation of religious-spiritual idioms of distress (possession/obsession, mediumship) and diagnostic psychiatric categories, besides economic and political aspects. India's elite and higher middle class, including most Indian psychiatrists, perceive "possession" as marginal and stigmatizing in terms of being contrary to a progressive rational and scientific discourse. Therefore, Indian mental health professionals favor diagnostic categories as provided in DCM and ICD to frame dissociative experience, as for example "conversion disorder," that is far more commonly used than MPD. In Brazil, not only the psychiatric diagnosis of an individual, but the discipline of psychiatry in general is stigmatized and marginalized. Kardecist diagnostic categories and framing modes of experiences and narratives thus develop approaches to de-stigmatize patients via alternative and/or complementary explanatory models. At the same time, approaches evolve that strengthen the discipline of psychiatry in terms of integrating different framing modes of dissociation experiences.

In both examples, we observe processes of variation of cosmopolitan psychiatric explanatory models and the framing of dissociative experiences and related narratives over time. As the Indian example indicates, local modifications of the globalization of psychiatric explanatory models within different cultural and socio-political contexts also relate to public discourses that are reflected in media (film) productions. The same is true for Brazil, where the popular medium Francisco Cândido "Chico" Xavier (1910–2002) published several hundred psychographic books with over 20 million copies sold in Brazil alone. Especially his works with the "ghostwriters" Emmanuel and André Luiz have been influential in the development of Spiritist explanatory models and healing practices. André Luiz is the main character of "Nosso Lar" (Xavier 1944), one of Xavier's most famous works, which as a movie (Assis 2010) became a blockbuster in Brazil. The main topic is the life and death of medical doctor André Luiz, who develops from a suffering and afflicting spirit to a helping one. He becomes an inhabitant of a colony in the spiritual plane which provides a hospital where afflicted and afflicting spirits are treated, an idea that is essential for the disobsession process. Since the 2000s, Spiritist narratives and framing of experience are also increasingly integrated into and elaborated within the popular *telenovelas* (*cf.* Jhin 2010) and other TV-productions in Brazil, thus promoting their acceptance within the Brazilian population (*cf.* Kurz 2015).

Thus, the emergence, development, and distribution of explanatory models as a conglomerate of diagnostic categories, illness narratives, and interpretations of experience are not restricted to clinical practice, spiritual discourse, or scientific progress but are influenced and transported by popular media. Media integrates, contests, and affects contradictory and complementary approaches (not only) related to mental health over space and time.

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