Multiple Mental Health Literacies in a Traditional Temple Site in Kerala: The Intersection between Beliefs, Spiritual and Healing Regimes

Abstract

The notion of 'mental health literacy' has been proposed as a way of improving mental health problem recognition, service utilisation and reducing stigma. Yet the idea embodies a number of medical-model assumptions which are often at odds with diverse communities' spiritual traditions and local belief systems. Twenty participants were recruited to this study consisting of mental health service users (N = 7), family carers (N = 8) and community members (N = 5) in a temple town in Kerala, South India participated in semi structured interviews exploring the variety of beliefs and practices relating to mental health. Our findings indicate that the issue may be better understood in terms of multiple mental health literacies which people deploy in different circumstances. Even those sceptical of traditional and spiritual approaches are knowledgeable about them, and the traditional practices themselves often involve detailed regimes of activities aimed at effecting an improvement in the person's mood or condition. Therefore, we argue it is appropriate to consider mental health literacy not as a unitary universal phenomenon but instead as a mosaic of different literacies which may be deployed in different settings and in line with different experiences and which may operate in synergy with each other to enable treatment but also facilitate a sense of meaning and purpose in life.

Multiple Mental Health Literacies in a Traditional Temple Site in Kerala: The Intersection between Beliefs, Spiritual and Healing Regimes

According to the World Health Organisation (WHO), it is estimated that globally 450 million people suffer from mental disorders (WHO, 2012). Around 80% of these live in low-and middle-income countries (LMICs) yet comparatively less is known about the situation in these nations compared to higher income countries with a greater concentration of researchers and clinicians and where data is more frequently collected. India is currently classed as a LMIC (Mallapur, 2019). In this paper we explore the beliefs and practices of people with mental health problems, family carers and other community members in a semi-urban town in Kerala, a state on the Southwestern Malabar Coast of India. Kerala is India's second least impoverished state (Reserve Bank of India, 2013) and highest in terms of UN sustainable development goals (SDG India, 2022), yet the prevalence of mental health problems is increasing, from 272 per 100,000 people in 2004 to 400 per 100,000 by 2020 (Joseph, et al., 2020). Evidence shows that seeking help from medical personnel may be undertaken only after community resources, spiritual and traditional practices have been tried (Sukesh and Nair (2020). In the past the problem has often been characterised as one of India having few trained mental health personnel and mental health resources (Prince et al, 2007; Saraceno, et al. 2007). However, the application of models of provision derived from practice in the global north to low to middle income countries is subject to increasing criticism concerning the applicability of mental disorder categories and the solutions which are believed to follow from these (Sax and Lang, 2021).

India comprises many diverse cultures, languages, ethnicities and religious affiliations. According to the 2011 census in Kerala; 55% are Hindus, 27% are Muslims and 18% are Christians. These majority religions intersect with a variety of local belief systems and practices. This diversity of religious beliefs has led to numerous perspectives around mental disorder. For example, some understand and explain mental distress using a western biomedical framework, while others use more traditional systems such as Ayurveda, which attributes illness to an imbalance of humours. The very term 'western' is itself controversial, but following veteran cultural psychiatrist Suman Fernando (e.g. 2010; 2017) we shall use this imperfect term to denote a way of looking at human problems derived from European and North American clinical and intellectual traditions. In India, supernatural, astrological and religious explanations are common, including Karma, Evil eye and spirit possession

(Chowdhury, et al.,2001; Raguram, et al.,2002; Halliburton, 2004; Khandelwal, et al., 2004; Padmavati, et al., 2005; Saravanan, et al., 2007). Hence, the practices of seeking help are grounded in this medical, cultural and religious plurality. These include a hospital or clinic, temples, mosques and churches in the country as well as indigenous faith healers.

Religious belief and spiritual awareness are important to the majority of the population in Kerala, particularly when explaining distress and confusion. Despite this, the Western (American and European) concepts of mental health and disorder guide a good deal of education for health professionals such as doctors and nurses, and informs the majority of health care delivery practice. Thus, the predominant form of treatment available involves a diagnosis, the use of medication and a focus on internal psychological factors. This kind of practice typically does not acknowledge the pillars of Indian culture, including religion, family, Indian philosophy and medicine. There are conflicting accounts of the value of religion and spiritual practice in mental health care (Jakovljevic, 2017). Some pose religion as being of no explanatory importance, and as a source of guilt, delusions and dependence (Behere, et al., 2013). On the other hand, religion can be seen as an important means of attributing meaning and purpose, a source of hope and a feeling of community extending opportunities for support and meaning making by those with mental health problems and their families (Chaudhry, 2008). Mental health professionals and service users endorse both sides of this complex relationship between religion and the causes and treatment of distress.

The study reported here took place in Chottanikkara in the district of Ernakulam, on the eastern outskirts of Kochi, Kerala, India. In Ernakulam 45% of the population report that they are Hindu, with 38% professing Christianity and 16% Islam. Chottanikkara itself is one of the smallest temple towns in Kerala with a population of 9719. The Chottanikkara Temple is a nationally famous temple dedicated to the mother goddess Durga. People from outside the area, the wider state of Kerala and the whole of India visit the temple seeking relief from mental health problems. The Chottanikkara Devi (or goddess) is said to be able to cure her devotees. Of particular importance in the healing process is the ritual of Guruthi Pooja at the temple which is attended in the evenings by those seeking recovery from mental health problems. This ritual invokes the goddess Mahakali, the form in which the deity is believed to manifest herself in the evening (Halliburton, 2004).

Mental Health Literacy

Awareness about mental health is often understood in terms of 'Mental Health Literacy' (MHL). The term was initially introduced by Jorm and colleagues (1997) who defined it as 'knowledge and beliefs about mental health conditions which aid their recognition, management or prevention'. Mental health literacy campaigns have claimed success at both reducing stigma associated with seeking psychiatric help, and minimising stigma associated with the mental health problem itself (Mcluckie, et al., 2014; Kutcher, et al., 2016). It is argued that improved mental health literacy will eradicate the view that people with mental health problems are lazy, unsuitable for marriage and parenthood, unreliable workers and are dangerous. Reaching this objective is important in a culture, where "actions appropriate according to dharma maintain the purity and honour of the family, lineage and caste while the inappropriate ones defile it" (Viswanath and Palakonda, 2011 pp. 148-149). In the sense of dharma emphasised in Hinduism, the concept focusses on duties, rights, laws and a sense of the 'right way of living'. Often the coverage in the media reinforces and normalises existing societal beliefs (Stuart, 2006). Evidence suggests that individuals with higher levels of MHL are more likely to understand their own mental health, increase their resilience and sense of control over their mental health and enhances help-seeking efficacy (Furnham and Swami, 2018). It is reported that those with a low MHL are more likely delay help-seeking and are likely to terminate their treatment earlier (Jung, et al., 2016).

Mental health problems have been a focus of particular concern in Kerala (Lang, 2019) so, taken at face value, mental health literacy could provide a useful way of enabling people to better understand their own mental health and that of others around them (Jorm, 2012). Whilst Kishore, et al.'s (2011) work examined the distinctive cultures of belief associated with rural and urban dwelling, what remains to be examined is the extent to which the area of residence itself informs the kinds of beliefs which participants entertain. For example, it may be that sites which are believed to be associated with healing or spiritual comfort afford a specific set of beliefs and practices compared with other locations.

The study presented in this paper re-examines an important problem with Jorm's (e.g. 2012) definition of mental health literacy, namely that it involves a unidimensional, Westernised notion of mental health, and assumes that biomedical and psychotherapeutic approaches are effective, yield less stigma and represent a more advanced and educated approach to distress and disorientation. A high score on Jorm, et al.'s (1997) self-report mental health literacy scale

indicates broad agreement with a medico-psychotherapeutic approach to both problem recognition and treatment. This approach animates a good deal of what is being attempted in the global mental health movement and the World Heath Organisation's mhGAP programmes (Sax and Lang, 2021; Mills and Hilberg, 2019). In this view, other beliefs and practices are often presented as ignorant or superstitious (Furnham and Hamid, 2014); in other words, as representing a lack of mental health literacy. This focus tends to under theorise the nature and meaning of the variety of self-help, familial and community beliefs and activities which may seek to tackle the distress and manage the social disruption associated with what in the West is termed mental disorder. Perhaps then it would be productive to consider not merely how local beliefs and practices can be supplanted by a westernised notion of mental health literacy but instead consider how multiple 'mental health literacies' from a variety of different traditions and healing regimes may intersect in managing these difficulties.

Therefore, the current paper considers the relationship between religious beliefs, locally nuanced understandings of the human condition and contemporary medical and psychotherapeutic formulations of mental ill-health. We will thus attempt to bridge the gap between religious beliefs and scientific understanding of mental health and examine how these might co-exist as multi-faceted mental health literacies in a population, and how these different literacies might be deployed.

Method

Participants

Semi structured interviews were conducted with twenty participants. Sampling included invitations to those in contact with mental health organisations and their carers, as well as snowball, participant driven sampling to identify community members and additional service user and carer participants. The interviewees were split into three separate profiles, caregivers of people with a mental health problems (N = 8, Mean age: 50.8), community members (N=5, Mean age: 40) and service users diagnosed with a mental health problem (N=7, Mean age: 42). In total there were 16 females and 4 males. Sixty five percent (13) reported their religion as Hindu and 35% (7) identified as Christian.

Location

As described above, interviews were carried out in a semi-urban neighbourhood at Chottanikkara in Ernakulam district, Kerala India. The village is famous for a temple associated

with curing mental health problems and following traditional healing practices. All interviewees were residents in Chottanikkara.

Interviews

The study was ethically reviewed by committees at the researchers host institutions (De Montfort University, Leicester and Tata Institute of Social Sciences, India) and as part of the recruitment process, participants were reminded of their rights including the voluntary nature of their participation, anonymity and confidentiality and the right to withdraw.

In-depth interviews using a profile specific interview guide were undertaken. For users and carers the interviews focused on onset of illness, course, significant events in the lives of the patients, explanation for perceived abnormal behaviour, experiences with treatment, self-help activities, reasons for choosing a specific religious site for 'treatment'. Community members were questioned about their attitudes toward and experience of mental ill-health, and how it is addressed in the area. The interviews were carried out in the local language, Malayalam, by researchers trained to undertake qualitative interviews. The interviews were recorded, translated and transcribed. The thematic analysis was informed by the approach of Braun and Clarke (2006) and by the epistemological stance and approach to lived experience found in descriptive phenomenology (Davidsen, 2013). Using these approaches, we examined how mental health problems and their amelioration were understood in the three groups of participants. Thematic analysis can be applied flexibly to enable researchers to navigate through a series of interpretive decisions to achieve a coherent and defensible analysis. We were attentive to both latent and explicit meanings in the corpus of interview material (Giorgi and Giorgi, 2008). Themes were characterised and focussed upon according to their apparent significance (Braun and Clarke, 2006) with a view to creating a descriptive account of how they subjectively experienced their reality. Analysis was an iterative process, which included the following elements. After reading and re-reading the data, through the lens of mental health literacy one author (FH) initially, the emerging network of features was discussed within the wider authorship team and the picture emerging of multiple ways to understand mental health literacy was further thematised. What was striking was that alternatives to the medical model of understanding mental health problems were often well articulated and coherent, even by those sceptical of them, and could not readily be characterised merely as ignorance. This led to our consideration of themes concerned with the spiritual amelioration of distress and disorientation, and the promotion of wellbeing, and then to a variety of self-help activities which were largely secular in nature. Finally, some participants tendered

explanations as to why medical approaches and consulting medical practitioners were not more popular options for people suffering mental health problems.

Findings

Explanations for mental health problems

Participants' understandings of mental health problems derived from a number of different spiritual and healing traditions. Medical understandings often co-existed with explanations allied to the religious beliefs to which participants and their family members subscribed. Accordingly, remedies were sought for their problems through religious measures. This was seen in explanations towards mental illness.

As scholars of religion in India have noted, the major religions are often informed also by more localised belief systems, often centred upon nature and geography (Rowkith and Bhagwan, 2020). Explanations for the problems were often based on culturally accepted reasons such as evil spirits, sacred Kavu (sacred temple), black magic or karma (actions) of their past lives. These explanations were ones that were readily available in the local culture, and often appeared to derive from suggestions by various individuals including close family, faith healers, priests, astrologers or significant others. The belief that the cause of the change in behaviour was due to the activity of evil spirits was an often repeated theme in most narratives, particularly in the temple-users in Chottinikkara.

The role of spiritual factors in aetiology

The following excerpt from an interview with a carer of a person diagnosed with psychosis demonstrates not only religious beliefs but a mixture of ideas and beliefs, especially places (the Sacred Mangrove tree at the temple) which is indicative of the synthesis between a major religion and nature beliefs as noted above. This is seen in the notion that the geography and topography resonate with their experiences. Here is a carer participant responding to a question about why she thought her mother in law has a mental health problem:

Interviewer: What do you think the reason could be?

Participant: If you ask why I don't know whether there is any particular reason. Then if we have to say, we are Christians, mother [in this case the Goddess popularly known as Chottanikkara Amma] has something to do with the sacred mangrove [at the Kavu temple]. We tell Kavu and all serpent mangrove something like that" (Participant 2, Carer, female)

Here, the participant, whose primary religious affiliation is Christian, is also drawing on a rich panoply of local spiritual entities. She made reference to the serpent God Naga or Goddess Durga. In addition to her mother in law, the child of a friend also had a mental health complaint, so someone told her to go to Kavu because the child was believed to have a serpent curse.

“One of her children had a complaint. So, someone told her to go to Kavu because the child has a problem at home” (Participant 2, Carer, female)

The serpent curse was used as a way of explaining why a person might display symptoms which might meet the medical definition of psychosis, and that this could be relieved by performing a ritual at the sacred mangrove tree at Chottanikkara. This participant also discussed the possibility that one person’s problems, in this case the mother-in-law with a mental health problem, may “spread” to other family members.

“To be frank having a family member with Psychiatric problem at home and living with them we would become patients.” (Participant 2, Carer, female)

As has been noted elsewhere (Radhakrishnan, 2020), the beliefs are allied to a set of practices which are understood to ameliorate or make manageable the problems. Our concern is not whether these practices are effective in any simple sense, but rather, what is interesting is that they make the identified matters of concern actionable – they tell the sufferer and his or her companions what to do. For example, for one of the female service users with a diagnosis of schizophrenia, her mental health problem was attributed to evil spirits, demons and ghosts but it was in combination with being ‘plump’. They were told by a traditional healer how to dispel these problems. This was seen in the following narrative:

“Any time these demons and ghosts possess fair plump people, so we should broom and mop the room we sleep in.” (Participant 1, User, female)

These factors in combination create a practical explanatory model (Ugwu and Kok, 2015), which led some of the research participants to seek spiritual help or traditional healing rather than (or as a supplement to) medical help involving a complex and nuanced picture of multiple causal scenarios and ameliorative actions.

Among community member participants, especially those with a connection to health care, there was awareness of these kinds of beliefs and practices, but they were described in rather different terms, indicating a degree of distance between the speaker and the ideas described. This is seen in the following two excerpts, the first from a man on the temple committee and the second from a female social worker.

"Then they think that the possession is out of their body. It is a blind belief. They have been brought up like that. Nothing, even the medicine and the counselling will not change this mental state" (Participant 17, Community Member, male)

Interviewer: Why do you think it [mental health awareness] is relevant in this community?"
Participant 17: "The common people, that this issue is due to some curse or due to black magic. That is what we get to know from them we enquire" (Participant 23, Community Member, female)

The notions are being described as not something one would subscribe to oneself. It is as if the speakers and by implication the interviewer are somehow beyond these supernatural beliefs; as if mental health problems would only be thought of as a curse by people from lower classes. This sense of distance between the speaker and ordinary temple attendees was apparent in other community members' accounts too:
"They believe that the possessed power has gone from their body. By this some will get cured, some won't" (Participant 16, Community Member, male)
There is an implicit and sometimes explicit downgrading of supernatural and religious beliefs and those that hold them are not susceptible to reason or evidence – it is 'blind belief'. Thus, whilst this participant would share a belief in the medical model of mental health problems that underlies Jorm's notion of mental health literacy, she is also fluent in the other beliefs and practices prevalent in the community, albeit with some scepticism concerning their value. Hence, even amongst people who subscribe to the medical model there exists a literacy with other belief systems and practices.

Methods of help based on spiritual beliefs
The pervasiveness of spiritual accounts of the cause of mental health problems meant that religio-spiritual means of ameliorating the problem were attractive. While the choice of source of help was largely based on the explanations for the illness, there were other factors which

influenced the choice. In a majority of cases, seeking religious treatment was advised by family members or traditional healers. As many people suffering with mental disorders do not seek help for themselves, the initiative to seek religious treatment was usually by the family. Various significant persons often negotiated this decision through time, each of whom would have their own impression of what to do. Some people, particularly caregivers, question the efficacy of temple healing. This participant expressed disbelief in religious influence in addressing mental health problems in the face of other family members explaining her daughter's symptoms as resulting from someone cursing her family by making offerings to a spirit [Chathan or Kuttichathan, a mischievous spirit in local demonology]. Many members of her family have told her that praying is the only way to cure this. This has scared her daughter who believes that someone is going to harm her further by making offerings to a spirit. However, participant 3 sees this belief as damaging, so refuses to visit the temples. As she said:
"I don't listen to this because I don't believe in this. And so they go to other people. So, there is added problems due to this. They say all these issues will resolve only if we go to the Chathan temple and pray for two to three days. Because I don't believe we have not gone to these temples" (Participant 1, Caregiver, female)

One caregiver who cares for her daughter with a diagnosis of schizophrenia was offered different advice from both a medical and spiritual background. She expressed her scepticism towards temple healing, after questioning why they did not experience any positive results after praying, visiting temples and seeking out medical advice.

"After I wake up, early in the morning, I pray to all deities. Now even if the doctor asks me not to take a bath, I was told not to wet my body hair too much, I heat the water and take a bath. But even after I received the 'Ushasahasranamam' and 'Lalithasahasranamam' (Hindu prayers) and called upon every God, I don't know why there is no positive result." (Participant 3, Caregiver, female)

As seen in the excerpts above concerning the aetiology of mental health problems, participants often describe these activities and beliefs as belonging to 'they' or 'people'; that is someone else, rather than endorsing the beliefs themselves. Thus, whilst acknowledging the prevalence of such belief, they are implicitly distancing themselves from the supernatural and religious beliefs which are – as described above – characteristic of the 'common people' who are seen as not susceptible to reason or evidence. This theme was continued in a variety of other

quotations, particularly by participant 20 who was a female nurse speaking of mental health symptoms:

"People addressed this illness with sorcery and other unscientific ways" (Participant 20, Community Member, female)
Interviewer: Did anyone share their experience? Say for example treating mental illness with sorcery?
Participant 20: "Some of them would interpret that they were possessed. Then we would advise them to consult a doctor and take medication which they will out rightly reject. They would insist on religious means to cure it. But that is not the case. If you are mentally unstable you have to treat it" (Participant 20, Community Member, female)

Participant 20, was asked later by the interviewer, "and you said some won't consult a doctor. What would be the reason?" to which she elaborated that people would prefer "religious means" over medical advice:
"The same reason. They believe in other religious means" (Participant 20, Community Member, female)

This theme was continued in a variety of other participants' accounts:

"They would insist on religious means to cure it" (Participant 16, Community Member, female)

This perspective was apparent from many community members; that people did not heed 'scientific evidence' and often resisted being urged towards medical treatment. Many community members expressed frustration that people did not want to listen to medical advice and still sought spiritual solutions, despite being told it would not help. Participant 18 also highlighted this.

Interviewer: "What is the reason for not taking medicines?"
Participant 18: "People addressed this illness with sorcery and other unscientific ways [. . .] They prefer offering to gods and pooja over medicines" (Participant 18, Community Member, female)

Whilst the interviewees themselves expressed this epistemological and practical distance from the beliefs and practices they were well-aware of the many residents and visitors who attended temple healings, rituals and made use of faith healers. However, these were described as largely ineffective and likely to fail in tackling mental health problems. They reported that patients expressed their dependence on God during times of crisis, as a ritual, as a tradition and as a powerful symbol. Despite expressing scepticism themselves, participants were able to describe in detail how sufferers would often take part in rituals to rid them of mental health problems. A male member of the temple board talks about what religious rituals people with mental health problems participate in.

“They sit for Bhajana [participating in singing a song of praise] for certain days. They participate in the pooja [act of worship] and take the ghee [a kind of clarified butter] which is worshipped on the Goddess. Some will go cured. Some will return in the next year. Then we would say this alone would not help. And better see a doctor.” (Participant 17, Community Member, male)

“I used to hear from people that if they have ghee or go to a temple, people may get some relief. But I never had been to such a thing. There are a lot of people who like that, we used to visit such people [. . .] The people used to believe in all kind of superstitions. They take even severe patients to such temples for religious rituals related to mental health. As I said about S, that woman still think that it is due to religious reasons the illness still exists” (Participant 18, Community Member, female)

The way these participants characterise the situation, there is a persistent quality to the beliefs and a meticulously ordered and choreographed sense of what may be done in relation to each kind of problem, at the same time as indicating that the speaker him or herself does not fully endorse the practice. Participant 18 noted that patients believed in religious and spiritual factors so strongly, they would go to extreme lengths to pay for religious rituals:

“If it is Hindus, they go and approach the priests in the temples and spend a lot of money by selling even their properties” (Participant 18, Community Member, female)

Here, not only is scepticism expressed regarding the value of the practices but that those seeking comfort in this way are wasting money too, and that perhaps the officiants at these ceremonies are somewhat remiss for taking it. This reflected a strong sense of scepticism among the community member participants.

People who suffered with the mental health problems themselves, explained in the interviews the spiritual and religious rituals they used to rid themselves of these disorders. The majority of service users did not mention seeking help from a medical doctor but rather from temple healing:

"I open up about my grievances there is a powerful energy (Shakti) existing. On the occasion of a difficulty, one will be protected/ rescued" (Participant 15, User, male)

The sense of place, space and natural entities (the sacred mangrove for example) combined with ritual has been noted in other accounts of spiritual healing practice (Rowkith and Bhagwan, 2020). The religious rituals applicable to people with mental health problems are often endowed with a precise chronology, with recommendations as to when the practices should be performed and for how long, as well as the particular deities invoked. There is a sense in these rituals that plotting and planning one's life is implicated in effecting a cure. This was explained by several people with mental health problems, and a particularly detailed account was offered by participant 1:

"Morning we circumambulate around the Banyan tree [i.e. move in a circular fashion around a sacred tree, *ficus benghalensis* believed to provide fulfilment of wishes and provide material gains], it is a medicine for mental illness. From the banyan tree, it would shower and fall on our body [. . .] They chant in the temple. So they will make us listen to it. Then in any one of these they should not eat for a day, they need to observe fasting and the madness will go [. . .] So when humans circumambulate all the illness would be healed. Through their shower, during 10AM all illness would get cured [. . .] There is a dot on the centre of Guruvayurappan's [a form of Vishnu, a supreme God in Hinduism] forehead. If you meditate on this dot for six months your mind will be able to concentrate" (Participant 1, User, female)

In this and other accounts there is a strong sense of time and place to the recommended rituals, providing a chronological structure to the devotions and providing a pattern to the process of

walking, fasting and meditating. Far from being mere ignorance and superstition, this is nuanced and specific to the troubles devotees seek to address (Radhakrishnan, 2020). We would therefore argue that to be fluent in this kind of healing regime represents a literacy in its own right, albeit one which exists outside of the Western medical canon.

Praying

The issue of praying is worthy of further attention because it is a specific aspect of religious observance that cut across the different groups of participants in this study. A majority of the caregivers of people with mental health problems used praying for two different reasons, which included healing the mental health problem and providing strength to deal with the cared-for person with a mental health problem. Carers were not inclined to define their own troubles as meriting health professional intervention, but rather as something managed through prayer or related religious observance like chanting.

Interviewer: "How can we develop strength to endure things in life?"
Participant 4: Pray to God. Eat well. When I say eat well I mean to eat what your body require rather than over eating." (Participant 4, Caregiver, female)

Participant 4 highlights that praying to God helps her with personal strength to look after her daughter with schizophrenia. It is important to note that even though she earlier in the interview she was asked "how do you look forward in life (in reference to dealing with difficult times)", that "God is the one who directs everything in life. When I see others in difficulty, I feel sadder so I pray for them". She did not mention about needing any mental health intervention but felt that God was enough support for her. This is an important comparison to the community members who felt that religious means were unhelpful for people suffering with mental ill-health. Here, by contrast, it is explained as a positive aspect of someone's coping mechanisms.

Participant 7 echoes the point from participant 4, talking about the specific prayers she does to help her deal with caring for someone with mental illness.

Participant 7 "I call upon Guruvayurappan. Chant 'Namam'. I pray to Guruvayurappan to help and to protect my child. And I read the Bhagavatam as well. Then, it's a Friday today so I have chanted 'Sahasranamam' in the morning. I chant 'Vishnusahasranamam' before that.

Sometimes I do complete and sometimes I don't. If there isn't anything to be read, I read its first part. Today, after having to read that, I chanted "Sahasranamam" and read a small portion of the Devi Sahasranamam." (Participant 7, Caregiver, female)

"When I feel like it's getting more difficult I pray to God to provide me with the strength and to protect me from danger, so even if I travel far… for some time now I go to all temples near and far" (Participant 8, Caregiver, female)

Strikingly, community members expressed the importance of praying to in maintaining good mental health. Despite their disbelief in spiritual factors in causing or curing mental health problems expressed elsewhere, they nevertheless value prayer for maintaining good mental health as expressed with particular fluency and emphasis by one participant.
Interviewer: "What do you do to keep your own mental health?"
Participant: "I pray to God to always to have good mental health."
Interviewer: "What can we do to keep good mental health as similar to exercise or dieting for physical health?"
Participant: "I avoid unnecessary thinking and I pray well" (Participant 17, Community Member, male)
Participant 18, a community member, also talked about praying to God to help her manage her working life, stress and tension. Despite her mental health nursing background, she still supported the use of praying to cope with tension (a term which in India is used to denote stress and anxiety). In this respect she differed from other nurses, who pushed for a more medical treatment of tension.
Interviewer: "How can we manage work stress or tension?"
Participant 17: "We need to overcome. I pray to God to give strength [. . .] I pray to God to give me strength and health" (Participant 17, Community Member, female)

The prayer reflects more than just religious belief. Like many of the aspects of living with mental health problems addressed above it is intimately connected with practice. In this case the devotional activities divide up the day into periods for prayer and chanting, carve out moments of calm amidst the demands of the caring role and offer a socially legitimate form of respite from the material burdens of caring in favour of a connection of the self to something that might be called 'the numinous'.

Service users also reported the use of praying to facilitate recovery. Many of the users not only mentioned their belief in religious rituals and deities but, as with carers and community members they focussed on practice as well. Religious involvement was associated with taking part in activities, so in a sense religious congregations are ‘communities of practice’.

“When we have mental difficulty, we should listen and engross ourselves blissfully in songs and stories about Lord Krishna” (Participant 10, User, female)

“If we devote ourselves 24 hours in God listening to these bhajans, chants, Narayaniam (Hindu Prayer) in tape for six months you will be alright” (Participant 13, User, female)

There is a notable contrast between these patterns of observance and ritual and conventional notions of mental health literacy. Many mental health literacy campaigns, like much of the global mental health have attempted to replace or modify beliefs which are seen here as somehow mistaken or mere superstition, but as these quotations illustrate, the ideas promoted under the rubric of mental health literacy have to compete with a whole range of living practices, ways of life, forms of organising one’s time or one’s social life. The forms of ritual, belief and practice provide an important social cement which bring people together in a way which the secular, scientific beliefs about mental health do not.

Non-spiritual self-help methods

In addition to the spiritual beliefs and practices outlined above, a variety of more secular or non-spiritual self-help methods were described, the choice of which was also apt to reflect participants’ explanations for the problem. The common non-spiritual self-help strategies involved maintaining a healthy routine, engaging in hobbies, having a job and sharing their problems.

Caregivers described numerous methods to deal with mental health problems. The majority of interviewees suggested hobbies they participated in, including listening to music and sitting in the garden. This is explained by a female caregiver who looks after her mother in law with psychosis.

Interviewer: “So when you listen to music, it’s a relief right?”

Participant 2: “I feel that my difficulties will reduce when I listen to good songs” (Participant 2, Caregiver, female)

“Then when I do get some free time, I spend it in the garden” (Participant 3, Caregiver, female)

One caregiver who looks after her son with a diagnosis of bipolar disorder and obsessive compulsive disorder mentioned that they would attempt to adopt healthy living strategies to reduce their distress. They indicated the importance of not over-indulging in food, which contributes to a balanced lifestyle. The notion of balance is central to the Hindu notion of Sattva, and the notion of restoring a sense of balance between the affected functions, the body, the environment and the person as a whole which is said to be important in the widely-practiced system of Ayurvedic medicine (Hadapad, et al., 2020). This was described similarly by a female service user with a diagnosis of schizophrenia, who was given the advice by a healer that mental ill-health affects ‘plump’ people, above.

This sense of balance, where the labour of caring is offset by appreciating music or time in the garden, or where a path is struck between overindulgence and hunger, was integral to the sense of wellbeing maintained. Again, there is a sense that the belief is practical in nature inasmuch as it leads to a suite of actions to tackle the problem, and involves a chronology – the time of labour is followed by the time of rest, the indulgence by abstention in a cyclical fashion, this sustaining the person’s ability to cope.

Hobbies and occupations

One community member mentioned engaging in hobbies to deal with the stress of looking after someone with mental health problems. As well as listening to music and gardening mentioned above, a couple of additional hobbies were mentioned, in the form of reading and writing. This echoes the previous point, that maintaining mental health and dealing with stress is not merely a matter for mental health services but is also addressed through self-help methods.

Participant 16: “I avoid unnecessary thinking and I pray well.”
Interviewer: “Is it easy to avoid?”
Participant: “No.”

Interviewer: "How do you do that?"
Participant 16: "When we are alone it increases. So, I won't sit alone. We don't have time to be like that even after work. If time is available, then I write something" (Participant 16, Community Member, male)
[. . .]
Interviewer: "What do you do to keep the mind in peace when you are alone?"
Participant 16: "I read. When I get a lot of time, I read the paper and have water when it is hot" (Participant 16, Community Member, male)

Like the caregivers, community members also expressed the importance of healthy living to improve mental health problems. They explained the importance of exercise and yoga rather than healthy eating. Community members often explain self-management, both formal in the sense of yoga, praying or taking part in activities such as walking, reading or writing.
Interviewer: "To have sound mental health what could one do?"
Participant 17: "Do yoga. Exercise daily. Walk. I walk a lot which gives me sound mental health"
[. . .]
"Self-control, yoga, meditation are more effective ways than treatment" (Participant 17, Community Member, male)

Service users participated in similar hobbies to both the caregivers and the community members. The most common two hobbies mentioned were reading and writing, especially when the participant was asked what they do to manage their mental health when it gets particularly bad. This was explained by a female user with conversion disorder.

Interviewer: "What do you do for your peace of mind?"
Participant 11: "I sleep for a while. Sometimes I feel sad, and I feel like crying. But I won't cry because when my eyes swell, my husband will know that I cried. I get tensed when I think too much. So, it's better not to think too much."
Interviewer: "What do you do to mitigate your thoughts?"
Participant 11: "When old memories come to my thoughts, I'd just neglect them and think of something else. Sometimes, I read books." (Participant 11, User, female)

"Reading good books help you to take good decisions. This would be strong. If the subjects that is being read provides them happiness, it helps" (Participant 19, User, female)

For those with mental health problems the desire to engage in some sort of activity often had a more practical basis. Self-help methods here often included paid work, which was suggested as a way to occupy the mind. Participant 11 went on to talk about a need to get work, almost as a way to keep the 'old memories', which she mentioned earlier, becoming too much.

Interviewer: "What will you do in your life in future?"
Participant 11: "I want to go for part time work. If I get, I'd go" (Participant 11, User, female)

But sometimes one's family presented objections:
"I wanted to go back to work, but my children did not want to" (Participant 10, User, female)

Participant 15, a male with depression, talked about going back to work; however, he focused on wanting a less stressful job, or a job with "no responsibility".
"I want to have a job with no tensions and a life with no physical shortcomings. A job with no responsibility" (Participant 11, User, female)

Tension comes up a great deal in accounts of unhappiness in India. In the UK, people may describe 'stress', however in India people refer to 'tension'. This is often used as an idiom of distress. For service users a job was associated with escaping 'physical shortcomings', but participants as a whole formulated self-help in terms of practical activities – gardening, reading, writing, listening to music, practicing yoga or going out to work. Once again, the focus is on doing things though in this case they are more secular than spiritual. In a sense then, this 'literacy' of self-care among participants is concerned with activity and practice, rather than work on one's psychological aspects. Thus, this represents another parallel literacy of mental health and wellbeing that coexists with the medical-model understanding of mental health promoted in mental health literacy campaigns.

Discussion

In this paper we have suggested that the notion of mental health literacy, as formulated by Jorm and colleagues (1997) represents a somewhat partial and medically influenced understanding of the situation, whereas in everyday life a variety of other understandings practices are brought

to bear on the issue which are considerably more than mere backward-looking superstition. Often the drive to improve mental health literacy is informed by the view that people should recognise mental health problems according to the categories of DSM or ICD, and that people's failure to do so indicates the need for further education and awareness raising on the matter (Saraf, et al., 2018). In this respect it shares a common conceptual and practical heritage with the movement for global mental health, with its focus on medico-psychotherapeutic concepts, explanations and service delivery models. The limitations of this kind of approach in cross cultural contexts have been widely criticised over at least four decades (Kleinman, 1980; Mills and Hilberg, 2019; Sax and Lang, 2021), yet the promise of mental health literacy initiatives remains persuasive to many practitioners and international organisations.

In contrast to the view that a narrow, medical version of mental health literacy should be promoted, we would argue for the value of a more pluralistic approach. As the themes and quotations above illustrate, perhaps a better model is that of multiple mental health *literacies*, which people may deploy differently depending on the perceived nature of the problem and their position in the social structure. Whilst a medical model may appeal to health professionals and has been a mainstay of health policy and education for professionals in India, other groups may adhere to spiritual or self-help techniques due to their ready availability and the ease with which they can be integrated into existing beliefs and lifestyles.

As we have seen, the latter so-called traditional approaches are distinctive in that they offer regimes of living practices, ways of life, forms of organising one's time or one's social life. They are, in an important sense, fundamentally about doing things, including valued spiritual practices such as chanting, praying, meditating and visiting sacred places or places of worship. Supernatural causes for distress and confusion were a repeated aetiological theme across all interviews in this study and a shared phenomenon despite scepticism towards these ideas being expressed by some participants. This contrasts with an earlier study by Srinivasan and Thara (2001), who reported that explanations in terms of supernatural causes for mental health problems were not widespread, specifically in urban areas. The current study however demonstrates the strength of religious belief over scientific formulations of the issue, and how the interaction of these different literacies helped to shape the perceptions and experiences of mental health problems in Chottanikkara's communities. In this respect, our observations harmonise with those of other scholars such as Sax (2009) who explored ritual healing practices in the Himalayas and noted their particular appeal to people of low status whose spiritual

activities tied in with their quest for social justice. The benefits of spiritual practice and traditional healing have been explored by many other authors (e.g. Raguram et al, 2002). Ranganathan (2014) sees temple sites and sacred places – and presumably the rituals taking place there - as serving an important function of refuge for people in distress.

A good deal of previous research on mental health literacy in LMICs has limited its data collection methods to asking participants to identify mental disorders in vignettes (e.g. Sahar, et al., 2015). This approach may assess the degree of alignment between local populations' views and contemporary psychiatric categories, but it does not address how people deal with different episodes of 'tension', 'distress' or 'mental illness'. In much of the existing research on mental health literacy it is assumed that people in LMICs such as India are merely ignorant about how to identify and tackle mental health problems. However, as we have shown, a complex array of beliefs, sources of support and practices exist with which lay people attempt to ameliorate distress or problematic behaviour. Indeed, from the point of view of lay people it way well appear that ritual healing, ayurvedic medicine and conventional allopathic psychiatry are comparable in efficacy (Halliburton, 2004). Frequently, ritual, magical and Ayurvedic approaches are tried first, and a scientifically trained doctor will be consulted only if the former approaches are deemed to be showing insufficient progress. People from the community, people with mental health problems and those who care for them have therefore developed and deployed a variety of traditionally informed self-help methods and religious practices, which they find very efficient. Kleinman (1978) discussed the notion of people's 'working models' of illness, which might prompt them to do things which a Western-trained health professional might find unintelligible. In this case one could say that explanations in terms of spirits and healing practices such as praying, chanting, hobbies and exercise represent a working model in Kleinman's (1978) sense. The situation however is more complex than that, because it is clear that people are aware of working models other than their own, they have a sense of what others believe even if they are sceptical themselves. That is why we believe it is important to consider this situation as involving multiple literacies which people can deploy depending on the circumstances, the kinds of help available or which they desire and their social or occupational position. Being aware of these multiple literacies is valuable in any attempt to bridge the gap between science and religious beliefs about mental health problems; it is important to consider that people are not merely suppositious or ignorant but instead may be literate in a variety of explanatory and ameliorative idioms which differ from the ones promoted by health educators or health organisations.

It may be that people in Chottanikkara have developed 'resilience' through the use of the self-help methods they describe, such as praying, chanting, hobbies and meditation. This in itself may be a key factor in combating the effects of mental health problems. Resilience is defined as the 'ability to bounce back after facing extreme stress' (Bhamra, et al., 2011). In turn, this means that people with mental health problems could be trained in resilience as a way to improve their health and quality of life. During times of extreme stress, individuals without attachment to others struggle to identify an overall goal or reason for living (Bush, et al., 2012; Cokley, et al., 2012). Those with a theological perspective tend to view the stressful experiences as part of a larger narrative, which helps them overcome hardship (Kelley, 2020). The positive aspects of religions seem to be that they can provide a series of practices and activities, give hope, resilience and mental fortitude which can improve mental health and wellbeing.

Community members felt that people with mental health problems were reluctant to seek treatment, instead deciding that religious healing was more desirable than scientific approaches. As one said "Another reason is they think once this illness will not be cured". As other authors (e.g. Pinto, 2016) have noted, while medical expertise is acknowledged, it is common to find that people in India do not believe it will effectively cure them, and turn to traditional healers instead. In addition, there is a fear of being medicated long term or locked away. In many global mental health initiatives, these foundational beliefs, social and spiritual commitments are treated as if they were obstacles to assessment and treatment Roberts et al, 2020). To resolve this, there needs to be a movement away from the Western biological approach and start to incorporate culture, self-help methods and resilience into the assessment and training of local personnel. As seen particularly from the interviews with the community members, there is still a sense of downgrading of people's traditional beliefs in favour of Western models, which may have the paradoxical effect of making pathways to treatment less accessible and long-term adherence less likely. In this respect, at both local and international levels, mental health literacy initiatives are an example of what several authors have termed 'biocommuicability' (Briggs and Hallin, 2007; Holland, 2017) an analytical concept that addresses communicative efforts where health is concerned, which encourage citizens to subscribe to a particular governmental or expert-defined message. This is embedded within an approach to discourse, self-awareness and power popularised by Nikolas Rose (e.g. 2001) who writes of the 'duty to be well' and of how citizens are encouraged by public health messaging

and popularisations of scientific ideas to hold the 'correct' ideas about their own and others' health and conduct themselves so as to maintain it as responsible members of society (Brown and Baker, 2012). From this point of view, mental health literacy, and the wider global mental health movement can be seen as interventions to promote this expert-approved form of thinking and conduct. At a local level in the present study this can be seen in the community members' valorisation of medical approaches and their corresponding downgrading of spiritual and traditional approaches. It could also be argued that the supervenience of medical model approaches in mental health is a legacy of the colonial period (Mills 2001), yet even in the present day, the medical approach continues to successfully surround itself with notions of effectiveness, modernity and enlightenment.

Conclusion

In conclusion, we would argue that a more holistic approach to different ways of understanding the human condition and how to make sense of distress and disorientation would be beneficial and appropriate for the residents in neighbourhoods like Chottinikkara. Whilst, as Sood (2016) reminds us both global and national approaches to mental health have a tendency to downgrade , such that their belief systems are recognised and respected within the medical approach, allowing agency and self-expression alongside prescribed treatment.

The idea of bridging the gap between scientific and traditional approaches to mental health treatment involves mobilising and synthesising the multiple mental health literacies outlined here, which in turn may relieve stigma and enable access to mental health services. However, a mental health literacy model focussed solely on medical understandings of the issue is missing important factors within Indian society, such as cultural, religious and spiritual beliefs and their attendant practices and healing regimes. Instead, we would advocate a push toward multiple mental health literacy models, to foster understanding not only of different mental health problems but incorporating successful self-help methods such as yoga, exercise and meditation. This kind of approach can already be seen in programmes such as the 'Dava and Dua' where dava (medicine) and dua (prayer) are combined (Sheilds, et al,, 2016) rather than running in separate courses as they often do at present. However, care may need to be taken, for as Sood (2016) cautions, the 'dava' may entirely supplant the more biographically and socially embedded 'dua'.

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