Drowning in Enchanted Waters:
The Role of Practiced Islam in Mental Health Nosology and Treatment Seeking Behaviors Demonstrated in Urban Bangladesh

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DECLARATION

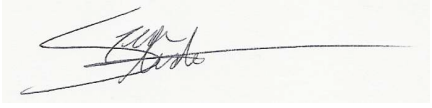
For submission to the Examination Committee.

Regarding my Master's Thesis with the title:

Drowning in Enchanted Waters:
The Role of Practiced Islam in Mental Health Nosology and Treatment Seeking Behaviors Demonstrated in Urban Bangladesh

I declare that:

1) This thesis is the result of independent investigation.
2) This thesis has not been currently nor previously submitted for any other degree.
3) I have used no sources other than those mentioned in my bibliography. Where my work is indebted to others, I have made proper acknowledgement.



Heidelberg: 5 May, 2010 .....

Dedicated to the millions of fabulous people the world over who are limited by mental health morbidity;

To those who strive daily to relieve the suffering of those people - regardless the method;

And to the families who live in daily fear, confusion, and helplessness.

Someday, the world will listen to your stories. And act.

Watercolor by Laery, paraplegic patient at the Center for the Rehabilitation of the Paralyzed (CRP), Savar, Dhaka, Bangladesh.

Acknowledgements

I would like to thank Prof. Dr. Hidayetul Islam, founder and director of the Dhaka Monorog Clinic, for allowing me to conduct my fieldwork at his clinic, granting me access to his patients, and going very much out of his way on a regular basis to help me with translations and cultural explanations. The opportunity to work with and learn from Prof. Islam was a wonderful blessing - without his help, my fieldwork would have been considerably less fruitful, and I cannot possibly extend to him enough gratitude.

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Thank you all, so very much!

Bhalo theko,

দিয়া পাগনি

Summary

"A drowning man will clutch at a twig." - Bangladeshi Proverb

In Bangladesh, there are two parallel mental health paradigms. The biomedical psychiatric system is under-funded, under-staffed, and often the final form of care accessed by patients when other treatments have been unsuccessful. The traditional religious approaches to mental health are based on Islamic doctrine and heavily influenced by cultural and socio-historical contexts. These two perspectives often find themselves at odds with each other: The former is perceived as curative only of the symptoms and not the underlying cause, and entirely devoted to science; the latter is perceived to be socially obligatory and only recognizes two causes of mental illness: *jinn-e dhora* (possession) or *ban mara* (religious cursing).

Because popular and historical perceptions of mental illness are embedded in religious phenomena, mental symptoms in Bangladesh are overwhelmingly manifested somatically or as behaviour deviant from the cultural norms, both of which are externalizations of illness. This model of mental health leads to the construction of culture-bound symptoms, which are understood within in the Bangladeshi cultural mental health paradigm but cannot be found in Western diagnostic schemes. The religious approach succeeds in providing an explanatory model for abnormal conduct and inexplicable physical sensations not recognized by the DSM-IV.

Detailing three-months of field research in urban Dhaka, this thesis includes background information on the Qur'anic attitude toward mental health, an introduction to Bangladeshi culture, symptomotologic and diagnostic psychiatric data gathered at the Dhaka Monorog Clinic, and a description of traditional religious healers, detailing their diagnostic and treatment modalities.

My research shows that more than half of all mental patients seeking treatment from biomedical facilities report receiving religious treatments for their afflictions before (or while) receiving biomedical treatment. This demonstrates a tendency toward pluralistic care seeking strategies by the patients and their families. However, there is no system in place in Bangladesh to direct treatment seeking behaviours; what is needed is a referral system that integrates both biomedical and cultural Islamic approaches. A handful of religious healers have been documented as referring patients to psychiatrists either directly, after an exorcism that left residual injury, or after initially medicating them with psychotropics. However, the biomedical community fails to recognise traditional religious healing or to consider integrative care, rejecting treatments that are not scientifically proven to be effective.

This report utilizes case studies and personal anecdotes to provide insight into the parallel mental health treatment systems in Bangladesh and serve as a springboard for future research.

Table of Contents

Introduction

"We shall not cease from exploration and the end of all our exploring will be to arrive where we started...and know the place for the first time." - T.S. Eliot

My pen flowed uninterrupted across the paper, my breathing remained steady and metronomic, and not even an unintentional blink or a gaze held too long gave away the tsunami that I'd just felt hit me in that small, overstuffed office on the second floor of a bare and bulb-lit cement building. One hundred seventeen psychiatrists. Eight psychologists. One hundred fifty-six million people. Sixteen percent adult morbidity. The numbers were not new to me; I'd been repeating them for months back in Germany as I prepared for my research on the under-researched topic of mental health nosology[1] in Bangladesh. But now, living in Dhaka and a few weeks into my fieldwork, I rolled through those numbers again. I realized that the situation was *not* that there was no mental health care system in place. Rather, the Bangladeshis had a diagnostic treatment system based on socially-bound perceptions of health. Individuals sought treatment for what they recognized within their own cultural milieu to be mental health problems, and were often relentless in their search for proper attention; they just sought treatment in places unrecognized by Western psychiatry.

The idea of an underlying universality to mental health that is expressed culturally became the carotid artery of my research, and led me to my current perspectives on social mental health phenomena and the role of culturally-informed paradigm integration. Recognizing the need for reflexivity and the impossibility of true objectivity, detached neutrality was never my primary concern; instead, my research evolved into gathering information on a paradigm formerly unknown to both myself and to an extensive population that shares many of my own cultural conditionings. In order to present my findings to this population,

[1] The study of disease diagnostics.

I found it prudent to be critical of why I made the observations I did. Pursing objectivity would only couch the material in counterfeit impartiality, which could invalidate my findings; I chose instead to recognize my own cultural conditionings to amplify both the differences and the similarities between the two mental health paradigms that I researched.

In every culture, there are social norms that are expected to be upheld. My initial suspicion was that the consultation of traditional healers before any biomedical mental health providers was one of those precepts throughout Bangladesh. I therefore postulated that the medical amalgamation between traditional and biomedical terminologies, diagnoses, treatments, and idioms of distress would be highly prevalent in the Bangladeshi mental health paradigm. I have always hesitated to refer to this overlap as a form of hybridity, primarily owing to the strength of the local norms and the efforts of psychiatrists[2] in Bangladesh to practice "pure science." I began my research seeking to define both this popular cognizance and the translation of popular mental health terminology within the biomedical explanatory scheme; I concluded my fieldwork with an understanding of two parallel but only vaguely amalgamative mental health milieu.

While psychiatric practitioners in Bangladesh continually translate cultural perceptions of mental illness into the diagnostic criteria outlined in the DSM-IV, they do not perceive themselves as doing so and rather see religiously-oriented idioms of distress to be a sign of the patient's inadequate education. Whereas there is a strong movement in the West to integrate traditional treatment methods into the biomedical paradigm, Bangladeshi psychiatrists are so determined to maintain their status as scientists that they disregard the centrality of Islam in popular Bangladeshi understandings of mental illness.

The following report integrates case studies and personal anecdotes in a primarily qualitative account of my observations throughout three-months of field research in urban Dhaka, Bangladesh. My primary research fields were biomedical in nature and oriented around a Western perception of psychiatry, though markedly lacking a psychological aspect. The interviews that I conducted with traditional Islamic healers were also influenced by the urban setting. I begin with an introduction to my research foci,

[2] The WHO Mental Health Atlas defines 'psychiatrist' as: "A medical doctor who has had at least two years of post-graduate training in psychiatry at a recognized teaching institution. This period may include training in any sub-specialty of psychiatry" (2005: 33).

approaches, and methods, followed by a background on biomedical and anthropological theory necessary to understand the later discussion of comparative milieu. A review of Bangladeshi cultural priorities and habits is critical to understanding the development of a traditional mental health paradigm and why it functions, and I also provide background on Islam and its literary perception of mental health before integrating and comparing that knowledge to popular perceptions in Dhaka. Finally, I present a short ethnography of the Dhaka Monorog Clinic and the data collected there, which leads to more in-depth accounts of religious healers and their diagnostic methods, diagnoses, and treatment methods used for mental disorders.

One hundred seventeen psychiatrists. Eight psychologists. One hundred fifty-six million people. Sixteen percent adult morbidity. These values represent only biomedical mental health practitioners; before the country's first mental hospital opened in Pabna in 1957, there was a traditional system for the treatment of mental disorders that, while perhaps now overshadowed by the modern discourses on dualism, hybridization, globalization, secularization, and reductionism, remains central to Bangladeshi health seeking behaviors.

Through my ethnographic accounts of both the psychiatric and religious mental health paradigms in Dhaka, this Master's thesis will present the anthropology and ethnopsychiatry communities with a cognitive foundational understanding of the cultural and religious milieu that influence perceptions of mental health in Bangladesh. My hope is to motivate future research in this field and initiatives for an amalgamative system that integrates cultural nosology and treatment methods with biomedicine, thereby rendering both therapeutic systems more effective for the patients and their families.

Chapter One: Approach, Methods, and Research Question

"Research is to see what everybody else has seen and to think what nobody else has thought."
- Albert Szent-Gyorgyi

There were two primary parts to my fieldwork: the theoretical and the practical. To appropriately analyze both spheres, I regarded my research question and data-gathering from many different perspectives, each requiring its own background research.

My research methodology was varied, primarily due to the qualitative and quantitative complexities involved in mental health research, especially in a country where limited related fieldwork has been conducted. I focused my research approach on semi-structured interviews. Because of my limited Bengali proficiency, I spent a considerable amount of time discussing question formulation with my hired translator, Mohiuddin Golam ("Mohi"), until he was able to conduct dialogues without my intervention, allowing him to discern the metacommunications of the interviewees and other cultural nuances that I otherwise would have missed. I interviewed four main groups of people: Biomedical psychiatric practitioners, religio-traditional practitioners, patients at both the Dhaka Monrog Clinic (DMC) and the National Institute of Mental Health (NIMH), and the "gatekeepers"[3] of those suffering from mental health morbidity. Patients never came to an interview alone and families played a pivotal role in illness expression, characterizing mental illness manifestations as social behaviors rather than the internal processing of the patient.

In order to gain an understanding of Islam and of the mental health systems in Bangladesh, I conducted a broad-based literature review. Given the cross-disciplinary nature of my research, the review included research on medical anthropology, psychology, psychiatry,

[3] With the term "gatekeeper" (Rashid 2007; Monawar Hosain, et.al. 2007), I am referring primarily to the patient's families, friends, and other "guardians" (Wilce 1995) who generally accompanied the patients on their visits to various practitioners.

cultural diagnostology, religion, education, perceptive modernity, economics, politics, history, and wars and revolution. As a foundation for biomedical[4] symptomatology and diagnostology, I referred principally to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition (DSM-IV) (with support from the World Health Organization's (WHO) parallel ICD-10).

I prepared four case studies[5] based on DSM-IV symptomatology, though I did not use this method as broadly as I would should I repeat similar research. These case studies representign Depressive Disorder, Schizophrenia, Post-Traumatic Stress Disorder, and Dissociative Trance Disorder. Though I was only able to disseminate them to four practitioners, the variability in diagnoses and treatment methods I received was invaluable to my research findings, and I would highly recommend that future studies employ this or a similar method on a broader scale.

I quickly realized that it was impossible to research psychiatry in Bangladesh at all without a deep understanding of the religious and cultural perceptions that pervade popular ideas of mental health. Therefore, instead of solely investigating how Bangladeshis differentiate between psychotic, somatic, and emotional disorders, I began reorienting my research questions to include how those differentiations are embedded in a religious paradigm. I found it impossible to separate mental health from the rest of the social milieu, and I began asking not "What are the socially-acceptable methods of mental health seeking behavior in Bangladeshi society?" but rather, "Why is it a social expectation to seek religious healing for mental health issues, and how does that presumption color health seeking behaviors, popular attitudes toward biomedicine, and stigmatization of different diagnostic labels?"

The suggestion that trauma is a universal phenomenon that is handled in a biological, culture-proof, pan-human subconscious is belied by the fact that only one of 219 patients I observed was diagnosed with Post-Traumatic Stress Disorder (PTSD). I therefore had to reconsider my original focus on Schizophrenia, PTSD, Depression, and Dissociative Trance Disorder and the conceptualization of those distinct mental ailments within the Bangladeshi mental health paradigm. Instead, I began to look at the influence of Islam on

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[4] I refer to the psychiatric and psychologic disciplines as "biomedical," and occasionally "Western" when focusing on socio-cultural discrepancies and perceptions.

[5] See Appendix 3. Reviewed by Martha L. Maness, a clinical psychologist in Massachusetts, USA

the daily lives of all Bangladeshis - whether they actively practice the faith or not - and I saw how a culture based on oral and religious tradition can confound mental illness sufferers who are presented with biomedical explanations of their problems. In a country facing modernization, I began to focus on how these Islamic ideas and concepts changed not only perceptions of mental health in urban Dhaka, but also attitudes toward the faith that has defined Bangladeshi culture for almost a millennium.

Chapter Two: Ethnopsychiatry and Psychological Anthropology

"Your paradigm is so intrinsic to your mental process that you are hardly aware of its existence, until you try to communicate with someone with a different [one]." - Donella Meadows

Contemporary scholarly discourse questions whether mental health and its diagnosis is fundamentally culture-relative or universal, which is further confounded by the lack of pathophysiological knowledge of mental disorders. There remains very little general biomedical understanding of the etiology of mental illness (Kendell 1975: 70-71; Helman 1994: 258; Millard 2007: 276), a situation that lends itself well to the association of mental health phenomena to other worldly possession and other culturally-embedded illness explanations, as can be observed throughout history in every documented society. Some critics argue that the contemporary biomedical mental health model is therefore insufficient and needs revision: Thomas Szasz (1960), for example, believes that psychology and psychiatry are starkly differentiated, the former a mere excuse mechanism for socially unacceptable behavior, and the latter a misnomer for physical brain defects.

The DSM-IV was published by the American Psychiatric Association in 1994 and is considered to be the primary source of information on mental health disorders in modern biomedicine for both children and adults. The Fifth Edition of the manual is expected to be published in 2012, and ethnopsychiatrists like Arthur Kleinman are focusing their efforts on the inclusion of a more robust explanation of cultural factors and social illness in the revision; he believes that the DSM-IV's symptom-based approach to diagnostics is inadequate for the recognition of culture-bound syndromes[6] and other context-specific phenomena.

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[6] Though there is little other mention of culture and its influence on mental health in the DSM-IV, in Appendix 11, there is a list of the following culture-bound syndromes: *amok, ataque de nervios, bilis/colera, vouffee delirante, brain fag, dhat, falling-out, ghost sickness, hwa-byung, koro, latah, locura, mal de ojo, depression, sangue dormido, shenjing, shvairuo, shen-k'uei, shin-byung, spell, and susto.*

Cecil Helman (1994) begins his chapter on one of the most neglected aspects of anthropology and health in general by describing the two primary investigators of cultural psychiatry: Western-trained psychiatrists and social anthropologists. The former have historically focused on unfamiliar psychiatric disturbances, attempting to fit them into Western mental health explanatory schemes. The latter have busied themselves with "definitions of 'normality' and 'abnormality' in different cultures, the role of culture in shaping 'personality structure,' and cultural influences on the cause, presentation and treatment of mental illness" (Helman 1994: 246). I have endeavored to study the dual Bangladeshi paradigms from both perspectives.

Similarly, anthropologists must adopt a more pluralist *Weltanschauung*, Bibeau (1997) contends, if they wish to represent the true workings of a given society, a task that is becoming ever more complex in the face of globalization and creolization. Bibeau defines three problems that cultural psychiatrists cannot ignore: 1) Identity systems (language, collective representations, symbolic orders) are threatened by globalization; 2) If an individual's world experience is based on cultural idioms, then the possible idiomatic contradictions due to globalization and (medical) pluralism have heretofore undefined consequences; 3) There now exist flexible identities defined by "multiple belongings, multi-locale communities, [and] long distance networks" (Bibeau 1997: 18). In South Asia, where the youth population measures value on a scale of Western modernization (Nisbett 2007; Leichty 2002; Lukose 2005), the simultaneous separation and plurality of mental health methods was a worthy gap for my research to address.

In addition to the variability inherent to human interpretation, psychiatric diagnostic methods and categories are also living entities that change and are subject to external, cultural influence. Sometimes, Helman (1994) notes, psychiatry can be (and is) used as a form of social control, using stigmatized diagnoses to dictate behavior; in many cases, certain diagnoses may actually inhibit sociability and respectability as opposed to increasing awareness and opportunities for affective treatments (Helman 1994), a situation that well describes the lack of psychiatric transparency in Bangladesh.

Embedded in socio-political and -economic contexts, many psychiatric illnesses are therefore manifested somatically in non-Western countries, though their expressions vary

widely across cultures (Kirmayer and Young 1998; Helman 1994; Wilce 1998). Arthur Kleinman (1980) offers that a strong feature of many folk illnesses is somatization and emotional states are often embodied physically, especially among lower socio-economic classes and in cultures that stigmatize emotional expression. *Psychologization*, Helman writes, "is more common among upper middle-class professionals and executives with a college or graduate school education" (1994: 268).

Ethan Watters (2010) uses in-depth case studies in Hong Kong, Sri Lanka, Zanzibar, and Japan to demonstrate his thesis that, "how a people in a culture think about mental illnesses--how they categorize and prioritize the symptoms, attempt to heal them, and set expectations for their course and outcome--influences the diseases themselves." Therefore, in many cases, the Western psyche is itself a mode of globalization; Watters says, "In teaching the rest of the world to think like us [Americans], we have been, for better and worse, homogenizing the way the world goes mad" (2010: 2). This homogenization is evident in urban Bangladesh, though cultural norms remain strong enough that the effects of this psychiatric globalization is being disseminated slowly, and along educational stratification lines.

Chapter Three: The Outsider's Guide

"Western mental health discourse introduces core components of Western culture, including theory of human nature, a definition of personhood, a sense of time and memory, and a source of moral authority. None of this is universal." - Derek Sommerfield

3.1 Introduction to Bangladeshi Culture

The first thing that any visitor notices upon arrival at Zia International Airport in Dhaka is the number of people. Voices hum and dirty flip flops scratch against old linoleum or loose pebbles; travelers gawk at the "lack of personal space" and the fluid movement of bodies sliding past each other; but there is no alternative in a small land with the world's seventh largest population (CIA World Fact Book, July 2009). The urban population represents 27% of the total[7] 156 million (and is increasing annually at a rate of approximately 3.5%)[8], and 45% lives below the international poverty line.

Bangladesh has the third-largest Muslim population in the world, falling behind only Indonesia and Pakistan, with between 83% (CIA WFB) and 88% (2001 Bangladesh Census) of its total citizenry. Just under half of the world's Muslims live in Asia and between the religion's populations in Pakistan, India, and Bangladesh, 23% of the Islamic world calls South Asia home (Gulevich 2004:111). However, what makes these statistics even more striking is the fact that Bangladesh is almost exactly the same size as Iowa, USA and about two-fifths (⅖) the size of Germany, each home to approximately 3 million and 83 million people respectively[9].

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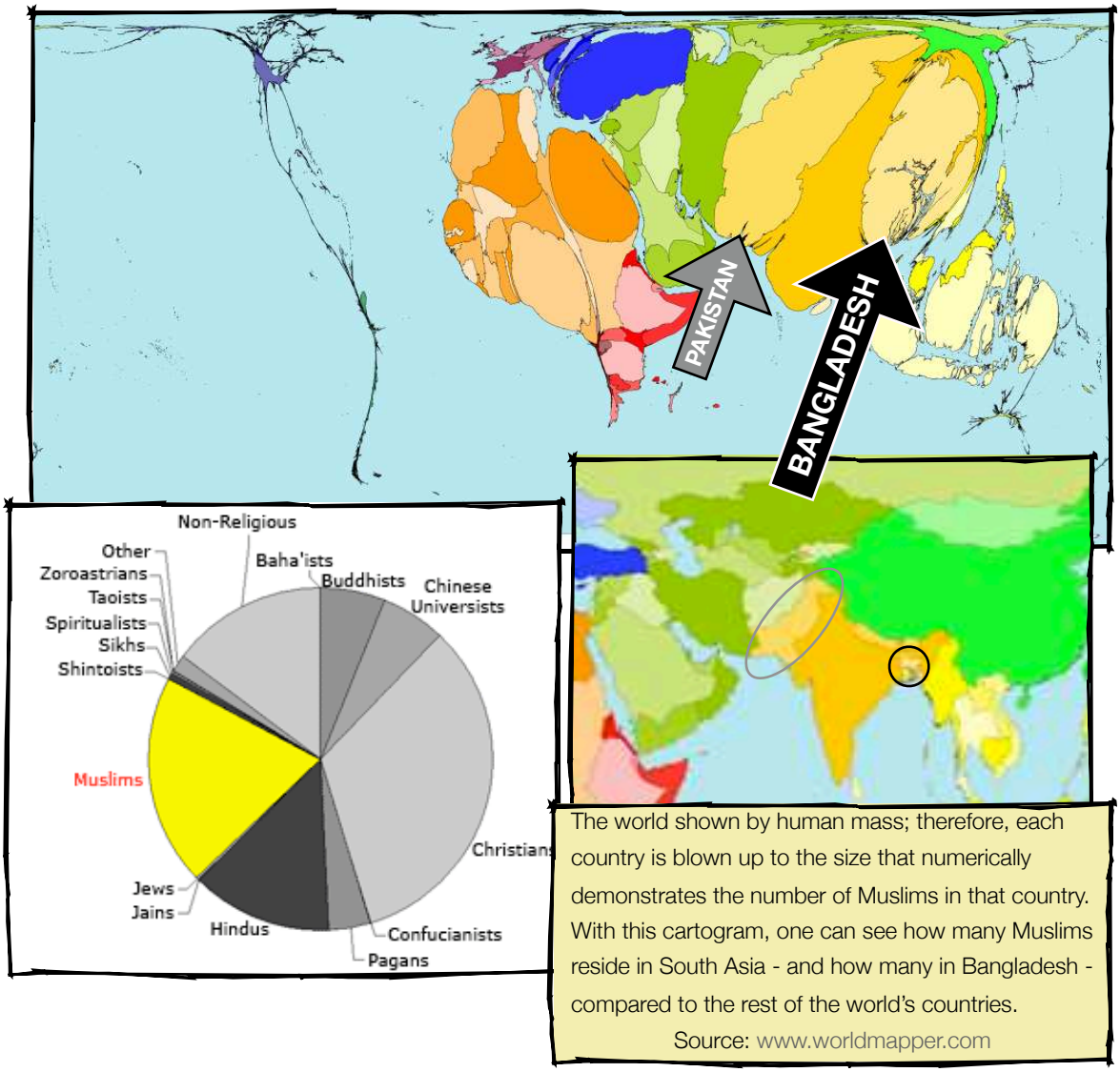
[7] Dhaka has an average population density of approximately 1400 people/km², and up to 8000 people/km² in some slums.

[8] Everyone in Dhaka "comes from the village" though Dhaka itself is seen as an unfortunate money-making necessity. I met no one who expressed comfort in the city, but everyone seemed resigned to its existence and purpose.

[9] Iowa: 56,272 mi² (145,744 km²)
Bangladesh: 55,599 mi² (144,001 km²)
Germany: 137,847 mi² (357,021 km²)



The world shown by human mass; therefore, each country is blown up to the size that numerically demonstrates the number of Muslims in that country. With this cartogram, one can see how many Muslims reside in South Asia - and how many in Bangladesh - compared to the rest of the world's countries.

Source: www.worldmapper.com

The population size and its relative religious geographical isolation means that Bangladesh has evolved in a way that balances its people and Islam with a strong notion of hierarchy, a distinct perception of 'self' and society, and a unique attitude toward modernization.

Bangladeshi culture is defined by its hierarchies, which are present in everyday social expectations of respect. However, perceptions of social hierarchies and the roles assigned to each stratum come laced with preconceptions and assumptions. One middle class informant explained to me that the upper and the lower classes are very similar: "They can do whatever they want; they don't have to care." Instead, he told me that the middle class shoulders the burden of culture because it is wealthy and educated enough to understand social expectation but poor enough not to be able to escape them: "We must care what we wear, what we eat, whether we divorce, where we work, and who we are with." The

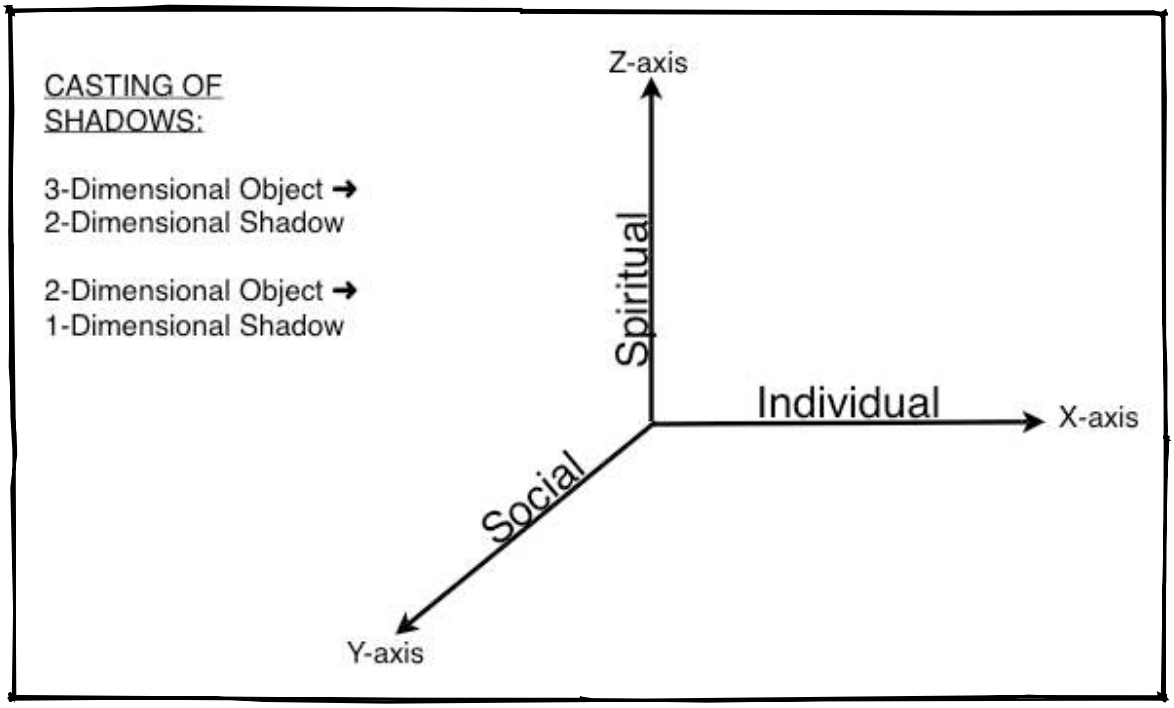
informant's sister added that it is obvious that poor people have no stress or anxiety in life because they can sleep peacefully anywhere on the street and at any time without pills.

When I asked Dr. Alam, Deputy Director of the NIMH, about the role of culture in mental health in Bangladesh, he emphasized the importance of family. He told me that in Bangladesh, the fundamental role of the family is to care for its ill members. Therefore, he says, the level of domestic mental rehabilitation is much higher in Bangladesh than in many other countries.

This focus on family and hierarchy that defines their culture leads many to categorize Bangladeshis as sociocentric, one of Kirmayer's (2007) classifications[10]; however, one must be careful with such grouping mechanisms. It is important to recognize the reductive and simplistic nature of this model in the presence of cultural heterogeneity. While the role of culture in the effusion of individual characteristics must be considered, Bangladeshis cannot be homogenized as a sociocentric society. During my fieldwork, I saw that Bangladeshis did conceive of an individualistic self, their skin a boundary and identity (Kakar 1981; Marsella 1985; Roland 1988; Chakraborty 1991; Bose 1997), and their corporeal, intellectual, and emotional integrity personal and internal.

One can observe this phenomenon from a more mathematical perspective: Using simple geometry to describe a three-dimensional field where the individual is the x-axis, the society the y-axis, and the cosmos the z-axis, one can clearly see that a three-dimensional culture that revolves around a spiritual axis casts a two-dimensional shadow. Thus, life problems in those cultures are manifested in that second dimension, or along the y-/social-axis, which serves as a shield to the individual. Secularization eliminates the third dimension, thereby projecting the majority of shadow into the first dimension: At the level of the internal self, which is why some categorize more temporal Western cultures as being egocentric.

[10] Egocentric, sociocentric, ecocentric, and cosmocentric.



With their problems being predominantly reflected along the social axis, the Bangladeshi notion of 'self' is a fascinating one that has developed alongside a cultural history defined by natural disaster, poverty, large families, hierarchy, and religion. However, it remains true that there is rarely a moment when a Bangladeshi is alone. *Ad-da* (আড্ডা), which is literally translated as "gossiping" or "chatting," is extremely common and reflects this propensity for social connection. Bangladeshis spend hours together simply engaging in *ad-da* because, otherwise, as a Bangladeshi friend pointed out to me, "what's the point?" However, *ad-da* is rarely authoritative or answer-focused: Something is or is not and should be defended or argued, but there is no questioning why something is or what would be the repercussions of change. There is little concern for purposes behind things; focus is paid to the fatalistic perspective that things are as they are, and the hypothetical question of 'why?' is almost never addressed.

Therefore, when I focused my interview questions on *why* people had the perceptions and perpetrated the behaviors they did, I received confused looks and regurgitated answers again of *how*. I initially struggled to understand the problem with my interview questions and why they were so often misconstrued by my informants. As I observed how Prof. Islam's patients did not inquire about why they had the problems they did, or where those problems came from, or what the nature of the problem was, it struck me that I was not

asking questions in a way that Bangladeshis knew how to answer them. “We are thinking about cure, not prevention,” explained one informant: Bangladeshis don’t seek to give meaning to human suffering, they seek to find relief from it. Why should they question a problem for which they already have the solution? The popular understanding is that mental suffering is the result of *jinn-e dhora* (possession) or *ban mara* (cursing), and the problems just need to be ameliorated.

3.2 Islam in Bangladesh

Although most history books neglect Islam’s arrival in Bangladesh completely, those that do mention it generally attribute the religion’s introduction to the Greater Muslim Conquest of 1203 AD (Razia and Banu 1992). However, Bangladeshi accounts date the religion’s influence as far back as the Sufi traders and the conquest of the Sind region by Muhammad bin Qasim around 700 AD[11] (Mohar 1985: 29). There was significant Muslim expansion around this time and the Arabs were notorious for their conquests of Africa, Europe, and Asia. The tenets of Islam that dictated following a single book without sects or denominations served as a unifying power throughout the new Muslim territories and before long, the Arab nations had built a strong navy and had become the foremost maritime people in the region. This new access led to the development of a robust trade culture, connecting East and West. It was reportedly through this commercial tradition that Islam originally came to Bengal; even the name of the Bangladeshi region Chittagong[12] is believed to be a corruption of the Arabic name *Shāti’ al-Gangā*.

Islamic rulers are said to have come to the land advocating principles of equality, which appealed to the lower caste Hindus in Bengal, who could now free themselves from social chains and discrimination through religious conversion. As is historically the case with large-scale religious transitions, many local beliefs and practices that did not fit into Islamic dogma were used and altered over time to bridge cultural and religious custom gaps. The *tabiz* is the perfect example of a morphed symbol: Talismans have been used in the Bangladeshi region for upwards of 4500 years to ward off spirits, bring luck, and

[11] The oldest Arabic Islamic inscription found in Bangladesh is a large stone block on display in the National Museum that dates back to 652 AD.

[12] Even today, about half of the Chittagonian language is pure Arabic words or words derived directly from Arabic roots (Mohar 1985: 39).

protect people against other evils, say leading archaeologists. However, today, the *tabiz* is strictly a religious symbol, that, while not enjoying any reference in the Qur'an, is accepted throughout Bangladesh to be an icon of Islam and Allah's power to heal.

The majority of the Bangladeshi population considers itself to be *Sunni* of the *Hanafi School* (as outlined in the Constitution). However, there remains a strong Sufi influence that pervades all religious thought and practice in the country. Sufism is a sect of Islam based on emphasizing a love of Allah as opposed to a fear of Him. The sect stresses a more direct, unstructured, and personal devotion to Allah in opposition to the strict ritual observance often seen in *Sunni* and *Shi'a* Islam, which consider Sufism to be heretical. Many Bangladeshis still consider themselves to be 'converts' and perceive this status as proof of their passivity, allowing them to distance themselves from the associations of Islam with terrorism and to scorn the militancy that they see as gripping Muslim countries to their West (and affording them the relished opportunity to make disparaging remarks about Pakistan).

Though there was a much stronger Islamic influence in India during the rule of the Mughal Empire in the region (1526-1858 AD) than there is today, the current distribution of the Muslim faith leaves Bangladesh religiously isolated. This religious seclusion from other Muslim countries[13] had many lasting effects on religious perspectives and Bangladeshi culture, which some people describe as a "Muslim India." However, this comparison is also a misnomer that resurrects stark memories of the 1951 Language War fought against India in which the territory won its right to speak Bengali and thereby maintain many of the region's separate customs.

Even more etched into the Bangladeshi cultural memory is the Liberation War of 1971 (known outside the country as the Pakistan Civil War of 1971) through which Bangladesh won its full independence from West Pakistan after one of the century's most bloody and terrifying wars. Isolated geographically by Indian borders, economically by South Asian politics, and religiously by their own fervent distaste for anything that reminds them of West Pakistan, Bangladesh has been free to adapt its religious mental health paradigm without external censorship.

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[13] Post-WWII designations put Bangladesh (East Pakistan) under the rule of Islamabad, which is 2021 km away and completely set apart geographically with India between.

3.3 Mental Health in the Qur'an

The majority of literature that mentions mental health in the Qur'an focuses on the history of Arabic medicine, which has little bearing on the popular practices in Bangladesh. However, some connections exist and it is critical to look at the greater Islamic and Qur'anic perspective of mental health before comparing it to that demonstrated in Bangladesh.

Some Islamic notions have been exaggerated and misconstrued when introduced to new cultures and taken out of an Arabic lingual and historical context. Arabic medicine itself is based on Hellenistic methods, and was a uniform health milieu that was widespread throughout the Islamic territories (Esposito 1999: 198); however, non-Arab Muslim[14] countries have often seen the development of unique medical systems that represent a mixture of Arabic and traditional approaches influenced by cultural interpretation.

With the British colonization from 1757-1947, the majority of the traditional treatments for physical illnesses in South Asia were usurped by the new European medical paradigm. This dichotomy meant that the biomedical focus for corporeal afflictions led to a stark distinction between mind and body and treatments for mental illness remained in the hands of religious healers in Bangladesh.

The first Islamic mental hospital was founded in 805 AD in Baghdad (Koening 2005: 29), as caring for the mentally ill[15] is considered to be a form of charity to the needy - a religious obligation of all Muslims dictated by the Qur'an. Al-Razi, known as 'the Father of Islamic Psychiatry,' was the first to write about neuropsychiatric disorders (in the 20th century) within religious dogma, attributing some mental problems to nervous breakdowns or other physiological causes as opposed to a blanket causation scheme attributed to evil spirits. He was also the first to refer to psychotherapy (*Al-Ilaj Annafsani*) and that a change

[14] Many make the mistake of using the terms "Arab" and "Muslim" interchangeably, a gross misuse of both labels. The former is a race of people that live primarily on and around the Arabian peninsula (Saudia Arabia, Yemen, Oman, Iraq, Jordan) and who's native tongue is Arabic, whereas the latter denotes the followers of Islam. Bangladeshis belong to the second, but not the first group. There are many Muslims in the contemporary Middle East who do not speak Arabic, though their traditions and medical practices much more closely mirror those of the Arabs than do those found in Bangladesh and other Muslim countries further afield.

[15] Some scholars reference *Sura An-Nisa'* (Women), part 5, which says, "Do not give to those of weak mind your property that God has put in your charge (as a means of support for you and for the needy), but feed and clothe them out of it (especially with the profit you will make by exploiting it), and speak to them kindly and words of honest advice" (Ünal 2008: 174) as evidence that the Qur'an orders care for the mentally infirm; however, from the context, many other scholars are convinced that the passage is referring solely to women.

in mind precedes a change in body, a conceptualization of psychosomatic doctrine (Koening 2005).

Most contemporary on the subject are the thoughts of Dr. Abu'l-Mundhir Khaleel ibn Ibraaheem Ameen (2006), who claims that, though there are some illnesses that are best treated with biomedicine, there are also many that can be successfully cured through religious healing methods; he is adamant that reciting the Qur'an to someone who is suffering can never worsen the condition. The Islamic belief in the unseen is a cornerstone of the religion, as is the belief that Allah is the ultimate arbiter of health and illness. In *Sura Al-An'ām* (Cattle) 6:17, the Qur'an says, "If God touches you with affliction, there is none who can remove it but He; and if He touches you with good - it is He Who has full power over everything" (Ünal 2008: 269), which leads its readers and followers to the understanding that belief in Allah is a cure for illness. For this reason, Muslims understand that not seeking medical attention when ill is *haram* (a sin/unethical religious crime) - a Muslim's body is the property of Allah and its neglect is an affront to Him.

Ameen assigns three Islamic explanations for mental illness: *Jinn* affliction, witches and witchcraft, and the evil eye[16]. He separates mental and nervous illnesses into four categories: Delusion, Epilepsy, Depression, and Anxiety and contends that, "no person is free of delusions....Even those who are righteous and upright in their religious commitment are not free from the problems of delusion" (2006: 281). Delusion itself is one of the most serious types of disorders, he writes, because, while *jinn* possession can be cured through reciting *ruqyah*[17], the disease itself is circuitous and serious:

> If the delusion of having being possessed by the jinn or having been bewitched takes hold of a person, then his thinking becomes confused and his life becomes chaotic; his glands start to malfunction and the signs of possession or bewitchment appear in him. He may suffer convulsions or lose consciousness as the result of what modern psychology calls autosuggestion. (Ameen 2006: 282).

The symptoms of delusion include increased or irregular heart rate, increased blood pressure, a malfunctioning digestive system, stomach pain, decrease in libido, tense

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[16] Similar notions can be seen in cultures throughout the world, though in Islam, "the origin of the evil eye is liking something, then the evil soul follows it, pursues it and seeks to do harm to it, seeking help to apply its poison by looking at the object" (Ameen 2006: 253). In the *Sunnah*, Mohammed himself exclaims before he forbids tattoos that, "The evil eye is real," a passage that serves as evidence of truth.

[17] The recitation of *sura,* seeking refuge in faith, and remembering and supplication to Allah.

muscles, and headaches; furthermore, Ameen asserts that, while many people may develop the symptoms of true *jinn* possession, the majority are actually suffering from the delusion of possession - true possession is infrequent (Ameen 2006: 283).

In his next chapter, Ameen describes Epileptic seizures as caused by four phenomena: (1) Individual potential and heredity; (2) Brain malfunction; (3) Changes in neurological activity; and (4) *Jinn* possession (2006: 285). In cultures worldwide, epilepsy has been historically attributed to supernatural forces and been called a 'divine' or 'holy' sickness due to its sudden and often temporary affliction.

Though Depression is considered to be one of the symptoms of *jinn* possession, Ameen admits that sometimes the disorder is simply one caused either by external stressors or internal hormones. The remedies for depressive and anxiety disorders can be found in the calming nature of religious practice. In *Al-Ra'd* (Thunder) 13:28, the Qur'an reads: "Be aware that it is in the remembrance of, and whole-hearted devotion to God, that heart finds rest and contentment" (Ünal 2008: 505).

Religious healing methods sometime conflict with more modern medicine due to the *ayat* in *Al-Māedah* (The Table) 5:3 that says, "This day I have perfected for you your Religion (with all its rules, commandments and universality), completed My favor upon you, and have been pleased to assign for you Islam as Religion." This assertion not only places Islam in a position of dominance above all other religions, but insinuates that any new innovations are assertions that Muhammad betrayed the message of Allah. This passage provides insight into hesitation toward shifts in religious dogma and modern Qur'anic interpretation.

Jinn (জ্বীন) are the most oft-cited source of mental health issues in the Islamic health paradigm; however, nowhere in the Qur'an does it say that *jinn* can harm or possess humans. Before He created humans (*insaan*) out of clay, Allah created the *jinn* race from smokeless fire (Qur'an 7:12; 55:15; 15:26-27) and the angels (*jarista*) from light. The *jinn* race itself is understood throughout the Muslim world as being "spirits of evil or the beings that invite man to evil, as opposed to the angels, who invite him to do good, both

being alike invisible[18] to the human eye" (Ali 2002: 314). Although there are direct references to *jinn* in the Qur'an, the Holy Book does not use this term exclusively to refer to this race, but also to denote the slaves of Solomon (Qur'an 21:82; 27:17; 34:12; 38:37); the leaders of men who, through their detachment and status remain separate and unseen by their subjects (Ali 2002: 315); Jews (Qur'an 46:29); Christians (Qur'an 72:1); clever and sharp men, who, if they become weak[19] and abject in their work, one would say that "his jinn fled away" (Ali 2002: 315); friends of men together with those men in a single assembly (*ma'shar*) or community (Qur'an 6:130); the human dwellers of cities that were destroyed due to their committing of sins (Qur'an 6:131); and men of fiery temperament or rebellious[20] nature who incite evil in others (Ali 2002: 527; Qur'an 72:6).

The last two chapters of the Qur'an, *Sura Al-Falaq* and S*ura Al-Nās* outline how a Muslim can best seek divine protection from illness and other mischief and are the most commonly recited for mental health purposes. S*ura Al-Nās* prays: "I seek refuge in the Lord of humankind, the sovereign of humankind, the deity of humankind, from the evil of the sneaking whisperer (the satan), who whispers into the hearts of humankind, of jinn and humankind." It is probable that, '*jinn*' in this case is referring to all of the aforementioned parties described by the term and not just the race of invisible beings.

Ameen reports that some *jinn* exercise power over men by setting houses on fire, throwing furniture, or causing physical harm such as limb paralysis, headaches, tightness in the chest, or "insanity when the jinn focus their harm on the brain," (2005: 47). While it may not be as prevalent as many Muslims believe, *jinn* possession is possible for two main reasons: The bodies of *jinn* are less dense than those of humans, so there is no reason that they should not be able to enter humans - just as electricity runs through wires, and the stories of possession are so numerous that rejecting them is simply denial (Ameen 2005: 51).

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[18] The root of the term *jinn* originally comes from the Arabic '*janna*,' which means concealed, hidden, or protected and always carries a negative connotation.

[19] There are a great number of references to the strength of a *jinn* and its ability to give unnatural powers and brawn to those they accompany.

[20] This allegory can also be observed in the rebellion of the snake against Adam, the two of whom demonstrate the personality dichotomy between *jinn* and humans.

The Furqaan Institute of Islamic Healing has a self-diagnose section on its website that lists the most common symptoms for different mental disorders[21] within the Islamic mental health milieu, making it easier for readers to ascertain whether they should seek religious or biomedical treatment.

Jinn possession (Furqaan IIH)	Being "crazy" (Furqaan IIH)	*Jinn* possession (Ameen 2005: 87)
Wanting to keep the lights dim	Having all sorts of hallucinations	Disobedience of religion
Having horrifying dreams in which one is being chased (eg. by a black dog, snake, or insect)	Displaying two extremes: either laughing over serious matters or becoming extremely depressed over small things	Erratic behavior
Thinking that the house never looks clean	Looking in the mirror and feeling that one is different that oneself	Spontaneous and temporary limb paralysis
Crying without reason	Behaving abnormally	Seizures
Getting irritated over small things without reason	Becoming obsessive	Quickness to anger or to weep
Not being able to sleep at night, and/or waking up just about the same time every day	Feeling perpetual negativity	Sitting on the toilet for a long time
Biting/grinding teeth while sleeping	Having affected self-esteem	Talking to oneself
Feeling sleepy often while reading the Qur'an	Finding oneself unattractive	Nightmares
Starting to yawn within five minutes of beginning to read the Qur'an		Insomnia
Feeling that one is not oneself when looking in the mirror		Talking in one's sleep

Jinn and psychiatric illness are directly associated in the popular illness explanatory model in Bangladesh, though the powers that the race is popularly understood to have are not presented in the Qur'an itself. For example, in Bangladesh, social belief dictates that, like humans, *jinn* have social structures, families, and multiple religions. They are, however, invisible and can meddle in the affairs of humans. The majority of human interaction with *jinn* is with the evil ones, though some good *jinn* have been known to fall in love with humans and intend them good through their possession. However, despite the intentions of the *jinn*, interface invariably leads to negative effects for the human.

[21] The disorders that the *jinn* can cause through this possession are varied but serious, and include: Intense fear (hearing and seeing things, feeling that someone is following them, or haunting them in their own homes); Psychological and nervous diseases (insanity, Depression, anxiety, Epilepsy, tension, *Waswaas* (hearing the whispering of *Shaytan*), and Personality Disorders); Physical sickness for which there is no biomedical cause or treatment; Hallucinations; Engendering enmity between family members; Female problems (heavy bleeding, infertility, menstrual irregularities, and vaginal infections); Sexual problems (premature ejaculation, and impotency); And damage to houses and other material possessions (Ameen 2005: 52-53). Most often, these disorders are caused by an individual's own religious negligence.

A differentiation must therefore be made between practiced Islam and scholarly Islam[22], the latter of which is only narrowly understood in Bangladesh. The only direct connections I heard made between *jinn* and the Qur'an were the widely held beliefs that because *jinn* were mentioned in the Qur'an, they obviously existed, and that if one reads *Sura Al-Jinn* (72:1-28) seven[23] times, then he has effectively called the *jinn* to himself and will thereafter be possessed.

Many Bangladeshis facing modernization struggle with reconciling a belief in *jinn* with a Western education that emphasizes scientific empiricism. The most common resulting belief is that *jinn* do exist, but they are not responsible for mental disorders in human beings. While many patients at the DMC believed that religious healing worked for them, there were just as many, who, after receiving biomedical medications found themselves in a difficult conundrum, as questioning the existence of *jinn* is equivalent to questioning the validity and truth of the Qur'an itself. In most cases, telling a mental patient who believes in *jinn* that they do not exist does not and cannot help him/her. Healing must incorporate religious and social beliefs and give the patient a solid explanation based in their own comprehension, so that they can play an active role in their healing process[24].

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[22] Because it is a religious mandate that all Muslims read the Qur'an at least once in their lives, young Bangladeshi school children are taught to pronounce the Arabic alphabet in order to "read" the only true version of the holy text aloud. To read the book in translation does not fulfill this requirement and I met only one person - the son of an *Imam* - who had ever read it in Bengali.

[23] There were several references made throughout my research to the number seven: tying seven knots in a string, collecting water from seven rivers, having seven uses for the aromatic plant costmary (*costus*) to rid one of *jinn* possession, repeating something seven times, etc. In the *Sunnah* it is written that Mohammad commanded humankind to do seven things (visit the sick, attend funerals, say *yarhamuk-Allah* when someone sneezed, fulfill one's oaths, help those who have been wronged, accept invitations, and spread *Salaam*) and forbade it to do seven things (wear gold rings, drink from silver vessels, use silken saddle pads, wear Qasiyy garments, and wear silk, brocade, or silk brocade) (Ameen 2005: 109). There were also several references to the number three (asking snakes three times to leave before killing them, repeating prayers three times, drinking *zam-zam* water in three swallows), and the number twenty-one, which is seven times three.

[24] For an interesting example of this concept, see the Bollywood film "*Bhool Bhulaiya.*"

Chapter Four: A New Psychiatry for an Old Land

"Formerly, when religion was strong and science weak, men mistook magic for medicine; now, when science is strong and religion weak, men mistake medicine for magic. - Thomas Szasz

4.1 History and Status of Psychiatry and Psychology in Bangladesh

The extent of research regarding mental health in Bangladesh is staggeringly limited and heavily quantitative. The World Health Organization (WHO) is the leader of this data production with its 2008 foundation of the Mental Health Gap Action Project and the publication of various catalogues such as the WHO-AIMS Report on Mental Health System in Bangladesh (2007), the International Pilot Study of Schizophrenia (2007), the Mental Health Mapping Project (2007), and the Mental Health Atlas (2005). Through their various studies, the WHO has determined that mental and neurological disorders are responsible for 13% of the global burden of disease. However, despite this evidence, mental health is largely neglected and under-researched - particularly in low and middle income countries - (Rochon et al., 2004; WHO Mapping Project 2007: 17) by public health workers, social scientists, and ethnopsychiatrists alike.

The first recognized attempt at collecting quantitative data on the prevalence of mental health facilities and initiatives in Bangladesh was managed by Rezaul Islam (1993); he reported 30 practicing psychiatrists in the country (1993: 492), and while his quantitative data has been supplanted by later surveys, they do offer a comparative gauge for growth. Furthermore, Islam's limited qualitative data regarding popular health seeking behavior at the time is an invaluable window into the attitudes of Bangladeshis toward mental health even today. Such reportage of cultural health mannerisms are largely ignored by WHO documents on mental health, which are almost entirely epidemiological and quantitative in nature. This one-sided approach is tragic considering the WHO's own breakdown of basic

health into three fundamental categories: Social health, physical health, and mental health (WHO Constitution Preamble). One needs all three in balance in order to fit the optimal biopsychosocial health model.

Falling in the low income country group, Bangladesh's per capita total health expenditure in 2005 was $58 (international), of which the government provided $26. In 2005, Bangladesh spent 0.5% of the total health budget on mental health (WHO Atlas 2005: 80). This lack of financial support continues today and ultimately leads to heavy economic burdens for the families of mental patients. The country's first National Mental Health Policy[25] was released in 2006, and its Substance Abuse Policy[26] was formulated in 1990 and is still in effect. Bangladesh's National Mental Health Program[27] was written in 1984 and the 1999 Mental Health Act drafted an updated Lunacy Act, which originally appeared in 1912 and has served as a baseline standard for the care and treatment, benefits, and rights of the mentally ill ever since (WHO Atlas 2005: 80). Furthermore, there is no human rights board that can serve to investigate or monitor mental health facilities (WHO-AIMS 2007: v) and no official authority responsible for assessing issues such as the allocation of funding[28].

(WHO ATLAS 2005: 80; WHO-AIMS 2007: vi, 12)	**WHO Atlas 2005**	**Extrapolation** (Country Totals assuming tot. pop. in 2005 = 142 million)	**WHO-AIMS 2007**	**Extrapolation** (Country Totals assuming tot. pop. in 2007 = 150 million)
Proportion of health budget to GDP	3.50%			
Per Capita total expenditure on health	$58			
Per Capita government expenditure on health	--	$0.29		
Percentage of total health budget spent on mental health	0.50%	10,625,373.1 Taka = US $154,067.91	<0.5%	
Mental Health Policy	No		Yes; 2006	

[25] A document defined by the WHO Mental Health Atlas as: "a specifically written document of the Government of Ministry of Health containing the goals for improving the mental health situation of the country, the priorities among those goals and the main directions for attaining them." Such a document may contain some or all of the following components: Advocacy, promotion, treatment, and rehabilitation (2005: 14).

[26] A document defined by the WHO Mental Health Atlas as: "a specifically written document of the Government of Ministry of Health containing goals of prevention and treatment activities related to the use, abuse and dependence of alcohol, prescription and non-prescription including illicit drugs" (2005: 20).

[27] A document defined by the WHO Mental Health Atlas as: 1) "a national plan of action that includes the broad and specific lines of action required in all sectors involved to give effect to the policy. It describes and organizes actions aimed at the achievement of the objectives. It indicates what has to be done, who has to do it, during what time frame and with what resources;" and/or 2) "any type of care, supervision and rehabilitation of mental patients outside the hospital by health and social workers based in the community" (2005: 16).

[28] Of those funds allocated to mental health, 67% are apportioned directly to mental hospitals even though the majority of patients are treated at outpatient clinics (WHO-AIMS 2007: v).

(WHO ATLAS 2005: 80; WHO-AIMS 2007: vi, 12)	**WHO Atlas 2005**	**Extrapolation** (Country Totals assuming tot. pop. in 2005 = 142 million)	**WHO-AIMS 2007**	**Extrapolation** (Country Totals assuming tot. pop. in 2007 = 150 million)
National Mental Health Program	Yes; 1984			
Substance Abuse Policy	Yes; 1990			
Latest legislation enacted in	1912			
Disability benefits for persons with mental disorders?	Yes			
Total number of human resources for MH per 100,000			0.49	
Total psychiatric beds per 10,000	0.065	923		4415
Psychiatric beds in mental hospitals per 10,000	0.03	426		
Psychiatric beds in general hospitals per 10,000	0.009	127.8		
Psychiatric beds in other settings per 10,000	0.024	340.8		
Number of psychiatrists per 100,000	0.05	71	0.0729	109.286
Number of neurosurgeons per 100,000	0.01	14.2		
Number of psychiatric nurses per 100,000	0.06	85.2		
Number of neurologists per 100,000	0.02	28.4		
Number of psychologists per 100,000	0.002	2.84	0.0071	10.71
Number of social workers per 100,000	0.001	1.42	0.00214	3.214

Mullick and Goodman's survey of psychiatric morbidity (2005) in 5 to10-year-olds throughout Bangladesh resulted in a rate of 15% (Monawar Hosain et al. 2006: 19) and the WHO Mental Health Atlas similarly reports behavior disorders in 13.4% of Bangladeshi elementary school children (20.4% males and 9.9% females) (2005: 80). Monawar Hosain et al.'s survey of mental disorders in rural Bangladesh yielded an average morbidity of 16.3%[29] of the adult (≥18 years) population (2005: 21). These values are consistent with those presented by other sources such as the National Mental Health Survey (2003-2005), which reports a country-wide morbidity rate of 16.05% (WHO-AIMS 2007: v)[30] - the breakdown being approximately 19% of all women and 14% of all men.

While there are reportedly 50 outpatient mental health facilities in Bangladesh, none incorporate follow-up care into their service provisions (WHO-AIMS 2007: v). Along with the 31 community-based psychiatric inpatient units, there are 11 community residential facilities that designate 55% of their beds for children and adolescents only. However, of these units' total admitted patients, 81% are female and 73% are children (WHO-AIMS 2007:

[29] The breakdown of that 16.3% was 8% Depressive Disorders, 5% Anxiety Disorders, and 3% Psychotic Disorders (of which four of the nine recorded cases were later diagnosed as schizophrenia by a Western-trained psychiatrist using DSM-IV criteria).

[30] There is another study that is currently in the works, which, by mid-2010 is planned to publish information on the mental health of children under the age of 18 in 25 rural and 25 urban centers in Bangladesh. The study is called "Prevalence of Mental Disorders among Children."

4). Only five of the 18 wards at the Pabna Mental Hospital (est. 1957) are designated for women.

The most striking feature of these surveys is the representation of diagnosis. The WHO Mental Health Atlas reports that, "Schizophrenia, affective disorders and anxiety neurosis were common among adult psychiatric outpatients (77%) (Ahmed, 1978), and Dissociative Disorder (Hysteria[31]) (21.65%) and Epilepsy (19.59%) among child psychiatry outpatients (Rahim et al, 1997)" (2005: 80). According to the WHO-AIMS Report, patients in outpatient facilities are most often diagnosed with either neurotic disorders (20%), mood disorders (20%), or schizophrenia (30%) (2007: 3).

The common misdiagnosis of other psychosomatic and psychological illnesses as schizophrenia is obviated by the fact that within the 31 community-based psychiatric inpatient units, 42% of patients are diagnosed directly with Schizophrenia and 37% with mood disorders (WHO-AIMS 2007: 4). The evidence of misdiagnosis in Bangladesh is further supported by data contesting that 70% of mental health cases in hospitals are diagnosed as Schizophrenia and 30% as mood disorders (WHO-AIMS 2007: 4, 5). These values are most staggering, however, when one compares them to the averages presented in the DSM-IV, which cites only 0.5-1% of mental health patients being diagnosed with Schizophrenia, 1%-3% with Conversion Disorder, 1-14% with PTSD, 0.4-1.6% with Bipolar I Disorder, 1.5-2.5% with Obsessive Compulsive Disorder (OCD), and a point prevalence of 5-9% of women and 2-3% of men with Major Depressive Disorder (DSM-IV 1994: 282, 455, 426, 354, 422, and 341, respectively).

Though the WHO-AIMS Report suggests that 4% of the medical training for doctors (and 2% for nurses) is devoted to mental health (2007: 10), Dr. M. Faruk Hossain, a night psychiatrist at the Dhaka Monorog Clinic, says that mental health as a practice is so undervalued that he estimates 90-95% of all Bangladeshi doctors "will not be able to name 10 major mental disorders, let alone diagnosing and treating one." Whatever the actual value, there remains an acute lack of concern for and attention to psychiatric and psychologic concerns among medical practitioners, which results in high risks for misdiagnosis and false prescription, as well as prolonged health-seeking processes for patients who do not receive accurate and

[31] Many would argue that Hysteria is better described as the precursor to Conversion Disorder, though Conversion and Dissociative Disorders are often symptomologically very similar.

informed referrals. Quite often, patients arrive at psychiatric clinics many years after their symptom onsets: They have sought religious treatment, which failed to rid them of their symptoms, and since those complaints are overwhelmingly physical and behavioral in nature, they go to local physicians, then to specialists, and then, when all tests are inconclusive, finally to psychiatrists.

Furthermore, in a society engulfed in social stigma concerning mental illness, many suffering from psychiatric morbidity do not seek any sort of aid at all for fear of social repercussion. Psychiatric diagnosis can lead to a drop in status for both the patient and the patient's family, and Dr. Faruk admits that many Bangladeshis "would rather commit suicide than be diagnosed with a mental disorder" because such a label results in an inability to marry or work. He says:

> So, in social and practical life, if someone is known to have some kind of mental illness, his life is ruined - he is doomed. So, in our society, people try to suppress it, try to keep it a secret for many years. Unless he or she poses a threat to the family members - unless he or she becomes violent, aggressive, start breaking household objects, attacking family members, then they take him or her to an expert for treatment. You know, I think there are thousands of people staying in the streets with severe psychiatric disorders - severe mental disorders. Nobody is paying any notice to them, neither the professionals, neither the government. They need treatment, they need rehabilitation, they need care, they need food and shelter. Nobody is taking care of that.

Of the approximately 100 psychiatrists in the country in 2007, 54% worked both for the government and in the private sector, and the remainder worked solely in the private sector, thereby limiting their accessibility to the poorer and rural masses. The density of psychiatrists in Dhaka remains five times greater than that throughout the rest of the country, again rendering biomedical services out of reach for the villagers[32]. In total, there were 31 psychiatrists in 2007 who worked in outpatient facilities, 56 in community-based inpatient units, and only four in mental hospitals (WHO-AIMS 2007: 13).

Deputy Director of the National Institute of Mental Health (NIMH), Bangladesh, Assoc. Prof. Dr. Md. Faruq Alam reiterated to me that, in 2009, there were 117 psychiatrists and eight clinical psychologists trained in psychotherapy serving the growing Bangladeshi population of approximately 156 million. Rough math, based on a morbidity rate of 16% distributed

[32] Seventy-three percent of the Bangladeshi population is rural.

across the entire population yields about 24 million Bangladeshis suffering from some kind of mental health problem, allocating each psychiatrist more than 205,000 patients[33].

In a paper he gave at the 2005 International Conference on Psychiatry in Dhaka, Prof. Hidayetul Islam outlined socio-demographic features at several Bangladeshi mental health facilities; referral, diagnostic and treatment patterns; and the problems relating to the development of mental health care in Bangladesh. Some of these findings show that 30-51% of out-patients and 39-75% of in-patients in government facilities are suffering from Schizophrenia. Private practices see 76.4% chronic and only 23.6% acute cases, which demonstrates the Bangladeshi cultural norm of keeping problems behind closed doors until behavior becomes uncontrollable, oftentimes exacerbating otherwise relatively simple mental health disturbances.

Pharmacological therapy is the primary mode in 90% of private treatments and 100% of those given by government facilities, for a total of 96% of all cases. Electroconvulsive Therapy (ECT) is used in 4.14% of cases at private clinics and 11% of those at government facilities. Private clinics prescribe psychotherapy in conjunction with pharmacotherapy in 18.4% of cases (though this value is inconsistent with the much lower value that I personally observed of less than 1%) and alone in 2.1% of cases. Prof. Islam's study found that government facilities prescribed psychotherapy in 4.7% of cases and in 4% of cases by itself, which is, however, inconsistent with the finding that they use psychopharmacology in 100% of cases. Even disregarding these discrepancies, what is important is that just because psychotherapy is prescribed does not mean that it is utilized. In fact, considering the lack of appropriate resources, it is more likely that almost none of those patients receive psychotherapy at all. Prof. Islam found that the primary issues encountered when developing psychiatric and psychotherapeutic programs are social stigma, patient ignorance, and general lack of population exposure to psychiatry, low government priority, lack of funds, and lack of trained manpower.

Though the NIMH itself has a psychotherapy unit that employs ten people, only three are certified in the practice: One social worker and two occupational therapists. Because there are

[33] For a rough comparison, there were an estimated 45,615 psychiatrists in the USA in 2000 (Scully and Wilk 2003: 248), when the total population was approximately 280 million, according to the 2000 Census. Assuming a 16% morbidity rate purely for comparative purposes, there would be 44,800,000 American suffering from mental health issues, yielding an average of 982 patients per psychiatrist in the USA.

only those three government-secured jobs for psychologists anyway, there is little incentive for graduates[34] to pursue the field. However, many traditional healers, in an effort to "modernize" and give social validity to their practices, often "professionalize" by claiming to offer "psychotherapy" to their patients.

One example of this phenomenon is Dr. S. M. Ayub, a homeopathic practitioner, psychic, and astrologer, who approaches his mental patients with conversation: "I meet the patient and have *ad-da* with her; I tell her that I am her friend and she can talk to me." During his *ad-da* sessions with his patients, Dr. Ayub observes the demonstrated symptoms, and works out what problems are manifest and whether or not the patient is suffering from a mental or physical disorder. Dr. Ayub describes psychotherapy as a treatment strategy combining meditation, counseling, and spiritual medicine. He considers himself to be a psychotherapist because he sits down and has "normal conversations" with his patients and "talks to them like a friend." He sees his psychotherapy patients (all of whom are female because "only women are affected by psychological problems") twice a week on Sundays and Thursdays for between 6-21 sessions in total and he designates someone who comes to him as a psychotherapy patient if he "gets the gut feeling that they just need to talk." The sessions are private, he says; only the nearest relatives are allowed to be in attendance, and he admits that they almost always are.

Another reason why psychotherapy is so underutilized is the financial binds that suffocate many families affected by mental health problems. Though they may not be able to afford to stay at private clinics or hospitals, there is a policy forbidding staff at those clinics from giving patients information on alternatives like the Bangabondhu University Clinic or the NIMH, whose services are either free or cost comparatively very little. While Dr. Faruk is trained in psychotherapy, he currently is not practicing - he tried when he first started working at the Dhaka Monorog Clinic (DMC), but the management told him to stop giving extra attention to only a few patients. He was asked by Prof. Islam to begin again, but when

[34] Of the four or five (of the 34) public universities that offer psychology as a course of study, all of the graduates of the field graduate with a Bachelor of Arts, not Science, and none go into practice. The reasons for this situation are multi-fold, but are based in economics: Bangladeshis can no more afford to pay someone's salary to listen to them than the students themselves could offer the service even if they wanted to: Culturally, psychologists are deemed to be unnecessary ("that's what family members are for") and the goal of the vast majority of university graduates is simply to have a piece of paper in their hands at the end of their studies so that they can apply for government or bank jobs, which are the most stable and lucrative. Furthermore, most students of psychology did not actually choose that course of study, but are studying the subject because that is what they were assigned and their other option was to not attend university at all.

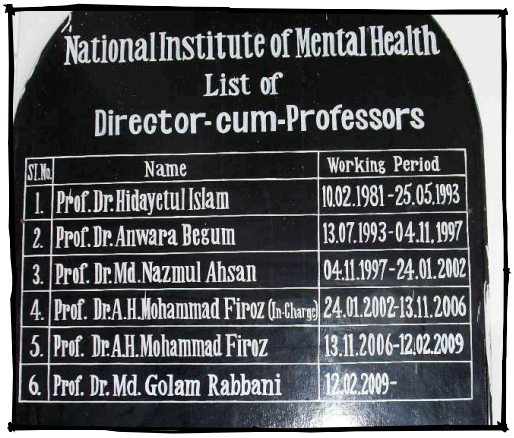
as he described the logistics of needing a private space and an on-call nurse nearby, he was again advised to abandon the idea.

The DMC is not alone in its hesitancy to embrace psychotherapy; one informant says that, “most psychiatric hospitals don’t want to pay for psychotherapy services.” There is currently a balanced monopoly on mental health, so even if people don’t receive the treatments that they truly need, they will keep coming anyway - “they have nowhere else to go.” The majority of mental health patients in Bangladesh are not even aware that a facility such as the NIMH exists, offering free beds for in-patients and free care for out-patients. Whereas a month’s stay at the DMC can cost between Tk25,000-35,000 (US$361-506), a paid room or cabin at NIMH can cost between a mere Tk3500-6000 (US$50-87). However, the NIMH has no website, no digital database, and no advertisement scheme.

Furthermore, “The Doctor’s Association is so extremely corrupt, you have no idea,” laments another informant, who cites numerous violations to medical ethics including taking commissions from medication brokers, accepting gifts from pharmaceutical companies in exchange for prescribing solely their products, and ordering unnecessary testing in order to reap greater monetary benefit from patients. “The Medical and Dental Council is utterly dysfunctional,” this informant says, relating several stories that describe how simple it is to “bribe supervisors to get certificates.” There are no background checks for the certificates - no one bothers whether the doctors are certified, honest, or knowledgeable, as long as they can pay the underhanded fee. He cites Forensic Psychiatry as having the largest degree of corruption: As long as a plaintiff can bribe an official in the department, he will be provided with official documentation that he is not psychologically fit to stand trial or that he is eligible for reduced sentencing due to mental health issues. This informant also admits that the popular perception that criminals and terrorists use mental hospitals - where they do not need identification - as hideouts carries a degree of validity. “It doesn’t happen too often,” he says, “but it does happen.”

4.2 Ethnography of the National Institute of Mental Health, Bangladesh

The National Institute of Mental Health (NIMH) is a deceptively large red brick building obscured from the main road in *Sher-e-Bangla Nagar* by a thick row of trees and a wall, though a large faded blue sign in both English and Bengali announces its presence. The foyer is large and mostly empty, with two help desks encased in glass, one to the left and one straight ahead. The ceiling is two stories high, giving the room an airy feeling. On wall to the right is a black placard on which are displayed (only in English) the names of all of the NIMH directors since its foundation in 1981, though it was not formally established with its current name or with both in- and out-patient departments until 2001. Also to the right is a dark hallway of waiting, worried faces, and the shuffle of plastic flip-flops. Many patients lie across a couple of chairs or simply on the floor, heads sometimes propped in the lap of a relative. Others stand against the wall and eye me suspiciously as I am hurried past the sufferers who have been waiting for hours. No one questions this hierarchy of the tall white woman in a plain *salwar kamiz* usurping their place in line, though I shamefully nudge


National Institute of Mental Health
List of
Director-cum-Professors

Sl.No.	Name	Working Period
1.	Prof. Dr. Hidayetul Islam	10.02.1981-25.05.1993
2.	Prof. Dr. Anwara Begum	13.07.1993-04.11.1997
3.	Prof. Dr. Md. Nazmul Ahsan	04.11.1997-24.01.2002
4.	Prof. Dr. A.H. Mohammad Firoz (In-Charge)	24.01.2002-13.11.2006
5.	Prof. Dr. A.H. Mohammad Firoz	13.11.2006-12.02.2009
6.	Prof. Dr. Md. Golam Rabbani	12.02.2009-

my translator and mumble ignored pleas to make an appointment or wait my turn to see the on-duty diagnostician. My status, however, means that I am afforded unannounced and unplanned personal interviews with both the NIMH Director and Deputy Director and later access to the patients themselves.

Dr. Faruk works also at the NIMH and arranged this first visit for me. He escorted us up the cement stairs and down a sun-lit hallway that looks into a center courtyard that has been turned into an aviary. We were led to an office just wide enough for the Deputy Director's four mismatching chairs for guests. Behind the dented desk were piles of boxes, from floor to ceiling, spilling over with printed leaflets and other literature. There was an old monitor in the corner of the desk, which sat idly.

Obviously accustomed to interviews and speaking about the NIMH, Dr. Md. Faruq Alam began spilling out figures and tidbits about the Institute without my prompting. He began by noting that communicable diseases (such as cholera, dysentery, HIV&AIDS, etc.) have for so long been the sole concern of health policy in Bangladesh, that only now is the government starting to heed non-communicable diseases, the category into which mental health falls. He continued with a schematic of the Institute itself, which has six departments: Adult Psychiatry; Child, Adolescent, and Family Psychiatry; Forensic Psychiatry; Community and Social Psychiatry; Clinical Psychology, Psychotherapy, and Social Work; and Geriatric and Organic Psychiatry. Three investigative sub-departments supplement these six with radiology, pathology, and anesthesiology for ECT and minor surgery.

Because the Bangladeshi government does not see mental health as an important national issue, the Institute receives very little funding, which leads to severe understaffing: "Practically, we do not have any manpower - we have the theoretical model in place, but cannot utilize it," Dr. Alam sighed. This lack of resources means that the psychiatrists themselves do the majority of the grunt work around the NIMH, running and organizing all Institute programs and initiatives, which minimizes the amount of time that they are able to spend with the patients. Furthermore, the Institute was designed as - and its focus remains on being - an academic facility and not a mental hospital. Therefore, both in- and out-patients are generally teaching subjects for the students there.

There is currently a program in place for doctors to do their post-graduate work in psychiatry, as well as an MD program for psychiatrists that started in 2008 and has six students enrolled. The NIMH is also planning to begin an MPhil in Psychology program and organize initiatives for training psychiatric nurses and clinical psychologists, but these plans are awaiting both funds and qualified professors.

The NIMH's in-patient department boasts 150 beds, some paying and some non-paying. The latter are perpetually filled, whereas the former oftentimes stand empty, as they cost TK113 (~$1.50) per day. Private cabins cost TK200 (~$2.75) per day, and the Institute is in the process of instituting an additional 50 beds for drug addicted patients. Despite these efforts to expand the NIMH, Dr. Alam stresses that, "The concept currently is to not encourage mental hospitals" because "people are just restrained there." "Mental hospital psychiatry is not modern," he asserts, citing Italy as having no mental hospitals and therefore being the world leader in alternative treatments. Following this example, the NIMH has reoriented its focus and programs to discourage institutionalization. Instead, the NIMH's objective is to "try to restore social functionality as soon as possible [to the patients]," and reintroduce them to their community environments. However, due to a lack of resources and logistics matching Italy's, these goals seem out of NIMH's reach and at the cost of efforts toward amalgamative pluralism with the preexisting religious paradigm.

Instead of adding more beds for in-patients, the NIMH has developed a plan that will make mental health assessment and treatment more widely accessible. This new strategy involves a community mental health service project that integrates mental health diagnostics and treatment into the pre-existing primary health care services offered around the country at the *thana*[35] level. Dr. Alam asserts that there is "a good heath care system in Bangladesh" and he sees a future where mental health is included in that system.

The NIMH is already in the process of a trial implementation of this plan: The current model involves four *thana* around Dhaka. In these four sub-districts, NIMH has proposed a joint program with an Italian NGO to take 20 mental patients from the hospital and provide them with Community Mental Health Service as a model. This three-year program has a total budget of Tk50,000,000 (US$723,238), with which NIMH plans to train 7000 field health

[35] Bangladesh is sectioned into (decreasing in size): Districts (*zilla* - জেলা), Subdistricts, (*upazilla* or *thana*), Union *Parishads*, Wards, and then villages. There are approximately 464 *thana* (থানা) in Bangladesh.

workers including all kinds of medical practitioners, MDs, and nurses to recognize mental health problems and distribute the appropriate corresponding medication, or refer the patients to the established psychiatric community for treatment. Dr. Alam laments that NIMH has to try to work through the established primary health care system, as it cannot afford to build more buildings and start a parallel system from scratch. There has already been some progress made, though - the Deputy Director reminds me - regarding the broader dissemination of psychiatric medications.

Citing the success of psychopharmacology in Bangladesh as a first step to integrating mental health into the social health paradigm, Dr. Alam boasts that NIMH was able to disseminate psychotropic injections imported from Denmark for about Tk300 per shot, which people generally only need once a month. Otherwise, all medicines are produced in Bangladesh, which makes them very inexpensive; Bangladesh even exports to African countries and other South Asian countries. “You can get almost any kind of medicine here,” he says, and adds that Bangladesh’s three main exports are manpower, garments, and medicines.

The NIMH is a struggling mental health benefactor due to resources, though the Institute is blessed with a few visionaries who have shouldered the responsibilities of change and growth. There remains, however, little recognition of the benefits of medical pluralism and virtually complete disregard of the role of Islam in the popular mental health paradigm.

Chapter Five: Field and Findings

"Symptoms of mental illness are the lightning in the zeitgeist, the product of culture and belief in specific times and specific places." - Ethan Watters (2010: 3)

5.1 Ethnography of the Dhaka Monorog Clinic

The guard eyes me suspiciously as he jumps to his feet to open the gate. Wearing a drab brown uniform, he cocks his head to the side as he unbolts the Masterlock knockoff holding the two sides of the accordion doors together. There is a warbled screech as he wrenches it open, forming a gap just narrow enough for me and Mohi to pass through. I have the immediate impression that the iron gates are less to keep people out than in.

The waiting room is painted yellow and accented by the noon-day light fighting its way through the leaves, dirty windows, and metal bars. The nurses at the desk look up briefly from their busied shuffling of papers, phone calls, and the globular mass of people standing before them, questions suspended on their lips, and they squint at me briefly in apathetic confusion. Every other pair of eyes in the dingy room is poised on me, though I do not seem to have interrupted much. There is a baby squirming and chirping in its mother's lap to Mohi's left and a man in a traditional white Muslim cap called a *tupi* twittering on his cell phone to my right. An older man is napping on the couch and another is vacantly rubbing his chin.

There is constant movement in the acute stillness - a woman in a *burkha* sits straight and stares ahead while the man next to her swings his crossed legs and looks around with his head on a swivel. A young boy holds his father's hand in the hallway as the man mumbles into his cellphone. The small TV stashed high in the corner is off, allowing the human sounds to echo: The shuffling of sandals, the hum of Bengali, the silent and stolen stares that burn in my direction, the occasional click of a door, the screech of the gates, and the constant mumble of the baby's thoughts. The noise steadily increases as more people arrive and the chairs fill, though no one takes the empty seat next to me. No one has a book; there is no rack of old magazines. There are no iPods and no elevator music in the background; there is just the fan that moves the warm, moist air. The men on the chairs to my far right are squeezed shoulder to shoulder and are passivley resting their hands on each other's thighs. The man with the young son who was sitting to my right stands up and walks to the desk in a moment of impatience; their chairs are absorbed by two other men, both taking care not to sit too close to me. There is a fresh water dispenser in the corner opposite the television and the occasional chipper sound of a cell phone ringing. One man is has flung off his plastic sandal and is inspecting his bare foot.

It is almost 1400 and the patients in the waiting room are becoming restless; the doctor is two hours late. Many have travelled a long way and have yet a long journey home before them.

Case Study: Shika

The waiting room eyes were the same every day: some were clenched closed, fighting back pain or unwanted images; some darted nervously around the yellow room, envying the others that stared vacantly at the cold tile floor; and there were always the curious ones that shot glances in my direction, completely uncaring as to whether or not I caught them staring. Sometimes my translator would nudge me with his elbow and report on how long a set had been leveled on me, a tone of bemusement in his voice. But today, Mohi had not yet arrived and I sat patiently in a corner, the only person in the room with reading material on hand. I was awoken from my literary reverie by a middle-aged woman wearing a year-beaten *sari* wrapped back up over her head. She harshly grabbed my left knee, uncrossed my legs, and held my feet brusquely to the floor. She bowed in front of me and I tried to motion to her to stand up, but she refused. Two men rushed over to pull her off of me but she shook them off wildly and threw off her *hijab*. She looked at me directly, blew in my face and then pointed frantically to her head. I smiled as the older woman seated next to me rotated her hand in a circle around her head and mumbled the English word "crazy." I turned back to the expectant woman at my feet and I blew gently on her head and touched her hairline with the fingers of my right hand. She was overjoyed and threw herself backward into a seated position on the floor. She scrunched into a ball across from me with her back against Prof. Islam's door and started reciting *dhikir*. The men returned to pull her to a more appropriate standing position, but she fell limp as though dead, closed her eyes, and did not move at all until they let her slump back onto the floor, at which point she came alive again and resumed her seated position across from me, looking up at me occasionally and smiling broadly.

When Prof. Islam arrived and several people in the waiting room stood as he to walked his office, the woman lunged across the floor toward him and swept her hands over his feet while reciting *sura* and praying for him. When she was finally pulled away, Prof. Islam went into his office and the men holding the woman followed him in. I followed last and took my seat as an observer. The woman, Shika, as she was introduced, had been placed in the patients' chair beside Prof. Islam and she lit up when she saw me, blurting out the traditional "*as-salaamu alai-khum*," to which I responded, "*walai-khum wa-salaam*." She squealed with delight. In the office, it became clear that the two men who had been trying to control her were her husband and son and while they spoke to Prof. Islam about Shika, she began to cry and sing Bengali songs. The men were holding her back from her constant efforts to touch Prof. Islam when suddenly, she leapt through their grasp and out of her chair toward me. She grabbed my hand and sang to me that I was her sister and she was mine. When the men tried to pull her away, she again fell limp to the ground like a sack of rice and remained in this self-induced half-catatonic state until I grabbed her hand and tried to help the men pull her into the chair next to me, coaxing her to sit in my broken Bengali: "*Chair-e boshen; boshen*." Shika's response to this coaxing was to begin singing, "sit down, stand up, sit down..." all the while trying to act out her dictated motions. The men were able eventually to pull her to her feet, but we could not pry my hand from hers until I looker her in the eye, smiled, and said, "bye!" At this point, she smiled gleefully, let go of me, threw up her hands, and starting walking out on her own, repeating "bye!" and "*as-salaamu alai-khum*."

Shika began having symptoms six months ago, the men reported, but seemed fine on her medication until ten days ago when she stopped taking the pills. She was in Prof. Islam's office for a total of nine minutes, during which time he diagnosed her with Schizophrenia in the psycho-manic phase and told her accompaniment that she needed to be admitted to his clinic.

My primary field, the Dhaka Monorog Clinic (Institute of Community Mental Health) was founded in 1984 and is still run by Prof. Hidayetul Islam, arguably the leading Western-

trained psychiatrist in Bangladesh[36]. Prof. Islam's private clinic has both in- and out-patient services, which serve an average of 50-60 in-patients (top capacity is 75) and 30-40 out-patients on a given day. This patient flow means that Prof. Islam spends an average of 6-8 minutes with each out-patient, depending on whether he or she is returning or new, respectively.

The five MDs on Prof. Islam's staff have their degrees and are doctor qualified by the Bangladeshi Medical Council. There are three psychiatric specialists: Prof. Islam, his son, and his daughter-in-law. The office staff consists of a manager, an accountant, a supervisor, and some supporting staff. There are two psychiatric social workers who purportedly occasionally hold clinics for the families of in-patients, six trained and qualified nurses, and a few nurses who are trained but have yet to fully earn their diplomas. In total, there are 65 people on the DMC payroll.

There are no registers for out-patients; therefore, each time that a returning patient comes for a follow-up appointment, his or her case must be fully re-introduced and oftentimes Prof. Islam deduces his previous diagnosis through the re-telling of the story and by looking at the medications that he prescribed to the patient at the last visit. Initial consultations cost 500Tk (US$7.23) and follow-ups cost 300Tk (US$4.34) a piece, which, for some Bangladeshis, is several days' income[37]. Furthermore, medications cost on average 300-500Tk for a two-week dosage.

Prof. Islam does not inform his patients of their psychiatric diagnoses for several reasons: Primarily, he cites the stigma surrounding mental illness; public perception holds that only major and terminal illnesses have concrete biomedical terms, so if the problem is given a name, then it becomes a much greater social burden. Furthermore, he says, the majority of Bangladeshis are highly ignorant regarding the biomedical mental health paradigm and would not understand the nature of the condition anyway, thereby causing increased anxiety.

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[36] Being one of the first (and only) Bangladeshis to study psychiatry abroad in England, Prof. Islam graduated in 1964 with his D.P.M. from the Institute of Psychiatry in London. After working for a few years, he returned to Bangladesh in 1970 and joined the Pabna Mental Hospital as the Senior Consultant Psychiatrist. Upon its opening in 1981, Prof. Islam served as the Director-cum Prof of Psychiatry at the National Institute of Mental Health (NIMH) and over the course of his career he has also served as the Director of WHO Programs of Mental Health in Bangladesh and as a temporary advisor to the Regional Director of WHO, SEARO.

[37] As a reference base, having a new *salwar kamiz* tailored from scratch costs around 300Tk, a rickshaw ride for about half an hour is about 15Tk, and a taxi ride across the city (sometimes more than an hour) costs between 100-150Tk.

However, I was told by another informant that most psychiatrists are not personally confident in their diagnoses. By not giving the patient a diagnosis (or giving only vague details - "your problems are anxiety-related") practitioners keep themselves safe. Prof. Islam says that, "Knowing the diagnosis is too shocking [for the patients and their families]," so he only tells his patients their diagnoses if they are well-educated and specifically ask, and even then with caution.

Because no official diagnosis is either given to the patients or written anywhere in their records, patients who seek treatment from other practitioners present these new doctors with a puzzle of stories, frustrations, and sheets of paper only listing the medications the patient has been taking. Another consequence of this opaque diagnostic system is that there are no groups available for social support, either for the patients themselves or for their families; it is furthermore impossible for people to seek each other out due to the stigmatization of mental health, the resulting discrimination against those affected by it, and the general ignorance of diagnostic terms as a commonality. Dr. Faruk is convinced that a group akin to Narcotics Anonymous would be hugely beneficial in Bangladesh, but avenues for starting self-help groups are blocked by cultural overtones.

However, mental health in Bangladesh is traditionally diagnosed as one of two things - *jinn-e dhora* (possession) or *ban mara* (religious cursing)[38] - so the idea that there are hundreds of contemporary biomedical clinical diagnoses and sub-diagnoses simply cannot be understood without a great deal of background education on the subject. Understanding this cultural perception contextualizes this opaque approach to diagnostology and softens its implications in Western ears.

There are certain cultural advantages to this orientation of secrecy, whether or not they are recognized by their facilitators. The primary virtue is perhaps best expressed by an entry in my journal early on during my fieldwork: "I feel like the DMC is a form of sanctuary where people are finally allowed to have the problems that they do - they can have them here and they can leave them here; without a name, their diagnoses can't follow them."

[38] See Appendix 1 for a dictionary of terms with brief definitions, or consult Chapter 6 for further details.

Age (average)		Total Patients		Muslim		Hindu		Christian		New		In-Patient		Returning	
♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀
32.7	33.9	104	115	98	112	2	2	1	0	22	22	6	9	77	83
33.3		219		210		4		1		44		15		160	

Over the course of my research, I sat in on more than 240 diagnostic interviews for 219 different patients. Of these 219 cases I observed and for whom I was able to gather data,[39] 97.6% were Muslim and, demonstrating how long it takes to recover from a mental illness, 73% of the patients were returning to the clinic.

My role at the DMC was that of an observer. I sat in the waiting room until Prof. Islam arrived every day and then joined him in his office. Mohi and I followed the interviews, each taking separate notes that I compared and combined later in the afternoon. When Mohi was absent, Prof. Islam would re-hash an interview in English for me and give me a brief overview of the situation. When a patient came in who had a history with religious treatment, Mohi and I would explain briefly who I was and what my purpose at the DMC entailed, and ask for an interview. If the whole party was in agreement, we would take the patient and family members to a back room with four chairs around a table and conduct the interview. I was fully aware throughout my research that gathering my informants at a biomedical psychiatric clinic would color my findings - an assertion that Prof. Islam underscored several times with comments such as, “The people who come see me are mostly enlightened - most are well-oriented.”

At the DMC, the assumption is made that, if a patient (or a member of the patient’s family) has or is working toward a university degree, the patient has not sought any kind of religious healing for their mental health problems. If this turns out not to be the case, the patient (or family member) is chidingly and half-rhetorically asked how they could possibly still ascribe to such foolish perceptions of illness etiology. *Jinn* possession is often described by those who give credence to biomedical doctrine as being woefully “unscientific.” He explained to me that even his prescription sheets formally had a notice across the top that translated to:

[39] Not all of the numbers add up to 219 in each of the categories as I was unable to procure all of the demographic information for each of the patients; however, the values given above do show a very close approximation to the actual values and the percentages are taken by dividing the given value by the total counted for that category (i.e. for Muslim patients: 210/(210+4+1=215)=97.6%).

"No more superstitious treatment for mental disorders; get scientific treatment for mental illness."

However, he found that this solicitation did little to stem the pluralism that occurred among his patients with traditional religious healing. He maintained this attitude, though, often laughing outrightly when his patients spoke of their experiences with religious treatments such as *tabiz* (talisman) and *pani pora* ("enchanted water")[40]. His clinic embodied what anthropologist Ruma Bose described in his article about popular perceptions of possession among Bangladeshi immigrants in London:

> Psychiatry as a secular system has no structure for accommodating religious belief, and merely notes 'religion' as a demographic detail in history taking. It views religious imagery and beliefs in the 'supernatural' as the patient's attempts at explaining psychotic experience with culturally derived ideas, a culture specific influence on the content of a delusion, a mechanism for externalization of inner conflicts, an expression of internalized bad objects, repressed wishes, dissociated 'selves' or simply a primitive way of explaining misfortunes and mental illness. (1997: 3)

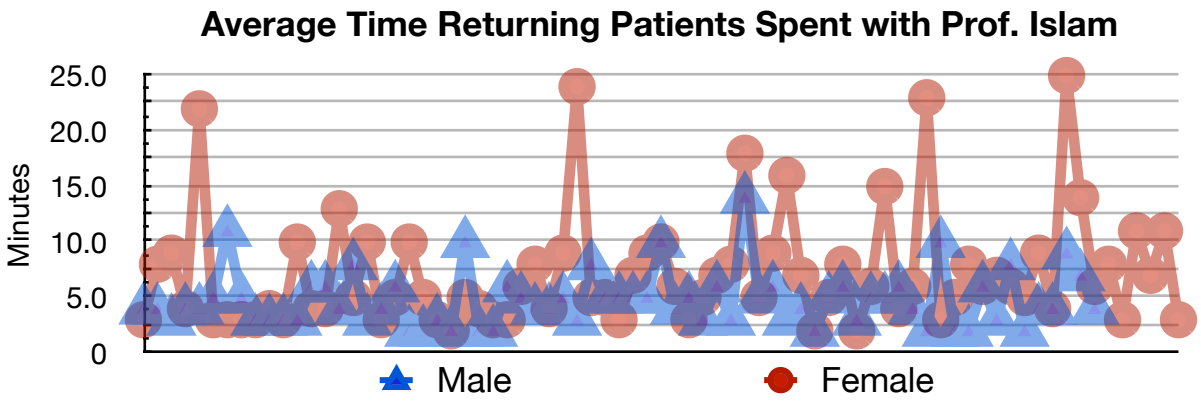
However, despite his belief that there is no effectivity associated with religious mental health treatments, Prof. Islam's mannerisms with his patients generally demonstrated care and empathy. After reading Wilce's accounts of clinical dialogue and metacommunication in Bangladesh, I had tuned my observations to the conversational dynamics: Who were the dominant speakers? To whom did Prof. Islam direct the conversation? What were the other, more subtle discourses such as body language and eye contact? The first thing that struck me was how Prof. Islam focused the majority of his questions and energy on the patient.

When patients (especially those returning patients diagnosed with either Schizophrenia or Bipolar Disorder) were spoken over and dominated by their accompaniment, Prof. Islam made no move to quiet the speaker, but rather often tried to engage the patient with his next question. However, it was sometimes obvious that both Prof. Islam and the patients' accompaniment felt that the mental problem had sapped the patient's ability to express him-/

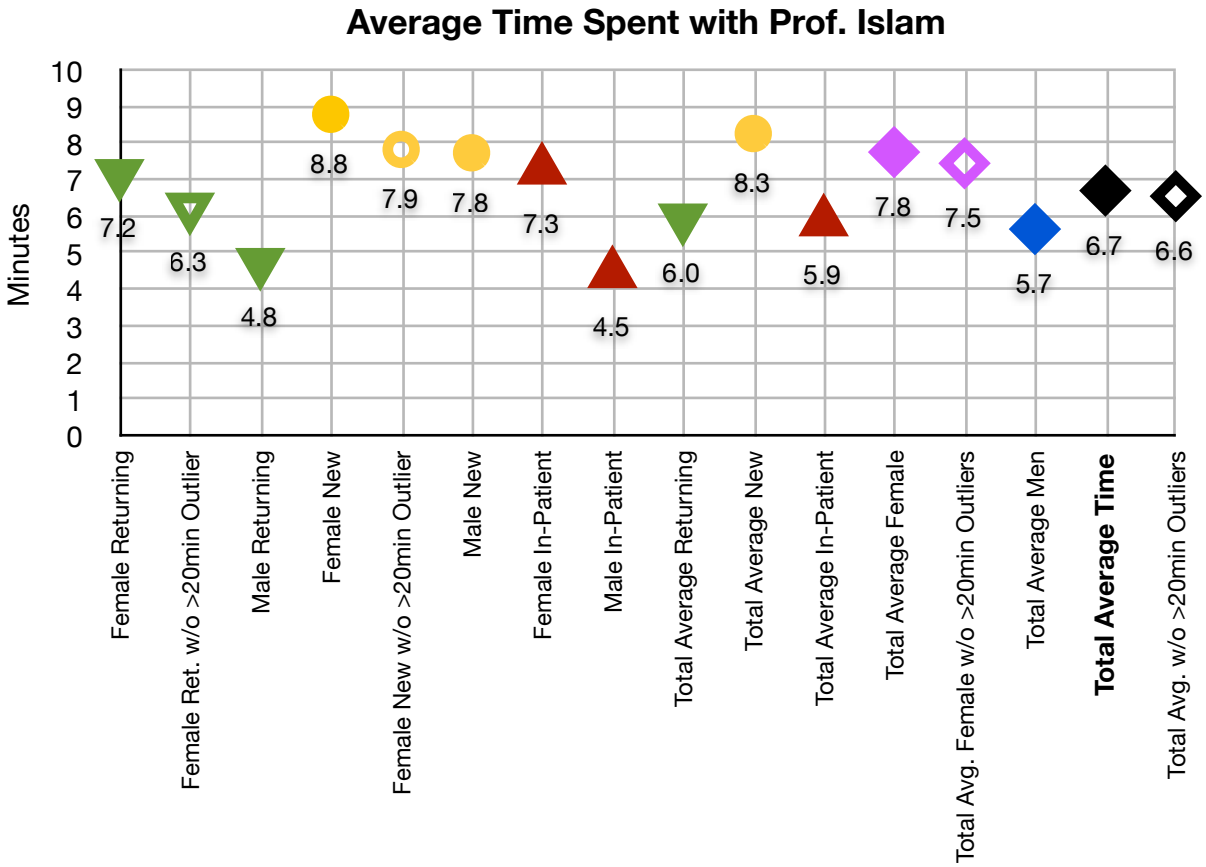
[40] See Appendix 1 for a dictionary of terms with brief definitions, or consult Chapter 6 for further details.

herself; in those cases the patients were generally ignored or hushed. Furthermore, if a patient ever said anything at odds with what the "sane" person accompanying them declared, it was assumed that the patient's account was untrustworthy. This was most often the case when a female patient would come in with her husband who said that he was treating her well and was very supportive, despite what the patient reported.

Prof. Islam only cut off a speaker when it was becoming obvious that the rant was not leading to any gross progress. He was fairly intolerant of tears, as they seemed to take up time and make the discussion more problematic. When Prof. Islam did ask questions of the patients, they generally revolved around sleep, eating, and sexual patterns. However, the questions were notably phrased in a social context: Instead of asking about personal emotions, he asked questions like, "What is your family condition?" "What is your household financial situation?" And "Is there any current crisis in your home?" There were only a few sessions during which Prof. Islam lectured a great deal; these were cases of Adjustment Disorder with emotional immaturity (29 minutes, female); Emotional Stress Disorder (18 minutes, female); Schizophrenia (23 minutes, female); and Psychogenic problems (25 minutes; female - a couple needing marital counseling). During these interviews, the accompanying family members were sometimes asked to leave and the women listened patiently.



These sessions were outliers. The average amount of time that Prof. Islam spent with patients was a little more than seven minutes, during which time he listened to their complaints, analyzed their symptoms, diagnosed them, and wrote them a prescription. The average amount of time that he spent with female patients was more than two minutes longer than he spent with his male patients, and there was only a small difference in the time he allotted for new patients compared to the returning ones.



One of my psychiatric physician informants told me that due to the lack of time allotted by psychiatrists to each patient, he estimates that approximately 40% of diagnoses are either wrong, or not accurate enough to offer fully effective treatment. This informant also estimates that 20% of mental patients who are hospitalized do not need to be but are either because the doctors are seeking increased revenue or because old family disputes seek to deprive them of job opportunities, wealth, and/or property rights. Though such imprisonment is not altogether common, it does happen enough around the country to be recognized as a problem.

Furthermore, this informant told me that between 10-20% of the patients he sees do not actually need medication, but its distribution remains both a lucrative practice for the practitioners and an expectation of patients to receive something tangible as treatment. However, biomedicine and 'magical' pills and injections, while widely accepted to be effective, are popularly understood to be so only on a healing and not a curative basis. Western treatments are perceived by many to be quick-acting, short-lasting remedies that treat symptoms but not disease, as well as making patients sleep too much.

Therefore, the fact that Prof. Islam issued medicinal prescriptions to all but three of the patients we saw together (one because he sent her to get more tests done before labeling her

pains as somatic instead of organic, one because he diagnosed her with physical problems and told her to rest for a few days, and the other being the couple needing marital counseling) is not surprising. When he did prescribe 'social support' in conjunction with the medication, I saw no explanation of what that support was to look like or where the patient was supposed to find it. Purportedly it should come from the family, Prof. Islam told me later, because there is no system for social workers and no programs in Bangladesh that act as support groups for the mentally infirm and their families. To one patient, he prescribed psychotherapy in conjunction with the Bipolar medication (but did not tell her where to find it) and to another, he prescribed OCD medication and 'behavior therapy' that consisted of meditating for 15 minutes three times a day while chanting to himself, "There's nothing wrong with me."

Because traditional religious treatment methods are protracted at the longest to a few weeks during which the patient should drink *pani pora* ("enchanted water") every day, the concept of taking pills every day for a few months (let alone years or the rest of one's lifetime) is completely foreign to the majority of Bangladeshis. Therefore, I noticed an accordingly high rate of medicinal non-compliance. Of the returning DMC Bipolar Disorder and Schizophrenia patients alone, 18 directly admitted (without prompt) to taking themselves off of their medication as soon as their symptoms subsided, only to be bewildered and distraught when they returned. This perception of treatment leads many Bangladeshis to believe that injections (administered once and then symptom-free for about a month) are more potent and curative than pills.

Dr. Faruk laments the fact that, while there are "other modalities of intervention [for psychiatric illness], they're not available in Bangladesh." He lists approaches such as psychotherapy, talk therapies, group therapies, behavior therapies, play therapies, and others. Dissociative Disorder and Conversion Disorder, he says, don't require medications, though they are readily distributed in Bangladesh. Furthermore, many cases of both Anxiety and Depressive Disorder would be better treated with therapies other than medication, but there are no such alternatives available. What exacerbates this issue is that a reaction to a given medication is seen as a form of proof that the diagnosis was correct and the treatment is working; few recognize that many psychotropic medications are potent enough to change the behavior of anyone to takes them, no matter what their symptoms.

Living conditions at the DMC were often described to me by in-patients as prison-like. The second floor is designated for men and the third floor for women, and each is a large and open, though locked, room that has a small balcony (caged with iron bars like all windows in Dhaka city) and two private rooms on each side, each with two water-proof mattresses, and a small desk. The large room has approximately 30 beds, all packed in next to each other. Often, patients will have all four limbs tied with cloth bindings to the bedposts, where they will remain for most of the day. Many of the in-patients are so medicated that they sleep for about 20 hours a day and when they do move about, they shuffle in a zombie-like fashion. There is a caged-in television in each of the big rooms that is generally blaring (though I saw no one on the women's floor paying it any heed) and everyday around 1630 there is tea and sometimes music downstairs in a small, fenced-in yard.

In-patients have all of their personal belongings taken from them upon their arrival. They have no personal money save what their family leaves at the front desk for their uses (though if they ask one of the DMC staff to go buy them something with that money, it rarely happens). Their cell phones are confiscated, so their only access to the outside world is when they receive a phone call at the front desk. Visiting hours are from 1000-1800 daily, and if the patients pay for a private room, it is encouraged that a family member stay with them at the DMC. The patients receive three meals a day of *bhat* (rice) and *dal* (lentil sauce), and generally some form of vegetable curry once a day. Occasionally, workers come in with a pitcher of water and some bananas for a snack.

5.2 Quantitative Data Collected at the Dhaka Monorog Clinic

The human brain automatically categorizes - it labels experiences, information, and other data and files them for more organized utility later on. This system is influenced by personal experiences, enculturations, and knowledge categories. Anyone who re-evaluated my field data would organize the illness narratives, symptoms, reactions, mannerisms, relations, responses, and diagnoses differently. This human variability, in a brilliant paradox, is the attempt to calculate the immeasurable and to categorize the inexpressible that confounds and motivates all study of human nature. Throughout my research, I developed my categorizations in a way I thought would best capture the nature of my observations in a narrative style that would also be the most readily understood by my readers.

Dhaka Monorog Clinic In-Patient Registry

from 12 September 2009 to 19 October 2009*

Age	Sex		Marital Status				Traditional Healing sought?			
(Avg. in years)	♀	♂	Married	Un-married	Divorced ♀	Divorced ♂	Yes ♀	Yes ♂	No ♀	No ♂
32.7	22	17	18	15	2	2	11	8	11	9

* Data from 13 cases are missing due to incomplete registration data.

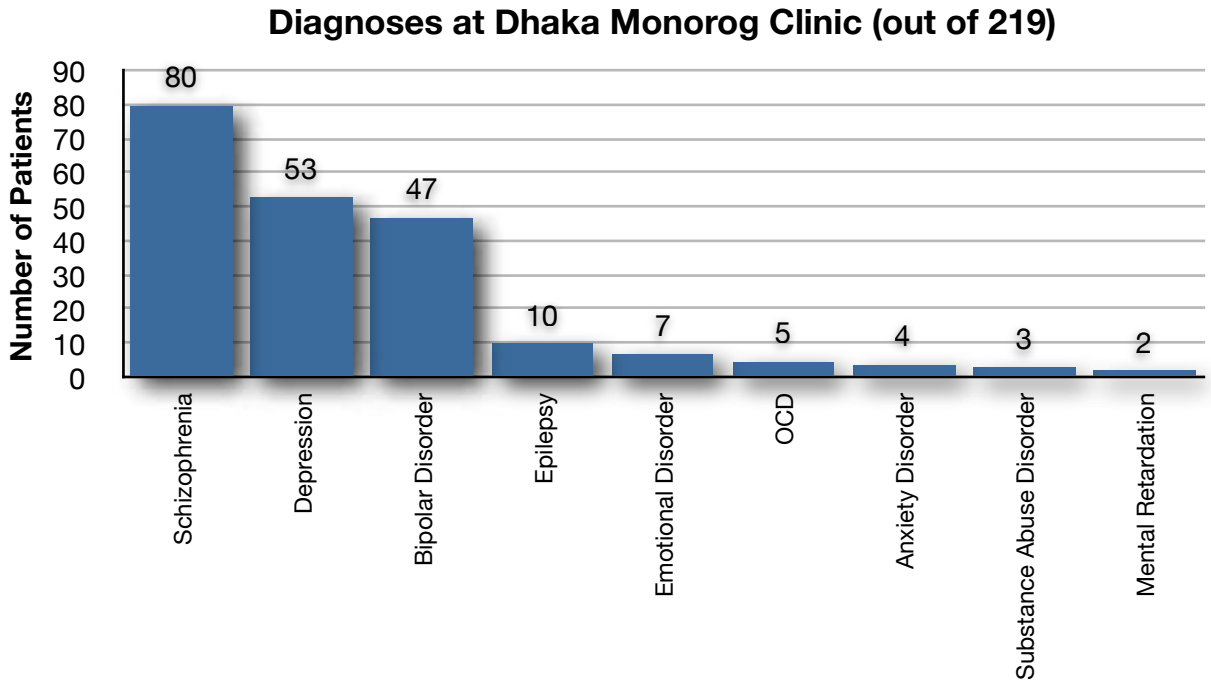
Of the 52 newly-registered in-patients who arrived at the Dhaka Monorog Clinic between 12 September and 19 October, 2009, data was collected from 39 of them regarding their treatment seeking practices. Eight of the 17 men and half of the women admitted to seeking treatment from religious healers. I was able to gather biomedical psychiatric diagnoses for those 19 patients: The most common diagnoses were Schizophrenia and Bipolar Disorder, which is understandable considering how difficult it is to manage people with these illnesses in the home. The extremely high percentage of the patients who were not married is also a telling commentary on the stigma surrounding mental health.

Diagnoses of those who sought religious healing before coming to the DMC:

Disorder	♀	♂	Total
Psychosis	0	2	2
Schizophrenia	2	1	3
Mental Retardation (Learning Disability)	0	1	1
Bipolar (Mood) Disorder	3	2	5
Substance Abuse	0	1	1
Depression	1	0	1
Conversion Disorder	1	0	1
Unknown	4	1	5
Totals	**11**	**8**	**19**

The data for the in-patients did not wholly represent those gathered from the 219 patients with whom I sat for diagnostic interviews. Of these latter cases, 36.5% were described by Prof. Islam as being Schizophrenic in nature, 24.2% were labelled as Depression, 21.4% as Bipolar Disorder, 4.5% as Epilepsy cases, and 3.2% of the cases were Emotional/Stress

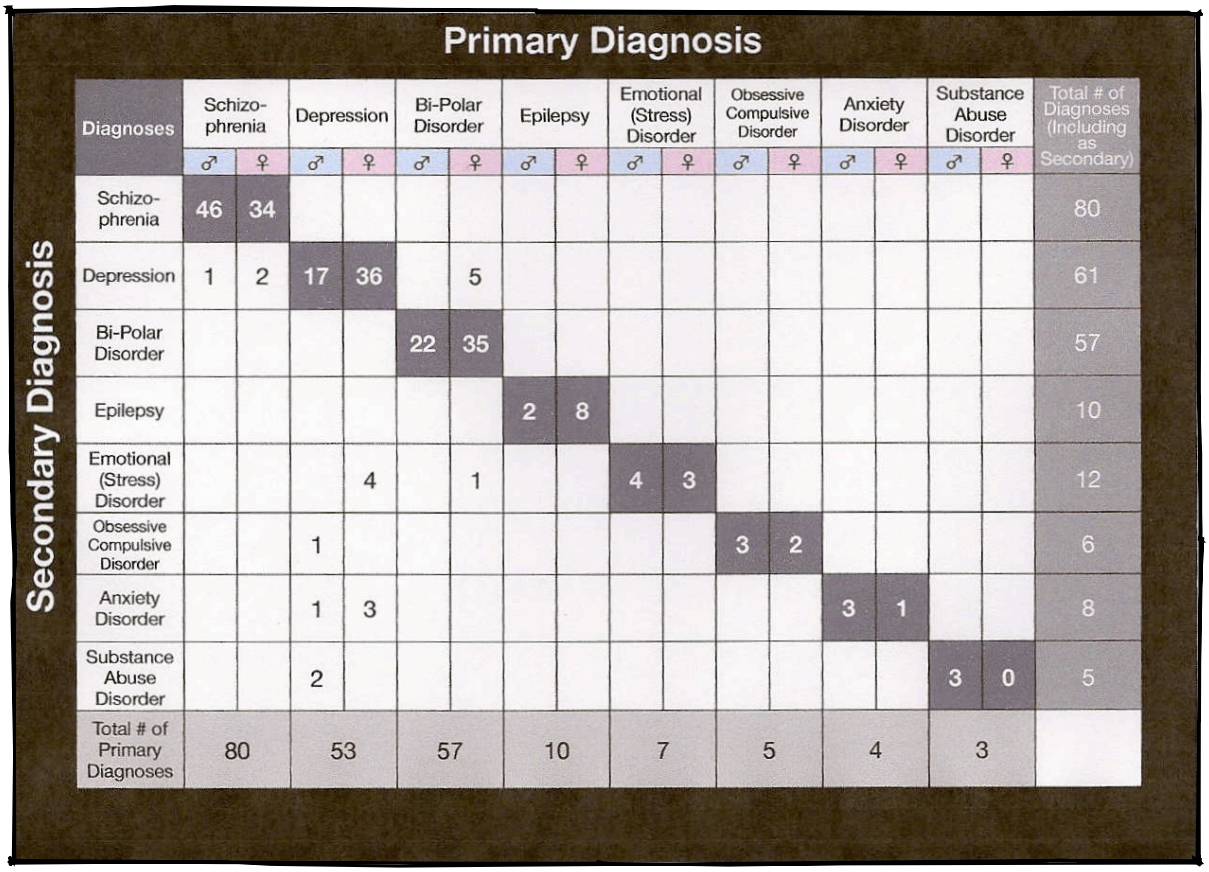
Disorder. Together, Schizophrenia, Depression, and Bipolar Disorder constituted 86.8% of all diagnoses at the DMC during my research period.



However, as the following table shows, some illnesses were diagnosed as secondary, in conjunction with a primary. This was most common with Depression being noted as a secondary diagnosis eight times - five times with female Bipolar Disorder patients. There are many interesting themes demonstrated here, not least of which is the fact that there are fewer than half the number of male Depression patients as female. If one adds the seven women who had Depression as a secondary diagnosis, the discrepancy is even clearer. Furthermore, four times as many women suffered from what Prof. Islam diagnosed as Epilepsy. Therefore, even with similar symptom menus, men were more likely to be diagnosed with Bipolar Disorder or Schizophrenia than either Epilepsy or Depression.

There were also 9 diagnoses that were only made once. The most interesting aspect of these single diagnoses are the PTSD, Conversion/Dissociative Disorder, and Somatization Disorder cases, which I originally hypothesized would be much more prevalent diagnoses and be more representative of what other studies have found in other parts of the world. Because the symptoms themselves of these disorders are often not stark enough from a Bangladeshi perspective to warrant protracted mental health treatment seeking behavior - which is the

only way one eventually finds her way to a psychiatrist - many women eventually come to develop Bipolar disorder or severe Depression.



Primary Diagnosis

Secondary Diagnosis

Diagnoses	Schizo-phrenia		Depression		Bi-Polar Disorder		Epilepsy		Emotional (Stress) Disorder		Obsessive Compulsive Disorder		Anxiety Disorder		Substance Abuse Disorder		Total # of Diagnoses (Including as Secondary)
	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	
Schizo-phrenia	46	34															80
Depression	1	2	17	36		5											61
Bi-Polar Disorder					22	35											57
Epilepsy							2	8									10
Emotional (Stress) Disorder				4		1			4	3							12
Obsessive Compulsive Disorder			1								3	2					6
Anxiety Disorder			1	3									3	1			8
Substance Abuse Disorder			2												3	0	5
Total # of Primary Diagnoses	80		53		57		10		7		5		4		3		

5.3 Culture-Bound Symptoms

	Schizophrenia		Bi-Polar Disorder		Depression		Top 3 Totals			Overall Totals		
Symptoms (expressed by patient or 'gatekeeper'/family member; non-directed)	♂	♀	♂	♀	♂	♀	♂	♀	⚥	♂	♀	⚥
Insomnia/sleep disturbance/always tired	8	6	3	5	5	10	16	21	37	18	30	48
Angers easily (*mathar gorom*)	7	5	4	6	4	5	15	16	31	22	21	43
Paranoid/suspicious feelings	17	9				4	17	13	30	20	14	34
Loss of appetite	3	3	2	5	5	7	10	15	25	11	18	29
Restless/fidgety	9	1	2	2	1	4	12	7	19	16	11	27
"Depressed"/acute sadness (*hotasha*)		2	2	1	2	9	4	12	16	5	17	22
Lack of interest in school/job/chores/ other daily activities	4	1	1	1	4	6	9	8	17	12	10	22
Sleeps excessively	6	4	1	3	3	3	10	10	20	11	11	22
Auditory hallucinations	13	8					13	8	21	14	8	22
Jinn possession (*Jinn-e dhora)*	4	5	1	5	1	3	6	13	19	6	16	22
Trouble with social integration	6	4	1		2	3	9	7	16	11	10	21
Medication non-compliance	8	4	3	3			11	7	18	11	10	21
Talks to self/random mumbling (*elo-melo kota*)	9	6	1	1	1	1	11	8	19	12	8	20
Emotional swings (low↔high)	2	3	1	2		5	3	10	13	4	15	19
Headache (*mathar beta*)	2	1	1	2	1	3	4	6	10	5	13	18
Lack of self-care	5	6		1		1	5	8	13	5	12	17
Excitable/shouts	5	2	3	3		1	8	6	14	10	7	17
Violent behavior/outbursts/ aggressiveness	2	4	1	2	1	1	4	7	11	8	8	16
Financial/economic issues	5	1	2	1	1	2	8	4	12	11	5	16
Physical weakness	5	2	1	2		3	6	7	13	7	7	14
Cannot speak/quiet	3	3		2	2		5	5	10	5	9	14
"Anxiety"/"tension"		2	1	1	1	3	2	6	8	3	10	13
Dizziness ("spinning head" / *matha ghura*)	1	3	1	1	2	1	4	5	9	5	7	12
Cries easily and a lot		2		2		5	0	9	9	0	12	12
Easily frightened/irrational fear	2	1		4		3	2	8	10	2	10	12
Withdrawn	2	3	1	2	1	2	4	7	11	4	8	12
Hands shake (uncontrollably)	1	3		4	1		2	7	9	4	7	11
Memory loss	2	2	1		1	3	4	5	9	5	6	11
Lethargy/lack of emotion/drive	2	2			2	4	4	6	10	4	7	11
Drug/substance/internet/gambling addiction	1		1		2		4	0	4	10	0	10

Somatic symptoms	(8)
Emotional symptoms	(7)
Behavioral symptoms	(12)
Causal factors	(3)

The non-directed symptoms[41] given by the patients or their accompaniment were overwhelmingly somatic or behavioral in nature. Above is a chart of the thirty symptoms most commonly voiced, and color-coded based on categorizations of those complaints into somatic, behavioral, or emotional symptoms, or causal factors. Also displayed on the chart is the prevalence of each of those complaints within the three most common diagnoses at the DMC.

In the 219 illness narratives, there were 61 different somatic symptoms listed, 54 behavioral symptoms, and only 19 emotional symptoms. In total, there were 283 individual somatic complaints, 391 distinct behavioral complaints (almost all by family members), 166 separate emotional complaints, and 135 cited causal factors. As I compared these symptoms to those outlined in the DSM-IV and ICD-10 (see Appendix 3), I came to realize that there is a heavy prevalence of what I termed "culture-bound symptoms;"[42] I was encouraged in my conclusion by Dr. Faruk's conviction that psychiatric illnesses themselves are universal, but the symptoms presented are not: "Our psychiatric textbook are written in the West, but they don't even know some problem....If you try to match our [Bangladeshi] symptom with ICD-10 or DSM-IV, you will not be able to make many of the diagnosis. You will fail."

The Bangladeshi colloquialism ***mathar gorom*** (literally meaning "hot head" and referring to a quickness to anger) was a significant concern across the board, not only with the three most common diagnoses. This propensity to anger easily (and generally grow violent) was a foremost concern among family members who found the behavior change difficult to manage. Often, if this *mathar gorom* was associated by the family with *jinn-e dhora* (possession by *jinn*), it was noted how strong the patient would become during their anger (and violent) episodes.

Elo-melo kota is the Bengali term describing the propensity to mumble to oneself or repeat prayers repeatedly under one's breath. This culture-bound symptom is similar to the DSM-IV outlined symptom of "disorganized speech (e.g., frequent derailment or incoherence)," (1994:

[41] Meaning that I did not ask whether the patient had X or Y, but rather let them make the lists for themselves, picking out what they considered to be "abnormal" behavior for Bangladeshi society.

[42] A take-off on Laurence Kirmayer's (2007) culture-bound *syndromes*.

286) except that the culture-bound symptom is always housed in a religious context and refers colloquially to the Sufi practice of *dhikir*[43].

Matha ghura can be translated literally as "spinning head." This term is similar to constant dizziness but is not entirely the same; rather, the term is often use to denote a feeling of loss of control or bearings and is a type of headache. This symptom was mentioned as a player in almost all the different biomedical diagnoses, not one in particular.

The Bangladeshi culture dictates that female youth are not to spend time alone in the company of their male counterparts, a tradition that - especially in the more rural areas - is still strictly upheld. However, with the advent of internet chat rooms, FaceBook, and cell phones, there is a growing counter-culture that involves a new kind of interaction. The emphasis of *ad-da* has incorporated new technologies and is coloring the way that youth perceive relationships. Commonly used by Bangladeshis for this phenomenon is the English word "**affair**," which should not be interpreted to carry its English meaning of marital infidelity; instead, it is a Bengali colloquialism that connotes either simply "going out" or "forbidden love." Cell phones are the key medium for conversation in these prohibited ventures, and the cases of psychological "affair" issues dealt with by Prof. Islam at the DMC were diagnosed as Depression or Emotional Disorder. (The ages of the girls were 15, 18, 17, and 18 years. One was even admitted at the Clinic as an in-patient because she (a Muslim) wanted to marry a Hindu boy.) Dr. Faruk attributes such mental illnesses to the social taboo surrounding the discussion of topics such as religion, family discord, and especially sexuality: "If she falls in love with a boy, she has to suppress that feeling - she can't talk about it with her family or her friends, and her family will arrange marriage to another person. So she will not be able to cope and she will develop psychiatric illness," he says.

Another culture bound symptom is what I have come to call "**introvertism**" (though it could also be seen as a culture-bound syndrome in some cases). Being introverted and being Bangladeshi are contradictory to the point that the personality type may as well be medicalized. Anyone who does not willingly and often engage in *ad-da* is considered to be one step behind 'normal' by the vast majority of the population who can think of nothing more engaging than gossiping. Simply being introverted in Bangladesh is treated with a

[43] This practice is the repetition of the many names of Allah, Qur'anic *sura*, and other prayers, and is intended to bring the chanter into a heightened spiritual state.

similar sincerity as being autistic in the United States, whereas one can be introverted in the West and still be a valued, contributing member to society. However, in Bangladesh, someone wishing for "alone time" and preferring to read a book is exhibiting behavior bordering on *mathar kharap*, is considered to be mentally ill, and treated as such. This issue is another example of the gravity of behavioral and social symptoms of mental disorders in Bangladesh: Nothing is considered to be the matter with a Bangladeshi until he or she starts to act differently in a way that negatively affects his/her society.

Another common culture-bound symptom that was seen most often with Schizophrenic, Depression, and Bipolar Disorder patients was a **loss of memorizing power**. In a culture that emphasises rote memorization and unquestioned acceptance for scholastic, religious, and occupational success, this focus on regurgitative brain power is understandable. However, this symptom was only recognized among those few patients still attending academic institutions and was also sometimes noted as a concern regarding the medication they were receiving and not the disorder itself.

A burning sensation experienced either in a specific body part (head, throat) or all over the body could also be categorized as a culture-bound symptom. The term ***jala kore*** (জ্বালা করে) translates to "burning feeling," is a phenomenon that seems to be a mental health symptom unique to Bangladeshis, and is culturally understood to denote *jinn-e dhora*. From a religio-cultural perspective, this conclusion is obvious, owing to the divine conception of the invisible creatures from smokeless fire. Thus, to feel a burning sensation throughout or over one's body obviates the presence of fiery *jinn*. The term is also associated with the mental illness of unrequited or forbidden love, and was described by an informant in that respect as being closer to a somatic *mathar gorom*: "When your boyfriend will have a bed with another lady, this is what *jala kore* is."

Dr. Faruk's concern with culture-bound symptoms in Bangladesh revolves mostly around those expressed by patients with Conversion Disorder, the condition that "has the most cultural influences." He laments the fact that many traditional and religious healers take women suffering from Conversion Disorder and "treat" them in ways that can cause them further trauma, such as tying them down, beating them with a stick broom to drive the *jinn* out of its possessive state, or shoving burning hot chili into her nostrils to cause her to cough,

gag, sneeze, or hiccup in order to exorcise the *jinn*. Dr. Faruk noted that, if a psychiatrist does not diagnose a patient correctly with Conversion Disorder, he or she is probably being treated with anti-psychotics and Bipolar medications. He estimates that in 75% of Conversion Disorder cases, the patients are first socially diagnosed with *jinni dhora* or *ban mara*, which can lead psychiatrists to misinterpret an illness narrative plea for exorcism. However, Dr. Faruk maintains that the majority of these patients are actually reacting psychologically to traumatic experiences that present themselves in an accepted cultural paradigm of *jinn* possession:

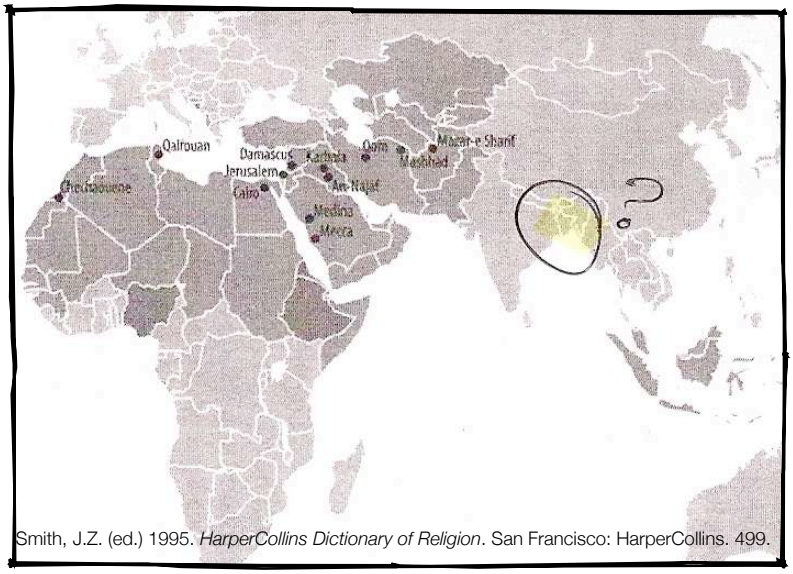
> Conversion Disorders are the most affected by culture. What happens in the West with Conversion Disorder? [Patients] usually develop muscular weakness or difficulty hearing or talking. But in Bangladesh, people tend to behave as if they have been possessed by spirits...They think that some spirits like *jinni* or *bhut* or some other evil spirits have possessed the patient. In the West, they present with physical symptoms - motor or sensory deficits. But here in Bangladesh, they present with behavioral disturbances, like abnormal jerky movements of the body, talking bizarre things, burning all over, dizziness, palpations of the heart. So, these are because of our culture - in our culture, their presentation is affected by their belief in *jinni* or ghosts.

Chapter Six: An Islamic Mental Health Milieu

"Allah is the Protector of those who have faith. From the depths of darkness He will lead them forth into light." - Qur'an 2:257

6.1 Bangladesh's Practiced Islam and its Mental Health Traditions

Psychodiagnostics in Bangladesh cannot be studied without a deep understanding of the role that Islam plays in popular perceptions of mental health, particularly regarding its origin and its treatment. Because Bangladesh has been either forgotten or neglected for a long time from all perspectives -- Historical, political, religious, health, etc -- the country has developed a uique relationship between popular perception of Qur'anic teachings and mental health implications. Just as the 1995 HarperCollins *Dictionary of Religion* failed to include Bangladesh on its map of the distribution of the world's Muslims, many falsely assume that all Muslim countries follow the same religious guidelines and practices, including those related to illness and health. However, even the few who recognize that each Muslim country has its own cultural traditions mixed into the traditional Islamic dogma often fail to classify Bangladesh.



Smith, J.Z. (ed.) 1995. *HarperCollins Dictionary of Religion*. San Francisco: HarperCollins. 499.

Prof. Islam looked at me one day and said with a sigh: "If you do psychiatry in this country, you really have to understand the whole social situation." For example, NIMH Director Prof

Dr. Md. Golam Rabbani explained that it does not make much sense to Bangladeshi Schizophrenic patients to ask them if they hear voices because auditory hallucination often carries with it a connotation of the divine, relating to the ability of the Last Prophet, Mohammed to hear Allah's intentions[44]. Similarly, Bose (1997) and Chakraborty (1965) both report that, "In Bengal, where to see something unusual is a common event in stories, myths, and in the experience of mystics, visual hallucination is not unusual in the phenomenology of mental illness. It does not solely signify an underlying organic pathology as it does in Western psychiatry" (Bose 1997:10).

The fact that so few Bangladeshis have read the Qur'an themselves means that they are dependent on the religious teachings disseminated by the Mosques and have little opportunity to consider critically what they are told in cultural contexts. This situation lends itself well to rumor and misunderstanding, which plays a pivotal role in practiced mental health treatment seeking behaviors and the perceptions of psychiatric illness etiologies. For example, mental illness in Bangladesh is believed to be caused by one of two religious-based phenomena: Either one is possessed by *jinn*, or has been religiously cursed. The first, known as *jinn-e dhora*, is the belief that one has been attacked internally by an evil *jinn*. The latter cause - known as *ban mara* - is inflicted upon a person through a spell cast by reading certain passages of the Qur'an backward. Because one is most easily affected by religious misfortunes if (s)he has been negligent in faith, the social stigma associated with these afflictions means that many suffering from the most severe psychoses - known widely as *pagol* - have rocks thrown at them by taunting children and are highly shunned by general Bangladeshi society. When they are not on the streets fending for themselves, *pagol* are chained or tied up - usually in their own homes, but also commonly at mental health clinics and by religious healers themselves.

Jinn-e dhora and *ban mara* in urban Bangladesh are most commonly manifested through symptoms such as irritability, loss of appetite, quickness to anger, disrupted sleep patterns,

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[44] The origin of the Qur'an is founded upon the belief that Allah sent his *ayat* (verses) down to Earth through the angel Gabriel, who spoke the messages to Mohammed, who heard them and repeated them to his *sahabi* (direct followers, like the Disciples in Christianity), who wrote them down. This compilation of *ayat* and *sura*, compiled over years by the *sahabis* is known, in its entirety, as *ohi*. This term is the root of *ohi nazil*, which means that, "something fell into you; you didn't come up with it yourself" (and is remarkably similar in connotation to the German "mir ist etwas eingefallen," or the English "it just hit me..."). The religious perception is that the Qur'an should not be read and absorbed, but it should rather "fall into" its believers. Therefore, to "hear voices" can be considered in the Bangladeshi religio-cultural paradigm to be a very positive experience.

sudden excessive religious fervor, abrupt and random fainting spells, the perception that other people are watching and/or murmuring about him/her, auditory and visual hallucinations, and frequent and sudden mood variability, all of which can be easily integrated into the allopathic psychiatric diagnostic paradigm, resulting in a deceptively simple disorder comparison.

One of my primary research goals was to determine the folk categories of psychiatric distress in urban Bangladesh, which led me to the understanding that the real diversity was found with the different healers, each with different diagnostic and subsequent treatment methods. Generally, religious healers did not use the same methodologies for the same diagnoses - they were more oriented toward the patient's problem within that individual's social sphere, adding a degree of personalization that was considerably lacking in the automated practice of filling out prescription sheets. The primary factors dictating the consultation of religio-cultural healers are economic, religious, availability, social pressure/expectations, referral from other practitioners, and the "drowning man" effect.

6.2 Traditional Religious Healers

Though there are several distinct types of religious healers who have different titles and expertise, on a colloquial level, the names are often used interchangeably. This practice complicates determining from which specific kind of healer a given psychiatric patient has received treatment.

Pir

Pir is the traditional term for a Sufi master whose disciples are called *murid* (মুরীদ). One must be born with the powers of a *pir*, which are passed down through generations of these practitioners. In the village, every family has a *pir* whom they worship, as they are considered to be the living beings with the closest connection to Allah. No human has spoken directly to Allah (His messages were heard by Mohammed through Gabriel's voice), but the hierarchy begins with the Last Prophet. Directly under Mohammed in Allah's priority to humans are the *sahabi*, the direct disciples of Mohammed who wrote Islam's second most holy book, the *Hadiz*. (The *Hadiz* is an account of the lifestyle and philosophies of Mohammed himself.) However, the *sahabi* have all left their human forms and, therefore, the next tier in the hierarchy - the *pir* - are needed on Earth to serve as prayer conduits to Allah. It is furthermore

believed that *pir* never die, but rather sleep in their *mazar*/*dargah* (tomb/very large *mazar*) while continuing to carry the prayers of humans to Allah.

Because of this more direct connection to Allah, *pir* are able to heal both mental and physical illnesses through divine means. It is popularly believed that some powerful *pir* have the ability to control certain *jinn* and entice the creatures to work on their behalf in the unseen world. In his attempt to reconcile this belief in the ability of select, very religious humans to exercise some control over the fire-borne creatures, Ünal's Note 10 for *Sura Al-'Ahqāf* (Wind-Shaped Dunes) 46:32, explains that:

> Like angels, the jinn move extremely fast and are not bound by the time and space constraints within which we normally move. However, since the spirit is more active and faster than the jinn, a person who lives at the level of the spirit's life, and who can transcend what we know as the limits of matter and the confines of time and space, can be quicker and more active than them. (2008: 1029)

However, not all *pir* have such strength and other traditional religious healers generally require the aid of a *Libra* assistant when handling *jinn* exorcisms.

Many in contemporary urban society view *pir* as a commercial mechanism, as they advertise heavily in newspapers and magazines and often charge more money for consultations and treatments than do other kinds of religious healers. While the *pir* himself will not charge his clients for his services, patients are expected pay the *murid*, who manage their *pir*'s accounts. However, this commerciality does not seem to hinder the *pir*'s popularity or the public's understanding of their validity and piousness as religious healers. *Pir* most often prescribe prayer, *pani pora*, *tel pora*, *tabiz*, or *fuk* to their patients, even to those who seek their help for more innocuous concerns such as passing exams or arranging good marriages.

Huzur

A *huzur* is a religious healer for both physical and mental illnesses who extensively and almost exclusively uses Qur'anic remedies through the recitation of *sura*. A title equivalent in English to that of "sir," *huzur* is the colloquial term for *Imam* (religious leaders at a Mosque), though while all *Imam* are *huzur*, not all *huzur* are *Imam*. However, not all *Imam* practice healing. Those *huzur* who do heal - whether or not they are *Imam* - have spent their lives in close relation with a Mosque, though they are not considered to be as spiritually powerful as

pir. Therefore, the term is also used idiomatically to refer to someone who wears a beard and regularly attends Mosque.

Huzur are not connected to others of their kind through associations or coalitions; they work alone and there is little lateral professionalization of their healing practices. Because women are not allowed inside the Mosque, if the patient seeking treatment from an *Imam huzur* is female, a male family member will either go to the Mosque and summon the *huzur* to come to the home or he will relay the woman's symptoms to the healer who will then issue the man her treatment (most commonly a *tabiz* or *pani pora*). Not all *huzur* perform *jinn* exorcisms, but those who do find gender-neutral environments for their female patients.

Fakir

The term '*fakir*' was historically used to denote both male and female poor vagabonds and can be translated to "one who wanders and heals others." While the term is also used colloquially for beggars[45] (*bhikkuk* - ভিক্ষুক) because they are also vagrant, it is a contemporary misnomer, as most all *fakir* settled after the British occupation ended into *fakir bari* ("*fakir* home") with their working chambers attached. Today, *fakir* are widely recognized throughout Bangladesh as religious healers who treat both physical and mental health disorders.

Kabiraj

A *kabiraj* is a type of religious healer who uses almost exclusively herbal treatments in conjunction with the recitation of *sura* and is popularly understood to treat only physical ailments. There are even some *kabiraj* who specialize in and only treat specific problems, such as jaundice. However, the term '*kabiraj*' is often used idiomatically to denote all forms of traditional healers, including those involved with mental health.

Khadem

Khadem are spiritual leaders who work at *mazar* and do not engage in healing further than listening to prayers. Due to a *khadem's* status, people come to him and ask for his *doya* (দোয়া / দু'আ - blessings) and that he engage in *milad* on their behalf. "He has two primary objectives in his role as a *khadem*: One is mental and the other is spiritual," explains one

[45] However, the primary difference is that beggars carry with them no distinct philosophy, whereas the *fakir* once did in their wanderings - beggars offer no services in exchange for donations. A "*shadhu*" or "*shonnashi*" is the Hindu equivalent of the former meaning of *fakir*, though these counterparts do differ in that they generally live in the jungle and meditate.

informant. The latter focuses on his relationship with Allah, acting as a conduit for those who come to him and aiding them in their search for greater faith. The former focuses on listening to those who come to him with more worldly problems such as needing to rid themselves of danger, earn more money, find a better career, or ameliorate family problems. The three *khadem* who work at the *Shahali Temple Mazar* in Mirpur-1, Dhaka serve as spiritual guides and keepers of the peace in minor disputes. Originally, one *khadem* told me, people only came to the shrine with religious objectives; however, contemporary visits include many more concerns regarding worldly affairs.

One informant explained to me that the *mazar* is "a good place for the *pagol* who has no ties with the family," because many people come to the shrine with *takapoisha* (monetary change) set aside for donations, some of which must go to the homeless and destitute. Oftentimes, people visit the shrine to pay off prayer debts (*manot*), which are made by promising Allah that if something that the individual wishes for (a good test grade, a good job, etc.) becomes reality, then that person will pay Him back with donations to the poor and through prayer. Thus, many of the *pir* caskets or mini shrines are littered with small bills, coins, and other offerings that embody the culture-bound psychological healing process that occurs at the *mazar*.

Ojha

Ohja know how to counteract spells and curses that affect both physical and mental functioning; they are exorcisers and intervene in daily life problems. *Ojha* are most commonly known for their practices of different forms of *jhar-fuk*, though some other research indicates that *ojha* are interested in the reasons why people become ill, often attributing disease to *bhut*-instigated infestations of invisible creatures known as *tejo,* which act in ways remarkably similar to bacteria and viruses (Klass 1996: 49).

Astrologers

Astrologers are very commonly consulted for both health and social problems throughout Bangladesh. Astrological perceptions pervade the cultural understanding of faith and other cosmological phenomenon and are even referenced often by other religious healers. Though many astrologers tend to distribute herbal remedies to their patients, many clients also seek

out this kind of healer for their propensity to serve as a sort of cultural psychologist, offering answers and reasons for unexplainable emotions, and often serving as a type of family counselor by attributing discord to external sources.

6.3 Religio-Cultural Mental Afflictions - Diagnoses

6.3.1 Jinn-e Dhora

Jinn-e dhora (জ্বীনে ধরা) is the term for the state and act of possession by a *jinn*. The possessed individual manifests unnatural physical and behavioral symptoms including silence, quickness to anger, quarreling with family and friends, headache, chest and belly pain, loss of appetite, restlessness, not heeding one's husband's (or in-laws') orders properly, talking back to or arguing with one's husband or in-laws, regularly leaving home after lunch or sundown without an explicit reason to go somewhere (females only), aimless wandering, hysteria, loneliness, and not wanting to be around other people or to talk to others (introversion). This state is similar to - but more serious than - *kharap batash*.

Should family members notice any of the above symptoms that denote *jinn-e dorse*[46], they will seek religious treatment, as it is popularly understood that no biomedicine can be effective against religious ailments. Patients have already been diagnosed either by themselves, their families, or their other social groups by the time that they reach the religious healers, whose responsibility it is to rid the patient of the *jinn*.

There is a strong cultural tradition of ghost stories and other 'superstitious' beliefs that primarily involve *jinn* and *bhut* (roughly translated to "ghost") in the dark, near very old trees, or in graveyards. Some healers refer to *jinn-e/bhut-e dorse*, which means that the possession comes from either *jinn* or *bhut*, but it matters little which for the course of treatment prescribed.

[46] "*Dorse*" is an idiomatic form of "*dhora*" that is used commonly in the Bangladeshi dialect of Bengali.

Case Study: Shimul

Sixteen-years-old and accompanied by both parents at Prof. Islam's clinic, Shimul is a quiet and solemn girl who curtly answers direct questions, but otherwise stares passively downward as her father explains her case with gregarious gesticulation. Occasionally, Shimul's mother will whisper ancillary information to her husband, who will then repeat it for Prof. Islam's benefit. They tell how the girl would randomly begin convulsing and her body would shake and bend abnormally, in a way that he described as "bow-like;" this problem would also manifest itself during her sleep. Six or seven months ago, Shimul suffered from a severe headache, at which time she tried to pull out all of her hair. Shimul's parents and extended family all strongly believe that this ailment is caused by *jinn* because, when she was given a Qur'an to hold, she dropped it; such an incident is unforgivable in Islam and would only happen if the person were possessed by an evil force that did not respect the Holy Book. Shimul was so upset by the incident that she ran and struck her head several times against a wall in self-punishment and did not stop until she was pulled away by her family members, who have come to ask Prof. Islam to perform an exorcism, a proposition to which Prof. Islam responds with a strong bout of laughter. Shimul's father believes that religious healing is the proper course for his daughter, but was surprised when reading the Qur'an aloud to her did not mitigate her symptoms. After Shimul and her mother leave the room, the father stays behind to request treatment from *pir*. In response, Prof. Islam hands him a prescription sheet for Epilepsy medication.

For those suffering from *jinn-e dhora*, the most common *sura* I was told were recited over the patients are *Sura Ar-Rahman* (55:33-36), *Sura Kaferun* (109), *Sura Ikhlas* (112), *Sura Falak* (113), and *Sura Nas* (114)[47]. The final two *sura* (also written *Sura Al-Falaq* and *Sura An-Nas*) are two of the most important and oft-cited *sura* for curing illness in general, and Ameen contends that this phenomenon is due to the fact that before these two *sura* were revealed, Mohammed himself sought refuge with Allah from the *jinn*[48] and the 'evil eye'[49] (Ameen 2005: 152).

[47] However, Ameen (2005) adds *Sura Al-Faatihah* (1:1-7), *Sura Al-Baqarah* (2:1-5/163-164/255-257/285-286), *Sura Aali 'Imraan* (3:18-19), *Sura Al-A'raaf* (7:54-56), *Sura Al-Mu'minoon* (23-115-118), *Sura Al-Saffaat* (37:1-10), *Sura Al-Ahqaaf* (46:29-32), *Sura Al-Hashr* (59:21-24), *Sura Al-Jinn* (72:1-9), and *Sura Al-Humazah* (104).

[48] Ameen maintains that, while the above *sura* treat the patient, there are others in addition thereto that specifically punish the *jinn* themselves: *Ayat Al-Kurisy* (*Sura Al-Baqarah* 2:255), *Sura Al-'Nisa* (4:167-173), *Al-Maa'idah* (5:33-34), *Al-An'aam* (6:93), *Al-Anfaal* (8:12-13), *Al-Tawbah* (9:7), *Ibraaheem* (14:15-17), *Al-Hijr* (15:16-18), *Al-Isra'* (17:110-111), *Al-Anbiya'* (21:70), *Al-Dukhaan* (44:43-52), *Al-Hajj* (22:19-22), *Maryam* (19:68-72), and *Al-Mulk* (67:5-11).

[49] Bangladeshis do not attribute mental disorders to the 'evil eye' like is commonly seen in other Islamic cultures. See the definition of *nazar* in the glossary in Appendix 1.

Case Study: Khaleda

Khaleda wears her *hijab* draped loosely around her peppered black hair and expresses herself with surprising animation. She struggles to stay seated on the edge of her chair as she leans toward Prof. Islam. While she speaks, she integrates English conceptualizations into her illness expression, repeating the word "torture" several times. She is 37-years-old and married with two children, one of whom has been diagnosed with mental retardation; the second just underwent a stressful operation. She mentions that in eighteen years of marriage, her husband has never taken her out or given her any money to spend on herself. Shortly after the birth of her first, "abnormal" child, Khaleda's husband and in-laws began treating her poorly, blaming her for the child's condition and beating her. She began to contemplate suicide regularly and even swallowed a bottle of pills. After recovering from her overdose in the hospital, she has been suffering continuously from headaches, wrist and knee joint pain, neck pain, and sleep problems. She has lost interest in living, doing her daily chores, and maintaining her family.

As she is blamed for her "abnormal" child, Khaleda has even asked her husband to divorce her several times, which he will not do out of regard for social norms; he is a prominent businessman concerned about his image. Furthermore, though she finds no interest or enjoyment from sexual interaction with her husband, she is forced to engage; she started taking birth control pills in order to fulfill her husband's sexual demands. She has become very afraid of her husband and feels that she has to act like a very reserved person in his presence, although that is not her personality type. She is having difficulty sleeping and is afraid of being alone; however, during the day, she is kept wildly busy managing her children, servants, and in-laws. The body pain has made it difficult for her to be able to control her "abnormal" child, for whom she has tried to find assistance, but each person hired has quit within the first month of beginning the job. In addition to having high blood pressure, her relatives have diagnosed her as suffering from *jinn-e dhora* and suggested that she seek treatment from an *ohja* or *pir*. They believe that she is suffering due to social, personal, and religious phenomena.

Prof. Islam is unsure as to whether her physical symptoms are somatic or due to hypertension, but he diagnoses her with Multi-dimensional Depression and Stress Disorder, gives her medication, and advises her to take a few days rest and find someone who can help her take care of her "abnormal" child.

6.3.2 Ban Mara

If one reads certain Qur'anic *ayat* or *sura* backward,[50] it is known as a type "*kufori*" (an Arabic word meaning the forbidden action of "harm done unto another") and is material for use in black magic. The cursing act is a very prominent crime in Islam and results in its perpetrator forfeiting Allah's grace for eternity. However, this threat does not seem to have stemmed the perceived frequency of its casting.

[50] Even the letters are read backward; for example, the sentence "the dog jumped over the stream" would not be read "stream the over jumped dog the," but rather "maerts eht revo depmuj god eht."

The most well-known *kufori* curse, known as *ban mara* in Bangladesh, is meant to eventually kill its victim and is usually sent indirectly to the receiving individual. This indirect cursing is accomplished by performing *kufori* to another living thing (such as a tree or a small animal), which subsequently dies and transfers the curse unto the person.

Such actions can also be employed through the malevolent use of a *tabiz* through a practice known as *tabiz kora*[51]. In this case, the *kufori* curse (usually *Sura An-Nas*) is written on a small piece of paper and rolled up along with some part of the victim (eg. a strand of hair) and a piece of a bone from a dead person, a chili seed, or something else inauspicious, and sealed. The victim's name is written on the *tabiz,* which is then hidden in the victim's immediate surroundings (eg. buried in the house or hidden under a matress). The more of these *tabiz* with which one is cursed, the more cursed that individual becomes.

6.3.3 Bhut

Jinn are not the only creatures believed to play a negative role in the lives of humans. As there is no reference in the Qur'an to *bhut* ("ghosts") or any other form of magical creature, they must fall under the *jinn* category from a religious perspective and are known technically as *jinn-at*. However, from a social perspective, there is a large difference between *bhut* and *jinn*. *Bhut* are the lost souls of people from other religions and those Muslims who were either murdered or who committed suicide, or whose burial rites were not properly completed. *Bhut* roam the places where they died, and while *jinn* have a body and a society - albeit invisible to humans - *bhut* do not have bodies and are not members of a community. They are external forces that act on humans, whereas *jinn* act from an internal position. While *bhut* are also invisible to humans, they have few powers other than inflicting fear. Therefore, if a magical creature appears in the form of a snake, black dog, man with goat's feet, or other evil portent, then it must be a *jinn* in disguise. Even with this understanding, when someone sees something strange or bad (like creepy shadows at night), he will blame the occurrence on the presence of *bhut*. However, if someone acts strangely, then the cause must be *jinn*. Though *bhut* are not an Islamic phenomenon, patients are often rid of their influences through the same methods as those employed to exorcize *jinn*.

[51] *Tabiz kora* is also the term used for the act of preparing a 'good' *tabiz* to counteract one that is cursing an individual.

6.3.4 *Pagol*

The term "*pagol*" is used very often in Bangladeshi conversation and is similar in its different meanings and connotations as the word "crazy" in English. As a noun, the word is most commonly used to label people who are living on the streets and have no sense of who or where they are - or what they are doing. They are perceived as not caring what they eat, who throws rocks at them, or why they're spit upon by passers by. Regarding different levels of mental health morbidity, *pagol* is the adjective used to connote the most extreme levels of *manoshik rog* (mental illness). While general *manoshik rog* does not carry with it negative consequences for other people, *pagolami* (noun) is associated with violence and *mathar gorom*, which pose a threat to those around them; one informant exclaimed: "*Pagolami* is totally the mad thing! Rich and educated people call it 'mad' and illiterate people call it '*pagol*.'"


A female *pagol* living alone on the streets of Dhaka.

However, in addition to this more clinical use of the term, *pagol* is also used to connote men who are so engaged with their religious beliefs that they are completely unconcerned with any social or personal issues. These people are considered to be more connected to Allah and to have a closer relationship with Islam than the common man; these people are god-gifted. They are found all over the country and will sometimes find very large trees or *mazars* and hang around those places, doing *dhikir* (repetitious prayer). They are not considered to be healers, though some people, when they go to visit the *mazar*, request prayers from these holy *pagol* to help them during their times of stress and need. If a person goes to a *mazar* to complete a *manot*, they will often be approached by one of these *pagol* (called "*baba*" (বাবা; father)), be touched on the head, and told that the *pagol* will pray for them. There is no tangible medicine involved - just prayers that the *pagol* offer without expectation of payment. However, as they are just lonely nomads, most people offer them food in return for their services. This use of the term is much less popular than the first.

Finally, *pagol* is often used colloquially much in a similar fashion as its counterpart in English: Just as a person can be "crazy in love," or one friend can say to the other, "Dude, you are crazy [for doing that]!" so, too, can the term be used in Bengali.

6.3.5 Kharap Batash

Literally meaning "bad wind," this term is not related to bodily humors like similar terms used in Ayurvedic and Tibetan medicine. Instead, the word means that, while a *jinn* did not directly possess a person, the individual has been affected by the workings of evil *jinn* by passing through their aura or a place that they had previously jinxed. This affliction is not nearly as serious as direct *jinn-e dhora*, and one informant equated the two with the snake in *Harry Potter and the Chamber of Secrets*: If one looks directly into the snakes eyes, the person dies; but if he sees the eyes indirectly (eg. in a mirror), the person will just be paralyzed or frozen. Similarly, the symptoms associated with *kharap batash* are homogenous with, but less severe than, those expressed by patients suffering from *jinn-e dhora*.

6.3.6 Mathar Kharap

Directly translated to mean "bad head," or more colloquially, "problems with the head," this term is used to denote someone who is either in a serious stage of being a *pagol* or is in the very initial stages of mental problems.

6.3.7 Mathar Gorom

Mathar Gorom literally means "hot head" and is used idiomatically to describe someone who angers easily and is most often violent as a result. *Mathar Gorom* is one of the most common symptoms of all mental health problems in Bangladesh, most significantly *jinn-e dhora.* Generally, the individual gains an unprecedented amount of strength from the *jinn* during his/her fits of outrage and violence. The term is more serious than - though similar to - the English colloquialism "hot-headed."

When someone displays symptoms of *mathar gorom*, his immediate community tries to calm him down and give him cool water to drink[52]. The attitude and verbiage is much like it is in

[52] However, there is not a prevalent idea of 'hot and cold' foods, medicines, or illnesses in urban Bangladesh as there is around the rest of the Asian subcontinent, so no connections can be made between the disorder and bodily humors.

the United States, telling someone to "be cool, dude," "cool down," or "take a chill pill," and Bangladeshis usually say: "*Mathar thanda kor*" or "make the head cool."

Case Study: Dipak

Twenty-eight-year-old Dipak's symptoms began when he was in the fifth grade. At first, he would frighten very easily, but as time went on and he proved to be a good student, other symptoms started to become more obvious and prevalent. Dipak developed *mathar gorom* and sudden, violent outbursts during which he would roam around in a funk and try to break everything he could find. He began to believe that his family members were trying to hurt him and the only way he could protect himself was to preemptively attack. He began to feel that all of the people on the street were criticizing him and his behavior and perceptions eventually rendered him unable to engage in daily work and other affairs.

Dipak's family started taking him to traditional religious healers, and he was told by a *huzur* that he was suffering from *jinn-e dhora*. For treatment, Dipak was given *pani pora* to drink, *tel pora* for a massage over his entire body, and several *tabiz* to wear. In order to ultimately exorcize him of the *jinn*, Dipak returned to the *huzur* for a ritual where the healer sat across from the patient and next to his assistant, a Libra (*tula rashi*). The Libra put some *tel pora* on his thumb and stood before a mirror held by the *huzur* in which he said he could see the *jinn*. The *jinn* then temporarily possessed the Libra, through whom it was able to speak to answer the *huzur's* many questions: Who are you? Where do you come from? Why are you disturbing Dipak? The *huzur* then told the *jinn* to leave, but it started to laugh and responded that it would not. Then, the *huzur* cast a spell on it and told it that if it did not leave, it would be destroyed. This exorcism was reported by the *huzur* to have been a success, but that the *jinn* had harmed Dipak's brain, which was now "defective" and he should seek out someone who could help him with his psychiatric problem.

Since he has been taking Prof. Islam's Schizophrenia medications, Dipak's *mathar gorom* and other symptoms have decreased dramatically in severity and prevalence, but he is still not capable of being effective in the work place. Dipak told me that the only reason he came to Prof. Islam's clinic in the first place is because he felt like a drowning man who would clutch at anything to try to save himself.

6.4 Diagnostic Methods

Every traditional healer seemed to have slightly different methods of determining whether or not their patients had been cursed or possessed. Generally, these methods were only reported once and rarely had specific names. The following are three examples of diagnostic methods that I heard of being used more than once.

String Method

The string method of diagnosis involves taking a string and measuring a person's height. If, after the measurement, the string shortens, then the person has been cursed or is possessed by a *jinn*.

Case Study: Miriam

One day, as a student at a prestigious university in Dhaka, Miriam went over to a female friend's house where she was convinced to cut her hair and to eat something strange, which she could not identify. When she returned home, she felt ill and started to behave abnormally - she could no longer memorize for her classes or concentrate on her studies, and she always felt restless. As soon as Miriam's mother found out that her daughter had been convinced to cut her hair (the length of a Bangladeshi woman's hair symbolizes her beauty), she was convinced that the reason was a cursed *tabiz*. Miriam was taken to a *huzur* who, in order to determine whether or not she had truly been bewitched, used *jaffran* ink to fill out the table of symbols for a counter-*tabiz* and pasted the paper on a ceramic (*china mati*) plate. He then poured water onto the plate and asked Miriam to drink the water. She then bathed in more water enchanted by the plate.

When her symptoms did not improve, she went to a *pir* who took a long blue cotton string and measured her height from head to toe. After measuring this height, the string had shortened and the *pir* took to treating her by infusing a tub of water with leaves of a *boroi* tree and having her bathe in it. When this treatment also failed to yield results, Miriam's family brought her to the Dhaka Monorog Clinic at the recommendation of some of her relatives. She has been receiving medication for Schizophrenia and Bipolar Disorder for the past three to four years and is feeling much better, though her symptoms relapsed a few years ago when she stopped taking the medications, thinking that she had been cured.

Dim Pora

Literally translated to "enchanted egg," the *dim pora* diagnostic method involves tying a freshly laid, raw egg - over which *sura* have been read and the religious healer has blown (*fuk*) - with a *kaitan* (black string used for *tabiz*) to one's waist. As it is virtually impossible to tie such a thing securely, the egg almost always immediately falls to the ground and cracks. If the egg yolk breaks upon hitting the ground, then the individual is possessed. If the yolk remains whole, then the person is fine.

Incensed Cotton Balls

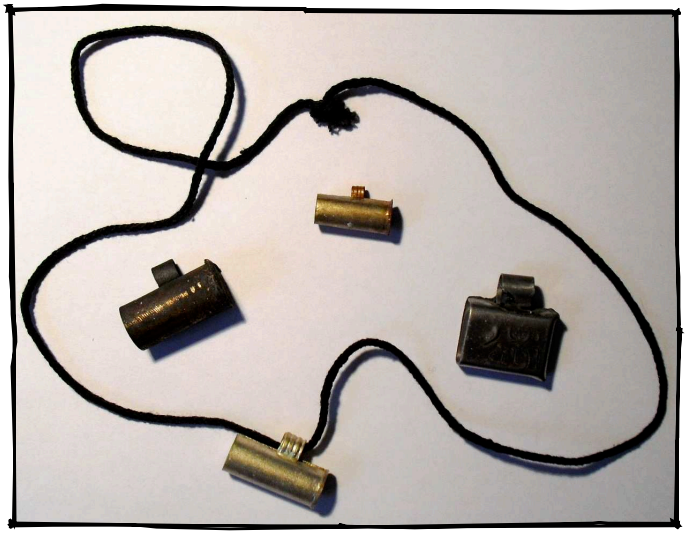
Case Study: Nasrin

About four years ago, Nasrin's husband was sick for two weeks, during which time she did not sleep. When her husband regained his strength, Nasrin visited her mother-in-law's grave to pray in thanks and returned home. Upon her arrival, she began biting herself and others and would recite *dhikir* and other very difficult *sura* over and over again. She saw visions of Mecca and Medina, continuously poured water over her head, and was soon unable to recognize anyone around her - including her husband. She described herself as going "totally *pagol*" when she would be excitable and see hallucinations of a snake with three heads. At first, she came straight to the Dhaka Monorog Clinic, where she was admitted as an in-patient for three months. After her symptoms balanced out, she returned home and discontinued her medications on her own accord. When her symptoms returned, she was admitted to the NIMH for a month, after which time she seemed fine, though she had re-started taking her prescription from Prof. Islam while at the NIMH. Afterward, when she stopped taking the medication again, thinking that she'd been cured, and the symptoms returned, Nasrin went to a *huzur* who set about diagnosing her with *jinn-e dhora* by putting scented oil on two small cotton balls and stuffing them up her nostrils. Her reaction was to start to laugh and to try to give the *huzur salaam* (blessings in the name of Allah), which is how he new that she was possessed. She was given *pani pora* to drink and a *tabiz* to wear around her neck. *Nasrin* does not believe that her psychiatric medications for Bipolar Disorder have been effective at all, but rather that *jinn* are responsible for her problems and if she feels better, it is because of the religious treatment that she has received. She has been again taking Prof. Islam's prescriptions for the last few months.

6.5 Religio-Cultural Treatment Methods

6.5.1 *Tabiz*

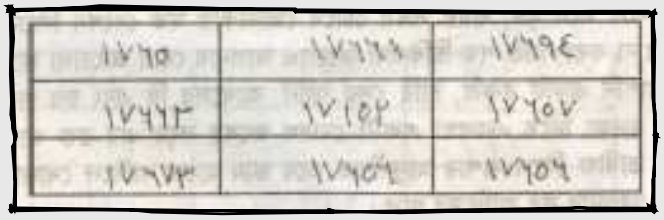
Local archaeologists cite the use of amulets for health as beginning around 4500 years ago in the region now called Bangladesh. However, since most attribute the real rise of Muslim influence in the area to about 800 years ago, the *tabiz* demonstrates an interesting amalgamation of historical healing methods with the incoming religious fervor and medicinal paradigm. *Tabiz* in Bangladesh today are strictly religious in nature, housing a rolled parchment with a *sura* or *ayat* from the Qur'an written on it in *jaffran* (জাফরান) ink, (or a series of numbers and symbols that refer to specific *ayat* and *sura*) sometimes dipped into *pani pora*, and blessed by a religious healer before wear. The body of a *tabiz* is called a *maduli* and it can be made of different metals depending on the social status and disorder of the wearer. Most commonly, *maduli* are made out of cheap brass



or other inexpensive alloys. The *tabiz* is hung by a black thread known as *kaitan* (কাইতন) or *daga* (দাগা) around the individual's neck, wrist, or waist. Some women wear *tabiz* in their hair.

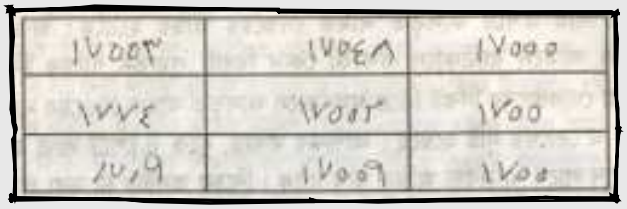
Though religious healers will tell you that the no *tabiz* is effective without a holy man reciting the correct *sura* and performing *fuk* (blowing) over the talisman, there are many self-help *tabiz* books on the market. Below are two short examples from one such book.[53]

Tabiz of Jalisto Jinn



If you have traveled alone recently at night along a river or through a junction of four roads, then you have most probably been possessed by a *jalisto jinn*. The symptoms of this ailment include feeling restless, angering easily, losing interest and motivation to perform your regular daily jobs, and turning noticeably inward and silent. In order to cure this problem, you must sacrifice a red-colored hen and collect some soil from the four-road junction. Save some of the hen's blood before putting its body and the soil into a *patil* (clay pot) and securing it tightly. Put the *patil* under your bed and wait three days, at which time you will take the *patil* to a river and throw it in. Take the saved hen's blood and copy the corresponding chart onto a piece of paper. Roll up the parchment and put it into a silver *maduli* that you tie onto your right hand with *kaitan*.

Tabiz of Satar Brikkho Jinn



If you have traveled alone at night by a riverside or near a jungle, you may have been possessed by a *satar brikkho jinn*. The symptoms associated with this form of possession are chest pain, feeling a cold and heavy weight on the chest, and dizziness. Should you suffer from these indicators, you must donate a goat, 4 kilograms of wheat, 500 grams of butter, and 18 feet of cloth to a very poor man*. Then, sacrifice a single colored hen and use her blood to write the chart shown here on a piece of paper, which you should then roll into a silver *maduli* and tie around your right hand with *kaitan*.

* This donation to the poor is a ritual known as *sadka*, (সদ্‌কা) which carries the effect of basically showing Allah that you have helped another, so He should help you with your current problem (getting rid of the evil *jinn*, in this case).

While *tabiz* are widely popular around the country, there is a small Bangladeshi minority who believe in religious healing but do not believe that a *tabiz* can be of any help. There was one patient at the DMC who refused to wear the *tabiz* she was given from a *huzur* because she had seen on a television program that the most devout Muslims would never wear one;

[53] মাওলানা ওয়ালিউলাহ্ আববাসী [Maolana Owaliwullah Abbasi]. 2008. "আদি ও আসল: সোলেমানী খাবনামা থালনামা ও তাবীজ" [Adi o Ashol: Solemani Kabnama, Falnama o Tabiz;" "The Ancient and the Original: The King Solomon Meanings of Dreams, Astrology and Religious Talismans."] Dhaka: Naim Islami Publications.

similarly, in a *hadeeth* in the *Sunnah* narrated by Ahmad, he claims that Mohammad once said, "Whoever ties on an amulet has committed *Shirk* [(sin)]" (Ameen 2006: 277).

6.5.2 *Pani Pora and Tel Pora*

Pani Pora

There are several different ways in which *pani pora* ("enchanted water") is prepared. Some are more complicated and stringent than others, but for the most part, the methods are very similar. One technique involves the patient managing a large clay cooking pot (*patil*) into which (s)he must pour water gathered from seven different rivers. Then, the religious healer recites some *sura* and gives *fuk* (blows) over the water, which will enchant it. This water is meant for drinking, though sometimes drops of it are put on the fingers and then flicked into the patient's eyes or, if there is enough prepared, sometimes the patient will be asked to bathe in it. Very often, *tabiz* are dipped into prepared *pani pora* to give them more divine power, though in some cases, the *tabiz* itself was used to create the *pani pora*, by dipping the enchanted *tabiz* into the water along with recitation of *sura*. The *pani pora* blessing ceremony has been known to work through cell phones, audio speakers (people hold water bottles up to the speakers while the *sura* are being recited), and other long distance means.

Tel pora

Tel pora ("enchanted oil") is prepared in much the same way as *pani pora*, though most often with mustard seed oil (*shorisha tel* - সরিষা তেল); it is not drunk but rather rubbed all over the body. In cases of *manoshik rog*, the *tel pora* is sometimes only rubbed on the head and face. There are also more involved methods of preparing *tel pora*, such as taking a *kaitan* (black *tabiz* string), tying seven knots in it and putting the string into the *tel pora* before it is rubbed onto the body. Thereafter, the patient should tie the *kaitan* around his/her waist.

In *Sura Al-Noor* (The Light) 24:35, the oil of olive trees is said to be blessed, and in the *Sunnah* it is written that, "The Messenger of Allah said: 'Eat olive oil and smear it on your bodies, for it comes from a blessed tree'" (Ameen 2005: 146). Olives, however, are not readily found in the climes of Bangladesh, so other oils have been substituted for the ritual.

6.5.3 Jhar-fuk

One of the most common diagnostic and treatment methods used by traditional healers with patients who suffer from seizure-like symptoms is to tie them down and beat them with a broom (*jharu*). If the patient ceases to convulse, the healer knows that the individual is suffering from *jinn-e dhora* and can be properly treated with religious methods such as *pani pora* and *tabiz*. However, if the patient's convulsions do not stop, then some healers realize that the problem is something more serious and often refer the patient to other "doctors[54]," or sometimes directly to psychiatrists for further treatment.

Otherwise, *jhar-fuk* (ঝাড়ফুক) involves beating a possessing *jinn* out of a person (the practitioners were careful to assure me that the patients go into a trance during the beating and cannot feel it) or shoving burning incense or chili up the patient's nostrils. Sometimes, treatments like this can go on daily for a week or longer, and some patients do not survive the ordeal.

Many of these patients are purportedly young brides who are finding it difficult to adjust to their new homes, do not want to work in the households of their in-laws, do not work with the proficiency expected, or express desire to return to their natal homes. When a broom is not used, other treatment methods are to beat her with a hot iron rod that has been put in a fire or a bamboo stick whose end has been put into a fire. Sometimes, she is just poked with the end of this burning stick[55]. Other times, the healer will burn incense and force her to breathe in large quantities of the smoke.

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[54] Anyone who practices biomedicine in any form, from podiatry to psychiatry,

[55] The "iron treatment" can be translated as *istri chikitsha* (ইশতরী চিকিসা) and the "fire treatment" in general as *agun chikitsha* (আগুন চিকিসা). "Beating" can be best translated as *jhara* (ঝাড়া).

"Evidence from the *Sunnah* that points to the existence of the jinn"

On pages 48-49 of his book, Ameen (2005) recounts a narration from Matr ibn 'Abdul-Rahmaan Al-A'naq:

> Umm Abaan bint Al-Waazi' ibn Zaari' ibn 'Aamir Al-'Abdi told me, from her father, that her grandfather Al-Zaari' brought a son of his - or a son of his sister's - to the Messenger of Allaah. My grandfather said: When we came to the Messenger of Allaah in Madeenah, I said: "O Messenger of Allaah, I have with me a son of mine - or a son of my sister's - who is insane. I have brought him to you so that you may pray to Allaah for him." He said:
>
> "Bring him to me."
>
> So I took to him (the child) who was with the caravan, took off his travelling [sic] garments and dressed him in two handsome garments. Then I took him by the hand and brought him to the Messenger of Allaah. He said:
>
> "Bring him close to me and turn his back towards me."
>
> Then he took hold of his garment at the top and bottom and started hitting his back, until I could see the whiteness of his armpits, and he was saying, "Come out, enemy of Allaah; come out, enemy of Allaah." Then the child's eyes started to look different than they had before. The Messenger of Allaah sat him down in front of him and prayed for him and wiped his face. After the Messenger of Allaah had prayed for him, there was no one among the delegation who was better than him.

6.5.4 Bari Bondho

Literally meaning "closed home," this ritual is performed by driving stakes into the four corners of a home, sealing all windows and doors, and reciting *sura* as a form of religious exorcism of evil forces. Most generally, *bari bondho* (বাড়ী বন্ধ) is a treatment for *tabiz kora* and other forms of *ban mara*.[56]

[56] In a similar ritual, the *Sunnah* recounts that Abu'l-Nadr took a bucket of water and recited *Sura Al-Saaffaat* (Those Aligned in Ranks) 37:1-10 over it; subsequently, he sprinkled it in every corner of the house and reported that, "They (the jinn) screamed at me, saying, 'You have burned us! We will leave you alone'" (Ameen 2005: 75).

6.5.5 Various

Case Study: Saiful

About twenty years ago, Saiful went out into the fields to fetch the family cow. When he did not return when expected, his family began to worry and set out to look for him, but without avail. Later that evening, Saiful came home on his own, but instead of coming inside the house, he climbed a 30-yard tall *debdaru* tree and jumped into the water below. His family fished him out and drug him home as he screamed, "I will not leave; I have been bound with chains for 7 kror (70,000,000) years, so I will definitely not leave! You may try, but you shall fail!" Saiful's family did not know what to make of his outburst, which was soon accompanied by laughing a lot and talking to himself, feeling constantly tired and weak - though simultaneously restless, and suffering from spontaneous paralysis of his hands and legs.

Saiful's family brought him to several religious healers, one of which diagnosed him through a method called *boithak*, which literally means "meeting." Some men accompanied the *fakir* to Saiful's house, where they played music and sang folk songs until midnight, when the *fakir* had a *bhar* (which means "heavy" and is used to denote temporary possession by a spirit). This spirit spoke through the *fakir's* body and told the family that Saiful was being possessed by a good *jinn* who was slowly turning evil.

The first *fakir* treated Saiful with *gamcha dhowa* (গামছা ধোওয়া), which involved him buying a new *gamcha* (thin towel), collecting water from seven of Bangladesh's 213 rivers, and gathering leaves from a *nim* tree. The fakir then mixed the water, *gamcha*, and leaves together in a large vat, into which he dipped a *tabiz* and asked Saiful to bathe.

The next *fakir's* treatment method was the most effective for Saiful and involved cutting up a pumpkin (*kumra* - কুমড়া) and grinding the pieces into a juicy slush. This pumpkin juice was to be mixed with the crystal formed from the juice of a *tal* (the fruit of a *palmyra* tree), which, when the fruit's juices are heated in an oven and then let to cool, crystalize and are generally drunk pure as *tal misri* to help a sore throat or lost voice. After Saiful drunk the concoction, he was healed for about three years; however, when his symptoms returned, Saiful was unable to return to this *fakir*, as the healer had died in the mean time.

Unable to again receive the the *kumra-tal* drink, Saiful was treated with *navhi khola* (নাভী খোলা), which literally means "open navel." First, Saiful had to find a cup made out of *pitol*, a heavy, common metal in South Asia (white brass), into which he put mustard oil and garlic. The *fakir* read some *sura* over the mixture to bless it and then Saiful held the mouth of the cup to his navel for an hour.

The final traditional treatment that Saiful received before being referred to Prof. Islam by a former patient involved gathering the thorns of a *borroey* fruit tree and some *tush*, which is the blended and ground *ammon dhan* (coverings from the *ammon* rice grains that are spit out of the machines after the grains are processed). These ingredients were mixed in a jar, inside which a fire was lit that had to be tended throughout the night. In the morning, there were names of specific *sura* written in the ash at the bottom of the jar, which they brought to a river in order to cool it off and complete the ritual.

Referred to Prof. Islam, Saiful's family likens their situation to that of a drowning man who will clutch at anything - even a straw that he knows cannot bear his weight - in a last ditch effort to save himself. They have been seeking treatment from Prof. Islam for Saiful's Schizophrenia for eighteen months and are very confused as to how his medication is supposed to help. They said that they hope for positive effects, but they were upset and disenchanted by Prof. Islam's assertion that a full recovery from Saiful's problem is very unlikely, especially in such an advanced stage of the illness: "It is like diabetes or high blood pressure," Prof. Islam told the family; "It can be reduced, but it is very difficult to ever fully recover.

6.6 Ethnography of a Fakir

Shortly after my expression of interest in religious healers, my host family sat me down and told me of a *fakir* who lived very near to us. With wide eyes, they talked over each other to explain how he shackled his patients together in the winter months, marched them out to the river, and subjected them to four hours of repeated submersion in the water, simply to "find out the people who are really *pagol*" and separate them from the others without such serious mental disorders. I asked if I could meet this healer.

The room was small, dark, and rectangular with an abnormally high ceiling. The *fakir's* desk was in the middle of the room, pressed up against the wall opposite the door, dividing the space almost in half. Perpendicular to the desk were two rows of benches like stadium seating, upon which many young women a few children, an old lady, and a couple of young men were perched. Behind the *fakir*, three teenage boys clutched the bars on the window to peer into the room at different angles, breaking the rectangular hole of light into curvaceous triangles. There was another doorway leading to the rest of the small home next to the chair in which I sat. A young woman brought in four small glasses of Coke and some chocolate-covered biscuits. About midway through the interview, a middle-aged man came in to assist

the *fakir* in answering questions. The *fakir* himself was old and feeble. Thick-rimmed round glasses several decades old balanced on his small nose; he had rolled shoulders and was missing several teeth. The spectators were originally quiet and reserved, though they eventually come to overpower the *fakir* in his answers, giving their own perspectives and suggestions upon which the others elaborated. The *fakir* accepted these gallery comments as commonplace, yielding to them except in a few instances, when he again commanded attention and the room fell silent in a moment of surrender. Otherwise, he leaned back in his office chair, which nearly swallowed him, and allowed others to answer my inquiries. Signaling the end of the interview, he stood, mumbled that he had never told anyone as much about his work and that he must now bathe in preparation for an exorcism, and walked out of the room. On his way out the door, the *fakir* turned and asked whether I would like to return on Thursday to see a few curing sessions. I was sternly reminded that I must bathe just before arriving so that I would not be susceptible to the spirits that would be angered by the ensuing process. I agreed.

During my subsequent visits to the *fakir bari*, I learned that mental diseases come in many forms and have many varied etiologies: Unrequited love, sexual weakness, relationship restrictions in childhood and as a wife (and other family problems), and deep mourning are the most prominent causes of *brain-er dosh* (brain defect), a loss of mental strength developed after an individual has been faced with the aforementioned life-changing events. However, one could also be suffering from *bhor kora* (ভর করা - synonym to *jinn-e dhora*); the symptoms that the *fakir* most commonly encountered associated with this affliction included easy agitation, headaches, shouting or crying often and randomly, being 'jumpy,' and feeling disoriented or confused. He explained that, when such people developed body- and headaches, it was because the *jinn* possessing them was physically beating them.

Every Thursday the *fakir* hosted a *milad,*[57] (led by the *Imam* who also did the *namaj* (5x/day prayer)) and in which anyone could participate, not only those seeking treatment. The *milad* generally lasted around two hours and was a formal Islamic group prayer. At the *fakir bari*

[57] In order to participate in the *milad*, one must be ritually pure (ie. not ill (relatives attend on behalf of patients), freshly bathed, and not menstruating) and have brought candles, rose water, and incense sticks (*mum bati* - মোম বাতি, *gulap jol* - গোলাপ জল, and *agor bati* - আগর বাতি, respectively). The ceremony itself is a traditional Muslim communal prayer session in which all Muslims may participate. Many Bangladeshis host *milad* for occasions such as erecting a new building or moving into a new house. During the ritual, everyone gathers in a room - separated by a wall that segregates the men from the women - for about two hours and recites the *Durud Shorif*, which calls upon the power of Allah for protection.

was a mini *mazar* and the closed casket of a *pir*. Having this *pir* facilitated the *fakir's* ability to reach Allah more directly with his prayers and blessings.

The *fakir's* diagnostic and treatment methods depended on a ritual he called "*nalish*," which translates to "complaint." *Nalish* were collected in a book on the *fakir's* desk wherein patients wrote their names, addresses, and a question regarding their problems. Then, that night at around midnight, the *fakir* would meditate and pray deeply until he entered into a trance state (*bhar*) during which he was told from what the patient was suffering and what treatment he should administer: "*Ki vabe bhalo kori nijae bhabte pari na*," he explained: ("I don't even know myself how I treat my patients; [it comes from a divine source]").

I employed this *nalish* system to present my four prepared case studies as prospective patients, paid TK10 each, and returned the following day to hear the diagnoses and treatments that the *fakir* would assign to each (see Appendix 3.2). The *fakir* was hesitant to give too much information without the patient being there, but from the information I was able to gather, the most intriguing part was the increasing complexity of the prescribed *tabiz.* The first three cases were diagnosed as different forms of *jinn-e dhora* and the last as a type of *kichuni* (Epilepsy) for which a very special *tabiz*[58] was necessary to cure.

The 75-year-old *fakir* reported seeing 30-100 patients a day and having treated more than a *cror* (10,000,000) people in his 60 years in the profession[59]. His primary treatments for mental problems were issuing *tabiz*, *pani pora*, *tel pora*, *doya*, and performing *jhara* with a red, oblong, foam-filled bat. His *doya* were also palpable and consisted of knotting a piece of cloth or a *tabiz* string (*kaitan*) seven times - once for each recited *sura* - and then tying it around the patient's arm above the elbow. His *pani pora* was prepared to last a patient 21 days, drinking a little each day. (The number 21 came to him in a vision and was purported to yield optimal benefits for the patients.) Ultimately, the *fakir* repeated to me several times that the most important part of any of his treatments was a deep belief in Allah's powers: "My

[58] To make this charm, we would have to procure: (1) a tooth of a dog that died on a Saturday or a Tuesday; (2) a *tabiz* casing (*maduli)* made from 8 different metals; (3) 21 sewing needles; (4) 21 *borshi* (fishing hooks); (5) 21 different kinds of thorns (from trees, bushes, etc); (6) a vile of musk (cologne from a deer's gland located between its back and rectum); (7) *ay tanir jambra* (leather from a blacksmith's bellow); (8) soil from 101 different mosques; (9) soil from 22 different *bazaar* (markets); (10) iron/steel from a falcon's nest; (11) soil from a *shoshan* (Hindu crematorium); (12) water from both the full ebb and the full tide of a river; (13) water from a *khat* (river port); (14) river water from a river without a port; and (15) water used to wash a masthead lamp on a boat. However, if one had the necessary funds, these items could all be purchased from the *fakir* at one time.

[59] This value must be exaggerated because if it's true, then, taking only Fridays (the Muslim Holy Day) off of work and never taking another day off in 60 years, he would have had a patient load of more than 532 patients per day.

patients are healed through the blessings of Allah; faith is the key thing,"[60] he said. Such a deep belief in the healing powers of religion sometimes made it difficult to conduct interviews - for example, my translator was raked by several old women when he asked on my behalf how the *pani pora* process worked. They perceived him to be questioning its efficacy and not its process (I had meant the latter), and they became quite angry that I should be questioning the validity of Allah's role in the healing process. They returned curtly that, "faith is all that is necessary, so why do you ask more questions?" For this reason - and also for fear of losing his powers - I was not told the specific *sura* that the *fakir* recited.

Before I left at the end of my final visit, I took one last look at the chunk of several hundred metal locks hanging proudly on the wall above the *fakir's* desk. Each *pagol* that stayed at the *fakir bari* was chained up for the duration of his/her treatment. Therefore, when he successfully cured each of his mental patients, the *fakir* kept the lock as a symbolic souvenir of unlocking both the patient's physical and mental illness chains. He was looking forward to adding another lock to the collection soon, and I was granted access to interview the current *pagol* in the *fakir's* keeping.

Case Study: Mahbubur

The place where 30-year-old Mahbubur lives is bare in every aspect. There is no bed, just a thin mat on the floor and a pile of old rags for a pillow. A younger, naked man crawls on hands and knees from around a dark corner to eye me curiously but impassively. Mahbubur has put on a shirt for the interview, and I am told to wear my sandals as opposed to take them off out of respect for entering his living space. The man's right foot is attached to a chain on the floor; it appears that his world is limited to a seven foot radius that includes his toilet, shower, and bed. There are half-burned candles on the shin-high table to my right. We have a large audience behind us in the doorway and the patient does not take his eyes off of me as he speaks. He stands with his legs crossed and the other chained man behind him emerges from the shadows and leans sitting against the wall opposite us. This other *pagol* appears to be about 18-years-old and is brought some soap to bathe. The patient tries to speak to me in English, managing only that his mental problems stem from his family problems. He came to the *fakir* directly having already diagnosed himself as being a *pagol*.

Mahbubur complains of insomnia and describes how he used to take a hammer and try to break anything that he could. He worked abroad in Saudi Arabia for a while, at which point his family decided to get him married without his consent. Soon afterward, he lost all energy and desire to do anything, including go to school. When his family took him to the Farmgate Hospital for his drug addiction and suicide attempts, he was given medication but his condition only worsened. He then decided come to the *fakir bari*, where he is quite pleased with the herbal and spiritual treatments; he believes that he will be fully healed within four months. At the *fakir bari*, Mahbubur is beaten with a stick and chained to the floor, a condition that he believes is helping to heal him. He has also received *pani pora*, *tel pora*, *tabiz*, and any other treatments that come to the *fakir* during his midnight prayers. Mahbubur's perspective is that this treatment is much more humane than what he received at the hospital, and considers those conditions to be much worse.

[60] However, he also sometimes received Hindu patients, with whom he employed the same treatment methods. He shirked off my question about how the faith part works in that situation.

6.7 Conceptual Amalgamation and Medical Pluralism

Dr. Faruk once explained to me that, "Traditional healers have no government authority to practice; people go to them out of ignorance and only because they don't know that mental health problems can be treated by science." Instead, at least half of the psychiatric patients that I saw or interviewed had either previously or were simultaneously seeking pluralist mental health treatments. Dr. Faruk guessed that it would take another five decades to create the necessary awareness of psychiatry so that "everyone comes to us." In order to make this psychiatric goal a reality, Prof. Islam told me excitedly that he has trained about 2000 medical practitioners and about 4000 health practitioners in mental health issues in the past few decades to create awareness of psychiatry and to teach the people from whom the masses seek help "about mental illness." These trainees are offered an allowance while they take part in the seminars and it has led some *pir* and *kabiraj* to directly refer patients to Dr. Islam and others in the biomedical psychiatric community.

Some noteworthy examples of medical amalgamation between religio-traditional and biomedical mental health paradigms are *narikel pora* and *brain-er dosh*. I see these models as examples of possible solutions for addressing both the physical and spiritual needs of Bangladeshi mental health patients.

Case Study: Narikel Pora

One famous *pir* who works a few kilometers outside of Dhaka proper engages in *narikel pora*. He enchants the milk of a coconut, which he has instructed a patient showing symptoms of psychosis to purchase from one of the vendors on his premises. What the patient does not know is that the *pir* previously injected a small amount of psychotropic into the coconut milk, which the patient then drinks. Thus, the patient leaves feeling exorcised from his possessing *jinn* and temporary relief from his psychotic symptoms and feels that he has addressed the social expectation of seeking religious healing. The *pir* then refers the patient to a psychiatric clinic.

Similarly, some religious practitioners have been known to exorcise their patients of the *jinn* possessing them and then explain to their patients that the departed *jinn* left residual brain damage, and that they should seek additional treatment from a psychiatrist.

Case Study: Siddique and *brain-er dosh*

At 25-years-old, Siddique has been suffering from mental health problems since he was in the ninth grade, when he began dreaming about a man draped in black robes that would approach him and tell him: "I will take you away." As a result, he suffered from *mathar gorom* to the point where he would run out into the street and find random people to beat up. His intense anger made him go "totally crazy," and he would break everything he saw. Siddique experienced the same abnormal strength and energy in his body when he got angry that has been cited by other patients as proof of possession by a more powerful being. Other times, he would feel that his "brain got stuck" and he would have to lie down and not think about or do anything. Slowly, his dream changed so that the robed man would torture and beat him, and he would wake drenched in sweat.

Witnessing their uncontrollable son, Siddique's parents decided that his activities were due to the influence of an evil *jinn*, so they took him to a *huzur* who performed *jhar-fuk* in order to drive the *jinn* away. When this treatment failed to produce positive results, they took their son to a different *huzur* who diagnosed Siddique with the help of a Libra (someone born under that zodiac). The huzur closed all the doors and windows and turned out the lights. In this pitch black environment, they wrapped the Libra in a blanket and gave him a mirror to hold in his hand. The *huzur* recited some *ayat* to call the King of the *Jinn* (*jinn badsah* - জ্বীন বাডশাহ). The *jinn badsah* replied to the *huzur's* questions through the Libra as a medium. The King explained that Siddique became possessed by a *jinn* while he was walking along the path to his school; there is a very large *kali mandir* along this path, where the Hindu goddess Kali is worshipped. Kali's skin is all black and her tongue is brilliant red from drinking blood; she wears a necklace beaded with decapitated heads and holds a *kharg* sword in her hand. If there is a goddess to fear, she is the one. It was near this *mandir* that Siddique was possessed by the evil *jinn*. The King then brought his subject who was possessing the boy to speak through the Libra and departed (otherwise, the stress of controlling two *jinn* would have been too taxing for the Libra). When the Libra could see the *jinn* in the mirror he was holding in the dark room, the *huzur* hurried to capture it by reciting some *sura* over a cotton string and then tying seven knots in the string so that the *jinn* could not escape. The *huzur* then put the knotted string into a glass bottle, into which he poured boiling hot water, thereby killing the evil *jinn*.

The *huzur* then announced that the *jinn* had successfully been exorcized from Siddique's body, but that it had "eaten some blood from [his] brain," causing residual brain problems for which he referred the boy to a psychiatrist. However, the family returned home, considering the situation to have been resolved. Within a few days, Siddique's symptoms returned and his family realized that because *jinn* families are so tight-knit and they were responsible for one's death, that the *jinn's* family was returning for revenge and causing Siddique's symptoms to return.

In 2009, Siddique's family brought him to Prof. Islam's clinic where he received medication for his Schizophrenia. However, both Siddique and his family believe that he is suffering from a mixture of *jinn-e dhora* and mental problems and are wary of biomedicine, which seem to have caused Siddique's new inability to memorize, his forgetfulness, and his excessive sleeping.

Conclusion

"Giving her medication is like giving water to the leaves of a tree instead of to the roots; giving her medication will not make her father take care of her." - Mohiuddin Golam

One hundred seventeen psychiatrists. Eight psychologists. One hundred fifty-six million people. Sixteen percent adult morbidity. These numbers are staggering, but they only describe mental health care in Bangladesh within the biomedical model. There is a significant illness milieu and treatment system that also concerns itself with mental health in Bangladesh that cannot be disregarded: The traditional mental health model in Bangladesh, which is couched in popular Islamic faith.

Bangladeshi culture and its attitudes toward mental health have been shaped by a myriad of factors, including politics, language, war, religion, hierarchy, globalization, medicalization, the notion of 'self', and political, geographic, and religious isolation. Each of these variables has influenced social perceptions of and approaches to mental illness diagnostic and treatment seeking behaviors. These factors have also led to the development of an under-researched mental health tradition, unique because of its diversity of illness perspectives, culture-bound symptoms, and a pluralistic - though not amalgamative, or integrative - treatment system.

Both biomedical institutions such as the Dhaka Monorog Clinic and the National Institute of Mental Health, and traditional religious healers similarly seek to provide care to patients suffering from mental illness. However, because these two paradigms find themselves continually at odds with each other, neither is capable of providing the comprehensive care needed by the majority of religious Bangladeshi sufferers of mental health issues. These two mental health models are working in parallel, though rarely in tandem, with each other, resulting in a highly pluralistic treatment-seeking behavior system. However, if the biomedical psychiatric system continues to disregard traditional healing and the significance

of religion to its patients, these two models will become further polarised and ineffective at appropriately addressing mental health needs.

Social and religious obligations must be recognised in mental health care; patients' health and social needs must also be addressed. The gap between traditional religious healing and biomedical psychiatry must be confronted, and will require the collaboration of multiple perspectives, models, and agents. This challenging task requires impartiality and compromise: The Bangladesh government must recognize the mental health burden of its population, the people must understand that they are not alone in their suffering, and the two mental health paradigms must find a way to integrate treatment and referral modes in order to most affectively address both spirit and symptoms.

Ultimately, I hope that the research presented in this thesis will encourage future projects involving subjects like amalgamative care initiatives that combine biomedical and religious mental health models, the recognition of the role of faith in mitigating psychological illness, culture-bound symptoms, the impact of gender on traditional diagnostic and treatment methods, and the evolution of mental disorders through prolonged treatment seeking.

Appendices

1. Glossary - Bangladeshi Mental Health and Religious Terms and Definitions

One of the most frustrating issues regarding literary research on the topic of Islam and Bangladesh in general is the lack of a universally-accepted transliteration system between the different languages. Therefore, in addition to brief definitions, the inclusion of the Bengali spelling of the terms, and a transliteration into English of the words using the transliteration system (Roman script) found in *Learning Bengali* (Dakshi 2002: 2-4), I have also begun a list of all the different ways I have found to spell the given terms in different sources. This list is by no means exhaustive, but one can easily see the issue presented when using search engines for the spelling of a word in only one of the following ways.

Term	Different Spellings	Transliteration	বাংলা	Concise Definition
Abe Jam Jam	Zam Zam	ābe jām jām	আবে জাম জাম	"The holiest water in the world" that comes from a well in Saudi Arabia and has healing powers. This water is perceived by Bangladeshis to be very helpful for mental illnesses, though it is expensive and hard to come by on the Asian subcontinent; the only real way to get any of the water is for someone to bring it back from a *hajj* to Mecca and Medina. (See also Ameen 2005, page 142-144 for more information.)
Aina Pora		āynā paṛā	আয়না পড়া	If something has been stolen, one can consult a *fakir* and, after paying the consultation fee, the diviner will tell the victim where the object is now located by looking into a mirror that reveals its location.
Ayat		āyāt	আয়াত	Individual sentences or prayers from the Qur'anic *sura*.

Term	Different Spellings	Transliteration	বাংলা	Concise Definition
Ban Mara		bān mārā	বান মারা	If one reads certain Qur'anic *sura* backward, it is known as a type of *kufori* and is material for use in black magic. (Doing harm to others is not allowed in Islam, and all harm done unto others is considered *kufori*.) The cursing act is a very prominent crime in Islam and results in its perpetrator never being able to call himself a Muslim again and forfeiting Allah's grace for all of eternity. However, this threat does not seem to have stemmed the frequency of its casting. *Ban mara* is the most well-known *kufori* curse in Bangladesh and is meant to eventually kill its victim. The curse must generally be sent indirectly to that receiving individual. This intent is accomplished by performing *kufori* to another living thing (such as a tree or a small animal), which subsequently dies and transfers the curse to the person.
Bari Bondho	Bari Bont(h)u Bari Bonto	bāṛi banḍa	বাড়ী বন্ধ	A ritual often performed by religious healers that involves driving stakes into the four corners of a home, sealing all windows and doors to the home, and reciting *sura* as a form of religious exorcism of evil forces caused generally by the placement of cursing *tabiz* (see *tabiz kora*) on the premises or another form of *ban mara*. See also "Bondhu Ghor."
Batash Laga		bātās lāgā	বাতাস লাগা	*Hawa* (wind) and *batash laga* (more common) are synonyms to *kharap batash* and is a form of remote possession.
Bati Chalan		bāḍhi cālān	বাটি চালান	Literally translated to "continuously running bowl," this ritual is performed in order to determine where in a house an evil *tabiz* (see *tabiz kora*) has been hidden. The family engages a local religious healer who comes to the home with his *Libra* assistant. The *Libra* holds out a large bowl into which the *huzur* recites some *sura* and performs *fuk*. Then, the bowl will start to move on its own, pulling the *Libra* behind it to the place where the *tabiz* has been hidden or buried. When the bowl has guided the *Libra* to the hiding place, it will make circles around the actual location of the charm and show the *huzur* where he should dig (or look under pillows/mattresses if the floor is not made out of dirt).
Bhor Kora		bhar karā	ভর করা	Synonym to *jinn-e dhora*.

Term	Different Spellings	Transliteration	বাংলা	Concise Definition
Bhoy		bhay	ভয়	*Bhoy* is an intense fear, generally of invisible things, dark places, and creatures such as snakes. Sometimes in modern clinical diagnostology, a complaint of *bhoy* is associated with trauma.
Bhut	Bhoot Būt Bhūt	bhūt	ভূত	Most often translated into English as "ghosts," these beings are bodiless spirits of humans who have been denied ascension due to being murdered, committing suicide, or receiving improper burial rites. They do not have a community and they are more a means of scaring humans than possessing or controlling them. They linger most often near their own death places, cemeteries, and other dark areas.
Bondho Ghor		baṇḍa ghar	বন্ধ ঘর	A ritual during which all windows and doors to a building are closed, and people come sit together pray to Allah for heath, protection, and other things.
Brain-er Dosh		breiner dos	ব্রেইনের দোষ	This term is literally translated to "brain sickness" and is used to mean that someone's "thinking power is not strong." This observation is usually made when observing someone by calculating, memorization, or creative projects. People with *brain-er dosh* are considered to not be able to count very high and needing a long time to grasp even simple concepts. More commonly, one hears the corresponding English term "brain defect," which is considered to be any sort of head problem. Oftentimes, traditional/religious healers will tell their patients that they have driven away the *jinn*, but the possession left them with residual "brain defect," for which they should seek help from allopathic psychiatrists. Even the illiterate use this term, and they use it to refer to anyone with a mental problem. Bangladeshis don't tend to differentiate between the Western idea of a brain and a mind, as the mind is perceived to be located in the chest with the heart, because the mind feels.
Chap		cap	চাপ	This term refers to physical pressure. Emotional and work pressure is usually referred to by the English word 'pressure.' However, one does occasionally hear the phrases: "*Kajer chap*," "*porashona chap*," and "*shomborka chap*" (work pressure, academic pressure, and relationship pressure, respectively).

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Chal Pora		cal paṛā	চাল পড়া	If something has been stolen, a *fakir* or *huzur* will send the victim *chal pora*, which is uncooked rice over which he has read the necessary *sura* and *ayat*. The theft victim then distributes the rice to many different people, including all those suspected of being the thief. The culprit will be unable to properly chew the rice and will thereby give away his guilt.
Chinta kora		cintā karā	চিন্তা করা	Excessive and circuitous thinking, most often associated with mental disorders due to unrequited love issues; dwelling on something.
Dab Pora		ḍāb paṛā	ডাব পড়া	See *narikel pora*.
Dhatu koi (Dhat Syndrome)		dhātu kkay	ধাতুক্ষয় (ধাতুক্ষয়)	Considered by many to be a culture-bound syndrome, *Dhat* is a feeling of intense anxiety and stress that afflicts young men who masturbate to relieve sexual tension, but who also believe that the strength of a man is held in his semen. Therefore, any loss of semen is considered to be a loss of life vitality, and those afflicted with *Dhat* generally show symptoms including physical weakness, memory loss, sleep disturbance, and unusual bodily sensations like coldness or burning.
Dhikir	Dikir Dhikr Jikir Jhikir	dhikir	ধিকির	This practice is the repetition of the many names of Allah, Qur'anic *sura*, and other prayers, and is intended to bring the chanter into a heightened spiritual state.
Doya	Daowa Doa Dowa	doyā	দোয়া	Generally, this term refers to blessings imparted upon a person by a religious leader that have come directly from Allah due to the leader's prayer on the person's behalf. However, sometimes a *doya* is a physical prayer piece, like knotting a piece of cloth or string several times (once for each recited sura) then tying the string around the patient's arm.
Dukkha		tukhha	তুখঃ	A term used to express profound sorrow or a prolonged and unforgettable sadness. Those familiar with more Western concepts generally substitute the word 'depression' for *dukkha*.
Elo-melo kota		ela-mela katā	এলো-মেলো কতা	*Elo-melo kota* is the Bengali term describing the propensity to mumble to oneself or repeat prayers repeatedly under one's breath. This culture-bound symptom is similar to the DSM-IV outlined symptom of "disorganized speech (e.g., frequent derailment or incoherence)," (1994: 286) except that the former is always housed in a religious context and refers to the Sufi practice of *dhikir*.

Term	Different Spellings	Transliteration	বাংলা	Concise Definition
Fakir	Fokir Fokīr	phakir	ফকির	Literally and historically referring to one who is homeless and wandering but is not a beggar (as they pray to earn the money they receive), these religious healers are generally more associated with the lower social strata even contemporarily. After the British Period, *fakir* have generally settled into what are known as *fakir bari*, or 'fakir house,' out of which they run religious healing practices.
Hijra		hijṛā	হিজড়া	In Bangladesh, some also call the *hijra* to heal them through song and dance. Cancer patients are particularly known for using this method of cultural healing. Contrary to the belief that *hijra* are only found in villages in India, the transgender people are present all over Bangladesh, including in Mirpur 7. (These men dress in women's clothes, and have their own, large community, which has recently led the Indian government to recognize non-gender on all official forms.) However, it is generally believed that the *hijra* healing powers only extend to physical ailments and do not reach into the realm of mental health.
Huzur	Hujur	hujur	হুজুর	The best direct English translation would be "sir," leading to the term's wide use and ambiguity. However, in Bangladesh, the term is most commonly associated with an *Imam* who practices religious healing as well as attending to his duties at the Mosque.
Jala Kore / Jale	Jhala kora	jālā kare / jāle	জালা করে / জ্বালে	The term literally translates to "to feel a burning sensation" or "burning" and this phenomenon seems to be a mental health symptom more or less unique to Bangladeshis and is understood to mean *jinn* possession. From a religio-social perspective, this is a most obvious conclusion, owing to the divine inception of the invisible creatures from smokeless fire. Thus, to feel a fiery, burning sensation throughout or over one's body obviates the presence of *jinn*. The term is also associated with the mental illness of unrequited love.
Jhara		jhāṛā	ঝাড়া	The ritual of using a broom to beat the *jinn* out of the person that it is possessing.
Jhar-Fuk	Jhar Fuq	jhāṛphūk	ঝাড়ফুঁক	*Jhar-fuk* treatment involves beating a *jinn* out of a person - most commonly with a broom - or shoving burning incense or chili up the patient's nostrils. The *fuk* part of a j*har-fuk* treatment refers to the blowing either directly onto the patient or over enchanted water (*pani pora*).

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Jinn	Jinni Gini Ginn Genie	jīn	জ্বীন	The race of beings that Allah created before humans out of smokeless fire. They are invisible to the human eye and have familial, social, political, and other structures similar to those of humans. It is important to note that the Qur'an does not use this term exclusively to refer to this race, but rather with many other, generally overlooked meanings: The slaves of Solomon, the leaders of men, evil men, Jews, and Christians. It is generally believed that any abnormality in a person's actions, behavior, speech, movement, or appearance is due to possession by a *jinn*.
Jinn-er Achor		jjīner āchar	জ্বীনের আছর	A synonym to *jinn-e dhora.*
Jinn-e Dhora		jjīne dharā	জ্বীনে ধরা	This term is used to describe the state and act of possession by a *jinn*. The possessed individual manifests unnatural behaviors and this state is similar to - but more serious than - *kharap batash*. Some symptoms of this ailment include silence, quarreling with family and friends, *mathar gorom,* weakness after pregnancy, not heeding husband's (or in-laws') orders properly, talking back to or arguing with husband or in-laws, regularly leaving home after lunch or sundown without an explicit reason to go somewhere, aimless wandering, hysteria, loneliness, and not wanting to be around other people or to talk to others; however, there are many other symptoms associated with this ailment. *Jinn-e aschor*, *jinn-e dhora*, *jinn-e dose* and *bhor kora* are all terms used interchangeably to refer to possession by *jinn*.
Kabiraj	Kobiraj Kobiraz Kabiraz	kabirāj	কবিরাজ	A type of religious healer who uses almost exclusively herbal treatments in conjunction with the recitation of *sura* and is generally understood to treat only physical ailments. There are even some *kabiraj* who specialize in and only treat specific problems, such as jaundice.

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Khadem		khātem	খাতেম	A spiritual leader who does nothing for health further than serve as a prayer delivery boy to Allah. Due to his status, people come to him and ask for his *doya* and that he engage in *milad* on their behalf. A *khadem* has two primary objectives: One is mental and the other is spiritual. The latter focuses on his relationship with Allah and acting as a conduit for those who come to him, aiding them in their search for greater faith as well. The former focuses on listening to those who come to him with more worldly problems such as needing to rid themselves of danger, earn more money, find a better career, or ameliorate family problems. *Khadem* work at a *mazar* and serve as spiritual guides and keepers of the peace in minor disputes. Originally, people only came to the *mazar* with religious objectives; however, contemporary visits include many more concerns regarding worldly affairs.
Kharap Batash		khārāp bātās	খারাপ বাতাস	Translated into English as “bad wind,” the concept has nothing to do with either weather pressure changes or the more commonly assumed scholarly reference to a bodily humor (which can be found in neighboring south Asian mental health traditions such as Ayurveda and Tibetan Medicine). Instead, *kharap batash* refers to an evil aura that surrounds a bad *jinn*, which can negatively affect any human who happens to walk through or otherwise come into contact with it. Reactions to *kharap batash* are not nearly as potent as those to direct contact with or possession by *jinn* and are therefore easier to treat.
Kharej		khārej	খারেজ	A “healer” who is simply interested in religious treatments and activities who has purchased a couple of books relating to *tabiz* and herbal concoctions and begins to offer his services. He has not undergone any actual training and is not recognized by most as having enough religious power to be helpful.
Kufri		kuphrī	কুফরী	The term refers to the rejection and disbelief in any of the Islamic pillars of faith and is etymologically related to the Arabic word *kafir*, who are unbelievers and therefore sinners.
Manoshik Rog		mānasik rog	মানসিক রোগ	“Mental illness”
Manoshik Rugi		mānasik rugī	মানসিক রুগী	“Mental patient”

Term	Different Spellings	Transliteration	বাংলা	Concise Definition
Manoshik Shastho		mānasik sāstha	মানসিক স্বাস্থ্য (মানসিক স্বাস্থ্য)	"Mental health"
Matha Ghura		māthā ghuṛā	মাথা ঘুড়া	Literally translated as "spinning head," this term is similar to constant dizziness but is not entirely the same; rather, the term is often use to denote a feeling of loss of control or bearings and is a type of headache.
Mathar Golmal		māthār golmāl	মাথার গোলমাল	This term and *matha kharap* both translate to "head is not working properly," which is colloquially construed as a mental problem.
Matha Gorom	Mata Goram	māthā garam	মাথা গরম	Literally meaning "hot headed," the term has a similar - though starker - meaning than its English counterpart: It is used to describe a state characterized by a shortness of temper and a propensity to anger easily, often leading to violent and excited behavior. Sometimes, it is used literally to denote a burning sensation in the head, but this use is rare.
Matha Kharap		māthā khārāp	মাথা খারাপ	Literally meaning "bad headed," the term is used to denote mental issues that are less severe than *pagolami* but still obvious and socially problematic. See also *mathar golmal*.
Matha Thanda		māthā ṭhāntā	মাথা ঠান্তা	Literally meaning "cool headed," the term is similar to its English translation, connoting calmness and level-headedness. However, in the case of mental health, it is sometimes used literally to describe a cold sensation in the head.
Mazar	Majar	mājār	মাজার	The gravesite - shrine - of a *pir* where the abject poor and mentally ill often gather to pray through the *pir*'s conduits called *khadem*. The *mazar* is "a good place for the *pagol* who has no ties with the family," because many people come to the shrine with *takapoisha* (money) set aside for donations, 2.5% of which must go to the homeless and destitute according to *shari'a* (Islamic) law. Oftentimes, people visit the shrine to pay off prayer debts, which are made by promising Allah that if something that the individual wishes for (a good test grade, a good job, etc.) then that person will pay Him back with donations to the poor and prayer.

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Milad		milād	মিলাদ	A form of formal Islamic group prayer led either by an *Imam* or a *Khadem* for which the participants must sometimes bring incense sticks, rose water, and candles. Men and women are separated usually by a wall through which the women can hear the prayer leader. The ceremony is often held to bless a new home or property, ward of *jinn* and other forms of evil, cleanse the soul, and ask for luck in a certain endeavor. There is much singing involved, shoes must be removed, and women must cover their heads.
Narikel Pora		nāṛikel paṛā	নাড়িকেল পড়া	Literally "enchanted coconut," another term is *dab pora* which is used to connote "enchanted green coconut." After the coconut is enchanted by *sura*, the milk is drunk by the patients.
(Bod/ Kharap) **Nazar** (Laga/ Dea)	Najar (lage) Nojor	(bad/khārāp) najar (lāgā)	(বদ/ খারাপ) **নজর** (লাগা)	A phenomenon similar to that known in other cultures as "evil eye," the affliction in Bangladesh is one affecting only small children from birth generally to age two or three (though some parents have been known to take evasive precautions until their children were five or six years old). *Nazar* is most often unknowingly caused by a stranger's praising (and thereby jealous) glance, leading to the widespread practice of Bangladeshis refusing to compliment children. The most practiced way to avoid *nazar* is to paint a coin-sized black spot (*tilak* or *tip*) on the child's left upper forehead with either eyeliner (*kajol* - কাজল) or ash. If a baby dies from *nazar*, the elder family members pierce the ears of all of the siblings as a form of protection from all evil things. One *fakir* uses *pan pora* to prevent *nazar laga*. This remedy is prepared by blessing a pan leaf with *sura* and *fuk*, dipping it in enchanted mustard seed oil (*tel*) and then rubbing the leaf on the child's navel. When the parent has finished rubbing, the leaf must be burned.
Ojha		ojhā	ওঝা	*Ohja* are commonly perceived not to be religious healers, per se, but rather someone religious who knows how to counteract spells and curses that affect both physical and mental functioning. They are exorcisers and practice practical intervention in daily life problems. *Ojha* are most commonly known for their practices of different forms of *jhar-fuk*.

Term	Different Spellings	Transliteration	বাংলা	Concise Definition
Pagol		pāgal	পাগল	This term is used very often in Bangladeshi conversation and is similar in its different meanings and connotations as the word “crazy” in English. As a noun, the word is most commonly used to label people who are living on the streets, are dirty, have no sense of who or where they are - or what they’re doing. They are commonly perceived as not caring what they eat, who throws rocks at them, or why they’re spit upon by passers by. Regarding different levels of mental health morbidity, *pagol* is the word used to connote the most extreme levels of *manoshik rog*. While general *manoshik rog* does not carry with it negative consequences for other people, *pagols* are associated with violence and *mathar gorom*, which pose a threat to those around them. The term is often used much in a similar fashion as in English: Just as a person can be “crazy in love,” so, too, can the term be used in Bengali.
Pani Pora		pāni paṛā	পানি পড়া	“Enchanted water” involves the recitation of specific Qur’anic *sura* over some water, followed by the healer blowing over its surface (*fuk*). Generally, this water is taken home with the patient in bottles that they have personally provided and drunk over a prescribed period of time. Some religious healers mandate that the water itself come from seven different rivers and others don’t seem to mind from where the water comes. Sometimes patients will not only drink, but bathe in the enchanted water. The *pani pora* blessing ceremony has been known to work through cell phones, audio speakers, and other long distance means.
Pari	Pori Pary Pory	parī	পরী	This term is used very infrequently in Bangladesh, but if one asks for a meaning, one will either hear that a *pari* is an angel or a female *jinn*. Some will say that only male *jinn* can attack a woman and only *pari* can attack and possess men. However, other sources cite *pari* as surviving from pre-Islamic stories and as being akin to the English word “fairy.” In the Middle East, most *pari* are considered to be benign supernaturals. *Pari* are not, however, ever equated with witches.
Pir	Pīr Peer	pir	পির	Widely believed to refer only to Sufi holy men, the term is also used in Bangladesh to denote the holiest tier of Islamic religious healers. Considered to be the only living beings with a direct connection to Allah, they are highly sought after as healers for both physical and mental ailments.

Term	Different Spellings	Transliteration	বাংলা	Concise Definition
Pret		pret	প্রেত	Roughly translated as a version of the English word “soul,” *pret* is generally better described as being an “essence of life” that does not remain after death.
Qur’an	Koran Koraan Quran Qur’aan	kur’ān	কুর’আন	The third and holiest of Islamic religious texts. It is known as the “Qur’an Sharif” and is the transcription of the Last Prophet - Mohammed - as he spoke as a conduit of Allah through the angel Gabriel over the period of 23 years and writen by Mohammed’s *sahabi* (disciples).
Sura	Soorah Soora Sūrah	surā	সুরা	The chapters in the Qur’an, of which there are 114 arranged from the longest (*Sura Al-Fatihah*) to the shortest (*Sura Nas*) as opposed to chronologically. The *sura* are comprised of *ayat*, which may be read and recited individually.
Tabiz	Taveez Tabij Ta’awīz	tābij	তাবিজ	A small religious talisman - the casing, *maduli*, is usually cylindrical in shape, though it can also be a box - into which a paper with Qur’anic references (written with *jaffran* ink) is rolled and sealed with dry wax. It is worn most often as a necklace, tied around the arm above the elbow, or wrapped around the waist, always on a black string known as *kaitan*.
Tabiz kora		tābij karā	তাবিজ করা	A ritual similar to *ban mara*, but where a piece of parchment with the *kufri* written on it is rolled into a *tabiz* that is buried or hidden where the victim lives.
Tel Pora		tel paṛā	তেল পড়া	“Enchanted oil” involves a process very similar to *pani pora* except that oil - most often mustard seed or peanut oil - is used instead of water. While a drop or two of this oil may be ingested in some cases, it is most commonly put to therapeutic use through massage into the body. People suffering from mental illness will receive *tel pora* that will be rubbed all over their faces and heads, as well as over the rest of their bodies, particularly if they are suffering from somatic symptoms.
Unmad		ummad	উম্মাদ	Synonym to the adjective *pagol*.
Upridosh		upri dos	উপরি দোষ	Directly translated as “an illness of excessiveness, there is usually a trigger, which causes the person to act completely abnormally, though he acts normally otherwise. An example of a different manifestation of the disorder would be a very rich person who has sufficient money for everything, but has a habit of stealing things anyway. A similar term is *upri-shobhab* and can be translated as “excessive character.”

2. Brief Encyclopedia of Bangladeshi Herbal Medicines

The first anecdote that a believer in herbal medicine in South Asia who is also familiar with modern psychotropics will provide is how biomedical psychiatric medications were largely founded due to *Rauwolfia Serpentina*[61], a plant found across the Asian subcontinent and in other tropical locations. For example, Murphy Halliburton (lecture 2009) reports that there is long-standing evidence that allopathic mental health paradigms have borrowed from Ayurveda and other traditional healing modes. Nathan Kline wrote his "Use of Rauwolfia Serpentina Benth in Neuropsychiatric Conditions" in 1954, which led to the production of Reserpine, the first affective anti-psychotic used in biomedical treatments (which is still used today to treat hypertension). These treatment methods in Ayurveda demonstrate a distinct treatment of the mind as a machine and its characterization of a cognitive tool. The exhibit at the Bangladesh National Museum in Dhaka on herbal medicine (সালোয়ার কামিজ) observes:

> Bangladesh has a rich heritage of herbal medicine. Over the centuries, people have depended on the nature around them, and through trial and error, have learned the special properties of the plant in their environment. Here traditional medicines are widely sold in bazaars, some having clear therapeutic values and some of dubious efficacy. This therapy was gradually replaced to a large extent by the use of medicines produced from pure molecules of active ingredients of medicinal herbs with a more specific or precise pharmacological activity. Scientific study of the chemistry of medicinal plants is opening up a new horizon in chemotherapy.

This blurb points out the underlying belief in how valid herbal medicines are; note that the phraseology attributes the active molecules back to the medicinal herbs themselves, thereby relegating "modern" medicine simply to a distillation of "traditional" medicine.

Below is a chart of some of the herbs used in Bangladesh for symptoms commonly associated with mental health problems, and the part of the plant that is used to supply the medicine.

Latin Name	Bengali Name	Symptoms	Part of Plant Used
Rauwolfia serpentina	Sarpagandha (সর্পগন্ধা)	Blood pressure, insomnia, brain disorder, dysentery	Roots
Coccna cordifolia	Telakucha (তেলাকুচা)	Diabetes, dermatitis, hypertension, gonorrhea	Roots/leaves

[61] A tropical shrub/small tree amed after Leonhard Rauwolf, a German botanist who died in 1596. Sometimes, the spelling is "Rauvolfia" and it is colloquially known as Indian Snakeroot (*R. Serpentina*).

Latin Name	Bengali Name	Symptoms	Part of Plant Used
Hibiscus rosa-sinensis	Jaba (জবা)	Dysentery, piles, cough, fever, anti-fertility	Roots/leaves/flowers
Datura metel	Dhuthra (ধুতুরা)	Anesthesia, pain, asthma, epilepsy, rheumatism, hypertension	Roots/leaves/seeds
Ocimum sanctum	Tulshi (তুলসী)	Stomach disorder, stimulant, cough, fever, malaria, common cold, hypertension	Leaves/flowers/seeds/ whole plant

The fact that three of these herbal medicines are used to treat blood pressure or hypertension indicates that these biomedical terms have either replaced traditional notions of the same idea or have been recently added to the therapeutic repertoire of these plants.

Bangladesh is known for its many different kinds of oils, which are not only used for *tel pora*, but also as curative agents for many other ailments, a few of which are listed below:

- Saf flower (কুসুমফুল)
- Soyabean (সয়াবীন)
- Linseed (তিসি)
- Niger seed (সারগোজাতিল)
- Sunflower (সুর্যমুখা)
- Coconut (নারিকেল)
- Mustard (সরিষা)
- Til (তিল)
- Ground nut (চীনাবাদাম)

The most common spice used by religious healers is *kali jira* (কালি জিরা) and is considered to be the best all-around herbal medicine, as it “works for all ailments.”

3. Four Prepared Case Studies

I presented the following fictional case studies of patients (demonstrating DSM-IV-specific symptoms that would denote a specific biomedical diagnosis) to various healers and elicited possible diagnoses and treatment methods based on their professional knowledge of mental health issues. The case studies were professionally reviewed and substantiated prior to dissemination by Martha L. Maness, a Licensed Mental Health Counselor and Senior Clinician in Massachusetts, USA. I chose the following biomedical disorders prior to conducing my fieldwork for the reasons provided below:

Major Depressive Episode: "Depression" has achieved perceived ubiquity as a disorder that crosses socio-cultural and physical borders. While the impetuses behind the contraction may vary (even significantly), similar symptomotologic phenomena have been documented world-wide.

Janaki is 19 years old and has recently married into a high class family with a fair amount of money, so she lives in a comfortable home, has a cell phone, and eats hearty meals regularly. Though she's only been married for four months, her in-laws have noticed that she has not made much of an effort to make friends with the other young women in her village, nor has she gone to the cinema, a reportedly favorite past time of hers. She does her chores without question but without enthusiasm, interest, or energy, and she always looks tired. Her husband says that she often cries silently to herself at night when she thinks he's sleeping, and seems to have no opinion about things that they do together. Janaki finished her schooling through the 12th grade, and though she had aspirations of attending university, she seemed secure in her parents' decision for her to marry after earning her diploma and appreciative of their efforts to find her a caring and progressive husband (who encourages her to make friends and explore her interests). Of her own accord, she remains inside their home almost all of the time, the exception being when she must go to the market to purchase food or other necessities, where she almost always forgets at least one item on her list and has been known to yell at and get very angry with vegetable sellers with whom she feels that she has to haggle an unnecessarily large amount. Last week, she threw the bag of oranges back at the woman selling them and stomped away back home without purchasing anything.

Schizophrenia: The World Health Organization (WHO) noted Schizophrenia to be one of the most prevalent mental disorders world-wide, with some of the most universal symptoms. Kiev (1964) is a strong proponent of the biological approach to mental illness and believes that, "The form of mental illness which Western psychiatry calls 'schizophrenia,' has its basis in human biology, and will be found in all cultures, though the specific content of the delusions will vary according to the cultural context" (Millard 2007: 274). Furthermore, the

WHO International Pilot Study of Schizophrenia demonstrated stark commonalities between 1202 psychotics around the world and thereby designated schizophrenia as a universal disease category (WHO IPSS 1975).

Munu is 23 years old and has stopped bathing or washing her clothing and no longer seems to care that her hair is tangled. About eight months ago, Munu miscarried her first child after six months of pregnancy, but only seemed to be sad at first. Then, a month later, she retreated from almost all aspects of social life and hardly even spoke to the members of her own family. It was then that she started insisting that she was still pregnant. Sometimes, when people would try to explain to her that her baby had died, she would go wild and start screaming, holding her stomach and go back and forth between consoling the "baby" and defending its life loudly to those who denied it. She retreated into her own, closed-off world and had little interest in doing any housework and only lay around everyday uninterested in anything but her baby. When the time came that she would have delivered had she not miscarried, and no baby came, she began to believe (but only sometimes) that she had indeed given birth to a baby boy. In the other times, she became highly emotional and accused the other members of her family, most prominently her mother-in-law, of stealing her son away from her. After meals, she would sometimes hold a wad of rags to her breast and "feed him." Munu's answers are usually only one or two words long - which are sometimes mixed up - and she often complains of unidentified and delocalized pain. Since "the birth," she shows almost no emotion and shows no interest in and a lack of motivation toward her housework, refusing to do chores or cook; this attitude is quite at odds with her behavior before the miscarriage, when she was always helpful around the house and eager to please.

Post-Traumatic Stress Disorder (PTSD): PTSD provides a unique window into both biomedical psychiatry and psychology as well as allowing for a perspective on trauma and how it is manifested in Bangladeshi culture. Many traumatologists believe their subject to be universal, though there is growing dissension of this notion among ethnopsychiatrists.

Ever since he spent a month with his uncle in a nearby village last summer (about 5 months ago), Bibu has been having nightmares and has a hard time falling asleep. Last month, he wet his bed. He wakes up sweating and rolls himself in his blanket tightly, even though it is very hot outside. He doesn't like to be hugged, held, or sit on his father's lap anymore, like most 7-year-old boys do and he once did, and he won't hold hands with his best friend, which has severely strained their relationship. He doesn't like to be around the house when his baba is home because he becomes clumsy. When his uncle came to visit for his sister's wedding, Bibu did not leave his mother's side and refused to spend time with the grown ups, even though most boys his age were very excited for the opportunity. Though he often seems

unfocused - daydreaming - at home, Bibu's grades in school have become very good and he spends many hours in the afternoons working on his homework and studying. However, he has been sent home from school four times in the last month due to acting out behaviorally and becoming uncontrollable. He goes out to play cricket in the street with the other neighborhood boys whenever he's done with his homework. The only time he comes home before he is called for supper is when he has sudden, inexplicable outbursts of anger and gets himself into a fight with the other boys about the game.

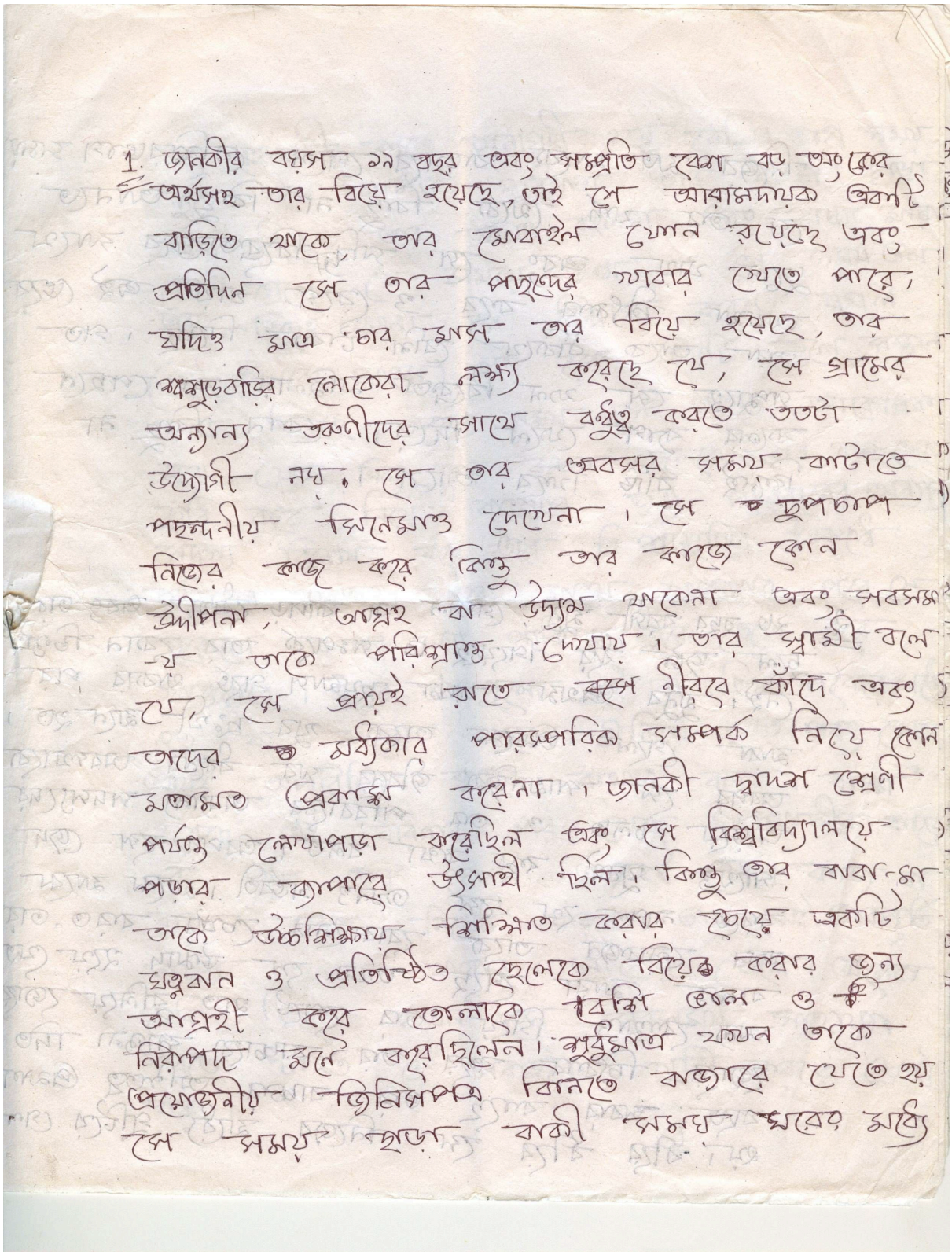
Dissociative Trance Disorder (DTD): One of the most differentiated aspects of traditional South Asian perceptions of mental health and biomedical psychiatry is the treatment of possession and physical dissociation. While severe forms are often treated biomedically as Epilepsy or Conversion Disorder, there is extensive literature outlining the ingrained value and meaning of spirits in many South Asian cultures - including Bangladesh - as playing a distinctive etiological role in lay health paradigms (eg: shamanic ritual in India (Helman 1994: 277) and the prerequisites for *Lha-mo/-pa* training in traditional Tibetan medicine (Schenk 1993)). Investigation of the relationship between DTD and possession leads to many sub-queries regarding the differentiation (or lack thereof) between ritual and somatic possession; social taboos, acceptance, and stigma; possession as a socially-acceptable means of communicating psychological and intimate antagonisms (i.e. providing a voice to oppressed women[62]); and therapeutic healing and curative methods.

Fatima sometimes loses all awareness of her surroundings and her eyes seem very distant or out of control. When this happens, she will sometimes start convulsing and talking in a language that no one can understand. The emotions that her face shows are a mix between fear, frustration, and concentration, and she shakes uncontrollably sometimes for minutes at a time. She often pantomimes actions that she does daily, like cleaning and cooking, but she does so very quickly and mumbles inaudibly throughout the movements; she never seems to notice the other people around her, as though she is alone with the object of her mime. The episode generally ends when she falls to the ground and "awakes" with no recollection of what happened.

[62] Helman notes that in some of the spirit possession cults in Africa, "women who seek power and aspire to roles otherwise monopolized by men 'act out thrusting male parts with impunity and with the full approval of the audience.' All these forms of 'abnormal' behaviour in public by large crowds of people are, however, also strictly *controlled* by norms, since their timing and location are clearly defined, and structured in advance" (1994: 249 - emphasis original).

3.1 Translations of the Four Case Studies into Bengali

Translated by Mohiuddin Roni, student of Geology at Jahangirnagar University, Savar, Dhaka.



1. জানকীর বয়স ১৯ বছর এবং সম্প্রতি বেশ বড় অঙ্কের অর্থসহ তার বিয়ে হয়েছে, তাই সে আরামদায়ক একটি বাড়িতে থাকে, তার মোবাইল ফোন রয়েছে এবং প্রতিদিন সে তার পছন্দের খাবার খেতে পারে, যদিও মাত্র চার মাস তার বিয়ে হয়েছে, তার শ্বশুরবাড়ির লোকেরা লক্ষ্য করেছে যে, সে গ্রামের অন্যান্য তরুণীদের সাথে বন্ধুত্ব করতে ততটা উদ্যোগী নয়। সে তার অবসর সময় কাটাতে পছন্দনীয় সিনেমাও দেখেনা। সে চুপচাপ নিজের কাজে করে কিন্তু তার কাজে কোন উদ্দীপনা, আগ্রহ বা উদ্যম থাকেনা এবং সবসময় তাকে পরিশ্রান্ত দেখায়। তার স্বামী বলে যে, সে প্রায়ই রাতে বসে নীরবে কাঁদে এবং তাদের মধ্যকার পারস্পরিক সম্পর্ক নিয়ে কোন মতামত প্রকাশ করেনা। জানকী দ্বাদশ শ্রেণী পর্যন্ত লেখাপড়া করেছিল এবং সে বিশ্ববিদ্যালয়ে পড়ার ব্যাপারে উৎসাহী ছিল। কিন্তু তার বাবা-মা তাকে উচ্চশিক্ষায় শিক্ষিত করার চেয়ে একটি ধনবান ও প্রতিষ্ঠিত ছেলেকে বিয়ে করার জন্য আগ্রহী করে তোলাকে বেশি ভাল ও নিরাপদ মনে করেছিলেন। মুর্মুমাত্র যখন তাকে প্রয়োজনীয় জিনিসপত্র কিনতে বাজারে যেতে হয় সে সময় ছাড়া বাকী সময় ঘরের মধ্যে

নিজের মত থাকে। বাজারে গেলে বেশিরভাগ সময়
সে তার দল থেকে কিছু না কিছু আনতে
ভুলে যায় এবং সে সব্জি বিক্রেতাদের সাথে
অযথা চীৎকার করে ও রেগে যায় এই ভেবে
তারা তাকে ঠকিয়ে বেশি টাকা নিচ্ছে। গত
সপ্তাহে সে ফল বিক্রেতা মহিলার ~~~~ পেছনে
ফলের ব্যাগ ফেলে দিয়ে, কোন কিছু না
কিনেই বাড়ি ফিরে আসে।

২. ২৩ বছর বয়সী মুনু, গোসল বা কাপড় কাঁচা এবং তার
চুলে জট বেঁধে গিয়েছে এ সম্পর্কে তার কোন চিন্তাই
নেই। মুনুর প্রথম বাচ্চা দুইমাস গর্ভে থাকার পর
মারা গেলে প্রথমে তাকে খুব দুঃখী মনে হত
এরপর সে স্বাভাবিক জীবনের সব ধরনের অবস্থাকে
এড়িয়ে চলত ও তার পরিবারের অন্যান্য সদস্যদের
সাথেও খুবই কম কথা বলত। এরপর সে জেদ
করতে লাগল যে সে তখনও গর্ভবতী। মাঝে মাঝে
যখন লোকজন তাকে বোঝানোর চেষ্টা করত, তার
বাচ্চা মারা গেছে তখন সে উন্মাদ হয়ে যেত,
অন্য কোথাও গিয়ে তার পেটে হাত বুলিয়ে জোরে
জোরে চিৎকার করে তার বাচ্চাকে লালনা দিত
যাতে সবার কাছে তার বাচ্চার অস্তিত্ব প্রমাণ
হয়। ধীরে ধীরে সে নিজের মধ্যে গুটিয়ে গেল

জিবু গৃহস্থালীর কাজে অনাগ্রহী হয়ে বেশির ভাগ সময়
মুখে বলে কাটাত, খুব্বিমাত্র তার বাচ্চা ছাড়া
অন্য কিছুতে তার আগ্রহ রইলনা জিবু বাচ্চা মারা
না গেলে যে সময়ে ভূমিষ্ঠ হত সে সময় তখন।
জিবু কিছুই হলনা সে বিশ্বাস করতে লাগল
(খুব্বি মাঝে মাঝে) যে, কেন জিবুটি ছেলে সন্তান
ভূমিষ্ঠ দিয়েছে। অন্যান্য সময় সে অত্যন্ত আবেগপ্রবণ
হয়ে যেত জিবু তার কচি ছেলেকে তার কাছ থেকে
চুরি করে নিয়ে যাওয়ার জন্য পরিবারের অন্যান্য
সদস্য বিশেষ করে তার স্বামীর বিরুদ্ধে
অভিযোগ করত। মাঝে মাঝে যাওয়ার পরে সে
পুরোনো কাপড় দলা পাকিয়ে বুকে চেপে ধরে
যাওয়াত। খুনুর উত্তরগুলো দুই বা তিন শব্দের মধ্যে
হত যা মাঝে মাঝে গুলিয়ে যেত জিবু সে
প্রায়ই অপরিচিত ব্যক্তির কাছে বলত। "বাচ্চা"
হয়েছে এই বারণার পর থেকে গৃহস্থালীর কাজে
-র প্রতি তার কোন আগ্রহই নেই। কাজ বা
রান্না করতে নিষেধ করত, তার এই ভবঘুরে
বাচ্চা মারা যাবার আগের চেয়ে অনেক
বেশি ভিন্ন যখন সে সবসময় সাহায্য
করতে চাইত ও সবাইকে খুশি করতে চেষ্টা
করত।

3. প্রায় পাঁচ মাস আগে বাচ্চেই এক গ্রামে গত গ্রীষ্মে মামার সাথে অবস্থান কাটিয়ে আসার পর থেকে প্রতি রাতে বিবুর ঘুমাতে কষ্ট হয় ও ৪ দুঃস্বপ্ন দেখে। গত মাসে সে তার বিছানা ভিজিয়ে ফেলে-ছিল, সে ঘর্মাক্ত হয়ে জেগে ওঠে এবং নিজেকে শুষ্ক করে চাদর জড়িয়ে নেয়, যদিও বাইরে অনেক গরম থাকে। সে তার বাবার কোলে উঠতে বা তাকে জড়িয়ে ধরতে ~~আর~~ পছন্দ করেনা যা বেশীরভাগ সাত বছর বয়সী বাচ্চারা করে এবং সেও এক-সময় করত, এবং সে তার সবচেয়ে প্রিয় বন্ধুর সাথও ধরেনা ও যার প্রভাবে তাদের বন্ধুত্ব ভেঙ্গে যাচ্ছে। তার বাবা যখন বাড়িতে থাকত তখন সে জড়সড় হয়ে যেত ও আশেপাশে থাকতে চাইত না। তার বোনের বিয়ে উপলক্ষে যখন তার মামা বেড়াতে গেল বিবু তার মায়ের কাছ ছেড়ে অন্যবয়সীদের সাথে থাকতে অসম্মতি জানাল, যদিও তার বয়সীরা অমন সুযোগ চাইছিল। যদিও বাড়িতে তাকে মাঝে মাঝে অন্যমনস্ক লাগত, বিবুর স্কুলের গ্রেড খুবই ভাল আসত এবং বিকেল বেলা বাড়ির কাজ, পড়া তৈরী করতে কয়েক ঘন্টা কি কাটিয়ে দিত। যাইহোক গত মাসে অবাধ্যতা ও উদ্ধত ব্যবহারের জন্য তারবার তাকে

তাকে স্কুল থেকে বাড়ি পাঠিয়ে দেয়া হয়েছে। তার বাড়ির কাজ শেষ করে সে পাশের বাড়ির ছেলেদের সাথে রাস্তায় ক্রিকেট খেলতে যায়। যেদিন সে খেলার মধ্যে হঠাৎ রেগে গিয়ে অন্যান্য ছেলেদের সাথে ঝগড়া করে সেদিন সে রাতের খাবারের আগে ফিরে আসে।

৭। ফাতিমা মাঝে তার চারপাশের অস্তিত্বকে হারিয়ে ফেলে এবং তার চোখ অন্যরকম হয়ে যায়। যখন এমন হয় তখন তার খিচুনী হয় ও ~~এমন~~ এমন ভাষায় কথা বলে যা কেউ বুঝতে পারে না। তার মুখে চেহারায় তখন ভয়, হতাশা, আরও অনেক কিছুর মিশ্র অভিব্যক্তি প্রকাশ পায়। প্রায়ই সে গৃহস্থালীর কাজ বা রান্না যা সে প্রতিদিন করে এসব কথা খুব দ্রুত ও ফিস ফিস করে বলে ও অঙ্গভঙ্গি করে দেখায়। সে তার আশেপাশের লোকজনের প্রতি খেয়াল -ই করেনা, যেন সে ছাড়া আর কেউ নেই। যখন সে মাটিতে পড়ে যায় তখন এমন করা বন্ধ হয় এবং জেগে উঠার পর তার কিছুই মনে থাকেনা।

3.2 Results of the Four Case Studies

Case Studies	Case 1	Case 2	Case 3	Case 4
DSM-IV	Depression	Schizophrenia	Post-Traumatic Stress Disorder	Dissociative Trance Disorder
Prof. Dr. Hidayetul Islam	Depressive Disorder due to marital discord	Schizophrenia with delusions	Emotional Disorder (chance of abuse that needs to be explored psychologically)	Epilepsy (Absence Disorder)
Fakir	Her memorizing power has been reduced, which is a very bad sign. When she understood that she would never study again, her brain was affected, which made her angry and became *mond-kharap* and was possessed by a very evil *jinni*. She should be brought personally to the 'fakir' and she should bring with her three bottles for *pani pora* treatment. When the girl comes, she will also receive a *tabiz*. The *fakir* wanted to have a *boithok* with her to analyze for a different treatment.	This is a miscarriage case, which means that a *jinn* possessed the patient and caused her to have a miscarriage. If the woman comes to the *fakir*, then she will have a normal child. We said that the husband only wants to make her normal again and is not concerned about a baby. Because she is possessed by a *jinn*, she should come alone on Thursday at 1100. The *fakir* did not agree to narrate any other methods of treating this case.	When he visited his uncle's house, he was possessed by a *jinn*, but is mostly suffering from *nazar* (evil eye) from his uncle. For treatment, Bibu must be brought in personally to receive treatment; the *pan pora* treatment will not work on children as old as he is.	Hers is an epileptic case, for which there is a special kind of *tabiz*. For this talisman, one needs several different ingredients: (1) a tooth of a dog that died on a Saturday or a Tuesday; (2) a *maduli* made from 8 different metals; (3) 21 sewing needles; (4) 21 *borshi* (fishing hooks); (5) 21 different kinds of thorns (from trees, bushes, etc); (6) vile of musk (cologne from a deer's gland located between its back and rectum); (7) *ay tanir jambra* (leather from a blacksmith's bellow); (8) soil from 101 different mosques; (9) soil from 22 different bazaar/markets; (10) iron/steel from a falcon's nest; (11) soil from a *shoshan* (Hindu crematorium); (12) water from both a full ebb and full tide of a river; (13) water from a *khat* (river port); (14) river water from a river without a port; (15) water used to wash a masthead lamp on a boat. However, if one has the funds, these items can all be purchased from the *fakir* at one time.
Dr. Faruk Hossain	Depressive Disorder	Schizophrenia or Delusional Disorder	Sexual Assault	Seizure Disorder (Generalized Seizure)

Case Studies	Case 1	Case 2	Case 3	Case 4
Dr. Bart Main Child and Adolescent Psychiatrist (Massachusetts, USA)	Apathy and disengagement, difficulties concentrating, interrupted sleep and weeping are symptoms of depression. The critical element to sort here is whether she is grieving the loss of her vocational opportunity and/or previous life and social connections versus she really can't identify why she is sad which indicates major depression. It would also be important to consider if she has recently begun hormonal contraception which could have a mood effect.	This sounds to me like a psychotic depression. In some cultures, hysterical somatic symptoms are common. I'm not sure whether this would be applicable in this cultural context. I would try to sort this out by getting history about her premorbid coping style since somatizing isn't usually something that comes on in adulthood but rather is a long term style.	My best guess here is that this boy was sexually abused during his visit. His outbursts, avoidance, and hyperarousal and nightmares are all symptoms of PTSD.	This story is most consistent with epilepsy. In some cultural contexts "speaking in tongues" is common but generally would be identified as a religious experience and normalized by those around her.

4. DSM-IV and ICD-10 Diagnostic Criteria

This information is copied directly from the respective manuals.

Diagnostic Criteria: DSM-IV (pg. 728)	Diagnostic Criteria: ICD-10
Dissociative Trance Disorder (Somatoform Disorder)	
A. Either (1) or (2) (1) Trance, i.e., temporary alteration in the state of consciousness or loss of customary sense of personal identity without replacement by an alternate identity, associated with at least one of the following: a) Narrowing of awareness of immediate surroundings, or unusually narrow and selective focusing on environmental stimuli b) Stereotyped behaviors or movements that are experienced as being beyond one's control (2) Possession trance, a single or episodic alteration in the state of consciousness characterized by the replacement of customary sense of personal identity by a new identity. This is attributed to the influence of a spirit, power, deity, or other person, as evidenced by one (or more) of the following: a. Stereotyped and culturally determined behaviors or movements that are experienced as being controlled by the possessing agent b. Full or partial amnesia for the event B. The trance or possession trance state is not accepted as a normal part of a collective cultural or religious practice. C. The trance or possession trance state causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. D. The trance or possession trance state does not occur exclusively during the course of a Psychotic Disorder (including Mood Disorder with Psychotic Features and Brief Psychotic Disorder) or Dissociative Identity Disorder and is not due to the direct physiological effects of a substance or a general medical condition.	**F44.3 Trance and possession disorders** Disorders in which there is a temporary loss of the sense of personal identity and full awareness of the surroundings. Include here only trance states that are involuntary or unwanted, occurring outside religious or culturally accepted situations. ***Excludes:*** states associated with: · acute and transient psychotic disorders (F23.-) · organic personality disorder (F07.0) · postconcussional syndrome (F07.2) · psychoactive substance intoxication (F10-F19 with common fourth character .0) · schizophrenia (F20.-)

Diagnostic Criteria: DSM-IV (pg.457)	Diagnostic Criteria: ICD-10
Conversion Disorder (Somatoform Disorder)	
A. One or more symptoms or deficits affecting voluntary motor or sensory function that suggest a neurological or other medical condition. B. Psychological factors are judged to be associated with the symptom or deficit because the initiation or exacerbation of the symptom or deficit is preceded by conflicts or other stressors. C. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering). D. The symptom or deficit cannot, after appropriate investigation, be fully explained by a general medical condition, or by the direct effects of a substance, or as culturally sanctioned behavior or experience. E. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation. F. The symptom or deficit is not limited to pain or sexual dysfunction, does not occur exclusively during the course of Somatization Disorder, and is not better accounted for by another mental disorder. Specify type of symptom or deficit: With Motor Symptom or Deficit With Sensory Symptom or Deficit With Seizures or Convulsions With Mixed Presentation	**F44 Dissociative [conversion] disorders** The common themes that are shared by dissociative or conversion disorders are a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements. All types of dissociative disorders tend to remit after a few weeks or months, particularly if their onset is associated with a traumatic life event. More chronic disorders, particularly paralyses and anaesthesias, may develop if the onset is associated with insoluble problems or interpersonal difficulties. These disorders have previously been classified as various types of "conversion hysteria". They are presumed to be psychogenic in origin, being associated closely in time with traumatic events, insoluble and intolerable problems, or disturbed relationships. The symptoms often represent the patient's concept of how a physical illness would be manifest. Medical examination and investigation do not reveal the presence of any known physical or neurological disorder. In addition, there is evidence that the loss of function is an expression of emotional conflicts or needs. The symptoms may develop in close relationship to psychological stress, and often appear suddenly. Only disorders of physical functions normally under voluntary control and loss of sensations are included here. Disorders involving pain and other complex physical sensations mediated by the autonomic nervous system are classified under somatization disorder (F45.0). The possibility of the later appearance of serious physical or psychiatric disorders should always be kept in mind. ***Includes:*** conversion: · hysteria · reaction hysteria hysterical psychosis ***Excludes:*** malingering [conscious simulation] (Z76.5) **F44.0 Dissociative amnesia** **F44.1 Dissociative fugue** **F44.2 Dissociative stupor** **F44.3 Trance and possession disorders** (See Dissociative Trance Disorder) **F44.4 Dissociative motor disorders** **F44.5 Dissociative convulsions** **F44.6 Dissociative anaesthesia and sensory loss** **F44.7 Mixed dissociative [conversion] disorders** **F44.8 Other dissociative [conversion] disorders** **F44.9 Dissociative [conversion] disorder, unspecified**

Diagnostic Criteria: DSM-IV (pg.327)	Diagnostic Criteria: ICD-10
Major Depressive Episode ("Depression") (Mood Disorder)	
A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of these symptoms is either (1) depressed mood or (2) loss of interest or pleasure. 1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). 2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others). 3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% body weight in a month), or decrease or increase in appetite nearly every day. 4) Insomnia or hypersomnia nearly every day. 5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down). 6) Fatigue or loss of energy nearly every day 7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick) 8) Diminished ability to think or concentrate, indecisiveness, nearly every day (either by subjective account or as observed by others) 9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. B. The symptoms do not meet criteria for a Mixed Episode (335). C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism). E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.	**F32 Depressive episode** In typical mild, moderate, or severe depressive episodes, the patient suffers from lowering of mood, reduction of energy, and decrease in activity. Capacity for enjoyment, interest, and concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem and self-confidence are almost always reduced and, even in the mild form, some ideas of guilt or worthlessness are often present. The lowered mood varies little from day to day, is unresponsive to circumstances and may be accompanied by so-called "somatic" symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression worst in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. Depending upon the number and severity of the symptoms, a depressive episode may be specified as mild, moderate or severe. ***Includes:*** single episodes of: · Depressive reaction · Psychogenic depression · Reactive depression ***Excludes:*** Adjustment disorder (F43.2) Recurrent depressive disorder (F33.-) When associated with conduct disorders in F91.- (F92.0) **F32.0 Mild depressive episode** Two or three of the above symptoms are usually present. The patient is usually distressed by these but will probably be able to continue with most activities. **F32.1 Moderate depressive episode** Four or more of the above symptoms are usually present and the patient is likely to have great difficulty in continuing with ordinary activities. **F32.2 Severe depressive episode without psychotic symptoms** An episode of depression in which several of the above symptoms are marked and distressing, typically loss of self-esteem and ideas of worthlessness or guilt. Suicidal thoughts and acts are common and a number of "somatic" symptoms are usually present. Agitated depression; Major depression; Vital depression Single episode without psychotic symptoms

Diagnostic Criteria: DSM-IV (pg. 286)	Diagnostic Criteria: ICD-10
Schizophrenia (Psychotic Disorder)	
A. *Characteristic symptoms*: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated): - Delusions - Hallucinations - Disorganized speech (e.g., frequent derailment or incoherence) - Grossly disorganized or catatonic behavior - Negative symptoms, i.e., affective flattening, alogia, or avolition B. *Social/occupational dysfunction*: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement). C. *Duration*: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences). D. *Schizzoaffective and Mood Disorder Exclusion*: Schizoaffective Disorder and Mood Disorder With PSychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods. E. *Substance/general medical condition exclusion*: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition. F. *Relationship to a Pervasive Developmental Disorder*: If there is a history of Autistic Disorder or another Pervasive Development Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).	**F20 Schizophrenia** The schizophrenic disorders are characterized in general by fundamental and characteristic distortions of thinking and perception, and affects that are inappropriate or blunted. Clear consciousness and intellectual capacity are usually maintained although certain cognitive deficits may evolve in the course of time. The most important psychopathological phenomena include thought echo; thought insertion or withdrawal; thought broadcasting; delusional perception and delusions of control; influence or passivity; hallucinatory voices commenting or discussing the patient in the third person; thought disorders and negative symptoms. The course of schizophrenic disorders can be either continuous, or episodic with progressive or stable deficit, or there can be one or more episodes with complete or incomplete remission. The diagnosis of schizophrenia should not be made in the presence of extensive depressive or manic symptoms unless it is clear that schizophrenic symptoms antedate the affective disturbance. Nor should schizophrenia be diagnosed in the presence of overt brain disease or during states of drug intoxication or withdrawal. Similar disorders developing in the presence of epilepsy or other brain disease should be classified under F06.2, and those induced by psychoactive substances under F10-F19 with common fourth character .5. ***Excludes:*** Schizophrenia: · Acute (undifferentiated) (F23.2) · Cyclic (F25.2) Schizophrenic reaction (F23.2) Schizotypal disorder (F21) **F20.0 Paranoid schizophrenia** Paranoid schizophrenia is dominated by relatively stable, often paranoid delusions, usually accompanied by hallucinations, particularly of the auditory variety, and perceptual disturbances. Disturbances of affect, volition and speech, and catatonic symptoms, are either absent or relatively inconspicuous. Paraphrenic schizophrenia ***Excludes:*** Involutional paranoid state (F22.8) Paranoia (F22.0)

Diagnostic Criteria: DSM-IV (pg. 422-423)	Diagnostic Criteria: ICD-10
Obsessive Compulsive Disorder (Anxiety Disorder)	
A. Either obsessions or compulsions: *Obsessions as defined by (1), (2), (3), and (4):* (1) recurrant and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress (2) the thoughts, impulses, or images are not simply excessive worries about real-life problems (3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action (4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion) *Compulsions as defined by (1) and (2):* (1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly (2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. Note: This does not apply to children. C. The obsessions or compulsions caused marked distress, are time consuming (take more than 1 hour per day), or significantly interfere with the person's normal routine, occupational (or academic functioning), or unusual social activities or relationships. D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder). E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.	**F42 Obsessive-compulsive disorder** The essential feature is recurrent obsessional thoughts or compulsive acts. Obsessional thoughts are ideas, images, or impulses that enter the patient's mind again and again in a stereotyped form. They are almost invariably distressing and the patient often tries, unsuccessfully, to resist them. They are, however, recognized as his or her own thoughts, even though they are involuntary and often repugnant. Compulsive acts or rituals are stereotyped behaviours that are repeated again and again. They are not inherently enjoyable, nor do they result in the completion of inherently useful tasks. Their function is to prevent some objectively unlikely event, often involving harm to or caused by the patient, which he or she fears might otherwise occur. Usually, this behaviour is recognized by the patient as pointless or ineffectual and repeated attempts are made to resist. Anxiety is almost invariably present. If compulsive acts are resisted the anxiety gets worse. ***Includes:*** anankastic neurosis obsessive-compulsive neurosis ***Excludes:*** obsessive-compulsive personality (disorder) (F60.5) **F42.0 Predominantly obsessional thoughts or ruminations** These may take the form of ideas, mental images, or impulses to act, which are nearly always distressing to the subject. Sometimes the ideas are an indecisive, endless consideration of alternatives, associated with an inability to make trivial but necessary decisions in day-to-day living. The relationship between obsessional ruminations and depression is particularly close and a diagnosis of obsessive-compulsive disorder should be preferred only if ruminations arise or persist in the absence of a depressive episode. **F42.1 Predominantly compulsive acts [obsessional rituals]** The majority of compulsive acts are concerned with cleaning (particularly handwashing), repeated checking to ensure that a potentially dangerous situation has not been allowed to develop, or orderliness and tidiness. Underlying the overt behaviour is a fear, usually of danger either to or caused by the patient, and the ritual is an ineffectual or symbolic attempt to avert that danger. **F42.2 Mixed obsessional thoughts and acts** **F42.8 Other obsessive-compulsive disorders** **F42.9 Obsessive-compulsive disorder, unspecified**

Diagnostic Criteria: DSM-IV (pg.355-358)	Diagnostic Criteria: ICD-10
Bipolar Disorder (Mood Disorder)	
Bipolar 1 Disorder, Single Manic Episode A. Presence of only one Manic Episode (see p. 332) and no past major Depressive Episodes. (Note: Recurrence is defined as either a change in polarity from depression or an interval of at least two months without manic symptoms.) B. The Manic Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizopreniform Disorder, Delusional Disorder, or Psychotic Disorder not otherwise specified. Bipolar 1 Disorder, Most Recent Episode Hypomanic A. Currently (or most recently) in a Hypomanic Episode (see p.338). B. There has previously been at least one Manic Episode or Mixed Episode (see p. 335). C. The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. D. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizopreniform Disorder, Delusional Disorder, or Psychotic Disorder not otherwise specified. Bipolar 1 Disorder, Most Recent Episode Manic A. Currently (or most recently) in a Manic Episode. B. There has previously been at least one Major Depressive Episode (see p. 327), Manic Episode (see p. 332) or Mixed Episode (see p. 335). C. (Same as Most Recent Episode Hypomanic - D) Bipolar 1 Disorder, Most Recent Episode Mixed A. Currently (or most recently) in a Mixed Episode B. There has previously been at least one Major Depressive Episode, Manic Episode or Mixed Episode. C. (Same as Most Recent Episode Hypomanic - D) Bipolar 1 Disorder, Most Recent Episode Depressed A. Currently (or most recently) in a Major Depressive Episode (see p. 327) B. There has previously been at least one Manic Episode or Mixed Episode. C. (Same as Most Recent Episode Hypomanic - D) Bipolar 1 Disorder, Most Recent Episode Unspecified A. Criteria, except for duration, are currently (or most recently) met for a Manic, a Hypomanic, a Mixed, or a Major Depressive Episode. B. There has previously been at least one Manic Episode or Mixed Episode. C. The mood symptoms cause clinically signifiant distress or impairment in social, occupational, or other important areas of functioning. D. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder ad are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disrder Not Otherwise Specified. The mood symptoms in Criteria A and B eare not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).	**F30 Manic episode** All the subdivisions of this category should be used only for a single episode. Hypomanic or manic episodes in individuals who have had one or more previous affective episodes (depressive, hypomanic, manic, or mixed) should be coded as bipolar affective disorder (F31.-). ***Includes:*** bipolar disorder, single manic episode **F30.0 Hypomania** A disorder characterized by a persistent mild elevation of mood, increased energy and activity, and usually marked feelings of well-being and both physical and mental efficiency. Increased sociability, talkativeness, over-familiarity, increased sexual energy, and a decreased need for sleep are often present but not to the extent that they lead to severe disruption of work or result in social rejection. Irritability, conceit, and boorish behaviour may take the place of the more usual euphoric sociability. The disturbances of mood and behaviour are not accompanied by hallucinations or delusions. **F30.1 Mania without psychotic symptoms** Mood is elevated out of keeping with the patient's circumstances and may vary from carefree joviality to almost uncontrollable excitement. Elation is accompanied by increased energy, resulting in overactivity, pressure of speech, and a decreased need for sleep. Attention cannot be sustained, and there is often marked distractibility. Self-esteem is often inflated with grandiose ideas and overconfidence. Loss of normal social inhibitions may result in behaviour that is reckless, foolhardy, or inappropriate to the circumstances, and out of character. **F30.2 Mania with psychotic symptoms** In addition to the clinical picture described in F30.1, delusions (usually grandiose) or hallucinations (usually of voices speaking directly to the patient) are present, or the excitement, excessive motor activity, and flight of ideas are so extreme that the subject is incomprehensible or inaccessible to ordinary communication. Mania with: · mood-congruent psychotic symptoms · mood-incongruent psychotic symptoms Manic stupor **F31 Bipolar affective disorder** A disorder characterized by two or more episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (hypomania or mania) and on others of a lowering of mood and decreased energy and activity (depression). Repeated episodes of hypomania or mania only are classified as bipolar. ***Includes:*** manic-depressive: · illness · psychosis · reaction ***Excludes:*** bipolar disorder, single manic episode (F30.-) cyclothymia (F34.0) **F31.8 Other bipolar affective disorders** Bipolar II disorder Recurrent manic episodes NOS

Diagnostic Criteria: DSM-IV (pg. 428)	Diagnostic Criteria: ICD-10
Post-Traumatic Stress Disorder (Anxiety Disorder)	
A. The person has been exposed to a traumatic event in which both of the following were present: - The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat tot he physical integrity of self or others - The person's response involved intense fear, helplessness, or horror. B. The traumatic event is persistently reexperienced in one (or more) of the following ways: - Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. - Recurrent distressing dreams of the event. - Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). - Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event - Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following: - Efforts to avoid thoughts, feelings, or conversations associated with the trauma - Efforts to avoid activities, places, or people that arouse recollections of the trauma - Inability to recall an important aspect of the trauma - Markedly diminished interest or participation in significant activities - Feeling of detachment or estrangement from others - Restricted range of affect (eg., unable to have loving feelings) - Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal lifespan) D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following: - Difficulty falling or staying asleep - Irritability or outbursts of anger - Difficulty concentrating - Hypervigilance - Exaggerated startle response E. Duration of the disturbance (symptoms in criteria B, C, and D) is more than 1 month. F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.	**F43.1 Post-traumatic stress disorder** Arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. Predisposing factors, such as personality traits (e.g. compulsive, asthenic) or previous history of neurotic illness, may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. Typical features include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks"), dreams or nightmares, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma. There is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are commonly associated with the above symptoms and signs, and suicidal ideation is not infrequent. The onset follows the trauma with a latency period that may range from a few weeks to months. The course is fluctuating but recovery can be expected in the majority of cases. In a small proportion of cases the condition may follow a chronic course over many years, with eventual transition to an enduring personality change (F62.0). Traumatic neurosis

5. Dhaka Monorog Clinic Statistics

5.1 Symptoms

Non-Directed Symptoms Expressed by Patients Tallied by Biomedical Diagnosis

Symptoms (expressed by patient or 'gatekeeper'/family member; non-directed)	**Schizophrenia**		**Bi-Polar Disorder**		**Depression**		**Obsessive Compulsive Disorder**		**Epilepsy**		**Emotional (Stress) Disorder**		**Substance Abuse Disorder**		**Post-Traumatic Stress Disorder**		**Acute Panic Episode**		(Mal-) **Adjustment Disorder** (+Personality Disorder)		**Conversion/ Dissociative Disorder**		**Mental Retardation**		**Somatization Disorder**		**Anxiety Disorder**		**Post-Infective Confusional State**		**Total number of patients complaining of given symptom**		
Somatic	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	⚥
Loss of appetite	3	3	2	5	5	7						1	1															2			11	18	29
Talks to self/random mumbling (*elo-melo kota*)	9	6	1	1	1	1							1																		12	8	20
Headache (*mathar beta*)	2	1	1	2	1	3				2	1	2										1				1				1	5	13	18
Physical weakness	5	2	1	2		3	1																								7	7	14
Cannot speak/quiet	3	3		2	2					1												1		1						1	5	9	14
Dizziness ("spinning head" / *matha ghura*)	1	3	1	1	2	1				1																	1	1			5	7	12
Hands shake (uncontrollably)	1	3		4	1						1								1												4	7	11
Memory loss	2	2	1		1	3						1															1				5	6	11
Unlocalized physical pain		1	1			2					1	2							1							1					3	6	9
Fainting spells		1							1	5		1												1							1	8	9
Neck pain	1				1	2						2				1						1						1			2	7	9
Fever			1	1	1	2					1																1	1		1	4	5	9
High blood sugar/pressure		3				2				1	1	1																			1	7	8
Chest/stomach/diaphragm pain	1			1		3					1																1	1			3	5	8
Breathing problems	1	1			1							2				1											1				3	4	7
Loss of sensation/temporary paralysis		2		2																		1									0	5	5
Convulsions/shaking		1								1	1	1										1									1	4	5
Difficulty walking		1	1								1	1										1									2	3	5
Nausea	1	2			1																						1				3	2	5
Lack of sexual interest						2	1					2																			1	4	5
Weight gain	1	1	1	1																											2	2	4
Bodily contortions/flailing			1							1												1		1							1	3	4
Hand/wrist/finger pain						2																				1					0	3	3
Disorientation	1			1		1																									1	2	3
Heavy head (*matha bhar*)	2																										1				3	0	3
Impotence	1		1		1																										3	0	3
Rocks back and forth		1				1		1																							0	3	3
Back pain			1	1	1																										2	1	3
Somatic problems ∴ menopause				1		1																						1			0	3	3
Sweats profusely						2																									0	2	2
Burning throat	1				1																										2	0	2
Trouble chewing		1			1																										1	1	2
Poor kidney function				1		1																									0	2	2
Sporadic loss of eyesight	2																														2	0	2
Burning head	1																					1									1	1	2
Speaks slowly	1	1																													1	1	2
Physical illness				1		1																									0	2	2
"Brain defect"/belief of abscess inside the head		1																												1	0	2	2
Increased heartrate																												1			0	1	1
Knee pain																						1									0	1	1
Hyperthyroidism				1																											0	1	1
Light head							1																								1	0	1

Symptoms (expressed by patient or 'gatekeeper'/family member; non-directed)	**Schizophrenia**		**Bi-Polar Disorder**		**Depression**		**Obsessive Compulsive Disorder**		**Epilepsy**		**Emotional (Stress) Disorder**		**Substance Abuse Disorder**		**Post-Traumatic Stress Disorder**		**Acute Panic Episode**		**(Mal-) Adjustment Disorder** (+Personality Disorder)		**Conversion/ Dissociative Disorder**		**Mental Retardation**		**Somatization Disorder**		**Anxiety Disorder**		**Post-Infective Confusional State**		**Total number of patients complaining of given symptom**		
Body itches all over			1																												1	0	1
Sniffles											1																				1	0	1
Dehydration	1																														1	0	1
Liver problems						1																									0	1	1
Toothache																											1				0	1	1
Toothache						1																									0	1	1
Cold headed (*Mathar thanda*)	1																														1	0	1
Swelling legs			1																												1	0	1
Heavy tongue (*muk jorna jai*)	1																														1	0	1
Hands and legs lose warmth	1																														1	0	1
Burning all over the body						1																									0	1	1
Loss of taste					1																										1	0	1
Grinds teeth		1																													0	1	1
Multi-dimensional speech				1																											0	1	1
Monotone speech (*jikir*)				1																											0	1	1
Tried to rip out own hair										1																					0	1	1
Electrolyte imbalance						1																									0	1	1
Premature ejaculation																													1		1	0	1
Loss of memorizing power	1																														1	0	1
Totals	45	41	16	30	22	44	3	1	1	13	9	16	2	0	0	2	0	0	2	0	0	9	0	3	0	3	8	9	0	4	108	175	283

Symptoms (expressed by patient or 'gatekeeper'/family member; non-directed)	**Schizophrenia**		**Bi-Polar Disorder**		**Depression**		**Obsessive Compulsive Disorder**		**Epilepsy**		**Emotional (Stress) Disorder**		**Substance Abuse Disorder**		**Post-Traumatic Stress Disorder**		**Acute Panic Episode**		**(Mal-) Adjustment Disorder** (+Personality Disorder)		**Conversion/ Dissociative Disorder**		**Mental Retardation**		**Somatization Disorder**		**Anxiety Disorder**		**Post-Infective Confusional State**		**Total number of patients complaining of given symptom**		
Behavioral/Social	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂
Insomnia/sleep disturbance/ always tired	8	6	3	5	5	10				1		5	1											1			1	2			18	30	48
Paranoid/suspicious feelings	17	9				4	1						1				1											1			20	14	34
Restless/fidgety	9	1	2	2	1	4	1		1	1	1	1										1					1	1			16	11	27
Lack of interest in school/job/ chores/other daily activities	4	1	1	1	4	6			1		1	2															1				12	10	22
Sleeps excessively	6	4	1	3	3	3						1															1				11	11	22
Auditory hallucinations	13	8											1																		14	8	22
Trouble with social integration	6	4	1		2	3		1	1		1											1		1							11	10	21
Lack of self-care	5	6		1		1				1												1		2							5	12	17
Excitable/shouts	5	2	3	3		1							2											1							10	7	17
Violent behavior/outbursts/ aggressiveness	2	4	1	2	1	1			1	1	2		1																		8	8	16
Withdrawn	2	3	1	2	1	2						1																			4	8	12
Drug/substance/internet/ gambling addiction	1		1		2								5						1												10	0	10
Talkative/loquacious	1		4	2						1										1											5	4	9
Cannot concentrate	5		1		2		1																								9	0	9
Animated/jovial			3	1		2						1																			3	4	7
Wandering/random walking	4			1		2																									4	3	7
Cannot control thoughts	2	2					2																								4	2	6
Suicide threats/attempts	2					2						1																			2	3	5
Washes/bathes incessantly		1				1	1	2																							1	4	5
Completely dependent				2																		1		2							0	5	5

Symptoms (expressed by patient or 'gatekeeper'/family member; non-directed)	**Schizophrenia**		**Bi-Polar Disorder**		**Depression**		**Obsessive Compulsive Disorder**		**Epilepsy**		**Emotional (Stress) Disorder**		**Substance Abuse Disorder**		**Post-Traumatic Stress Disorder**		**Acute Panic Episode**		(Mal-) **Adjustment Disorder** (+Personality Disorder)		**Conversion/ Dissociative Disorder**		**Mental Retardation**		**Somatization Disorder**		**Anxiety Disorder**		**Post-Infective Confusional State**		**Total number of patients complaining of given symptom**		
Visual hallucinations	2	3																													2	3	5
Introverted	1			1	1	1																									2	2	4
Irrational behavior/impulsive	1			1		1					1																				2	2	4
Cannot control actions	2	2																													2	2	4
Afraid of being alone				1		1						1					1														1	3	4
Quarrels often with family				1	1	1							1																		2	2	4
Writes in air/on desk with finger	1					1						1																			1	2	3
Increased religious fervor		1	1	1																											1	2	3
Uncooperative			1	1	1																										2	1	3
Claustrophobia				1	1																						1				2	1	3
Lack of confidence	1					1						1																			1	2	3
Lack of patience/tolerance		1		1																											0	2	2
Cannot tolerate old/dirty		1						1																							0	2	2
100-yard stare	1	1																													1	1	2
Cannot make simple decisions					1																						1				2	0	2
Financially irresponsible													2																		2	0	2
Cannot tolerate siblings		1								1																					0	2	2
Unaware of surroundings	1	1																													1	1	2
Craves attention						1																									0	1	1
Self-punishment/humiliation				1																											0	1	1
Lazy									1																						1	0	1
Reading Qur'an very loudly				1																											0	1	1
Apologizes excessively	1																														1	0	1
Saluting everyone around	1																														1	0	1
Feels others can read mind		1																													0	1	1
Public indecency	1																														1	0	1
Thinks people look at him/her differently							1																								1	0	1
Feels others are making passes at spouse	1																														1	0	1
"Behavior problem"											1																				1	0	1
"Type-A personality"							1																								1	0	1
Lies often								1																							0	1	1
Cannot tell time																						1									0	1	1
Confused																														1	0	1	1
Fantasies																				1											0	1	1
Totals	106	63	24	35	26	49	8	5	5	6	7	15	14	0	0	0	2	0	1	2	0	5	0	7	0	0	6	4	0	1	199	192	391

Symptoms (expressed by patient or 'gatekeeper'/family member; non-directed)	**Schizophrenia**		**Bi-Polar Disorder**		**Depression**		**Obsessive Compulsive Disorder**		**Epilepsy**		**Emotional (Stress) Disorder**		**Substance Abuse Disorder**		**Post-Traumatic Stress Disorder**		**Acute Panic Episode**		(Mal-) **Adjustment Disorder** (+Personality Disorder)		**Conversion/ Dissociative Disorder**		**Mental Retardation**		**Somatization Disorder**		**Anxiety Disorder**		**Post-Infective Confusional State**		**Total number of patients complaining of given symptom**		
Emotional	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂
Angers easily (*mathar gorom*)	7	5	4	6	4	5	1	2	1	2	2	1	2														1				22	21	43
"Depressed"/acute sadness (*hotasha*)		2	2	1	2	9						3															1	2			5	17	22
Emotional swings (low->high...)	2	3	1	2		5				1	1	1						1										2			4	15	19
"Anxiety"/"tension"		2	1	1	1	3	1					1																2		1	3	10	13
Cries easily and a lot		2		2		5						2																1			0	12	12
Easily frightened/irrational fear	2	1		4		3				1		1																			2	10	12

Symptoms (expressed by patient or 'gatekeeper'/family member; non-directed)	**Schizophrenia**		**Bi-Polar Disorder**		**Depression**		**Obsessive Compulsive Disorder**		**Epilepsy**		**Emotional (Stress) Disorder**		**Substance Abuse Disorder**		**Post-Traumatic Stress Disorder**		**Acute Panic Episode**		(Mal-) **Adjustment Disorder** (+Personality Disorder)		**Conversion/ Dissociative Disorder**		**Mental Retardation**		**Somatization Disorder**		**Anxiety Disorder**		**Post-Infective Confusional State**		**Total number of patients complaining of given symptom**		
Lethargy/lack of emotion/drive	2	2			2	4						1																			4	7	11
Frantic	1			3	1	1																									2	4	6
Fear of (impending) death			1	1	1	1											1										1				4	2	6
Constantly annoyed	1	2				1						1																			1	4	5
Easily annoyed/irritable				1	1	1						1																1			1	4	5
Self-blame/guilt		2	1							1																					1	3	4
Low self-esteem (beauty)						1						1																			0	2	2
Panicky						1																									0	1	1
Feels lonely					1																										1	0	1
Dwells on memories of aggression in childhood							1																								1	0	1
Dwells on the future								1																							0	1	1
"Dashed dreams"							1																								1	0	1
Pessimistic																			1												1	0	1
Totals	15	21	10	21	13	40	4	3	1	5	3	13	2	0	0	0	1	1	1	0	0	0	0	0	0	0	3	8	0	1	53	113	166

Symptoms (expressed by patient or 'gatekeeper'/family member; non-directed)	**Schizophrenia**		**Bi-Polar Disorder**		**Depression**		**Obsessive Compulsive Disorder**		**Epilepsy**		**Emotional (Stress) Disorder**		**Substance Abuse Disorder**		**Post-Traumatic Stress Disorder**		**Acute Panic Episode**		(Mal-) **Adjustment Disorder** (+Personality Disorder)		**Conversion/ Dissociative Disorder**		**Mental Retardation**		**Somatization Disorder**		**Anxiety Disorder**		**Post-Infective Confusional State**		**Total number of patients complaining of given symptom**		
Causal Factors	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	⚥
Jinn possession (*Jinn-e dhora)*	4	5	1	5	1	3				1		2																			6	16	22
Medication non-compliance	8	4	3	3						1		1																		1	11	10	21
Financial/economic issues	5	1	2	1	1	2						1	1						1								1				11	5	16
Family problems/separation/ abroad	3	4				1						1																			3	6	9
Trouble with in-laws		1		1		3						2																1			0	8	8
Physically abused		2		1		2						2																			0	7	7
Arranged marriage	1	1		1		3						1																			1	6	7
Subject of blame						2						3				1															0	6	6
Unrequited love						2					1	2								1											1	5	6
Has "sinned"		2	1	1						1																					1	4	5
Forced to engage sexually						2						2																			0	4	4
Divorced		1			1	1		1																							1	3	4
Genetic predisposition	1	2																													1	2	3
Unemployed	2																										1				3	0	3
Pregnant		1				1																						1			0	3	3
Cannot conceive a baby						1																						1			0	2	2
Mishandling of the Qur'an			1							1																					1	1	2
Barrenness		1																													0	1	1
Overworked		1																													0	1	1
Chained up			1																												1	0	1
Son recently died in auto accident					1																										1	0	1
Labeled as "Pagol"				1																											0	1	1
Not married					1																										1	0	1
Recently began menstruating																						1									0	1	1
Totals	24	26	9	14	5	23	0	1	0	4	1	17	1	0	0	1	0	0	1	1	0	1	0	0	0	0	2	4	0	0	43	92	135
Sum Totals	190	151	59	100	66	156	15	10	7	28	20	61	19	0	0	3	3	1	5	3	0	15	0	10	0	3	19	25	0	6	403	572	975

5.2 Symptoms for Individual Biomedical Diagnoses

Schizophrenia

Symptoms (expressed by patient or 'gatekeeper'/family member; non-directed)	**Schizophrenia** ♂	♀	Total
Paranoid/suspicious feelings	17	9	26
Auditory hallucinations	13	8	21
Talks to self/random mumbling (*elo-melo kota*)	9	6	15
Insomnia/sleep disturbance/ always tired	8	6	14
Medication non-compliance	8	4	12
Angers easily (*mathar gorom*)	7	5	12
Lack of self-care	5	6	11
Restless/fidgety	9	1	10
Sleeps excessively	6	4	10
Trouble with social integration	6	4	10
Jinn possession (*Jinn-e dhora*)	4	5	9
Physical weakness	5	2	7
Excitable/shouts	5	2	7
Family problems/separation/ abroad	3	4	7
Financial/economic issues	5	1	6
Loss of appetite	3	3	6
Cannot speak/quiet	3	3	6
Violent behavior/outbursts/ aggressiveness	2	4	6
Cannot concentrate	5		5
Lack of interest in school/job/ chores/other daily activities	4	1	5
Withdrawn	2	3	5
Visual hallucinations	2	3	5
Emotional swings (low->high...)	2	3	5
Wandering/random walking	4		4
Memory loss	2	2	4
Cannot control thoughts	2	2	4
Cannot control actions	2	2	4
Lethargy/lack of emotion/drive	2	2	4
Dizziness ("spinning head" / *matha ghura*)	1	3	4
Hands shake (uncontrollably)	1	3	4
Headache (*mathar beta*)	2	1	3
Easily frightened/irrational fear	2	1	3
Nausea	1	2	3
Constantly annoyed	1	2	3
Genetic predisposition	1	2	3
High blood sugar/pressure		3	3
Heavy head (*matha bhar*)	2		2
Sporadic loss of eyesight	2		2
Suicide threats/attempts	2		2
Unemployed	2		2
Breathing problems	1	1	2
Weight gain	1	1	2
Speaks slowly	1	1	2
100-yard stare	1	1	2
Unaware of surroundings	1	1	2
Arranged marriage	1	1	2
Loss of sensation/temporary paralysis		2	2
"Depressed"/acute sadness (*hotasha*)		2	2
"Anxiety"/"tension"		2	2
Cries easily and a lot		2	2
Self-blame/guilt		2	2
Physically abused		2	2
Has "sinned"		2	2
Neck pain	1		1
Chest/stomach/diaphragm pain	1		1
Disorientation	1		1
Impotence	1		1
Burning throat	1		1
Burning head	1		1
Dehydration	1		1
Cold headed (*Mathar thanda*)	1		1
Heavy tongue (*muk joma jai*)	1		1
Hands and legs lose warmth	1		1
Loss of memorizing power	1		1
Drug/substance/internet/ gambling addiction	1		1
Talkative/loquacious	1		1
Introverted	1		1
Irrational behavior/impulsive	1		1
Writes in air/on desk with finger	1		1
Lack of confidence	1		1
Apologizes excessively	1		1
Saluting everyone around	1		1
Public indecency	1		1
Feels others are making passes at spouse	1		1
Frantic	1		1
Unlocalized physical pain		1	1
Fainting spells		1	1
Convulsions/shaking		1	1
Difficulty walking		1	1
Rocks back and forth		1	1
Trouble chewing		1	1
"Brain defect"/belief of abscess inside the head		1	1
Grinds teeth		1	1
Washes/bathes incessantly		1	1
Increased religious fervor		1	1
Lack of patience/tolerance		1	1
Cannot tolerate old/dirty		1	1
Cannot tolerate siblings		1	1
Feels others can read mind		1	1
Trouble with in-laws		1	1
Divorced		1	1
Pregnant		1	1
Barrenness		1	1
Overworked		1	1
Somatic	35		
Behavioral/Social	35		
Emotional	10		
Causal Factors	14		

Bi-Polar Disorder

Symptoms (expressed by patient or 'gatekeeper'/family member; non-directed)	**Bi-Polar Disorder** ♂	♀	Total
Angers easily (*mathar gorom*)	4	6	10
Insomnia/sleep disturbance/ always tired	3	5	8
Loss of appetite	2	5	7
Talkative/loquacious	4	2	6
Excitable/shouts	3	3	6
Medication non-compliance	3	3	6
Jinn possession (*Jinn-e dhora*)	1	5	6
Animated/jovial	3	1	4
Restless/fidgety	2	2	4
Sleeps excessively	1	3	4
Hands shake (uncontrollably)		4	4
Easily frightened/irrational fear		4	4
"Depressed"/acute sadness (*hotasha*)	2	1	3
Financial/economic issues	2	1	3
Headache (*mathar beta*)	1	2	3
Physical weakness	1	2	3
Violent behavior/outbursts/ aggressiveness	1	2	3
Withdrawn	1	2	3
Emotional swings (low->high...)	1	2	3
Frantic		3	3
Talks to self/random mumbling (*elo-melo kota*)	1	1	2
Dizziness ("spinning head" / *matha ghura*)	1	1	2
Fever	1	1	2
Weight gain	1	1	2
Back pain	1	1	2
Lack of interest in school/job/ chores/other daily activities	1	1	2
Increased religious fervor	1	1	2
Uncooperative	1	1	2
"Anxiety"/"tension"	1	1	2
Fear of (impending) death	1	1	2
Has "sinned"	1	1	2
Cannot speak/quiet		2	2
Loss of sensation/temporary paralysis		2	2
Completely dependent		2	2
Cries easily and a lot		2	2
Memory loss	1		1
Unlocalized physical pain	1		1
Difficulty walking	1		1
Bodily contortions/flailing	1		1
Impotence	1		1
Body itches all over	1		1
Swelling legs	1		1
Trouble with social integration	1		1
Drug/substance/internet/ gambling addiction	1		1
Cannot concentrate	1		1
Self-blame/guilt	1		1
Mishandling of the Qur'an	1		1
Chained up	1		1
Chest/stomach/diaphragm pain		1	1
Disorientation		1	1
Somatic problems ∵ menopause		1	1
Poor kidney function		1	1
Physical illness		1	1
Hyperthyroidism		1	1
Multi-dimensional speech		1	1
Monotone speech (*ilkir*)		1	1
Lack of self-care		1	1
Wandering/random walking		1	1
Introverted		1	1
Irrational behavior/impulsive		1	1
Afraid of being alone		1	1
Quarrels often with family		1	1
Claustrophobia		1	1
Lack of patience/tolerance		1	1
Self-punishment/humiliation		1	1
Reading Qur'an very loudly		1	1
Easily annoyed/irritable		1	1
Trouble with in-laws		1	1
Physically abused		1	1
Arranged marriage		1	1
Labeled as "Pagol"		1	1
Somatic	26		
Behavioral/Social	25		
Emotional	10		
Causal Factors	10		

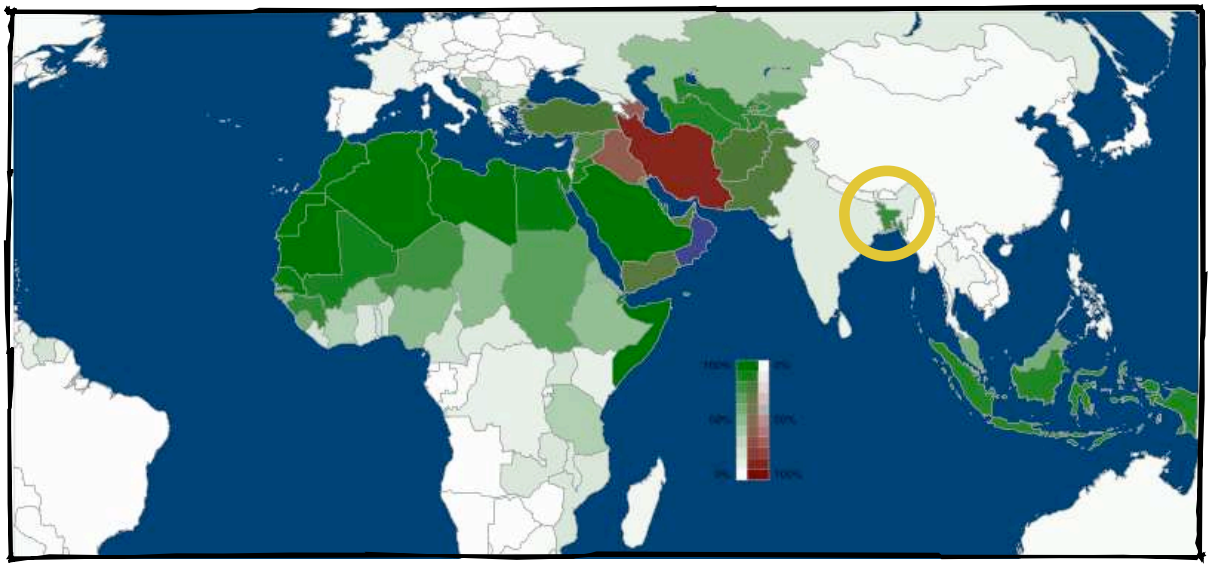
Depression

Symptoms (expressed by patient or 'gatekeeper'/family member; non-directed)	**Depression** ♂	♀	Total
Insomnia/sleep disturbance/ always tired	5	10	15
Loss of appetite	5	7	12
"Depressed"/acute sadness (*hotasha*)	2	9	11
Lack of interest in school/job/ chores/other daily activities	4	6	10
Angers easily (*mathar gorom*)	4	5	9
Sleeps excessively	3	3	6
Lethargy/lack of emotion/drive	2	4	6
Trouble with social integration	2	3	5
Restless/fidgety	1	4	5
Emotional swings (low->high...)		5	5
Cries easily and a lot		5	5
Headache (*mathar beta*)	1	3	4
Memory loss	1	3	4
"Anxiety"/"tension"	1	3	4
Jinn possession (*Jinn-e dhora*)	1	3	4
Paranoid/suspicious feelings		4	4
Dizziness ("spinning head" / *matha ghura*)	2	1	3
Neck pain	1	2	3
Fever	1	2	3
Withdrawn	1	2	3
Financial/economic issues	1	2	3
Physical weakness		3	3
Chest/stomach/diaphragm pain		3	3
Easily frightened/irrational fear		3	3
Trouble with in-laws		3	3
Arranged marriage		3	3
Cannot speak/quiet	2		2
Drug/substance/internet/ gambling addiction	2		2
Cannot concentrate	2		2
Talks to self/random mumbling (*elo-melo kota*)	1	1	2
Violent behavior/outbursts/ aggressiveness	1	1	2
Introverted	1	1	2
Quarrels often with family	1	1	2
Frantic	1	1	2
Fear of (impending) death	1	1	2
Easily annoyed/irritable	1	1	2
Divorced	1	1	2
Unlocalized physical pain		2	2
High blood sugar/pressure		2	2
Lack of sexual interest		2	2
Hand/wrist/finger pain		2	2
Sweats profusely		2	2
Animated/jovial		2	2
Wandering/random walking		2	2
Suicide threats/attempts		2	2
Physically abused		2	2
Subject of blame		2	2
Unrequited love		2	2
Forced to engage sexually		2	2
Hands shake (uncontrollably)	1		1
Breathing problems	1		1
Nausea	1		1
Impotence	1		1
Back pain	1		1
Burning throat	1		1
Trouble chewing	1		1
Loss of taste	1		1
Uncooperative	1		1
Claustrophobia	1		1
Cannot make simple decisions	1		1
Feels lonely	1		1
Son recently died in auto accident	1		1
Not married	1		1
Disorientation		1	1
Rocks back and forth		1	1
Somatic problems ∵ menopause		1	1
Poor kidney function		1	1
Physical illness		1	1
Liver problems		1	1
Toothache		1	1
Burning all over the body		1	1
Electrolyte imbalance		1	1
Lack of self-care		1	1
Excitable/shouts		1	1
Washes/bathes incessantly		1	1
Irrational behavior/impulsive		1	1
Afraid of being alone		1	1
Writes in air/on desk with finger		1	1
Lack of confidence		1	1
Craves attention		1	1
Constantly annoyed		1	1
Low self-esteem (beauty)		1	1
Panicky		1	1
Family problems/separation/ abroad		1	1
Pregnant		1	1
Cannot conceive a baby		1	1
Somatic	32		
Behavioral/Social	26		
Emotional	14		
Causal Factors	14		

6. Maps

Dhaka City

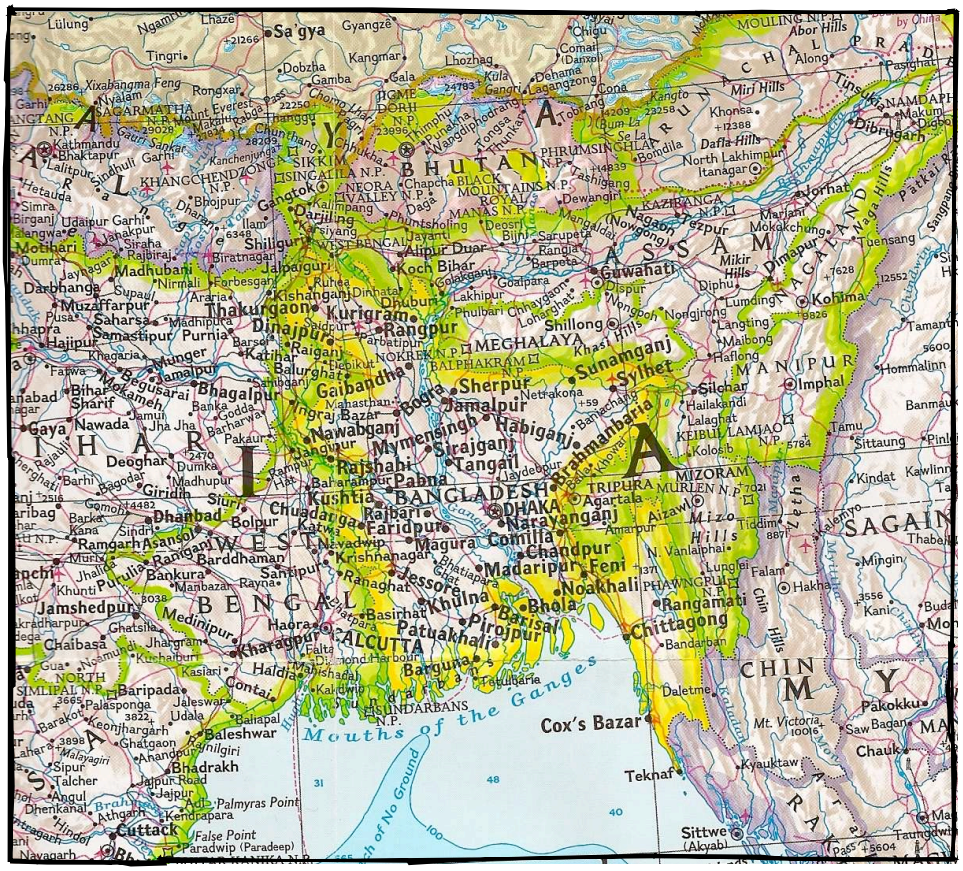
Extent of Islam



<http://www.islam-inside.co.uk/images/islam%20map.gif>

Bangladesh

South Asia. 1997. Washington D.C.: National Geographic Society.



Bibliography

Books

Ali, Maulana Muhammad (ed./trans.). 2002. *The Holy Qur'an. With English Translation and Commentary*. Ohio: Ahmadiyya Anjuman Isha'at Islam Lahore Inc.

Ali, Muhammad Mohar. 1985. *History of the Muslims of Bengal Volume 1a: Muslim rule in Bengal (600-1170/1203-1757)*. Dhaka: Islamic Foundation of Bangladesh. (ISBN: 984-06-9024-8)

Ameen, A.-M.K.i.I.A. 2006. *The Jinn & Human Sickness: Remedies in the Light of the Qur'aan & Sunnah*. Riyadh: Darussalam.

Barbato, A. 1998. *Schizophrenia and Public Health*. *Nations for Mental Health report by Division of Mental Health and Prevention of Substance Abuse*. Geneva: World Health Organization.

Dakshi, A. 2002. *Learning Bengali: A Self-tutor on a Phonetic Basis*. Kolkata: Sanskrit Pustak Bhandar.

Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition (DSM-IV). 1994. Washington D.C.: American Psychiatric Association.

Esposito, John L. (ed.). 1999. *The Oxford History of Islam*. Oxford: Oxford University Press.

Gelder, M., D. Gath, and R. Mayou. (eds.) 1991. *Oxford Textbook of Psychiatry*. Oxford: Oxford University Press.

Gulevich, Tanya. 2004. *Understanding Islam and Muslim Traditions*. Detroit: Omnigraphics.

Helman, C. 1994. *Culture Health and Illness.* Oxford: Butterworth-Heinemann.

Herman, J. 1997. *Trauma and Recovery. The Aftermath of Violence - from Domestic Abuse to Political Terror.* New York: Basic Books.

Kendell, R. 1975. *The Role of Diagnosis in Psychiatry*. Oxford: Blackwell.

Kiev, A. 1972. *Transcultural Psychiatry.* Harmondsworth; Penguin.

Kleinman, A. 1980. *Patients and Healers in the Context of Culture.* Berkeley: University of California Press.

Klass, M. 2003. *Mind Over Mind: The Anthropology and Psychology of Spirit Possession*. Maryland: Rowman and Littlefield.

Koening, H.G. 2005. *Faith and Mental Health: Religious Resources for Healing*. Pennsylvania: Templeton Foundation Press.

Mental Health and Behaviour Disorders (Chapter 5): International Classification of Diseases (ICD-10). 2007. WHO (World Health Organization) and DIMDI (German Institute of Medical Documentation and Information) (WHO link: <http://apps.who.int/classifications/apps/icd/icd10online/>)

Moore, A. 1992. *Cultural Anthropology. 2nd Edition*. 1998: Collegiate Press.

Naji, A.A. (ed.). 1996. *The Muslim Almanac.* 1996: Gale Group.

Patel V. and R. Thara, ed. 2003. *Meeting the Mental Health Needs of Developing Countries. NGO Innovations in India.* New Delhi: SAGE Publications.

Radice, W. 2007. *Teach Yourself: Bengali*. London: Hodder Education.

Razia, U.A.B. and A. Banu. 1992. *Islam in Bangladesh*. Leiden: E.J. Brill.

Richards, A. Ed. 1974. *Joseph Breuer and Sigmund Freud. Studies on Hysteria: Editor's Introduction.* The Penguin Freud Library: Vol.3. London: Penguin Books: 31-46.

Salamone, Frank. A (ed.). 2004. *Encyclopedia of religious rites, rituals, and festivals.* New York: Routledge.

Schubel, V. 2003. *Pir*. In Claus, P., S. Diamond, and M. Mills (eds.). *South Asian Folklore: An Encyclopedia*. New York: Routledge. 478.

Sharan, P., I. Levav, S. Olifson, A. de Francisco, and S. Saxena (eds). 2007. *WHO Research capacity for mental health in low- and middle-income countries: Results of a Mapping Project*. Geneva: World Health Organization & Global Forum for Health Research.

Smith, J.Z. (ed.). 1995. *HarperCollins Dictionary of Religion*. San Francisco: HarperCollins.

Strachey, J. 1974. *Sigmund Freud: A Sketch of his Life and Ideas*. In Richards, A. (ed.) 1974. *Joseph Breuer and Sigmund Freud. Studies on Hysteria: Editor's Introduction.* The Penguin Freud Library: Vol.3. London: Penguin Books: 11-30.

Sykes, K. 2005. *Arguing with Anthropology. An Introduction to Critical Theories of the Gift.* New York: Routledge.

Ünal, A. 2008. *The Qur'ān with Annotated Interpretation in Modern English.* New Jersey: Tughra Books.

Watters, E. 2010. *Crazy Like Us. The Globalization of the American Psyche*. New York: Free Press.

WHO-AIMS Report on Mental Health System in Bangladesh. 2007. Dhaka: World Health Organization. (WHO link: http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html).

WHO Atlas: Global Resources for Persons with Intellectual Disabilities. 2007. Geneva: World Health Organization.

WHO International Pilot Study of Schizophrenia. 2007: Geneva: World Health Organization.

WHO Mental Health Atlas. 2005. Geneva: World Health Organization.

WHO Multi-country Study on Women's Health and Domestic Violence against Women: Summary Report. 2003. Geneva: World Health Organization.

WHO: Preamble to the Constitution of the World Health Organization. 1948. As adopted by the International Health Conference: New York, 19-22 June 1946.

Wilce, J. 1998. *Eloquence in Trouble. The Poetics and Politics of Complaint in Rural Bangladesh.* New York: Oxford University Press.

মাওলানা ওয়ালিউলাহ্ আববাসী [*Maolana Owaliwullah Abbasi*]. 2008. "আদি ও আসল: সোলেমানী খাবনামা থালনামা ও তাবীজ" [*Adi o Ashol: Solemani Kabnama Falnama o Tabiz*: "The Ancient and the Original: The King Solomon Meanings of Dreams, Astrology, and Religious Talismans."] Dhaka: Naim Islami Publications.

Articles

Ahmed, S.U. 1978. Analysis of the epidemiological data of 600 psychiatric patients. *Bangladesh Medical Reserach Council Bulletin 4*, 43-48.

Bibeau, G. 1997. Cultural Psychiatry in a Creolizing World: Questions for a New Research Agenda. Transcultural Psychiatry, Vol. 34, March 1997. McGill University: 9-41. (Sage Publications link: http://tps.sagepub.com/cgi/content/abstract/34/1/9).

Bose, Ruma. 1997. Psychiatry and the Popular Conception of Possession Among the Bangladeshis in London. *International Journal of Social Psychiatry* 43, 1: 1-15.

Breslau, J. 2004. Cultures of Trauma: Anthropological Views of Posttraumatic Stress Disorder in International Health. Introduction. In *Culture, Medicine and Psychiatry.* A. Kleinman, ed. Kluwar Academic Publishers: 113-126.

Chakraborty, A. 1965. Visual Hallucinations. Paper read at the 16th Annual Conference of the Indian Psychiatric Society, Srinagar.

Choudhury, A., M.N. Alam, S.M. Ali, et al. 1981. Dasherkandi Project Studies. Deography, morbidity and mortality in a rural community of Bangladesh. *Bangladesh Medical Research Council Bulletin 7*, 22-39.

Dein, S. and S. Sembhi. 2001. The Use of Traditional Healing in South Asian Psychiatric Patients in the U.K.: Interactions between Professional and Folk Psychiatries. *Transcultural Psychiatry 38*: 243-257.

Gutschow, Kim 1997. A Study of 'Wind Disorder' or Madness in Zangskar, India. In: T. Dodin and H. Räther (eds.) *Recent Research in Ladakh*, 7. Ulm: Ulmer Kulturanthropologische Schriften: 177-202.

Healy, D. 2006 The Latest Mania: Selling Bipolar Disorder. *PLoS Med* 3(4): 185.

Islam, R. 1993. Psychiatry in Bangladesh. *Foreign Report: Psychiatric Bulletin* 17: 492-494.

Jacobsen, Eric 2007. 'Life-wind Illness' in Tibetan Medicine; Depression, Generalised Anxiety, and Panic Attack. In: M. Schrempf (ed.). *Soundings in Tibetan Medicine. Anthropological and Historical Perspectives*. PIATS 2003. Leiden/Boston: Brill: 225-246.

Kirmayer, L. 1988. Mind and Body as Metaphors: Hidden Values in Biomedicine. M. Lock and D.R. Gordon (eds.). *Biomedicine Examined*: 57-93.

Kirmayer, A. 2001. Cultural Variations in the Clinical Presentation of Depression and Anxiety: Implications for Diagnosis and Treatment. *Journal of Clinical Psychiatry 62*: 22-30.

Kirmayer, A. 2007. Psychotherapy and the Cultural Concept of the Person. *Transcultural Psychiatry 44, 2*: 232-257.

Kirmayer, A. and A. Young. 1998. Culture and Somatization: Clinical, Epidemiological, and Ethnographic Perspectives. *Psychosomatic Medicine 60*: 420-430.

Lamb, G., A. Anfield, and A. Sheeran. 2002. Access to a Child Mental Health Service. A Comparison of Bangladeshi and non-Bangladeshi Families. *Psychiatric Bulletin 26*: 15-18.

Leichty, M. 2002. "Out here in Kathmandu": Youth and the Contradictions of Modernity in Urban Nepal. In D. mines and S. Lamb (eds) Everyday Life in South Asia. Bloomington: Indiana University Press: 37-46.

Lindberg F. and L. Distad. 1985. Post-Traumatic Stress Disorders in Women Who Experienced Childhood Incest. *Child Abuse and Neglect*, Vol. 9: 329-334.

Littlewood, R. 1992. DSM-IV and Culture: Is the Classification Internationally Valid? *Psychiatric Bulletin 16*: 257-261.

Lukose, R. 2005. Consuming Globalization: Youth and Gender in Kerala, India. *Journal of Social History* 38 (4): 915-936.

Millard, Collin. 2007. Tibetan Medicine and the Classification and Treatment of Mental Illness. In: M. Schrempf (ed.). *Soundings in Tibetan Medicine. Anthropological and Historical Perspectives.* PIATS 2003. Leiden/Boston: Brill: 247-283.

Miller, K., P. Omidian, M. Kulkarni, A. Yaqubi, H. Daudzai, and A. Rasmussen. 2009. The Validity and Clinical Utility of Post-Traumatic Stress Disorder in Afghanistan. *Transcultural Psychiatry 46*: 219-237.

Monawar Hosain, G., N. Chatterjee, N. Ara, and T. Islam. 2007. Prevalence, pattern, and determinants of mental disorders in rural Bangladesh. *Public Health (Journal of the Royal Institute of Public Health)*, 121: 18-24.

Mullick, M.S. and R. Goodman. 2005. The Prevalence of Psychiatric Disorders among 5-10 Year Olds in Rural, Urban and Slum Areas in Bangladesh: An Exploratory Study. *Social Psychiatry and Psychiatric Epidemiology* 40: 663-671.

Nichter, M. 1981. Idioms of distress: alternatives in the expression of psychosocial distress. A case study from South India. *Culture, Medicine, and Psychiatry* 13: 367-390.

Nisbett, N. 2007. Friendship, Consumption, Morality: Practising Identity, Negotiating Hierarchy in Middle -Class Banglalore. *The Journal of the Royal Anthropological Institute* (NS) 13: 935-950.

Pies, R. 2004. Moving Beyond the “Myth” of Mental Illness. In: J. Schaler (ed.). *Szasz Under Fire. The Psychiatric Abolitionist Faces His Critics*. Chicago and La Salle: Open Court. 328-353.

Rahim, D.A., S.M. Ali, M.G. Rabbani, et al. 1997. Analysis of psychiatric morbidity of outpatient children in Mitford Hospital, Dhaka. *Bangladesh Medical Research Council Bulletin 23*, 60-62.

Rahman, R. 1972. Social Class and Schizophrenia in Pakistan (Bangladesh). *Transcultural Psychiatry* 9: 130-135.

Rashid, S.F. 2007. Accessing Married Adolescent Women: The Realities of Ethnographic Research in an Urban Slum Environment in Dhaka, Bangladesh. *Field Methods* 19, pp. 369-383. (Sage Publications link: http://fmx.sagepub.com/cgi/content/abstract/19/4/369).

Reiss, S. 1972. A Critique of Thomas S. Szasz's "Myth of Mental Illness." *American Journal of Psychiatry 128*: 1081-1108.

Schenk, A. 1993. Introducing Trance: On the Training of Ladakhi Oracle Healers. In: M. Brauen and C. Ramble (eds.). *Proceedings of the International Seminar on the Anthropology of Tibet and Himalaya*. Zurich: Ethnologie Schriften Zürich, 331-342.

Scully, J. and J. Wilk. 2003. Selected Characteristics and Data of Psychiatrists in the United States, 2001-2002. *Academic Psychiatry 27:4*: 247-251.

Szasz, T. 1960. The Myth of Mental Illness. *American Psychologist, 15*: 113-118.

Van Ommerren, M., J.T.V.M. de Jong, B. Sharma, I. Komproe, S. Thapa, and E. Cardena. 2001. Psychiatric Disorders Among Tortured Bhutanese Refugees in Nepal. *Archives of General Psychiatry 58* (5): 475-482.

Wahed, T. and A. Bhuiya. Oct 2007. Battered Bodies & Shattered Minds: Violence Against Women in Bangladesh. *Indian J Med Res* 126: 341-354.

Wilce, J. 1995. “I Can’t Tell You All My Troubles”: Conflict, Resistance, and Metacommunication in Bangladeshi Illness Interactions. *American Ethnologist* Vol 22 #4: 927-952. (JSTOR link: http://links.jstor.org/sici?sici=0094-0496%28199511%2922%3A4%3C927%3A%22CTYAM%3E2.0.CO%3B2-9)

Wilce, J. 1998(b). The Pragmatics of “Madness”: Performance Analysis of a Bangladeshi Woman’s “Aberrant” Lament. *Culture, Medicine and Psychiatry 22*: 1–54.

Websites

"Bangladesh." Last update: 4 January 2010. *CIA World Fact Book*. <https://www.cia.gov/library/publications/the-world-factbook/geos/bg.html>

"The Biopsychosocial Model of Health and Illness." <http://cnx.org/content/m13589/latest/>

"Health and Well-being." Mission Islam. <http://www.missionislam.com/health/>

"Islam Map." *Islam Inside: Introducing Islam to Christians and Atheists*. <http://www.islam-inside.co.uk/images/islam%20map.gif>

"Jinn Possession: Self Diagnose." Accessed: 30 August 2009. *Furqaan Institute of Islamic Healing*. <http://www.fiqh.org/self-diagnose/>

"Lunacy Act of 1912." Ministry of Law, Justice, and Parliamentary Affairs, Bangladesh. <http://www.bdlaws.gov.bd/pdf_part.php?id=96>

"Mental And Behavioral Disorders. Chapter V (5) - F00-F99." *International Statistical Classification of Diseases and Health Related Problems: 10th Revision (ICD-10)*. Version for 2007. <http://apps.who.int/classifications/apps/icd/icd10online/>

"Mental Health (*manosik rog*)." Banglapedia.com. <http://banglapedia.search.com.bd/HT/M_0218.htm>

"Muslims." Accessed: 18 October 2009. Worldmapper.org. <http://www.worldmapper.org/display_religion.php?selected=564>

"Pabna Mental Health Hospital." Banglapedia.com. <http://banglapedia.search.com.bd/HT/M_0217.htm>

"WHO Facts on Mental Health." *WHO Mental Health Homepage*. <http://www.who.int/mental_health/en/>

Other

American Psychiatric Association Statement on the Insanity Plea. 1982. Washington, DC: American Psychiatric Association.

Halliburton, M. 27 May 2009. Phenomenological Assumptions and Aesthetic Orientations in Ayurvedic and Biomedical Psychiatry. *Transcultural Psychiatries* lecture series. Ruprecht-Karls-Universität Heidelberg, Germany.

Kirmayer, L. 17 June 2009. Cultural Psychiatry in a Globalizing World. *Transcultural Psychiatries* lecture series. Ruprecht-Karls-Universität Heidelberg, Germany.

Map: South Asia. 1997. Washington D.C.: National Geographic Society.

Rashid, M. 2008. Living in Silence: A Close Look at Child Sexual Abuse in Dhaka. BRAC University: Unpublished Master's Thesis.