

THE PSYCHOMEDICAL CASE
HISTORY OF A LOW-CASTE
WOMAN OF NORTH INDIA

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ABSTRACT

This anthropological psychomedical case history of 35 years in the life of Sita describes and analyzes the complexity of behavioral symptoms called ghost possession and fits in the Delhi region of North India. The conditions contributing to these alternate mental states will be shown to be due to biological, cultural, and psychological causes. An absentee father in military service, the deaths of 12 of her siblings as infants in Sita's childhood, and three of her girl friends during pubescence are linked with the culturally conditioned belief that death may be due to a malevolent female ghost

and with the individual psychological fear that mating results in death. In her childhood, Sita developed an anxiety disorder that contributed to her ghost possessions after she married at 15 years of age. With the birth of her first child, Sita's possessions became fits. Although formerly her behavior would have been labeled hysteria, the present analysis points to multiple causes—genetic and other biological processes, an anxiety disorder, and culturally induced stresses—which produced sufficient pain to trigger Sita's alternate mental states.

INTRODUCTION

BACKGROUND AND THEORY

The present study¹ covers the first 35 years in the life of a rural woman called Sita, who was born and continuously lived in the Union Territory of Delhi, India.² In 1958 after her wedding and mating with her husband she experienced ghost possessions, according to village diagnoses. Subsequently, for three years she suffered from possessions and thereafter from fits.

We met Sita for the first time in 1958 when we were engaged in holistic ethnographic research oriented chiefly around the changes

that Sita's marital village was undergoing owing mainly to urban influences from the City of Delhi. We attended some of the prenuptial and postnuptial ceremonies for Sita's marriage and once witnessed her possession. Because of the intrinsic psychological, social, and cultural interest in the episode of ghost possession, we interviewed Sita, members of her marital family, and one of the curers who had treated her. Twenty years later, we again encountered Sita in her marital village where we were studying the changes that had taken place after two decades. Sita at 35 years old had developed into a mature wife and mother. She proved to be intelligent and articulate at both periods of time and was willing to tell us about herself, her natal and marital families, and other kin. She said she had suffered from possessions, fits, and many physical complaints, and provided a detailed medical history. Other members of her marital family were cooperative and frank in relating Sita's problems.

The rich psychological,³ personal, and familial data provided by Sita and her relatives lend themselves well to analysis in terms of a psychomedical case history. Moreover, the

¹ Fieldwork was supported by the Social Science Research Council and the National Science Foundation (1957–1959); the American Institute for Indian Studies, and the Indo-U.S. Sub-Commission for Education and Culture, the Indo-American Fellowship Program (1977–1978). We acknowledge with thanks many persons for making these periods of fieldwork possible and successful. They are listed and our gratitude expressed in S. Freed and R. Freed, 1976, pp. 28–29; 1978, pp. 9–10; 1982, pp. 200–201; R. Freed and S. Freed, 1979, p. 292; 1980, p. 329; 1981, p. 55. We thank Drs. Barbara G. Anderson and Robert C. Ness for undertaking the time-consuming but extremely valuable task of reading and criticizing the manuscript.

² Due to the nature of this study and the growing literacy and expansion of education in the Union Territory of Delhi, we have tried to mask the identities of individuals, places, and institutions as much as possible. To protect individuals in this case history pseudonyms have been given for the main cast of characters. Otherwise individuals, villages, and institutions are not identified by names.

³ The words, psychological or psychology, are used broadly to include psychiatry, psychoanalysis, and to some extent neurology. Where only psychiatry or psychoanalysis is meant, these terms are used. Langness and Kennedy (1979) provide a brief history of the use of psychology in anthropology.

social and cultural context of Sita's life has been thoroughly studied, which adds an ethnographic dimension to the analysis. The study can therefore be characterized as an anthropological psychomedical case history. The phrase "case history" in contrast to "life history" refers to "an organized set of facts relevant to the development of an individual . . ." especially when the facts are related to the psychological and medical history of the individual (Warren, 1934, p. 38; Morris, 1969, p. 208). A life history, "an extensive record of a person's life as it is reported either by the person himself or by others or both, . . . whether it is written or in interviews or both" (Langness, 1965, pp. 4-5) does not apply to the data about Sita because the information ends with her thirty-fifth year, is not complete, and focuses on her psychomedical background. Despite these restrictions, anthropological techniques used in life histories are employed to reconstruct Sita's case history, particularly her early years (Aberle, 1967, pp. 79-80).

Sita's case history is of interest for a number of reasons. First, few case histories of Indian women exist and only a slightly larger number of life histories.⁴ Second, Sita's 35 years covered a period of marked social, political, and economic change in India: for example, in the rural area of the Union Territory of Delhi, the educational level had risen dramatically, there had been a substantial increase in salaried urban occupations, agri-

cultural technology had advanced from bullocks to tractors, population had increased at a rate of more than 2 percent a year, and the Government of India introduced socialized medicine and the Family Planning Programme. The cultural milieu in which Sita's personality was formed had changed, which presents the interesting problem of whether such changes would diminish or enhance the likelihood of a person's developing behavioral responses similar to Sita's. Finally, research on diverse mental states that began during World War II has added new dimensions to the study of human behavior, pointing up the need for extensive biological, psychological, and cultural knowledge in the field of psychomedical anthropology and in the gathering of data for a case history (Foulks, 1972, pp. 112-113; Amkraut and Solomon, 1974, pp. 541-542; Cassel, 1974, pp. 471-473). Interpretations of the biomedical and psychological aspects of this anthropological psychomedical case history are inferential because of the limitations of anthropological fieldwork and the necessity for reconstruction.

The focus of Sita's case history is the investigation of multiple causes in the reconstruction of her 35 years of life with emphasis placed on biological, cultural, and psychological causes of possessions and fits. To do so, research findings from the past four or more decades regarding hysteria, possessions, fits, and alternate mental states are introduced in this section on background and theory for a better understanding of the setting and world view of Sita and the villagers of the Union Territory of Delhi. These research findings have been applied to the data in this study. So, too, indigenous village terms and behavioral symptoms for Sita's possessions and fits are compared with Greek and Ayurvedic humoral and Western-scientific medical traditions and classifications for an understanding of beliefs regarding the relationship between hysteria and possession. From this matrix of possible causes and interpretations, this intensive analysis points to specific biological, cultural, and psychological bases for Sita's possessions and fits (Chapple, 1980, pp. 742-746). Because of the worldwide distribution of behavior known as

⁴ The relatively few recent life and case histories of Indian women present generally skimpy information. For example, Freeman (1979, pp. 188-193, 232-239, 273-286, 316-323) provides data about the possession and attempted suicide of the wife of an untouchable. Garg and Parikh (1976) present mini-case histories of 21 students, one of whom is a woman. Jacobson (1974), in an article on Indian women as goddesses and wives, draws on the life cycle of one woman to illustrate some of her points. D. D. Karve (1963) presents life histories of males in five Maharashtrian Brahman families, only incidentally including information on related females, among them the well-known female anthropologist, Iravati Karve. Nanda (1976) offers some skeletal life histories of Indian women. Shirley Jones (1976) provides a sketchy case history of a woman who suffered possession as a result of working as a servant. Cormack (1975) based her study on Indian students at Columbia University.

possession by a supernatural being, this case history is of consequence for comparative scientific analysis and for diagnosis and treatment. There are few such complex studies for the scores of millions of North Indian females and probably none in depth for low-caste rural women. India, the second most populous country in the world, is still about 76 percent rural. Since the biomedical, cultural, and psychological world of the rural Indian woman merits much more scientific study than it has so far received, this type of study should provide the stimulus for further investigation along these lines, not only for women but also for men.

This monograph is divided into five parts: The first, on background and theory, contains the definitions, theories, techniques, and methods for comprehending this anthropological psychomedical case history. It provides a review of the classifications and reclassifications of diverse mental states, associated behavioral processes, and various traditions which have influenced the labeling and classifying of such mental states, in particular the use of the term hysteria. This information on background and theory is then applied to the 35 years of Sita's life, divided into three phases: the first, her early years (1943–1957), pertains to growing up in her natal village; the second recounts the events and ceremonies leading to her wedding, mating, and possessions in 1958; and the third deals with the intervening years, 1959–1978, during which Sita became a mother and householder and her possessions turned into fits. Throughout the 35 years of Sita's case history, biomedical data as well as psychological and cultural information are presented in order to provide a theoretical basis for understanding her possessions and fits. The conclusion of this monograph integrates and summarizes the findings.

FIELD TECHNIQUES

Sita's case history was gathered in the context of two holistic village studies, the first in 1958–1959 and the second in 1977–1978. In both periods, the research focused on the changes taking place in many aspects of village culture, due mainly to influences emanating from Delhi. The theoretical back-

ground of the research and field methods in the 1950s are presented in S. Freed and R. Freed (1976, pp. 17–28). Procedures in the 1970s were similar. The major difference between the two periods of research was that we were in India 21 months in the 1950s and eight months in the 1970s.

The discussion of methods outlined here emphasizes principally the techniques used in interviewing Sita and her relatives and the taking of censuses, for the data that census-taking generates are fundamental in any holistic anthropological research and are pertinent to this case history. During both field trips, we gathered information from villagers and obtained censuses of all households including Sita's family of marriage. We used a modification of the genealogical method of Rivers (1971, pp. 52–59), incorporating a list of subjects on which we sought information. We charted the kinship ties of members of a family and obtained names, ages, sex, degree of education if any, place of birth, caste and clan names, occupation, property owned, and other economic data. While doing so, we became acquainted with a number of family members, encouraged conversations about themselves and the village, and welcomed any information they cared to give us. This method served us well whenever we wished to visit a family again to obtain additional information and was extremely helpful in getting to know as many villagers as possible. It provided basic demographic data for numerous problems that required the selection of a sample across castes. For studying change, the census data, separated by about 20 years, have proved invaluable, for they provided minutiae of family members and of changes within a family. In the case of Sita, the early census data provided an entry for renewing our old acquaintance with her and members of her family of marriage (S. Freed and R. Freed, 1969, 1982, 1983).

For interviewing Sita and her relatives, the main technique was open-ended, eliciting, and exploring types of questions which hold the informant's attention for an extended period of time and provide explicit and factual information as well as values, opinions, and a wealth of data which directed, close-ended questions miss. This technique offers an excellent opportunity for observing and better

understanding the interviewee. Usually the informant feels that the anthropologist is very much interested in what is said. Moreover, the anthropologist, here and there, incorporates general questions which probe such subjects as family structure, usual and unusual biological, psychological, and historical events, changes in life cycle and life style, information about births, marriages, deaths, and personality traits and proclivities.

In both field trips we used similar field techniques but in the first we were restricted in interviewing Sita because of her youth and chaperonage by her female in-laws. Dyadic interviews consisting solely of interviewer and respondent are difficult to arrange. Interviews tend to occur by chance. The anthropologist walks through the village with a number of possible informants in mind, and if he or she encounters one of them and the conditions are favorable, an interview takes place, often outside in a courtyard, caste compound, or while people are resting from work in the fields. Interviews with women are especially difficult because they are usually working in the fields, home, and at the cattle sheds. Family members, nearby kin, and neighbors frequently interrupt. Males, who rank as senior to females, may interrupt and thereafter the women remain silent. A mother-in-law directs the activities of a daughter-in-law, so she too can terminate an interview.

Anthropologists learn to deal with the complexities of interviewing and at the same time evolve techniques for attaining rapport under quite difficult conditions. Only occasionally can they set the time, place, and length of an interview. If an anthropologist tried to control interviewing conditions as a psychiatrist does, by holding interviews at fixed times and places, the kind of rapport an anthropologist needs to work in a community would be lost. The anthropologist's rapport derives from living in the community, being seen in all parts of it regularly, getting to know the villagers, first through the census and then through visits to as many households as possible, during which time the nature of the visits are recorded in a notebook. Although group interviews require considerable skill, they often provide insight about interactions between members of a household, kin, or neighbors. In gathering Sita's case history, we

encountered all of the above problems in interviewing, but on some occasions were able to interview Sita alone or nearly alone.

There is a relationship between the rapport of an anthropologist and transference in psychotherapy. Sometimes an anthropologist may establish a bond deriving from a feeling of identification by the informant—identification in terms of someone that the informant knows who resembles the anthropologist, or experiences which the informant thinks are or may be similar. For example, in 1958, when we first interviewed Sita, she mentioned that she felt at ease with us because we reminded her of her teachers whom she liked. In 1978, she remembered our early encounters and was pleased that we remembered her. She also said that Ruth Freed was like her grandmother who had a fair complexion. Since her grandmother was a member of Sita's natal family the process of identification which could lead to transference was established. Since we did not work intensively with Sita over a long period of time and our methods were not psychiatric, we did not encounter transference (Freud, 1978, pp. 116–117).

Interviews on all subjects including census data were recorded in notebooks almost verbatim and form the corpus of this case history. Once we introduced our villagers to the process of note-taking, they were not bothered by it and often asked us to be sure to write everything down accurately.

The presentation of Sita's case history is sequential from her birth to 1978. Information about her natal and marital villages, the surrounding region, and low castes stems from general fieldwork in the 1950s and 1970s as well as from interviews with Sita and members of her marital joint family (Wax, 1971; S. Freed, 1972; S. Freed and R. Freed, 1976, 1978; R. Freed and S. Freed, 1979, 1980, 1981).⁵

CLASSIFYING MENTAL STATES

During the past four decades, research on mental states and associated behavior gave

⁵ For further information on field methods and techniques, see S. Freed, 1972; S. Freed and R. Freed, 1976, pp. 17–28; R. Freed and S. Freed, 1979, pp. 289–291; 1980, p. 337; 1981, pp. 85–91.

rise to two major problems: 1) the so-called labeling controversy and 2) the nature and causes of diverse mental states that depart in some way from so-called normal consciousness. General questions in the labeling controversy are: Is the label related to or derived from the cultural context? Does the label contribute to and reinforce mental illness? Do the labels of Western medicine and psychiatry apply cross-culturally? What constitutes abnormal or deviant behavior? What are the processes which lead to abnormality or deviance (Foster and Anderson, 1978, pp. 84–86)? Research on the nature and causes of alternate mental states has focused on changes in mental states induced by drugs, biological substances acting on or in the body, psychological disturbance, or unusual events. These states have been referred to in the literature by a number of phrases: Altered States of Consciousness, Alternate States of Consciousness, and the Hallucination-Perception Continuum (Ludwig, 1966; Fischer, 1969; Siegel, 1975; West, 1975; Tart, 1979, pp. 158–219; Zinberg, 1979, pp. 1–36; L. Peters, 1982, p. 41). The terms conscious or consciousness in contrast to unconscious or unconsciousness have generally been used to indicate opposite mental states. Because of research in the field of dissociation and other types of mental states, the definitions for the opposite types of mental states cloud the findings that mental states of different types may be ranged along a continuum and that what formerly were classified as conscious or unconscious states are too simplistic because some so-called conscious states, such as daydreaming or sleepiness without being asleep, are part of this continuum. So, too, some unconscious states are not totally so inasmuch as a person in a hypnotic state is subject to suggestion from the hypnotist and carries out activities. This explanation is a brief rendering of why we use “alternate mental states” and avoid the words conscious or unconscious except when referring to a specific source (Warren, 1934, pp. 57, 163, 261, 285; Morris, 1969, p. 283).

Research stemming from these two problems, the labeling controversy and alternate mental states, to some extent has brought about changes in the recent reclassification of mental states (American Psychiatric Association, 1981), and has reemphasized the need

to consider biological factors as well as cultural and psychological. The following theoretical review of the labeling controversy and alternate mental states is applicable to Sita's possessions and fits and is provided to familiarize the reader with changes in classification and cognitive problems of diverse usages.

LABELING CONTROVERSY

Fifty years ago, Benedict identified one of the main issues in the labeling controversy: The problem of the relativity of normality. She argued that behavior accepted and even extolled by the standards of a specific society might be regarded as abnormal or at least bizarre by other standards. One of the questions she asked was how far we can determine that abnormal categories for behavior are absolute (Benedict, 1934, p. 60). She wrote:

... The vast majority of the individuals in any group are shaped to the fashion of that culture. In other words, most individuals are plastic to the moulding force of the society into which they are born. In a society that values trance, as in India, they will have supernormal experience.

... From the point of view of absolute categories of abnormal psychology, we must expect in any culture to find a large proportion of the most extreme abnormal types among those who from the local point of view are farthest from belonging to this category. The culture, according to its major preoccupations, will increase and intensify hysterical, epileptic, or paranoid symptoms, at the same time relying socially in a greater and greater degree upon these very individuals. Western civilization allows and culturally honors gratifications of the ego which according to any absolute category would be regarded as abnormal. The portrayal of unbridled and arrogant egoists as family men, as officers of the law, and in business has been a favorite topic of novelists, and they are familiar in every community. Such individuals are probably mentally warped to a greater degree than many inmates of our institutions who are nevertheless socially unavailable. They are extreme types of those personality configurations which our civilization fosters The relativity of normality is important in what may some day come to be a true social engineering the major problem is not a consequence of the variability of the normal from culture to culture, but its variability from era to era. (Benedict, 1934, pp. 74–77)

Benedict addressed the problem of absolute categories by indicating "that differences in temperament occur in every society," and further stated "that these temperament types are very likely of universal recurrence" (1934, p. 74). Her concern with differences between societies in labeling individuals as abnormal was ahead of the times. More recently others have addressed and enlarged upon the question of abnormality, deviant behavior, and the bases for classifying mental states.

In more recent times, Goffman (1981) and Rosenhan (1973) raised questions regarding the stigma arising from labeling people as insane and the treatments that result from such labels. Szasz (1981) called attention to Freud's and Charcot's contribution to the classification and treatment of hysteria. According to Szasz, hysteria had previously been attributed to a physical disability—the medical basis for illness at that time—but with no discernible cause. Freud and Charcot caused it to be classified as a mental illness without a biological basis. In so doing, they provided the impetus for attributing mental illnesses to sociocultural rather than biological causes. Szasz, however, selected only one aspect of Freud's contribution to the study of hysteria and nothing about earlier beliefs regarding it, as will be indicated later. Goffman, Rosenhan, and Szasz have been categorized as labeling theorists.

Simon (1980) in a review of the history of hysteria notes that at the time of his writing, c. 1978: "Clinical experience suggests that female therapists tend to diagnose hysterical character far less often than do male therapists. Hysterical character may be ascribed to men but seldom is" (Simon, 1980, p. 240).

Murphy (1976), in opposition to the labeling theorists, presented data from the Alaskan Eskimo and Yoruba of Africa, indicating that insane (psychotic) behavior is labeled and that both of these people distinguish between insane and sane behavior. For neurotic behavior, such as is found in anxiety and depression disorders, there were no labels, but the symptoms for neurotic behavior were recognized. For what Murphy classifies as "norm violation" and compares to psychopathic behavior, specific terms were used by both the Eskimo and Yoruba. For example, the Eskimo term was translated as "his mind knows what to do but he does not

do it" (Murphy, 1976, p. 1026). A similar abstract term occurred among the Yoruba. The definition of a psychopath is "someone who consistently violates the norms of society in multiple ways." Based on her careful study of these two societies, she further suggests that certain types of behavior can be and are identified cross-culturally.

Since Murphy provides labels for psychotics and psychopaths but no labels for a broad range of cases which formerly were lumped under the terms psychoneuroses, neuroses, and recently neurotic disorders (American Psychiatric Association, 1981, pp. 9–10), the problems of classifying neurotic disorders mark their nebulous and changing position as types of mental states. This nebulousness includes dissociation. Further criticisms of Murphy's claim to the universality of her first category—psychotics—have been shown by differences in diagnoses, confinement, and syndromes by American and British psychiatrists, sociologists, etc. (Stillings, 1977, pp. 482, 484; Townsend, 1977, pp. 480, 482).

Robert Edgerton (1976, pp. 63–65, 73–74), using the concept of deviance rather than abnormality, points out that the processes which lead to deviant behavior should be studied and not deviance *per se*, that is, the labels for the processes leading to such behavior. According to him, deviance in the form of deviant behavior implies the breaking of rules (1976, pp. 111–112). He notes that in societies where men are dominant over women, possession provides a model whereby women are able to negotiate or cope with their subordinate position through the deviant label implied in possession as illness (1976, pp. 64–65). Since Sita is a member of such a society, it seems reasonable to raise the following questions based on Edgerton's suggestion to study the processes leading to deviant behavior: Is Sita's behavior deviant? If so, how has she broken rules? What is the process by which she became deviant? How have her possessions and fits allowed her to negotiate or cope with her subordinate position as a married woman and member of a low caste? These questions will be answered in the context of this case history.

ALTERNATE MENTAL STATES

Research since World War II has revealed the need for studying biological and cultural

as well as psychological aspects of human behavior in order to understand alternate mental states. Anthony Wallace (1961) added a new dimension to anthropology which contributed to the development of psychological anthropology from the earlier culture and personality studies. Wallace compared pibloktoq (arctic hysteria) with Freudian theories regarding hysteria, arguing that a calcium deficiency in the Eskimo diet and other ecologically related factors were involved in pibloktoq. He pointed out that the culture and personality approach in anthropology was based on cultural and psychoanalytical theories for understanding the formation of personality but ignored the organic or biological approach.⁶ His point of view derived from the use of drugs for the treatment of mental states in World War II and thereafter, the period from which the concept of alternate mental states developed.

Wallace further suggested that Freud's cases of hysteria may have been caused by dietary deficiencies, such as vitamins and calcium. In a revision of his 1961 article, Wallace (1972, pp. 374–382), referring to the calcium deficiency hypothesis, called attention to the research of Pitts and McClure (1967) regard-

ing "Lactate Metabolism in Anxiety Neurosis." They conducted a series of tests with two groups: (1) patients with anxiety neuroses and (2) normal controls. Three types of infusions were given these groups: (1) sodium lactate; (2) lactate with calcium; and (3) a saline glucose infusion. For those with anxiety neuroses, the sodium lactate infusion precipitated anxiety attacks; the lactate with calcium affected them mildly; and the saline glucose had no effect. Only a few of the normal control group were affected by the sodium lactate, none by the lactate with calcium, or by the saline glucose. From these results, it appears that lactate is a substance contributing to anxiety attacks; calcium when added to lactate reduces the severity of such attacks, and a saline glucose solution (non-lactate) has no effect. Calcium has physiological and neurological functions in the human body. It is necessary in the diet and the richest source is milk and other dairy products. Hypocalcemia results in increased neural excitability, neuromuscular irritability, and behavioral disorders. The correct concentration of calcium in the body is maintained by hormones. Homeostasis of calcium in the body may be disturbed by disease of the parathyroid glands, diet deficiencies, and an imbalance may result in tetany (twitching and periodic painful muscular spasms) (Pitts and McClure, 1967; Katz and Foulks, 1969; Wingate, 1972, pp. 82, 415).

The major impact of Wallace's two articles was to question Freud's theories as to the causes of hysteria and other mental states and to provide a model for analysis of theories of mental illness, one which includes biological as well as psychological and cultural variables in a case history. This model has influenced the compiling of Sita's case history and accounts for the terminology, "a case history in psychomedical anthropology."

Foulks, a psychiatrist with anthropological training, followed Wallace's model in his study of pibloktoq among the Eskimo of Alaska. He and Wallace attribute their interest in pibloktoq to Solomon Katz, a human biologist whose "special research interests related to calcium biology and mental function" (Foulks, 1972, p. xiii). Foulks's inclusion of a number of variables is an internal expansion of Wallace's model. He states that

⁶ This statement of Wallace's is not entirely accurate inasmuch as Margaret Mead, Benedict, and Boas adhered to the Boasian tenet that the study of anthropology consists of the biological and the cultural, and that the two are interrelated (Boas, 1949, 1965). In the Foreword to Boas (1965, pp. 5–12), Herskovits states: "Even in its earlier form, it [the book] lays bare the anatomy of the whole science of man, *demonstrating that human capacity as manifested in forms of thought and behavior is essentially a continuing contrapuntal play between what is physically inherited and what has been learned—that is, between physical endowment and culture*" (Herskovits, 1965, pp. 8–9, emphasis added). See also Schneider (1983).

Commenting on articles by Mead and Benedict, Kluckhohn, Murray, and Schneider (1967, p. 522) write: "Dr. Benedict further develops the basic themes of Mead . . . and Frank She reminds us that the culture of every group must have patterns for dealing with incapable biological facts"

In the present climate of opinion, where people are inclined to shuck off culture and where some scholars are increasingly oriented toward biological determinism, it would be well to reexamine the point of view that biological and cultural attributes go hand-in-hand and that understanding depends on both.

the study of "human behavior is multiply determined and that single, linear, causal theories lack comprehensive and predictive values" (Foulks, 1972, p. 113). He considers that culture, personality, environment, demography, medical history, biology, and other factors are essential in understanding the occurrence of arctic hysteria (Foulks, 1972, pp. 113–114).

Although Wallace (1961, 1972) and Katz and Foulks (1969) stressed the relationship of calcium, circadian rhythms, and ecological variables to hysteria, Foulks's findings indicate many differences among the subjects. The findings show that arctic hysteria-like behavior occurred first in childhood or early adolescence, that all individuals had recurrent respiratory infections and otitis media, that some suffered birth or head trauma, and many had experienced high fevers. There were considerable differences among subjects regarding the level of calcium and magnesium and the presence of signs of organic and cerebral electrophysiological problems (Foulks, 1972, pp. 98–99, table XVI). Ten cases showed a diversified psychological pattern ranging from paranoid suspiciousness to suicide, dissociative hysterical states, alcoholism, and merely running away. Patterns in small traditional villages differed from those of larger villages and towns. Foulks's findings indicate that *pibloktoq* may be a behavioral symptom for a number of mental disorders, each with multiple causes.

These findings point to the problems encountered in labeling deviant behavior and alternate mental states. The position of Foulks and Wallace reinforces the need for studying all possible factors. The major point is that each setting may be different in terms of several important variables for predisposition to alternate mental states, such as ghost possession and *pibloktoq*, and that one cultural-specific mental state is not necessarily the same as another, although they may have been labeled as possession (Foster and Anderson, 1978, pp. 96–99).

Ludwig (1966, p. 225), using the phrase "altered states of consciousness," defines them as "any mental state(s), induced by various physiological, psychological, or pharmacological maneuvers or agents, which can be recognized subjectively by the individual

himself (or by an objective observer of the individual) as representing a sufficient deviation in subjective experience or psychological functioning from certain general norms for that individual during alert, waking consciousness. This sufficient deviation may be represented by a greater preoccupation than usual with internal sensations or mental processes, changes in the formal characteristics of thought, and impairment of reality testing to various degrees."

He describes five types of altered states of consciousness:

1. Reduction of exteroceptive stimulation and/or motor activity. Examples: solitary confinement, highway hypnosis, and sensory deprivation.
2. Increase of exteroceptive stimulation and/or motor activity and/or emotion. Under this category are excitatory mental states resulting from sensory overloading, which include possessions and/or hysterical conversion reactions.
3. Increased alertness or mental involvement arising from activities such as fervent praying, prolonged vigilance of any kind, and intense absorption in a task.
4. Decreased alertness or relaxation of critical faculties, which appear mainly when active, goal-directed thinking is minimal, include mediumistic and hypnotic trances, daydreaming, and reverie.
5. Presence of somatopsychological factors which are due to changes in body chemistry or neurophysiology. Examples: dehydration, hypoglycemia, hyperventilation, and auras preceding epileptic seizures or migraines (Ludwig, 1966, pp. 226–227).

Some of these mental states may be classified as deviant, but not others. They may be drug-induced or relieved by drugs; and they may be voluntary or involuntary. When involuntary, the inference is that psychological and/or physical factors cause changes in the chemical balance of the body, affecting the brain and central nervous system, which result in altered states of consciousness. The states in turn may be reduced, alleviated, or eliminated by drugs or by reduction, alleviation or elimination of the involved psychological or physical factors (Ludwig, 1966, pp. 227–230).

Altered states of consciousness may be useful in cultures which foster them, such as being necessary for the shaman and patient in a cure. A possession may provide freedom for the possessed to express aggression, sexual conflicts and desires, and to reduce tension and fear. The types of altered states of consciousness found in any one society may depend on the outlets in the society for frustration, loneliness, stress, and other emotional problems (Ludwig, 1966, p. 232).

Although Ludwig's second category, "increase in exteroceptive stimulation," is most applicable to Sita's case, he notes that there may be overlap between his categories of altered states of consciousness and multiple causes (Ludwig, 1966, p. 226). Characteristics particularly pertinent to Sita are: body image changes, dizziness, weakness; perceptual distortions with regard to sight, sound, and voice; daydreaming and sleepiness; exteroceptive stimulus or deprivations; relaxation of faculties through hypersuggestibility, including cultural conditioning to possession as well as the suggestibility induced by an exorcist. Furthermore, the wide variety of alternate mental states include many that are considered popularly as normative, such as sleeping and dreaming. There are also differences in waking as well as sleeping and in other mental states so that a person who goes through a period of great stress and is possessed may go through a continuum of different mental states (Mischel and Mischel, 1958, p. 253). For these reasons, Zinberg's (1979, p. 1, fn. 1) use of alternate is preferred to altered states of consciousness. Our usage of alternate mental states avoids the problems related to the word consciousness although when identifying the specific research of an author, we use the phrase employed by the author.

Tart (1979) has expanded on alternate mental states by fitting them into a linked series of discrete states of consciousness or discrete altered states of consciousness. He, Ludwig, and Zinberg point out that the diversity of mental states and knowledge about them may be both adaptive and maladaptive. West (1975, p. 300), using the terms, hallucinations and dissociative states, instead of altered or alternate states, writes that life experiences may affect the brain in ways which

leave permanent neural traces. Memory, thought, imagination, fantasy, and other ideas and images result from these traces. The content and meaning of hallucinations are understood in terms of biological, psychological, and cultural causes. West (1975, p. 300) states: "When material ordinarily or normally expected to be associated with conscious information is blocked off, or conversely appears out of context, we may speak of it as dissociated"

From the point of view of multiple causation for behavior, research indicates that there is a relationship between the neuroendocrine system and the central nervous system. In effect a simple signaling system exists which sends or triggers a chemical substance passing from one cell to another and modifies behavior. The evidence indicates that there are a number of neurotransmitters which are chemical messengers in the endocrine systems (Whybrow and Silberfarb, 1974). Because of these findings regarding the central nervous system and neurotransmitters, biological causes as well as symptoms associated with alternate mental states, permanent neural traces, and neurotransmitters will be considered in Sita's case history (Chapple, 1980, pp. 744-747).

What may provide the answer to the triggering of some alternate mental states and associated behavior, such as possession and fits, is the discovery of the endorphins and enkephalins. Research on the effects of drugs on mind and body led to the discovery of a tissue constituent on nerve cells, called a receptor, into which drug opiates such as morphine could fit. As a result of this discovery, the question was raised as to why a drug such as morphine (derived from the poppy) would fit into a receptor found in humans and other animals inasmuch as many humans in the process of evolution never encountered the drug or the poppy. The answer seemed to be that there must be an endogenous substance or substances with morphine-like qualities in human and animal bodies. This conclusion then led to the search for such endogenous substances, and the finding of the enkephalins and beta-endorphin.

Although the enkephalins are in terminals of short neurons and beta-endorphin is in terminals of long neurons, thus substances

in different systems of the body, they are endogenous morphine-like substances that carry a message to the nerve cells through the receptors to which they become attached. Such an endogenous substance is the key which fits into the lock (receptor) and turns it so that the nerve cell acts upon the message. The message of the substance then causes the relief of pain and probably at certain levels the triggering of dissociated and other forms of behavior called alternate mental states. The endogenous substance is called an agonist and is analgesic. Morphine acts in the same way because it fits the receptor and turns it, sending the message to the nerve cell. The drug naloxone also fits the receptor for morphine-like substances but it cannot turn the lock; it instead blocks the receptor from receiving messages from morphine and from endogenous morphine-like substances. Naloxone is an antagonist. It has been used to test the analgesic effects of endogenous substances. From research with opiate drugs, enkephalins, beta-endorphin, and naloxone it seems probable that beta-endorphin and the enkephalins are endogenous substances in the body which relieve pain from mental and physical stress by causing dissociative states, lasting for a period of time. Some questions remain as to the combination of causes which trigger the mechanisms in the brain and central and peripheral nervous systems. Experiments with acupuncture appear to substantiate the release of these morphine-like substances in the body, providing analgesia. The question remains as to what other circumstances cause the release of these endogenous substances and relief from pain.

Evidence from cross-cultural studies of shamans who go through elaborate initiation periods seems to indicate that similar physiological mechanisms are also involved in the alternate mental states called possession, trance, or possession-trance. Specific types of drumming, stressful physical activities, and psychological stress may trigger the mechanisms. Deficiency of calcium, hormonal malfunctions, and genetic factors may be stressors triggering the endogenous substances. Anxiety as well as other emotions should also be considered as stressors. Although the evidence of the existence of these morphine-like, endogenous substances in human and animal

bodies is clear, the degree to which and the exact manner in which they affect behavior requires more research, especially with regard to cross-cultural types of alternate mental states such as possession, trance, possession-trance, and fits. The foregoing review of research on alternate mental states, conditions inducing them, pain, and stressful events precipitating them are pertinent to Sita's case history. (The following references apply to the foregoing text on pain, stress, endogenous substances, and dissociative states: Selye, 1956, p. 47, chap. 9, 13, pp. 216-218; Neher, 1962; Rabkin and Streuning, 1976; Cleghorn, 1977; Dehen et al., 1977; Urca et al., 1977; Levine, Gordon, and Fields, 1978; Akil, Richardson, and Barchas, 1979, pp. 239-247; Bonica, 1979, pp. 15-29; Goldstein, 1979, pp. 249-261; Hughes, 1979, pp. 215-226; Kosterlitz, 1979, pp. 205-214; Watson and Barchas, 1979, pp. 227-237; Snyder, 1980, 1984; Kline, 1981; Pert et al., 1981; Henry, 1982, pp. 394-408; Jilek, 1982, pp. 326-343; Pomeranz, 1982, pp. 385-393; Prince, 1982a, pp. 303-316; 1982b, pp. 409-423; Saffran, 1982, pp. 317-325.)⁷

PSYCHIATRIC CLASSIFICATIONS

Recently the American Psychiatric Association reclassified and revised its nomenclature for mental disorders based on field trials before adoption of the nomenclature. "A nomenclature of diseases is a list or catalogue of approved terms for describing and recording clinical pathological observations" (American Psychiatric Association, 1981, pp. 1-11; quote, p. 399; Appendix F, on field trials, pp. 467ff.). For the term "neuroses" derived from Freud's "psychoneurosis" which included four types—anxiety neurosis, anxiety hysteria (phobia), obsessive compulsive neurosis, and hysteria—presently no consensus exists as to definition. As a result the association suggests that the term "neurotic disorder" be used descriptively and that "neurotic process" be used to indicate the etiological process of the disorder (American Psychiatric Association, 1981, pp. 9-10). The selection and description of the behavior as-

⁷ For an excellent presentation of endorphins and enkephalins, see R. Prince, (1982c). For more complex explanations, see Beers and Bassett (1979, chap. 17-22).

sociated with these terms are in the context of diagnosis of patients by American psychiatrists. Hysteria is no longer a disorder classified among the neurotic disorders. However, in 1979 prior to reclassification of mental disorders by the American Psychiatric Association, the International Classification of Diseases listed a series of neurotic disorders classified as hysteria (American Psychiatric Association, 1981, pp. 1-2, 5, 446-457, hysteria on p. 450). These classifications may still be in effect internationally.

Anxiety disorders beginning with childhood are pertinent to this study, but the diagnostic criteria in terms of different cultures are not strictly applicable in village India. What was formerly known as hysteria may be classified as a Phobic Anxiety Disorder; if it is linked with possession states, it is a Dissociative Disorder (American Psychiatric Association, 1981, pp. 50-53, 225-233, 253-260). The Association defines Dissociative Disorders as follows:

The essential feature is a sudden, temporary alteration in the normally integrative functions of consciousness, identity, or motor behavior. If the alteration occurs in consciousness, important personal events cannot be recalled. If it occurs in identity, either the individual's customary identity is temporarily forgotten and a new identity is assumed, or the customary feeling of one's own reality is lost and replaced by a feeling of unreality. If the alteration occurs in motor behavior, there is also a concurrent disturbance in consciousness or identity, as in the wandering that occurs during a Psychogenic Fugue. (American Psychiatric Association, 1981, p. 253)

Hysterical neurosis, conversion type, is now categorized as Conversion Disorder under Somatoform Disorders. It is defined as a disturbance with "a loss of or alteration in physical functioning that suggests physical disorder but which instead is apparently an expression of a psychological conflict or need. The disturbance is not under voluntary control and after appropriate investigation cannot be explained by any physical disorder or known pathophysiological mechanism" (American Psychiatric Association, 1981, p. 244).

When conversion symptoms are limited to pain, they are categorized as Somatoform

Disorders but under the subcategories of Conversion Disorder and Psychogenic Pain Disorder, defined as having psychologically induced pain which is not attributed to any other mental or physical disorder (American Psychiatric Association, 1981, p. 247). Thus, there is a linkage between what were previously categorized as hysteria and conversion hysteria and are now categorized as anxiety disorders, dissociation disorders, and somatoform disorders. The new definitions of somatoform, conversion, and psychogenic pain disorders emphasize that they are psychological disorders *only if they cannot be explained by any physical disorders or any other mental disorders*. These psychiatric terms and qualifications are pertinent to Sitata's case history (American Psychiatric Association, 1968, pp. 39-40; 1981, pp. 241-249).

TRADITIONAL USAGES

Although the foregoing sections on classifying alternate mental states and psychiatric disorders stem from the labeling controversy and research on the various causes of diverse mental states, they do not reflect problems of anthropologists and other behavioral scientists with the multiple usages of different disciplines and societies for identifying mental and related physical disorders (Moerman, 1979, p. 65; Prince, 1982a, p. 303). For these problems, anthropologists working in psychomedical anthropology need to know and use a number of systems for classifying and understanding behavior representing diverse mental states: (1) the anthropological; (2) the psychiatric, and (3) the indigenous usages and modes of thought in the society in which the alternate mental states occur. The terms, etic and emic, derived from linguistics (Spindler, 1980, p. 32), therefore, fall short in psychomedical anthropology and are rarely used in this study because different terms and methods for gathering data and for analysis depend on a variety of disciplines, Greek and Hindu humoral medical theories, and indigenous curing practices and beliefs. The anthropological terms and definitions, when they exist, are presumed to be sufficiently broad to apply cross-culturally. The terms, definitions, and descriptions or symptoms of

alternate mental states and related behavior used in a specific society reflect cultural usage within the society. Methodologically, the anthropologist should begin with these terms and relate them to indigenous definitions and descriptions, and then to anthropological and psychiatric terms. When necessary, Western biomedical terms and symptoms should be applied to the cultural concepts regarding related physical disorders (Foster and Anderson, 1978, pp. 86–88).

Here we are primarily concerned with the terms and usages for alternate mental states formerly identified as phobic and conversion hysteria and currently as anxiety, dissociative, somatoform, conversion, and psychogenic pain disorders by psychiatrists; possession by anthropologists; and ghost possession and fits by village society in the Union Territory of Delhi. We compare these systems of classification and usage and their bases and origins for relative congruence or dissonance in analyzing this case history. In so doing, we indicate similarities in the traditions of Greek and Hindu humoral medical theory related to the terms possession and hysteria. Biomedical terms and symptoms, when pertinent to the case of Sita, are primarily Western-scientific medical in origin except in the context of indigenous usages.

ANTHROPOLOGICAL USAGES

The origin and use of the term possession in anthropology may be traced to Tylor's concept of animism (1958, p. 10) which he classified in two parts: "souls of individual creatures capable of continued existence after death or destruction of the body; . . . other spirits, upward to the rank of powerful deities." "Supernatural beings," the more inclusive phrase for spirits and deities, is used here.⁸ Tylor (1958, pp. 210–211) describes possession of a medium by a demon and further indicates that such possession has been the dominant theory of diseases, such diseases being driven out by exorcism.

⁸ Since the traditional literature of Hinduism does not distinguish between religion and magic, as has been the case in the West, the broader phrases "supernatural beings" and "supernatural beliefs" are more accurate for this monograph.

A limited review of the literature on possession reveals that the term includes voluntary or involuntary seizure of a person by a supernatural being; it may apply to mediums, diviners, shamans, and cult members; it is ritualistic or may be a behavioral disorder; it is used the same as or in conjunction with the word *trance* or may represent combinations of the foregoing; and it has been identified by the psychiatric term *hysteria* (Kiev, 1964, pp. 9, 21; Ozturk, 1964, pp. 350–351; Bourguignon, 1965; 1979, pp. 247–265, 279–287; Ioan Lewis, 1966; Montgomery, 1974/1975; LaBarre, 1975; Langness, 1976; Crapanzano, 1977).

In recent decades, anthropologists have tried to subdivide possession behavior into more specific categories, sometimes mixing anthropological, culturally specific, and psychiatric usages. For example, LaBarre (1975, p. 10) in the context of hallucinations and hallucinogens differentiates possession from *trance*, stating that possession is used for a state in which the body "is possessed or held by an invading alien spirit"; whereas *trance* is used "to designate a cataleptic or hypnotic state of partial consciousness and high suggestibility." He further declares that from the psychological point of view possession or invasion of a human body by a supernatural is inadmissible and is the dissociated state identified as phobic hysteria, in which "The phobic projects some unwanted evil aspect of the psyche into an as-if-outside person or spirit" (LaBarre, 1975, p. 16). He differentiates possession or phobic hysteria from conversion hysteria, in which the hysteric projects and transforms psychic anxiety into "as-if-physical pain" (LaBarre, 1975, pp. 16–17).

LaBarre correlates suggestibility with *trance* but not with possession. To some extent we disagree. The anthropological use of possession is based on the cultural belief in possession, thus conditioning or providing suggestibility for an alternate mental state or behavioral outlet accepted and recognized in the society. The distinction between possession and *trance* is generally based on the former being involuntary and the latter, voluntary. We would qualify this statement because an individual growing up in a society in which possessions occur would learn possession behavior from observation, but in

possession might act it out subconsciously, that is involuntarily. In any case, LaBarre notes the Pan-Indic distribution of possession and exorcism (LaBarre, 1975, p. 24), a finding which has been confirmed by studies from various regions of the sub-continent of India (Oscar Lewis, 1958, pp. 295–299; Majumdar, 1958, pp. 234–236; Opler, 1958, pp. 553–566; Harper, 1963, pp. 165–177; Montgomery, 1975/1976; Carstairs and Kapur, 1976, pp. 110–112; Hitchcock and Jones, 1976; Rex Jones, 1976; Shirley Jones, 1976; R. Freed and S. Freed, 1979, pp. 322–324; Freeman, 1979, pp. 188–193; Hockings, 1980, pp. 162–170).

Bourguignon (1965) differentiates between possession, trance, and possession-trance. For example, possession-trance occurred in a modern suburb of Delhi, where individuals sought possession by Durga, a deity of the Hindu great tradition, and exhibited trance states (R. Freed and S. Freed, 1962, pp. 253–262). Simple trance, according to Bourguignon (1979, pp. 247–250, 280–283) occurs when there is an absence of possession beliefs. Thus, she and LaBarre distinguish between trance *per se* and possession. Bourguignon (1979, pp. 280–283) further states that a distinction should be made between possession beliefs linked to pathological states and those which are not. The pathological states should be defined and labeled as cultural-bound syndromes in the emic sense; in the etic sense they should be identified as hysteria, or possibly by other terms for behavioral disorders. This dichotomization is not applicable in our approach which identifies the state by the anthropological term possession, by the psychiatric term dissociative disorder, or whatever the symptoms indicate, and by the village terms for ghost possession and fits. This principle applies to Sita's dissociative behavior.

From the anthropological point of view the simplest and broadest definition of possession, applicable cross-culturally, is: the belief in the seizure, possession, or invasion of a human being by a deity, spirit, ghost, or demon, i.e., a supernatural being. The anthropological term possession and the definition avoid the distinction between pathological and nonpathological states of possession. The reason for using a multiple system of classi-

fication is to avoid the identification of the pathological state in anthropological terms, and to use the cultural terms and descriptions before arriving at the psychiatric term. This procedure deals with possession as a form of behavior and then relies on the cultural context, the actual behavior, psychological concepts and terms, and biological conditions, to identify the mental state.

There seems to be no cross-culturally useful word in anthropology for a "fit" or "fits," except possession. Perhaps this lack is because fits in earlier times and still today have been believed to be seizures by supernatural beings. Words having a similar meaning are: convulsions, seizures, and spasms. When a fit is attributed to seizure by a supernatural being, it belongs within the meaning of the term possession. The nature of the fit and the explanation of its causes may or may not distinguish it from possession.

PSYCHIATRIC USAGES

The anthropological term possession is essential in tracing the origin and usages of corresponding psychiatric terms from ancient Greek culture to Freud's time and the present. Of specific importance are the words epilepsy and hysteria. In the Homeric epics of the *Iliad* and *Odyssey* (eighth century B.C.), disturbed mental activity was attributed to deities having possessed a person and driven him or her mad (Harris and Levey, 1975, p. 1261; Simon, 1980, pp. 65–72). Later in the classical period of Greek antiquity (fifth and fourth centuries B.C.), Hippocrates (c. 460–370 B.C.) is credited with the theory of humoral diseases and the refutation of mental illness caused by supernatural beings. Humoral medicine in this period is identified as originating in the Hippocratic corpus. This body of humoral medical theory and treatment, which presumably at first was passed along orally, contains several books describing case histories and diseases from different times and places. The two earliest books date from this period and sometimes are attributed to Hippocrates; the other books are probably the works of later authors (Chadwick and Mann, 1950, p. 29; Harris and Levey, 1975, pp. 1135, 1246).

The general principle in Greek humoral

medicine was that health consisted of the homeostasis of four humors: blood, phlegm, yellow bile, and black bile. Imbalance of these humors resulted in ill health. Humoral imbalance could lead to disturbances of the mind caused by a number of external factors: climate, seasons, winds, and types of foods eaten in association with the seasons. Based on these causes, disturbances of the mind were similar to physical illnesses. In addition excitation by various emotions and the intake of different substances could lead to imbalance as well as restoring balance when treated by a physician (Foster, 1978, pp. 4–7; Simon, 1980, pp. 48, 215–219).

From our point of view, an interesting aspect of the Hippocratic corpus is the combination of mental illnesses referred to as the “sacred disease.” The Greek word *epilepsis*, used once in the corpus, has frequently been taken to refer to epilepsy. Literally, *epilepsis* means seizure; such seizure was considered to be sent by a deity or supernatural being. The Hippocratic corpus on the subject of the sacred disease attempted to show that this so-called disease, most often associated with epilepsy, was not due to possession or seizure by a supernatural being but rather consisted of a number of different mental disorders due to physical and emotional causes in terms of humoral medical theory. Thus, the so-called sacred disease encompassed fits, possession, and other disturbed mental states as well as hysteria and epilepsy (Temkin, 1933, pp. 280–285; Chadwick and Mann, 1950, pp. 179–193; Simon, 1980, pp. 220–225, 238–244). Even though the belief lingered in classical Greek culture that mental diseases could be caused by supernatural beings, as illustrated in the tragedies of Aeschylus, Sophocles, and Euripides, and the comedies of Aristophanes, from Homer through Plato to Aristotle, medical explanations of madness changed from seizure by supernatural beings to the effect on the minds of human beings by humoral imbalance (Simon, 1980, chap. 8, 9).

Included in the Hippocratic corpus are treatises “On the Diseases of Women” and “On the Nature of Woman,” from which theories about the wandering uterus (*hystera*, the Greek word for uterus or womb) and the term hysteria derive. The treatises though sometimes attributed to Hippocrates have never

been proven to be his work. Some evidence indicates that the theory of the wandering uterus diffused from ancient Egypt (Veith, 1965, pp. 9, 11–13). However, humoral theory held that organs of the body could be displaced due to factors affecting the humors. This theory incorporated the wandering uterus as one such organ and was to persist to the nineteenth century linked with hysteria as a disease of women. Hysteria in classical Greek culture was further identified by fainting and seizures and was thought to be related to sexual problems. In retrospect it seems such behavior and labeling owed much to the attitudes toward women; their subordinate and secluded position, and the preference for a male-with-male basis for companionship, love, and homosexuality. These attitudes toward women and masculine companionship (but as far as we know without homosexuality) were similar to attitudes we found in the rural Delhi region (Morris, 1969, pp. 650, 1472, 1547; Dodds, 1973, pp. 67, 68, 70, 72; Dover, 1973; Simon, 1979, pp. 180–194; 1980, pp. 124–139, 238, 242–244).

“Hysteria as a culturally sanctioned dumb show in which patient, doctor, and family all participate, has a continuous history from antiquity to the present” (Simon, 1980, p. 243). Linked with this tradition and similar to cultural traditions in which possession is found, the position of women in ancient Greece was low as it is today in India and other parts of the world where possession exists (Veith, 1965, pp. 10–12; Pomeroy, 1975, chap. V; Simon, 1980, pp. 244–257).

Galen (c. A.D. 130 to c. 200), a later physician of humoral medicine born in Pergamon, Asia Minor, and practicing there and in Rome, added to and modified two theories regarding males and females and hysteria, deriving from the Hippocratic corpus. The first of these reinforced the inferior position of women. The Hippocratic corpus presented the theory that females were imperfect males. The belief was based on the idea that both male and female semen existed tied to the right-left anatomical and physiological concepts for male and female. Galen followed the right-left principle but with the right spermatic artery supplying blood of fine quality to the right (male) side of the uterus; the left spermatic artery, arising near the kidney,

bringing blood of a water-urinary kind to the left (female) side. He also believed in an inferior female semen manufactured by the ovaries, which he considered to be female testes. Galen, however, said that the uterus did not wander. Followers of Hippocratic or humoral medicine paid no attention to this statement of Galen's any more than they did to his statement that hysteria could be found in both sexes and was due to lack of sexual intercourse because the retention of semen for both sexes resulted in an imbalance in the system. Another precept of Galen's which seems to have been ignored was "hysterical passion is just one name; varied and innumerable, however, are the forms which it encompasses" (Sarton, 1954, pp. 3, 6, 15, 20-21, 23, 51-55; Veith, 1965, vol. 1, pp. 31, 35-37, quotation, p. 39; Simon, 1980, p. 265).

Another theory which had its origins in the Hippocratic corpus and was later expanded by Galen is the theory of different types of temperaments and mental states being related to the humors. According to Temkin (1933, p. 287; 1971, pp. 51-56) the corpus distinguished between choleric and phlegmatic types of temperament; according to Sarton (1954, pp. 52-55), the theory of temperaments is an ancient tradition based on a theory of four qualities, which by Hippocrates's time was based on the four humors and their interactions with dry, wet, hot, and cold substances. In the discussion of the sacred disease in the Hippocratic corpus, however, two temperaments are mentioned: choleric and phlegmatic, the former due to excess of yellow bile, the latter, to excess of phlegm. Epilepsy was believed to occur in the phlegmatic type. Terms comparable to these four humors and related temperaments are sanguine (blood), choleric (yellow bile), phlegmatic (phlegm), and melancholic (black bile). Disorders of these humors were believed to result in comparable mental disorders. Galen's further contribution was "that the habits of the soul follow the temperament of the body," an idea which would contribute to the biological ascendancy of matter over mind rather than otherwise, but it along with earlier humoral theory would then place the burden of deviant or abnormal behavior upon the temperament of the body (Sarton, 1954, p. 55).

The beliefs deriving from the Hippocratic corpus and later Galenic theories were to influence the development of psychoanalysis and psychiatry in the nineteenth century. These beliefs are: *epilepsis* refers to a seizure and various mental states; the illness labeled hysteria was originally a part of the sacred disease, namely caused by seizure by a supernatural being, and later in humoral theory believed to be due to displacement or wandering of the uterus; mental illnesses are related to the type of temperament characterized by the four humors and result in different types of mental diseases; hysteria, identified by fainting and seizures in ancient Greece, was generally considered to be a disease of women, despite Galen's statements to the contrary; hysteria was also considered to be due to lack of sexual intercourse. The inferior position of women was related to humoral theories indicating that females were incomplete males. In more recent times, the mental states associated with the label "hysteria" are thought to be related to the sexual and status problems derivative from the subordinate position of women, the effects of male homosexuality, and concepts of male superiority which existed in ancient Greece, but then were expressed in terms of humoral medical theory (Sarton, 1954, pp. 88-93; Veith, 1965, pp. 13-14, 31-39).

The Greek revival in Europe of the eighteenth and nineteenth centuries swayed the early physicians working with patients with mental disorders, many of whom—among them Charcot, Freud, and Breuer—had a classical education, and whose writings and researches were known to each other. Freud was further influenced by Greek mythology as presented in the revival of Greek tragedies in the theater (Simon, 1980, pp. 43-46, 98, 141-143; Trosman, 1976, pp. 46-70). Freud attributes his work on hysteria and related sexual theories to Josef Breuer (1842-1925) and to the French neuropathologist, Jean Martin Charcot (1825-1893). Freud's collaboration with Breuer began in the early 1880s and terminated in 1895 with their "Studies of Hysteria" (1893-1895). During this period, when Freud was gradually turning from neurophysiological to psychoanalytical work, he spent a number of months in Paris in the winter of 1885-1886 studying with Charcot,

whose influence, together with Breuer's, marked a turning point in his career (Miller et al., 1976, pp. 115-131; Pollock, 1976, pp. 133-135, 146).

At this time, the concept of the wandering uterus was still part of the theory and treatment of so-called hysteria in Europe. Charcot influenced the medical profession to think of hysterical conversion as a neurological disease brought about by psychological trauma. However, in his earlier years, he treated hysterical seizures with ovarian compressors, i.e., a treatment aimed at putting the wandering uterus in place and comparable to humoral medical treatment (Simon, 1980, pp. 238-239). Freud was influenced by these theories and treatments as well as by Charcot's induction of hysterical phenomena through hypnosis. As West (1975, p. 305) and Miller et al. (1976, pp. 119, 121, 122) have pointed out, Charcot became aware that different kinds of consciousness (alternate mental states) exist as a result of his finding that the stream of consciousness broke up in his hypnotic experiments and replicated hysterical phenomena.

After returning to Vienna from studying with Charcot, Freud for a time used electrotherapy treatments for the uterus and hypnosis to treat hysteria because of Charcot's influence and because medical science at that time explained diseases as being based on organic causes and resisted psychological explanations. Thereafter, he discarded hypnosis and electrotherapy (Freud, 1938, p. 6) and through his studies of hysteria went on to develop his theories of mental diseases. He attributed his concept of the sexual etiology of hysteria and other mental disorders to Charcot and Breuer, but for hysteria his ideas of sexual etiology and the predominance of hysteria among females seem to have been influenced by his classical education. However, Charcot, Freud, and others recognized that hysteria occurred in both sexes (Freud, 1938, pp. 937-938; Trosman, 1976, pp. 66-70; Simon, 1980, pp. 45-46). In 1925, Freud in his autobiography wrote that "What impressed me most of all while I was with Charcot were his latest investigations upon hysteria . . ." (Miller et al., 1976, p. 130).

The cultural milieu, including its scientific knowledge and technology, in Austria at the

end of the nineteenth century may have contributed to Freud's findings regarding hysteria. For example, as late as 1904, cases of dissociation were diagnosed as mixtures of tetany and hysteria. The first demonstration that tetany was associated with reduced concentrations of calcium in the blood did not occur until 1908 (Wallace, 1961, p. 273). The bases of many alternate mental states were not recognized until the 1950s and 1960s. Further, the subordinate position of women existed in the Victorian age and into the twentieth century, for males were the authority figures in families (Campbell and Narnoll, 1972, p. 437). Along with these characteristics of everyday life, considerable sexual repression and inhibition existed for females. Dissociation in the form of fainting and seizures along with related physical causes may have allowed some of these females an escape when the society allowed no other relief or means of coping with unbearable situations. The amount of sexual repression characteristic of the Victorian and Post-Victorian eras was a factor in the diagnosis of hysteria because the threads of belief regarding hysteria persisted from earlier times (Sarton, 1954, pp. 91-92; Veith, 1965, p. 35). Freud's (1978) analysis of "The Fragment of a Case of Hysteria" (Dora's case history) has confounded and at the same time reinforced some of these early beliefs (Marcus, 1974).

INDIGENOUS INDIAN USAGES

Belief in ghost possession as a form of illness in the rural region of Delhi is related to ideas concerning the dead. The general belief is that immediately after cremation, the soul of the deceased in the form of a ghost lingers in the cremation grounds and around the village for 13 days. Then, depending on the age of the deceased, the cause of death, and whether the proper cremation and mourning rites were observed, the soul may linger on earth and may possess people, or may journey to the land of the dead for judgment by Yama, the god of the dead. His judgment is based on the actions of the deceased in all past lives and determines whether the soul will be reborn or released from the round of rebirths.

Both males and females suffered from ghost

illnesses, which were attributed to the souls of deceased persons who became ghosts if they died untimely deaths, were in some way unable to fulfill all the requirements of adulthood, whose kin did not observe the proper funeral rituals, or whose behavior while living endangered the community. Ghosts were souls in limbo who had brought cognitive disorder to the community's view of an ordered world. They were tied to the world of the living until their destined time on earth had elapsed. As misfits, it was believed that ghosts envied the living and tried to take their souls. The personalities of the dead and living persons were intertwined based on relationships which had existed between them as family or lineage members, affinal relatives, friends, or neighbors. These ghostly characteristics are pertinent to Sita's case history (R. Freed and S. Freed, 1980, pp. 515-535).

Both male and female ghosts existed in village lore. Males were generally possessed by male ghosts; females, by female ghosts. Very probably the reason that ghosts were believed to possess victims of the same sex was due to the relative segregation of male and female activities. The exceptions to this dichotomy were infants of either sex, who if they died were believed to have been taken by female ghosts who had died without issue or at childbirth. In 1978, however, one woman was believed to be possessed by her dead husband's ghost. She had been raised in an urban environment where the sexes were less segregated and was unaware of many of the village beliefs about ghosts (R. Freed and S. Freed, 1980, pp. 526-530).

Ghost illnesses took two forms in rural Delhi. The first type followed an encounter with a ghost but did not involve possession. A person saw a ghost, fainted, and thereafter became ill. The second ghost illness was unsought possession. A person lapsed into unconsciousness. One or more alter-ego voices, identified by witnesses as ghosts, spoke from the unconscious or semiconscious person, who then relapsed into silent unconsciousness followed after a while by a return to consciousness; or else the victim was restored to consciousness through the techniques of bystanders or exorcists. After recovery from an attack, an individual had no memory for the events, was not injured during them, but

could identify the ghosts, providing their names were elicited by the witnesses or curers during the possession. Behavior during these ghost illnesses may be classified as alternate mental states. Ghost possessions occurred most often among new brides.

Although some villagers did not believe in ghosts or ghost possessions, the majority of them did and recognized that "the ghost had come" when an attack took place. The villagers who did not believe in ghosts were chiefly male followers of the Arya Samaj sect of Hinduism, whose doctrine proscribed beliefs in diverse spirits and multiple deities. However, in 1978 an Arya Samaji about 50 years old said that he had experienced a series of ghost possessions although he commented that Arya Samajis were not supposed to believe in ghosts. In addition, an eight-year-old schoolgirl from an Arya Samaj family had a series of possessions. Although 1978 was a more prosperous period than 1958, greater stress existed due to conflicting systems of health care, more intense political rivalry, pressure from proponents of family planning, considerably more crowded living conditions, drunkenness, thefts of cattle and tubewell motors, a great rise in the incidence of malaria which formerly had been almost eliminated, technological accidents, and other factors related to change.

A curer was generally called a *bhagat* (exorcist) or *siyana* (wise man). The term *shaman* has also been used by anthropologists for the curer who "took off" the ghost. Although this term has generally been attributed as coming through the Russians from the Tungusic word *saman*, Eliade (1964, pp. 4, 495-507) recently has put forth the cogent position that it derived from the Pali *samana* and the Sanskrit *sramana* of India by adoption from Sino-Buddhism (Lamaism) in Central Asia and Siberia. The term *shaman* has been used by anthropologists for indigenous curers and includes those who may or may not go into possession-trance during the process of curing. The curers of ghost possession whom we encountered in the Delhi rural region did not go into possession-trance. Their main function was to exorcise, drive off, or take away the ghost troubling the possessed. Although a number of terms were used for diverse curers (*bhagat*, *fakir*, *hakim*, *siyana*,

vaid, and the English “doctor”), we use the word exorcist for the curers of ghost possessions. During the curing session, the exorcist uses his power to control the ghost but does not propitiate it although he promises to make offerings at the shrine for Kalkaji (goddess of the cremation grounds) on behalf of the afflicted person (Morris, 1969, p. 1190; Hunter and Whitten, 1976, p. 350; Spiro, 1977, p. 419).

The indigenous terms used for ghost were *bhut*, *preta*, *opera*, *upri hawa*, and *jinn* or *jind*. *Bhut* was the general term for ghosts and was most often used.⁹ It was customarily used with words signifying seizure, possession, and attack. For example: *bhut grasth*—attacked by a ghost; and *bhut lagna*—possessed by a ghost. *Opera* referred to the ghost of a woman who was married and therefore would have been more readily suspected of ill-will than a young unmarried female. *Upri hawa* appeared to have been introduced into the village after 1958 and had partly supplanted *opera*; it also meant an apparition of a person who had died and become a wandering soul or ghost. *Preta* was rarely used since it was associated with ghosts taking the form of animals or having an unusual characteristic, such as feet that were turned backward. *Jinn* (from Islam) referred to a spirit who entered one or could appear before one—similar to the *Jinn* in the tale of Aladdin’s Lamp (R. Freed and S. Freed, 1979, pp. 305–306, 318, 322–324; 1980, p. 527).

Because Ayurvedic medicine was revived in India throughout the 1950s and 1960s partially due to government dispensaries and clinics staffed with Ayurvedic practitioners, villagers during our 1977–1978 field trip displayed more knowledge of Ayurvedic concepts than in 1958. In order to distinguish between the village terms and symptoms for Sita’s fits, epilepsy, madness, and delirium, we give the terms, village descriptions and

other comments about cases illustrating the terms, and wherever possible the medical theory behind the cases. For example, the type of fit Sita had (*daura*, pronounced *dora*) was attributed to wind getting into the mind and causing the individual to have the fit and fall unconscious, a typical Ayurvedic diagnosis. In Sita’s marital village this fit was distinguished from epilepsy, which was called *mirgi* (Pathak, 1976, pp. 544, 1160). Whenever the terms fit or fits are used in this monograph, the word *daura* applies; for epilepsy, the word *mirgi* applies.

The villagers were familiar with two cases of epilepsy during both periods of fieldwork. The earlier case of a young girl who died before 1958 was never treated, but in 1977–1978, a young man regularly took pills for epilepsy, prescribed by a physician trained in Western-scientific medicine (R. Freed and S. Freed, 1979, pp. 326–327). The young man’s father described the first appearance of the symptoms while his son was suffering from pneumonia and was taken to a hospital in the City of Delhi for treatment. He had a high fever with delirium (*sarsam*), during which he shouted abusively, arose from his bed, and jumped out of a window into an airshaft. He had to be pulled out by the neck with a hooked instrument. Thereafter he had intermittent bouts of foaming at the mouth and falling unconscious, diagnosed as epilepsy, for which he daily took preventive medicine. In spite of his disability, he worked in the City of Delhi and commuted daily.

Villagers distinguished epilepsy, fits, and ghost possessions, from one another and also from madness (*pagalpan*) and delirium (*sarsam*), a disordered state of the brain, occurring during serious illness and high fever. Two individuals were labeled by the villagers as mad, a condition that they claimed was caused by too much joy or sorrow. The first case, in 1958–1959, was a village midwife, about 50 to 55 years old whose behavioral symptoms included great suspiciousness of everyone, extreme jealousy of females who talked with her husband, and visions of insects before her eyes, probable symptoms of paranoid psychosis. However, the early stages of her illness were described as ghost possessions. They had occurred a number of years before 1958 (R. Freed and S. Freed, 1979, p. 326). The

⁹ In 1958–1959, we gathered terms whenever pertinent to the ethnographic data. In 1977–1978, we made a concerted effort to obtain as many terms, meanings, and symptoms for illnesses as possible. From 1959 to 1977, changes had occurred in the village dialect and vocabulary. There was greater standardization toward urban written Hindi because literacy and urban employment increased.

second case of madness was a young man who had shock treatments in the 1970s and appeared sane and functioned in everyday life in 1977–1978. Villagers' descriptions of his symptoms indicate manic fits with violence, but the word used for his mental illness was *pagalpan*. He was a member of a wealthy landowning family whose head, his father, was an extremely authoritarian male. Two of his brothers had tuberculosis, and one sister died from it. After his shock treatments, he and his wife lived separately from his father's joint family.

Western medicine has been practiced in India ever since it was introduced by the British; however, psychiatric methods of treatment were not introduced until 1922 and have not spread as rapidly as chemical-therapeutic methods of treatment (Nandi, 1979, p. 21). Nandi (1979, pp. 24–29) has pointed out that the rural population of India is less apt to seek such treatment than urbanites, that for success in India, particularly in the rural areas, the Freudian-derived theories and techniques require adaptation to and understanding of the rural milieu. Hoch (1979, pp. 53–54) suggests using beliefs familiar to the patient, such as ghosts and the evil eye, to stimulate ideas and the flow of communication between patient and psychiatrist. He further suggests the use of techniques of indigenous curers, such as a penetrating look, quiet observation, and feeling the pulse, to establish confidence and rapport. Surya (1969) has likewise indicated the need for psychoanalysts to understand the differences between Indian and Western families, especially with regard to independence-dependence training, ego mechanisms, and family structure. Kakar (1978) and Roland (1982) follow along somewhat similar lines.

Although the villagers have taken to Western medicine when available through government programs, but more particularly through popular pharmaceutical medicine (antibiotics administered primarily by pharmacists or their assistants), very little of the bases for such medicine was understood (Gould, 1957, 1965). Except for the one man who had undergone shock treatment, there was little or no knowledge in the village regarding Western psychotherapeutic treatment and no cognizance of psychoanalysis.

Shock treatment, if described to a villager, might to some degree be considered similar to exorcism, but that a patient should at regular times visit a psychiatrist, talk about him or herself and pay for so doing, would not be comprehended. Villagers would not spend the time or money. The basis of compatibility between the village concepts and psychoanalysis would be the way in which exorcists talked with ghosts in order to find out who the ghosts were in relation to the patient. If a *modus operandi* might be worked out along these lines, psychotherapy might be more successful at the rural level, at least for dissociative states such as ghost possessions. Perhaps village exorcists could be trained, similar to the singers among the Navajo or the Aro village scheme of T. A. Lambo in Nigeria (Evans, 1972; Carstairs and Kapur, 1976, pp. 137–138). The major problems would be bringing patient and psychoanalyst together and obtaining government funds to pay for such treatments. Indian psychiatrists are coping with some of these problems by using the traditions of Hinduism and knowledge of village behavior, especially the ways in which villagers cope with stress and tension in everyday life (Alexander, 1979, pp. 33–43).

Carstairs and Kapur (1976), psychiatrists, carried out an intensive study in Kota village on the southwest coast of India, near Mangalore, "to compare the prevalence and patterns of mental disorder in three South Indian communities which, in spite of sharing the same environment, the same religion, and the same language for centuries, have been able to maintain some easily perceptible differences in their way of life and cultural traditions" (Carstairs and Kapur, 1976, p. 19). Three castes were studied and differences in incidence and kinds of disorders were found from caste to caste, which is not surprising since castes have different subcultures.

Among the types of disorders were possessions. Carstairs and Kapur note that there were two types of possessions, voluntary and involuntary, that they occurred among men and women but that women had the greater incidence. Those who had voluntary possessions often earned their living by summoning a spirit, becoming possessed, and offering a solution to a problem. They were not dis-

turbed by the possessions and were revered for having special powers. Both types of possessions were experienced by men and women, but for involuntary possessions, there was a greater number of woman sufferers. They suffered from and resented the possessions (Carstairs and Kapur, 1976, pp. 110–112). Carstairs and Kapur report hysterical possessions and fits as follows:

We find it difficult to believe . . . that voluntary possessions are hysterical phenomena . . . in a culture in which a belief in Bhutas and spirits is common, this is one of the acceptable ways of earning status in the society and often of making a living. The involuntary possessions are in all likelihood distress signals; in each of the ten cases there was evidence of family disharmony. . . . (Carstairs and Kapur, 1976, p. 112)

Hysterical fits usually follow a bizarre pattern and may last for long periods. Pattern may be different in different fits. Injuries are rare. History of psychological stress is often reported. (Carstairs and Kapur, 1976, p. 163)

Thus, involuntary possessions and fits are classified by Carstairs and Kapur as hysteria. Although the word “seizure” applies to these types of possessions and fits, Carstairs and Kapur’s involuntary possessions and hysterical fits are similar to the terms used in the Delhi region where bhut *lagna* means to be possessed by a ghost and *daura* translates as a fit.

A further understanding of village usages and attitudes toward alternate mental states can be obtained from a review of Ayurvedic humoral theories regarding mental states, and the origins of Hinduism and associated beliefs in deities and other supernatural beings. The Hindu origins for spirit or ghost possession can be traced to the Atharva-Veda, the last book of the four Vedas, which are the earliest and most holy of Hindu texts. The four Vedas date from about 1500 to 900 B.C. In the Atharva-Veda illness is defined as caused by an intrusive spirit with attendant soul loss and possibly death. The book prescribes the spells, rituals, and cures carried out by Brahmins (priests) to exorcise the spirits causing illness (Basham, 1954, p. 232; Thapar, 1976, pp. 29–31; R. Freed and S. Freed, 1979, pp. 290, 302–313).

Indo-European civilization in North India after the Vedic age in the times of Buddha (c. 566–480 B.C.) and Ashoka (c. 274–232 B.C.) displayed similarities to Greece in possessing a theory of medicine based on early texts referred to as the Ayurveda, the book of knowledge for long life (Jolly, 1951, p. 18, original in German, 1901). Now, as then, this system of medicine is called Ayurvedic. Although not identical, the Indian and Greek systems share a number of features, including the belief that supernatural beings can cause illness. The Ayurveda mentions the derivation of this belief from the Atharva-Veda. The major similarities between Indian and classical Greek medical theories are the concept of humors and the belief that health is due to their homeostasis. India differs from Greece in having three humors (*tridosas*): air, phlegm, and bile, rather than four as in Greece: blood, phlegm, yellow bile and black bile.¹⁰

Ayurvedic theory also differs from Greek humoral theory regarding conception. Conception in the Ayurveda depends on the combination of sperm and menstrual blood. “Mention is also made of the sperm of women, yet it is expressly stated that it has no influence in the formation of the foetus . . .” (Jolly, 1951, p. 73). The mother contributes the soft parts of the body, while the father creates the hard parts (Jolly, 1951, p. 81). The latter theory may have been based on cultural beliefs regarding the physiology or behavior of males and females.

In general, Ayurvedic physicians diagnose illness based on the homeostasis of the three humors in relation to six seasons of the year and the types of illness generally prevalent in them; the effects of winds and various climatic conditions; and in particular, diet from which the concepts of hot and cold foods derive (hot and cold being the qualities of the food and not their temperature) and whether the foods are sweet, bitter, salty, astringent, sour, or acrid. These qualities of food are

¹⁰ The three humors in the Delhi region were identified as *vayu* (wind) or *hawa* (air), *koff* (phlegm or mucous), and *pitt* (bile). Jolly (1951, pp. 59, 179) gives as Sanskrit equivalents: *vata* for *vayu*, *kapha* for *koff*, and *pitta* for *pitt*. Kutumbiah (1969, p. 66) uses *vayu*, *pitta*, and *kapha*.

correlated with the seasons, which in turn are correlated with each humor and disorder resulting from them (Jolly, 1951, pp. 53–58; Kutumbiah, 1969, pp. 35–40, chap. III; Plalnarp, 1971, appendix A, pp. 359–381).

Although the origins of Greek and Hindu humoral theories may never be clearly demonstrated, both may have had their beginnings in the region of Eastern Europe from the Baltic to the Black Sea, and most probably in the Kazakh-Kirghiz Steppes, from which the Greek and Indian Indo-European speakers migrated (Thapar, 1976, p. 29; Littleton, 1982, pp. 28–31). Thereafter, the Greek and Indian systems appear to have developed separately. Through trade, conquest, and migration within the Old World *Oikumene* (the inhabited civilized world which stretched from Gibraltar to India and possibly beyond to China) (Kroeber, 1948, pp. 423, 784; Jolly, 1951, pp. 18–29), the two medical systems later probably came to influence each other again. For example, although Greek humoral theory does not include air as one of the humors, the Hippocratic corpus considers air “to be the main cause of all diseases” (Temkin, 1933, p. 304). In like vein, Ayurvedic medicine does not include blood among the humors as does the Greek system. However, it considers blood to be one of the *dhatu*s, constituents that support the body. At times under specific conditions, the *tridosha* (three humors) are *tri-dhatu*s and function as any other *dhatu*s (Kutumbiah, 1969, pp. 34, 45–46, 214). The conquests of Alexander in the northern part of the subcontinent and the later invasion of the region by hordes of Islamic conquerors with their adaptation of Greek humoral theories, known as Unani and Unani Prophetic medicine, were but part of the ongoing stream of history in the Old World from India to the Mediterranean (Basham, 1954, pp. 48–50, 58–60, 490–491, 499; Bürgel, 1976; Foster, 1978, pp. 7–8; R. Freed and S. Freed, 1979, pp. 314–315).

Early Ayurvedic texts attributed to the two physicians, Charaka and Susruta, developed two somewhat similar classifications of disease.¹¹ Charaka proposed three categories: (1)

physical illness arising from abnormal conditions of the body; (2) accidental maladies from causes such as a miscellany of spirits and poison; and (3) mental disorders from not being able to obtain desired objects or from disliked relationships. Susruta offered four categories of diseases based on their causes: (1) those owing to trauma from outside the body and those due to (2) bodily, (3) mental, and (4) natural causes. Mental diseases are due to too much anger, grief, fear, joy, etc., in other words excess of emotion, a belief still found in the Delhi region and similar to one in the Hippocratic corpus. The brain may be too warm, moist or dry in relation to these emotions; and madness may result from excessive phlegm or bile (Temkin, 1933, p. 298; Kutumbiah, 1969, pp. 79–80). Susruta's fourth category, nature, consists of diseases brought about by a curse, a deity, or spirits (Kutumbiah, 1969, pp. 80–81). In addition, diseases of children may be due to the influence of heavenly bodies, especially the nine *grahas* (Sun, Moon, Mars, Mercury, Jupiter, Venus, Saturn, and the descending and ascending nodes of the moon, Ketu and Rahu, called demons). These *grahas* are believed to have presiding deities or spirits with power to act upon humans. The word *graha* means “seizes” (Dowson, 1950, p. 114; Daniélou, 1964, pp. 165–166, 315–316; Kutumbiah, 1969, pp. 199–201).

Ayurvedic medicine has a series of categories for alternate mental states, such as epilepsy, madness, and possession. As in the Hippocratic corpus, diverse mental states and causes are classified as epilepsy, for example, mental states which “arise in the heart” be-

for Charaka and the fourth century A.D. for Susruta, are generally considered to be the work of a number of physicians following after Charaka and Susruta. The dating of these documents is based on paleography, but the dates for the two physicians, Charaka and Susruta, were probably before the documents. They may have lived before the Christian era. The Atharva-Veda, the fourth and last book of the Vedas which had practical folk cures for people and cattle and prescribed rituals for exorcism by Brahman priests, is considered to be the source of the stimulus for the development of Ayurvedic medicine, but Ayurvedic medical theory goes much beyond it. Basham (1954, pp. 498–499) describes the curing practices of the Vedas as being in a “primitive state of medical and physiological lore” (Jolly, 1951, pp. 1–29; Kutumbiah, 1969, pp. x–xxxvii).

¹¹ The exact beginnings of Ayurvedic medicine are difficult to ascertain. Two compendia of medical theories have been associated with the names of early physicians (Charaka and Susruta), but the actual documents, which probably date around the first to second centuries A.D.

cause of grief, anger, greed, fear, joy, and mental excitations. What is referred to as "old epilepsy" resembles the disorder that today is known as symptomatic epilepsy, which was considered incurable. Six types of madness caused by imbalance of the humors and/or the emotions were considered more extreme than epilepsy. These were caused by:

1. Imbalance of air (*vata* or *vayu*), which resulted in laughing without reason;
2. Imbalance of bile (*pitta*), indicated by violence or violent possessions;
3. Imbalance of phlegm (*kapha*), identified by loss of intelligence, memory, and appetite, accompanied by vomiting, salivation, silence, loneliness, sleepiness, and general lack of grooming.
4. If all three of the humors (air, bile, phlegm) were out of balance, the condition was incurable.

5. In addition, madness could be caused by painful excitation, such as the loss of property, or a wife, and
6. By poison.

Ghost or spirit possession (*bhutonmada*), considered the worst form of madness, was caused by supernatural beings, usually malevolent. Its remedy was exorcism through fumigation and offerings to supernatural beings (Jolly, 1951, pp. 175, 178–180). *Mada* has been translated as intoxication and excitation. These two meanings of *mada* are comparable to alternate mental states caused by taking drugs or alcohol, by drumming, or by emotional excitation (forms of stimulus excitation). These concepts from humoral medical theories and the Atharva-Veda have persisted in the rural Delhi region. They represent the "health culture" within which Sita's psychomedical case history unfolds.

EARLY YEARS (1943–1957)

CRISIS STAGES IN LIFE

The following descriptions of three stages in Sita's life (childhood, 1943–1957; marriage, 1958; motherhood, 1961) incorporate some well-known theories pertinent to the life cycle. The best known is van Gennep's 1908 study. An individual passes at different critical times in life through a series of ceremonies, rituals, and events known as rites of passage. Van Gennep's concept of the purpose of a rite of passage "is to enable a person to pass from one defined position to another which is equally well defined" (1961, pp. 2–3). This theory about rites of passage has been found to apply cross-culturally, and in our experience particularly so in the rural Delhi region (R. Freed and S. Freed, 1980, p. 340). In this region, a series of stages in life are celebrated depending upon sex, age, and caste affiliation. Orthodox Hinduism has long had an idealized series of four stages in life after childhood, namely, celibate, householder, hermit, and homeless wanderer. Traditionally the celibate, hermit, and homeless wanderer stages apply to males of the twice-born castes (Brahman, Kshatriya, and Vaishya). The stages of hermit and homeless wanderer (renouncers of worldly affairs) occur in later years (Basham, 1954, pp. 158–159).

At the village level, members of the twice-born castes may still celebrate the investiture of the sacred thread for young males, who during this rite of passage briefly enact the role of celibate but immediately thereafter are married. Thus, this initiation ceremony has been incorporated into the marriage rite (R. Freed and S. Freed, 1980, pp. 443–445). However, most villagers generally pass directly from childhood to householder at the time of their marriage rite of passage, as did Sita at her marriage. Her wedding provided the pivot between the two stages. Women also take on another role when they bear their first child, the role of mother. This change in status and associated behavior is likewise celebrated by a series of events which constitute the birth rite of passage. For women, marriage and childbearing are crisis periods. In Sita's case we shall find that both were traumatic (R. Freed and S. Freed, 1980, pp. 347–401, 404–506).

Village society to some degree recognizes these life crises by regularly celebrating associated rites of passage, thus enabling children and adults to learn about them by participating in and/or witnessing the celebrations. The rites of birth, marriage, and death cover long durations, include numerous partici-

pants, and contain many events, rituals, and ceremonies which for the most part are also social and socializing events. During the time a rite of passage takes place, the individual undergoing the rite learns the new roles he or she is to play. The rite of passage encapsulates the person, placing him or her in limbo during this learning period. The liminal or transitional stage theoretically allows the person to adapt to new and sometimes traumatic circumstances, especially when strangers are a part of the rite of passage (R. Freed and S. Freed, 1980, pp. 542–544). Van Gennep considered the rite of passage to be a time during which one became integrated into a new family, kin group, or community (Kimball in Introduction to van Gennep, 1961, pp. viii–xi). How well one is integrated and able to adapt to the situation may depend on how well one was enculturated or prepared in childhood for these stages of life. Adaptation is also related to the physical and psychological potential of an individual. The following description of Sita's early years provides clues to her potential for adaptation to the two main crises in her life: marriage and motherhood.

BACKGROUND FOR 1943

In 1943 when Sita was born, India was still part of the British Empire and had been strongly influenced by it, especially by the rule of Queen Victoria and the standards of behavior of the Victorian Age. India was primarily an agrarian nation, characterized by joint families usually ruled by a dominant male. This family structure and the Indo-European cultural traditions characterizing the Union Territory of Delhi were somewhat akin to the Viennese culture in which Freud practiced. If anything, Indian culture was more repressive with regard to women due to the custom of *purdah*, introduced by Islamic peoples. As an agricultural country, it resembled ancient Greece in some of its ancient myths about deities and its value on male dominance and the submissiveness of females (Eliade, 1978, pp. 129, 187–199; Simon, 1979, pp. 184–187, 190–192, 194).

Family structure in the rural area consisted of an authoritarian, senior male to whom other members of the family were subordinate.

Age and sex were important in the family hierarchy with males dominant over females, and elders over those younger. Sons were preferred to daughters to the extent that, at the turn of this century, female infanticide was still practiced. Even in the 1950s, males were given preferential treatment over females, resulting in more males in the population than females (Gazetteer Unit, Delhi Administration, 1976, pp. 119–120, tables 1 and 2). The preferred family structure was joint, based on descent in the male line with daughters marrying out of the family and going to live in their husbands' natal family. Families experienced changes, expanding and reducing their numbers and occasionally splitting into separate nuclear families, which in time might develop into joint families (S. Freed and R. Freed, 1969, p. 347, table 1; 1982, p. 199).

For the foregoing reasons, including the ancient Indo-European cultural traditions, Freudian psychoanalytical theories are pertinent in the case of Sita. However, they require some adjustment to the cultural context as well as to new advances in understanding alternate states of the human mind. The symbolic nature of myths, festivals, and rites of passage show similarities to the Greek myths, known by Freud through the works of the ancient Greek dramatists (Daniélou, 1964, chap. 5, 6, 7; Eliade, 1978, chap. 8, 10; R. Freed and S. Freed, 1980, pp. 337, 340–342; Littleton, 1982, pp. 3, 54 [fn. 13], 73, 274).

In this reconstruction of Sita's "Early Years" and the following section on "Marriage, Mating, and Possession," most of the information is based on knowledge of village life and interviews with Sita in 1958. In some instances, the information derives from Sita's interview in 1978, and will be so indicated because Sita's omissions about her natal family in the 1958 interviews are relevant to her case history.

VILLAGE LIFE

In the rural Delhi region, villagers traced descent patrilineally and belonged to patrilineal clans. Residence after marriage was usually in the village of the husband and the household of his parents. Wives were taken from outside both the husband's village and a group of additional villages which were considered

to be related to it (S. Freed, 1963). Thus, one found the following rules of marriage: exogamy of lineage, clan, village, and related villages; endogamy of caste; and the proscribing of marriages into clans of relatives on both the mother's and father's side of bride and groom (R. Freed and S. Freed, 1980, pp. 411–414).

Because of these marriage practices, the life cycle and places of residence of males and females differed. A male remained in his village of birth at marriage; a female left hers. A male during his lifetime had close ties with two villages, his village of birth, and the village from which his mother came, usually referred to as the mother's brother's village, which was also the village of his maternal grandparents. He had ties with his wife's village but seldom visited it after marriage; and his wife's kin, other than her brothers, except in rare instances would not visit her village of marriage. A female on the other hand had close ties with her village of birth, her mother's brother's village, and after marriage if all went well with her husband's village. Because females married out of their natal villages and lived in their husbands' villages, most of the ties of friendship from their childhood and youth with girls their own age did not endure. These differences for males and females in the three types of villages should be borne in mind to understand Sita's problems (S. Freed and R. Freed, 1976, p. 70).

Sita was born in a village located close to the conurbation of Delhi. At her birth this region was primarily rural, but after the Independence of India in 1947 the city expanded and parts of the rural region were incorporated into the modern sections of the city and its suburbs so that the people in the remaining rural villages had urban contacts and more males than previously obtained work in the city. Sita's natal village was one of these rural villages. Because of its position, the village was lively and exciting. According to Sita, there was considerably more "hul-labaloo" than in her marital village which was at a greater distance from the city.

In a number of other respects Sita's natal village differed from the average rural village in North India. First, the population consisted only of members of Sita's caste instead of many different castes. Second, the village

was more modern than many villages because of its location. Third, the school catered only to boys and girls of Sita's natal village so that the low-caste children experienced no discrimination in school. Fourth, Sita's village was easily accessible to the village where the shrine of Kalka, the mother goddess of the cremation grounds, was located. Kalka was usually referred to with the honorific *ji* as Kalkaji. This goddess was worshiped by Sita's caste, especially the women, for the birth, welfare, and health of their children. Another nearby shrine was devoted to Jahar, a Muslim-Hindu saint, also known as Guga Pir or Sayyid. Both of these supernatural beings were propitiated by members of Sita's caste, Jahar for the birth and survival of infants and Kalkaji when they fell ill and might die. Kalkaji is one of the derivatives of Kali, the Hindu goddess of death and destruction. Fifth, the area had long been subject to Islamic religious beliefs. A population of Sita's caste settled there in the eighteenth century. Often their settlements, identified by the word *sarai*, were originally temporary camping sites (Gazetteer Unit, Delhi Administration, 1976, pp. 62, 1028–1029).

From 1947 onward during the time that Sita was growing up, the Government of India through its Constitution and a series of laws attempted to excise the repression of low castes. In 1951, laws were passed favoring the socially and educationally backward castes and tribes. In 1955 an act was passed punishing attempts to enforce untouchability (Tinker, 1962, pp. 132–133). Although today castes exist, and low castes are discriminated against, their condition was beginning to improve during the period of our first fieldwork. In general, the urban low castes seem to have had a better chance than the rural, possibly because the urbanites were not subject to the landowning castes (L. Rudolph and S. Rudolph, 1969, pp. 132–154; S. Freed and R. Freed, 1976, pp. 143–147).

Sita's natal village was similar to other villages in this region in that each village had its own cremation-burial and grazing grounds; after 1947 the majority of inhabitants were Hindus; the language spoken was basically Hindi with dialectical differences from standard urban Hindi; and married Hindu women were still subject to a limited form of pur-

dah. This custom consisted of wives covering their heads and the portion of their faces below the eyes in public or before men in their husband's generation or older, including males in the joint family household. All females, but especially wives in their child-bearing years, were restricted in their freedom of movement beyond the village and its surrounding fields unless chaperoned by their husbands, brothers, or mothers-in-law. They, however, walked around the village and worked in the fields providing they were properly veiled (Jacobson, 1974, pp. 115–116; S. Freed and R. Freed, 1976, pp. 69–70).

The economy of the rural region was partially for subsistence and partially for a cash market. With increasing literacy from the 1940s to the 1970s a growing proportion of males from the countryside worked in urban occupations, police or military service. However, the economy was based primarily on agriculture with a two-crop season of grains, vegetables, fodder, sugarcane, fruits, and some cotton. Zebu cows and water buffalo were important for dairy products and dung. Zebu bullocks were used for plowing and both bullocks and, to a lesser extent, water buffalo as draft animals. Cultivation was with the hoe, and harvesting was by sickle. Throughout most of the region, regardless of purdah or caste, women and children worked in the fields as well as the men. For example, women and children from five years of age gathered fodder, and girls at about age 12 helped with cultivating and harvesting grains and other crops. Girls learned these chores before marriage as their marital families expected them to carry out similar work in addition to cooking and caring for children and the household. Girls from five years of age and younger were caretakers of infants. The early development of these work patterns resulted in responsibility for chores to be done and the care of children. Boys in their early years had less responsibility and more freedom. Milking and care of the cows and water buffalo devolved on women except for herding and grazing the animals on the common lands, taken care of by men. Water was obtained from wells or, in a few wealthy families, from hand-pumps. Agricultural land was irrigated from canals or from Persian wheels. Tube-

wells and tractors were introduced in the late 1950s and 1960s as was electricity (S. Freed and R. Freed, 1978).

In 1958, transportation between villages and cities was still difficult, as there were few paved roads. Transportation between villages was usually by foot, bicycle, and horse or bullock carts; but buses and trains ran throughout the region and were convenient, especially for trips to Delhi as the railway station in Old Delhi was the hub of the bus and train network. A few well-off, high-caste villagers owned motorcycles and even more rarely an automobile. For commuting into Delhi, bicycles, buses, and trains were most often used. Cattle, camels, goats, and sheep were seen on the Grand Trunk Road and other roads going in and out of Delhi. The bicycle was ubiquitous. Commuters to Delhi from villages would put their cycles on the tops of buses to use between the bus stations and places of employment.

In villages, there was no running water or plumbing in households and no hygienic sewage disposal. Fields were used for human defecation and urination. Diseases such as amoebic and bacillary dysentery, hepatitis, typhoid, and malaria were endemic and so, too, infestations of helminths. Other contagious diseases were colds, measles, chicken pox, mumps, influenza, pneumonia, bronchitis, smallpox, cholera, tuberculosis, and leprosy. By 1958, cholera and smallpox were under control so epidemics of them were rare. Malaria was on the wane because of spraying with DDT. All of these diseases were more hazardous during Sita's childhood. Few villagers, except in the most urbanized locations, made use of urban health services, which were only gradually to spread through the rural regions by the 1970s (Directorate of Public Relations, Delhi Administration, 1957, pp. 111–113; O. Lewis, 1958, chap. 8; Singh, Gordon, and Wyon, 1962; R. Freed and S. Freed, 1979, pp. 293–303).

FAMILY AND LIVING CONDITIONS

The household in which Sita was born and grew up contained a joint family composed of her father's elder brother, her father's younger brother and later his wife and small

daughter, Sita's mother, father, siblings, and a paternal grandmother and paternal grandfather, the latter dying in Sita's childhood. We have little information from the 1940s about this family, but her father's elder brother and head of the joint family had no children and probably became a widower early in Sita's childhood. Sita supplied no details about him other than that he farmed the 1.2 hectares of family land owned jointly by the three brothers and had never gone to school. Sita's father's younger brother, traditionally a warm figure to a niece, in contrast to her father's elder brother, an authority figure, was a bus conductor in the City of Delhi, a good job for a village man. He had the equivalent of a high-school education, unusual for the low castes at that time.

Sita's father, who also had a high-school education, enlisted in military service in 1943 shortly after Sita was conceived, but he was granted leave to come home at the time of her birth. She was his first child. He shipped overseas for months at a time and served in Russia, America, and various parts of India. Sita said, "My father liked every place he went; he was on ships for six to seven months at a time." She took pride in her father having gone into the streets to fight during the Muslim-Hindu riots of 1947. He was granted leave for two months of every year, the only times when Sita saw him. For most of Sita's early years, he was an absentee father. Sita's mother was nonliterate, as were almost all village women of her generation.

Sita attended the village school. The education of females of her caste in her natal village was greater than in the more rural villages for the same period of time, no doubt because the village contained only one caste (R. Freed and S. Freed, 1968, 1981, pp. 119-123, 129-139; S. Freed and R. Freed, 1976, pp. 46-51). Although the proportion of literate individuals in India had increased from 1931 to 1971 and there had been a spurt in female literacy since 1941, females still lagged behind males in literacy and rural people behind city people. For the Census of India "a person is literate if he can both read and write with understanding in any language" (Gazetteer Unit, Delhi Administration, 1976, pp. 795, 797).

Sita said that her mother and father were

both good to her. She took great pride in her father's and younger uncle's education as well as her own, her father's military service, her younger uncle's job in the city, and the fact that the joint family owned land. All of these characteristics were unusual for low castes in villages in the 1940s and 1950s.

When Sita was born, most village buildings consisted of mud huts although some wealthy landowners built brick houses beginning in the 1920s. Sita said that she and her joint family lived in a one-room mud hut until shortly before her wedding. Among the low castes, living was generally in the one-room dwelling and what cattle or other animals they owned were kept in a cattle shed or open compound (Spate, 1954, pp. 178-179, fig. 36). Sita's family at various times owned a zebu cow, water buffalo, or goat for dairy products, and one or two bullocks for plowing and use as draft animals.

The family dwelling was used for storing food and clothing and for sleeping. Most daytime activities, including cooking, were carried on outside. In the cold months everyone slept inside; in the hot season, outside. As a general rule females slept separately from men, mothers often having one or two children in a bed with them. An infant slept at the head of the mother's bed. Boys by the age of five to six slept with their grandfather or father; girls of similar age slept either with their mother or grandmother. A new bride and her husband slept together and apart from others in the family. The string cots on which people slept were approximately the size of Western twin beds, but would at times accommodate two adults or a woman and her children. In quite poor families, older children might sleep on the floor of the hut.

Generally, coitus was instigated by the husband who came to his wife late at night; or it sometimes occurred during the day in the house or fields when no one was around. Under these conditions, children witnessed or were aware of the primal scene as was indicated in doll-play sessions conducted in Sita's marital village. Such experiences, due to living conditions, may have been similar to Freud's, for before the age of four years he lived in one room with his whole family (Jacobson, 1974, p. 118; Das, 1976, pp. 9-10; Freud, 1978, pp. 79-80; Simon, 1980, pp.

210–211; R. Freed and S. Freed, 1981, pp. 67–68, 96–102).

The sleeping conditions may have been unusual for middle and upper class European and American families in Freud's day as well as today in uncrowded, urban apartments or suburban houses, but many families in developing countries still sleep in one room. Whether children witness, are exposed to, or sense the primal scene, it would be unreasonable to expect that such experiences, when so many children have been and still are exposed to them, are necessarily traumatic. More probably what affects the children would be how they were experienced and interpreted.

In an agricultural village bulls roam the lanes to mate with cows, and Sita could not fail to witness these matings, which would have triggered comparison with the copulation of her mother and father (Fenichel, 1945, pp. 213–214). Freud (1967, p. 624) wrote that "sexual intercourse between adults strikes any children who may observe it as something uncanny and that it arouses anxiety in them." If this is so, then untold millions of children, past and present, must have developed anxiety because of the primal scene. Whether anxiety from witnessing the primal scene develops into a neurotic disorder or is a universal condition more probably would depend upon additional factors. The basis of the anxiety might be the emotional climate regarding coitus, such as love for one parent and jealousy of the other, and inhibition and secrecy on the part of parents, or fear of punishment on the part of the child due to trying to act similarly or some unhappy event shortly thereafter, such as a death in the family. The temptation to imitate the parents could be based on excitation arising from witnessing activities hidden by parents and curiosity to see what would happen when imitating these activities (Fenichel, 1945, p. 196).

SITA'S SIBLINGS

Sita presented an incomplete picture of her family and siblings in 1958. She said that she had two brothers and one sister, qualifying the statement by explaining that the sister was her father's younger brother's daughter.

In the Hindi kinship system, patrilineal cousins are called brother or sister.

Not until 1978 did Sita report that her mother gave birth to 15 children. After Sita, her mother bore five daughters and then four sons, all of whom died in infancy. In 1955, a son was born who survived. Another son was born in late 1957 or early 1958, near the time of Sita's wedding; he also survived. Two sons and a daughter were born after 1958, but they died in infancy. Thus, Sita's mother bore eight sons and seven daughters, of whom three survived infancy. One of the surviving sons died in 1969.

In 1978, Sita reiterated a number of times that she was the firstborn and the only surviving daughter. She said, "When my father went into military service, I had been in my mother's womb between two to three months, but my father returned the day I was born." Obviously his return was a point of pride with her. She also indicated her father was in military service 17 years (1943–1960).

In reply to a question about the times and causes of death of her infant siblings, Sita said, "Mostly they died at the age of two, three, or four months. My father came home on leave for two months every year. Five girls were born after me and they died; then four boys who also died. When my mother had children, they were strong and healthy, but my mother had no milk in her nipples so they were given buffalo or cow's milk. The children grew very weak."

A further question about Sita's siblings elicited this response: "I was given mother's milk. Only I had my mother's milk. None of the other children." For the other children, she said, "My mother had milk for only four to five days and none left after that. Her babies took one to two kilos of milk every day. When they were given cow or buffalo milk, they had indigestion. My youngest brother, who is still alive, was fed on goat's milk. When my father was overseas, he brought three to four tins of powdered milk from America or wherever he went."

Sita's mother gave birth to the first 12 of her 15 children approximately between 1943 and 1958 when Sita's father was in military service and for the most part out of the country except for two months' leave once a year.

Under these circumstances it is somewhat surprising that Sita's mother conceived and bore 12 children within 15 years. Ideally husband and wife were supposed to observe a postpartum tabu against coitus for six months. Women of a number of castes within an age range of 20 to 60 years said that not everybody observed the tabu. Generally, women said observance of the tabu depended upon the husband. If he did not wish to observe it, his wife could not. Seclusion after delivery varied from 40 days for the Brahman and Jat castes to seven to nine days for low castes.

In Sita's mother's case, due to the deaths in early infancy of 12 of her children and the fact that 14 of them were not nursed after four days from birth, the amenorrhea and associated anovulation usually provided by nursing a newborn infant were lacking. Thus, she was not protected by lactational contraception and would have been able to conceive more often than a breastfeeding mother. Despite her fecundity, the probability of conceiving with coitus taking place only during a period of two months once a year would seldom exceed 20 percent during one menstrual cycle. Further the odds against progressing beyond 20 weeks' gestation are about 43 percent (Harrell, 1981, pp. 797-805; Millard, 1982, pp. 147, 152-153; Anderson, 1983, pp. 27-30).

Because of these odds, it would be unusual for a woman to bear 12 children in 15 years, especially when her husband was absent 10 months of the year. However, in this part of North India, there has long been a belief in the equivalence of brothers, based on patrilineal descent and the idea that the family line should be perpetuated at almost any cost. As a result, brothers have been known to mate with their brothers' wives in the absence of their husbands. Ideally in past times, a younger brother may have been introduced to sexual relations by his older brother's wife. A warm relationship between the two was encouraged because the younger brother was a potential spouse, should the woman be widowed, but sometimes an older brother took his brother's widow as a wife. During both of our field trips there was evidence that older and younger brothers mated with a brother's wife in his absence although not necessarily

with his knowledge or consent. Mandelbaum (1974, p. 34, fn. 6) has confirmed this practice for North India.

A song alluding to this practice was popular in villages at the time of weddings. According to the lyrics, when the young men entered military service or sought work far from home, their wives stayed behind in the house of their husband's family and only occasionally were allowed to visit their parents' houses. Out of loneliness or pressure they submitted to the desires of a widowed elder brother-in-law, especially when he was the authority figure in the household. Since this song was sung by teen-age girls, Sita would have been familiar with it (R. Freed and S. Freed, 1980, pp. 392-394, song on pp. 392-393).

Although the practice of mating with a brother's wife was illegal, it took place both in 1958 and 1978. Newspapers in the City of Delhi from time to time carried accounts of the practice when a woman and members of her natal family protested and brought the matter into court. We have no evidence from Sita that her mother mated with her father's elder or younger brothers, but if she did, the odds against bearing 12 children may have been reduced. Had such matings taken place and had Sita been aware of them, they would in all probability have had a considerable impact on her and would have produced anxiety and confusion in her mind regarding her mother's mating with her husband during a two-month period once a year, and alternately with her husband's brothers, and the subsequent pregnancies, births, and deaths (O. Lewis, 1958, pp. 189, 192; Maloney, 1974, pp. 301, 469; S. Freed and R. Freed, 1976, p. 75).

When interviewed in 1958, Sita did not mention the deaths of her siblings for two reasons. First, she tended to shy away from discussions of death, and, second, her in-laws were present or within hearing distance during the interviews. In Indian marriages, parents of both the bride and the groom tried to find out whether their child's future spouse was healthy. The ancient laws of Manu state that it is the duty of a parent to do so (Bühler, 1969, pp. 76-77; R. Freed and S. Freed, 1980, pp. 410-411). Although low castes and other villagers were not familiar with the texts upon

which this belief was based, the general principles trickled down through the castes and were observed. Every family was anxious to have a wife who was sufficiently healthy to do hard work and bear a number of offspring for their son. Deaths in a family raised questions about health, especially when a series of infants died. Early in a marriage a wife could be returned to her parents and the marriage dissolved by the groom's family if the bride and her family proved undesirable.

When detailing the deaths of her siblings in 1978, Sita was obviously disturbed and inadvertently mentioned them in the context of the births of her own children. Sita provided no information regarding the infancy of the boy born in 1955, who later died at 14 years of age, nor did she give the cause of his death, only that her mother died of grief within a year from his death. Sita displayed decided warmth in discussing the brother born in 1957 or 1958, whom she took to live with her in 1970. He was born shortly before her wedding so that he did not usurp her place in the family as did the first surviving brother born in 1955.

The different emotions shown by Sita regarding the two boys may be interpreted as follows. Until the birth of the first surviving brother, Sita was the equivalent of an only child. With his birth and survival, she lost that status and the invidious comparison was made that because he was a son, he was much more favored than she. To add to Sita's negative feelings toward this brother, his survival resulted in her marriage (Pollock, 1972, pp. 480–481). Customarily Sita would have become engaged about three years before marriage, around the age of 12 years. Because the average age for menarche was around 15 years, it was usual to engage a daughter and have her married by 12 to 13 years of age. Mating, however, did not occur until after menarche. Sita said that when her father and his elder brother tried to arrange her engagement, the family of the groom refused to contract for the engagement and marriage because she had no brothers. When Sita was about 12 years old, a brother was born; and when he was two years old, Sita's engagement was celebrated in 1957. The wedding took place early in 1958.

The father of a prospective groom generally would not agree to an engagement and marriage unless the bride-to-be had at least one brother to provide the customary services of intermediary between the bride's and groom's families and, when the bride's father died, to continue the mandatory gifts to his sister at yearly festivals and for the birth and marriage rites of her children. Thus, the birth and survival of this brother toward whom Sita revealed no warmth and little information made possible Sita's marriage and contributed to her leaving her natal family, both of which she was to find difficult (S. Freed and R. Freed, 1978, pp. 115–118, 122–126; R. Freed and S. Freed, 1980, pp. 399–400, 443, 456–459). In this society, where male children were desired far more than females, Sita linked the birth of her first surviving brother with marriage, mating, and child-bearing, and with her changed statuses from beloved only daughter to a secondary position to her brother, and from daughter and sister to daughter-in-law, sister-in-law, and wife. The last three statuses were less prestigious and more submissive than the statuses of daughter and sister. They also involved more hard work, loss of childhood freedom, and other constraints (S. Freed and R. Freed, 1976, pp. 66, 70, 71; R. Freed and S. Freed, 1980, pp. 347–350).

From a psychoanalytical point of view, it is possible to infer that Sita was jealous of her infant siblings and wanted them to go away. Then when they died, she felt guilty. Later the same wish recurred with the surviving brother, born in 1955, but was buried under her resentment of him as a boy when he displaced her in her parents' attentions and made possible her marriage (E. Jones, 1967, p. 387; Campbell and Naroll, 1972, pp. 439–440; Pollock, 1972, pp. 476–477, 479–481).

In 1958, Sita at first did not mention her mother so we asked whether she was alive. Sita replied, "Yes, she's like my mother-in-law." When asked whether she liked her mother, she answered, "Yes, didn't I come out of her belly?" Although this expression was characteristic of village idiom it did not provide much information about the mother and daughter relationship. However, Sita's

position as the first and only child to survive until 12 years of age provided her with the love and attention of her father, mother, grandmother, and father's younger brother. To some degree Sita displayed rivalry with her mother, talked little about her, but liked to discuss her father's military service and exploits. To her he was a hero and she benefited from his prestige. Sita may have been afraid of her father's older brother, for she mentioned him briefly only once. Her mother and grandmother worked in the household and fields, and they usually took Sita everywhere with them until she entered school. When Sita's mother was in seclusion and taking care of her ever-failing infants, the grandmother helped by taking over many of the daily chores which meant they both had less time for Sita who was often alone and free to do as she pleased.

One cannot but wonder how Sita as a small child reacted to the once-a-year visits of her father and subsequent births and deaths of her siblings. Our interpretation follows. Intermittently, Sita slept with her mother or grandmother. Given the alternating displacements from bed to bed, she connected the incompletely understood sexual relations of her parents to the births and deaths of her siblings, and her own guilt about wishing them dead. She came to think that she may have caused the deaths by so wishing inasmuch as infants and small children were believed capable of casting the most powerful evil eye. In addition, the displacements from bed to bed and absences of her father for long periods of time aroused anxiety regarding his possible death, and the loss of love from her mother, father, and grandmother. She was upset and jealous when each new sibling took her place in her mother's bed, and felt the same way when her father did so, although later wishing she could take her mother's place. When her father came home on leave, she became excited and sometimes fearful as to what would happen while he was home. These alternating displacements in Sita's early childhood, the absences of her father for long periods, and the deaths of her siblings that were explained as due to a malevolent female ghost resulted in fluctuations in Sita's sense of security or basic trust in her parents

and a sense of evil, which provided the basis for an anxiety disorder (Freud, 1924, p. 393; 1962, pp. 214–218, 343, 345; 1967, p. 262; Fenichel, 1945, pp. 93–94, 194–195, 208–210; Erikson, 1950, pp. 75, 81, 220–221, 222–226, 232–233; M. Tolpin, 1970, pp. 284–285, 297–298; Campbell and Naroll, 1972, pp. 437–440; Maloney, 1976, p. 109).

INFANT DEATHS

The deaths of Sita's infant siblings had considerable impact on her in childhood and are related to her case history in later years. We explore a number of possible causes of death including the beliefs of villagers about such causes. The information obtained from Sita about these infant deaths is summarized in the following: In 1958 Sita never mentioned the deaths of her siblings; she only said that she had two brothers and a sister (the small daughter of her father's brother), all of whom were members of her joint family. In 1978 she inadvertently mentioned the deaths of her infant siblings and indicated throughout her interview that she was afraid of death, dead persons, and ghosts. She then said with regard to the dead infants, "Mostly they died at the age of two, three, or four months" (the postneonatal period). In Sita's words she was the firstborn and was given her mother's milk, but none of her siblings could take their mother's milk after the first few days of nursing. When they were given cow's or buffalo's milk, they had indigestion, symptoms of diarrhea, rumbling noises in their stomachs, and spasms. Sita's youngest surviving brother, born c. 1957–1958, was fed goat's milk. After Sita's birth, five girls followed by four boys were born; all died within two to four months. Two brothers, born in 1955 and 1957–1958, survived infancy; then an additional two boys and one girl were born who died in infancy.

The incidence of infant mortality in India has long been high, but during the time in which these infants were born (1943–1961 and possibly a few years later), the infant death rate in the Union Territory of Delhi gradually declined from 162.0 per thousand in 1941 to 70.8 per thousand in 1961, representing a combined rural-urban infant mortality rate

(Gazetteer Unit, Delhi Administration, 1976, table 2, p. 858).¹² In the villages, the numerous deaths of children from birth to age five years were attributed to ghosts taking the souls of the children. It was generally believed that if a mother died at birth or shortly thereafter, the infant would not survive; either the same ghost would take both mother and child, or the ghost of the mother would take her infant. If a daughter-in-law in the same household died without issue or in childbirth and was believed to have become a ghost (*opera*), and

then an infant later died, that *opera* was believed to have caused the infant's death. As a result beliefs about female ghosts were the earliest supernatural beliefs learned by Sita, as well as other children, beginning with the death of her first infant sibling. These beliefs conditioned her sense of reality and were to persist throughout her 35 years (M. Tolpin, 1970, p. 291; Kakar, 1978, pp. 88, 105; R. Freed and S. Freed, 1980, pp. 528–529; 1981, pp. 60, 104–108).

When an infant fell ill, mothers and grandmothers tended it with the hope that it would recover. At the same time they propitiated the mother goddess or goddesses believed to cause the sickness or to be able to ward off the ghost or evil spirit trying to take the infant's soul. In the case of an illness believed to be caused by a ghost, the goddesses most apt to be propitiated were the Crossroads Mother Goddess (Chaurahewali Mata), who had a shrine in every village, and Kalkaji. In case of doubt as to the cause or kind of sickness all the mother goddesses might be propitiated (R. Freed and S. Freed, 1979, pp. 306–309). Diagnosis of the seriousness of the disease was based on "fever." Fever was determined by a flushed face and feeling the forehead of the person; thermometers were not used. In fact many illnesses were identified simply as "fever," as was the case for diseases in many parts of the world before the nineteenth century (Imperato, 1983, p. 34). Without fever, an illness was considered inconsequential. As a result a sick infant could easily worsen and lose considerable weight without the mother realizing the seriousness of the illness. Such an infant often died within two or three days. The nonliterate village watchman was supposed to report all births and deaths with their causes to the district police station periodically. He received information as to the cause of death from an often equally nonliterate head of the household in which the infant had died. In short, accurate and complete information on infant mortality seldom existed.

In the Harvard-Punjab-Khanna study (Wyon and Gordon, 1971) in 11 villages in the Ludhiana District of Punjab, located to the north of the Union Territory of Delhi, 1957–1959, the causes of infant mortality (0–11 months from birth) are given by the terms

¹² Chandrasekhar (1959, pp. 32–66) presents an extensive study of the causes of infant mortality in India from 1901 to 1955. During this period, infant mortality gradually decreased, especially from 1925 to 1955, with variations from city to countryside and within different ethnic and religious populations. One of the major problems in this study was the reporting of births and deaths. Births were less often registered than deaths. Causes of deaths, especially of infants, were even more difficult to ascertain; so too were the ages of the deceased.

Infant mortality throughout the world has been decreasing in this century. However, the rates of decrease vary. For example, Western countries have had a generally greater rate of decrease than the developing countries. India's position in this comparison is unenviable. In 1901 the infant mortality rate was 232 per thousand infants under one year of age born alive. In 1952 the lowest infant mortality rate in the world was for Sweden with a rate of 20 per 1000 live births. The highest rate in the same year was for Egypt with 163 per 1000 live births. India in 1943, the year of Sita's birth, had a rate of 165; in 1953 it was 119. Countries with higher rates than India in 1952 were Chile (134) and Egypt (163—only the section of the country with Health Bureaux) (Chandrasekhar, 1959, pp. 90–95, Chart no. 1, p. 90; tables: 9, p. 90; 10, p. 92; and 11, p. 95). Chandrasekhar (1959, chap. IV) provides extensive details on the causes of infant mortality in India for 1901–1955. The Harvard-Punjab studies carried out in the late 1950s in Ludhiana District provide more recent data for the causes of death as does the Delhi Gazetteer (Singh, Gordon, and Wyon, 1962; Gordon, Gideon, and Wyon, 1965b; Gordon, Singh, and Wyon, 1965; Gazetteer Unit, Delhi Administration, 1976, p. 857, table 1, p. 858). Padmanabha (1982) covers mortality for India from 1901 to 1978 in a series of tables. In particular, he points out the high neonatal and postneonatal rates drawing attention to rural-urban differences, degree of education, and other selected characteristics as well as the main causes of death in infancy and childhood (Padmanabha, 1982, tables 9, 10, 11, 12, p. 1288; tables 13, 14, 15, 16, p. 1289).

used in rank order from highest to lowest incidences: (1) peculiar to infancy, immaturity; (2) diarrheal diseases; (3) tetanus; (4) birth injuries, post-neonatal asphyxia, atelectasia; (5) pneumonia; (6) unknown causes; (7) other residuals tied with measles; (8) infections of newborn tied with accidents; (9) congenital malformations; (10) typhoid fever; (11) tuberculosis; and (12) other known causes (Gordon, Singh, and Wyon, 1965, table 1, p. 907, pp. 906–908). In general this list of causes applied to Sita's marital and natal villages in the 1940s and 1950s, but for Sita's infant siblings the most probable causes were diarrheal diseases, unknown causes, and possibly immaturity. Singh, Gordon, and Wyon (1962, pp. 874, 878) for the 11 villages in the same study state that newborn infants had a lower level of medical care than any other age group and their mortality rate was at the high level of 73.9 neonatal infants (0–27 days) per 1000 live births per year. Overall infant mortality rates (0–11 months) were 156.2 deaths per 1000 live births per year. Health care if sought was primarily from indigenous curers. These conditions were similar to those we found in the Union Territory of Delhi in 1958–1959. These causes are best considered in terms of birth order, infectious parasitic diseases, and genetic or nutritional diseases for comparison with the symptoms described by Sita (Gazetteer Unit, Delhi Administration, 1976, pp. 857–858).

Immaturity and subsequent death were not unusual for a primipara birth. Deaths due to tetanus in the neonatal period usually took place within the first six days although by the late 1950s in the Delhi region deaths from tetanus had decreased due to instructions from government midwives to village midwives. Because these two causes of death occurred immediately after birth, they do not apply to Sita's siblings. Other factors contributing to deaths of infants in the neonatal period (0–27 days) are the age of the mother at birth and birth order. Infant mortality rates are greater when the mother is either very young or relatively old. The best example is the firstborn who is more apt to die when the mother is young. The risk of infant death begins to increase with the fifth birth and rises substantially thereafter. A tenth-born or later child has only half as much chance of sur-

viving as a second-born child, which has the greatest chance of survival. Further, the shorter the intervals between births, the greater the chance of infant deaths. These conditions do not always apply, for in the case of Sita's mother and her offspring, Sita, the firstborn, survived even though her mother was then quite young. While nursing Sita, her mother may have had postpartum amenorrhea for about 11 to 12 months and the related anovulatory and amenorrhic protection from conception due to daily lactation if no supplementary foods were given to the infant. However, between six months to one year of age, Sita would have been fed occasional snacks and by one year would have begun to sit and eat with family members, thus reducing the number of breastfeedings per day and the associated protection from conception for Sita's mother. Because Sita's mother did not have the protection of lactational contraception for her succeeding infants, she conceived at shorter intervals (Jelliffe and Jelliffe, 1979, pp. 117–121; Harrell, 1981, pp. 797, 805; Simpson-Hebert and Huffman, 1981, p. 128; Millard, 1982, pp. 147–148, 150–153).

When Sita's two surviving brothers were born (her mother's eleventh and twelfth births), the chances for their survival should have been relatively slim. However, by this time, Sita's father was in India more often than previously and probably arranged for better care at delivery and thereafter for the two boys. As for the last three infants (thirteenth, fourteenth, and fifteenth), who had the same problem with drinking milk and who died, no further information exists. Although birth order may have played some part in the deaths of these babies, it is rather odd that the eleventh and twelfth infants survived when nine earlier children did not. Most probably birth order is a contributing factor rather than a determinant of the cause of death (Chandrasekhar, 1959, pp. 115–118, 136).

Infants who are breastfed usually obtain immunity from infectious diseases. However, immunity is not total and decreases when nursing diminishes. In the case of Sita's infant siblings who died, they lacked the immunity from breastfeeding. Still the symptoms described by Sita do not suggest any contagious or venereal diseases other than

diarrheal diseases, which are common among nonbreast-fed infants. The indigestion of the infants described by Sita consisted of gas, inability to take different kinds of milk, spasms, rumbling in the stomach (more probably the intestines), and diarrhea. The spasms or convulsions suggest, among other diseases, malaria, which was endemic in the region in the 1940s and 1950s, but the babies did not have the intermittent fever characteristic of malaria. Infants are susceptible to contagious diseases from six months to three years of age, during which time nursing tapers off, other foods are taken, and they lose the immunity acquired from their nursing mothers, and have not yet built up their own. However, breastfeeding provides considerable immunity to a variety of diseases. Therefore, Sita's siblings would have lost their immunity early. These infants were described as healthy at birth and later with no fever or symptoms associated with typhoid. Hepatitis, a disease which includes as one of its symptoms the inability to ingest food, was endemic, but it is excluded on the basis of its ready identification by villagers because of the yellowing of the eyeballs; the village term is *piliya* (*pila* means yellow). Hemolytic incompatibilities of blood types (ABO and Rh), sickle-cell anemia, and hemophilia also do not fit the symptoms given by Sita although they are found in India (Russell, 1956; Haga, 1959, pp. 1–2; Gordon, Chitkara, and Wyon, 1963, p. 355; Cohen, 1970, pp. 414, 432, 436; Williams and Jelliffe, 1972, p. 52; Hart, 1973; Reed, 1975, pp. 72–75; Jelliffe and Jelliffe, 1979, pp. 85–96; Kan and Dozy, 1980, p. 389, table 1; Friedman and Trager, 1981, p. 159).

Williams and Jelliffe (1972, pp. 43–44) have pointed out that "There is still insufficient evidence to show how much diarrhea is due to infections (bacterial or viral), to the physical characters of the food, to lack of habituation or to congenital or acquired deficiency of lactase or of other enzymes." This statement requires consideration of diarrheal diseases caused by a virus or bacteria, or diarrhea caused by an inadequate secretion of the lactase enzyme and inability to absorb milk sugar. These types of diarrheal diseases cause an infant to become dehydrated and to starve to death (Wingate, 1972, p. 229).

In the villages in the Delhi region, viral or bacillary dysentery could be caused by nursing practices for the newborn. A newborn was fed for the first two days with *guti*, a mixture of sugar and water. *Guti* could contribute to the infant's developing a preference for a sweeter taste than that provided by mother's milk. The mixture could cause one of the dysenteries since the water, although warmed, might not have been brought to a rolling boil and it might have been placed in a contaminated container. The sugar used in *guti* was *gur*, brown sugar, usually stored in large cakes in the domicile where rats crawled over them and nibbled at the sugar. The reason for feeding the newborn *guti* was to wait until the colostrum (containing protein and less sugar and fat than milk) in the mother's nipples changed to milk about the third day after delivery when the infant was then nursed for the first time by its mother. Modern practice in hospitals is to put the infant to the mother's breast immediately and have it suck the nipples for the colostrum because delayed nursing may affect the mother's ability to lactate. Further diminution in the amount of mother's milk may result from failure to empty her breasts, poor nursing procedures, medical complications, and psychological disturbance.

If an infant did not thrive on its mother's milk, villagers in the Delhi region blamed the mother. In the Krishna myth, Putana, a malevolent witch, is sent by Kansa to find Krishna and kill him. When she finds him, she urges him to take milk from her poisoned breasts. He does and drains them until she dies. Krishna, as an avatar of Vishnu and thus immortal, survives (Kakar, 1978, pp. 146–148). The myth fosters the belief that milk from an evil woman kills and may be part of the good–bad mother complex in India. The jealousies in joint households among daughters and daughters-in-law may have reinforced the belief that it is the daughter-in-law (mother) who is to blame when the child does not thrive on her milk. John Gray (1982, pp. 220–221, 234–235) has found in Nepal that only in-marrying women are believed to be *boksis*, sorceresses who cause sickness. He points to the paradox that a daughter is pure and a goddess before marriage and when in her natal home, but due to her sexuality when

she becomes a wife and mother, she is regarded as a *boksi* in her marital family. These beliefs are somewhat similar to those found in North India regarding the purity of daughters and the sexuality of daughters-in-law, who may become *operas* if they have an untimely death and die without issue. Such beliefs make life difficult for a mother whose infants will not take her milk. Blaming her for her inability to nurse contributes to psychological problems, further endangering her nursing ability.

When mother's milk is insufficient or dries up, the cause may be malnutrition, a premature birth, an endocrine malfunction, or a child's refusing her milk for unknown reasons, which would upset the mother and could cause all the milk to dry up due to lack of suckling, or other psychological problems. Delay in starting to nurse a baby may also affect a mother's ability to nurse, just as failure to empty her breasts can cause a diminution in the amount of milk produced and lead to further complications. All of these possibilities could have applied to Sita's mother. She may, also, have suffered from a hormonal disorder since a number of hormones from the pituitary gland, ovaries, and placenta are involved in lactation. So, too, is the brain. When the first child born after Sita refused her milk, Sita's mother may have become afraid to nurse so that thereafter her milk dried up when each newborn rejected her milk. Given the deaths of so many of her babies and the multiple causal possibilities, most probably both physiological and psychological causes contributed to Sita's mother's nursing problems (Benson, 1971, p. 211; Hellman, Pritchard, and Wynn, 1971, pp. 468-470; Cowie, 1972; Williams and Jelliffe, 1972, p. 44; Jelliffe and Jelliffe, 1979, pp. 11, 22-23, 24; Harrell, 1981, p. 798).

When Sita's mother was unable to nurse her babies, the children were given the milk of a zebu cow or water buffalo. Some of the infants were given powdered milk which Sita's father brought back from America and other countries. The infants could not digest these milks so that they died within two to four months from birth. Their deaths were due to dehydration and starvation, either from inability to digest these milks or from complications resulting from bacillary or viral dys-

entery contracted from the way in which the milks or *guti* were prepared and fed to the infants.¹³ There is no information as to what

¹³ Diarrheal diseases, such as amoebic and bacillary dysentery, were endemic in this region principally because of the unhygienic preparation and handling of food and the lack of pure water and sewage disposal systems. For example, after milking the cows and water buffaloes, village women prepared the milk by slow-cooking over smoldering dung cakes. The milk was thinned with water before and after cooking. It was cooked a long time but was not brought to a rolling boil because it was not watched while cooking. Then it was left standing in the cooking pot when the fire died out. All of this was done outdoors or in a small open shedlike niche where the *chulha* (a cookstove made of clay and plastered periodically with cow dung) was the main equipment. The milk was drunk from vessels or glasses which had been cleaned with ashes or scoured with soil and then rinsed with cold water from wells or handpumps. This water could contain various infectious organisms. When nursing bottles were used at the village level, a rarity, they were not sterilized, nor were the rubber nipples, for the concept of sterilization was unknown. Nor was the milk in a nursing bottle kept warm. All of these and the following conditions fostered weanling diarrheal diseases (Gordon, Chitkara, and Wyon, 1963, pp. 355, 358, 360-372; Nerlove, 1974, p. 212; R. Freed and S. Freed, 1979, pp. 330-331; 1980, pp. 368-369; 1981, pp. 58-59).

Although much stress is laid on eating with the right hand (the non-polluting hand) throughout India, the everyday use and cleanliness of hands contributes to the spread of infectious diseases, especially the dysenteries. In rural Delhi the left hand is reserved for cleaning one's anus with cold water after defecating in the fields. Children, when they reach two to three years of age and can hold the deep-squat position, defecate in gulleys outside the house. Usually older female siblings cleanse the children, ages two to three, with cold water and gradually teach them to clean themselves. In the absence of an older sibling, the mother performs this task. She also takes care of cleansing infants the first two years after birth. Soap and warm or hot water were seldom used in the 1950s because heating water and soap were costly. In washing children (done outside), mothers stood them or held them in a small bowl or basin and poured and rubbed water over them. In so doing, the mothers cleaned their noses and ears, removing mucous and other dirt with their hands. Although both hands might be used in the washing and bathing of children, more often the right hand was used. The right and left concepts regarding the use of hands with the left hand tabued while eating was based on beliefs regarding purity and pollution and not on concepts regarding infectious diseases. (For further information on sanitation, cleanliness, and hygiene in the village setting see R. Freed and S. Freed, 1979, pp. 295-302.)

the first surviving brother was fed, but the second surviving brother, who was still alive in 1978, was given goat's milk.

The content of milk is important in ascertaining whether an individual can digest it. Milk contains among other products, lactose or milk sugar, which is a disaccharide consisting of glucose and galactose, and which provides a high carbohydrate count and perfect liquid food for an infant, without which, unless an adequate substitute can be obtained, an infant will die (Kretchmer, 1972, p. 71). Until relatively recent decades, the inability to digest milk has been termed an allergy. The concept of an allergy to milk has been revised recently due to research on the lactase enzyme which is necessary in the digestion of lactose. Because of the complex of terms and symptoms associated with lactose and lactase we hereafter refer to the health problems related to them as the lactose-lactase complex (Wingate, 1972, pp. 17, 154-155, 246; Harris and Levey, 1975, p. 1514).¹⁴

What is there in milk that has contributed to its being called a nearly perfect food, but which causes a large number of people to have difficulty digesting it? Milk is secreted from the mammary glands of female mammals as food for their young. Humans use mother's milk, the milk of cows, and of a wide variety of other mammals. Milk is considered an almost complete food because it contains fats, proteins, salts (including calcium and phosphate), lactose (milk sugar), and a number of vitamins (including vitamin D, which is necessary for the proper utilization of calcium). Depending upon the mammal from which the milk is obtained, the amounts of the foregoing contents vary.¹⁵ The substance which may have caused Sita's sib-

lings to be unable to imbibe their mother's milk or that from a zebu cow or water buffalo is lactose, a carbohydrate and a disaccharide. It is one of three disaccharides essential to the human diet, which are digested by enzymes in the body (Kretchmer, 1972, p. 71; Wingate, 1972, pp. 153-155, 246, 277; Harris and Levey, 1975, pp. 452, 1514, 1777).

The enzyme necessary to digest lactose is lactase, which acts as a catalyst on lactose to separate or hydrolyze it into two monosaccharides, glucose and galactose. Three lactases have been isolated, of which at least two take care of digesting lactose. One of the three is found in the small intestine, and it takes

He also (table 2, p. 480) lists the lactose content of various dairy products. The lactose content of milk is important in determining whether a lactose malabsorber can digest it. Most commercially prepared powdered and canned milks have a high lactose content and can prove deadly to infant malabsorbers. Undiluted evaporated milk can lead to renal failure, gangrene, and death. Because large numbers of Central, North European, and European derived populations are lactose absorbers, they place a high value on milk drinking. As a result nutritional programs have been promoted for giving powdered and other milks to the people of developing countries and to indigenous populations of North America with the belief that milk will improve their health. These populations, however, have the highest numbers of lactose malabsorbers. For them such programs are not only wasteful but dangerous. Where there are high incidences of lactose malabsorption in the population, the only suitable dairy products are those with a low lactose content. Curd, known in the United States as yogurt, and cheese, due to fermentation change lactose to lactic acid and provide nourishment to malabsorbers; these products cannot be fed to infants because they cannot drink them. It is also less costly to substitute other foods for dairy products (Kennedy, 1971; McCracken, 1971, pp. 479-480, tables 1 and 2, note: p. 480, p. 494; 1973; Pollitzer, 1971, pp. 505-506, table 1; Underwood, 1971, p. 508; Andersson et al., 1973; Gudmand-Hoyer, 1973; Mourant, 1973; Johnson, Kretchmer, and Simoons, 1974, pp. 228-229; Abrams et al., 1975; Flatz and Rothauwe, 1977, p. 230; Johnson, 1981).

Although domesticated cattle and probably dairying and milk drinking were present in the Harappan culture of the Northwest Indian subcontinent, c. 2500 to 1700 B.C., today there is a high incidence of lactose malabsorbers among Pakistanis and North Indians. There is, however, evidence of some regional difference (Minturn and Hitchcock, 1966, pp. 108-109; Johnson, Kretchmer, and Simoons, 1974, p. 217; Johnson, 1981, p. 13, table 2.2).

¹⁴ Carbohydrates in the Human Diet: There are three disaccharides necessary in the human diet: (1) Maltose (consisting of glucose and glucose); (2) Sucrose or cane sugar (consisting of glucose and fructose), and (3) Lactose or milk sugar (consisting of glucose and galactose). Sucrose, fructose, and galactose can be converted by enzymes to glucose (Wingate, 1972, pp. 86-87).

¹⁵ Human beings use the milk of cows, mares, goats, buffalo, camels, asses, zebras, reindeer, llamas, and yaks. The lactose content of the milk from these animals varies. McCracken (1971, p. 480, table 1) lists the lactose content of mammalian milk, indicating some variability depending on who did the study and for different regions.

care of about 90 percent of the digestion of lactose. This lactase is secreted within the brush border of the epithelial cells of the small intestine and there it is that lactose is hydrolyzed into its constituent monosaccharides. They are then absorbed into the intestinal epithelial cells and subsequently into the blood; both are metabolized by the liver. If the amount of lactase secreted in the small intestine is insufficient, then malabsorption of milk may occur depending on the lactose content of the milk, which varies among mammals. For example, goat's milk has a lower lactose content than zebu cow or water buffalo milk, and a nursing woman's milk has the highest content of all (McCracken, 1971, pp. 479-480, tables 1 and 2, p. 480; Kretchmer, 1972, pp. 71, 75; Johnson, Kretchmer, and Simoons, 1974, pp. 199-200; Gary Gray, 1978).

Although it has long been known that milk may cause diarrhea in some populations, research on the possible causes was not begun

until the last half of the nineteenth century, and at first was carried out on dogs. By the 1950s and 1960s it was generally accepted that hydrolysis of lactose takes place in the small intestine. In the 1960s and thereafter it was found that hypolactasia was present in infants and adults in many human populations, including North India. Humans suffering from lactose malabsorption usually but not always show the following symptoms after drinking milk: meteorism (painful distension of the intestines with gas), boryborygmia (rumbling noises in the stomach or intestines), abdominal fullness, loose stools or diarrhea, and sometimes abdominal pains, symptoms similar to those for Sita's infant siblings (McCracken, 1971, p. 481; Andersson et al., 1973; Gudmand-Høyer, 1973, pp. 37-38; Johnson, Kretchmer, and Simoons, 1974, pp. 197-207; Flatz and Rotthauwe, 1977, pp. 212-213; Gary Gray, 1978; Sahi, 1978, pp. 1074-1078).

A series of causes of lactose malabsorption have been found to exist. Research over the past two to three decades indicates that the secretion of the lactase enzyme in the small intestine may be affected by congenital, pathological, and genetic factors. These three causes may be pertinent to Sita's infant-sibling deaths and to her own medical history. Congenital malabsorption of lactose may be due to immaturity at birth. Normally, the lactase enzyme is not activated in the fetus until the end of the first trimester of pregnancy and does not secrete until the full pregnancy period is terminated with delivery. Therefore, an immature infant would not be able to imbibe and digest milk of high lactose content as well as a mature infant, i.e., the immature infant would be a lactose malabsorber. Congenital malabsorption of lactose may also be due to pathology, i.e., disease contracted by the offspring in the birth process. Other pathological factors which could affect the production of lactase are a variety of diseases, among them infant diarrhea and diseases of children past the weanling stage. The adult type malabsorber may have a reduced or inadequate amount of lactase for absorbing lactose due to disease. Drugs and surgery also can reduce lactase secretion, adding to the list of pathological causes (Flatz and Rotthauwe, 1977, pp. 212-213; Paige,

← What has not been taken into consideration in India regarding the lactose-lactase complex are the diverse populations and castes with different economic conditions and food customs, or their histories. For example, numerous people have penetrated India from the North, Northeast, and Northwest. Many of the low castes, who generally do not own land, have migrated to different parts of India. The members of Sita's caste began to camp in temporary settlements in the Delhi region during the rule of the Moghuls. Some of these castes may have been herders and may have obtained milk when necessary from animals with milk of low lactose content, such as camels and goats, or if they came from the Himalayan region from yaks (McCracken, 1971, p. 480, table 1).

In southern Punjab and the adjoining rural region of Delhi, the daily diet consisted of whole wheat bread (*roti*), an occasional small dab of cooked vegetable, milk, curd, buttermilk, butter, and ghee providing the people owned dairy animals, the animals had not gone dry, and there was enough to go around to the male members of the family first, then to children, and last to adult women. In the 1950s villagers did not have electricity or any form of refrigeration. As a result although fresh milk, was drunk the day the animal was milked, the balance of the milk was turned into curd, butter, buttermilk, and ghee. In 1958 more milk was drunk by adults, especially males, then in 1978. Even then tea with milk and sugar in it was replacing the adult custom of drinking milk. In 1978, young children were given milk before adult members of the family providing the family owned a lactating animal.

1981, pp. 151–152, 158; Welsh, 1981, pp. 69–70, 73–77).

In the following genetic discussion of the lactose–lactase complex, we use the symbols representing genes most often found in the literature. Genetic factors for the secretion of lactase are presumed to be based on three allelic autosomal genes, one of which is dominant (L) for the ability to secrete a sufficient amount of lactase to hydrolyze lactose in the small intestine; the other two genes are recessive and are unable to generate sufficient lactase to digest milk of high lactose content in the small intestine. These recessive genes are indicated by l_1 , l_2 . Thus LL indicates a person who is homozygous for the dominant gene and who is a lactose absorber. Ll_1 or Ll_2 represents persons who are heterozygous dominant and who are lactose absorbers. The genotypes l_1l_1 and l_2l_2 are indicative of persons who are homozygous recessive for a lesser secretion of lactase and who are lactose malabsorbers. The literature on the lactose–lactase complex, however, often simplifies the symbols for the phenotypes and genotypes by using PLA for a person who is a phenotypic lactose absorber; and PLM for a person who is a phenotypic lactose malabsorber. Since only a person who is homozygous recessive can be a lactose malabsorber, sometimes LM is used.

The onset of these three allelic genes differs; apparently the dominant gene operates from birth onward. The recessive gene l_1 may have its onset any time from 11 months after birth (around the time of weaning) to 20 years of age. The age at onset varies in different populations. Persons who are homozygous for this gene (l_1l_1) are called lactose malabsorbers (PLM or LM) but are also classified as having adult hypolactasia. Because of its early onset in some cases, adult hypolactasia is somewhat of a misnomer. Therefore, we prefer the term post-weanling-adult hypolactasia. A hormonal factor such as thyroid or some other inhibiting bodily trait may be related to the decrease in the secretion of the lactase enzyme in post-weanling-adult hypolactasia. The third allelic gene but the second recessive gene (l_2) is similar in its function to the first recessive gene except that it is active at birth. Infants who are homozygous for it cannot digest milk of high lactose content such as

their mother's milk, or that of a cow or buffalo. They can digest goat's milk which has a lesser lactose content. Persons who are homozygous for this gene (l_2l_2) are classified as having infant hypolactasia or alactasia because they are lactose malabsorbers (PLM or LM). Infants who have or had infant hypolactasia before the development of milk substitutes and knowledge about the lactose–lactase complex, and in developing countries where no knowledge or medical treatment exists, will die or have died within a few months of birth unless goat's milk or some other substitute is or was available. It is this type of hypolactasia which may have afflicted Sita's siblings. As a result of early death from infant hypolactasia in developing countries where this trait occurs frequently in the population, and in populations to which the knowledge of the trait has not yet spread, there is as yet less evidence for the genetic history of the trait in family lines than there is for post-weanling-adult hypolactasia. Since Sita's later case history reveals the possibility of infant hypolactasia as well as post-weanling-adult hypolactasia for her and her children, there may be supporting evidence for a history of these genetic traits in her family line. In addition to the foregoing, perhaps not all is known about these three allelic genes; but it is known that for lactose absorbers and malabsorbers the type of lactase is the same but not the amount secreted (Cook, 1967, 1973; Elliott, Maxwell, and Vawser, 1967; Rosensweig, Huang, and Bayless, 1967; McCracken, 1971, pp. 481–482; Rosensweig, 1971, 1973; Graham and Paige, 1973; Sahi et al., 1973; Flatz and Rothauwe, 1977; Sahi, 1978; Paige, 1981; Welsh, 1981).¹⁶

¹⁶ Recessive genes for infant and post-weanling-adult hypolactasia (lactose malabsorbers) have been found in Asia, Africa, Greece, the Middle and Near East, Oceania, among Scandinavians and Indians of North and South America, and the Eskimo. The high incidence of the dominant gene for lactose absorption is generally found in North and Central European populations and migrants from these regions. The distribution of these genes seems related to the development of dairying. The theory is that the autosomal recessive gene for lactose malabsorption was earlier than the dominant gene for lactose absorption. After dairying was introduced and milk began to be drunk a mutant gene for a higher level of secretion of the lactase enzyme seems to have occurred

Since Sita said that all her infant siblings were strong and healthy at birth, lactose malabsorption due to immaturity is not applicable to their deaths, nor are pathological factors. Genetic infant hypolactasia is a more probable cause of death inasmuch as the symptoms of hypolactasia resemble those of the infants. If, however, all of Sita's siblings could not imbibe their mother's milk or that of a cow or buffalo, then 14 out of 15 children of Sita's mother and father had homozygous recessive genes for infant hypolactasia. We have no information as to whether Sita's parents were able to take milk of high lactose content. The fact that both of them survived into adulthood at a time when nothing was known about lactose malabsorption and no medical services were available to them would tend to establish that they were heterozygous, that is, each had one dominant gene for absorption and one recessive gene for malabsorption. However, since before the 1940s in India and even thereafter people of their caste were quite poor and often did not own a cow or water buffalo, it is possible that one or both of Sita's parents were given goat's milk in infancy and survived even though they had infant hypolactasia. What rules against the latter possibility is that Sita from birth onwards was nursed by her mother for about two years. Thus, she was a phenotypic lactose absorber (PLA) and may have been hetero-

zygous or homozygous dominant. If Sita had a different father from the other 14 children, then the possibility that the 14 infants had parents who had infant hypolactasia would account for their lactose malabsorption. If all 15 children had the same mother and father, with Sita having either two of the dominant genes or one dominant and one recessive gene, there is some question as to whether all the 14 other children had genetic infant hypolactasia unless one parent was l_2l_2 and the other was Ll_2 , and Sita was heterozygous dominant, Ll_2 . Such pairing might account for the ratio of 14 PLM:1 PLA for 15 children. If Sita's parents, on the other hand, were heterozygous for the dominant and recessive genes, the random assortment of genes for 15 children would tend to result in a ratio of about 12 PLA:3 PLM. But since Sita was a lactose absorber (PLA) and her siblings seem to have been lactose malabsorbers (PLM) then the ratio is 14 PLM:1 PLA. The question then is: Were all 14 children lactose malabsorbers due to the recessive gene for infant hypolactasia? (Cook, 1967, pp. 527, 529; Rosensweig, Huang, and Bayless, 1967; McCracken, 1971, pp. 481-482; Rosensweig, 1971; Meeuwisse, 1973; Flatz and Rotthauwe, 1977, pp. 212-213; Sahi, 1978, pp. 1075-1078, 1080-1081; McKusick, 1983, p. 685).

As indicated earlier, Sita's mother may have mated with her husband's elder brother during her husband's absence overseas. The younger brother had a healthy daughter five years of age in 1958 so he might be ruled out; the elder brother was probably a widower and his wife may have died without issue and become the *opera* in the minds of Sita's mother and grandmother. Thus, the elder brother was the most likely candidate for the fathering of Sita's infant siblings. However, there is insufficient evidence regarding the genes of Sita's parents and her father's brothers to determine who fathered the 15 children. The most plausible reasons for the infant deaths of 12 out of 15 infants is that a fair number of infants died because they had infant hypolactasia and the others probably died of bacillary or viral dysentery.

Complicating the evidence for the causes of death of an infant or young child is the emotional reaction of parents. It is not sur-

← or been present in the populations which made it possible to digest lactose after weaning so that people could drink milk of high lactose content (Cook, 1967, 1979; Elliott, Maxwell, and Vawser, 1967; McCracken, 1971, pp. 482-495, tables 3 through 12; Simoons, 1971; Kretchmer, 1972, pp. 73-74; Johnson, Kretchmer, and Simoons, 1974, pp. 215-219; Ransome-Kuti et al., 1975; Flatz and Rotthauwe, 1977, pp. 230-236, table 6, p. 234, figs. 1 and 2; Bayoumi et al., 1981; Johnson, 1981).

Possibly the alternate mental states of possession and possession-trance may be related to hypolactasia and a calcium deficiency due to the inability to imbibe milk, along with other psychological, cultural, and biological causes of pain and stress. It might be worth plotting the distribution of infant and post-weanling-adult hypolactasia to find the degree of fit with Bourguignon's world distribution of possession states and other reports of possession and trance, especially among hereditary shamans (Bourguignon, 1968; Kehoe and Giletti, 1981; Bourguignon, Bellisari, and McCabe, 1983; Kehoe, 1983; I. Lewis, 1983).

prising to find that parents who have no knowledge regarding the biological cause of an illness and death cling to the belief that a supernatural being is responsible (Culliton, 1972, p. 283; Powledge, 1973). Given the village system of belief, deaths of infants with symptoms of spasms or convulsions, as in dysentery or infant hypolactasia, were often attributed to possession by a malevolent female ghost, thus allowing the mother some catharsis for her grief. This belief, held by most mothers when their babies died, was impressed on Sita's mind at the time of death of her first sibling. As Sita's infant siblings weakened, they often cried. Another reinforcing belief was that a crying baby invited the evil eye or a ghost. Mothers would tell their babies not to cry or a ghost would get them. Although Sita's father in later years was influenced by Western-scientific medical treatment, some of his and his daughter's early beliefs persisted as will be shown in the treatment of Sita's ghost possessions and later illnesses (Singh, Gordon, and Wyon, 1962, pp. 878-879; Jacobson, 1974, p. 107; R. Freed and S. Freed, 1979, pp. 303-306; 1980, pp. 528-529; 1981, p. 60).

MOTHER'S BROTHER'S VILLAGE

The mother's brother's village designates the natal village to which a married woman returns for visits after marriage. Because her children accompany her on her visits to her natal village, they refer to it as their mother's brother's village. It is, as noted earlier, the village of the mother's parents as well as of her brothers.

Visiting the mother's brother's village is looked on by a mother and her children generally as a happy time. On such visits, a mother resumes her role of daughter, has more freedom than in her husband's village, and generally does not cover her face in public or follow purdah restrictions. She has less work because, as the saying goes, "When a daughter-in-law is in the house, why should a daughter work?" Maternal grandparents like to see their grandchildren and indulge them more than would be the case in their natal (father's) village. When a mother and her children are preparing to depart after a visit, her parents or brothers provide new clothing

and other gifts for them and the mother's husband's family. In time, the children realize that their maternal grandparents and mother's brother or brothers send them gifts at festivals and rites of passage, especially birth and marriage.

The mother's brother's village is also a place of refuge for a woman who is having difficulties with her husband and/or other members of his family. It is visited by a woman after the seclusion period that follows the birth of her first child so that she may show her parents their new grandchild, a visit which enforces the postpartum tabu against mating while she is nursing the infant. Some families allow their daughters-in-law to visit their natal village after the birth of each of their children, but usually daughters-in-law discontinue these visits after the first two or three births. In any case, permission to visit depends on the head of the family who takes into account, among other considerations, how badly the family needs the daughter-in-law's labor (Jacobson, 1974, pp. 131-132; S. Freed and R. Freed, 1978, pp. 123-124; R. Freed and S. Freed, 1980, p. 400).

Although visits after the death of a child might not be allowed, in the case of Sita's mother they seem to have taken place more often than was customary. The reasons were due to her husband's absence, to the small amount of land which could be worked by other members of the joint family, and possibly to her unhappiness. She must have suffered from the generally negative attitude directed toward her, a woman whose children had died and who did not have a living son for many years of her married life. In any case, she and Sita visited the mother's brother's village frequently. One time they stayed for six months, usually a sign of trouble. Due to the rape of a school friend in her natal village, Sita stayed six months in her mother's brother's village. It was obvious from Sita's comments that she knew the village well, especially in her early teens.

Because as a child Sita passed considerable time away from her natal village on visits to her mother's brother's village, she was able to observe that her mother behaved differently in the two places. For example, her mother followed the restrictions of purdah in her husband's village but not in her natal

village, generally had more freedom in her natal village than in her husband's, and did not have to defer to men as much. Although Sita was somewhat aware that a woman and her consanguineal relatives had a lower status in the woman's husband's village than the husband's relatives, she was not herself affected by the custom and was incompletely prepared for her future role as a daughter-in-law in her own husband's village. In her natal village she was treated as a little pure goddess and in other ways was equal with her consanguines. In her mother's brother's village she was treated deferentially and as a beloved granddaughter. In her marital village her statuses would be lower and her roles changed (S. Freed and R. Freed, 1976, pp. 63-78; R. Freed and S. Freed, 1981, pp. 74-75).

Sita's mother's brother's village had special importance in her life because it was there that over the years she formed an intimate friendship with a girl called Taraka, who was a daughter of her mother's brother, thus a matrilateral cousin. They were about the same age. Sita said, "I used to live like her. We lived in the same household and became like one." These statements implied that they were not only very close but carried out similar activities together and in effect were doubles of each other (Freud, 1924, pp. 387-389). This mutual identification was to affect Sita's later years.

When Sita first mentioned Taraka, she said that she fell into a well and drowned. Gradually the facts emerged. This death occurred in 1956. Because the two girls exchanged confidences, Sita knew that Taraka had illicit sexual relations two or three times with a young male in Taraka's natal village (i.e., Sita's mother's brother's village). Not only was this an extramarital liaison but it also violated the prohibition of sexual relations between natives of the same village: all such persons are thought to be fictively related, and sexual relations between them are thus tabued (S. Freed, 1963a; S. Freed and R. Freed, 1976, pp. 59, 151-152; R. Freed and S. Freed, 1980, pp. 411-414).

Sita recounted that, "Taraka started joking with a boy while she was on her way to the well. He could tell that she had a bad character and began seeing her at night." Sita emphasized that Taraka was the only girl in the

village who carried on such a relationship with a boy in the village, perhaps to indicate that she, Sita, was in no way involved. Sita said that when she became aware that Taraka was having an illicit affair, she told her that if her husband-to-be or father were to find out, they would not let her live. Taraka's affair with the boy started before her wedding, at which time she was pregnant. Her parents knew of her pregnancy and therefore quickly arranged her wedding and provided a small dowry because of the probability that her in-laws would kill or return her if they found out. Taraka had not yet gone to her husband for first mating, which customarily took place at *Gauna* (usually the second visit of a bride to her husband and the time of first mating).¹⁷ When Taraka went to her husband for the first mating, her husband's parents learned she was pregnant. The in-laws and husband then renounced all rights to Taraka by returning her to her father.

Sita later enlarged on the details of Taraka's death, amending her first account by stating that when Taraka was returned to her parents she pleaded with her father saying, "I have made a mistake. Please forgive me." In anger, he replied, "I won't keep you. Go jump in a well." Under these circumstances in rural India, "... the girl has the choice ... between suicide and prostitution" (Williams and Jelliffe, 1972, p. 118). Another possibility is that the father of such a girl will kill her.

Sita said that when she and a group of girls, including Taraka, were playing in the fields, Taraka said that she had to defecate, ran from them, and fell in a well. Then Sita changed her statement, indicating that Taraka asked Sita to accompany her but she did not. Furthermore, Sita claimed that if she had, Taraka would have pulled her into the well with her. Sita's ambivalent, troubled, and inconsistent statements reveal her guilt concerning Taraka's suicide.

Before the statement about Taraka pulling

¹⁷ At the time of a wedding in the 1950s, the bride visited her husband and in-laws for the first time, but did not consummate the marriage. First mating usually occurred at *Gauna*, after the bride had attained menarche.

her into the well, Sita said, "Had I known that Taraka was going to jump in the well, I would have jumped with her, but if Taraka had tried to pull me with her, I would have pulled away." The intimacy of the two girls, their related activities, and Sita's identification with Taraka continued to haunt Sita.

Because of the inconsistency of Sita's statements regarding her own and Taraka's behavior, Sita's overemphasis that Taraka was the only girl in the village to behave so, and Sita's contradictory statement that she and Taraka were like one, there is some reason to believe that Sita participated with Taraka and the village boys in sexual or semi-sexual experiments in her mother's brother's village. Further grounds exist for Sita's flirting with young males outside of her village of birth, for one young man told us that when he attended marriage parties in other villages, the girls would go into the fields at night with the young male guests. This behavior was the subject of gossip and song. There is no proof that Sita engaged in such behavior but she may have fantasied participation by identification with her closest friend and then felt guilty about her fantasies and her hesitation and indecision in preventing Taraka's suicide. Her remarks revealed mental conflict, a tendency toward suicide, and a certain amount of self-dramatization.

Young married girls in this region were sometimes reported to have drowned in wells. The drownings were suicides, murders usually by a husband or father, or accidents. Regardless of the truth, villagers usually suspected foul play either by a father whose daughter may have been illicitly pregnant or a husband who did not like his wife. Since such matters were subject to the authority of the head of the family, villagers did not intervene (R. Freed, 1971; Jacobson, 1974, p. 121).

SCHOOL

Sita liked school and attended through fourth grade. In school she took part in skipping, running, and dramatics with the girls who were her classmates. Once for six months (1955–1956) Sita visited her mother's brother's village and attended school there. This

was the time when her maternal cousin, Taraka, became pregnant, had her wedding, and later jumped into the well. Sita was upset when she talked about her school days in her natal and mother's brother's villages because of Taraka and a somewhat similar event in her natal village.

In relating Taraka's suicide, Sita said she was playing in the fields with some girls when Taraka jumped in the well. She contradicted herself, for she had earlier said she did not play games in the village fields after school with her girl friends and usually did not go with them to the fields unless they forced her to go. The games which the girls played were *kabaddi* (R. Freed and S. Freed, 1981, p. 83), soccer, and wrestling, considered boys' games in her marital village. Sita later said she did not play them because a sister-in-law was standing nearby. It seems that in her natal and mother's brother's villages, Sita had more freedom than girls of a similar age in her marital village, probably because the girls in her caste in her marital village did not attend school. Her contradictory statements indicate guilt, shame, and an effort to fit in with her in-laws' standards.

We asked Sita whether her parents disapproved of these after-school activities, to which Sita replied negatively, adding she did not know why she did not play the games, but that her parents had never forbidden her to do anything, had never scolded or beaten her, she had never been beaten by anyone, nor had anyone spoken to her in anger. These statements seemed truthful. Her parents, then, were unusual since children were frequently admonished and punished with beatings (R. Freed and S. Freed, 1981, pp. 75–77). These differences from the norm may have been due to her being the only surviving child, the long absences of her father, the frequent visits to her mother's brother's village, and her being one of the first generation of girls from her caste to attend school. They also indicate that she was not reared in the customary village tradition with strict rules and discipline by male and female authority figures.

Except when she began to attend school or visited her mother's brother's village, Sita was more isolated than was customary in a North Indian village. She, therefore, may not have

learned the usual social skills from siblings. For example, testing play, which is kinesic and includes sports and games, was first learned within a family in approach-avoidance games such as hide-and-seek. Sita had no such opportunities at home because her first surviving brother and patrilineal female cousin were between one to three years old when she was about 13. This background may account for her ambivalence about playing in the fields after school, but she was there when Taraka jumped into the well (R. Freed and S. Freed, 1981, pp. 82-83).

In her natal village school, Sita had two girl friends about the same age, Mara and Rukmini. They, as well as Taraka, died in the period preceding Sita's marriage, Mara in 1955, Rukmini in 1957. The male teacher of the fifth grade was said to be the cause of Mara's death. He went to the fields where girls were playing and, according to Sita, said "bad things to them." A boy saw him touch Mara's breasts and told her father. The father interrogated her and discovered that the teacher had stuffed a cloth in her mouth so she would not cry out. Then he raped her. After learning that his daughter had been raped, the father himself raped her, cut her throat, and threw her in a well. According to Sita and village gossip, the father bribed the policeman investigating the case, who did nothing to the father but arrested the teacher, who was then tried and imprisoned for six months. He was found to have had a previous record for molesting girl students when posted in another village. The death of Mara took place before Taraka's death. The school was closed for a month, and thereafter none of the parents sent their daughters beyond the fourth class because a man taught the fifth grade. Due to this death, Sita never again attended school in her natal village and could not become a teacher.

Stories about male school teachers molesting girl students circulated throughout the region in the late 1950s. The word "molesting" implied "illicit sexual behavior" or "attempts at it." The stories had their basis in fact as well as in the general attitude regarding nubile females (R. Freed and S. Freed, 1981, p. 135). Kakar (1978, p. 94) has commented on Dube's (1955, pp. 196-197) observation

that young males in India are fascinated by adolescent girls to the extent of trying to fondle their breasts and have intercourse with them in contrast to their fear of sexually mature women. If a young female wandered around by herself or by accident was unchaperoned when no one was around, a male might not hesitate to rape her. There was no question of innocence absolving her from blame.

These attitudes may have stemmed from the Ramayana, one of India's two great epics. In the Ramayana when Sita, the wife of Rama Chandra, the hero-god of the epic, stepped out of a magic circle drawn to protect her, Ravan, a demon king, carried her off to his kingdom, Lanka. Rama Chandra rescued her, but his subjects believed that she had been defiled and so she was exiled. Later, Rama Chandra recalled her and her twin sons from banishment, but because of public opinion, Sita chose to go down into the earth from which she came (in effect a supernatural suicide). As a result of this oft-told story, villagers considered that Sita's abduction was her fault, an attitude they extended to any female who was raped. It was useful in keeping girls from attending school and in teaching them a submissive role in keeping with purdah. The same attitude made it easier for males to rape females, who were accustomed to comply with the wishes of males.

In this context Sita's attitude toward Mara's death reflects an independent line of thought, not customarily heard among village girls of her age although in 1978 such an attitude was more often expressed than in 1958. Sita's sense of justice was violated by the actions of the teacher and Mara's father. She knew the details of the case because Mara had confided in her. Sita affirmed, "It was the teacher's fault and he should have been punished, not Mara. It was very bad for the father to behave as he did. Mara's father told people that she was his daughter and he had every right to do with her as he liked."

According to customary village law deriving from the Dharmashastras, ancient Hindu religious laws, the father as head of the family had the power of life and death over its members. For example, we recorded the case of a young girl who was married but had not yet

gone to her husband for first mating. She was pregnant when her parents sent her to her husband at *Gauna*. Her in-laws discovered the pregnancy and returned her to her father to do with as he pleased; he hanged and cremated her. Although the villagers, including men who were in police service, talked about the death at great length, they did not report the killing to the district police station, thus validating the ancient custom of the father's jurisdiction over his daughter and the father-in-law's jurisdiction over a daughter-in-law (Maine, 1963, pp. 147–149; R. Freed, 1971; Derrett, 1978, pp. xxi, 2–5, 7).

Rukmini, Sita's second school friend to die, had recently been married. When she was sent to her husband's village for mating, she came down with what was reported as a combination of typhoid and malaria. According to Sita, Rukmini died because she drank cold water to abate the fever. Although this death was attributed to two diseases and the wrong remedy (cold water), Sita seemed to associate Rukmini's death with her marriage and living in a strange village, that of her husband. Villagers were suspicious of strangers, and since marriage was with a stranger, rituals were performed to protect the prospective spouses in a marriage. Illnesses could also be caused by strangers, so Sita linked beliefs about strangers, illness, death, marriage, mating, and birth in her growing complex of anxiety about her future marriage. Given the general belief that disease and death were often due to supernatural beings, especially ghosts, and the Ayurvedic concept that drinking cold water could result in a humoral imbalance in Rukmini's system, which made it easier for a ghost to take her, we can better understand Sita's mental conflicts about marriage, mating, and death (van Gennep, 1961, pp. 19–20, 26).

With the deaths of Taraka, Mara, and Rukmini, Sita lost her closest friends. Sita's three friends married and/or mated then died in the same period of time that Sita's first surviving brother made it possible for her to be engaged. The birth of this brother and Mara's death occurred in 1955. Taraka's death took place about six months after Mara's in 1956; Rukmini died in 1957. Within a brief period, Sita's best friends died as a result, in her line of reasoning, of marrying, mating, and interacting with strange males. In the same period,

Sita's schooling was stopped, her ambition to become a teacher was thwarted, and she became engaged. These traumatic events took place during three years, and in the fourth year she, too, was wedded and mated.

SUPERNATURAL BELIEF SYSTEM

The system of supernatural beliefs into which Sita was born consisted of a wide assortment of beliefs and supernatural beings, some of them deriving from Islam but most from Hinduism. The earliest conditioning for these beliefs was in the context of rites of passage, festivals, and curing practices. It began at birth and influenced the individual through participation, observation, imitation, and the yearly recurrences of many of these events (R. Freed and S. Freed, 1981, pp. 104–105).

Spiro (1962, p. 113) has noted that: "In most traditional societies, where religious beliefs and practices continue to carry conviction, religion is the cultural system *par excellence* by means of which conflict resolution is achieved . . . religion serves as a highly efficient culturally constituted defense mechanism." If this theory holds, the belief system of Sita's natal village should have provided her with the means of coping with mental conflict. For example, the belief that a female ghost caused the deaths of infants in earlier times of high infant mortality pointed to the female ghost as scapegoat when no other causes were known. This belief was a defense mechanism for a mother whose infants died so that her mental conflict as to the responsibility for the deaths could be resolved. However, the system of belief may create conflict if it perpetuates fear and anxiety. It may foster trust or distrust, hate or love, based on the malevolent or benevolent characters of the supernatural beings, who may be identified with family members by children who are frustrated or threatened with the powers of these supernatural beings in the socialization process. For example, as a small child, Sita was told that when she cried that a ghost would take her. Her early conditioning to the belief in female ghosts, who took her siblings, provided her with a good–bad female role model, which later was to develop into a defense mechanism for her inner conflicts. On the other hand, a belief system may become

inadequate if it cannot change along with other changes taking place within the culture. Even if it can, some of the earlier beliefs may persist but eventually become outmoded. For example, as infant mortality decreases in India through the introduction of new medical practices, the belief that a female ghost causes the death of infants may not survive. While a cultural system undergoes change, individuals within it, such as Sita, may have to make decisions as to which of the alternate beliefs to follow—the old or the new, thus creating new mental conflict (Erikson, 1950, pp. 237–238; Spiro, 1953, pp. 380–381).

This description of beliefs and practices pertaining to the supernatural world of Sita's childhood is selectively related to the concept that this supernatural system provided a culturally conditioned defense mechanism for coping with problems during Sita's 35 years. The celebration of village and national festivals was fairly similar among all castes. The rites of passage differed depending on whether the villagers were low or high-caste, or followers of the Arya Samaj or Sanatan Dharma. We devote ourselves to the low-caste practices except when those of the high castes impinge on them. The curing practices for children were mainly in the hands of women and with a few exceptions were fairly similar for all castes.

Sita's natal and marital villages had no temples as places of solace or outlets from mental conflicts or other problems. Women of all castes, except some of the Arya Samaj Jats, worshiped primarily mother goddesses and were responsible for the simple rituals of most but not all village festivals. They might visit the shrine of Kalkaji once or twice yearly. They could not generally follow a celibate religious life nor did cults exist at the village level where women could seek possession-trance by a deity. Since there were few ritualistic outlets for anxiety and no system of confession or catharsis for them in the supernatural belief system, the main outlets for situations of stress were in propitiating goddesses for the welfare of their children and in ghost possessions. These activities did not always allay anxiety (Ness, 1980, pp. 167, 171–174, 177).

For Sita's caste the philosophical and orthodox concepts of Hinduism had begun to

penetrate more deeply with the advent of schooling and literacy. The process of Sanskritization, one whereby the sacred texts and rituals of the Brahmins and other twice-born varnas (classes of castes) are gradually copied by lower castes, contributes to the ongoing religious system (Srinivas, 1952, pp. 30–31). Until the advent of literacy and accessibility of schooling for the lower castes, the process was slow, incomplete, and often lacking, especially with regard to *samskaras* (orthodox Hindu rites of passage) because Brahmins did not officiate at rites of passage of the lowest castes. For example, members of the twice-born castes may seek release (*moksha*) from the round of rebirths. Low castes seldom sought such release. When asked about it, they often replied that they had never seen it. Similarly, the various paths which led to *moksha* were not practiced by most of the population. The most generally known path was *karma*, that is, action, which depending on whether it was good or bad could result in rebirth at a different level in the next life. This belief was disturbing to low-caste people whose status was attributed to their actions in past lives. The areas of life in which Sanskritization more easily penetrated were those which were visual, i.e., they could copy the practices of the other castes when they witnessed the ceremonies of weddings, births, and funerals, and the observance of festivals. Additionally, they could pick up knowledge from stories about culture heroes and heroines from the epics and Puranas, which were recited at religious festivals, and in school, and were dramatically and interestingly portrayed in the cinema (R. Freed and S. Freed, 1962, pp. 251–252; 1980, pp. 482, 483, 485–487). With literacy and a kind of homogenized nationalist Hinduism taught in the schools, the low castes were learning more about Hinduism than formerly (R. Freed and S. Freed, 1980, pp. 334–335).

This learning process was particularly effective through stories deriving from the two great epics, the Mahabharata and the Ramayana, and from the Bhagavata Purana (the stories about Krishna's birth and life). These myths seemed to have a profound effect on children who identified the leading personalities (often deities) with members of their own family. Extracts from these myths were

told or enacted during festivals in the villages, and were seen in the cinemas. By the 1970s, village women had begun to read the religious stories to their children from simplified versions bought cheaply in marketplaces (Kakar, 1978, pp. 4–6; R. Freed and S. Freed, 1981, pp. 145–147).

Sita first heard the myths in the village, then learned the national versions in school. Later she went to the City of Delhi for the celebration and pageant of the Ram Lila (Lord Rama Chandra's return from Lanka). The Bhagavata Purana contrasts wealthy high-caste and poor low-caste people, incorporating the idea that pride in wealth and family cuts people off from moksha (release from round of rebirths), but through bhakti (loving devotion) worship of Lord Krishna the low castes had access to Hinduism learned from stories about Krishna (Hopkins, 1966, pp. 14–15; Marriott, 1966, p. 212; Pandey and Zide, 1966, pp. 177–181; Kakar, 1978, pp. 4–6, 63–69, 140–153; Roland, 1982, pp. 244–245).

rites of passage

The main rites of passage in the region were for birth, marriage, and death. Because Sita's mother bore nine children who died successively after Sita's birth and before her wedding, Sita was repeatedly exposed to beliefs that engendered anxiety regarding birth and death. Even though a small child, Sita would have noticed her mother's changing shape and later may have related it to the recurrent visits of her father and the eventual birth of a baby. Before delivery of the first sibling, Sita began to sleep with her grandmother instead of her mother. Because of the cramped quarters in which Sita's family lived, she became aware as she grew older of preparations for delivery. The delivery and lying-in area was separated from the rest of the room only by hanging bed coverings around the bed. Males were barred from the room and children directed outside to play, but they wandered in and out of the hut, especially when hungry. Given the crowded conditions, children became aware that "something different and dangerous" was taking place. As a first and only child, Sita would have missed her usual attention, especially since her grandmother

as the senior woman in the household assisted the midwife in delivery and aftercare of mother and infant.

In due time Sita learned that when a baby was born, the midwife tied and cut the cord and placed the baby on the earthen floor saying, "It is the earth that will have the burden of taking care of it" (R. Freed and S. Freed, 1980, p. 362). The life of the baby was believed to rest in the expelled afterbirth until the child began to breathe. If the child did not breathe, the placenta was warmed in an iron dish; if the infant still did not breathe, it was dead. Since none of Sita's siblings-to-be resulted in stillbirths, the cord and afterbirth of the living infants were buried in the floor of the room in which the baby was delivered.¹⁸

Childbirth is tense and anxiety producing by itself. But in Sita's family, as infant after infant died, the small hut contained more than its share of human misery. Sita, at first hardly out of infancy, was caught up in an inexplicable and frightening situation of a crying infant, an anxious and guilt-ridden mother, and a distressed grandmother.

The rituals during the first days after childbirth would have impressed Sita with the supernatural danger surrounding an infant and the greater value of a male child compared with a female child. First the birth was announced by beating a large metal plate for a boy; a small plate, for a girl. Often a plate was beaten only for a boy. In addition to announcing the birth, the plate was beaten in the belief that noise warded off evil spirits and ghosts who might otherwise take the infant. It was more important to protect boys than girls. This difference in attitude was also apparent because other ceremonies after birth were celebrated for boys but not for girls. For example, on the third day after the birth of a son, *Nhanbar* was celebrated, at which time hand prints, swastikas, creepers, and other auspicious symbols were affixed to each side of doorways of the houses belonging to mem-

¹⁸ With the construction of brick houses with cement floors, the placenta and cord were buried in a caste compound or the courtyard of the building. By 1978, some families had discontinued the practice, except in joint families where an old mother-in-law insisted on its continuation.

bers of the baby's lineage, indicating that a new member had been added to it. In the evening, wives and daughters of the baby's lineage, neighbors, and friends gathered to sing songs for the new mother and her baby. Sita became aware of the cultural preference for males, not only from witnessing the celebrations but also from discussions between women before and after babies were born, and from the joyful responses of fathers to the births of sons as contrasted with subdued reactions to the births of daughters (Kakar, 1978, pp. 57–58; R. Freed and S. Freed, 1980, pp. 365–366).

Shortly after her delivery, Sita's mother received gifts and clothes for her baby, herself, and members of her family of marriage. These gifts, usually brought by her brother, were sent by her parents. The attention given each new infant and the gifts, which for a male infant were always better than for a female, added to Sita's jealousy of the baby. When Sita's mother bore sons, song sessions were held for them but not for a girl because as the villagers said, "A girl is a disaster" (R. Freed and S. Freed, 1980, pp. 366, 378–381).

After her infants died, Sita's mother was barred from weddings and attending song sessions held for other mothers and their infant sons because she was considered inauspicious and suspected of having a ghost hovering around her who might attack the new mother and child or the bride and groom. As a result, Sita did not go to the song sessions, for children went with their mothers. Sita said that she never attended song sessions in her natal village but did not offer a reason, although she would have known that her mother was considered to be inauspicious. For the same reason Sita's mother was prohibited from visiting women during their seclusion after the birth of an infant. She and all females were barred from such visits during their menses because they were considered polluting. It was believed that inasmuch as a new mother and child were in a polluted condition due to childbirth, it would be dangerous to allow any additional pollution in the birth chamber. Thus, Sita gradually came to associate her status as a female with the births and deaths of her siblings, and the pollution and ghost beliefs regarding new mothers and their babies, with menses and child-

bearing (R. Freed and S. Freed, 1980, pp. 378–383).

When Sita visited her mother during the lying-in, she saw a pot with a smoldering dung fire placed on a small stool or the floor with a bowl of water over it for the mother and child to drink. The fire served, also, to purify and warm the room. An iron sickle was placed under the bed to protect mother and child from evil spirits or ghosts. A long iron chain, used to keep cattle together, circled the bed, and served as an additional magical device against harm to mother and infant. After the death of her first sibling, Sita's grandmother put iron bracelets (amulets) on the wrists and ankles of Sita and of each new infant to ward off the ghost who was believed to be taking the babies. Infants wore necklaces with an ivory tooth and small gold or silver objects representing the sun and moon to protect them from unfriendly winds and the evil eye. In some cases, as in Sita's family, a *tawiz* (locket with a mantra in it) to ward off death from ghosts and other evil spirits was obtained from a wise man (R. Freed and S. Freed, 1979, p. 322; 1980, pp. 362–363, 377–378, fig. 5, p. 378).

On the sixth day after birth for the worship of Mother Sixth (Chhathi), Sita's grandmother drew the figure of Bemata on the wall with dung and charcoal. Bemata is somewhat of a mystery, sometimes identified as Chhathi or Chatulani, the midwife who attended Lord Krishna's mother, except that Krishna was supposed to have delivered himself. Village women identified Bemata as a goddess who visited the baby late at night and wrote its fortune on its skull. Mothers were supposed to stay awake to watch for her, but they said they never did, perhaps because they were afraid. In the morning, Sita's mother and paternal grandmother held Bemata worship. The mother sat on a stool, holding the infant in her lap while worshiping the goddess. The grandmother rapped her knuckles against her own temples to frighten evil spirits. Then Sita's mother gave thanks to Bemata for protecting her and her infant from evil spirits during the six days from birth, considered the most dangerous (the time during which deaths from puerperal fever or tetanus usually occurred). After worshiping, the mother lit a lamp containing ghee or oil, took soot

from the lamp, and using her finger drew the soot around the baby's eyes to protect the child from evil spirits and supposedly to avert smoke, flies, and eye infections (R. Freed and S. Freed, 1980, pp. 372–374, fig. 3, p. 373).

During the lying-in, Sita's mother remained in bed for at least seven days, at which time she was attended by her mother-in-law. Thereafter she was able to go to the fields to relieve herself. The women of Sita's caste began to do some work by the ninth or tenth day. The pregnancy and lying-in period affected Sita. Until the last few months of pregnancy she slept with her mother; thereafter with her grandmother. When the babies died, she again slept with her mother except when her father was home. She continued this pattern until she was about 10 years old when she had her own bed. Thus, she went through a greater number of displacements, from her mother's bed to her grandmother's, than was customary for children.

Sita witnessed her mother's grief when a child died, and, as she grew older, the burial of each infant. As successive infants died, Sita's mother made a vow, when again pregnant and before giving birth, to worship Jahar after the child was born safely. Then on the ninth day after each birth, she worshiped Jahar.¹⁹ The worship took place at a *jal* tree (*Salvadora oleoides*) where she thanked the saint for the safe birth of her child. As her children sickened, she went to two shrines of

mother goddesses, one near Chirag Delhi, for Kalkaji, the goddess of the cremation and burial grounds, and the village shrine for Chaurahewali Mata, the Crossroads Mother goddess. At both shrines she left offerings so that her children would live. Sita, as did all small children, accompanied her mother (R. Freed and S. Freed, 1979, p. 307; 1980, pp. 395–396, 510–511).

Sita differed from most children because she became acquainted with death not once or twice but a number of times by the time that she was 14 years old. Her grandfather died, possibly her father's elder brother's wife and infant, nine of her infant siblings, and three of her girl friends. Children became accustomed to grandparents and some infant siblings dying, but did not as a rule experience from 13 to 15 deaths of people close to them by the time they were 14. The death of Mara when Sita was 12 had a severe impact given the conditions of death. Taraka's death was even more distressing because of the intimacy of the two girls. By the time of Rukmini's death, Sita had crystalized in her mind the belief that marriage and/or mating led to conception, birth, and death.

Since Sita and her mother were not invited to weddings and other events for a marriage, Sita learned little of the details or of the social interactions and joking that offset the tensions generated in bringing about a marriage. Although her father's younger brother was married in her childhood, the wedding as was customary took place in the bride's village. Sita and her mother did not attend because only males from the groom's village were invited. Sita in her early teens was present at the wedding of Rukmini and attended Taraka's nuptial events while she and her mother visited the village for six months. She may have glimpsed some of the ceremonies and events for this rite of passage during her childhood, but she did not have the benefit of learning the whole sequence of events, either in the groom's or bride's village. Neither did she have opportunities to take part in the social interaction between kin and friends from both the bride's and groom's sides. Sita would, therefore, have lacked a sense of the fun, teasing, joking, and happiness that permeated many of the events constituting a marriage (O. Lewis, 1958, pp. 157–

¹⁹ Jahar (sometimes Zahar), Sayyid, and Guga Pir are names for one historical figure. Pir means saint. The story of Guga Pir is somewhat obscure. He was a Hindu leader of the Chauhan Rajputs about A.D. 1000. He probably lived in Bikaner. According to the legend, Guga cut off his brothers' heads in a battle and presented them to his mother. She dropped dead when she saw them. A queen named Bachhal then told Guga that he was a sinner, no longer a Hindu, and thus could not be cremated so he should go to Guru Gorakhnath and learn the Muslim creed. As a result, Guga prayed to Dharti Mata (Mother Earth) to take him and then buried himself alive. Live burial and, according to the legend, speaking from his mother's womb before birth, constituted miraculous powers and Guga was, therefore, elevated to Muslim sainthood. In the Delhi region and Punjab, Muslims and Hindus celebrate Guga's birthday in the dark fortnight of Bhadrapad on the ninth. Therefore, the festival is called Guga Naumi (Guga Ninth) (Temple, 1884 or 1962, vol. I, pp. 121–209).

195; R. Freed and S. Freed, 1980, pp. 404–497).

In sum, her experiences with rites of passage were primarily with birth as it was linked to death. Birth in most contexts could have been a happy event, but not so in Sita's childhood. Marriage, rather than an occasion for fun and celebration, was linked with mating, birth, and death because of problems arising from an absentee father, the demise of her girl friends, her infant siblings' deaths, and her mother's inauspiciousness. This childhood background gave rise to fear and then anxiety, and as a result Sita was ill-prepared for marriage.

CALENDRIC FESTIVALS

Out of a multitude of festivals in North India, only those calendric observances originally involving supernatural concepts that could have provided Sita with culturally constituted defense mechanisms or which created further anxiety are discussed. Included in these events were stories which provided the rationale for their celebration. Most of these festivals fall in the dark fortnight of the moon, which is associated with sadness, sickness, and death (R. Freed and S. Freed, 1964, pp. 68–72, 83, 85–89).

The ceremonies celebrated in the dark fortnight were: Janamashtami, Guga Naumi, Akhta, Kanagat, Hoi, and Sili Sat; in the light fortnight, Sanjhi and Dusehra. These festivals are here treated in the order celebrated with Sanjhi coming after Kanagat, and Dusehra before Hoi. Other festivals and holidays of a happier nature affected Sita's life and are mentioned later in context, but those selected above provided her with explanations for birth, marriage, sickness, and death.

Janamashtami, Lord Krishna's birthday, was celebrated on the eighth of the dark fortnight in Bhadrapad (Aug.–Sept.). The number eight is symbolic of Krishna, for he was the eighth child of Vasudeva and Devaki and was said to have been born on the eighth.²⁰

²⁰ In the Bhagavata Purana, the number eight is associated with Krishna as follows: (1) Krishna was the eighth avatar of Vishnu; (2) he was the eighth son conceived by Devaki and Vasudeva; (3) he was born on the eighth of the dark fortnight in the month of Bhadrapad.

As the story goes in the Bhagavata Purana, it was prophesied that Devaki would bear a child who would kill King Kansa, Devaki's father's brother's son, and his killer would then inherit the throne. As a result Kansa kept Devaki and her husband imprisoned and each time Devaki bore a child, had it killed. Six children in succession were killed.

When Devaki was pregnant a seventh time, Vishnu of whom Krishna was to be an avatar (incarnation of the god on earth), miraculously transferred the fetus to the womb of Rohini, Vasudeva's second wife. She bore the son, Bala Rama, who in his childhood later was to play with Krishna, his younger brother. Both children were incarnations of Vishnu living on earth at the same time, which may be mind-boggling for people who hold a different system of thought and belief. The story probably helped to give Sita the belief that a deity may be anywhere and that anything is possible. Such beliefs may satisfy children if the deity and supernatural events are good and consistent with experiences in life, but if they are bad, or inexplicable, they may develop a sense of the uncanny as to what might happen to them (Freud, 1924).

The next child, Krishna, was born at midnight. Because he was a total incarnation of Vishnu, the deities saved his life by putting the palace guards to sleep and unlocking the doors and gates so that Vasudeva could escape with his newborn son. He fled with the baby across the Jumna River to the land of Gokul (Braj—today in Uttar Pradesh) and substituted Krishna for the newly born daughter (also a divinity called Maya—translated as “illusion”) of Yasoda, the wife of

Despite these strong associations of Krishna with the number eight, in 1977–1978 two people, both in their late 20s, said that Krishna was the seventh son. Lodrick (1981, pp. 112–113), reporting on the celebration of Krishna's birthday, called Janamashtami—which means “Birth Eighth”—states that Krishna was Devaki's seventh child. This change may be due to the following influences: The seventh child, Bala Ram, was transferred to Rohini's womb so that Krishna, the eighth child, was the seventh child to be born from Devaki's womb. Seven in North India is auspicious because in a Hindu wedding, the bride and groom go around the fire seven times; and seven is auspicious among Muslims too (Morgan, 1953, pp. 59, 366–373; Daniélou, 1964, pp. 165, 175–179).

Nanda, a cowherd. In the myth, Nanda and Yasoda are later described as the ideal, loving parents of Krishna. Vasudeva returned to the palace with Yasoda's infant daughter and placed her in his wife's arms. Kansa, who had learned of the birth, then tried to kill the infant girl by throwing her against a stone. The child, an avatar of the divine Maya, jumped into the sky and said to Kansa, "Fool, what is the use of your trying to kill me. He who is to be your death has been born somewhere. Victimize not poor Devaki and Vasudeva" (Morgan, 1953, p. 367).

The story of Krishna's birth is well known by all castes throughout India. In the end Krishna, the dark one, representing good, kills Kansa, symbolizing evil. Since the area where Krishna grew up is relatively close to Sita's natal village, the legend may have seemed especially real to her. It is easy to see how she could have identified the deaths of her siblings with those of Krishna's siblings, creating even greater mysteries about birth and death in her mind. Krishna, a prince, after killing Kansa and fulfilling the prophecy, later became Raja (ruler). Sita's identification with the Krishna legend would have been strengthened because of similarities between her father and the deity, both of whom were warriors. In the Bhagavad Gita, part of the Mahabharata, India's earliest epic about a war between two opposing but related people, Krishna, as the charioteer and representation on earth of the Supreme God, urges Arjuna to fight and kill his own kinsmen on the opposing side. He says it is his dharma (duty) to do so as a Kshatriya (the warrior class of castes) (Dowson, 1950, pp. 160-168; Morgan, 1953, pp. 96, 366-371; Daniélou, 1964, pp. 175-177; F. Edgerton, 1965, pp. 139-140, fn. 7, p. 140; Kakar, 1978, p. 146; R. Freed and S. Freed, 1980, pp. 331, 372-376).

In the same fortnight on the day after Janamashtami, Guga Naumi was observed (see fn. 19). Villagers throughout Delhi celebrated the day and told the story of Guga Pir's miraculous powers and burying himself alive (in effect, suicide), another story of death. Because Guga, a Hindu prince and warrior, buried himself in the earth, burial being a Muslim practice, both Hindus and Muslims celebrate the day and Guga is called Jahar, Sayyid, and Guga Pir. Sita as a small child

would have identified her father in his role of warrior with Krishna and Guga Pir (R. Freed and S. Freed, 1964, p. 83).

Often in the next dark fortnight in the month of Ashvin (Sept.-Oct.), as the summer monsoon subsided, cattle sickened and sometimes died from disease caused by flooding so villages closed themselves off from outsiders and held Akhta, a curing ceremony, to exorcise cattle disease. The ceremonies started at night and ran through the next day. Magical circles and other protective devices and rituals were used in addition to smoking the cattle and carrying off the pot used for smoking out the disease and leaving it far from the village. The belief was that by such activities the evil spirits causing illness would be driven out of the cattle and village. The rituals were similar to those formerly used to exorcise human epidemics of smallpox, cholera, typhoid, and other diseases which existed in this rural region when Sita was a small child. These exorcisms of human disease as well as Akhta impressed upon Sita the belief that illness was brought by a spirit that needed to be exorcised (Crooke, 1894, pp. 376-377; Beadon, 1913, p. 122; O. Lewis, 1958, p. 75; R. Freed and S. Freed, 1966).

Two men drew off the disease with a pot containing burning cow dung and smoking *gugal*, an incense burned at religious rites. The following day the village was encircled by all the animals while the villagers shouted, "Victory to Ranjha and Heer." The reason for shouting these names was because Ranjha was considered a fakir with magical powers with cattle. He and Heer were star-crossed lovers, akin to Romeo and Juliet, who flaunted convention (i.e., an arranged marriage for Heer). As a result of their love, they ran away together and then became separated. Heer's kinsmen caught up with her, killed her, and buried her. When Ranjha found her tomb, he went down into it burying himself alive. The legend goes that afterward Heer's kinsmen practiced female infanticide, a rationale for female infanticide in the Punjab. The story emphasizes the fate of star-crossed lovers, and villagers believed that Ranjha and Heer were rebirths of two earlier sets of lovers: Sassi and Punnun; and Mirza and Sahiban. For a girl it provided a sad lesson for choosing one's own lover. Sita must later have thought

of Taraka in association with this festival and the possibility that the same fate could have befallen her (Temple, 1885 or 1963, vol. II, pp. 507ff.).

When we witnessed an Akhta in 1958, it happened to fall on the first day of the dark fortnight of Ashvin, the day which customarily begins Kanagat, also called Shraddha, the fortnight for commemorating the deaths of ancestors, thus linking disease and death. At the end of Kanagat, members of Sita's caste fed cows; members of the twice-born castes fed Brahman priests (R. Freed and S. Freed, 1966, p. 87). Although this fortnight was concerned with death, it was to have an additional impact on Sita in her husband's multi-caste village, for Akhta and Kanagat were held at the time of Sita's possessions in her marital village in 1958. She would learn the differences in observances and religious customs of Brahmans and other castes as compared with low castes.

Immediately following Kanagat on the first day of the bright fortnight of the same month came the celebration of Sanjhi, also called Navratra or Nine Nights for the nine nights during which it was celebrated. Village girls and married women identified with the festival which is for a folk goddess who visits her parents and then returns to her husband and in-laws on the ninth. Images of Sanjhi and her small brother were made of clay and put on the outside of house walls. On the ninth, they were taken down and the face of Sanjhi was placed in a large pitcher with a burning wick which was floated on village ponds in the evening. The effect was lovely. Girls went singing through the lanes asking for sweets. The songs were about their problems with in-laws and the setting evoked a feeling of melancholy and nostalgia, especially on the part of recently married brides. Thus, Sita learned from the festival of Sanjhi that when a new bride was separated from her natal family she often was lonesome, had problems with her in-laws, and longed for her natal family (Marriott, 1955, p. 201; R. Freed and S. Freed, 1964, p. 87).

The day after the last night of Sanjhi, Dussehra was celebrated to commemorate Rama Chandra's victory over Ravan, the demon king of Lanka, and his return with Sita, his wife. The City of Delhi is the main center for

the pageant, the Ram Lila, which takes place yearly over a 10 day period with floats and actors depicting the events in the life of Rama and Sita. Villagers from miles around flock to see the play (*lila*). Since the natal village of the Sita of this case history was close to the city and her father was a military man, he and his family attended the pageant when his leave coincided with it. Sita, a low-caste child, as well as millions of females in India, knew the story well and from it learned the proper behavior of the ideal Indian woman: chaste, obeying her husband, not in any way disgracing him or causing him trouble, submissive, bearing sons, and if necessary dying for him, as Sita, the wife of Rama Chandra, an avatar of Vishnu, did by going down into the earth from which she was born. Sita's name, translated "furrow," a fertility term, is doubly symbolic (Kakar, 1978, pp. 63-69).

The Ram Lila is celebrated throughout North India. Hein (1958, pp. 295-296) from observations in 1949 and 1950 relates the effect on children of this enactment of the Ramayana during Dusehra. He says that the tone of the pageants or plays is a mixture of piety and light-heartedness but the message is the victory of good (Rama) over evil (Ravan, the demon king and his cohorts). In one performance he noted "the intent faces of row on row of wide-eyed children" (Hein, 1958, p. 296). He further notes that the yearly celebration of the Ram Lila and village recitations of the Ramayana reach countless numbers of nonliterate Hindus, imbuing them with a knowledge of Hinduism, its myths, and nationalism. In the villages yearly, professional storytellers recited the Ramayana (R. Freed and S. Freed, 1981, pp. 145-146).

As another incarnation of Vishnu, Rama Chandra, too, is believed to have lived on earth in North India. Since he was a prince and military man and separated from Sita, his wife, for long periods, the Sita of this case history may have fantasied about him and identified him with her father and her future husband. Males in this region were often named after Rama Chandra (usually written Ram Chandra) or Krishna and girls who were engaged to such men hoped that their future husbands would resemble the glamorous pictures they had seen of these two avatars of Vishnu (R. Freed and S. Freed, 1980, p. 439).

The idea that Rama Chandra and Sita, as well as other legendary couples such as Ranjha and Heer and Mirza and Sahiban, had numerous rebirths was promulgated by the belief in rebirth and because husbands and wives, especially happy wives, liked to think that in their future rebirths they would have the same spouse and children (Temple, 1885 or 1963, vol. II, p. x; 1900 or 1963, vol. III, pp. xxi, xxvi, xliii, 1–24; R. Freed and S. Freed, 1966, p. 685; 1980, pp. 536–537; Kakar, 1978, pp. 63–66).

Because Krishna, Guga Pir, and Rama Chandra were princes, Sita doubtless went through the age-old childhood process of thinking of her parents as high-ranking persons. This fantasy life and her orientation toward rank and prestige, important values in Indian culture, would lead to difficulty in adjusting to her multi-caste village of marriage, where her caste ranked among the lowest, and she as a wife ranked lower than daughters of the village. It also would contribute to disillusion when her parents did not live up to her expectations (Freud, 1962, p. 160; Das, 1976, p. 10; Kakar, 1978, pp. 68–71; R. Freed and S. Freed, 1980, p. 380, pp. 436–437 for “Lament of a Modern Sita”).

In the dark fortnight in the month of Kartik (Oct.–Nov.), on the seventh, mothers fasted and made offerings to Hoi Mata, a mother goddess who protected children. Although the day was for the long life of their offspring, Sita's grandmother told her it was observed for sons only. Thus Sita's mother did not observe it until her sons were born.

For all the foregoing events, except Janamashtami, special sweet foods were cooked which the children enjoyed, thus enforcing the memory of the events. On Janamashtami, women fasted from one night to the following midnight (the time of Krishna's birth), then everyone ate festive food.

In the spring, the last of the festivals to affect Sita was celebrated on the seventh of Chaitra (Mar.–Apr.) in the dark fortnight. This day was variously called Basora (Stale Bread), Sitala ki Saptami (Sitala's Seventh), and Sili Sat (Cold Seventh). Sitala is one name for the goddess of smallpox. In Sita's early childhood, this day would have been observed very carefully because smallpox epidemics still occurred. However, by the 1950s,

the emphasis on the goddess of smallpox had shifted, and Sili Sat was a day on which seven mother goddesses of sickness were worshiped. On the eve of Sili Sat, women prepared festive foods, usually different types of sweets and pancakes, and took care of some of the next day's work so that they could worship at the shrines early in the morning. The day was also called Basora because the bread was kept overnight and offered at the shrines the next day. The offerings to the various goddesses of sickness were to propitiate them so that they would not, in their malevolent aspects, inflict their illnesses on offspring. Thus, the day was for the welfare of children, calves, and other young animals. Women worshiped in lineage groups, usually by caste, but sometimes with neighbors. In the course of worship they partially circumambulated the village, in effect drawing their own magical circle by their procession to protect the village from strangers bearing diseases and evil spirits. As they wended their way through the village they sang songs. The shrines at which they stopped were: shrines to seven sisters, the major goddesses of poxes, skin disease, and most contagious diseases; the shrine to the founding ancestor of the village (a male), Bhumiya, who was always worshiped for the birth and welfare of children; and the crossroads goddess located at the intersection of three roads at the entrance to the village. A woman of the Sweeper caste held a cock or chicken over the head of a child or children of one of the high-caste families for whom she worked in the belief that all sickness and pain would be transferred to the fowl. For this service she was paid. This festival reflected the belief that sickness and death could be caused by mother goddesses, supernatural beings, who could be both malevolent and benevolent. Therefore, they had to be propitiated by worship and offerings (R. Freed and S. Freed, 1962, pp. 262–270; 1979, pp. 306–309).

The foregoing calendric events have been outlined to indicate the effect their celebration had on children, especially girls such as Sita, who accompanied their mothers and later helped with preparations for the festivals. Except for Akhta, they were celebrated every year. Akhta occurred fairly frequently even after cattle could be innoculated against dis-

eases, and was reported as still being held in 1983. During the 1940s and early 1950s the incidence of infectious diseases and deaths was greater than later in Sita's life. By 1958, villagers were aware of the concept of germs. The similarity between germs and supernatural beings entering the body and causing sickness and death resulted in a blurring of the differences between the two, but a recognition of contagious diseases. Thus, the impact of the belief that ghosts, evil spirits, deities, and germs caused disease and death formed the basis for Sita's understanding of sickness and health and a later belief in ghost contagion (R. Freed and S. Freed, 1966, p. 681; 1980, pp. 525–526).

CHILDHOOD ILLNESSES

Although Sita provided no information about the specific illnesses that she suffered as a child, she could not possibly have avoided all the diseases common at the time. The major contagious-infectious-parasitic diseases prevalent in the rural areas of Delhi were cholera, smallpox, typhoid, measles (rubella and rubeola), chicken pox, mumps, hepatitis, diarrheal diseases, influenza, tuberculosis, malaria, and various helminths. Sita probably never contracted smallpox, cholera, or suffered from any helminths. Cholera and smallpox had gradually come under control from the time she was born, and although they occurred occasionally even in 1958, outbreaks were rare. However, she may have had typhoid and could not have avoided attacks of diarrhea or an occasional respiratory infection. Typhoid was endemic to epidemic during the rainy season and numerous people had it, including children. Respiratory infections were quite common during the winter months and might become epidemic at the time of a wedding when numerous strangers were in the village. Malaria was endemic in the region when Sita was born, gradually came under control in the 1950s and almost disappeared, but returned in epidemic proportions in the Delhi region in the late 1970s. Sita may well have had malaria but never mentioned having had it.

Most sick children were treated by their mothers, often with the help of their grandmothers or other senior women who had more

experience and knowledge than a younger woman. However, if the sick child was a son, especially an only son in a fairly well-off household, then his father might take him to the city for medical care. Since Sita's father was away most of the year and quite young when he went into military service, he would have been in no position to influence Sita's medical care. Even had he been at home during the years when Sita was small, he would have entrusted her to his mother and wife for her treatment. His elder brother, the head of the household after his father died, would have left the treatment of the children in his mother's hands.

For diagnosing and treating childhood diseases, women paid particular attention to the symptoms of fever and poxes. In the presence of either or both, a child was put to bed, bathed with cool water, given various remedies, and offerings to mother goddesses were made. Relatively similar treatments were used for cholera and the poxes (smallpox, typhoid, measles, chicken pox). First, the illness was diagnosed. For example, the village symptoms for cholera were sudden onset, vomiting, and increasingly frequent watery diarrhea which resulted in rapid and extreme dehydration and death. Although the villagers said that the disease was due to eating, especially in hot weather, melons grown in river valleys or on irrigated land and to dirty vegetables and fruit, cholera is passed from one human being to another as a communicable disease by food and water which contain the bacillus, *Vibrio cholerae*. Houseflies help to spread the contamination. The villagers identified typhoid fever by a small almost invisible pox, said to be like small seeds or blisters which appeared on the chest and shone like rose-colored sequins. The first symptoms were hot skin, then a rash and the pox. The patient during these illnesses was kept in a dark room. Specific mother goddesses were propitiated with offerings and vows so that they would take off the disease (Davey and Wilson, 1971, pp. 36–42; R. Freed and S. Freed, 1979, pp. 327–330).

Since food constituted a source of disease, special foods were prescribed for sick people. For example, food was boiled and not cooked in ghee. Cumin seeds were omitted from cooking because they are black or dark like

Kali, the goddess of death and destruction. Therefore, ghee was banned because food cooked in ghee had to have cumin in it.

Other rules were that menstruating women and women of the lowest castes were not allowed near the house of a sick person. The rationale was that these classes were polluting, dirty, and evil, characteristics that could endanger the patient. Further, strangers who were not members of the patient's lineage, and people of other castes were not allowed to throw their shadows on the doorway or house where a sick person was staying because the shadows were evil. Nim (*margosa*) and nim *chameli* (*Millingtonia hortensis*) leaves were placed outside the house above the doorway. They were considered purifying and able to ward off evil, in addition to warning people that someone in the house was ill (R. Freed and S. Freed, 1979, pp. 328–329).

These beliefs and methods of treating sick children and to some extent adults portray a mixture of concepts deriving from the idea that disease is brought by a supernatural being (most often a mother goddess), by intrusive germs, or by combinations of food and air which cause imbalances in the body and result in disease or make one more easily susceptible to disease. In addition, when there was an epidemic of influenza, swamis (holy men) might visit a village and give injections of penicillin, despite the fact that influenza is caused by a virus. Other remedies for colds and constipation were used, such as aspirin and various patent medicines. Although most children and many adults were treated at home by family members, occasionally curers (Ayurvedic *vaid*s, exorcists, and specialists in specific types of ailments) were consulted. Men who worked in the City of Delhi sometimes consulted Ayurvedic, homeopathic, or Western-scientific physicians, but rarely took family members for such treatments²¹ (R. Freed and S. Freed, 1979, pp. 315–319).

²¹ The phrase Western-scientific medicine has been used generally to refer to the main type of scientifically based medicine practiced in North America, Europe, the British Isles, Australia, and New Zealand, and in use but with competing systems throughout the world. This medicine is based on the germ theory of disease, scientific research, professional medical associations, chemotherapeutic treatment, and specific surgical techniques. Les-

The care and treatment of children depended on the experience of the mother and the situation in which she found herself. Some mothers had many children, few resources, and little knowledge about treatment. Others were completely subject to their mother-in-law who decided what was wrong with the children and what should be done, which was probably the case in Sita's family in her earliest years. Although most women were non-literate, the elderly women had considerable practical experience with childhood illnesses.

Sita would have been treated as well and as carefully as possible, because until she was 12 she had no surviving sibling. Her appearance when we first saw her was that of a healthy teen-ager. As Sita was the only surviving child for many years, she would have become aware of how worried the members of her family were when she fell ill. The evident anxiety of her mother and grandmother and the careful treatment they gave her probably motivated her to be ill as a means of attracting attention, having her own way, and of extricating herself from situations which displeased her. Such motivation for becoming ill is found in children, especially when they are the first and only surviving child (Freud, 1978, pp. 42–44).

The basic concepts regarding sickness and curing then current in the rural Delhi region

lie (1976, pp. 5–8) introduced the phrase "Cosmopolitan Medicine" to be substituted for the ethnocentric terms Western or Western-scientific medicine. He considers the term scientific medicine to be misleading. He reviewed various other phrases but concluded that Cosmopolitan Medicine was the most appropriate. However, since the word Cosmopolitan does not always apply to the setting in which Western-scientific medicine may be introduced, namely throughout much of the rural developing world, the term may not fit or be recognized for what is intended. For example, in the rural Delhi region, Western-scientific medicine was sometimes referred to as *Angrezi* (English) medicine for the British who introduced it in India. More recently antibiotics have been associated with the West and with America. Because of these problems in nomenclature, the ethnocentric term Western-scientific medicine is used here. Helman (1978, pp. 107, 134, note 1) uses biomedicine. The rural Delhi usages are similar to the usages of Ayurvedic and Unani medicine, which are respectively associated with Hindu and Greek humoral medical theories.

derived from the earliest stratum of supernatural beliefs, the Atharva-Veda, which attributed disease to the invasion of the body by a supernatural being or a malevolent evil spirit. The contagious diseases of childhood were attributed to mother goddesses, who, although they were both benevolent and malevolent, in bringing sickness were described as malevolent. A sick child would consider them "bad." Since these goddesses were called "mothers," mothers by analogy could be bad. In Sita's mind these beliefs would eventually be linked with the cultural attributes of women, namely, that menstruating women were polluting, dirty, and agents of sickness and death, and that women who died in childbirth or without issue became ghosts who caused sickness and death (Kakar, 1978, pp. 89-90, 93, 147-149; R. Freed and S. Freed, 1979, pp. 306-309).

Concepts derived from Ayurvedic humoral theory were compatible with these beliefs, for if the body experienced an undue amount of air, it would be prone to the illness inflicted by the mother goddesses or ghosts. Conversely, if a person was afflicted with a contagious disease by a mother goddess of the disease, any additional stress caused by an imbalance of the humors would contribute to more serious illness.

Three dichotomies were related to ideas of sickness and health: (1) purity-pollution; (2) good-evil; (3) cleanliness-dirtiness. Purity-pollution was based on the belief that various bodily exudations were polluting: perspiration, saliva, mucus, urine, and feces; and the exudations of females as a result of menses and the birth process. The lower the caste ranking the greater the possibility of pollution. One's birth into a caste was believed to be based on the sum of a soul's actions in past lives which resulted in relative degrees of purity or pollution for each caste. Dirtiness and cleanliness, though recognized in terms of actual dirt or nondirt, still were attached to bodily exudations and at times correlated with purity and pollution, as too were good and evil. Thus, more often than not, a low-caste person would be called dirty by a high-caste person even though a high-caste person might be dirtier. The concepts of purity and pollution, dirt and cleanliness, and good and evil derive from beliefs about the inherited

statuses of castes, the lower castes being most prone to pollution, and tend to reinforce the earlier beliefs regarding health associated with concepts of an evil spirit invading one and causing illness (Mathur, 1964, pp. 96, 102-108; Dumont, 1970, pp. 46-52). The combinations of the two dichotomies of purity-pollution and cleanliness-dirtiness fostered beliefs in good and evil, and since caste position was based on action (karma), all three dichotomies were linked.

A menstruating woman (i.e., one who was so polluted), who had not followed the proper rituals and behavior at the time of menses might be both dirty and a carrier of evil. A low-caste menstruating woman was expected to be more evil and polluting than a high-caste woman whether menstruating or not. However, a menstruating woman of any caste was dangerous, polluting, and unclean, especially so in a delivery room. These beliefs are correlated with the low position of females once they attain menarche. Before menarche, they are goddesses; after attaining menarche, they are polluting, dangerous, and considered capable of any number of evils. The malevolent/benevolent aspects of goddesses reflect these beliefs, which have influenced the position of women in the subcontinent of India but have been slowly changing since the nineteenth century (R. Freed and S. Freed, 1979, p. 315; Borthwick, 1982; John Gray, 1982, pp. 221-222, 231-233, 234-236; Kondos, 1982, pp. 252-254; Mukherjee, 1982; Pearson, 1982).

A delivery room or its equivalent was, by definition, a place where all the forces of these three dichotomies existed and thus was fraught with danger to both mother and child. Early sources indicate that the place in which delivery occurred in the last century and much of this century was separate from the regular domicile, small, not very clean, and often located near unsanitary places, sources of contagious and infectious diseases, no doubt to keep the other inhabitants of a household from the resultant pollution (Chandrasekhar, 1959, pp. 127-129; R. Freed and S. Freed, 1979, pp. 315; 1980, pp. 359, 361-363, 383-388).

The average villager largely was unaware of many of the health programs the government initiated after 1947, and lacked the ba-

sic scientific knowledge necessary for choosing among the different curing systems. If anything, the different types of cures caused confusion; they were selected on the premises that if one did not work, another could be tried, or whichever was most easily accessible, as learned from family experiences (Gazetteer Unit, Delhi Administration, 1976, pp. 855–859, tables 1, 2, and 3; R. Freed and S. Freed, 1979, pp. 317–320).

Since older women were the most influential in caring for sick persons, their lack of literacy was a drawback with the changing times. Further, rural schoolchildren often had no science classes except at the higher secondary level. Even there the teaching was deficient since it was difficult to obtain good science teachers. The rural area lacked electricity until the 1960s and even in the 1970s many rural schools still were without running water. Thus, facilities for laboratories were inadequate. These statements do not necessarily imply that with science courses people would automatically choose Western-scientific medicine. The courses might at first create confusion, and new knowledge and beliefs at times conflict with old knowledge and beliefs (Gazetteer Unit, Delhi Administration, 1976, pp. 799–800; S. Freed and R. Freed, 1976, pp. 46–48, table 6, p. 47, table 7, p. 48).

Despite the eclectic assortment of cures for sickness, Sita was mainly influenced by early supernatural concepts, especially spirit intrusion, as causing illness because her mother, grandmother, and the head of the household (her father's elder brother), all nonliterates, were raised in this tradition. Of additional consequence, the people of Sita's natal village, located in a region strongly influenced by Islam, incorporated medical beliefs from the Islamic system known as Unani Prophet-

ic medicine. These beliefs concerned spirit possession and evil and were similar to corresponding concepts from the Atharva-Veda (Bürgel, 1976, pp. 54–56; Gazetteer Unit, Delhi Administration, 1976, pp. 60–62).

The preventive inoculations of Western-scientific medicine were an additional factor. Antibiotic medicines and some Western medical centers for the rural and poorer segments of the population were gradually introduced at the village level after 1947. The new elements had no basis in traditional religious-supernatural beliefs and were not introduced with correlated scientific teaching in the schools. The religious background for the earliest beliefs was, therefore, more deeply impressed on Sita's mind than later introductions of Western-scientific medicine. It provided the rationale for the deaths of her siblings and for her three girl friends becoming ghosts.

In sum, the primary early influences regarding sickness and health in Sita's childhood were: disease was caused by an intrusive spirit or supernatural being; germs were similar to intrusive spirits; the mother goddesses were malevolent and benevolent in that they could cause disease and aid in cures, and by analogy this line of thought applied to mothers. The threefold dichotomy of purity–pollution, dirt–cleanliness, and good–evil in relation to past actions and rebirth put the lowest castes on a plane with considerably more invidious characteristics than it did other castes. Worst of all for Sita, women when married, who menstruated and bore children and were more likely to be considered evil, ranked lower than unmarried daughters, and all females ranked lower than males in their own caste.

MARRIAGE, MATING, AND POSSESSION (1958)

The marriage rite of passage in the rural Delhi region of 1958 consisted of a series of events and ceremonies during which the bride underwent separation, transition, and integration. At the end of the period, she had passed from the world of her natal family, kin, and village to the world of her husband's family, kin, and village. Van Gennep (1961,

pp. 12–13) referred to this transfer from one place in society to another as “the pivoting of the sacred.” During this period, the individual went from an everyday, secular or profane state to a sacred or liminal state and back to a secular state. In marriage, the bride's transfer to her husband's society resulted in her being in a society of strangers. This point

of view is directly applicable to Sita, for the bride in village India was married to a stranger and the members of his society were all strangers. This pivoting of the sacred constitutes a "turning" in the life cycle. Mandelbaum (1973, p. 181) has described this turning as a period marked by a major transition at which time "the person takes on a new set of roles, enters into fresh relations with a new set of people, and acquires a new self conception." Benedict (1967) viewed changes in the life cycle as continuities and discontinuities depending on whether the individual was positively or negatively conditioned for future roles. In so doing she took into consideration the biological facts of sex and age, but claimed that if the conditioning was negative for specific types of roles to be assumed in later life, then unlearning the earlier conditioning might result in trauma. She illustrated her point with three contrastive types of roles: dominant-submissive, sexual-nonsexual, and responsible-nonresponsible. Erikson (1968, pp. 15-25) has given new meaning to the word crisis in terms of the life cycle, coupling it with "identity" and the adolescent period in American youth, although recognizing that identity crises or life crises may exist anywhere at different times. An identity crisis occurs "in severely conflicted young people whose confusion is due . . . to a war within themselves" (Erikson, 1968, p. 17). According to him, the process of this identity crisis is "located *in the core of the individual* and yet also *in the core of his communal culture* . . ." (Erikson, 1968, p. 22, emphasis in the original).

Thus, van Gennep distinguished between the two worlds with which a young bride such as Sita would have to deal at the time of marriage and pointed out that she would be in a liminal state during transition; Benedict emphasized the learning and unlearning of roles, biological changes, and possible trauma for later life; Mandelbaum pointed out the learning of new roles in the context of a major transition in life when the individual is placed in a new society and acquires a new self conception; and Erikson, somewhat like Benedict and Mandelbaum, indicates that an identity crisis may occur in adolescence where there is conflict within the person and it is based on the blending of two identities—the

individual and the cultural. These theories apply to Sita's case, especially in the year of her marriage, mating, and possession but also to the intervening years when Sita became a mother and householder.

MARRIAGE

A marriage rite of passage with its numerous prenuptial, nuptial, and postnuptial ceremonies and events typically continued for months or years. In Sita's case, a reduced time-span provided less chance for gradual adaptation because her engagement, wedding, and first mating were arranged within a period of no more than one year (1957-1958). Usually, these events stretched over a period of two to three years. Events leading to marriage began with a search for a groom by the bride's father. The principal events then were an engagement ceremony, preparations for the wedding, two letters arranging the date of the wedding, a series of oil baths, the wedding day, and subsequent postnuptial ceremonies before consummation of the marriage. Because Sita's engagement and marriage hinged on the birth and survival of a brother, born in 1955, these events and ceremonies did not begin until 1957 when she was 14 years old.

AGES AT MARRIAGE

To understand the timing of the various nuptial ceremonies and events, one needs to know a series of ages upon which a marriage turns and which apply to the potential bride and groom. These ages have been slowly raised by the passage of laws in India since the nineteenth century, at which time the wedding followed betrothal in the first, third, or fifth year (numbers thought to be auspicious). It was considered disgraceful if girls were married after the age of 15, but it was not customary to marry them before five years of age. Ages differed for boys and by caste. For example, a Jat boy could be no younger than five years and a Jat girl no older than 11 at the time of the wedding (Wood and Maconachie, 1882, p. 118).

Beginning in 1891, several laws raised the ages of the wedding and mating, having more impact on the age at mating. The first of these laws passed in 1891 made it rape to have

intercourse with girls under 12 years of age. The so-called Sarda Act (1929) raised the age at marriage to 14 years. This law instituted a series of Child Marriage Restraint Acts from 1929 to 1949, which progressively raised the minimum legal age for marriage to 15 years for a girl and 18 years for a boy. But to this day child marriages and early matings take place in India, especially in the rural areas (Maloney, 1974, p. 469; Mandelbaum, 1974, p. 87; Derrett, 1978, pp. 41, 81–82, 211–212).

In 1958 in the rural area of Delhi, the ages of marriage and mating turned on the probable age of menarche. Village marriages were planned so that engagements fell at least two to three years, or even earlier, before the estimated age at menarche, which was presumed to take place about 15 years of age. The wedding day was supposedly scheduled before menarche; first mating occurred from six months to a number of years after the wedding, depending on the age of the girl at engagement and the ability of her parents to complete the final payment of the dowry. To save money, families often married two daughters to two brothers at the same time because a double wedding cost less than two weddings on different days. If one daughter was 12 years old and the other five at wedding, the periods between wedding and first mating differed. Our data from 1958–1959 for females under 40 years indicate that the mean age at wedding was 13.3 years and the range was from five to 18 years of age. For menarche, the mean age was 15.8 years, and the range from 12 to 17.5 years.²² For con-

summation of the marriage, the mean was 15.7 years and the range 12 to 21 years of age (R. Freed and S. Freed, 1980, table 1, p. 405). Kakar (1978, pp. 71, 195, endnote 40), commenting on ages at marriage among Hindu brides, indicates that they are usually married between 12 to 18 years of age with the upper ages among the urban high castes. He further notes that the mean age at marriage in the 1961 Census of India was given as 15.8 years.²³

ENGAGEMENT

Because of the lack of a surviving brother, Sita's engagement had been delayed. Therefore, when the brother born in 1955 was about one year old, the arrangements for Sita's engagement, wedding, and consummation of the marriage were accelerated. Sita's father, then stationed in India, took leave to arrange her engagement and marriage to a youth, here called Ram Chandra. The prospective groom resided in a large joint-family household. In 1957 the final negotiations took place and shortly thereafter the engagement ceremony was held in the groom's village as was customary. Only males from both sides of the proposed marriage attended the ceremony, which was witnessed by elders from the lineage of the groom and from other castes, thus making the engagement and arrangements for dowry a binding contract. Although the wedding date was not set at that time, both parties

²² The average age at menarche in developing countries occurs later than in the United States where the age at menarche has declined in this century. The range for menarche is from age 11 to 18. The key factor in attaining menarche and continuing the menses appears to be weight relative to body height. Related factors may be genetic, nutritional, and the physical environment. Most of the data are based on studies of females from Europe and the United States (Frisch and Revelle, 1970; Frisch and McArthur, 1974; Delora, Warren, and Ellison, 1980, p. 61; Sandler, Myerson, and Kinder, 1980, pp. 84–85).

To what degree the accurate reporting of age of menarche was related to the age at wedding in this rural region of India depended on the age at wedding. This age was supposedly no later than 15 years, and preferably earlier. Marriage by age 15 depended on whether the bride's

family considered marriage before menarche more important than going into debt for a wedding and dowry, the economic benefits from a daughter's labor, and their estimate of when menarche might occur. Under these and probably a wide range of other circumstances, the ages given for time of wedding and first mating might be incorrectly reported.

²³ For the period from 1901 through 1955 in India vital statistics regarding birth, death, and marriage were based on the inadequate registration of births and deaths, inaccurate reporting of age (many people could not count and birthdays were not remembered or celebrated), and with regard to marriage, attempts to avoid the Child Marriage Restraint Acts. "The absence of any definite proof of the age of an individual nullifies attempts at social legislation" (Chandrasekhar, 1959, pp. 35–46, quote on p. 41). Our own experiences obtaining accurate vital statistics, especially for age, verify Chandrasekhar's findings.

were in favor of a wedding by 1958. Customarily the date was set by the bride's family to allow time to prepare for the wedding which took place in the bride's village (R. Freed and S. Freed, 1980, pp. 414–423).

PRENUPTIAL EVENTS

Shortly after confirmation of the engagement, Sita's natal family took advantage of a governmental subsidy then available to the low castes to build a brick house to replace their mud hut in time for the wedding. During this period, Sita's mother's brother was notified of the impending event so that he could bring the wedding gifts suggested by his sister. Sita's dowry consisted of jewelry, clothing, a sewing machine, brass cooking pots, a bed, bed linens, and quilts for Sita; clothing and personal gifts for her in-laws; a watch, cycle, ring, and clothes for the groom; and sums of money paid at the engagement, wedding, and consummation of the marriage. Food was ordered to provide for meals for 150 guests, which included the groom's party, Sita's lineage members and friends of the family in her natal village, Sita's mother's brother, and officers and friends who served with Sita's father. This wedding was unusually large for a low-caste family. Since Sita was an only daughter, her father valued his prestige as a military man, and the family was rather better-off than most low castes, the preparations for 150 guests and the dowry were sumptuous by the standards of the lower castes.

Sita's family decided to hold the wedding in February 1958, and notified the groom's family by sending a letter giving the date. The proposed date was based on the horoscope of the groom in relation to the month in which Sita was born. The letter was signed by five men of good character from Sita's village. When the groom's family received this letter, the adult male members of the family reviewed it and then returned it to the bride's family, indicating their acceptance.

From 11 to 21 days before the marriage, Sita's father sent a letter called *Lagan* to remind the groom's family of the date of marriage and to indicate the number of daily oil baths the bride and groom were to take before marriage. Supposedly these numbers were

based on horoscopes of the couple, but in fact the groom took seven and the bride five, which was the case in almost every wedding we attended. The baths were taken to purify the young couple on the specified number of days preceding the wedding, seven days for the groom, and five, including the wedding day, for the bride. These baths were the occasion of joking and much teasing of bride and groom by their kinfolk. During these days, Sita and Ram Chandra, her husband-to-be, each in their own village, wore their oldest and dirtiest clothes to avert the evil eye, the belief being that the evil eye will bring misfortune to one who looks handsome or lovely or is dressed beautifully (R. Freed and S. Freed, 1979, pp. 320–321; 1980, p. 426).

Every evening during the oil baths, women in the lineages of the bride and groom sang abusive and salacious songs. The noise ward off dangerous spirits. Salacious songs were believed to foster fertility, and abusive songs, aimed at insulting the opposite side in the marriage, averted misfortune. These songs referred to ideal personages or deities from Hindu myths, such as Sita, Savitry, and Krishna, but in a mocking way and often in modern contexts (R. Freed and S. Freed, 1980, pp. 430–441).

At the first oil bath, red strings were tied on the wrists and ankles of the bride and groom. They wore these strings thereafter, even when bathing and throughout the pre-nuptial, nuptial, and postnuptial marriage events to protect them from evil spirits. A number of the rituals symbolized fertility, such as placing a half coconut in the lap of the bride (analogous to pregnancy), pounding the materials for the oil bath in a mortar (a female symbol) with a pestle (a male symbol), and placing hand marks and drawing creepers on walls and doorways, which signified auspiciousness, fertility, and an extension of the lineage through birth. Many rituals were primarily segregative and protective, indicating that the boy and girl were in a transitional stage in the rite of passage, during which they would encounter strangers and after which the bride would gradually be integrated into her husband's family, and the groom, reintegrated into his natal family. For both bride and groom there were numerous protective symbols against their affinal relatives, who in

effect, were strangers and therefore deemed dangerous. These rituals and associated symbols were repeated numerous times in the pre- and postnuptial ceremonies as well as in the wedding (R. Freed and S. Freed, 1980, pp. 335–347).

DAY PRECEDING WEDDING

In both the groom's and bride's villages on the day before the wedding, the prospective spouses with their mothers and female relatives worshiped the potter's wheel, a fertility ritual. Two large pots filled with water were placed at the doorway for the bride and groom to drink from together after the wedding. Auspicious swastika and creeper signs were drawn on the pots and around the doorway. A *mandap* (symbolic of the marriage pavilion) consisting of a plow beam, a triangle of straw, and four small clay dishes filled with bread, was erected at the doorway to each house. A number of these items were fertility symbols; the bread was for prosperity and sufficient food in the future for the young couple. During the day, professional cooks prepared sweets for the wedding guests (R. Freed and S. Freed, 1980, pp. 461–465, figs. 12, 13, 14, 15, 16).

In the groom's village, Ram Chandra's family and lineage members gave a feast to honor him and a patrilineal cousin, both of whom were to be married on the following day in the brides' villages. Only males were invited. Women prepared the food and sang during the occasion but were not present in the area where the guests ate. Guests were members of the groom's lineage and caste, patrons, employers, friends, and neighbors from different castes. Persons from other castes were few and high-caste guests generally did not eat, saying they had just taken their meal. Two members of the Jat landowning caste were present, the president of the higher secondary school which Ram Chandra, the groom, was attending, and the wealthy landowner for whom Ram Chandra's father worked. He had lent the family Rs. 2000 to help with the costs of the wedding and a new brick dwelling.

After first worshipping at the village shrines and saying farewell to his mother, Ram Chandra set out late at night with his wedding

party (males from the village, mainly from his caste) for his bride's village where they were received early in the morning by his future father-in-law and where they stayed one day and night to complete the wedding ceremonies.

WEDDING DAY

On arrival of the groom's party in the bride's village, the respective fathers-in-law greeted each other ceremonially. Accommodations for the groom's party were in the village meeting house. There the honored guests were fed their first meal, the groom separately from the rest—exemplifying his transitional state. Around noon, the groom in his wedding finery accompanied by a band rode his new cycle instead of the traditional mare to Sita's house to be greeted by her and her female relatives. This was the first glimpse the couple had of each other. Sita was unveiled for she was not yet married and, therefore, not in *purdah*.

Thereafter Sita took her last oil bath, then dressed and was wrapped in a white mantle. By this time a full wedding pavilion had been set up outside Sita's house with a nearby canopy under which male dancers were to perform after the ceremony. The priest, a low-caste man, for Brahman priests did not officiate at low-caste weddings, checked the final arrangements for the ceremony. The groom entered and was seated on the bench opposite the priest so that the ceremonial fire was between them. Sita's mother's brother carried her in, placing her on the same bench to the right of the groom. The separate entrances of bride and groom were heralded by women singing and continuing to do so intermittently throughout the ceremony.

The priest had little knowledge of Sanskrit rituals so basically the wedding consisted of his reciting the *Brahma Gayatri*, known by all castes, the repeated pouring of clarified butter and sandalwood on the fire to the accompaniment of the ritual utterance, *svaha*, and telling a short story about married life (Daniélou, 1964, pp. 345–346). The main point of the wedding was for the bride and groom to circle the fire seven times; the first three times the bride led the groom; the last four, they reversed positions. They then again

sat on the bench opposite the priest but with the bride on the distaff (left) side, a symbol that they had become husband and wife. While the wedding was taking place and continuing sometime afterward, there was a gift-giving session, called *Kanyadan*, at which time wedding guests gave whatever they wished to Sita and her father.

A period of dancing by males of the caste community, two of them dressed in women's clothes, then started and lasted about an hour. The transvestites danced using sexual gestures, which were greeted by ribald comments. Spectators pinned rupees on the dancers to be contributed to the dowry.

Later as part of the fun, the groom was teased by his newly acquired female affines. His shoes were hidden by the wife of Sita's father's younger brother, for the return of which she asked a fee of Rs. 10. A meal was served the guests during this period, after which they went to sleep in preparation for departure early next morning.

FIRST VISIT

The following morning the major installment of the dowry was presented and the groom's party prepared to leave for home via the bus. Sita, dressed in her best, was well veiled and accompanied by her father's younger brother. During the bus ride and the entire first visit to her in-laws, she and the groom were never left alone together.

On arrival, female members of the groom's family greeted Sita at the bus stop and guided her to their house. For all of one day and night Sita was chaperoned by the women of her husband's household: her mother-in-law, sisters-in-law, and children in the family. At this time her husband's joint family lived in a two-room mud hut. With the money they had borrowed and would obtain from Sita's dowry they planned to build a brick house since part of the expense would be subsidized by the government. Sita's own family's experience was similar, for they too had taken advantage of this subsidy.

The main purpose of the new bride's first visit was to become acquainted with her husband and in-laws, with whom she would thereafter spend most of her life. Sita's natal family differed from her marital family. Al-

though both families were joint, her natal family was relatively small numbering 10 persons before her wedding, of whom three were small children (one an infant), and consisting of five females and five males. Her father was infrequently present, and her younger patrilineal uncle was absent during the day. In contrast, Sita's family of marriage consisted of 16 people, including Sita, of whom nine were males and seven females (nine adults and seven children). Her husband's grandfather, a man 80 years of age, was the nominal head of the family; her father-in-law, the active head, a man of 40. Both adult males worked on the land and were in the household daily as were all the members of the family. Thus, in her family of marriage Sita was to learn to adjust to a greater number of people and a predominance of males.

Because of purdah Sita had to learn to cover her face in front of the grandfather, father-in-law, his brother, and her husband's older brother. She was subject to the authority of her husband, mother-in-law, father-in-law, and when he wished it, the grandfather. She was expected within a short time to learn who all these people were, their relationship to her husband and herself, and to address and refer to them by kinship terms as names were not used. In time she would learn the real and fictive kinship relationships for the members of her husband's lineage as well as for other lineages in the village.

To be sure to avoid inadvertent violations of purdah customs, new brides generally were veiled most of the time although they found the custom oppressive at first, as did Sita. In this way Sita did not mistakenly uncover her face until she had learned the status of her male affines, lineage members, and neighbors. Most of the time she was quiet because the situation differed from her natal village.

The late afternoon and evening of the first day were spent in becoming acquainted and eating a meal. By 9 P.M. the family had gone to bed with the women sleeping apart from the men. Sita slept with her *jitani* (husband's elder brother's wife).

Next morning Sita and Ram Chandra played two games, the first of which was *Kangna Khelna* (string playing). All the while the women sang a teasing song. The groom

was handed a red string tied in seven knots; then he and Sita alternately were expected to untie the knots. When the groom broke the string (an inauspicious act), his father's younger brother's wife slapped him to offset bad luck. Next, the same woman dropped a red thread tied around a silver ring into a pan of milk. The object was to see whether Sita or Ram Chandra would find the ring, thus determining who would rule the house. The groom was expected to win, but Sita found the ring first. Then Ram Chandra forced her hand open and took it from her. Next they untied the red strings which they had worn around their wrists and ankles from the time of the first oil bath, indicating that the most dangerous part of the liminal or transitional stage had passed. Last the groom sat on his mother's lap, the bride on his lap, and one of Ram Chandra's younger brothers, a child of three or four years, sat on Sita's lap. This lap-sitting was symbolic of the fertility of on-going generations. Then Sita, chaperoned by her patrilineal uncle who had stayed with the men overnight, returned to her natal village.

SECOND VISIT

Sita's parents planned to send her to her husband for *Gauna*, first mating, at the end of June. For this occasion they readied the last of her dowry. Since Sita had reached menarche, the marriage was to be consummated during this visit. Sita's father had given her a sewing machine, mentioned earlier, in a lockable traveling case of which she was inordinately proud. She carried it with her on the bus. Her young uncle again accompanied her, leaving her there for a stay of four days.

Although the visit was primarily for first mating, it gave Sita a chance to become better acquainted with her in-laws, caste members, and village activities. While doing so, she was constantly attended by her female in-laws and the children in the family.

Sita knew that the first night of this second visit she was expected to sleep with her husband and have sexual relations. Village parents did not discuss sexual relations with their children. In fact sexual topics were tabu between parents and offspring. Sita said her mother never mentioned menses or sexual

intercourse, or prepared her for the sexual aspect of marriage. This information accords with other data obtained from married women.

That evening Sita's *jitanī*, the woman who regularly acted as intermediary between a bride and groom for the first mating, explained that Ram Chandra and she (Sita) were to sleep together and apart from everyone else in the unfinished room in the new brick building where Sita's marital bed and trunk reposed. Sita said she was afraid to sleep with Ram Chandra and would sleep only with her *jitanī*. This sister-in-law, a year or two older than Sita, complied with Sita's wishes but in the night moved away. When Sita awoke in the morning her husband was in bed with her, but he said nothing. As a result, the mating was put off until that evening.

The previous evening the sister-in-law had earlier cautioned Sita not to scream and to be quiet when Ram Chandra joined her. She said, "This is only natural and is how your mother and father had children." In questioning women about their first matings, they quoted similar standardized but not very informative explanations by *jitanīs*. Sita's sister-in-law's statements were not reassuring and probably had a greater emotional impact on Sita than they may have had on other young brides, given the nature of her childhood.

During this second visit, Sita went to the well to wash a skirt and fetch water. While there it was said that her foot caught on a rope and she slipped and fell in the well. Fortunately, two men of her caste who were working nearby threw one end of the rope to her, which she caught. They then pulled her out. Since new brides sometimes committed suicide by jumping in a well or were drowned by their husbands who did not like them, the village gossips spread rumors about this event.

We were walking through the caste compound shortly after this episode and saw Sita sitting on the ground in a state of shock and dripping wet. At the time we did not know who she was, other than that she was a daughter-in-law in her father-in-law's house. The eldest son of the landowner for whom Sita's marital family worked came to see what was wrong when they did not show up in the fields. Many women had gathered round Sita. Her

mother-in-law was most concerned to dispel any gossip of suicide or foul play. Later in September when interviewing Sita, she did not respond to a question regarding this event but looked at her mother-in-law who changed the subject. Her lack of response may indicate that she half-heartedly considered suicide. Although letting her mother-in-law answer was correct behavior, her mother-in-law was not exacting about such behavior.

The fall into the well might be construed as an attempt at suicide but it could have been an accident, for Sita was under considerable stress during this time and was not totally familiar with her surroundings. In her natal village one well was used by everyone; in her marital village the well for her caste was outside the low-caste side of the village. The men working near the well may have frightened her because of her father-in-law's instructions not to talk or joke with any men. Thus, she may have been accident prone. Because of her fear of death and the strange surroundings, the latter explanation seems feasible. On the other hand, she may have been experiencing the same ambivalence about committing suicide as when Taraka did so.

After four days, Sita returned to her natal village, knowing that in a few months she would be expected to stay permanently with her husband and in-laws. Ram Chandra took her to her father's house, generally not done by a husband. Thereafter, due to Sita's lack of a brother who was old enough, Ram Chandra fetched and returned her to her natal village.

THIRD VISIT

Toward the end of August on Rakhi Bandhan, a festival when sisters tie charms on their brothers' wrists, symbolizing the bond between brother and sister, Sita returned to her husband's village. First, however, she performed the charm-tying ritual with her two brothers, one an infant and the other three years old. This festival emphasized and fostered the bond between brothers and sisters, an aspect of which is that brothers act as intermediaries between their sisters' natal and marital families and are expected to help their sisters and their children as well as to

protect them from undue demands or harassment by their in-laws. Since Sita's brothers' ages at the time of Sita's marriage were disadvantageous for the role of a married woman's brother, her father, when he was in Delhi, or father's younger brother filled the gap. Sita's father, having served overseas from the age of 18, tended to ignore the custom against a daughter's father visiting her marital village. When he wanted Sita taken care of, he did not hesitate to visit her.

Sita approached her third visit with trepidation, knowing she was expected to stay permanently until her first child was born. By this time, she had become aware of the difficulties and stresses of adapting to the role and sexual behavior of a married woman, pleasing her in-laws, and becoming acquainted with her affines and their neighbors. She was also limited by different spatial and physical conditions. In her natal, one-caste village, members of the single caste could roam about the whole village and often left it to visit Delhi. In her marital village, Sita learned that she was not only limited to the village in her movements because of purdah and attendant chaperonage by her in-laws, but that her caste kept to the low side of the village except when they had specific business with members of the high castes. She found that the male members of her joint family of marriage did not own land but worked for a landowner and were subject to his call to work his fields. All the men, women, and children, who were old enough in her marital family, worked in the fields of this landowner. Even greater blows to Sita's pride were caste discrimination and the lack of prestige of Sita's family of marriage, which did not own land or have anyone in military service or in urban occupations.

The first four nights the young couple slept together and had sexual relations; then Sita began to experience her first ghost possessions. Possibly the most stressful physical condition for Sita after coitus was due to the construction of a brick dwelling by her in-laws. Although her family of marriage was still living in their mud hut, the walls of part of the brick house had been erected a little way off opposite the mud hut. Sita's belongings, including the marital bed and a trunk with clothing, were placed in one of the semi-

completed, unroofed rooms. It was in this space that she and Ram Chandra slept at night. The village had no electricity and a number of half-completed brick buildings surrounded the building in which they slept. At night the effect was eerie. When people, wrapped in white mantles, moved about in the dark to relieve themselves, they were wraithlike and cast flickering shadows.

POSSESSION

Cut off from her own family, subject to the wishes of her husband's family, limited by *purdah* in her freedom of movement, not knowing many villagers, having no friends, and being somewhat isolated throughout the day contributed to feelings of disorientation and sensory deprivation in Sita. Her nights consisted of alternating sexual excitation and fear. These stressful conditions and sensory stimulation and deprivation, together with her early background, made her a likely candidate for ghost possession. It was at this time that we first became aware of Sita and her possessions (Vernon, McGill, and Schiffman, 1958; Doane et al., 1959; Zubeck et al., 1961; Arnhoff, Leon, and Brownfield, 1962, p. 900; Jackson and Kelly, 1962; Orne and Scheibe, 1964).

On September 4, 1958, we were interviewing some members of Sita's caste about the worship of Jahar in the compound in front of her father-in-law's mud hut. A young, teen-aged girl, whom we later learned was Sita, was sitting on the ground in front of the house quietly working her sewing machine. We did not pay much attention to her since her face was veiled but surmised that she was a young bride. Within the space of less than an hour we were to witness this girl's possession. The possession and events preceding it provide some understanding of ghost possession in the Delhi region in relation to Sita's background.

The conversation of the people near Sita that immediately preceded her possession is significant, for she could have interpreted some of the comments and behavior as indirect reflections on her good character. Sita's husband's elder brother (a fictive relationship) was teasing her. He told us that he could do this because he was senior to her husband.

We replied that we thought it was the husband's younger brother who could tease a woman and not the husband's older brother. The people avoided answering directly, instead pointing to another man and saying, "He's also a husband's older brother and never says anything."

Then the man who had been teasing Sita commented that tailoring was suitable only for men, remarking that a male tailor could get anyone's measurements but that a woman could not. It had recently been accepted that a woman might sew clothes for relatives, and a sewing machine as part of a dowry carried considerable prestige. Although Sita had done nothing wrong, the aggressive teasing from which she could not defend herself and the fact that it was a breach of the traditional behavior of a man with his younger brother's wife could have disturbed her.

Suddenly, the mother-in-law began to tell us about an illness that was plaguing Sita during this third visit. Apparently she was aware of Sita's imminent possession just before it became obvious. The first symptoms that we noticed were when Sita shivered, complained of feeling cold, moaned, and was breathing hard. Women covered her with quilts but she continued to moan and talk. Then she lost consciousness. The ghost had come.

Sita's relatives helped her to sit up and wafted some smoke from burning cow dung into her face. She started to jerk violently and her relatives seized her to restrain her. Realizing that Sita was possessed, her relatives shouted at the ghost, "Who are you? Are you going?" The ghost, speaking through Sita, replied that it was going, and so the relatives released Sita who remained sitting. Suddenly she fell backward unconscious. The ghost had returned. This time Sita's relatives revived her by putting some water from a hookah into her eyes and pulling her braids. When she returned to semi-consciousness, she made a high-pitched wailing sound which seemed to announce the ghost's presence. There followed a conversation between the ghost and Sita's relatives in which the ghost identified itself as Taraka and said that it would not leave without Sita.

Again Sita fell unconscious and her relatives brought her back to the semi-conscious mental state by putting rock salt between her

fingers and squeezing them. She again emitted the wailing sound and the ghost was ready to talk. By this time, more women of Sita's caste were attracted to the scene and began to converse with the ghost. It complained that it had not been fed noodles (a delicacy) that morning although Sita had been given some. The women and the ghost then exchanged insults.

Sita sat quietly for some time and then once more lost consciousness. Her relatives again put rock salt between her fingers, but the ghost announced that it was leaving before they had a chance to squeeze her fingers together. Sita, however, asserted that she could see the ghost in the nearby, incomplete room of the new dwelling. The women tried to persuade her that nothing was in the room except a trunk. Then Sita fell back again and lay still. No effort was made to revive her and the spectators drifted away. Sita remained unconscious for several hours until an exorcist was summoned to revive her.

Although Sita's mother-in-law was distressed during the episode and once wept, the other people who were present treated the event quite matter-of-factly and seemed to know just what to do. During lulls in the possession, they speculated as to the ghost's identity and discussed ways of driving it away. Much of the conversation with the ghost was to determine its identity. The ghost called itself Taraka, a friend of Sita's from her mother's brother's village. Because Taraka drowned in a well, an untimely and violent death, she became a ghost. The ghosts of women who die such deaths do not keep their promises. On previous occasions when the ghost possessed Sita, it promised not to return. One of the women kept repeating that the ghost was a "widow [an insult] who did not keep her promises." In the last conversation, the ghost changed its name, boasting, "You can never get hold of me." The women decided that the ghost had been lying earlier about its identity but were not convinced that the new name was correct.

In addition to the hookah water, rock salt, cow-dung smoke, and braid-pulling that were used on this occasion to drive off the ghost, the spectators suggested other remedies: the smoke of burning pig's excreta, a copper coin, an exorcist, and beating the possessed person.

Sita's sister-in-law struck her once, but the son of the Jat landowner whom Sita's family served, who came in midway through the possession, protested, saying that Sita had some ailment and that no ghost was present. He seemed to appear whenever anything unusual took place in Sita's family. Most of the methods used by the villagers to exorcise ghosts involve shock (beating, pulling, and squeezing) and/or unpleasantness (e.g., burning pig's excreta and verbal insults). Certain substances such as salt and cow dung are inimical to evil spirits (Crooke, 1894, pp. 147-148, 194, 198, 201; O. Lewis, 1958, pp. 295-299).

During the days following Sita's possession, we gathered information from members of her family, the surrounding community, and from gossip throughout the village, in addition to interviews with the exorcists and Sita herself. Sita's mother-in-law said that when Sita came for her third visit she went to the fields to urinate and met the ghost of Taraka who said to her, "Stay there! Where are you going?" As a result, Sita had not gone to the jungle (a euphemism for going to defecate and urinate in the fields) for about five days. When new brides were in their husband's village, they covered their faces with their headcloths when defecating in the fields and were accompanied by a female relative. The chaperonage, custom of covering the face, and fear of the ghost resulted in Sita's being unable to relieve herself and added to her tension and anxiety.

Her mother-in-law said that the new bride had been possessed after coming for her third visit and that when the village remedies did not help, an exorcist was called. During these early possessions the ghost, identified as Taraka, said, "Ram Chandra is my husband." This statement meant that the ghost of Taraka was with Sita at the time of her being wedded to Ram Chandra, and as a result, the ghost was married to him too. The implication was that the ghost had been attached to Sita for some time. According to her mother-in-law, Sita was sensitive to sounds emitted by the ghost and her mother-in-law could tell when Sita was about to be possessed. Sita's mother-in-law, a simple woman who totally believed in ghosts, was greatly distressed by Sita's possessions and at this time she men-

tioned that Sita, while washing a skirt at the well, had slipped and fallen into it, the implication being that Taraka's ghost had disturbed her at the well. This incident suggests that Sita was in a confused state of mind that resulted in a semi-dissociative state. Going to the well must have reminded her of Taraka's suicide, for she believed that Taraka's ghost went everywhere with her. It brought up the possibility of her own suicide as a way out of her difficulties. Sita believed that Taraka's ghost was trying to take her away. These beliefs regarding Taraka's ghost are reflections of Sita's guilt about her joint activities with Taraka and the realization that what happened to Taraka might also have happened to her. In repressing her guilt, Sita made a scapegoat out of Taraka's ghost, who in trying to take Sita became malevolent. The guilty repression of the memory of their joint activities and her ambivalence toward Taraka's suicide is reflected in later years by Sita's placing the blame for her possessions and fits on Taraka.

Sita's mother-in-law, the senior woman responsible for all the young women in the family, earlier in the summer had been badly upset by another family member, the wife of her husband's younger brother. He worked in a nearby village during the day and came home late at night. This couple's first child died and his wife was unhappy and lonesome because of the death and her husband's absence. Indore Bija, a 50-year-old man who lived nearby, was from a lineage of Sita's caste that was somewhat antagonistic to Sita's in-laws. He was asthmatic and unemployed. In June he had enticed the discontented wife, lonesome for her husband and unhappy due to the death of her baby, into his house with an offer of sweets. Indore Bija's wife returned unexpectedly, found the two of them alone in the house, and started shouting at them so that everyone in the compound learned about the seduction. The unfaithful wife later quarreled with her mother-in-law and threatened to commit suicide by jumping in a well. As a result of her adultery, the young woman was disgraced and returned to her parents. Her cuckolded husband was miserable and sometime later separated from his brother and father and left the village permanently. Thus, one young wife had already caused quite

a bit of trouble in the family, and Sita's mother-in-law, who was pleasant but not very strong-willed or decided in her actions, was beset with anxiety about Sita. Sita had brought a larger dowry than any other bride in her caste, and the family needed the funds and material goods. In addition, Sita's father's position was sufficiently prestigious for him to start an investigation should anything happen to Sita (Das, 1976, pp. 22-23).

Jai Ram, the husband's fictive elder brother who teased Sita about her sewing just prior to her possession, was the eldest son of Indore Bija, the seducer of the unfaithful wife. As such, he acted incorrectly when he teased her, not unusual for him. Indore Bija was an irascible, difficult man who rarely provided for his children when they were young, sending them to live with various relatives. As a result, Jai Ram himself was a poor provider and had numerous family problems due to a long history of intermittent unemployment. It is not surprising, given his personality, the antagonism between the lineage of Sita's marital family and his own, and the problems besetting him, that he acted contrary to correct behavior and vented his frustrations by teasing and criticizing Sita, who could not answer back.

Sita would have been cautioned to avoid Indore Bija and the male members of his family and lineage. Furthermore, she would have learned that Jai Ram's wife had borne a series of children of whom only two survived. Because of the similar histories of infant deaths for Jai Ram's wife and Sita's mother and the belief in ghosts, Sita would have been afraid of contact with her since it was said that a ghost was taking her children. For her part, Jai Ram's wife was frightened by Sita's ghost possessions and avoided contact with her because that very summer she herself had borne an infant girl who, she was afraid, might die as had all of her other children but the infant and an older son. The tense relations between Sita's marital family and Indore Bija's and his son's families added to Sita's fears and anxiety.

Jai Ram considered himself an authority on ghost possession and in later years became a part-time practicing exorcist. He provided the following information about ghost possession, its cure, and some information about

Sita. First he said that she was 12 to 13 years old, then later modified his estimate, commenting that since she looked mature she was probably older. He inferred that there may have been a reason for her marrying at a later age than his wife had married. He said that Sita's possessions began on the occasion of her third visit and that the ghost was a girl friend of Sita's named Taraka, who was Sita's mother's brother's daughter. He quoted the ghost as saying, "I'll kill Sita and take her with me." He mentioned that Taraka died by falling into a well and that neither girl was married at the time. He was incorrect concerning Taraka, as she was married. He had no knowledge as to whether Taraka's fall was accidental or not.

According to Jai Ram, if two people were friends and one of them died, then the ghost of the dead person would enter the body of the living friend and try to take the friend. He explained how an exorcist "takes off" a ghost:

When a cigarette is burning, the fire burns the cigarette; the cigarette doesn't burn the fire. So a specialist by chanting mantras can draw off the ghost, but no one else can. To do so, the specialist undergoes hardships, visits the burning ghats [cremation grounds], and takes dead bodies so they will work according to his will. This specialist bribes the dead bodies in one way or another and through his power gets them to do what he wants. Even with living people, he can transfer one's trouble to another person just as he can transfer a ghost to another person. For example, if two exorcists start to quarrel, one exorcist will send his ghost to the other. If the other exorcist is more powerful, he will cut away this ghost with his mantras. If not, he'll suffer. If an exorcist has enough power, he will be able to cut off the ghost from this new bride.

This discussion not only revealed the believed source of power of an exorcist, it also indicated why Jai Ram, at the time a frustrated and powerless man, was fascinated by ghosts and exorcism and in time became an exorcist. Carstairs (1969, pp. 407, 409) has noted from his fieldwork in Rajasthan, India, that men who became shamans were previously unsuccessful in life. After adoption of the new role, they had considerably more prestige.

Generally, information passed along the

village grapevine between the low-caste side of the village and the high-caste side within one to two days, but in the process facts and fictions were distorted and confused. In the cases of Sita and the unfaithful wife who had been returned to her parents, a number of conflicting rumors were circulated by high-caste women who tended to denigrate the behavior of the low castes. One woman said that Taraka, the ghost, was also a bride in Sita's marital village and had jumped into a well, committing suicide. The first part of the statement was incorrect but Taraka did commit suicide by drowning herself in her natal village. Another woman said that the wife who had been seduced by Indore Bija had committed suicide when, in fact, she was returned to her natal village. A Jat woman, who rarely visited the low-caste side of the village and could not tell one new bride from another in that quarter, may have confused Sita with the stories about Taraka, or with a Brahman girl who had been killed by her father during the summer, for she said that Sita had an abortion before marriage. This gossip was without foundation because Sita attained menarche either late in 1957 or early in 1958, after the time she was involved with Taraka, who died in 1956. Thus, Sita probably could not have conceived. The Jat woman may have added the abortion element because the Brahman girl, like Taraka, had become pregnant before going to her husband for first mating, as a result of which her in-laws sent her back to her father. Despite the pleas of her uncle for an abortion, her father killed her (R. Freed, 1971). This death was common knowledge in the village and may have added to Sita's anxiety when she heard about it.

EXORCISM

Sita's ghost possessions ran through most of the dark fortnight of the month of Bhadrapad (Aug.-Sept.). Four exorcists attempted to cure her. The first exorcist, from a village in the Delhi region, treated Sita before she suffered the possession that we witnessed. Apparently he was unsuccessful, for a new curer was called for her next possessions. This curer worked in the City of Delhi and was recommended and fetched by one of the vil-

lagers. He conducted two curing sessions, the first for the possession we witnessed, and the second, for a session beginning in the evening of Janamashtami and lasting to 4:15 A.M. In the second session he used unidentified herbs to induce Sita to become possessed. In the early curing sessions the ghosts troubling Sita were identified, first as Taraka, and, second, as Rukmini, about whom little was known. The first ghost possessions, however, were by Taraka.

When the possessions recurred, the members of Sita's family of marriage became quite distressed and notified her father. The illness was considered so serious that he brought his two brothers and mother, and other relatives sent telegrams. He also brought two exorcists, one from New Delhi, and the other from a town south of Delhi. They conducted an all-night session during which members of Sita's natal and marital families were present.²⁴

We have no information about the techniques of the first exorcist, but the others used generally similar methods. All of them called on supernatural beings as the source of their powers. As a rule, these supernaturals were representative of Hinduism and Islam. The second exorcist, for example, said his main

power was from Hanuman, the monkey god who was the lieutenant of Rama Chandra and accompanied him in his rescue of Sita from Lanka, as recounted in the Ramayana (Dowson, 1950, pp. 116–117; Basham, 1954, pp. 412–415). Hanuman was the guru of this exorcist, but the exorcist negotiated with him through Hanuman's minister, a way of indicating the superordinate power of Hanuman. He also had as powers: the Conjurer of Dacca, a legendary magician; Kalka, the goddess of the cremation grounds; and Jahar. The last two supernaturals were regularly among the roster of powers for these curers.

When conducting a curing session, characteristically an exorcist first identified his powers (similar to familiars) and built up a belief in their strength with the patient and the patient's family. The idea was to imbue them with a faith in the powers' ability to drive out the ghosts through the actions of the exorcist. For example, an exorcist might say that his main power, Hanuman, was sitting on his right shoulder, and that a Muslim power was sitting on his left. He would claim that when he called his powers they would come immediately and take care of the ghost, a means of threatening it. In addition, the exorcist carried on a dialogue with the ghosts which included threats, bribes in the form of offerings of sweets to the ghosts, who were supposedly fond of them, and the promise of offerings to be made at the next fair for Kal-kaji held at Chirag Delhi.

The last two exorcists, who treated Sita jointly, were able to bring on her possessions by suggestion and hypnotic techniques. Their all-night curing session consisted of a series of possessions of Sita by the ghosts of Rukmini and Taraka, during which the curers negotiated with the ghosts possessing Sita. Their suggestion-hypnotic techniques involved using a bonfire as Sita's point of concentration and the repetitive chanting of mantras. During the session, Sita's possessions waxed and waned, alternating between being completely unconscious, having alter-ego voices speak from her which were identified as the ghosts, and sitting up and seeing a ghostly apparition. Toward the end of the session, in another alternate mental state, Sita pointed to different places in the caste compound saying, "The ghost is there, there, and

²⁴ We did not witness the all-night curing sessions but interviewed two of the shamans who officiated at them. There are a number of reasons, characteristic of the problems encountered in fieldwork, for not attending: the main one was that we were not told about them until the next day because Sita's possessions were unpredictable. Also, one possession and curing ceremony took place in the evening and night of Janamashtami when a drama celebrating Krishna's birth was performed on the high-caste side of the village, which we were obliged to attend. Sita's family was in all likelihood aware that the high castes wanted us present. The Jat landowner for whom Sita's marital family worked may also have told them not to call us, as he often intervened in such matters. The Jat caste, followers of Arya Samaj, professed not to believe in ghost possessions, and they and the Brahman caste who staged the Krishna drama wanted us to believe that the village was progressive. In a discussion of ghost possession with two staunch Arya Samaj Jats, they said possessions happened only among the low castes—a statement found untrue in 1958–1959 and again in 1977–1978. At the time of Sita's possession, which we witnessed, the eldest son of the Jat landowner for whom Sita's family worked showed up at the scene and denied that a ghost was present.

there." This state was similar to part of her earlier possession when she saw a ghost in the unfinished room in which she slept with her husband. These variations in Sita's possessions indicate that different degrees of alternate mental states exist, tying in with findings from experiments involving sensory deprivation and stimulation and with observations indicating that "the levels of possession and types of behavior vary from individual to individual and at different times for the same individual" (Mischel and Mischel, 1958, p. 253; Shurley, 1962; Kracke, 1967, pp. 23-24).

The curing sessions took place in the caste compound with members of Sita's family and caste present. Throughout the curing sessions the exorcists used a variety of substances and physical techniques. For example, they symbolically cut out the ghost by criss-crossing the ground with a knife; pulled Sita's braids and snipped off pieces of her hair, which they threw into the fire; and wafted unpleasant burning substances (such as cow's dung and pig's excreta) under her nose, to smoke out the ghosts. They insulted the ghosts verbally; beat and hit Sita; and squeezed rock salt between her fingers. Although some of these techniques were similar to shock treatments, they were considered threats to frighten the ghosts and drive them away.

In conversing with the ghosts, the exorcist sat cross-legged on the ground near and facing Sita. Sita was alternately lying down or propped up by her female relatives in a semi-sitting position on the ground or on a cot. The conversations with the ghosts allowed the ghosts to complain, abuse, and ask for whatever they wanted or believed they had been deprived of, usually sweets. When threatening techniques were used by the exorcist, the ghosts would say they were leaving. Upon cessation of the threats, the ghosts remained or returned and continued speaking, one of the reasons why it was said that ghosts did not keep their promises.

Although Sita was familiar with ghost possessions, especially of young brides during their first matings, the probability is that each person's possessions reflect events in their life experiences. Based on this theory, a possession or fit can be analyzed as can a dream. Thus, the foregoing possession contains a

number of representations. Sita had an onset of feeling cold and shivering similar to the symptoms of her infant siblings who, she believed, were possessed by a female ghost causing them to die. Sita's moaning and breathing represent the infants' sufferings to some degree and are similar to the sounds she heard in the one-room hut when her father and mother and others copulated. Sita's violent jerking mimics the movements of coitus, but also of the births she witnessed in the same hut. Her loss of consciousness can be identified with the cessation of the sexual act and falling asleep thereafter. The conversations of the ghosts with bystanders and later in other possessions with the exorcists consisted of demands and complaints by the ghosts and may be interpreted as Sita subconsciously expressing unhappiness with her married state. The complaints about being deprived of noodles (a sweet dish) and sweets indicate a lack of sexual pleasure (Freud, 1962, p. 164). These demands together with the ghost retaliating to the woman who was abusing her may have been subconscious attempts by Sita to obtain a change in her situation and an outlet for her aggressions, which as a new bride she had to suppress.

The ghost of Taraka, in effect, provided a screen for Sita's own guilt and a channel for the rage Sita felt about her frustrations and fears arising from her marital state. As a ghost, Taraka, with whom Sita identified and fantasized about sexual experiences, represented the conflicts Sita had about strange males, coitus, birth, and death. When Taraka spoke from Sita, saying "Ram Chandra is my husband," the interpretation of the villagers was that Taraka's ghost had been with Sita for some time and had gone around the fire with her and Ram Chandra at the time of their wedding so that Taraka, a ghost, was believed to be married to Ram Chandra also. Oddly enough, this statement was a self-fulfilling prophesy in the sense that all that Taraka meant to Sita would remain with Ram Chandra and Sita throughout their married life. The linking of Taraka and Ram Chandra reflected Sita's activities with Taraka, her attempts at relations with young males, and her regression and repression of her subconscious feelings about her father as a result of Taraka's suicide and Mara's death (Fenichel,

1945, pp. 217–219; Freud, 1967, pp. 619–621, 651; 1978, pp. 22–27).

SITA'S INTERVIEWS, 1958

For approximately a fortnight in September 1958, we conducted a series of three interviews with Sita, from which we have sketched the details of her early life and the life crisis or turning point in her life consisting of marriage, mating, and possession. Based on these interviews we describe Sita's physical and mental health; her attitudes toward menses, marriage, mating, and childbearing; and an analysis of her dreams.

PHYSICAL AND MENTAL STATES

Sita appeared to be in good health when we first interviewed her after witnessing her possession. If no males of her husband's generation or older were present while talking to us, Sita did not veil her face. Our first impression of Sita in these interviews was that she was a pleasant-looking, healthy, young, attractive, teen-aged girl. She was wearing a blue band tied around her neck which the exorcist had given her. He made it, read some mantras, and tied it on her; then he cut some hairs from her head, tied them up in a cloth around his waist, and took them as an offering to Kalkaji. Sita was a bit uncomfortable wearing the band and wanted to tie it around her arm. Her mother-in-law told her that the band looked nice on her and that it would keep the *opera* (ghost) out.

Sita asked us to take a photograph of her on Janamashtami. As was customary, she was accompanied by her husband's oldest sister, a girl younger than she, but the oldest daughter in Sita's marital joint family. The two girls stood side-by-side to be photographed. Sita was better dressed and fairer than her sister-in-law (husband's sister), who was somewhat drab in appearance. These differences to some extent were cultural for when teen-aged girls, whether married or unmarried, were in their natal village they customarily wore old and well-worn work clothes. New brides in their husband's village were expected to wear the finery brought in their dowry and to dress up when they went to the well to fetch water. They did so with their faces veiled, passing the inspection of loitering males who as

a village pastime watched the young brides going to and from the well and evaluated their attributes from what little might be seen.

Sita was somewhat better looking than the average girl her age, fairer and quite neat in appearance. Her clothes were attractive and well-fitted, probably because she sewed them. Characteristics of Sita, not seen in her sister-in-law, were a somewhat poised and posed stance and an obvious attempt on her part to look well in the picture. These features, in addition to her willingness to talk freely with us, distinguished her from the average females her age, especially new brides. She could best be described as more modern and independent than the average village girl, no doubt due to her urbanized, natal village and her father's influence.

In the first two interviews with Sita, her skin was clear, she seemed cheerful, smiled when she saw us, and was well-groomed. Thereafter, although she continued to be well-groomed and smiled in greeting, her physical condition changed because of the series of possessions and curing sessions, and the psychological problems she encountered mating with her husband and adjusting to her new home. In the last two interviews Sita said she had become quite weak and described how she felt emotionally and physically.

In the final interview she did not look very well; her eyes were tired with circles under them. She mentioned that she had been ill from ghost possession for over a fortnight. It troubled her that she had pimples on her face, which she had not previously had, and she asked whether we knew of some remedy for them. This request was consistent with Sita's pride in and awareness of her appearance. A number of times she said that she was becoming quite weak even though her father arranged for her to receive vitamin injections. Her legs, arms, and whole body ached, but she did not know why, so attributed these feelings to physical weakness. She said her head ached, blaming the headache on the exorcists who plucked out some of her hair and threw it into the fire when chanting to dispel the ghosts. Although the curing session had occurred a week earlier, she believed that her headaches were still due to the exorcists' treatment.

In one interview Sita said she was sewing

clothes for the children in the household. She had cut and begun to sew a *kamiz* (shirt) for one of her young sisters-in-law but ran out of thread and was unable to finish it. She had to wait until her mother-in-law was able to buy more thread for her. The inability to purchase the thread herself after the freedom of her natal village was frustrating.²⁵

She mentioned that when her grandmother had visited her a few days previously, she took her to the bus stop in the next village accompanied by all of the children in her husband's family. The trip—a half hour's walk—tired her and she felt weak. Then she and the children waited for her husband who was attending school there. She ended by saying again that it was difficult for her to pass the day when we did not come to see her. Then she felt lonesome, sad, and cried.

Loneliness was an oft-repeated refrain. She said, "It's lonesome here. There is no one to talk to except you. When I finish my work, I stitch clothes or just go to sleep. When I feel lonesome, I just go to sleep. Now I don't feel like working, just like sleeping. Before I was married I was quite active and did all sorts of work. Even when I came here the last time [her second visit], I was quite active and did all sorts of work in the house."

We arranged what was to be the last interview with Sita for early next morning. The first thing she said was, "I feel better but my hands and legs still hurt, and sometimes I feel giddy, sometimes sick to my stomach. I must be sleeping too much. When I am just resting on the cot, I fall asleep even when I don't want to." Incidentally, while describing falling asleep, she mentioned that the cot had a netting of tape (a modern prestige item) instead of string. She had brought it in her dowry, and it was the cot on which she and her husband slept at night.

²⁵ There are a number of reasons why Sita could not shop for her own thread even when accompanied by her chaperons. First, there was only one shop in the village located on the high-caste side where normally she would not go. Furthermore, she had no money to spend. Young wives were not given money by their husbands, who themselves had little money since they were under the authority of their fathers who administered the funds in a joint family.

Reverting to her giddiness, she reiterated:

I feel giddy all day long. If I am sitting still and get up I feel giddy as though I might fall down. I also feel or hear noises in my ears, forehead, and head. Sometimes it sounds as though someone is calling me, and sometimes the person says, "Sleep, sleep, sleep." I am hot during the day and it seems very hot all of the time. Even at night I don't feel cool. But I don't perspire. There is too much heat around me and I feel as though I am being suffocated, as though there is a heavy burden on me and weights pressing on my body, legs, feet, and chest. When I'm sitting down, I have difficulty breathing and feel a queer sensation in my stomach. It is as if there is a big burden on my stomach and it is becoming bigger and bigger. Late at night and early in the morning when it has cooled off a bit, I feel better, but whenever I am hot I become sleepy. When I feel lonesome, then I want to sleep.

Formerly these physical symptoms were characterized as hysteria. Currently they indicate a range of alternate mental states. The feeling that her stomach was growing bigger and bigger may have been due to a fear of being pregnant (Mischel and Mischel, 1958, p. 253; Abse, 1959, p. 274; Ludwig, 1966, pp. 227–230).

MENARCHE AND MENSES

It was not until the last interview in 1958 that Sita provided information about menarche and menses. She said that her menarche occurred at the age of 14, that she was presently 15, and her husband was 18 to 20 years old. (In fact he was 17 or 18 years old.) In a census taken of Sita's marital family, her mother-in-law said that Sita was 12 and her son 13 years old, possibly because she could not count accurately, had so many children she confused their ages, or more probably because more status accrued from marriage at an early age.

Sita's menses started from two to four months before her wedding. Although it was considered more desirable for a girl to be wed before menarche, the date of Sita's wedding had already been set. At the time of this interview, Sita said that she still did not understand menstruation. Her mother told her nothing and did not know when Sita's menses began. A girl in Sita's lineage, the equivalent

of a cousin, told her mother. But Sita said, "I don't know how my cousin knew." At this point in the interview, Sita's husband's sister, who was chaperoning Sita, asked, "What sort of questions are these people asking?" So Sita changed the subject.

KNOWLEDGE OF COITUS

According to Freud, in his analysis of the case of Dora, where hysteria exists there is no question of the innocence of the mind (1978, p. 49). Whether or not the term hysteria is applied to Sita, there is reason to believe that she had some knowledge of sexual relations prior to her wedding because of her discussions of the deaths of Mara and Taraka. As Simon (1980, pp. 240–241) has pointed out "Circumstances in the life of an individual (and perhaps of a culture) that seem to foster the use of hysterical symptoms involve a certain climate of 'motivated ignorance' in the family." Certainly, the culture into which Sita was born fostered such "motivated ignorance" in her family. It "suppressed sexuality" as well as overexposing and overstimulating individuals sexually by jokes and allusions every time cattle mated and by constant emphasis on fertility and childbearing, not to mention references to sexual activities in myths about Hindu deities. Despite the cultural stimulation, young girls were ill-prepared for the sexual role of a wife so that marriage in this respect as well as others constituted a discontinuity in sexual role behavior (Benedict, 1967). In effect the cultural messages were conflicting although ameliorated by fostering the importance of bearing children. The custom of purdah, which emphasized the need to protect women from sexual advances and rape, subjected them to male dominance, called attention to their sexuality, and made them vulnerable to rape. The head and face covering worn in purdah symbolized that the young woman had attained menarche and had been mated or was ready for mating. Before menarche young girls were considered pure goddesses, but not afterward. By Freud's theory of opposites, the covering of the head and lower portion of the face indicates a protection of the genitals. What one emphasizes, even though protec-

tively, is more apt to draw attention than otherwise (Freud, 1967, p. 391; R. Freed and S. Freed, 1980, pp. 437–438).

Most villagers had little knowledge of the biological basis of conception.²⁶ In this respect it is well to bear in mind that not until this century did scientists demonstrate that a sperm and egg must unite to start a new human being (Sandler, Myerson, and Kinder, 1980, p. 91). Thus, in this rural region young males and females generally entered into marriage with knowledge of mating and conception based on witnessing or becoming aware of the primal scene, being in the house when babies were born, and seeing the matings and deliveries of animals. Whether or not these experiences were traumatic, at least partially they prepared males and females for adult life. Women discussing pregnancies did so in terms of their stomachs; and symbolism regarding pregnancies and the birth of children referred to or used the word "stomach" (R. Freed and S. Freed, 1980, pp. 351, 354, 425, 490, 495).

The act of mating was expected to create a common bond between husband and wife. The justification for sexual acts was explained as necessary for procreation, but villagers also realized that men and women had sexual drives. Some of the songs sung at weddings indicated that a young girl was ready for sexual relations at the time of menarche or thereabouts. Villagers gossiped about parents who did not arrange their daughters' marriages so that the first mating would occur soon after menarche, and they predicted that the girls would go sexually astray if this sequence of events did not happen (Das, 1976, pp. 5–6; R. Freed and S. Freed, 1980, pp. 407, 431–432, 441).

Sita's earliest reference to sexual relations took place in the first interview, at which time she said that Taraka, the girl who committed suicide, had sexual relations with a young man two to three times and became pregnant before marriage. Two weeks later, upon being asked when she first learned about sexual relations, Sita answered that she had just come

²⁶ It is not surprising that conception was not fully understood in 1958, given the Ayurvedic influence, the low level of literacy, and the paucity of biological teaching in rural schools.

to know the previous year when she overheard some women talking in her parents' house. Her friends who were older than she and already married returned home and talked with her about their experiences and said that she, too, would experience them. They told her that she would be irritated, angry, and start crying. As a result, Sita said that when she came for first mating, she was terrified and told her sister-in-law that she would only sleep with her. Later in the interview she related the fear that she had of sleeping with her husband and said that he told her what to do, but that he too was shy and afraid when they came together. She added that she did not know if he had sexual relations before marriage but she thought not. When we asked her what he told her, she herself was then shy, stopped talking, went away for a few minutes, returned and changed the subject to her physical condition. Subconsciously she may have attributed her physical symptoms to sexual relations, especially the fear of being pregnant.

The ambiguity and contradictions regarding Sita's sexual knowledge could not be probed further due to the interviewing conditions. Some of the apparent contradictions can be explained by the same conditions. The information about Mara and Taraka was obtained when no one was within hearing distance. Some of the discussions of menarche, menstruation, and coitus did not take place in such isolated circumstances. However, very few girls of Sita's age were as free in speaking of these matters as she. Still, she was not able to describe her husband's sexual instructions; about this subject she was shy. Talking about sexual relations in the abstract was different from learning about the actual early experiences of a young married girl.

MARRIAGE AND CHILDBIRTH

In the context of Sita's discussion of her younger uncle's daughter of whom she was fond and planned to have visit her and even to arrange a marriage for her with Sita's six-year-old *devar* (husband's younger brother), we asked whether she would like to have a child now. She said not for four or five years because she was afraid to have one. She want-

ed to find out how to prevent childbirth, apparently having heard it was possible. Then she said "People in the villages have the bad habit of making a girl sleep with her husband so she quickly bears a child." As she was only 15 years old, she did not think she should have a child immediately. She believed a girl should not be married and mated until she was 22 years of age. Unelicited, she went further and stated that a girl should be free to choose her husband, should be educated and trained to work and earn, and then when ready she could choose her own husband and marry. These attitudes were quite untraditional and at the time relatively rare among young rural women. She expressed her disappointment in not being able to become a schoolteacher because of what happened to Mara. Her second choice was to be a dressmaker so she would not have to depend on her in-laws. She again mentioned that she could not go farther in school because of the men teachers who molested girl students. Her family was not against her going on in school, but when the teacher molested Mara, and the scandal spread, her parents would not let her continue. She added that she was terrified of male teachers. When she told her father so, then she was not permitted to study any more.

Sita differed from the average girl her age in terms of her desire for independence through occupations such as teaching and dressmaking. This attitude and her choice of teaching as an occupation were largely due to her urbanized natal village background and her identification with female teachers. Her attitude was fostered by being an only child for much of her early life and by her father's travels abroad and his reports of other customs. The City of Delhi with the diplomatic enclave and a number of modern amenities, including cinema houses, also contributed to Sita's independent attitude and beliefs about childbearing, marriage, and becoming a teacher. In 1958 low-caste rural families went to the cinema occasionally as a family unit, while men in high-caste families rarely allowed their women and girls to attend cinemas for fear they would develop new ideas and be corrupted.

Both rural and urban girls regarded teaching as an attractive occupation, provided they would be allowed to have one. In this respect,

Sita resembled other girls, but she differed from the norm among rural girls in her reason for choosing the occupation, namely to be independent. In a study of occupational goals of rural and urban schoolchildren in the Delhi region, one of the reasons given for occupational choice was "self." Among rural girls very few (3.8%) gave "self" as the reason. It ranked fifth out of eight choices among rural girls. Urban girls gave self (18.5%) as the third highest ranking choice. Sita's reason, "independence," would have been classified as "self." The first three highest ranking reasons among rural girls were nationalism, dharma, and family; among urban girls, dharma (ethical, correct, right, or religious behavior), nationalism, and self. Since Sita went only through the fourth grade, a comparison of her reasons with rural girls in the fourth and fifth grades shows that they made only four choices: nationalism (38.5%); none (30.8%); dharma (23.1%); and family (7.7%). These girls were in school in 1958, whereas Sita left school in 1955. Thus, though older, Sita displayed more sophistication about occupations, and her independent attitude was deviant from the rural norm, less so from the urban norm (R. Freed and S. Freed, 1968, pp. 7-11; table 14, p. 29; table 19, p. 33).

That Sita thought a girl should marry no younger than 22 years of age and should be able to choose her own husband was an index of urbanization and Western influences. In 1958-1959, an occasional urban middle or upper-class couple could be found who chose their own spouses (Ross, 1967, pp. 257, 268-273). Such choice was generally not possible in rural Delhi. Thus, Sita's attitudes regarding marriage, childbearing, and the injustice of what happened to Mara, the girl whose father raped and killed her, showed how different from the norm she was in her thinking. These points of view added to her inner conflict in attempting to cope with the current marriage system. The death of Mara occurred in 1955 before the deaths of her other friends, Taraka in 1956, and Rukmini in 1957. Sita's first surviving brother was born sometime around the death of Mara. These deaths disrupted Sita's peer group at a critical stage in her development. The blighting of her ambition to become a teacher due to the rape and death of Mara and the subsequent suicide

of Taraka, the girl with whom Sita most closely identified, topped by the birth of a surviving brother who usurped her place as only and favored child, resulted in a loss of self-esteem and cohesion of self. These events preceding Sita's marriage linked birth and death to marriage and mating and fixated her anxiety disorder (M. Tolpin, 1970, pp. 277-278; Wolf, Gedo, and Terman, 1972).

DREAMS

Toward the end of the next to last interview with Sita in 1958, she began to talk about being sleepy, sleeping, and dreaming. In this context she talked about her dreams. The dreams and parts related to the dreams have been italicized in the following direct quotation given by Sita without interruption. Our explanations are in brackets:

It's lonesome here. There's nobody with whom to talk except you. When I've finished work, I stitch clothes or just sleep. *I dream a lot. I don't remember much. But generally I dream that I'm passing through the village and all the boys are quarrelling with me. Then my mother-in-law wakes me up. I'm passing through the village going to fetch water or wash clothes. The boys are going to school or are bad boys of the village. I don't know their names. They try to molest me or take my hand. The boys are about 20 to 22.*

The day before yesterday my dadi [patrilineal grandmother] visited me; and I went to the bus stop with her. When I came back, I felt weak so one of the village boys made me sit on his cycle. Then some of the boys started cutting jokes with me so I got down from the cycle. Now I dream of this. The boys started teasing my husband because I had just come once or twice and they said, "You've started taking her on your cycle." So he told them that they shouldn't tease me or I'll be annoyed.

I also dream about my girl friends and classmates but I don't remember the dreams.

I don't like children making noise. In my home, I never allowed by brothers or sister [patrilineal cousin] to make much noise.

I didn't finish the *kamiz* I was sewing because the thread was gone and I have to wait for my mother-in-law to buy more for me. I can't go out of the house alone. I go with my mother-in-law. *When I took my dadi to the bus stop,*

all of the children [brothers and sisters of her husband] went with me. This was at K [a nearby village]. I felt tired and weak then, and met this boy over there [pointing to her husband sitting with his grandfather at a distance]. He goes to higher secondary school [there]. (At this point Sita covered her face as a village man passed.)

When you don't come to see me, it's difficult to pass the day. Then I feel lonesome, sad, and cry.

The italicized parts of the quotation from the interview with Sita are interpreted as one biographical dream, with interpolations due to her thought associations during the interview, and based on the context in which the dream was told and Sita's case history. Although the symbols and meanings extrapolated from the dream are derived from Freud, they are tempered by the context of North Indian village culture. In this connection, it is worth mentioning that the languages used in this region of North India (Hindi, Punjabi, and related dialects) are Indo-European languages, as are German and English, and that all of these languages share an ancient cultural tradition which influenced the early myths and beliefs of India, Greece, Rome, the Anglo-Saxons, much of the European continent, and all cultures with Indo-European languages today (Basham, 1954, pp. 28–38; Watkins, 1969; Hockett, 1973, pp. 301, 590–600; Eliade, 1976, pp. 187–199; Thapar, 1976, chap. 2; Littleton, 1977; 1982, chap. 9; Strutynski, 1977).

Although Freudian symbols derived from his interpretations of dreams cannot be employed literally, often they are sufficiently analogous, providing the interpreter has a knowledge of the Indo-European culture to which the symbols are to be applied. These symbols are useful in other cultural contexts, such as myths, stories, art forms, casual references in conversations, and even alternate mental states. For such interpretations, knowledge of the thought processes involved is necessary, such as condensation, distortion, fragmentation, joking, playing on words, doubling and multiplicity, displacement, reversal, allusion, and omission. (For the method of translating symbols in the context of rites of passage, see R. Freed and S. Freed, 1980, pp. 335–347.)

Freud (1978, p. 71) noted that:

A regularly formed dream stands . . . upon two legs, one of which is in contact with the main and current exciting cause, and the other with some momentous event in the years of childhood. The dream sets up a connection between these two factors—the event during childhood and the event of the present day—and it endeavors to re-shape the present on the model of the remote past. For the wish which creates the dream always springs from the period of childhood; and it is continually trying to summon childhood back into reality and to correct the present day by the measure of childhood.

Sita's biographical dream stands on three legs rather than two. It is an anxiety dream with the related themes of strangers, coitus, birth, and death. The psychoanalytical and cultural interpretations of the dream reflect both recent events (marriage, mating, and possession in 1958) and past events for two periods of Sita's life (1943–1954 and 1955–1957). The most recent events happened during Sita's first, second, and third visits to her marital village; the second or intermediate part of the dream refers to the period from 1955 to 1957 when Mara, Taraka, and Rukmini died. The earliest part of the dream refers to the events of early childhood which provide clues to Sita's later problems. Although the dream referents are brief, very little is needed to provide a biographical dream. The italicized elements in the quotation from Sita link the past and present together. The expression "passing through" ties all these events together with the themes in the dream (Freud, 1962, pp. 185–187; 1967, pp. 340–351, 382–385).

Background information from the interview in which the above quotation occurred supplements the analysis of the dream as do additional data from Sita's case history. Prior to recounting the dream, Sita described her physical and mental states saying she had become very inactive and slept a lot during the day. When she came to her marital village for the third time, she slept and had sexual relations with her husband for three or four nights and then experienced her possessions. Thereafter, she did not sleep with him for a period of about a fortnight during which time the curing sessions were held. The day Sita

accompanied her grandmother to the bus stop her husband asked if he could again sleep with her that night. She said, "No, I am too weak." During the night she awoke and found him in her bed. He told her that he was there only so that she would not be alone.

This reason, to some extent, was consistent with the village belief that one should not be alone. In 1958 villagers slept in the same room with other members of the family. One of our research assistants, an educated, urban woman, was also afraid to sleep in a room alone. "To be left alone for any length of time becomes stressful" to Indians (Surya, 1969, p. 389). Sita had been left to sleep alone in an unfinished building and a strange village for almost a fortnight except for her grandmother's visit. Although sleeping alone must have added to Sita's stress, the fact that she did so was an index of her degree of difference from many villagers and was due to her having long been an only child. Although she was lonely during the day, she feared sexual relations and so was ambivalent about being alone at night. Her ghost possession illness allowed her to avoid sexual relations with her husband and added to an earlier motivation for illness. However, when she was discussing her dream, she knew that she would resume sexual relations with her husband either that night or the next.

In the earlier part of the same interview Sita discussed her problems, provided additional information about her natal family, reiterated the details of her dowry (prestige items), and described her sewing machine with its lockable case which her father gave her. This case and machine were similar to a talisman which paved the way for Sita in her marriage, protected her from her fears, and maintained her self-esteem and identity. The Freudian analogy of a case representing a woman's genitals, and the key locking the case, the equivalent of protection from coitus and pregnancy, or oppositely the unlocking of the case and fulfillment of sexual desires, is well known (Freud, 1967, pp. 188, 389).

At this time, Sita was not sleeping well. She said that at night she was very hot and only cooled off in the early morning hours. Then she fell asleep and was awakened by her mother-in-law, a routine similar to her child-

hood when she was awakened by her mother or grandmother. As a result of her fears of what might happen to her at night, her sleep was disturbed. In the daytime, after finishing her allotted chores, she had nothing much to do as she had no thread to continue her sewing and had to wait for her mother-in-law to buy some. Thus, left alone she felt drowsy in contrast to her activity in her natal village before marriage. Disturbed sleep, restlessness, and dreams at night together with inactivity and sleepiness during the day contributed to alternate states of mind due to stimulus excitation and deprivation, and resulted in remembrance of things past and arousal of her fears regarding pregnancy and death in conflict with her little understood sexual excitation. These contrasting conditions together with a new way of life over which she had little control made it difficult for her to discharge her energy during the day. Her fear of encountering Taraka's ghost in the fields and around the well upset her normal physical routine for urination and defecation. Undischarged excitement and suppressed physical needs must have disturbed the functioning of Sita's physiological system (Fenichel, 1945, pp. 188-191; Freud, 1967, pp. 235-237).

The first of the themes in Sita's dream derives from her reference to the boys in the village whose names she did not know, in other words, strangers. In Sita's husband's village all the men and older boys were strangers to her just as she was to them. Sita's father-in-law (a stranger) had cautioned Sita about speaking or joking with any males (strangers) in the village and had instructed her to tell him if any man spoke to her or joked with her. Thus, when Sita met her husband at his school and his friends and classmates joked and teased her, she was embarrassed, afraid, and could not reply because they were strangers.

The reference to the boys trying to molest her or take her hand introduced the theme of coitus. It represented a fear instilled in girls about strange males trying to rape them and recalled Mara's experience and death. It accounts for Sita's later remarks that "I don't like boys and girls making noise. In my house, I never allowed my brothers and sister to

make much noise." These comments indicate that she was ashamed, startled, frustrated because she could not reply, and afraid in a situation over which she had no control. They showed the difficulty she was having adjusting to her new roles in her family and village of marriage. As a new bride, she had the lowest rank in the family pecking order and no authority over anyone. Furthermore, her caste ranking was quite low; and as a female, she ranked below all the male peers of her husband (his classmates and friends). Because her marital household was large with more males than females, it was a great deal noisier than her natal family, and there was nothing she could do about it. The same held for the teasing and joking remarks of the village boys and her husband's friends and classmates whenever she passed through the village. Despite the presence of all these people, she had no close or intimate friend and no one from her own lineage. She was not only alone but had little or no control over her life.

More explicitly one of the boys in her dream who tried to molest Sita and take her hand referred to her husband, the custom being that one did not refer to one's husband by name. He, too, was still a relative stranger and at the time of marriage a total stranger. Molesting and taking her hand referred to coitus with her husband for the word molesting implies sexual relations and holding "her" hand is a sexual reversal since the hand is a symbol of the male organ. Further, husbands and wives in the village did not hold hands in public or in front of anyone because physical contact and kissing were taken as a prelude to coitus. At this time Sita's daily life consisted of working in the house and fields when she was able to do so but as a new bride she was seen primarily as a sexual object. The constant visual review with side comments by males while passing through the village emphasized her position and added to her embarrassment (Freud, 1962, p. 163; 1967, pp. 362-363).

The sentence from the dream that "The boys are about 20 to 22," referred to strange adult males in the past and present. First, it referred to the ideal age at which Sita believed one should marry; second, to her husband,

who told Sita he was older than 17 or 18 years. Third, it referred to the males in Taraka's village, also strangers to Sita, with whom Sita and Taraka were involved. Last, the ages of 20-22 years applied to Sita's father when she was three to four years of age and had grown fond of this strange male who visited once a year, brought her presents, and gave her love and attention. Although her earliest remembrance of him probably was due to his displacing her in her mother's bed and the inexplicable activities she sensed or witnessed between him and her mother at night, the resentment or hate which she may first have had for him later turned to worship of a conquering hero. He was the only stranger in her early years who returned and did not forever disappear.

Sita's infant siblings, little strangers and threats to the love she received from her grandmother and mother, acted as strangely as did her mother and father in their sexual activities. Since small children are imitators, Sita probably imitated her parents by acting out the primal scene. Instead of her actions resulting in birth, her siblings died. Perhaps after the first sibling died, Sita continued to imitate the uncanny movements and sounds made by her parents and infant siblings confusing her actions with the births and deaths of each unwelcome little stranger. When Sita learned about female ghosts taking her siblings, she began to fear them and death. Her fear of female ghosts was intertwined with a fear of malevolent mother goddesses and became a composite female figure of ghosts, goddesses, and her own mother, whose sometimes contradictory behavior caused Sita to think of her mother as both good and bad. Based on these experiences and beliefs, Sita's excitement, guilt, and fear of punishment began a lifetime habituation to anxiety (Freud, 1967, pp. 287-289, 357-360).

When Sita accompanied her grandmother to the bus station in the next village, she said she felt tired and weak, signs of her diurnal restrictions, nocturnal activities, frustration, fears, and excitement. She then waited for her husband to finish his classes so he could ride her home on his cycle. She found herself in another strange situation when her husband's schoolmates (strangers) teased them about

riding the cycle together. This behavior showed greater familiarity than was customary in the village, although in the City of Delhi a wife might ride behind her husband on a cycle or motorcycle.

Because the boys knew that Ram Chandra and Sita had already mated, they teased them and joked about their riding the cycle. Traditionally in India the groom rides a mare to his wedding. Without knowledge of the Freudian interpretation, villagers were aware of the analogy of coitus to riding a mare. In 1958 grooms often substituted a cycle for a mare as was the case at Sita's wedding. The substitution of one symbol for another in the same context was easily made in the jokes of the village boys. The teasing and joking about riding the cycle aroused considerable shame in Sita, for people in whose presence one feels ashamed are often strangers (Kohut, 1972, p. 375; Levy, 1983, pp. 131, 133).

The uncomfortable emotion of shame probably brought to mind childhood situations when she was shamed beginning with her enculturation for modesty by her mother and grandmother. Boys and girls under two to three years of age generally wore only a shirt. The buttocks and genitals were visible so that individuals growing up in this society became aware quite early of the differences between males and females. Because of their sparse clothing, sexual display among small children went unnoticed by adults. However, mothers were adamant about modesty in girls as they grew older. At three to four years of age, poor low-caste girls began to wear panties. Later around six to eight years of age, they wore loose *silwar* trousers with a long shirt over them. Not until then were girls allowed to let their hair grow long; prior to these ages hair was cropped close to prevent lice and minimize problems of washing and grooming by mothers. At ages 10 to 12, all girls began to wear a scarf that covered the head but not the face. Mothers strictly enforced the wearing of clothes for girls, and they therefore learned to be modest. The final stage of modesty for Sita was her donning the headcloth and veil at the time of her wedding, indicating her status as a married woman and that she would soon mate with her husband. Modesty training for males was much more lenient than for girls, whose mothers regularly shamed them if they did not comply. In

a sense, there were four crackdowns for a girl with regard to modesty. The final one at marriage was the most difficult because it included the loss of freedom of movement (R. Freed and S. Freed, 1981, pp. 69–71).

Sita, who had no surviving siblings until 1955, had little experience with the teasing encountered among siblings in joint families. Neither had she witnessed much of the teasing and joking that was common at weddings. In her husband's village she was thrust willy-nilly into the teasing and joking situations attendant upon the newly married. Since the jokes alluded to sexual relations with her husband, she was ashamed and angry, which explains the statement that all the boys were quarreling with her. It implied just the opposite. It was she who wanted to quarrel with them but could not. This interpretation is reinforced by her husband's statement, "Don't tease her. She'll be annoyed." It indicated that Sita had a temper which she was trying to control among strangers. More significantly, it suggested that Sita, who had for long been the only child and center of affection in her natal family, was sufficiently narcissistic to be enraged by the lack of respect and teasing she received in her husband's village (Kohut, 1972, pp. 362–363, 366, 367–369, 372, 379; Terman, 1975, pp. 239, 253; R. Freed and S. Freed, 1981, p. 75).

The second time that Sita mentioned passing through the village, she said that she was going to fetch water or wash clothes and that the boys were going to school or were bad boys. She passed through *two* villages to take her grandmother to the bus stop. Passages through these villages recalled her natal and mother's brother's villages and happy as well as unhappy events in them as well as in her village of marriage since the villages in this region were relatively similar. All of the buildings clustered around a few intersecting narrow lanes. When strangers entered a village, they usually did so from the lane closest to the bus stop or railway station. Other lanes in the villages led to wells, fields, or neighboring villages. In Sita's childhood, she and her mother would have gone out the main lane to the bus stop to travel to her mother's brother's village just as she did with her grandmother from her marital village. When her *chacha*, her father's younger brother and favored uncle, returned from work via the

bus she ran to meet him, just as she did when her father was home. When her father took her to the City of Delhi, they went out the same way. Most of all these memories recalled her exile from home, to which she wanted to return (Freud, 1924, p. 391; 1962, pp. 185–186; 1967, pp. 279–280, 358–359; S. Freed and R. Freed, 1976, pp. 31–37, fig. 3 [map], p. 34).

The phrase “passing through the village” in association with going to the well to fetch water and wash clothes provides an index of Sita’s anxiety. Sita had to pass through the village to the well with her face veiled while the village boys and other older males commented on her appearance. She knew that they were aware that this was her third visit to her husband with all that a third visit implied regarding sexual activities. Since daughters-in-law had to fetch water twice a day from the well and periodically went there to wash clothes, she had to run this gamut of inspection regularly (Freud, 1967, pp. 435, 439 fn. 1).

Furthermore, passing through the village on the way to the well would be associated in Sita’s mind with what happened to her at *Gauna*, the time of her second visit and first mating, when she slipped, fell into the well, and was rescued by two men. As Sita passed through the narrow lanes with buildings on each side, the scene brought to mind the restraints on her as a wife and her nightly sexual activities. The similarity of the physical environment of her marital village to her natal and mother’s brother’s villages linked these activities with her earlier experiences and her guilt and fear about them. The rescue by two men combines two themes: birth and Sita’s love object, namely her father masked by her husband. It should be remembered that at this time Sita was 15, had recently attained menarche, was experiencing coitus, and was in the pubertal stage when sexual urges are strong and directed toward the male with whom she was most familiar, her father (Freud, 1967, pp. 118, 435–437, 439 fn. 2; 1962, pp. 344–345).

Dreams regarding water are indicative of birth. So too is a well. In this rural region one of the rituals in the birth rite of passage for a new mother was to go to the well 40 days after a child was born, leaving rice as an offering to the Mata (mother goddess) of the

well. The well symbolized a mother giving birth because of its round opening, and the water in it (Freud, 1962, p. 160; R. Freed and S. Freed, 1980, pp. 389–395).

Sita’s slipping and falling into the well, both at the time she fell and in the slight reference in the dream, were mixed up in her mind with her conflicting emotions regarding her sexual desires, which to Sita meant that coitus resulted in pregnancy and death. The memory of slipping recalled her sexual excitement, the fear she experienced during coitus, and earlier when witnessing her parents’ sexual activities and her own efforts at imitation in sexual play. In recounting her dreams, Sita described her physical condition and said she felt giddy, dizzy, and sleepy and heard sounds in her ears including “sleep, sleep.” It is probable that in her childhood, when she was awakened by the nocturnal sexual activities in the one-room hut, she interpreted the sounds and movements as something uncanny, most probably ghosts, and felt insecure. Her grandmother with whom she was sleeping then soothed her by saying “sleep, sleep.” In the context of sleeping with her husband and being awakened during the night and during the day when she had little to do, she was reminded of these past events and told herself to sleep to escape her thoughts, a form of self-hypnosis (Freud, 1924, pp. 393–395; 1967, pp. 252–253, 425–426, 435).

Although Sita provided no direct evidence of sexual play and masturbation in her interviews, data from Sita’s marital village and other parts of India show that both occur among children. Carstairs (1958, p. 72) in Deoli, Rajasthan, noted that children learned about sex from erotically stimulating each other at an early age. His informants agreed that most children masturbated and practiced heterosexual and homosexual play. We noticed in fieldwork that adults suppressed these activities if or when they noticed them, unless the child was under three years of age, in which case they ignored them. Since these activities seem to be universal, the damaging aspect of them may be related to the way in which parents respond to them (R. Freed and S. Freed, 1981, pp. 82, 96–102).

Passing through the village to the well brought back to Sita the village lore and gossip regarding wells and her own recent ex-

perience when she almost drowned or attempted suicide. These memories brought to mind the experiences of Mara and Taraka. Mara was thrown into a well after her father raped her and cut her throat. Sita said, "I also dream about my girl friends and classmates but I don't remember the dreams." This sentence indicates that the emotions, among them guilt, which the dream aroused were so upsetting that Sita repressed them. However, since they were said in the context of two preceding paragraphs of the quotation, which contained within them the themes of strangers, coitus, birth, and death and referred to the stories which Sita related about these girls, similar themes were present in her dreams about her girl friends. Village wells were places where the ghosts of females lurked who had either been drowned by their husbands and fathers or had committed suicide, as in the cases of Taraka and Mara. These ghosts were females who died without issue, before their time, and in troubled states of mind. Wells, therefore, were places where female ghosts could seize one and cause death. Thus, wells were places of death as well as of birth; and births, which resulted in deaths, came from mating with strangers.

The regular trips to the well under the stares of the village males reminded Sita of her activities with Taraka in her mother's brother's village when Taraka began flirting with a young man and then saw him at night. Although Sita said that no one else in the village misbehaved in this way, she seems to have protested too much since she also said, "I used to live like her. We lived in the same household and became like one" (i.e., Sita and Taraka), inferring that they carried on similar activities. How far Sita went in these relationships is suppositional, but the statements about passing through the village and the village boys molesting her and taking her hand applied as well to this earlier time, for "passing through" ties all the three legs of the dream together. If sexual play or coitus occurred between Sita and a young man in Taraka's village, Sita may have escaped the fate of Taraka because at that time she had not yet attained menarche. More consonant with Sita's anxieties about sexual relations is that she may have started these sexual adventures with Taraka but desisted because of Mara's sad fate. Whatever happened left Sita with

additional guilt and anxiety, for several reasons: fear that her character might be damaged; repression of her sexual desires; regression from adaptation to a male other than her father; and fixation of her anxiety disorder. Back of the dreams of her girl friends was the underlying and unrecognized wish that she would have her father as her lover. Whether this wish restrained her earlier activities or led to them is a moot question since both types of sexual relations were tabued, i.e., with her father and with a young male before marriage. The sexual reversal of "taking her hand" might also imply that Sita wished that whatever happened to Taraka and herself might have been otherwise, or that if Mara had not been raped by the male schoolteacher, then Sita might have become a teacher and need not have been married at age 15. Another interpretation is that the hand may indicate Sita's wish to be a male, not surprising considering the position of a wife in India (Freud, 1924, pp. 387-389, 401; 1962, pp. 135-137; 1967, pp. 363, fn. 1, 394; M. Tolpin, 1970).

Passing through the village and going to the bus stop so that Sita's grandmother could return home represented a journey. A journey is symbolic of death (Freud, 1962, p. 169). This symbol was recurrent throughout Sita's life, for her father regularly went away for long periods each year; then her infant siblings went away permanently. Each time her father or an infant sibling disappeared from the scene, Sita must have wondered whether they would return. Then Sita's three girl friends in succession went away. Each of these deaths was linked with mating. Since Sita's grandmother was at the age when death was considered timely, Sita could also expect that her grandmother might die before she again saw her. These thoughts were associated in Sita's mind with her chain of anxiety based on strangers, coitus, birth, and death. This history of continuous deaths left Sita with the fear that all those who were near and dear to her would die, that she would be left alone, that if she bore children her infants would die, and that she, too, would die before her time and become a ghost (Fenichel, 1945, pp. 92-94, 99, 208-209).

It was not possible for Sita to put together her subconscious fears about coitus, birth, death, and strangers and realize that they con-

flicted with her repressed desires, but these themes were reflected in her composite, biographical dream. In this respect she was like two people with opposite wishes for "... a dreamer in his relation to his dream wishes can only be compared to an amalgamation of two separate people who are linked by some important common element" (Freud, 1967, p. 620).

In sum, the biographical dream of Sita was a reiteration of present and past events in her life. These events showed that her sexual urges were in conflict with her earlier experiences regarding strangers, coitus, birth, and death. Because of the death of her infant siblings, Sita feared that if she bore children they, too, would die and that she would be responsible for their deaths. This fear stemmed from her own guilt when her infant siblings died, her ghost beliefs, and her mother's guilt regarding the infants' deaths. Sita related it to the belief that jealousy of her siblings, wishes for them to go away, and her later sexual desires caused the deaths of her siblings and friends. Her guilt was reinforced by the belief within the culture that females had stronger sexual passions than men and were to be feared. It was

one of the reasons given for marrying them before menarche (Carstairs, 1958, p. 73; J. Gray, 1982, pp. 234-236).

After the three interviews with Sita, we saw her only once more in 1958 while she was working in the fields with her mother-in-law. At the end of September 1958, she returned to her natal village for a long visit. Thereafter whenever her possessions were severe in her husband's village, she again visited her natal home. Thus a habituation to possessions may have been fostered as a way out of her stressful and painful conditions (P. Tolpin, 1974, pp. 152-154, 157, 159, 174). The visits back and forth continued for three years, during which time she did not become pregnant, thus postponing the time when she would bear a child, an event she feared. These possessions became an established pattern of behavior in her central nervous system which allowed her to escape from a situation with which she otherwise could not cope. The visits to her natal village achieved her desire for her father to take care of her, her wish to be with him in her natal village, and perpetuated the early childhood motivation for illness (West, 1975, p. 300).

INTERVENING YEARS (1959-1978)

CHANGE

During the period from 1959 to 1977, the villages of the Union Territory of Delhi underwent considerable change. The following information on change was obtained from members of Sita's caste and from other villagers. The major changes were in technology, economics, urban employment, and education. The introduction of tractors, electricity, tubewells for irrigation, improved seeds, chemical fertilizers, and the consolidation of landholdings that in the 1950s were inconveniently fragmented contributed to more productive methods of farming. Changes in crops, primarily the more intensive cultivation of vegetables, greatly increased the profitability of agriculture. Some members of Sita's caste, who in 1958-1959 still worked as agricultural laborers for one landowner, had since been able to rent land, farm it, and become independent agricultural

entrepreneurs. They stressed that since they no longer worked for one landowner, they were not subject to pressure from landowners. This new freedom was also partly due to changes in the system of moneylending which formerly obligated a landless debtor to work for his creditor. If they had time, both men and women worked for a variety of landowners at peak agricultural periods. Wages for seasonal work were comparatively good. Many women of Sita's caste worked in the fields even more than formerly because their husbands and sons had urban jobs.

The educational level had advanced greatly for both males and females in all castes. Many of the younger people had attended the village elementary school, study at the higher secondary level (high school) was commonplace, and a number of individuals had studied at the college level or in technical schools. Educated persons were better able to compete

for jobs in Delhi and there was an increase in the number of urban workers. Education was helpful in farm management, for many people read a daily newspaper to check market prices and studied farm manuals. Education was also useful in obtaining government loans for agricultural needs and for understanding banking and savings accounts. In 1958, only a few wealthy families had savings accounts, but in 1977–1978, members of all communities had them. In fact, a bank opened in a neighboring village in 1978. A number of older people noted that education had contributed to better behavior on the part of their offspring. They said that sons were more respectful of their parents and cooperated better with their brothers. They also commented that children learned better manners in schools.

Personal hygiene and village sanitation had improved. Due to the installation of hand-pumps within a courtyard or near a dwelling, people could bathe more conveniently every day. More people could afford to use soap. Small enclosures in courtyards had been built so that women could stoop down within them and bathe in relative privacy. Men, who were not required to display as much modesty, bathed at the handpumps. The villages were cleaner because the government had provided paved lanes with a gutter at one side to drain waste water. The streets were cleaned regularly by women of the Chuhra Sweeper caste who were employed by the government.

Urban contacts in the form of jobs in nearby cities and towns, attending cinemas, and visiting relatives due to improved transportation and increased income resulted in changes in the styles of clothing and hair, especially for men. A number of women in Sita's caste had their own sewing machines and sewed their own and their children's clothing. As a result, women no longer wore the *ghaghri* (a long, full, many-colored skirt), but more often wore a *silwar* suit consisting of full pajama-like pants and a long-tailed shirt or a dresslike garment with slits at side to knees, both worn over the pants). The women wore more closely fitted garments and many wore the sari on special occasions in the village or when they visited the city. Women were allowed to go together to shop in the cities or towns. Married women in the

childbearing years still tended to cover their head and the lower portion of the face in and out of the village, but the veils were skimpier and less opaque.

Beginning at the end of the 1950s, the government aided low castes by helping them to build brick houses so that almost every house in 1978 was of brick and many had two stories. The government issued ration cards with which villagers could obtain grain and other staples at stabilized prices. It also subsidized education for low castes and provided more schools. These schools were for everyone as were free medical treatments and services from hospitals and clinics, many of them dispersed throughout the region and easier to reach than formerly. People were living longer due primarily to the control of contagious diseases and less poverty which resulted in more and a greater variety of food, and consequently better nutrition. However, this improvement in health was offset by a considerable increase in malaria and typhoid. From the fall of 1977 to April 1978, the following stressful events may have contributed to an epidemic of ghost possession in March and April: an epidemic of typhoid in the fall that accompanied the monsoon; two hailstorms and a nearby tornado in the spring which destroyed crops; an epidemic of malaria with the onset of hot weather in March and April, coupled with a number of weddings (W. Peters, 1975).

The village was served by the traditional midwife and a nurse-midwife trained by the government who lived in a nearby village. The latter also disseminated information about family planning and arranged for sterilizations and abortions. A number of men and women of Sita's caste community had been sterilized. People spoke openly about sterilization and other forms of family planning, virtually unheard of in 1958–1959. The birth of a child was registered and the government midwife saw that the child was inoculated against tuberculosis and a number of contagious childhood diseases. Most low-caste people regularly registered births because a family then obtained an additional ration card.

There had recently been a reallocation of land in the village habitation site under the terms of which low-caste families received

small plots of land that they used principally for storing dung. In addition, because many houses had been enlarged by the addition of a second story, some low-caste families were able to have a room or a separate building for use as a men's sitting room (*baithak*). Some of these sitting rooms were decorated with religious pictures and a few had altars with electric lighting. The villagers had many radios, one telephone (which seldom functioned), and three television sets, one of which was in a low-caste household. Saturday evenings, many village children gathered there to see a film.

Electricity, which had come to the village in 1960, was in many of the dwellings. As a result, people had appliances such as irons for pressing clothes, electric hot-plates used principally for preparing tea, and ceiling fans. A few people had electrically powered fodder cutters and other such equipment. The rate for electricity was relatively low so that most households could afford it. Street lights made it possible to walk around the village more easily at night. However, electricity was not always available during the day and there were frequent power failures.

Some members of Sita's caste pointed to current problems, among them the job shortage and the fact that many jobs were still obtained through access to someone in an influential position and through bribery. Stealing in general, and in particular of cattle and tubewell motors, was a serious problem. One young man in the village had helped to rob a post office and had a reputation for pilfering in houses when doors were left unlocked. "Goondaism," a kind of petty gangsterism among unemployed youths, was also a problem. Dowries were still provided in a marriage, regardless of the 1961 law forbidding them, and the complaints on this score still were heard, more as a matter of disguised boasting.

FAMILY MEMBERS

How did these changes affect Sita and the members of her marital family? What other changes had occurred in this family? In 1958, the joint family consisted of 16 people; in 1977, there were 21 members. The eldest son had recently separated from his father's fam-

ily. Since there were eight people in his nuclear family, the joint family before the separation had consisted of 29 persons. The three daughters had been married for a number of years, had children, and lived in their husbands' villages.

Most outstanding in this family line were the changes regarding education and urban employment. In 1958, the men in the two older generations, the grandfather and his son, who was the acting family head in 1958 since his father was old and rather feeble, were non-literate. All the females except Sita were non-literate. The four oldest sons of the acting head were attending school, but none of the daughters or daughters-in-law. In 1977, the acting family head had become the family head, his father having died sometime previously. His two younger sons were attending the University of Delhi, and all the school-age children except one girl were going to school. This one girl, 14 years of age, the daughter of the eldest son, had completed the fifth grade; her parents did not plan to have her continue in school but rather to arrange her marriage soon. The pattern of educating the sons first and the daughters second was still characteristic of this region. This family was more progressive in the number of children educated and the degree of education than the average family of Sita's caste (R. Freed and S. Freed, 1981, pp. 119-123, 134-136).

In 1958, none of the males had employment outside the village, except for a younger brother of the acting head who was employed in a flour mill near the City of Delhi. In 1977, the four oldest sons of the family head worked in the City of Delhi, commuting by bus daily, each earning Rs. 400 per month.

In addition to the income from urban salaries, the head of the family regularly rented plots of land for growing tomatoes. He, his sons who were still in school, his daughters-in-law, and the older children in the household worked in the fields helping with cultivation and harvesting. Some of the women worked for landowners of both their own and nearby villages at peak harvest periods. Thus, the family's economic condition had improved considerably.

The age at marriage for males and females had risen. For example, Sita was planning to

marry her 16-year-old daughter within a year at age 17; two of her sisters-in-law had married later than 15 years of age and, at 18 and 20, still had not borne children although one was pregnant. Their husbands, attending college, were 24 and 22, respectively. Sita and her older sister-in-law had been sterilized as part of the Family Planning Programme of the Government of India.

Living conditions were definitely better in 1977. Starting in 1958, the family gradually completed a brick dwelling with five ground-floor and one upper-story rooms, each with a separate entrance, providing apartments for the nuclear families. There was a separate men's house, and adequate additional space for the cattle and for storing fodder. The dwelling was located around a large courtyard with its own handpump and a small bathing stall for the females. By village standards, Sita's family had a fair amount of space with separate rooms for each nuclear family. The family had installed electricity, an index of their comfortable economic condition, as not everyone in the village had done so.

Sita's father-in-law, in an interview on the changes that had taken place in the village from 1958 to 1978, said that his family and caste community had benefited from the changes in land laws, from governmental educational subsidies for scheduled castes, and from enhanced job opportunities. They were no longer subject to high-caste landowners, nor did they fear starvation as they had in earlier times.

FAMILY INTERVIEW

Sita was absent from the village during the fall and winter of 1977–1978. It was not until mid-March that we met her in the courtyard outside her dwelling where she was washing clothes at the handpump. We wanted to make an appointment to interview her but she said that she had been ill, had fits (*dauras*), and would not be able to be interviewed for another week or two. Then she abruptly went into the house.

Because we were in the vicinity, we went to see her father-in-law in the *baithak*, men's sitting room, located in an adjacent building, to ask about his treatment of sprains. Pre-

viously while we were interviewing the village midwife, Sita's father-in-law was treating her for a sprained wrist. We planned to inquire about his method of treating sprains as part of our research on village curing practices and at the same time gain rapport for further discussion about Sita and other family members. Most of this interview is given in the order recorded to convey the attitudes, beliefs, and thinking of the family members regarding the family as a unit and the effects of illness in the family, Sita's illnesses in particular.

When we entered the men's house, it was rather dark and was furnished with a number of string cots. Sita's father-in-law was sitting on one cot, and one of his younger sons, Surinder, who was six years old in 1958, was asleep on another cot, but when the doors of the *baithak* were opened, Surinder awoke. Sita's mother-in-law, having told us that her husband was in the men's sitting room, came in after us. Throughout the interview she stood near her husband's cot, in accordance with the conservative custom that married women did not sit when their husbands were present.

We began by asking Sita's father-in-law how he learned to heal sprains. He replied that he had learned from a man, who in turn had learned from someone else. He then went on to explain that there are veins running from the fingertips to the wrists. When a wrist is dislocated, he can set it right by pulling the fingers in the right direction. Until he sets the wrist, it is swollen and painful. Once set, the swelling and pain go away. He said that he did not charge for this work, stating that if he could do good for others, he would. He added that he also set sprains of feet, ankles, knees, shoulders, collar bones and any and all dislocations. To do so he said that he makes a pack of gur (brown sugar) and *haldi* (turmeric powder) for the area of the sprain or dislocation which draws out the pain, swelling, and accumulated blood. To clarify this procedure, he added that if someone has an internal injury and *haldi* is mixed with milk and then drunk, it draws off the pain. He further stated that *haldi* makes the blood circulate and will not let it accumulate in one place. The cool gur provides warmth. When

the gur and *haldi* are mixed and applied to the sprain, they provide warmth and stimulate the blood so that it flows freely and reduces the swelling. He provides this remedy six times. He further said, "I have no power in my hands but can feel the blood vessels. If they are out of place, then there's a swelling and I return the vessels to their proper location. I do not treat broken bones. If a person has a broken bone, I immediately tell him that I cannot do this work. When I twist a finger, there is a sound by which I know a bone is broken." He added, "There are some bonesetters in Delhi who set bones right and massage and bandage them, but after healing there is a curve in the bone. If it is a serious break, then one should go to the hospital. If the bone is badly broken, usually the man says, 'This is out of my control. You should go to the hospital.'"

From this description of the father-in-law's interest in curing and having seen him practice his skill on the village midwife, it was apparent that he was a gentle human being who believed that by providing his free curing services he was doing good deeds and gaining merit from right action or good karma. We then turned to family matters and gradually to the subject of Sita.

The father-in-law, as the head of the family, took precedence in answering questions. First, he recounted some of the events that had occurred since our early fieldwork, commenting on the employment of his sons and the better economic condition of his family and caste. He explained why Surinder was not at work: "Surinder is employed in the Delhi Municipal Corporation but is recovering from a liver illness, but it is not *piliya* [jaundice]. He went to a clinic in a nearby town because the Delhi Municipal Corporation provides health services there for its employees. Before going there, he was treated by a hakim for 15 days but got no relief and his condition grew worse so some people advised me to have him X-rayed at this clinic. He went there for the X-ray and also his spit was examined. After eight days, we received a report and the doctors prescribed 30 injections of streptomycin and 30 tablets of isoniazid, one each for 30 days. He has now taken them for 15 days. He has had a lot of relief,

coughed a lot, but now that has gone away. They did not admit him to the clinic. We give a village man, Krishna, the Nai Barber, eight annas and he comes here every evening and gives the shot. The clinic provides the medicine. It is a great help because before the treatment he could not even walk. Now he can get up, but cannot go to work yet. After 30 treatments the clinic will check him again. Because he could not work or get out of bed, he took leave from his job. In the past 15 days he has had so much relief that now he gets up and takes care of himself. The treatment of the hakim was useless. After eating Surinder used to vomit outside. This clinic is the only one close by and it is famous." (The facility is a well-known tuberculosis clinic but everyone in the family avoided identifying it as such.)

From discussing his son's illness, the father-in-law then went on to cover the health of the entire family, stating that for the last month there had been no other illnesses, no typhoid, malaria, or pneumonia, diseases which were then prevalent in the village. Then he said, "Sita is also all right although previously she was in a bad condition. But we had her X-rayed and will get a report in about a week. She gets fits, vomits, and blood comes out of her mouth. She was treated by a hakim who said an insect bit her foot many years ago and that affected her heart. Since we have to pay the hakim Rs. 8 a week and Rs. 5 for transportation and she has had no relief, we took her to the clinic. The times are costly so how can we afford to pay Rs. 13 a week when we can go to the clinic, which costs us nothing? We can go by bike or train."

When we asked why they had not gone to the clinic previously, the father-in-law replied, "It all depends on time. Until the right time comes, one becomes diverted and goes from place to place."

Surinder, who by this time was fully awake, offered an additional reason, "Earlier we took Sita to a hospital in the City of Delhi where she had three operations. There was something wrong with her stomach and she was operated on three times there. She had a ball in her stomach which grew and caused the fits. When she had the fits she made a noise like a railway engine. At the operation, they

took a small ball-like thing out of her stomach. She has been having fits for the past 20 years." While Surinder described Sita's operations, symptoms, and behavior, Sita's mother-in-law silently mimicked her fits.

In response to the question as to whether Sita's fits were similar to the ghost possessions which transpired in the months following her wedding, Surinder answered,

Yes, they are the same as before. We've wasted a lot of money on her illness and now with X-ray we'll know what to do about it. When my sister-in-law sits and worries about something, she gets fits. Her hands twist and she shouts so loudly that the whole village hears her. Then for one to two hours she lies dead and there's no breath in her. It was like this from the beginning. She had this before marriage and when a little girl. I have been seeing her do this for the past 15 years. We are six brothers in this family, and together with our wives and sisters, all of us have looked after her and watched so she does not have a fit. When she has a fit, she jumps out of bed and falls down. Three to four people have to hold her down and press the veins in her stomach to provide some relief. When she is ill, so much power enters her body that she cannot be controlled by four men. All of the men in the family keep alert so she doesn't have a fit.

Addressing the father-in-law, we commented that Sita looked intelligent and queried whether she may have had an accident and injured her head. Her father-in-law asserted, pointing to his head, "What is written in one's fortune can't be changed." As an afterthought, he added, "She had herself operated on for family planning [sterilized]. She has three sons and two daughters. All of them are healthy."

In an attempt to find out whether Sita's fits were related to any periodic events or causes such as physiological rhythms, menstruation, or cyclical or abrupt changes in the weather, a question was phrased in terms of whether Sita's fits had been affected by recent frosts and a tornado, or any monthly or seasonal changes (Halberg, 1969, pp. 675-677; Benson, 1971, pp. 709-710; Planalp, 1971, pp. 371-372). Sita's father-in-law commented accordingly:

Every 20 days to one month when new blood is made in her body the fit affects her, and then

it dries up. This is not necessarily once a month but when she regains her strength. Sometimes she'll be all right for three to five months; sometimes there is a seasonal effect, but I can't tell which for sure. But there's some air which touches her and then she has this disease when there's a cold wind and some rain has fallen. When we had the two recent hailstorms [one of which was associated with a tornado, striking some miles away near the University of Delhi], then she was affected. We immediately got a doctor from a nearby village, who took Rs. 15. He's a fair doctor, so-so. He told us that he was not capable of curing her but gave her a shot which kept the condition from worsening. The shot quieted her. She was unconscious three hours, and then she was all right. The doctor said, "I can't cure her but can provide you with enough time to get her to a hospital."

Reverting to Sita's history of illness, her father-in-law reiterated, "She has been operated on three times and now is afraid to go to a hospital for fear she will be operated on again."

We raised the question of whether it might not be possible to treat her with medicine rather than by another operation, and the father-in-law's response was, "That is why we had her X-rayed. There are many like Sita in the village. For example, Gopal Singh takes tablets and holds a job. His fits are not as frequent as Sita's. They come once or twice a year, and then he becomes unconscious. When he was about 15 years old, these fits started. I don't know what happens to young people at this age that causes fits."

Asked whether Sita's fits and ghost possessions might be due to age, a bad fall, or inheritance, the father-in-law answered, "It's not inheritance because Gopal Singh's parents never had fits. Probably his fits were due to falling down, that or a high fever during which time he was subject to air which causes this mental state."

We asked if Sita ever had a severe fever in childhood and he answered, "I don't know. She comes from a good family, but no one will admit that their child has some damage or fits."

Using the Ayurvedic concept of homeostasis, we asked whether Sita might not have some difficulty due to *vayu*, *pitt*, or *koff* being excessive or too little in her system, which

could be taken care of by medicine. He replied,

I'm trying for this. I have spent a lot of money to get her relief. I have spent the money and gone from one person after another to obtain relief, spending as much as Rs. 200 to 250 a day. Sometimes we have had to call for a taxi both ways when she was taken by these fits, only to hear when we got her to a *vaid* or a bhagat that she was all right. Then we would bring her back and she would have an attack again. I can't say that we didn't take care of her properly, but the treatments have had no effect on her body.

As is often the case during interviews, a man from across the lane came in at this point and started a conversation about arranging marriages because his son was to be married shortly. Both he and the father-in-law exchanged experiences about arranging marriages and the recent changes in marriage rituals. As a result, this interview broke up.

Additional information obtained during the course of the interview and duplicated in the census revealed that although Sita had five living children, her second child, a daughter, died at the age of three years. All Sita's children were attending school and doing well. The father-in-law stressed that Sita had herself sterilized, and the mother-in-law said she did not suffer from it afterward.

EXPLANATION OF INTERVIEW

Explanation of a number of points is essential for understanding this interview as well as for comparison with Sita's interview at the beginning of April 1978.

First, the reference to Surinder's illness as being due to the liver but not *piliya* requires explanation. *Piliya* was used in the village to refer to the yellowing of the eyeballs and skin due to hepatitis. Hepatitis from contaminated water and food was endemic in the region. Its treatment differs from that for tuberculosis. In humoral theory the liver-spleen, originally regarded as one organ, was often believed to be the seat of all disturbances of bile (*pitta*) in the body, thus affecting the digestion. It is possible that Surinder had tuberculosis of the stomach, intestine, or other internal organs but more probably pulmonary tuberculosis. The treatment for tuberculosis involves the drugs he was taking (Lyght

et al., 1956, pp. 652-655, 1069-1071, 1516-1538, Kutumbiah, 1969, p. 43; Davey and Wilson, 1971, pp. 108-110). The bases of diagnosis were that he had been X-rayed, his sputum was examined, and as a result the course of treatment consisted of streptomycin injections and taking isoniazid tablets for 30 days before returning to the tuberculosis clinic. He had a cough which had recently stopped. Surinder slept separately from the rest of the family and cleaned his own eating utensils. Further, the clinic was well known for specializing in tuberculosis and was separate from the rest of the hospital.

Tuberculosis, in developing countries such as India, is now treated as described above rather than by confining the patient to a hospital. The incidence of tuberculosis has increased in India since 1958. During our 1977-1978 field trip the government regularly passed out printed information in the villages on the prevention and treatment of tuberculosis. Villagers feared it and did not understand it. A number of villagers had tuberculosis, and two women died from it during the fieldwork. Although no villagers admitted that they had tuberculosis, almost everyone with whom we discussed health problems could name some or all of the people in the village suffering from it. In one well-off family, two sons, two wives, and one daughter were known to have it. One of the sons very carefully kept small children away from himself. He showed us the medicines he was taking, namely streptomycin and isoniazid, the nearest approach to admitting he had tuberculosis (Lyght et al., 1956, p. 1532; Davey and Wilson, 1971, chap. XI; Gazetteer Unit, Delhi Administration, 1976, pp. 864-866).

Sita's father-in-law was obviously distressed about his son's illness, its cost, salary loss, and the continuing expense and worry caused by Sita's illness. Although Sita had gone to hospitals a number of times, she was usually admitted through her father because of his military service. Sita's father-in-law, until Surinder's illness, had been prone to follow traditional customs regarding illness, such as consulting exorcists and Ayurvedic *vaid*s (physicians). When he found out that the treatment at the clinic was not only better but less costly in terms of time and carfare

and his son began to improve, he decided to continue to use the health service. It was available to all members of the family since four sons were employed by government corporations which provided health benefits. That the clinic was closer and took less time to reach than facilities in the City of Delhi were factors in its favor.

Sita's father-in-law, after discussing Surinder's illness and treatment, mentioned that Sita had symptoms similar to Surinder's—vomiting and blood coming from her mouth—except for her fits. Because of the good results with Surinder's treatment, the family members took Sita to the clinic to be X-rayed, the inference being that she, too, might have tuberculosis and be curable. The statements indicate lack of knowledge regarding X-rays, tuberculosis, and fits, but a faith in a remedy that works and a groping for a solution to Sita's problems. They also suggest that the family may have blamed Surinder's illness on Sita due to the mix of beliefs about ghosts, humoral theories, and contagious diseases, the latter being little understood, especially since there was a belief in the village that tuberculosis derived from and was passed on by the women in a household.

The interview disclosed that because of Surinder's illness and Sita's recurrent fits and treatment, an ongoing strain in family relations had contributed to the eldest son with his wife and children separating from the joint family. Surinder from early childhood had experienced stress as a result of Sita's possessions, fits, and other illnesses. These psychological stressors possibly made him a more likely victim of tuberculosis and may also have aggravated this illness (Day, 1951, pp. 1026–1027).

Surinder's comments about Sita were not entirely accurate, for he said that he had witnessed her fits for 20 years, then later said 15. He was lumping fits and ghost possessions together, owing to beliefs stemming from the Atharva-Veda and Ayurvedic medicine, as indicated under traditional usages for indigenous India. In 1958 he was six years old and three years later, when Sita's possessions became fits, he may not have distinguished between them. His later statement of 15 years is closer to the time Sita changed from possessions to fits after the birth of her first child.

This family interview revealed that the tol-

erance for Sita's condition was growing thin. Waxler (1977) has pointed out that the curing sessions for illnesses, labeled possession, which occur at the time of marriage in Sri Lanka, are a means of integrating the two kin groups in a marriage. If, however, the possessions continue and grow worse over a period of years, then the relationships between the groups are endangered. Had Sita's father not provided a good portion of the funds and access to hospitals for her treatment, it is entirely possible that her father-in-law and husband might long ago have returned her permanently to her father. So doing was not unusual so that the attempts to help Sita throughout the years spoke well for her in-laws, who were gentle and kindly people.

The influence of eclectic beliefs regarding health and illness was pervasive throughout the interview. Pressing the veins in Sita's stomach when she had a fit, having a high fever and then being affected by air, cold winds, and hailstorms have their origins in Ayurvedic medical theory (Kutumbiah, 1969, p. 162; Planalp, 1971, pp. 19–25; R. Freed and S. Freed, 1979, pp. 330–331). The reference to what is written on one's skull as one's fate was pointed out earlier in the celebration of Mother Sixth when Bemata visits a newborn child and writes its future on its skull. We heard it a number of times among members of Sita's caste during both field trips. The belief is related to karma (action) and rebirth, both Hindu concepts, and kismet (fate), a Muslim concept. The hakim's diagnosis that Sita's disease was caused by an insect's bite is not farfetched, for convulsions may occasionally be due to venomous bites as well as many other causes (Lyght et al., 1956, p. 1173). Storms and other climatic disturbances as well as the stressful climate of North India would in Ayurvedic medical theory constitute changes in wind or air affecting the body. From the point of view of stress and anxiety, all these factors could have contributed to Sita's fits, which Surinder recognized as brought on by worries and pain (Planalp, 1971, pp. xii, 9–15).

In answering the question pertaining to climatic and other causes affecting Sita, her father-in-law stated, "Every 20 days to one month when new blood is made in her body the fit affects her When we had the two hailstorms, then she was affected." He was, thus, establishing a connection between Sita's

fits and menstruation, although he worded his statements euphemistically and was unable to point to a clear pattern. He tied the recurrent fits in with a period of time for regaining her strength after a fit. The more probable interpretation would be that prior to the onset of menses Sita was more vulnerable to fits than at other times, but the fits depended on a build-up of physical pain, anxiety, and tension, some of which could have been brought on by the two hailstorms and a nearby tornado which injured the crops. Recent data on the premenstrual syndrome reveal that some women behave violently, so it is possible that Sita was subject to premenstrual tension, which is associated with psychiatric illnesses, crime, and deviant behavior. Her only outlet due to individual and cultural conditioning may have been fits (Dalton, 1959, 1960, 1961, 1968; Benson, 1971, pp. 709–710).

More than anything else this interview reveals how little the average villager knew about the causes of sickness, especially contagious diseases such as tuberculosis, and psychological disturbances. It also shows that although Sita's in-laws had been very supportive of Sita for many years their patience was wearing thin. The separation of the eldest son's nuclear family from the father was partly due to Sita's continual illnesses. Surinder's illness was an additional factor. When a son separated from his father, it was usually blamed on a daughter-in-law. In this case, the scapegoat would be Sita. In view of the poor understanding of contagious diseases or mental disorders, it is conceivable that subconsciously the family members believed that Sita was the cause of Surinder's illness. Shifting family and kinship relations indicate that the support received by Sita and her marital family from Sita's father might change in the future. All of these possibilities showed a reduction in tolerance for Sita's illnesses.

SITA'S INTERVIEW, 1978

Sita set a time for an interview some days after she expected to receive the report on her X-ray. It was arranged for the morning when her children had left for school and she had completed her household chores. We met in the courtyard of the family dwelling, and Sita led us into an immaculately clean room. With the door closed, there was complete privacy

for the session. The interview ran about four hours with one interruption when Sita's two youngest sons returned from school.

Sita set the tone of the interview with her introductory remarks. Recalling our interviews in 1958, Sita mentioned seeing the ghost in the room in which we were sitting. At that time she said she hung bedsheets in the doorway to keep from seeing the ghost. She continued, "I had just been married and at my third coming a ghost disturbed me. Then I was sick for three years because of the ghost, but I've been sick for the last 20 years. Before, I used to be fair and strong, but now I am very weak. I have been to all kinds of doctors and *vaid*s and have been taking medicine from a *vaid* for the past six months but with no effect." Then referring to her medical report from the clinic, Sita continued, "I have been so sick that I don't feel like eating anything. I was thinking that my sickness was TB, but it is not. It is something wrong with my kidneys and a wound in my stomach. I was sterilized six years ago. Then for two years there was nothing wrong, but the past year I have had trouble with my stomach." These comments indicate that she believed the ghost started all her troubles, that she had great anxiety about tuberculosis, and that she linked her stomach complaints with sterilization, the "wound" in her stomach and her kidneys.

This report of the 1978 interview has been organized by the major subjects covered but not in the order that Sita discussed them since there was no specific order. The subjects usually came up in association with other topics. Occasionally she was asked questions and sometimes she avoided them or answered them indirectly. A great portion of the interview was centered on Sita's pregnancies, operations, sterilization, fits, and possessions. Taraka still weighed on her mind, but she never mentioned Mara or Rukmini. She avoided the subject of death and it was not until we questioned her about visiting her parents that she revealed the deaths of her 14-year-old brother in 1969, her mother in 1970, and her infant siblings in her childhood.²⁷

²⁷ Although it was often difficult to ascertain exact ages and dates of birth and death, Sita was more accurate about such matters than the average villager. For example, she was quite precise about the birth of her son

Two themes were prominent in the interview. The first was that Sita's stomach had not been properly cleaned after the birth of her first child and thereafter had caused her trouble. The word stomach was used many times during the interview, covering primarily the uterus and those parts of the body related to childbearing and pregnancy. This usage is similar to one in Ayurvedic medicine, in which the word "yoni" includes the uterus, vagina, and vulva (Kutumbiah, 1969, p. 181). The second theme was that Taraka's ghost had possessed Taraka's mother and that Sita in turn had been infected by the ghost through contact with Taraka's mother. Sita believed that this infection persisted. In other words, she had never been able to rid herself of Taraka's ghost, and she blamed her 20 years of sickness on the ghost. However, when Sita was specifically asked whether she linked her physical complaints to her possessions and fits, she answered, "No, the stomach trouble is not connected with the ghost possessions or fits."

PERSONA AND PSYCHE

Sita's appearance was characteristic of the way in which she thought of herself and the way in which she chose to present herself. When we first arranged the interview she was dressed in everyday work clothing and left us hurriedly. For this interview she was dressed in a well-draped, excellent urban-style sari. Her hair was neatly parted in the middle, oiled, and carefully braided. From an immature teen-ager, she had developed into a slim, handsome woman. Her costume and the room were in keeping with her desire to show that she was in control of her surroundings, to maintain her prestige and self-esteem,

and to present herself as well-behaved and well-dressed as any high-caste urban woman. These traits had persisted from 1958, for even as a young girl Sita was careful of her appearance, showed considerable poise, and to some extent dramatized herself. These characteristics were fostered by her participation in dramatics in school, going to the cinema, and the encouragement received from her parents and grandparents as an only daughter and for long an only child. Her presentation of self was not usual among village women.

The subjects Sita discussed indicated that she possessed an alert mind, good memory, and was able to provide accurate information regarding her marital and natal families. She talked about changes that had come about during her lifetime, especially the status and education of females, which might have made her life somewhat easier had they taken place when she was a young girl. Items of pride and prestige were the number of educated people in her marital family and the fact that her sole surviving brother had become a teacher. She referred to plans that she and her husband had for the education and welfare of her children and seems to have been the prime mover in the push for education and good jobs in her marital family, thus projecting her own frustrated ambitions.

Sita emphasized that there was nothing wrong with her children. They were healthy and developed quickly. She took pride in their beginning to walk and run at nine months, and to talk with small words at about nine to 10 months. Of the five living children, she said that her eldest daughter and youngest son were the most solicitous of her, especially when she was ill. In answer to the question as to how her illness affected her children, Sita replied that her oldest daughter had failed three times in school because of her illness, and that when she (Sita) was ill, the children cried a lot. Otherwise they were happy.

Sita said that she treated all her children equally, but that she loved her youngest boy the most. She had enrolled him in a private English nursery school when he was four years old, and at the age of six he was in third grade. The school specialized in beginning the teaching of English to students at an early age. The young boy teased his family members when they could not understand his English. It was obvious that Sita was more am-

in June 1971, her last child. When she could not nurse him, she again became pregnant shortly after his birth. She was then aborted and sterilized in 1972. In obtaining ages and dates from Sita she simply said a child was such and such an age or about such an age. For example her oldest daughter was 15 to 16. She said one of her brothers died when he was 14 and her mother one year later. Based on an estimate that this brother was born sometime in 1955, we then estimated that he died in 1969, and his mother, in 1970.

bitious for this child than the others; she wished that she could afford a private tutor of English for him and was hoping that he might be able to go to the United States for higher education. She also wanted her oldest daughter to continue in school after marriage and eventually to become a teacher. Her husband was planning to arrange a marriage for this girl in which the husband and his father would allow her to continue her education. This plan was similar to one for Sita at the time of her wedding, namely that she would attend school in her husband's village and go on with her education. No attempt was made to implement the plan, since, then, it was unheard of for a married girl to attend school, but in addition no low-caste children attended the village school. That history repeats itself is trite but true.

Sita recognized that her husband and in-laws had treated her well and commented that had she and her husband separated from the joint family, she would not have been taken care of as well because large sums of money had been spent on her illnesses. Later in the interview she added that her husband's eldest brother's family had recently separated from the joint family. She also mentioned that there were fights in the household and that it was not like her natal family which was very peaceful. These fights upset Sita and aroused her anxiety. One of her problems may have been that, due to her illness, Sita did not take part in the cooking and ate apart from the rest of the household. Usually daughters-in-law are expected to carry out the cooking under the supervision of their mother-in-law, and only gradually does the senior daughter-in-law take over the mother-in-law's supervisory position. The sister-in-law who had separated with her husband from the joint family would have been entitled to this role. This sister-in-law was the *jitani* who introduced Sita to the subject of mating with her husband and told her mother-in-law that Sita was menstruating at the time of her first visit in 1958. At that time the sister-in-law was herself only 17 years old, had no education, and her dowry did not compare with Sita's. No doubt this woman and her husband resented the amount of attention Sita received and the problems she caused. Compared with other members of the family, the eldest son's nuclear family had less education and seemed

to value it less than did other members in the joint family. It is not surprising that when Surinder fell ill from tuberculosis, all these problems led to the separation of the eldest son in the fall of 1977. A separation is disturbing to all the members of a joint family, but particularly to the mother and father of the separating son. It may fester for a long time. For Sita it was another source of anxiety.

Through the years Sita visited her natal family regularly. At first, she went home because of her possessions; later she visited her parents to obtain medical services at a nearby hospital for herself and children. In 1969, her 14-year-old brother died and a year later her mother died. Sita attributed her death to grief (the giving-up-given-up complex described by Engel, 1968). She then took her surviving brother to live with her and every summer when he and her own children were on vacation from school she visited her father. At the time of the 1978 interview she said that she was planning to visit again as soon as the children were on vacation.

Sita had encouraged her brother to continue his education and he had become a teacher. In June 1977, he was married and Sita spent eight months, two months helping with the wedding arrangements and six months thereafter, staying in her father's home until February 1978. With great pride she related the details of her brother's education, occupation, wedding, and honeymoon trip to Jaipur in Rajasthan. She even accompanied the young couple on the honeymoon. Honeymoons were new in village India, but the idea for them seems to have been borrowed from reading English literature from the Victorian age when a mother accompanied a young couple on their honeymoon. Sita described all the sights she saw on the trip, showed us photographs from the wedding, and said that she was in good health the whole time and did not suffer from fits.

In all the interviews with Sita, she repeatedly emphasized how much money had been spent on her dowry, the gifts her father and brother sent her and how much they cost, and the amount of money her husband spent on her illnesses. Although these statements were a means of building her prestige, they also seemed to indicate how much these people cared for her. As such they reflect her

attempt to obtain their love. This searching for love stemmed from her early idolization of her father as a hero-god and the later shattering of her basic trust in him (Fenichel, 1945, p. 551; Devereux, 1980, p. 379). It is pertinent to her having taken her sole surviving brother to live with her when her mother died. In so doing, she was acting out the role of her father's wife, namely, as a mother to his son. However, the search for love should be viewed in terms of the cultural concepts for marriage and related emotions. The word love was generally not used in connection with a married couple, but a mother-in-law might say that her son did not like his wife, especially in the early years of marriage. With time, adjustment, and habituation most couples worked out a reasonable relationship. In describing close relationships, the expression most often used was that he, she, or they had affection for someone. Such affection could be between husband and wife or between anyone in a family. On the other hand, Kakar (1978, p. 153), a psychiatrist, says that Hindu women see the god Krishna as a son, and the stories about the love and sexual play between him and Radha, the milkmaid, provide a backdrop for the Hindu woman's feeling for her son. This statement would seem to indicate that the passion involved in Krishna's and Radha's relationship is transferred to an infant son, but it could also refer to the charming stories and pictures of Krishna as an infant. These stories provide the emotional basis for loving an infant even though there may be little or no love in a marriage. The basis is strengthened by the bonding between mother and infant during the child's early years of life. In any case, it is interesting considering these points of view that Sita's favorite child was her youngest son. From Sita's own statement, we infer that the reason she liked her oldest daughter and youngest son the best was because they were most solicitous of her welfare. She was self-centered about love.

In attempting to find out whether Sita was suggestible and had empathy for others, we asked whether she had a pull at her stomach whenever anyone questioned her about her stomach and menses. She replied, "Yes, I have that." But when asked whether she felt bad whenever she heard about or saw some-

one suffering she answered, "Nothing of the sort happens. I am just disturbed by my own illness." These replies indicate that she may have been prone to suggestion regarding her own physical condition but perhaps lacked empathy. However, it may be that because of her constant anxiety and fear of death that she pushed disturbing thoughts to the back of her mind as much as possible.

Her concern with self was emphasized by her single-mindedness in talking about herself and her illnesses throughout the interview. At one time she would have been characterized as a hypochondriac or conversion hysteric for dwelling on her physical complaints. Her narcissism related to her position in her natal family and indicates the degree to which Sita strove to maintain her self-esteem. It constituted a defense mechanism used as a means of survival and was reflected in her other defense mechanism, the belief in female ghosts as malevolent, in particular the ghost of Taraka who was responsible for her 20 years of illness.

Some of Sita's traits are admirable, others are not. Despite the combination of traits, we found her likable. Given the society into which she was born and the conditions with which she had to cope, we admired her. She early learned about malevolent female ghosts which provided her with a set of answers for the childhood deaths of her siblings and which she later used as a defense against her guilty feelings in connection with the death of Taraka, who thereafter haunted her. In addition, as the following pages will reveal, she had a number of organic disabilities for which she had little knowledge or education. The combination of her cultural setting, psychological disorders, and physical disabilities resulted in the persona and psyche of Sita, as described here.

PREGNANCIES

For three years after her wedding Sita visited back and forth between her marital and natal families and then became pregnant. At first she did not know she was pregnant, but she did not feel like eating, vomited, and did not tell anyone. After some months her mother-in-law told her she was pregnant. Other women have related the same tale for

their first pregnancy. In 1961, Sita bore her first child, a daughter, after an eight-month pregnancy. The birth occurred at 1:00 A.M. in a hospital, and the following morning Sita started nursing the infant. Thus, the hospital followed the modern practice of immediate nursing rather than the village practice of giving the baby *guti*. At delivery Sita said her daughter was weak, small, and had no hair—signs of immaturity. About two to two-and-a-half months after delivery, Sita visited her parents. Because the baby was doing poorly, her father arranged for Sita and his granddaughter to be admitted to a hospital where they stayed for another two or more months while the child was fed glucose.

Sita said that she had plenty of milk for all of her children but that this first child did not take much so she had to throw the milk away. While nursing her daughter, she had also nursed her husband's sister's son and her husband's elder brother's son. The implication of this statement, in the context in which given, was that it was not her milk which was at fault (as in her mother's case). After her first child was born, Sita complained of having "gas on her stomach," which she attributed to her stomach not having been properly cleaned after delivery. Sita also had back pains after the delivery and said, "If something goes wrong when the first child is born, then the trouble continues," a belief voiced by other village women.

After the release of Sita and her daughter from the hospital, she soon became pregnant due to not nursing her daughter while in the hospital and thereafter. This pregnancy resulted in a spontaneous abortion, for which she went to a hospital for a curettage. Sita's next pregnancy, around 1963 or 1964, lasted 11 months. Sita went to the hospital expecting to be delivered of twins because of her size and difficulty in walking. She was unconscious during and shortly after the delivery, but another woman in the ward said that she witnessed the delivery. She saw the nurse holding two infants and so she congratulated Sita on having borne twins, a boy and a girl. Later the nurse told Sita that she had not borne twins, only a daughter. When Sita persisted in asking about the boy twin, she said they released her from the hospital early on the third day without cleaning her stomach

properly, which resulted in further stomach problems.

Questions put to a number of village women regarding the possibility of a hospital attendant stealing a child resulted in no one having heard of such an occurrence. Sita may have borne twins, one of whom may have been stillborn or died immediately after birth. If such was the case, due to Sita's fear of death, her husband and other members of the family may have asked the physician and nurses to say that only one child, the daughter, had been born. It is, however, possible that fraternal twins were born and that the boy twin was sold to someone who wanted a son or to someone whose child died at birth. Whatever happened, the belief in the disappearance of the boy twin increased Sita's proneness to anxiety. Except in discussing this pregnancy, Sita never mentioned the girl "twin," who, family members said, died at three years of age.

About six months after being released from the hospital for this second delivery, Sita again had a spontaneous abortion and went to the hospital for curettage (c. 1964–1965). Upon examination by physicians, she was told an additional operation was required. Sita said she was unconscious for five to six days, during which time a woman physician removed two small stones and a ball of dirt from her backbone. Sita referred to this operation as a kidney wound. On the sixth day Sita asked the doctor if she could see what they had taken out of her body. The physician showed her and, said Sita, later won a prize for the operation.

Kidney stones (calculi) may be due to a congenital defect or may be familial and sex-linked to the female. The stones often cause excruciating pain which may be referred to as originating in the back or abdomen. The person suffering from them may writhe in agony. The way in which calcium is absorbed and excreted in the human body may be related to the formation of calcium stones. The information obtained from Sita, however, merely describes the removal of the stones, the length of time she was unconscious, and no more (Lyght et al., 1956, pp. 692–693, 701–704; Wingate, 1972, pp. 241–242, 355).

In 1967–1968, Sita, 11 months pregnant again, went to the hospital for delivery. The

physician recommended a Caesarean section, but her husband, saying he did not care whether she lived or died, would not let her be operated on again and took her home. Five days after going to the hospital, Sita was delivered of another daughter at home by the government nurse-midwife, who used Ayurvedic medicine.

Sita bore her first son in 1969. She said he was the only infant who looked healthy when he was born. All her other babies were small and weak. Another son was born in 1970, for whom there is no additional information. In June 1971, Sita's last child, a son, was born after 11 months of pregnancy. The delivery took place in a hospital where mother and child stayed 15 days while the infant was fed 22 bottles of glucose. Sometime later Sita returned to the hospital with the boy and the physician told her not to nurse him because she had fits. If she nursed him, the baby would shiver and have fits too. The baby was probably fed goat's milk, or a milk substitute, for the physician prescribed a diet for Sita, proscribing milk in her food and forbidding tea. The latter was because in the village tea was drunk with warm milk and sugar in it. He told her to eat porridge once a day as a substitute for milk, but Sita said she did not care for it. Her daily diet consisted of the usual *rotis* (round pieces of unleavened bread made of whole wheat flour) and a vegetable. Sita said that she put a little ghee in her vegetable, which is customary, but she may have thought that ghee (clarified butter) might not agree with her since it is a product of the cow or water buffalo. It is possible that the physicians who treated Sita in the early 1970s may not have been aware of the causes of lactose malabsorption and diagnosed the cases of Sita and some of her children as milk allergy or some other disorder. However, Sita seems to have been a post-weanling-adult lactose malabsorber. This genetic type of hypolactasia has its onset between weaning and 20 years. Most probably Sita already suffered from it by the time of her marriage. Sita's last son and possibly one of her daughters suffered from infant hypolactasia (although one daughter may have had congenital rather than genetic infant hypolactasia and the other may have died at three years of age due to post-weanling-adult hypolactasia or some other

ailment). In any case the diet prescribed for Sita was deficient in calcium unless she daily ate curd, customary among villagers if they had an adequate milk supply to make curd and butter. A lactose malabsorber can eat curd because through fermentation of the milk the lactose becomes lactic acid (Andersson et al., 1973; Harris and Levey, 1975, p. 938). Although Sita may have occasionally eaten curd whenever there was some available, with many people, especially children, in her joint household, she probably did not have enough milk or milk products for an adequate calcium intake. Due to a low milk intake and a primarily vegetarian diet, Sita probably lacked sufficient protein, riboflavin, and calcium.

It was difficult to determine exactly what instructions and information physicians had given Sita. When Sita was asked whether her milk was tested at the hospital, she avoided the question by answering, "When I nursed my last son, after a few months he started to get sick and shiver so the doctors told me not to give him my milk. I nursed all my children but stopped with this child. My mother had milk for only four to five days and none left after that" She related how her siblings were then fed cow's and buffalo's milk, had difficulty digesting it, and died. She also mentioned that her only surviving brother was fed goat's milk. Her indirect answer in avoiding the question indicates that she linked her nursing problems with her mother's although she said she had sufficient milk, not understanding that the quantity of her milk was not related to the lactose content of milk, lactose malabsorption, or the infant's ability to digest it. There may be more to the genetic endowment of Sita and her children regarding the genes for lactase activity since there is a wide range of variability for the onset of the post-weanling-adult type and less family case histories for infant hypolactasia than for the adult type, or for both types in one family line (Asp, 1973, p. 78). Because of Sita's fear of her infants dying and her unwillingness to admit that her milk might affect her babies, she may have interpreted the physicians' instructions and explanations in terms of her emotions and limited knowledge, as happens between physicians and patients all over the world. On the other hand, the physicians may not have known about the recent research

regarding the lactose/lactase complex. Even if they had, they may have adapted their explanations and instructions to terms which Sita might understand. Physicians in India, as well as in other countries, are influenced by their own cultural setting when providing instructions to patients (Helman, 1978, pp. 107, 108, 114, 125, 132-133).

Because of the frequency of Sita's pregnancies, her nursing problems, and the possibility that some of her children were lactose malabsorbers, Sita may not have nursed her children for extensive periods of time. Therefore, anovulatory protection against conception was reduced. The custom in this region was to nurse a child for two years on the average, but to begin feeding the child some solid food as soon as it had some teeth and could sit up and eat with the rest of the family. For the children who were lactose malabsorbers Sita probably provided goat's milk or a soya substitute, bottle feedings, which she had learned either from her mother or through information and supplies given her by hospital physicians. As a result, as in her mother's case, Sita became pregnant frequently.

The length of Sita's pregnancies—eight months in one case and 11 in three others—raises the question of the biological basis for them. Although the eight-month period for the first child may have been due to not recognizing pregnancy immediately, or to a slight menstrual flow after conception, more probably the eight-month period is accurate inasmuch as Sita said that when the child was born she was very small, weak, and had no hair. Prematurity is not unusual for a primipara. Her problem with nursing the first child and taking the infant to a hospital for glucose feedings may have been due to genetic or congenital lactose malabsorption, the latter due to prematurity. On the other hand, children believed to have been born after the average length of time with no medical examination prior to birth may not have been postmature but rather the time may have been miscalculated. A miscalculation may have been due to the problem of keeping track of time in rural India, the possibility that a spontaneous abortion unknowingly may have occurred shortly after conception followed quickly by another conception, or an irregular menstrual cycle. For these reasons it is

difficult to evaluate one 11-month pregnancy (Hellman, Pritchard, and Wynn, 1971, pp. 1026, 1057).

Sita, however, was far more accurate about time, dates, and ages than the average village woman her age. Since Sita said three 11-month pregnancies occurred, the chances are that three pregnancies running about 11 months did occur. The average length of pregnancy is 266 days. A case of 360 days duration is on record, and for a living encephalic monster as long as 389 days before spontaneous labor and delivery. Generally, a normal pregnancy can last between 240 to 300 days. If Sita reckoned the length of her pregnancy by lunar months, a 10-month period would fall within the normal range. If she were gravid more than five days into the eleventh (lunar) month, she would begin to exceed the normal period. The perinatal mortality rate for exceeding the expected confinement and delivery date is two to three times that reported for a term delivery. Thus, it is surprising that three of Sita's children were born alive and survived after a much longer than normal pregnancy (Benson, 1971, pp. 47, 52; Delora, Warren, and Ellison, 1980, p. 69).

Sita believed that her physical troubles started when her stomach was not properly cleaned after the delivery of her first child. When a woman was delivered of a child in the village, whether by the village midwife or the government midwife, the expulsion of the placenta was stressed as was massage thereafter by the midwife. For Sita's caste the new mother was secluded minimally from seven to nine days, but usually no more than 21. The 40-day seclusion practiced by the high castes is approximately the length of the six weeks of the puerperium in Western-scientific medicine, during which time the reproductive tract returns to the pre-pregnant condition. During this time the necrotic portion of the decidua left in the uterus is cast off in the lochia. In village language, this process and these terms were the equivalent of cleaning the stomach. After delivery, the midwife said she daily pressed and massaged the mother's stomach, so as to put the womb, which came down when the child was delivered, back into place. She massaged the mother for a period of seven to 10 days after

delivery. The ideas behind this treatment were that the uterus would be put back in place after the delivery and that the lochia would be completely removed (i.e., cleaning the stomach). These ideas are a part of Ayurvedic-humoral medical theory (Kutumbiah, 1969, pp. 182–183). Thereafter women of all castes no longer remained in bed although those women who observed the 40 days of seclusion refrained from all work.

What seems a feasible interpretation of Sita's stomach complaints is that she received different treatments in bearing her children and on comparison believed that her stomach was not properly cleaned after her first and second pregnancies. Due to her lengthy pregnancies, she may also have suffered from an endocrine disorder. To add to Sita's worries, there was a belief that if a new mother moved out of seclusion too soon, she would become ill because of either air or wind (an Ayurvedic concept), or a ghost, or both. This observation is not to deny that Sita had some basis for her physical complaints, or that she was an excessive worrier (Gideon, 1962, pp. 1225–1231; Gordon, Gideon, and Wyon, 1965a, 1965b; Benson, 1971, pp. 197–199; Hellman, Pritchard, and Wynn, 1971, pp. 417, 465–466; R. Freed and S. Freed, 1980, pp. 362, 366–367, 371–372, 382–384, 394–395).

In 1972 about half a year after the birth of her last son, Sita was sterilized, along with a number of women from her caste and marital village, in a camp on hospital grounds run by an American medical team. She had an induced abortion before the sterilization. She may not have told her husband or marital family about the abortion, as was the case with other women in the village.

In sum, Sita had nine pregnancies, bore six to seven children (the latter if the boy twin is counted), and had two spontaneous abortions and one induced abortion, all in about 11 years from 1961 to 1972. She said that her first pregnancy lasted eight months and three others lasted 11 months; we have no information on the length of pregnancies for two of her sons. She went to a hospital at least seven times and possibly more, and most of her children were delivered in a hospital. Although from 1958 to 1978, villagers had increasingly gone to hospitals, Sita was un-

usual in the number of times she went for childbirth and for operations. We attribute this behavior and choice of health services to her father's influence, access to such services, and her orientation toward modernity. Her behavior may also be compared to women in the West at the turn of this century and later, who resorted to hospitals and operations for relief of pain and who may have been labeled hypochondriacs or conversion hysterics.

STERILIZATION

To understand Sita's sterilization requires knowledge of sterilization in the Family Planning Programme of India. Mandelbaum (1974, pp. 77–80) indicates that sterilization has been one of the most successful aspects of the birth control program. It was introduced as early as 1959. Camps for vasectomies and tubectomies similar to fairs were set up and lasted a number of days in the early 1970s throughout the Delhi region. Individuals who were sterilized received gifts and cash incentives. Although the number of persons sterilized greatly increased during the Emergency Period (June 1975–March 1977) in India, sterilization of males and females had already been promoted for over a decade. From data obtained in fieldwork and from a recent newspaper report, sterilization appears to be the most effective and popular birth control technique. Moreover, during the Emergency many families with three or more children believed that either the husband or wife had to be sterilized if the husband held a government job and was not to lose it. Some instances of forced sterilizations were reported during this time, and it was these sterilizations that people opposed. Both before and after this period individuals were voluntarily sterilized (Manoharan, 1983).

A sterilization needs to be evaluated in terms of physical and mental trauma. Tubectomy or tubal ligation for women requires more complicated surgery than vasectomy for men. A convenient procedure in India has been to combine sterilization with the delivery of a woman's infant. Aftercare is particularly important. Not all cases of sterilization for village women in the early days followed this stricture. There were numerous cases in

Sita's marital village, especially if the sterilization was involuntary or believed to be so, when the women immediately thereafter worked in the fields and had no aftercare. Cases of physical and psychological trauma were reported, such as excessive bleeding or menstrual flow with pain, and one woman committed suicide. Recent reports, however, indicate that women now go to a hospital or preferably a nearby clinic where they can easily return for aftercare, and they refrain from work in the fields as long as possible, sometimes as much as six months (Delora, Warren, and Ellison, 1980, pp. 96-98; reports from our research assistants, 1983).

Sita voluntarily had herself sterilized in 1972. She already had three sons and two daughters when she found herself pregnant again after the birth of her last son. She, therefore, decided to have an abortion and sterilization. Along with other women from the village, she went to a camp set up on the grounds of a hospital. The nurses, according to Sita, were trying to find candidates for sterilization and promised Sita that they would have her stomach cleaned properly after the abortion.

Sita was not hospitalized after sterilization. Shortly after returning to the village, she carried on her usual work. The common side effects of tubectomies, such as backaches and irregular bleeding, characterized Sita's complaints. She said she started to menstruate for a month at a time with a break of only three to four days, for which she received some medicine from the camp, which later left the region. Physicians in the hospital, however, examined her and said there was nothing wrong. According to Sita, "Many women were sterilized there; and they are all right, but I am not." She claimed that ever since the sterilization she had been sick. Other village women reported that they, too, had excessive bleeding or menstrual flow after sterilization. Like Sita, they had borne a number of children, had experienced at least two spontaneous abortions, and may have been anemic.

Sita's willingness to be sterilized may be linked to her belief that sterilization would not only free her from bearing additional children but also from worrying about the deaths of future infants. Conceivably she also subconsciously may have felt that freedom from

anxiety about childbirth would make it unnecessary to repress her sexual desires. Sita was also influenced by her husband's government job and the government's promotion of family planning. A cartoon of a nuclear family consisting of father, mother, son, and daughter with the caption, "Two or three children. Enough," was seen throughout India during the 1970s. Sita's five children had already exceeded the desired limit of three children, and, since she had three sons and two daughters, it seemed unlikely that all her children, especially the sons, would die. Because each pregnancy had been difficult, nursing was a problem, and one daughter had died, Sita had been in a nearly constant state of anxiety about pregnancy and death. It was not surprising that she had herself sterilized.

Each person who chooses to be sterilized does so for his or her own reasons, but the gradual rise in voluntary sterilization in the Delhi region and India since 1958 indicates a major change in attitude regarding birth control, the number of children desired, and some understanding of the economics of bearing children in the world today. Thus, Sita was not culturally deviant because she chose to be sterilized.

MENSTRUATION

Sita seems to have linked sterilization with a possible reduction in menstrual flow so that when she began to have a greater flow after sterilization, her anxiety instead of being reduced continued and possibly increased. Menstruation in Sita's mind was originally associated with marriage, mating, and childbearing—not surprising given the belief that the wedding should precede menarche, and menarche should precede mating. Her attitude is best understood by reviewing her statements regarding menarche and menstruation from the 1958 and 1978 interviews. These statements conflict to some extent. In 1958 Sita said that she experienced her first menses when she was 14 years old and her wedding took place when she was 15. Menarche began about two to four months before her wedding. At the time of her wedding, she still did not understand menses, nor had she been told about them until they occurred.

In 1978 Sita stated that her menarche took

place at the time of her oil bath immediately preceding her wedding. At that time a girl friend told her what to do and not to take a bath. On the wedding day, still having her menses, she took a bath after the last oil bath in order to wash off the oil and put on her wedding garments. The next night when visiting her in-laws, Sita's *jítani* realized that Sita was menstruating and gave her underpants to wear. She also told Sita's mother-in-law that Sita was already menstruating. These events must have disturbed Sita because brides were not supposed to reach menarche until after their wedding, although since it is impossible to predict menarche, they sometimes did. In her later years, Sita said that menarche began at the time of the oil bath. It is possible that the first menstrual flow was irregular and slight. As a result, Sita may have considered a somewhat later heavier flow which started at the time of her wedding to have marked menarche. However, according to Freud's rule of thumb, the earliest statement is most apt to be correct. Therefore, Sita started to menstruate some months before her wedding. Sita's faulty memory was fostered in all likelihood by cultural pressures for a new bride to be wedded before attaining menarche, or possibly by fear that Taraka's fate could have been hers.

When Sita first began to menstruate she did not have much pain with her menses, but did have what she called a stomachache (menstrual cramps), backache, and fever (indices of primary dysmenorrhea). After first mating with her husband, she regularly had more severe menstrual pain with a stomachache and backache, probably forging a further link in her mind between mating, menses, and childbearing. These pains persisted even after the birth of her first child, indices of secondary dysmenorrhea (Lyght et al., 1956, p. 764; Wingate, 1972, p. 139; Sandler, Myerson, and Kinder, 1980, p. 87).

The physical symptoms which Sita described are important. The cramps and backache from which she consistently suffered since menarche indicate that she had primary dysmenorrhea. The persistence of these symptoms and the increase in pain that followed mating with her husband point to secondary dysmenorrhea. Both of these disorders may be due to multiple causes such as

inadequate nutrition, hormonal imbalance, overproduction of prostaglandins, and uterine muscle contractions. Primary and secondary dysmenorrhea and their causes were not recognized as such in rural Indian villages or in Freud's time, when Sita's physical complaints would have been considered symptoms of conversion hysteria. Sita's attitude toward menses, birth, mating, and death could have aggravated her dysmenorrhea. In addition, the Hindu view that menstruating women were polluting and could cause the death of a newborn and its mother if allowed near them during the delivery and seclusion period, and the belief that low-caste women were more polluting than women of other castes when they were menstruating added to her resentment and fears regarding menstruation (Lyght et al., 1956, pp. 764-765; Wingate, 1972, p. 139; R. Freed and S. Freed, 1980, pp. 381-382; Sandler, Myerson, and Kinder, 1980, pp. 87-89; Shodell, 1983).

A case can be made for Sita suffering from the premenstrual tension affective syndrome, which together with her other disabilities and anxiety disorder contributed to her fits. The premenstrual tension affective syndrome is defined as "a quantitative significant difference in the severity of observable mood changes during the paramenstruum from that observed in 'normal' women" (Friedman et al., 1980, p. 202). The time at which this syndrome is most likely to occur is during the first half of the paramenstruum, which is two to seven days before the onset of menstruation (the paramenstruum includes this period plus the period of menstrual flow) (Friedman et al., 1980, p. 193). Premenstrual tension is due to the accumulation of fluid resulting from sodium ion retention by increased steroid hormone activity during the last half of the menstrual cycle. It causes nervous irritability, owing to the swelling of the tissues of the brain and nerves. The symptoms of the premenstrual tension syndrome are pain in the back and breasts, respiratory difficulties, asthma, and sometimes seizures similar to epilepsy. They disappear with the onset of menstruation. The foregoing factors together with Sita's predisposition to anxiety could have caused considerable pain and other forms of stress, which together with her organic disabilities had their outlet in the be-

havior Sita described as fits (Lyght et al., 1956, p. 763; Selye, 1956, pp. 176-177; Dalton, 1959, 1960, 1961, 1968; Benson, 1971, pp. 709-710; Wingate, 1972, p. 341; Friedman et al., 1980, pp. 202-209; Sandler, Myerson, and Kinder, 1980, pp. 87-90).

The basis for Sita suffering from the premenstrual tension affective syndrome derives partially from her father-in-law's statement that "Every 20 days to one month when new blood is made in her body, the fit affects her and then it dries up." It is further supported by a series of events which began toward the last half of February 1978. At that time Sita returned to her marital family from her father's home, having been away eight months. She then learned first-hand about her brother-in-law's illness and treatment. Two severe hailstorms occurred at the end of February, one of which was associated with a nearby tornado; both damaged the tomato crop upon which Sita's marital family relied for part of their income. Sita, then, had an attack of fits. Shortly thereafter in March, Sita's marital family decided that Sita, too, should be X-rayed at the tuberculosis clinic. After waiting almost two weeks for the report, Ram Chandra, Sita's husband, went to the clinic on a Saturday, when he was free from work, and returned in the early evening. Sita, who anxiously awaited the report all day, then had fits for four hours, having learned that she needed another operation. The period of time between the first attack of fits and the second was approximately four weeks; it coincided with the paramenstruum before the period of her menstrual flow, the time at which she would be most likely to experience extreme premenstrual tension and fits.

Sita's information about her menstrual flow and excessive bleeding after sterilization was ambiguous and sometimes contradictory. When she first mentioned her sterilization, she said that for two years afterward there was nothing wrong. Sita also said that after she was sterilized, blood and urine came from her mouth when she had fits, and contradicted herself by saying that she had been sick ever since the sterilization. Yet when she was checked at the hospital, the doctors said that nothing was wrong. Later in the interview, Sita stated that after being sterilized her menses occurred for a month at a time with a break

of only three to four days between periods. She took medicine to reduce the excessive flow. She had been having her menses for 11 to 15 days continuously and excessive bleeding had existed since the sterilization. She mentioned that her menses had become more regular recently and her recent menstrual flow had stopped some days before the interview, pinpointing her last attack of fits just before the onset of menstruation.

The information regarding Sita's menstrual cycle and excessive bleeding after sterilization is hard to diagnose because women who are often pregnant as was Sita do not menstruate much during their childbearing years. As a result, they may not know the average number of days of their cycle or the duration of their menstrual flow. Cultural belief may foster the norm of a 28 day cycle, but the range may be from 25 to 34 days, not counting amenorrhea brought on by various causes such as lactation, malnutrition, shock, and other biological and psychological factors. In the first years after attaining menarche, there may be considerable variation in length of the cycle. The flow may last from three to seven days. It, too, may be affected by diverse factors. Since occasional bleeding may occur at ovulation and sometimes after conception, these variables may have contributed to Sita's confusion about menarche and lack of knowledge regarding her cycle.

Because Sita had been informed by the clinic that she needed operations for kidney stones and her "stomach," based on her case history she probably suffered from endometriosis, which is associated with pelvic pain, dysmenorrhea, and hypermenorrhea. The symptoms of severe pain disappear during pregnancy and after the menopause. Endometriosis affects women in their childbearing years, especially between the ages of 30 to 40 years, an additional factor applicable to Sita. It is due to endometrial tissue being implanted outside the uterus and later breaking apart and bleeding during menstruation. Evidence exists that endometriosis is due to a dominant autosomal genetic trait. It has been reported in mothers, daughters, and sisters. Uterine bleeding, however, may be a symptom of complications arising from pregnancy such as abortions, tumors of the uterus and cervix, and polyps. Associated with all of these

possibilities is pain. Treatment may involve hormonal and surgical therapy (Lyght et al., 1956, pp. 780–781; Wingate, 1972, p. 150; Sandler, Myerson, and Kinder, 1980, pp. 86–88; Harrell, 1981, pp. 800–804; McKusick, 1983, p. 158).

Until relatively recently in the West, Sita's stomach problems and her alternate mental states would have been considered symptoms of hysteria. This type of diagnosis would now be qualified given the biological bases of some of Sita's difficulties. However, cultural beliefs regarding women, menstruation, and reproduction have often been expressed as symptoms of conversion hysteria. For the millions of females, past and present, born in societies such as India and ancient Greece, where males are preferred to females, where woman's lot is more difficult than man's, and biological knowledge regarding the menstrual cycle and related symptoms of so-called hysterics is not widespread, one may conclude that females would resent the occurrence of their menses and all that was linked to them culturally, disabling or marking them as inferior. Since it takes a long time for scientific knowledge to diffuse, the attitude toward women and complaints related to menstruation and childbearing will continue to affect their position in the social order and be detrimental to their physical and mental health as it seems to have been for Sita.

ALTERNATE MENTAL STATES

Although Sita, like almost all human beings, experienced a number of alternate mental states, such as sleeping and daydreaming, the two alternate mental states with which we are concerned are her possessions and fits. Sita discussed a number of possessions which occurred among village women in 1978 and some which had taken place in the intervening years since 1958. She compared her own possessions with those of a young widow in a Brahman household who became possessed by the ghost of her dead husband sometime in the 1970s. According to Sita and other people in the village, the ghost of her husband appeared and told her to marry his younger brother, which she then did. Several villagers suffered possessions a month previous to this interview, among them a new bride in Sita's

caste community. Sita knew of her possession and very matter-of-factly categorized the new bride's experience as similar to her own.

Sita said that her ghost possessions turned into fits after her first child was born in 1961, three years after her wedding. Sita's description of her fits follows: "They start from the head. I feel giddy and drowsy. Then I can't see anything and everything goes dark. My legs, hands, and veins stiffen, then a pain goes to my stomach. I don't know what happens, but I have a pain in my heart, my eyes shut, and my tongue comes out. I shriek so loud that the whole village, even the Brahmans, know I am having a fit. I have a weak heart. Whenever there is a fight in the family or elsewhere, or if I see a dead body, I have fits."

Following is a summary of Sita's fits based on information obtained from her and members of her marital family:

1. She may fall unconscious from one to four hours.
2. When the fits first take her, she may get up from her bed and then fall unconscious.
3. She becomes violent so that it takes at least four people to hold her; or according to Sita, eight or nine people. At these times she tears her clothes and hits people; she is also very strong.
4. People who hold her down press the veins in her stomach (Ayurvedic treatment) to afford her some relief (Kutumbiah, 1969, pp. 162–163; R. Freed and S. Freed, 1978, p. 330).
5. Since her sterilization, blood and urine come out of her mouth at the time of her fits.
6. A hakim diagnosed her fits as due to an insect's bite and said she had a weak heart, possibly because she said she had pains in her heart at the time of her fits.
7. According to her father-in-law, every 20 days to one month when new blood is made in her body, the fit is most apt to affect her. Climatic conditions such as hailstorms and a tornado affect her, which he attributed to air touching her body (an Ayurvedic concept).
8. Sita and Surinder attributed her fits to fears, worries, and emotional disturbances. Surinder said that when she wor-

ries she twists her hands and shouts loudly.

9. Unpredictable events, such as storms, injury to crops, family fights, deaths, or fears of deaths, bring on the fits.

According to Carstairs and Kapur (1976, p. 163), fits similar to Sita's could be classified as hysterical fits and are differentiated from epileptic fits although they may have a bizarre pattern of behavior similar to epilepsy. There are a number of reasons for concluding that her seizures are not epileptic in addition to comments by villagers that her fits were not the same as those of the two known sufferers from epilepsy. An elderly woman of the Sweeper caste, who knew the two sufferers from epilepsy and had witnessed Sita's possessions and fits from the time of their first occurrence in 1958, said, "Sita has fits (*dauras*). They are not the same as *mirgi* (epilepsy). The young Jat takes tablets for epilepsy (*mirgi*), but Sita does not. Her illness started with ghost possession (bhut *lagna*), and ghost possessions and fits are not the same as epilepsy." Sita never had a bad fall. In all the times that she was treated in hospitals and consulted physicians, a hakim, and *vaid*s, none prescribed treatment for epilepsy. She was never given medication to be taken regularly as is characteristic of epileptics (Wingate, 1972, pp. 155-156).

Not all of Sita's fits involved falling unconscious, and she never hurt herself during the fits. At times she was violent and vented her rage by tearing her clothes and hitting people who tried to subdue her. On one occasion she ran to the railway tracks to throw herself in front of a train but was brought back before she arrived there, an attempted suicide or a suicidal fit associated with the menstrual cycle (Trautman, 1961; Wetzel and McClure, 1972). According to Sita, when she is in a violent state, her husband is afraid of her. Sita experienced some abatement of her fits while visiting her father and was quite well and suffered no fits during the trip with her brother and his wife on their honeymoon. During this period, Sita was released from her daily chores, worries, and responsibilities as well as being away from her marital family.

When Sita was asked, "Were you afraid that your children might die when they were

born?" she avoided a direct answer but instead replied, "Whenever I have fits, I don't know whether I have children or any other relatives. I start crying a lot and run away from the house." Indirectly, she was saying that the worries about children, in-laws, and the household were too much for her and so she ran away.

From 1958 to 1961 Sita was frequently possessed. Underlying her possessions were multiple stresses causing psychological and physical pain. The frequent pain may have triggered the release of the endogenous morphine-like substances known as endorphins and enkephalins, affected her central nervous system, and resulted in possessions. The recurrent stress and pain resulted in habituation to the dissociative state known as ghost possession. With the birth of Sita's first child and attendant nursing problems, her greatest fears were realized, for she knew that she would have to continue to bear children, worry about their deaths, adjust to life with her in-laws, and have her visits to her natal family curtailed. When her in-laws and other villagers no longer paid much attention to her recurrent possessions, they then turned to fits. It was as if the ghostly voices had no audience and were then repressed, resulting in an even more extreme form of recurrent behavior that became less acceptable than ghost possession in a bride (Ludwig, 1966, pp. 227-230; P. Tolpin, 1974, p. 174; Whybrow and Silberfarb, 1974; West, 1975, p. 300; Saffran, 1982).

From the foregoing it seems that Sita suffered from premenstrual tension and dysmenorrhea. Her fits tended to occur prior to the start of her menstrual flow. Through the years her premenstrual tension would have been exacerbated by her anxiety about becoming pregnant, which rose to a higher level as the time of her monthly period approached, resulting in fits, a behavioral pattern which began with her ghost possessions. Before the operation for their removal, she must have had severe pain from kidney stones. Her low back pain may have been due to them as well as to dysmenorrhea. Special stress or distress brought on fits: for example, the four-hour siege of unconsciousness the evening that her husband obtained the report of her examination at the clinic. This attack may well have been related to her

increasing anxiety during the long wait for the report and her fear of tuberculosis. The diurnal variation in pain perception may have contributed to the evening attack since the peak time for sensitivity to pain tends to occur in the evening (Folkard, Glynn, and Lloyd, 1976; Rogers and Vilkin, 1978).

In answer to the question as to whether she was cured of her possessions, Sita replied that although five or six exorcists had treated her she was never completely cured. In this context, she attributed her possessions and fits to the ghost of Taraka. The basis for this belief and her choices of cures stem from her childhood when her mother and grandmother took care of her when she was ill and from their beliefs regarding the deaths of her infant siblings. From the time of her first ghost possession, she was treated by a series of exorcists (*siyanas* and *bhagats*). When she began to have fits after the birth of her first child, she consulted a variety of such curers including a hakim and some *vaid*s. In the years from 1969 to 1976, she had experienced the deaths of one brother, her mother, borne her last child, had been aborted and sterilized, and had been told that her fits were due to drinking milk and that her last child would also have them if he drank her milk—thus, confronting her with all the problems of her own mother. During this period, she had the most serious onset of bleeding and fits.

In 1976 a curer gave Sita a protective amulet to control her fits. By 1978, Sita had worn the amulet for two years. Before obtaining it, she said that she had fits every two to three days. After the curer gave it to her, she said that she had fits only once every two to three months with this amulet, and she believed that she was able to control herself. It functioned to protect her from Taraka's ghost, much as had the blue band given her in 1958 by one of the exorcists to ward off the ghosts who were believed to be causing her possessions. The psychological effect of this protective amulet reduced her anxiety. It is also possible that between 1976 and 1978, she had less worries regarding pregnancy, less anxiety regarding infant deaths, and may also have been undergoing physiological changes, thus reducing her pain and fits, but she does not seem to have been able to escape from premenstrual tension and fits when she was unduly affected by stress.

For the most part Sita was treated by various curers for her possessions and fits, but when it came to problems which she considered to be strictly physical she went to hospitals where Western-scientific medicine was practiced. Her choices of cures and curers indicate the separation in her mind between illness caused by ghosts and physical complaints. From her point of view, indigenous curers better understood ghost possession, fits, and ghost contagion than practitioners of Western-scientific medicine. Her thinking followed the village view of her possessions and fits, namely that they were caused by a ghost.

Faith in treatment by indigenous curers for possessions and fits is based on common supernatural beliefs. These beliefs establish bonds between the curer and the persons seeking relief. The bonds provide the basis whereby a curer may sometimes help these people to find out truths about themselves, which may not have been the case with Sita. For example, when people suffering from possession are treated by exorcists, they believe that the exorcists can better diagnose the trouble because they recognize the supernatural being causing the possession. Because of this relationship, Hoch (1979, pp. 52–54) suggests that knowledge of the practices of indigenous curers and the attitudes of those seeking relief may prove useful in practicing psychiatry in rural India, but physical causes should likewise be considered.

A great deal has been made of the hierarchy of resort in selecting curers for a patient being treated under one or another system (Clark, 1970, pp. 183–214; Romanucci-Ross, 1977). In general, this system of selection starts in the family unit and then proceeds to an indigenous curer or curers and eventually, if no cure is obtained, ends with Western-scientific medicine. In India there are a number of systems of curing and many curers. During the 35 years of Sita's case history, the country has been undergoing rapid change, which has included the spread of Ayurvedic and Western-scientific health services provided by the government. As a result, the multiple choices may have created more anxiety in Sita than cures.

Sita's experiences reflect not only post-Independence medical developments in India but also a weakening of the familial authority

system, which made it possible in her later years for her in some instances to make her own decisions concerning her health. Partially this independence was related to greater freedom for women to journey outside of the traditional realm of house and farm in the village, but also her independence of thought had been part of her psyche since she was a young girl.

The seeming paradox of flitting from one extreme to another in the selection of curers during Sita's 35 years of life does not reflect a hierarchical system of referral. Instead it

reflects a dichotomy of choice. Sita has persisted in seeking indigenous curers for her dissociative states and Western-scientific treatment for the births and glucose feedings of her children. This dichotomy reveals the persistence of her earliest thought processes regarding ghosts and her father's and her own pragmatic attitude toward the birth of infants and affairs of the body. Yet to some degree the two are tied together, for Sita went to a hospital for the birth of her first child so that her baby might avoid the fate of her dead infant siblings (Gould, 1965).

CONCLUSION

This anthropological psychomedical case history of Sita presents the ecological, cultural, psychological, biological, and etiological complexity of ghost possession and fits in the Delhi region of North India. The intertwined causes of Sita's afflictions, which were first recognized as ghost possessions and later developed into fits, involve concepts and theories from several ancient systems of medicine; the social structure of families and castes in North India; the statuses of North Indian females; the psychological and socio-cultural tensions generated at the transitional periods of the life cycle, namely in this case, marriage, mating, and childbirth; the culturally acceptable patterns for managing psychological, sociocultural, and physical distress; and specific physical factors, such as hypolactasia, related calcium deficiency, kidney stones, and menstrual disorders. Sita's initial alternate mental state is known as ghost possession by villagers and possession by anthropologists. Psychoanalytic followers of Freudian theory formerly would have diagnosed Sita's possessions and associated symptoms as hysteria, one of the psychoneuroses. More recent psychiatric classification would identify Sita's possessions as dissociative behavior. Possession, an alternate mental state, may be induced by an increase of exteroceptive stimulation and/or motor activity and/or emotion. Sita's later fits and physical complaints would once have been classified as conversion hysteria. Today, in cases where there is no demonstrable organic basis or known physiological mechanisms

causing the pain complaints, her fits would be classified as a somatoform disorder. However, her biologically based ailments rule out this classification. Sita's possessions and later fits involved a gamut of somewhat overlapping alternate mental states and are due to an anxiety disorder combined with a series of physiological mechanisms causing pain.

The etiology of Sita's possessions derives from a childhood anxiety disorder based on a fear of being separated from her grandmother and parents, particularly her father. His long absences from home were linked with the early successive deaths of her infant siblings, for Sita, as the first and for a long time the only surviving child, was jealous of each successive infant and wished that it would disappear. When it did, she felt guilty and associated her guilt with the restrictions of the socialization process. Although she said her parents never punished her, she associated the occasional lack of indulgence, inattention, and strictures placed on her activities by her mother and grandmother with her complex of wishes regarding her mother and father and the disappearance of the babies. The supernatural belief in a female ghost who took the babies provided a cultural defense against her repressed wishes and guilt. She gradually transferred her affections from her mother to her father, as her mother continuously worried about the births and deaths of her offspring. In contrast, she saw her father as a conquering hero-warrior who indulged her wishes and brought her presents. She became ambivalent about her mother's

place in her affections. She saw her mother as a good-bad woman who did not always love her and who contributed in some way to the deaths of the infants. Even so, Sita still subconsciously identified with her mother, was jealous of her, and was afraid that she, herself, might become like her or might become a female ghost.

While attending school, Sita identified with her teachers as role models, thus deviating from her mother's role and from her subconscious feeling that she, a female, was bad or evil and might become like her mother. Her interest in acting in school strengthened a flair for dramatizing herself. School, her father's stories about his travels abroad, the lack of caste discrimination in her natal village, and the proximity of it to the city gave Sita a set of values regarding right and wrong and a desire for economic independence uncharacteristic of the average village girl of her age and time.

Sita's childhood anxiety disorder and fear of separation from her loved ones was perpetuated through the years by the continued absences of her father, repeated displacements from her mother's bed, awareness of the primal scene, and the deaths of nine successive siblings born between her birth and her wedding. These events created an intermittently insecure emotional setting concerning the basic trust of her loved ones and established the equation of mating and death, both of which she feared. Sita's anxiety disorder was more or less latent until aggravated by a number of psychological, sociocultural, and biological factors during her early adolescence and the turning point of her life, marriage. A series of traumatic experiences contributed to the fixation of Sita's anxiety disorder.

Early in her adolescence when she was becoming interested in young males, three of her girl friends died before their time, without issue, and under circumstances which led villagers to believe that they would become ghosts. The first of her friends to die had been raped by a schoolteacher. When her father learned what had happened, he himself raped her, cut her throat, and threw her into a well. He was never punished. This event violated Sita's sense of justice and shook her faith in

authority and father-figures. Moreover, the episode resulted in her withdrawal from school after the fourth grade and the end of her ambition to become a teacher.

After the death of her first friend, her second friend, a maternal cousin, became pregnant before mating with her husband and was forced by her father to commit suicide. Sita was to some degree involved in the early sexual activities of her cousin, for the two girls had been so close since early childhood that Sita said they were like one person. Therefore, Sita had feelings of guilt regarding these activities and her ambivalence in neither acting to prevent her cousin's suicide nor committing suicide with her. The activities which were a part of this relationship and the suicide of her cousin were to haunt Sita for the balance of her 35 years. They caused Sita to regress from her tentative experiments with members of the opposite sex and strengthened the repression of her sexual desires due to her fears of punishment and death. Sita was successively to convert the general belief that female ghosts were evil and caused death into two specific beliefs: first, that her cousin had become a ghost who haunted her, might take away her children, and might even kill her; and, second, that her possessions and fits were due to ghost contagion from touching her cousin's mother, who earlier had been haunted by her daughter's ghost. This culturally conditioned combination of ghost beliefs constituted a defense mechanism which would at times allow Sita to cope with her difficulties, but in the long run masked the deep-seated causes of her anxiety disorder. Sita's third girl friend died of typhoid compounded by malaria some months before Sita's wedding. All three of these girls died after mating, reinforcing Sita's equation of mating and death; and they all qualified for ghosthood, for they died before their time and without issue.

During the period when her friends died, Sita's two surviving brothers were born, the first of whom displaced her in the affections of her family. Her parents had already taken her out of school, and following the birth of the first son, her father hurriedly arranged her marriage. The wedding occurred shortly after the birth of the second son. The displacement

by her first surviving brother and her subsequent marriage shattered her basic trust in her father's love for her. Sita was ill-equipped by her enculturation for the change from relatively independent teen-ager with a highly privileged status in her parents' house to the rather low role and circumscribed movements of a daughter-in-law in her husband's house and was unprepared for the caste discrimination found in the multiple caste village of her marital family. Moreover, though excited by marriage and her husband, she was disturbed by the idea of mating and subsequent motherhood, for she feared the deaths that, in her experience, followed mating. By the third visit to her husband with nightly mating, probably permanent separation from her natal family, and frustration and concealed anger from the need to adapt to her marriage, her state of tension, anxiety, and physical complaints became too painful to bear, and all of these dammed-up feelings and biological disturbances were relieved in ghost possessions. The possessions lasted for three or more years, during which time she was able to go back and forth between her natal and marital families. With the birth of her first child and subsequent hospitalization for glucose feedings when the baby did not take much of her milk, some of her worst fears had materialized. She thought her child might die as had her mother's infants; and she knew that her visits to her natal family would be limited.

Without possessions, fits, or other dissociative states, such as fainting, Sita's psychological disorder was one of anxiety. It would be a mistake, however, to ascribe Sita's possessions and fits solely to psychological and cultural causes. Her medical history provides information as to what may have triggered the possessions and fits. She probably had post-weanling-adult hypolactasia and had begun to suffer from a calcium deficiency even before marriage. Nervous irritability from it was heightened by the onset of menarche and premenstrual tension. She also suffered from primary dysmenorrhea. Although these physiological changes occurred over a period of years, she had begun to suffer more intense pain by the time of mating with her husband. This biologically based pain and her psycho-

logical distress from her new way of life could have triggered the release of endogenous substances such as enkephalins and beta-endorphin that provided relief through possession. If so, it is no wonder then, with all these biological changes taking place, that Sita thought her mind and body were being controlled by someone other than herself who, she believed, was the ghost of Taraka.

When she encountered nursing difficulties after the birth of her first child, her mother told her for the first time that the deaths of her infant siblings were related to nursing problems and their inability to imbibe cow or buffalo milk. These revelations resulted in further anxiety. However, she still persisted in combining this cause of death with the earlier causes, namely, a female ghost who took the infants and the equation of mating with death. By this time, Sita suffered secondary dysmenorrhea and had constant pain. Since she was no longer a new bride, her marital family and neighbors paid little attention to her possessions which then changed to fits. In the succeeding years, Sita had a number of births, some pregnancies lasting 11 months, spontaneous and voluntary abortions, and an operation for kidney stones, and was contemplating another for the same complaint and for endometriosis. The latter condition, probably genetic and related to dysmenorrhea, is found in conjunction with miscarriages. The pain from these disorders of mind and body resulted in chronic, periodic fits.

Sita benefited considerably from her alternate mental states. At the onset of her possessions, she temporarily relieved her anxiety and received a number of secondary gains including support from her natal and marital families, a reduction in her work load and sexual activity, and permission to visit her natal home from time to time. Her fits, operations, and glucose feedings of her infants perpetuated these visits so that in due time she visited her father every summer. Despite her continuing problems, by 1978, Sita had managed to cope as well as possible with her life situation, given her background. She intelligently planned for the welfare of her children and had been the foster mother to her sole surviving brother when her mother died. In a way she was a leader as far as the women

in her marital family were concerned in pushing for education and worthwhile salaried employment. Thus, although she, herself, could not go on in school and achieve her ambition of becoming a teacher, she managed to pass along her ideas and aims in her natal and marital families—no small achievement given the nature of her suffering. If Sita had never had any chronic physical disorder, it is possible that she might never have experienced possessions and fits and that because of her anxiety disorder she would have been labeled by villagers simply as a “worrrier.”

An anthropological-psychomedical case study is perhaps the only way to analyze the etiology of alternate mental states such as a ghost possession and fits. From the point of view of treatment, a therapist would be lost in trying to treat a low-caste Indian woman without a thorough knowledge of ghost beliefs, Ayurvedic and Greek humoral medicine, Hindu mythology and religion, Islamic influences, Indian social structure, and an understanding of the rites by which changes in status are effected at transitional periods of the life cycle. Further, it would be necessary to obtain a complete biomedical history as well, for physical disorders, such as Sita's, were not recognized in the past history of

ghost possession or hysteria, nor were the effects known of endogenous substances, such as enkephalins and beta-endorphin. This study has shown that what was formerly labeled hysteria and conversion hysteria with the associated behavior of possessions and fits may reflect ethnosemantic usages for what were neurotic and psychotic disorders, which could involve real physical complaints. These ethnosemantic labels and the traditions evolving from them often ignored the multiple biological, cultural, and psychological causes, and diagnosed the disorders differently for males and females. In Sita's case, her anxiety disorder is neurotic. It together with the stresses resulting from her physical complaints, the cultural conditioning to the belief in ghosts, and the differences from her married and unmarried states resulted in alternate mental states of possessions and fits.

Analysis of alternate mental states in a specific culture would be greatly enriched by a significant number of comprehensive anthropological-psychomedical case histories that would be available for comparison. At the moment, such a body of data does not exist for North Indian women, certainly not for low-caste rural women. The case of Sita is offered as a step in that direction.

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