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PERCEPTIONS OF MENTAL ILLNESS IN A BANGLADESHI VILLAGE

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ABSTRACT

In this paper, we discuss the perceptions of people from a Bangladeshi village about what they considered to be ‘mental illness’. Observations, informal conversations, interviews, focus group discussions, and illness narratives include the perspectives of both the caregivers and the patients in Kakabo. The villagers provided us with local terms (e.g., *paglami*), their beliefs about illness causation, treatment, and its effects. Some illnesses were believed to be present from birth and mostly incurable. Supernatural causation and local cure were mentioned for some other categories of illness. There were very few instances when they accessed the existing mental health care in the big city. Widespread abuse of various substances was reported. In general, the participants showed broader acceptance of these conditions, excepting certain forms of substance abuse. We discus these findings in relation to defining their perceptions in terms of explanatory model(s). Our analysis is also concerned with the way people ‘embody’ their ‘illness experience’, and how this is made relevant for the process of coping with ‘mental illness’ in the family. Further investigation, however, is required to clarify some of the questions and ambiguities arising from this small-scale exploratory qualitative study.

Key words: mental illness, perceptions, qualitative study, village, Bangladesh.

I. INTRODUCTION

In the absence of reliable data, but based on global estimates, there are supposedly 14 million people with mental illness in Bangladesh and less than a hundred qualified psychiatrists [1]. In this country, as in most of the other developing countries, mental health is a low-priority area, compared to physical health needs [2]. The fact that there is no baseline estimate or exploratory study on mental illness in the community leaves us far behind in the process of incorporating the mental health component into primary health care, as recommended by the World Health Organization [3].

For any mental health intervention to be successful in a rural setting, or even before that, for any problem definition to be *valid* and *reliable* within the community, local beliefs need to be elicited and discussed, prior to any training in the biomedical model of mental illness. Studies repeatedly emphasize on the needs for exploring indigenous belief systems and explanatory models (EMs) [4]. Kleinman defines EMs as people’s perceptions of illness and treatment in a given society, in the context of their cultural beliefs and norms, and employed by all engaged in the clinical process, including the healer- patient interaction [5]. “The ‘view-from-nowhere’ objectivity of biomedicine and science’s discouragement of narrativity” [6] is problematic, whereas "narratives offer a method for addressing existential qualities such as inner hurt, despair, hope, grief, and moral pain which frequently accompany, and may even constitute, people’s illnesses" [7].

This paper discusses the perceptions and terms of people in a Bangladeshi village for what they considered to be 'mental illness'. Observations, responses and narratives included the perspectives of caregivers and patients. Some illnesses were believed to be present from birth and mostly incurable. Supernatural causation and local cure were mentioned for a particular category of illness. There were very few instances when they accessed the existing mental health care in the big city. Widespread abuse of various substances was reported. In general, the participants showed broader acceptance of these conditions, excepting certain forms of substance abuse. These findings are discussed in relation to defining their perceptions in terms of explanatory model(s). Our analysis is also concerned with the way people 'embody' their 'illness experience', and how this is made relevant for the process of coping with 'mental illness' in the family.

Little has been published about mental illness in Bangladesh. Jim Wilce's seminal work, *The Poetics of Madness,* in a Bangladeshi village, looked into the naturally occurring speech involving elements that the Bangladeshis call *pagal* focusing on the 'discourse analysis' [8] which, however, focuses on the relationship between language, society and culture. It offer valuable insights but is not entirely relevant to our current study objective. In this small-scale study, due to various constraints, we were unable to do justice to the unexplored terrain of such linguistic explorations and focused on eliciting and describing people's perceptions of mental illness in this rural community.

II. OBJECTIVES

Our goal was to explore people's perceptions of mental illness in a rural community with the following objectives: 1) to find out the local terms for conditions that people consider to be "mental illness", 2) to understand their explanatory model(s) of such illnesses, and 3) to understand the 'embodied experience' of the people (with mental illness) by listening to and going through their 'master narrative's.

Based on these objectives we initially formulated a few questions with the intention of modifying them depending on the emergent issues and categories of participants, whether they seemed to be 'mentally ill' themselves, or their caregivers or villagers. The key questions to fulfil our study objectives were: i) Do you or anyone that you know have any illness other than physical illnesses? ii) What are the names you have for conditions that are not physical? iii) Do you have 'mental illness' (*moner ashukh, moner rog* or *manoshik rog)* in the community? iv)What do you think causes these illnesses? v) If you know anyone who suffers from such an illness, how do you feel about her or him? vi)What happens if anyone has this kind of illness? vii) Whom do you seek for help? viii) What kind of treatment do you have? ix) Could you tell us more about such illness? x) Why don't you tell us what happened?

III. METHODOLOGY

Study site

This exploratory qualitative study was carried out in 2006 with selected participants from Kakabo village in the Savar sub-district [Fig 1]. Kakabo is a semi-urban village with about 2000 people and around 300 households. It is one of the two villages in the 8th ward of Birulia Union [Fig 2], under Savar Police Station in Dhaka district. Situated just about 25 kilo metres away from central Dhaka, the capital city of Bangladesh, Kakabo harbours people from all over Bangladesh who often migrate and make their home here. The place is near the capital but the living cost is surprisingly low and job opportunities abundant. Many find work in the thriving ready garments industry in nearby Savar. People are expecting a bridge connecting Kakabo and the Mirpur area in Dhaka over a long stretch of water body for quite some time. Once it is done, this village will undergo a very rapid urbanization. At the time of this study, mental health care facilities were non-existent. To our knowledge, no psychiatrist or mental health professional offered services in this village. The local health centre did not diagnose 'mental illness' or provide psychotropic drugs.

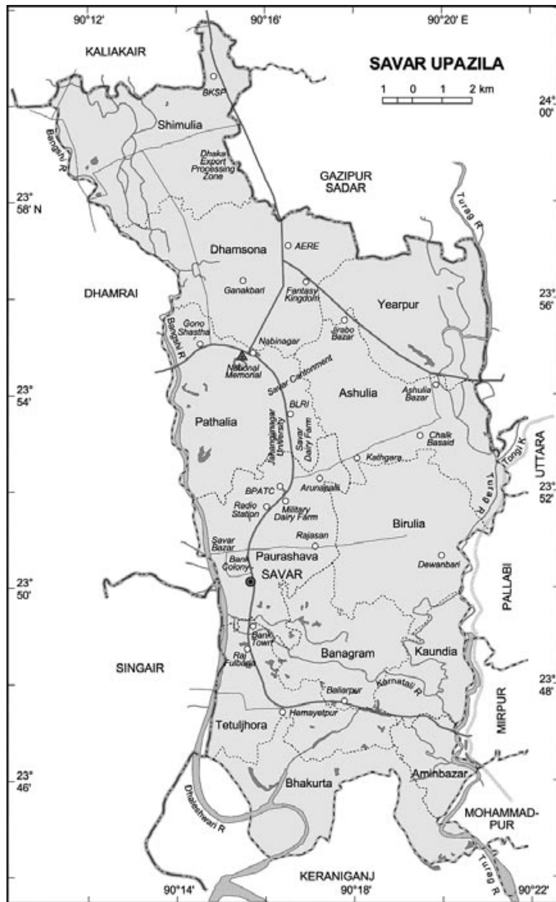

Figure 1: Map of Savar sub-district (showing Birulia union. *Courtesy:* Banglapedia)

Figure 2: Map of Birulia union (showing Kakabo village. *Courtesy:* Savar upazilla parishad)

Study procedure

The research included patients, caregivers and other villagers, men as well as women, young as well as older people. Our approach was a mixture of observation, (informal) conversations, focus group discussions (FGDs), illness narratives and free listing of illness terms. We obtained their informed consents and assured them of maintaining their privacy and confidentiality. The most important 'tool' was however our intuition and openness to what happened during our field visits.

Our purposeful sampling technique brought us closer to the study population that comprised people from the community, e.g., adult men and women with indirect and direct experience of 'mental illness' e.g, the caregivers. With further exploration, we conducted two FGDs, separately among men and women and three in-depth interviews to recount their *stories* and build the explanatory model(s) of 'mental illness' in the community.

We followed certain strategies and a multi-method approach, e.g., *triangulation* to provide as much credibility to our findings as possible. We cross-checked stories with other participants and our own observations, talked to them in informal & formal settings, and tried to have an wider *representation* by selecting a variety of participants – men and women, old and young, patients and caregivers. The researchers exchanged their experiences and views, argued and challenged each other to broaden the horizon of our thoughts & feelings throughout the entire study. Through this we hoped to reduce the *observer bias*. One of the Participatory Rapid Appraisal (PRA) tools, *freelisting,* was used to come up with a list of what is considered to be 'mental illness' in the community.

At first we thought that our struggle would be to find the local terms for 'mental illnesses'. Fortunately, the researchers already had access to the community because of prior participation in local events and we faced little difficulty. There were a few false leads and minor setbacks, but we managed to gain the trust and insider's view of almost all our participants. Besides, we found two key informants, an elderly woman in her fifties who offered her own yard to hold the FGDs, and a young man in his 20s. Both were willing to gather people and help us getting all of them involved during the discussions. We modified a schedule with key questions for qualitative interviews that was taken from a study done by Aidoo and Harpham (2001), an already modified version of what was originally developed by Kleinman (1980)[9,10]. To stimulate responses during our

informal discussions, FGDs and the in-depth interviews, we carried a checklist of key features of common mental illnesses proposed by Vikram Patel (2003) [11].

IV. RESULTS

First day at Kakabo

A man came running down the middle of the road, covered with dust, with only a worn-out checkered loongi on him. Young men sitting at the nearby roadside tea-stall kept yelling at him: "Aye adha-pagla[i]*…langra*[ii]*...come here…are you happy today?" Their tone was condescending, yet quite affectionate and the man they addressed did not seem to mind the language. He was about five feet tall, a small head, all skins and bones, a rough beard and a mustache. He had hazy eyes, looking straight ahead but responded whenever people called him. We learnt that his name was Ainal, the village pagal*[iii]*. We asked him if he would like to eat some moori*[iv] *(puffed rice). He started undoing his loongi and seemed restless and uncomfortable with us. We made a paper cone to give him the moori. He took it and went away happily. We met him again in the evening when we were having a discussion with the men in the village. He was running towards his house with a small packet of turmeric*[v] *and some money. People again addressed him as langra, or Ainal and had small talks with him. He only made sounds in response, and occasionally made gestures to reply to their queries about his recent whereabouts. Ainal obviously has a place in the village social life. People were affectionate, at least while we were around the place. We don't know how it must be at other times. Again he came and sat with us, ate biscuits like a child, enjoying the attention. Someone said we should not make him stay longer. His mother must be waiting for him. Ainal looked better, cleaner. He looked like he had a place among the others. He was a son who had a job to do for his mother.*

This is our first experience with a person (who appeared to be mentally ill) and for whom the villagers had several names, e.g., *pagal, adha pagla, brain out, mathhay chhit*[vi] etc. Soon we came to know more…

Turning the tables

After meeting Ainal, the village *pagal,* we were made to think about the encounter in retrospect: the way we approached him and reacted to his presence; our own taboos and fears. Listening to the villagers also stirred our emotions and brought forth materials from recent and distant memories that proved relevant to our study as well. Our discussion revealed our mindset before and during the study.

Both of us are medical doctors. One researcher had some training in psychiatry, was interested in the patients' narratives while seeing them in clinic, and she made efforts to look beyond the biomedical model. Here she had an opportunity to do exactly that, i.e., listen to stories and trying to understand the 'embodied experience' through this study but ironically she was now struggling with her psychiatrically trained mind which compelled her to think about the diagnosis and treatment. She was aware of this feeling of being trapped in the middle ground throughout this study. For the other researcher who had no background in psychiatry but three years of work in public health sector, the struggle was different. Apart from the research questions, she was keen to dig deeper into these stories and wanted to know more about the every day life, personal challenges, joys and sorrows of people (with mental illness), that could have profound effects on them and the people around them.

Their terms and our models

Gathering people's experience in discussions, narratives, stories and anecdotes we discovered many local terms for 'illnesses of the other kind', perceived causes, manifestations, outcome, and treatment seeking patterns. We present our findings from the different perspectives of women, en, the caregivers, with sections on their access to mental health care and their stigma, myth and social acceptance.

The Women

There was initial reluctance and little discussion until an elderly widow, looking tired and worn-out, retorted when we asked them if there was any illness that was not physical. At first she said, "*shoreer chhara ashukh hoy?"*(Is there any illness that does not have its place in the body?). But another woman, in her late 30s, picked up the hint and said that they did not have that many *moner ashukh*[vii] in their area but heard that it happened in other far-off places. This initial denial of the existence of such illnesses was overridden by

increasing enthusiasm among the crowd of women that had gathered in the courtyard and the women gradually opened up a vista of experiences.

During the discussion, they most frequently used term was *pagal.* Other terms to describe people who wandered aimlessly were: *Mental, Brain Out, Matha Out, Mathar Brain Nashto, Mathay Chhit.* According to the participants, these people were often very dirty and urinated or passed stool wherever they pleased. They would not eat or sleep properly and were often aggressive. They cried or laughed for no reason. *Dhoom pagal* was their term for the most severe kind of *pagal*, those who stayed naked in the streets. *Adha pagal* were those who stayed at home and did not bother their family members or neighbours. Most *pagals*, they believed, had this condition from their birth. For example, *Ainal* was like that from his childhood. But some became *pagal* because of torture or certain life events. One woman told us about a *pagli*[viii] who lived in a nearby village: "It was marriage that made her like this. She was all right before. Now her parents are dead. Her mother-in-law used to torture her." Most of the participants believed that a *pagal* could not be cured while a few commented: Who knows what would have happened if they had been treated! If they could spend enough money, maybe…" Some, however, said that if families could afford to take *pagals* to doctors, they would hardly get better.

Paye dhan harailo/Guptadhon paye haraile (Found the treasure but lost it) is a particular condition within the indigenous category of *pagal* or *brain out* mentioned by the villagers. Some villagers believe in a myth that 'finding treasure' (*Paye Dhan*) and then 'losing it' (*harailo*) could make someone *pagal*. This was illustrated in the form of a folk tale by one of the women:

> Lalu's father, Azam, was a farmer. Near *dakaat mora,* a place that is not far, he saw a hawk that used to come to this hole in a small hill under a big Banyan tree. He went to see what it was and found a heavy piece of shining metal. He thought it was *gayebi maal*[ix] and did not dare touch it. Instead, he went to his uncle and asked him to come with him. His maternal uncle declined but later went by himself without his nephew and took it all. Since then, Azam has been *pagal* and *matha out,* breaking everything, hitting people for no reason. No treatment could cure him. The *kabiraj* tried *jhar fuk* and doctors gave medicine but nothing worked. He gradually went worse with these thoughts and wandered around, lamenting: *Mamu*[x]*, amare dila na!* (O maternal uncle! Why didn't you give me anything!).

The women agreed that *paglami*[xi] was not as common as *batash-laaga,* by far the most common condition of 'the other kind' that was not physical. They thought that *bhut dhora, kalay dhora, batash laga, shapa batash*[xii] were caused by *jinns* or local *bhuts* who were all around at certain times during the day or night. According to them, newly wed brides were particularly vulnerable and the illness made them behave strangely (e.g. vocal abuse, breaking objects, disrespect to elders, uninhibited show of emotion, and convulsions). This was not limited to young women, however. Men and women of all ages could be affected. They attributed this to supernatural causes, but the common belief was that these conditions were usually curable if the afflicted people were taken to a *fakir* early, while there was still time to drive away the evil spirits.

The women also talked in length about *Chinta rog*, the worry illness and *Kheali bhab*, absent-mindedness. One mother proclaimed that she had been suffering from both these conditions. She told us that she did not feel like eating, could not sleep properly, had *buk dhak dhak*[xiii], sweating, and that she was always worried about the future of her family. Her constant worries were mostly related to paying the loans she had taken. She attributed the cause of *chinta rog* to this excessive worry and thought that *chinta rog* resulted in another illness which she named as *kheali bhab.* She felt that there was no real cure for her worries. Doctors were of no use. Sometimes treatment by a *fakir* reduced her sufferings but it was always there.

A few women came up with the term, *pratibandhi* for children with a low level of intelligence compared to other children of the same age. They said that there was no cure for such children and they were bound to grow up to become useless.

Men and nesha paani

With the men, we sat under the shade of a big *Koroi* tree in late afternoon. They were very interested. They had animated discussions among themselves and even shared with us that they had problems themselves. Most of these village men were at first amused watching two city women

coming and talking to them but we were able to pass that stage and established contact with them.

The men brought in a very different perspective on 'mental illness.'Just like the women, they began with discussions about *pagal*, *matha olotpalot*[xiv] and *batash laga, shaapa batash, bishakto batash* but then started to speak about *nesha paani*, the various forms of substance abuse in their community. We found that *nesha paani* was a common practice among men from the age of twenty to fifty. We asked them if they considered *nesha paani* to be a mental illness. A businessman said that it was *moner byapar*[xv], *hoite pare moner ashukh* (maybe, illness of the mind). He said: "If you do *nesha paani* for many years and after the age of fifty you become 'mental', you become *pagal.* You wander around, doing nothing, out of the way behaviour." Others told us that along with Pethidin, Heroin, Phensidyl, and various *nesha tablets* - locally made products, e.g., *bangla mod*, *ganja*, and *taari* were all available and extensively used. One man even offered us a bit of *taal* extract/juice, before it was fermented, but then they thought it was better not to, thinking that we might get drowsy.

We tried to elicit their explanatory model(s) and they came up with a few perceived causes, e.g., emotional hurt, devilish thoughts inside the mind, or just *moja*[xvi]. People who were dissatisfied with their work often did *nesha paani* if there was nothing better to do. They said: "Look, if someone is hurt emotionally, he takes *ganja*. If someone wants to harm someone else, he'll make him take heroin, that's dangerous." They described the various modes of taking drugs (*nesha paani)*: "When they do it for fun, they do it together, with friends. When they take it to relieve pain, they do it alone." Most of them had some idea about the short-term (forgetfulness, sleepiness) and long-term effects of *nesha paani.* They thought that there was no cure but 'self-cure' ("Only if someone really wants it, he can stop.") One man cracked a joke to which everyone laughed: It doesn't cost much to be good. Being bad is costly.

A contradictory view emerged when they were discussing how others feel about those who take *nesha paani.* Some admitted that people considered them to be bad people who had gone astray; they were often beaten up and sometimes parents would hand them over to the police. But this habit of taking *nesha paani* did not seem to be always looked down upon. It was also considered to be manly. One man summarized a male-centred attitude towards *nesha paani*:

> A man is not a man without *nesha paani* A man has to have some kind of *nesha* to get him through life. No man in this world can be without *nesha*.

Awareness of mental health care

None of our participants felt any doctor could cure these conditions. They mentioned that they frequently went to Savar or Dhaka for seeking treatment for their physical illnesses, but they did not do so for the 'other kind of illnesses. They had never heard of a psychiatrist and hardly knew about the existing mental health care facilities in Dhaka. A few of them had heard about the big Mental Hospital in Pabna, which they thought was the ultimate place for *pagals.* During our discussion, an adolescent girl laughed out loud and sang to us:

> *Jar jato bhabna, she jay Pabna.*
> (Those who worry, they go to Pabna)

Mirgi Rog

An independent source was an unmarried adolescent girl who acted as our guide in the village. She mentioned *mirgi rog*[xvii] and we later followed it up by visiting the house of a ten year old boy suffering from repeated convuvlsions (*khichuni*), who was known to have this *mirgi rog*. His mother, in her thirties, no formal schooling, gave us a graphic description of what is known in biomedical terms as epilepsy:

> When he was one to two years old, we thought it was *batash laga*, touch of the bad wind. He had *khichuni*, he fell on a cooking pot and hurt himself. When he has *khichuni*, froth and sometimes blood come out of his mouth. He clinches his teeth, loses his senses completely, sometimes he urinates and passes stool as well. He has fanning of toes and claw hands with jerky movement.

She said she did not know why her child had this, and shared with us what she heard from others who said that this was because she ate *mirgi machh*[xviii] or had *megher paani*[xix] on her head after delivery. She took her son to a city doctor who told her that it was because she took some medicine to kill the baby inside her. The mother took her son to see many doctors in Dhaka, who did X-Rays and prescribed medications. They told her to keep him away from fire, water and sharp objects. The villagers suggested that she should eat the head of

that *mirgi machh* which she tried but nothing worked. Even *jharfuk* could not cure her son. She said that she asked her son if he had seen a ghost or something, but the son said that he felt something was shaking inside his head. That is why she thought it had nothing to do with the spirits or even the mind. It was just *mathar rog*[xx]. The mother was very protective about her child and resented the comments by some villagers who told her that she should keep her other sons separate from the boy, implying that *mirgi rog* could be contagious. But she said that it made no sense – none of the members in the family ever got it and they drank from the same glass or ate from the same plate.

The experience of a father

The most striking experience that we had in the field was when we met Ainal*'s* father, about seventy years old and father of seven children. He was resting in his thatched house at the end of the village, facing the green horizon of paddy fields. A seller of trinkets and mud jewellery, he had seen better days and now appeared to live in extreme poverty. We saw him with a wide grin on his worn-out but still spirited face. He told us what it meant to be taking care of a son who was not like other children, who could not speak or think for himself at times, who had a tendency to get lost and was considered to be the village *pagal*. He had tried whatever he thought was useful, spent as much money as he could, and made efforts to get his son married. But in the end he had accepted his son's condition. We 'edited' his tale slightly to provide the reader with a direct experience of what he told us:

> Ainal is *Pagal, mathay chhit*. I have wasted so much money, went to India, Kolkata, *Ghutiari sharif*, of a *Jinda Pir*[xxi]. I did *manat*[xxii] in all the *mazars*[xxiii] in Bihar, Kuch Bihar, Jalpaiguri, Siliguri[xxiv]. I went to all the *Alga doctors*[xxv]. I will tell you the truth. I have never tried to take Ainal to a hospital. Never. I never sent him to a school… Few days after his birth, he had a *Batash*, he would not crawl, could not walk… No one in this village is like him. He can't speak but he understands everything, he works very hard. He can feed himself, he can take care of himself. He takes care of things in the house… But sometimes he is angry, cranky, starts crying, makes a lot of sound… *Aaaa*… without any reason. His brothers or sisters won't take care of him, I am worried about him… Last year he got lost after *Eid.* I went to many places, near and far, to *Tangail, Narayanganj, Tongibari*[xxvi]. Searched areas where the *pagals* lived and looked for Ainal. I almost spent ten thousand taka. Saw many *pagals* but no sign of Ainal, it was the worst time in our lives – as if the sky has fallen on our heads…. After three months and eleven days he returned…. The villagers like him, they never scold him, every one loves him and he is like that. Even if there is lump of gold on street he will never take it... We never have enough to eat as I have spent so much money on him and other children, now I am old, I can't earn the way I used to… No land of my own because I spent all my money on Ainal. I think, I worry about Ainal*'s* future. *Pagaler mon, dariyar dheu* (The mind of a mad man is like the waves of the ocean). Ainal is not a *dhoom pagal*[xxvii], but we worry about him because in this generation, these days, brothers and sisters don't take care of each other and so parents worry, specially about such a child. We tried to get him married…a villager got a beggar girl from Mirpur and we married them off. We thought if he had a family of his own he would do better, there would be someone to take care of him but it did not work… The girl was disrespectful, did not listen to any one. But villagers said that Ainal was not a proper husband and I did not argue with them. Ainal didn't like his wife, they used to fight. So she left. It is difficult, but I never lose hope. I always try every new things people tell me to try out. I always have some hope [sigh]. Not every one is the same. God has given unique power to each and every one. His mercy is on every one, people need help, without help where would they go? I'm a disciple of the *maiz bhandari*[xxviii]. I believe that life has a place for everyone**.**

Stigma, myth and acceptance

We found that the villagers talked openly about what they perceived to be 'mental illness'. There were some responses indicative of social stigmas and few myths about 'mental illnesses' in the community but beyond that we found a greater social acceptance of them. One young woman told us that mentally ill people kept their emotional sufferings to themselves. But women often talked to other women, which, they believed brought relief. They also told us that both men and women with *batash laaga* had difficulty getting married. Women were afraid to stay close to men who were *pagal* or *matha out*, because they were aggressive,

sometimes loud, and indecent. But they also said that they were more tolerant to one sick woman who was considered harmless. They would take her to their house and even let her sleep in their inner courtyard. Whoever we talked to, there was more sympathy in their voice and attitude than scorn or ridicule. One of the women said affectionately: They are *pagal*, they have their own mind. We let them be.

V. DISCUSSION

We will discuss these findings in relation to people's explanatory model(s) and the way they 'embody' their 'illness experience', and their coping with 'mental illness' in the family and the community. We will also make efforts to understand how poverty and the transitional state of a village like Kakabo, its gender difference, shift in the status of women, role of media, and lack of access to mental health care affect the 'mental illness' perceptions of its inhabitants. We will end with a short inquiry into the existing general acceptance of these conditions among the villagers.

Illness categories

Among Kakabo villagers we find at least six different types of 'mental illness', e.g. *pagal, bhut dhora, chinta rog, pratibondhi, mrigi rog, and nesha paani.* Their everyday knowledge offers them appropriate explanations, relieving their anxieties and offering them hope. They are mostly unaware that biomedicine has a few things to offer to illnesses such as *mirgi rog*, certain *nesha paani*, e.g., heroin abuse and a number of *paglami* (similar to mental illnesses, e.g., schizophrenia, bipolar mood disorders, brief psychotic disorders). We realize that we were always in a double bind for interpreting their local terms with ('western') biomedical concepts. We did not always try to find equivalent biomedical terms for these conditions knowing that these would not be accurate. Each society is different in thinking and categorizing their experience, and they express these in their culturally specific language. Kakabo is no exception.

A village in transition, a village in poverty

Kakabo village and its inhabitants live within an hour's drive from the capital city of Dhaka. A short stroll around the village is enough to make one realize that this is not a completely rural community. Most roadside tea-stalls have televisions with cable network. People watch foreign movies, take interest in the latest international news, and, are not immune from the consumerism spread by the advertising industry through the media. What they called *Paye Dhan Harailo* (Found the treasure but lost it) was a recurrent theme in our discussion.

The young men we talked to were not happy with their lives. They said they were involved in work they did not like. Through international TV channels and cheap video CDs, they are exposed to the lifestyle of the 'rich and famous'. Living close to the culture of the rich in Dhaka city raises false hopes and unrequited dreams of making quick money, adding dissatisfaction to their lot. This feeling of social deprivation can be directly linked to widespread drug abuse. While discussing *nesha paani* with the men, we also felt that the 'manly image' of film stars, show biz and media personalities could have influenced the behaviour of these people which made them experiment with smoking, alcohol and drugs like heroin. Non-judicious use of such substances can be attributed also to their availability and legally sanctioned access to sedatives such as diazepam (Seduxen), flurazepam (Aluctin) etc. that cause further deterioration of the overall well-being of specially young men.

The village is far from resolving its poverty. Our participants expressed guarded hope when they said that spending money might have cured the ill people. They expressed frequent worries that can be correlated with increased stress due to disintegration of joint families and loss of traditional values as a result of rapid urbanization, which does not necessarily reduce poverty. Micro credit is assumed to reduce vulnerability by increased income generation [12] but in Kakabo, it seems that it can also become a source of constant worry. One self-reporting patient of *Chinta rog* and *Kheali bhab*, told us that she and many other women like her worried about their future and their families, mostly in relation to loans. Profound commoditization of life has led to increased material demands among these rural people.

It should finally be noted that, contrary to our urban preconception, the Kakabo villagers do not believe in supernatural causation only. They attribute importance to individual choices, life styles and the nature of associated life events. It seems modernity is creeping into this village.

The gender question
We have seen a significant difference between the perceptions of women and men. Men spoke elaborately on *nesha paani* while women were mostly preoccupied with *chinta rog, kheali bhab* etc. It seems that men tend to take up *nesha paani* to deal with their emotional pain and are more affected by it than women. It brings into mind the question of greater mobility and financial capacity of men compared to women, a reason why men have more access to such addictive substances. Women, however, seem more prone to distress and worry for which there is no relief other than talking among each other or taking occasional help from the *kabiraj* or *fakir*.

Traditional healing works
There is need for more research to explore the role and efficacy of traditional healing in ‘mental illness’ and to assess the need for mental health interventions (e.g., anti-epileptic drug for *mirgi rogee*, psychotropic medications for *pagal* and detoxification services for *nesha-paani*). For example, the common condition of *bhut dhora* is believed to be curable and most traditional healers seem apt to identify and treat such conditions. In many cultures spiritual healing was found to be more effective in such conditions because the healers explained these in familiar terms, mobilized social support, took into account the core values, and comforted both the patients and their families. But, with the exception of *bhut dhora,* the Kakabo villagers leave their mentally ill to themselves and their families. It is obvious that although the Kakabo villagers felt the need to seek treatment for their physical illnesses, they were not keen to do so for the ‘other kind’ of illnesses. The nearby Savar Ganashasthya University has a practising psychiatrist and the nearby capital city has three hospitals with tertiary mental health care facility, but the villagers we talked to had never heard of a ‘psychiatrist’ and they categorised illnesses as various local conditions of ‘the other kind’, ‘not physical kind’ rather than putting them all under one category of ‘mental illness’. Another question that our study raises, therefore, is whether there is a perceived need for ‘mental health care’ in Kakabo.

Life has a place for everyone
The attitudes and narratives illustrate a broad level of social acceptance of the ‘mentally ill.’ People like Ainal have their social space among men and women. Villagers are not very secretive or ashamed of the ‘mentally ill’ among them. Marginalising the sick is not evident, and certain forms of substance abuse are accepted or condoned. Centuries of community living make people believe in an inclusive world-view, not reducing people to their functional state only. Or is it because the villagers expect little from life, and are satisfied with less? Many hold fast to their spiritual beliefs that God created all and that life has a place for everyone.

VI. CONCLUSION

We have explored the mental illness perceptions in this villageo. The emerging patterns, however arbitrary, illustrate that there is a hidden body of knowledge that needs further investigation. Not much much is known and little effort has been made to incorporate indigenous knowledge with the existing body of knowledge of mental health in Bangladesh. There is a paucity of studies in this particular research topic, and we believe that even this small-scale study can point towards a direction for future wide-scale investigations and intervention research in mental health.

Notes

i. *Adha Pagla* means halfwit. In this case people used the term affectionately for addressing *Ainal.*

ii. *Langra* usually refers to a disabled person;often used as a derogatory term for someone who does not have a limb or has trouble walking properly.

iii. *Pagal* is mad man (or woman). Most commonly used term for the deranged and the mentally ill.

iv. *Moori* is puffed rice.

v. *Turmeric* is the paste made from the rhizome (roots) of a plant, used in Asian countries for culinary purpose,e.g., to add yellow colour.

vi. *Mathhay chhit* = crack pot (derogatory)

vii. *Moner ashukh* is illness (*ashukh*) of the mind (*mon*).

viii. *Pagli* usually refers to a woman considered mad by the community; although the term is often used as endearment.

ix. *Gayebi mal* are objects thought to have supernatural origin.

x. *Mamu* is maternal uncle.

xi. *Paglami* is madness, the condition of being a *pagal.*All kinds of major mental illnesses are lumped together and considered as *paglami.*

xii. These are considered as 'conditions of the other kind' attributed to the works of the evil spirits.

xiii. *Buk dhak dhak* refers to anxious palpitations.

xiv. *Matha olotpalot*=turmoil inside the head

xv. *Moner byapar*= matter/affairs related to the mind

xvi. *Moja* is enjoyment.

xvii. *Mirgi rog* is Epilepsy like sickness.

xviii. *Mirgi maachh* is mirgi or mrigel fish, a big fish not liked by many.

xix. *Meger paani* is rainwater.

xx. *Mathar rog* is disease inside the head, usually associated with mental illness. Here, however, the mother was not associating this with the mind but the villagers did.

xxi. *Jinda Pir* is believed to be a holy man whose presence is felt even after his death.

xxii. *Manat* is the pledge made by people to give something in return if the blessing they received in the holy places actually brought in results.

xxiii. *Mazar* is the final resting place of the *Pirs,* the holy men.

xxiv. Places all over India.

xxv. *Alga Doctors* are non MBBS village doctors.

xxvi. Places near Dhaka.

xxvii. *Dhoom pagal* means completely deranged and insane.

xxviii. *Maiz bhandari* is an unorthodox Islamic sect originating from the village of *maiz bhandar,* Chittagong, in the Southern part of Bangladesh. They believe in religious tolerance and unconditional love for all beings through devotional songs and mystical practices.

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REFERENCES

1. World Health Organisation Bangladesh (WHO BAN): *Mental health & substance abuse.* Electronic document, accessed March19,2006,from http://www.whoban.org/nc_mental_health.html. (2006)

2. K.S.Jacob: "Community care for people with mental disorders in developing countries: problems and possible solutions" *The British Journal of Psychiatry*, **178**, pp 296-298. (2001)

3. World Health Organisation (WHO): *The introduction of mental health component into primary health care.* Geneva: World Health Organization. (1990)

4. D. Joel et al.: "Explanatory models of psychosis among community health workers in South India", *Acta Psychiatrica Scandinavica*, **108 (1)**, pp 66-69. (2003)

5. A. Kleinman: "Towards a comparative study of medical systems", *Science, Medicine and Man*, **1**, pp 355-365. (1973)

6. J.M.Wilce: Narrative transformations: Emotions, language, and globalization. *In*: C. Casey & R. Edgerton (eds), *Companion to psychological anthropology*. Oxford, Malden, MA: Blackwell, p 134.(2005)

7. T. Greenhalgh, B. Hurwitz: "Narrative based medicine: Why study narratives?", *British Medical Journal*, **318**, pp 48-50. (1999)

8. J.M.Wilce: "The poetics of 'madness': Shifting codes and styles in the linguistic construction of identity in Matlab, Bangladesh", *Cultural Anthropology*, **15(1)**, pp 3-34. (2000)

9. M. Aidoo, T. Harpham: "The explanatory models of mental health amongst low-income women and health care practitioners in Lusaka, Zambia", *Health policy and planning,* ***16*****(2)**, pp 206-213. (2001).

10. A. Kleinman: *Patients and healers in the context of culture*. Berkeley, CA: University of California Press. (1980)

11. V. Patel: *Where there is no psychiatrist: A mental health care manual* (1st edition). London: Gaskell. (2003).

12. A.M.R. Chowdhury: Impact of development interventions on health in Bangladesh. *In*: J. Rhode & J.Wyong (eds), *Community-based health care: Lessons from Bangladesh to Boston*, pp 61-84. Boston: Management Sciences for Health. (2002)