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Ayurvedic Psychotherapy: Transposed Signs, Parodied Selves

I am sitting around a table in an Ayurvedic hospital in North India with a psychologist, a doctor, the office gopher and a patient, a student in her early twenties. The patient, who has been here before, complains of pain in her lower back. The psychologist inquires after her sister and explains to the doctor that the sister has many mental problems. The psychologist, doctor and gopher take several minutes to discuss anxiety and depression while the patient sits silently. The psychologist talks about the need for a counseling and guidance center for students. Then the psychologist examines the patient’s case form and comments that she is extremely “sensitive,” using the English word (“bahut zyada sensitif”). The young woman says she is sleeping fitfully. The psychologist suggests that she have a positive outlook and tell herself that everything will be okay. She reassures her that the physical pain she is experiencing will go away. They discuss the patient’s career plans. She would like to get a job and live alone; then, she says, she would feel happy and peaceful. The psychologist tells her that remaining unmarried is out of the question for Indian women. You will be harassed by men, she says; you have to compromise. If you don’t marry who will you talk to? They discuss the placement of planets in the patient’s birth chart. Mars is poorly positioned (kharab). The conversation turns then to the young woman’s stomach problems. The psychologist and gopher launch into a long discussion of the patient’s diet. They recommend pomegranate and milk with cardamom. The young woman tells us of her fantasy of living in a village. The psychologist tells her she wouldn’t be able to adjust; villagers, she says, are very “orthodox,” using the English word. They discuss further details of the young woman’s diet. After she leaves the psychologist comments, “bahut emotional hai,” i.e. she is very emotional. She diagnoses the young woman with “secondary depression” due to physical problems.

This account is a sample of Ayurvedic psychotherapy as it has been (re)invented over the last decade and a half at a particular Ayurvedic hospital in North India. Ayurveda is a complex of indigenous South Asian healing practices which can be traced back three thousand years. At the hospital in which the above session unfolded, Ayurvedic psychotherapy is conducted by the above-mentioned psychologist who is trained in both psychiatry and kayacikitsa (one of the eight branches of Ayurveda which encompasses most of the medical treatment currently practiced). Such therapy is also conducted by Ayurvedic M.D. students specializing in mental health under the supervision of Dr. Singh, a prominent physician noted for his work in the field of mental health. Dr. Singh is the intellectual force behind the definition and development of Ayurvedic psychotherapy at his institution. In this paper I explore why the practice of Ayurvedic psychotherapy at this hospital, as I observed it, seems to trouble and even parody North American conceptions of the purpose and narrative course of psychotherapy. I argue that such sessions as I recount here disrupt one of modernity’s central assumptions, an essential interiorized self, at what would ordinarily be a key site in its deployment, the confessional form of psychotherapeutic consultation.
Sattvavajaya

In a passage in the eleventh chapter of the Sutrasthanam of the Caraka Samhita, considered to be one of the three oldest texts of Ayurvedic medicine, probably dating from several hundred years B.C., there is reference to three types of therapy, daivya therapy, yuktī therapy and sattvavajaya. In one of the more literal translations of the Caraka by a noted Ayurvedic scholar this verse reads:

There are three types of therapy—spiritual, rational and psychological. The spiritual therapy consists of recitation of mantras, wearing roots and gems, auspicious acts, offerings, gifts, oblations, following religious precepts, atonement, fasting, invoking blessings, falling on (the feet of) the gods, pilgrimage, etc. The rational therapy consists of rational administration of diet and drugs. Psychological therapy is restraint of mind from the unwholesome objects [Sharma 1986, Volume 1: 79] ²

Outside of this one verse, there is no other mention of sattvavajaya in any of the seminal Ayurvedic texts. Over the last fifteen years Dr. Singh has developed sattvavajaya as an Ayurvedic specialization which he translates as psychotherapy. In the Ph.D. theses written under his direction this translation of sattvavajaya first appears in a 1981 thesis primarily devoted to the use of certain Ayurvedic drugs for anxiety and depression. Prior to that time theses on mental health written by Singh’s students concentrated for the most part on mind-strengthening (medhya rasayana) drugs (e.g. Malviya 1976, Mehta 1976). The author of a 1980 thesis evaluated the effectiveness of “traditional mental health promoting practices” which he identified as health regimens (swasthvrīti), correct behavior (sadvrīti), and yoga. The research subjects underwent a program of “mental health education” which included training in the above three practices; sattvavajaya was not mentioned. The author of the 1981 thesis, after defining sattvavajaya as psychotherapy, comments that the mental restraint, or as he translates it, “mind control,” referred to in the above passage of Caraka, is achieved through “spiritual knowledge, philosophy, fortitude, remembrance and concentration” (Tripathy 1981: 25). He goes on to say that, according to Ayurveda, “volitional transgression (prajnaparadha)” is “the main etiopathological factor” in mental illness, and can be corrected through psychotherapy. It is not until five years later, however, that sattvavajaya was first used in M.D. research at this university. During the interim the concept seems to have been fleshed out by Singh and his students until, along with drugs, it became a primary treatment for mental disorders at the university’s Ayurvedic hospital.

In Dr. Singh’s 1986 book on Ayurvedic mental science, the discussion on sattvavajaya is less than a page long, suggesting that at the time of writing he was just beginning to elaborate his ideas on the subject. In that section, referring to the above-mentioned sutra (aphoristic passage) from Caraka Samhita, he wrote, “Sattvavajaya is that method of treatment through which one tries to bring the intellect (dhi), fortitude (dhṛti) and memory (smṛti) of the patient into a proper condition” (Singh 1986: 139). He draws on sutra elsewhere in Caraka to identify two methods of sattvavajaya: assurance to the patient of the return of lost objects or persons and inducement of emotions opposite to those associated with patient’s distress. In a joint paper written by Singh and a Czechoslovakian psychiatrist (also published in 1986) one more method of sattvavajaya, psychoshock therapy, whereby a patient is suddenly frightened to jolt them into another mental state, is added to this list (Nespor and Singh 1986: 29). Then, in a 1986 thesis
on the use of group sattvavajaya for irritable bowel syndrome another five techniques of sattvavajaya are listed: regulation of thought, reframing of ideas, channeling of assumptions, refining of objectives and ideals, and proper guidance in decisions (Murthy 1986: 53). In a list on Dr. Singh’s office observed in 1995, there was only one addition to this list: the inducement of patience in the mentally ill person. In conversation Dr. Singh informed me that reassurance and replacement of emotions are the two most important techniques of sattvavajaya.

Addressing the fact that sattvavajaya has only been mentioned once in the ancient texts, the 1986 M.D. student writes, “All these facts reflect one thing—psychotherapy including sattvavajaya was done by some specialists at the time of Caraka” (Murthy 1986: 55). He refers to another passage in which Caraka advises persons with mental disorders to visit specialists. Apparently in verses 46 and 47 of Sutrasthanam Chapter 11, solutions for mental disorder are identified as proper pursuit of righteousness, possessions and pleasure, service to experts, and knowing oneself, including one’s place, time, strength, and abilities (Sharma 1981, Vol. 1: 77-78). The student goes on to explain that most of the texts extant from that time are from the kayacikitsa branch of Ayurveda which concentrates on corporeal treatment. “However,” he writes, “whatever is available is very concrete and fundamental on the basis of which the whole concept of psychotherapy as prevailed in those days can be pictured very easily” (Murthy 1986: 55).

Embedded in this comment is a familiar national-cultural narrative of loss and recovery. In this version psychotherapy is posited as an aspect of the primordial essence of Ayurveda at the same time as and by means of a recognition of its decline and proposal for its revival. The construction of Ayurvedic psychotherapy metonymically mirrors the construction of Ayurveda itself as a traditional knowledge. The authors of countless Ayurvedic texts published over the last century employ a narrative in which ancient Ayurveda reflects the glory of ancient Indo-Aryan civilization while contemporary Ayurveda reflects the sad degradation of that civilization. This narrative, not unique to medicine, arose in the early nationalist historiography of the late nineteenth century. Of this historiography Chatterjee notes that in order to affirm India’s "historical agency for completing the project of modernity, ancient India had to become the classical source of Indian modernity, while ‘the Muslim period’ would become the night of medieval darkness” (Chatterjee 1993: 102). If such a narrative was vital to the construction of a national subject it was equally vital to the construction of a national medicine. This narrative dovetailed at least partially with European agendas by confirming the orientalist notion of classical origins of modern nations. In the mid-nineteenth century Orientalist scholars studying Ayurveda contrasted its current practice, which they considered to be steeped in superstition, with its ancient texts, which they recognized as based on sound erudition, even though, ironically, they consulted vaidyas (Ayurvedic practitioners) of their own era to interpret these texts. Thus Thomas Wise, a noted orientalist scholar of Ayurveda concluded “The native practice of medicine may now be said to be in this lamentable state of depression over all Hindustan; but it was far otherwise, as cultivated by the ancient Hindus” (Wise 1845: v). This orientalist valorization of ancient texts over current practice set a standard for scholarship that was accepted by those Ayurvedic practitioners who sought to prove Ayurveda’s authority, first to a nascent nationalist movement and later to the Indian Ministry of Health.
What is noteworthy in the case of Ayurvedic psychotherapy is not only that an entire field of specialization has been elaborated from one slok (verse) but also that this field is found to correspond to and thus anticipate modern psychotherapy. Thus in the collaborative paper by Singh and the Czech psychiatrist the technique of replacement of emotion is compared to shuttling in Gestalt therapy, while reframing of ideas is compared to Ericksonian hypnosis (Nespor and Singh 1985: 29). Since sattvavajaya literally means “winning the mind” the single reference to sattvavajaya from which Ayurvedic therapy has been (re)constituted could easily be interpreted to mean not a relationship between doctor and patient, but rather a mental discipline. In fact, of the three types of therapy listed in the verse, only one, yukti, translated above as “rational” therapy, seems to require the interventions of a healing technician. The others appear to refer to therapy that can be administered by oneself or by one’s family or community or by a practitioner who specializes in mediations with unseen realms. In the passage in Caraka which describes the treatment for unmad (insanity or psychosis) it is suggested that a friend of the ill person console or shock the patient, while in the passage on apasmara (understood by contemporary practitioners as epilepsy), it is suggested that a friend should talk to the patient about righteousness, wealth and so on (Sharma 1981, Vol. 2: 170; 177). The author of the 1986 thesis acknowledges that sattvavajaya could signify “subjective mind control” but argues that Caraka is speaking of “objective” mind control involving the doctor’s “interference” (Murthy 1986: 112). Dr. Singh confirmed this in conversation, saying that in sattvavajaya “a physician wins the mind of the patient.”

Imported Interiority

The psychotherapy practiced by the M.D. student in his 1986 research and observed by me at the same institution nearly ten years later was short term group psychotherapy, partly resembling psychotherapeutic paradigms of Europe and North America. While the student wrote that he incorporated the principles of Ayurvedic sattvavajaya into the therapy he did not elaborate. In personal conversation Dr. Singh told me that there is no fundamental difference between sattvavajaya and modern psychotherapy. In his opinion, both involve the removal of the mind from harmful sense-objects. In the discourse radiating from his (re)invention of sattvavajaya there is no reference to the mining of the mind to reveal a true interior self.

Yet genealogies of modern selfhood suggest that psychotherapy is an institution in which authentic interior selves are constructed, at the same time as and by means of the epiphany of their repression and the move toward their recovery. In The Subject and Power Foucault is concerned with a form of power and objectification which is key to the transformation of human beings into subjects in “our modern culture” (Foucault 1982: 210, 213). He traces this power to the “pastoral power” exercised originally by Christian ministers whose aim was to assure the salvation of the individual. One essential ingredient of pastoral power which has since diffused into modern institutions from medical consultations to police confessions, and from autobiographies to social work interviews, is its focus on the interior of the individual. As Foucault writes, “...this form of power cannot be exercised without knowing the inside of people’s minds, without exploring their souls, without making them reveal their innermost secrets” (Foucault 1982: 214). It is this mode of power which eventually “spread out into the whole social body,” becoming “an individualizing ‘tactic’” which infused family, medicine, psychiatry, education and the relations between employers and employees in the workplace
(Foucault 1982: 215). This individualizing tactic is productive of "truth—the truth of the individual himself" (Foucault 1982: 214). According to Foucault, therefore, it is a mistake to imagine that this power represses pre-existent individuals but rather, constructs individuals (Foucault 1979: 194). In the case of psychotherapy, a therapeutic consultation produces an interior self, complete with hidden conflicts and feelings, through a dual move of positing its suppression and soliciting its expression.

In modern civil society the counterpoint to public citizenship is private sentiment. Psychotherapy is one of several confessional idioms which reinforce a modern expressivism wherein revealed emotions and inner experiences become signs of an inner and non-rhetorical "real" self. Charles Taylor has detailed several historical strands in Europe and North America which reinforce this imagining of selfhood, from Romanticism through Freudianism and beyond into contemporary "human potential" movements (Taylor 1989). Of the relationship between interiority and expressivism which developed with Romanticism he observes, "The concept of an inexhaustible inner domain is the correlative of the power of expressive self-articulation. The sense of depth in inner space is bound up with the sense that we can move into it and bring things to the fore" (Taylor 1989: 390). Later he notes how Freudianism, though it insists on an objective understanding of depth as opposed to the artistic revelation advocated by the Romantics, nonetheless depends on this same relationship between interiority and expression. He writes, "The very terms of Freudian science and the language of his analyses require an articulation of the depths" (Taylor 1989: 446). According to Taylor, this turn toward expressivism involves a shift to an understanding of art as expression rather than mimesis (Taylor 1989: 379). Similarly we can argue more broadly that the turn toward expressivism involves a shift to an understanding of personal identity as expression rather than mimesis. Thus the source of personal identity is to be found within, as one's true nature, rather than in the social realm, as one's learned personae.

In this modern expressivism, then, the ways in which personal identity and emotions are constructed through social interchange are necessarily obscured (Taylor 1985: 278; Lutz 1988: 224). Paradoxically, the private authentic self of the modern era is both quintessentially individualized, and, at the same time, abstract, generic and categorizable. While the private self is a sign of personality she is also a "case," a subject of examination (including self-examination) which can be compared to other subjects. A "case," as Foucault points out, is an object both of knowledge and of disciplinary power: "it is the individual as he may be described, judged, measured, compared with others, in his very individuality; and it is also the individual who has to be trained or corrected, classified, normalized, excluded, etc" (Foucault 1979: 191).

Whereas, prior to the modern era, individuality in Europe was marked by ceremony, gift-giving, lineage, alliance and so on, which locate the subject in relation to ancestry, it is now marked by techniques of surveillance such as examinations which locate the subject in relation to a norm. Foucault writes, "All the sciences, analyses or practices employing the root 'psycho—' have their origin in this historical reversal of the procedures of individualization" (Foucault 1979: 193).

This modern narrative of the individual subject is noticeably akin to the modern narrative of national-culture discussed above: both narratives naturalize an identity which they simultaneously construct; both narratives assign primordial depth to something which is an effect of certain modern political exercises. These are parallel folktales, the first serving to
mystify the invention of interiorized individuals and the second to mystify the invention of cultures. Ayurvedic psychotherapy would presumably therefore, play a dual role: first, as a revival of authentic medical culture, the exercise of a practice with an assumed primordial dimension, and second as a discovery of authentic subjectivity, the revelation of a self with an assumed interior depth.

The extent to which the private expressivist self has been transposable into Indian settings, however, is questioned by social historians such as Chakrabarty who notes that the European split between public and private, false and authentic selfhood is never simply reproduced in Indian modernities (Chakrabarty 1992; 1993). Chakrabarty notes that, although such signs of the bourgeois private self as novels, diaries, letters, and autobiographies were introduced in India during the mid-nineteenth century, “they seldom yield pictures of an endlessly interiorized subject” (Chakrabarty 1992: 9). Similarly he observes elsewhere that nineteenth century Bengali widows did not experience the withdrawal of affection from in-laws as the withdrawal of an authentic inner love, but rather as the withdrawal of specific relations of dependency and responsibility with specific affinal kin (Chakrabarty 1993: 8). Thus the liberal humanist discourse of abstract rights of inheritance or remarriage could not address the radical particularity of the widows’ suffering. In colonial and postcolonial India, the institutions which have allowed Europeans and North Americans to imagine modern interiorized and expressivist selves, seem to serve rather to proliferate new kinds of socially centered and mimetic selves.

A handful of ethnographic vignettes from my observations in the Ayurvedic hospital mentioned above, demonstrate this process. They suggest that within group psychotherapy in the contemporary Ayurvedic hospital foregrounded above, psychological interior selves are not authorized as authentic, prior, or central. This casual subversion of the status of interior selves is, I will argue, not due to any lack of gesturing toward interiority, but rather to a relativization, even trivializing of interiority. The narrative I read in these stories is one in which the invention of a true inner self at the moment of the awareness of its repression seems to be not mystified but delightedly announced. Thus the artificiality of this “authentic” self is very evident, and the interiority of this self becomes one more surface ephemera.

Rhetorical Selves

Two young men arrive for group therapy. Seated around the table are the psychologist and the anthropologist, as well as another doctor and, off and on, the office gopher. The first patient, in his early twenties, complains of chronic weakness, stomach pain, muscular tightness, and constipation. The psychologist questions him about his future plans in relation to his family’s means and expectations, probing for a conflict between the two, which he denies. She then asks about his dreams. When he says that he dreams mostly about religious themes, holy rivers and temples, but sometimes about taking exams, the psychologist and the doctor exchange glances, smiling, nodding, and saying in English, “anxiety, anxiety.” Again the psychologist asks if he feels pressure from his family about his future, and again he says no and returns to the topic of his digestion. The psychologist informs him that the source of the problem is that vayu, one of the three dosa or bodily humors, is not circulating properly. She and the other doctor then spend fifteen or twenty minutes discussing his diet, recommending, at various points, dried fruits, warm milk with sugar and cardamom, lemon water to wash out his digestive tract, and so on.
Then he volunteers that he also has a history of piles. Here the gopher, who is avidly following the session, chimes in, telling the patient which hospital clinic he should consult for piles. No one seems surprised at or disapproving of the gopher's participation. After examining case records about the piles the psychologist briefly discusses diet again, and then refers to the worry which she identifies as "inside" the patient. She suggests once more that he is experiencing tension because of a lack of parental support to continue his studies. He tells her that actually, when he was twelve he was forced to have sexual relations with a man. He is concerned that this is the root cause of his piles. The conversation ranges then from the possible relationship between male homosexual behavior and piles, to remedies for piles. When the psychologist says the patient is afraid, he disagrees with her. The other doctor informs him then of his unconscious mind, and the psychologist explains that there is a "conscious," an "unconscious," and an "in-between," using the English words. Then she tells him to apply calendula ointment to his piles. You don't have a big problem, she says. Your weakness results from improper diet. She tells him to drink warm milk with turmeric, repeating, you don't have any special problem.

The psychologist then talks briefly with a second young man, a return patient who is still suffering from lack of appetite, weakness, back pain, and nightly discharges. She asks if there has been any improvement from the Ayurvedic medicines she prescribed. He says that one of them was effective and the other was not. She leafs through his chart and asks what he considers to be his greatest problem. He tells her it is lower back pain. They discuss his family and educational situation. She points out that since he is from a large family with a small income he must be worried about what he will do when he finishes his degree. You will have to get a job, she says. She tells him to keep taking the medicines and reassures him that the nocturnal emissions are not causing his weakness. She advises him to follow the same diet she has prescribed for the first young man. Then she spreads a cloth on the floor to demonstrate two hatha yoga asanas (postures) which she recommends for both young men. She shows them a picture of the asanas and then guides the first young man through the movements. The two asanas will be good for the digestion.

I have recounted this psychotherapy session in some detail in order to enable us to notice certain twists and turns in the diagnostic narrative. To begin with, the first patient reports what those raised in the aura of biomedicine would consider physical complaints. When traced to mental causes such complaints are framed as somatization. Yet while the psychologist suspects intrafamilial conflict she diagnoses the problem as improper circulation of vayu. She thus seems to confirm Obeyesekere's assessment of Ayurvedic treatment as somato-psyhic, rather than psychosomatic, tracing mental illnesses to physical factors (Obeyesekere 1977: 159; 1981: 238). In this as in other Ayurvedic narratives I have heard, however, the dosa or humors, of which vayu is one, flow freely and indiscriminately among psyche and soma. Indeed vayu is typically associated with both mental and digestive disorders.

In another therapy session on another day the psychologist elaborated her views on somatization. The one and only patient in that session was unusual in that he complained, not only of his physical symptoms, tension and headache, but also of extreme depression. This patient had previously visited the psychiatry department. The psychologist explained that people don't visit the psychiatry department unless they are screaming or exhibiting other extreme symptoms.
In India, she said to me, there is not much awareness about psychological problems. Usually people with psychological disorders come to the out-patient department complaining of physical ailments and are diagnosed by Dr. Singh with depression and/or anxiety. She said that many young people are concerned that their chest pain is a heart symptom when in fact it is a psychological symptom. There are so many family problems in this society, she added. In her psychotherapeutic discourse, then, there is a complex interplay of psyche, soma and community that goes beyond the interpretation of illness as psychosomatic or somato-psycho. Somatic complaints are interpreted as psychic concerns which are both traced to family and social difficulties and reinterpreted as dosic disturbances.

The psychologist uncovers the hidden emotion she is seeking when the first young man admits that his dreams about religious themes are interspersed with dreams of taking exams. Yet her and her colleague’s repetition of “anxiety, anxiety” seems to rest in a satisfaction with naming the emotion. When the patient resists her further inquiry about family conflict, the conversation veers into a long narrative of appropriate diet. Thus the reference to anxiety proves to be only a brief detour into interiority before a return to behavioral advice. Then the patient introduces yet another complaint, piles. Here the confessional dia-logic of the session is broken by the participation of the gopher, which seems to mark the session as a semi-public conversation structured around a multi-directional flow of advice. The psychologist again speculates on the source of the patient’s worry. It is then finally that he tells the story, a sexual scene no less, which would seem, in a standard psychotherapeutic narrative, to be a clue to the origin of his psychological problem. Yet, having identified his fear, without however inducing him to express it, what the psychologist offers is diminution of the problem and calendula ointment. Here she practices two of the nine techniques of sattvavajaya, reassurance and replacement of emotions. A North American psychotherapist, on the other hand, would more commonly practice an elicitation of emotions. In the Ayurvedic psychotherapy, the consideration of interiority, like the consideration of emotions, ends in its naming.

Lacan has suggested that the Saussurian bar between signifier and signified is like the repression barrier separating the Freudian unconscious from the conscious mind. According to him, the dream images of the unconscious mind generate meaning according to their relation with other signs rather than to their relation with their apparent signifieds. Lacan explains Freud’s statement that a dream is a rebus, writing,

So the unnatural images of the boat on the roof, or the man with a comma for a head, which are specifically mentioned by Freud, are examples of dream-images that are to be taken only for their value as signifiers, that is to say, in so far as they allow us to spell out the ‘proverb’ presented by the rebus of the dream....Freud shows us in every possible way that the value of the image as signifier has nothing whatsoever to do with its significiation, giving as an example Egyptian hieroglyphics in which it would be sheer buffoonery to pretend that in a given text the frequency of a vulture, which is an aleph, or a chick, which is a vau, indicating a form of the verb ‘to be’ or a plural, prove that the text has anything at all to do with these ornithological specimens [Lacan 1977: 159].
Lacan's point is that the significance of dream imagery and of linguistic signs lies less in the objects or concepts represented, than in the positions of these images and signs in relation to other images and signs. This point allows Lacan to insist on the primacy of the signifier rather than the signified (Meltzer 1990). That is, the signified is not a pre-existent conceptual terrain named by the signifier, but rather a conceptual terrain created by the signifier through a process of differentiation. The word "anxiety," for instance, does not so much refer to a pre-existent emotional state, as it carves out an emotional state by means of a differentiation from other emotion words. Lacan argues, "The unconscious is neither primordial nor instinctual; what it knows about the elementary is no more than the elements of the signifier..." (Lacan 1977: 170). For him the interior self is more rhetorical than authentic. In interpreting the unconscious, he writes, "we are at the mercy of a thread woven with allusions, quotations, puns, and equivocations" (Lacan 1977: 169-170).

Lacan suggests that the linguistic structure of the unconscious is disguised in Freud's work by the "pseudo-biological glosses with which it is decked out for popular consumption" (Lacan 1977: 167). He accuses professional psychoanalysis of having become a "compromise operation" which fails to acknowledge the "self's radical ex-centricity to itself" (Lacan 1977: 171). In the bulk of contemporary psychotherapy, the search for one's true self, assumed to precede repression and social presentation, is still paramount. Here, one might argue, the unconscious is still taken to be not signifier but signified, the repository of instincts, feelings and conflicts which can be either expressed or suppressed. In the Ayurvedic psychotherapy session, however, the unconscious appears not so much as the signified, a prior inner depth to be sounded, but as a name, a mere sign, empty of any vaster terrain of reference than its commensurability with and difference from two other signs, the conscious mind and the mysterious in-between. Like the Lacanian unconscious, this interior self seems more rhetorical and "ex-centric" than authentic. It is not any complex syntax of unconscious imagery that suggests the rhetoric of the self in this case, but, strikingly, the word "unconscious" itself. While the psychologist invokes the unconscious as evidence for hidden anxiety, she does not look to it for either the source or the solution to this anxiety. She traces both patients' fears to career pressures in their families. Moreover, it is not the expressive talk of the patients, exteriorizing their fear, that facilitates the cure, but rather the dietary, medicinal and yogic advice of doctors and gopher.

**Selfhood Deferred**

In another session a young man complains of gas pains, lethargy and sadness. After inquiring about his diet the psychologist asks about his economic situation and career plans. The patient reveals that he has twice failed to pass the exams for engineering school. The subject he finds difficult is chemistry. The psychologist suggests that he take time to notice the birds in the trees outside his window. She describes this practice as a form of yoga. She predicts that if his chemistry score improves, his sadness will disappear. She tells him to gaze at the birds and say to himself, I have to pass the engineering exam. She says that this is a form of meditation or concentration (*dhyan*). They discuss the young man's diet in detail. At one point the gopher lists off the vegetables which are currently seasonal and would help his condition. The psychologist suggests that the patient hire a tutor, study in the morning when he is fresh, and exercise by jogging on the roof of his apartment building.
Again in this session the psychologist is concerned to trace the patient’s emotion to an external cause, his low chemistry score. The solution to the low score is to be found in milk, mental discipline, tutoring and exercise. In addition to redirecting the patient’s mind with reassurance and replacement of his emotion, she advises him to redirect his own mind with a form of meditation. While meditation techniques also invoke an interior self, it is a self that is not so much personal (as in the psychotherapeutic formulation) as depersonalized. In fact, it might be argued that the deeper one goes in meditation the less one identifies with oneself as an individual and the more one identifies with the cosmos. Thus the meditation technique advocated by the psychologist encourages the patient to pursue a sense of oneness with other creatures as opposed to a sense of his own personal identity. Whereas in North American psychotherapy, the key to worldly success would be individuation, in this psychotherapeutic setting, the key to worldly success is de-individuation.12

In another session a young woman complains of insomnia, nervousness and chest pain. After some talk the psychologist ascertains that she is a very successful student who would like to continue with school rather than marry. The young woman’s symptoms first arose after a teacher was displeased with one of her papers. Worried that she would fail the class, she developed a fever and chest pains. She is still concerned that she may have a heart ailment. The psychologist tells her, you don’t have any heart problem, understand? She recommends to the young woman that she write down her daydreams and experiences in a diary.

When the young woman’s mother is shown in, the psychologist reassures her that her daughter does not have a heart problem. She asks if the young woman has any friendship with a young man and the mother says no. The patient reiterates that she doesn’t want to marry. She says she enjoys peace and quiet. The psychologist says that it is good to be alone but she should socialize more. She tells her that she doesn’t have to excel all the time. She refers to the Bhagavad Gita, saying that we should leave the fruits of our actions in God’s hands. She again recommends to the young woman that she write in a diary and then comments to the mother that her daughter is very “emotional,” again using the English word. She repeats that the young woman’s problem is not heart disease but simply worry. Because of worry she cannot sleep. She tells the daughter to stop studying at night and she tells her mother to give her warm milk with cardamom. Milk is necessary for heavy mental work. The psychologist and the mother agree that the girl’s worries are due to her schoolwork. The psychologist reassures the girl that everything will be okay.

When the conversation turns again to the topic of marriage, the daughter speaks passionately against the dowry system. The psychologist responds that she must pay a dowry in order to be married. We humans, she says, must follow the example of Shiva and Parvati (a Hindu god and his consort). If a daughter doesn’t marry the parents will worry. At the end of the session the psychologist says to the mother, “Your daughter is fine. She is very ‘emotional,’ very ‘sensitive.’” She turns to the daughter and reiterates, you have to pay a dowry, then turns back to the mother and lists off the family problems which are affecting her daughter. The mother nods in agreement. The psychologist tells the mother, “Inside she is suppressed” (Hindi verb dabna).

In this narrative as in the others there is a vacillation between the triumphant naming of interior states (the young woman is emotional, sensitive, and suppressed) and the offering of advice sprinkled with moral caution and spiritual inspiration. From the signs of the interior self, the worry, the sensitivity, we are instantly deflected out again into home remedies and social issues.
In a private conversation the psychologist also said that the excess emotions which cause mental illness arise from overflowing triguna, the three qualities which permeate not just mind but every other material substance. Thus the emotionality is both interior and exteriorized as a form of matter. Moreover, this discovery of emotionality again seems to glide over the nominative surface. To borrow a phrase from Roland Barthes, it is a "nomination in the course of becoming, a tireless approximation..." (Barthes 1974: 11). It seems less the recovery of a real self than the creative production of a psychological self, the kind of self expected from psychotherapy.

It is telling that the words on which interior selfhood is hinged—"emotional," "unconscious," "sensitive," "anxiety"—are largely English, clearly imported from European psychological discourse. Their value derives primarily from their association with other signs charged with a potent modernity such as "psychology" and "repression," rather than from their apprehension of a referent in the patient’s experience. An interior self is also invoked in the psychologist’s advice to the patient to write in her "diary." Again the English word carries modern European associations of individuality and the revelation of private lives. It is questionable, however, whether the diary the psychologist has in mind is any more pursuant of "authentic" interiority than the Indian diaries mentioned by Chakrabarty in his work on Bengali domesticity discussed above. The point of identifying the patient’s inner states seems to be not to seize the signified, to pursue a prior personality, but to savor the signs themselves, to proliferate character traits in the present. The construction of the interior self in the very instant of the awareness of its repression, is, it seems to me, not so much mystified, in this context, as relished.

I come to this insight, of course, through my own modern North American disconcertion at the seemingly cavalier and unexplanatory use of words such as anxiety, sensitivity, unconscious. When I would expect the discussion to turn to analysis it rests in characterization. I am left with the sense that the linking of the signs of self is itself sufficient. Bhabha notes that the colonial mimicry of European national institutions has the effect (for the colonist) of mocking "the monumentality of history," its "power to be a model" (Bhabha 1984: 128). Similarly the mimesis of European psychotherapy which is woven into the (re)invention of sattvavajaya, has the effect, for the anthropologist, of mocking the monumentality of the interior self, and its power to be a model. This self becomes, in these narratives, not an endpoint, a stable signified, but only another touchstone, another sign in a narrative of nervousness, strung together with stories about Shiva, vayu, and the virtues of warm milk. The interior self is not privileged as authentic but passed over as one more rhetorical moment in a psychological discourse. Bharati, a European scholar and Tantric practitioner, has argued that the only real Hindu self is the atma. "Everything else about a person," he writes, "...is ephemeral, conventional, relative" (Bharati 1985: 198). We might read this argument as an empiricist phonoceentrism wherein the statements of certain Indian acquaintances are taken to transparently represent an essential Hindu self. I would prefer to read it, however, as a gesture toward the unrepresentable. the "not this, nor yet this" of the Upanisads, a signified forever deferred (Mascaro 1965: 12).
Acknowledgments: I am grateful to Lorna Rhodes, Rebecca Klenk, Peter Moran and two anonymous PoLAR reviewers for their comments on an early version of this paper. I am also indebted for their helpful feedback, to the discussant, E. Valentine Daniel, and the audience and other presenters of the panel “Traveling Signs and their (Trans)local Subversions in South Asia” at the 1996 Annual Meetings of the American Anthropological Association.

1. Kayacikitsa is often translated as internal medicine or simply medicine. The other seven branches of Ayurveda are salya (surgery), salakya (related to illnesses above the collarbone), kaumarakrtya (pediatrics, obstetrics and gynecology), (toxicology), bhutavidya (related to illnesses caused by spirit beings), rasayana (rejuvenation therapy), and vajikarana (aphrodisiac therapy).

2. This passage is found in verse 54 of Chapter 11 of the Sutrasthanam.

3. This list of methods for mental restraint may well be taken from Chapter 10, verse 63 of the Cikitsasthanam on the treatment of apasmara (considered by contemporary practitioners to be the same as epilepsy), which states that close friends should turn the epileptic toward knowledge, fortitude, memory and concentration (Sharma 1981, Vol. 2: 177). In Caraka it is written that the therapeutic measures for epilepsy should also be adopted for unmad (insanity, psychosis) (Sharma 1981, Vol. 2: 171).

4. According to most Ayurvedic doctors and texts, prajnaparadha, which is also described as improper use of the senses, is a major etiological factor in physical illness as well.

5. These methods are discussed in verses 85-86 of Chapter 9 of the Cikitsasthanam (Sharma 1981, Vol 2: 169-170).


7. See, for example, Bhagavat Sinhaji 1981 [1896], Vaisya 1919, the Madras Report on Indigenous Systems of Medicine (Government of Madras 1923) and Dhyani 1987. This view was also confirmed by a professor of Ayurvedic history and several other Ayurvedic practitioners with whom I spoke.

8. Most of what was referred to as “group” psychotherapy at this hospital involved no more than one or two patients at a time, always of the same gender.

9. In Ayurveda it is an imbalance among the three dosa (usually translated as humors) which is responsible for illness. Very simplistically, the three dosa, which together govern all the bodily processes, are vata or vayu, the wind principle, pitta, the fire principle, and kapha, the water and earth principle.

10. In South Asia the last two complaints are frequently associated since it is widely believed that loss of semen leads to loss of strength.
11. Lacan's simultaneous insistence that the signifier is like the unconscious and that the signified is primary and the unconscious is not primordial can be, at first reading, confusing. His argument is that the unconscious like the signifier is a linguistic play which precedes any referent or imagined content within (or without) the unconscious.

12. Several scholarly works on the sociocentricity of Indian selves are relevant here. See, for example, Shweder and Bourne 1982, Marriott and Inden 1973, and Roland 1988.

13. The three guna are sattva, rajas, and tamas. Rajas is associated with energetic activity, tamas with inertia and sattva with qualities of calm, mental clarity, and righteousness.

References Cited

Barthes, Roland

Bhabha, Homi

Bharati, Agehananda

Chakrabarty, Dipesh

Chatterjee, Partha

Dhyani, Sivacarana
1987 Salient Features of Ayurveda. Varanasi: Chaukambha Orientalia

Foucault, Michel

Government of Madras
Lacan, Jacques

Lutz, Catherine A.

Malviya, P. C.

Marriott, McKim and Ronald Inden

Mascaro, Juan

Mehta, A. K.

Meltzer, Francoise

Mishra, S. S.

Murthy, A. R. V.
1986 *Non-Pharmacological Approach to the Management of Irritable Bowel Syndrome with Special Reference to Group Sattvavajaya*. Varanasi: Department of Kayachikitsa, Institute of Medical Sciences, Benares Hindu University.

Nespor, Karel and R. H. Singh
Obeyesekere, Gananath

Roland, Alan

Sharma, Priyavat, editor and translator

Shweder, Richard and Edmund Bourne

Singh, Ramahars

Sinhaji, Bhagavat

Taylor, Charles

Vaisya, Saligrama

Wise, Thomas