A STUDY OF PATIENTS ATTENDING MEHANDIPUR BALAJI TEMPLE: PSYCHIATRIC AND PSYCHODYNAMIC ASPECTS

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SUMMARY

A sample of 100 patients were selected randomly from 10 dharamshalas who qualified the diagnosis of neuroses and developed "trance". They were subjected to tests of suggestibility, intelligence, guilt, hostility and neuroticism. Patients with "trance" were significantly more suggestible and expressed more hostility and guilt as compared to those who did not develop trance. Significant differences were found on I.Q. and level of neuroticism in trance and non-trance patients as well. No significant differences were observed on suggestibility, I.Q., hostility, guilt and level of neuroticism in patients who developed trance either early or delayed.

Hysterical patients with trance and non-hysterical patients with trance failed to differ on suggestibility, I.Q. and projective measures of hostility and guilt. The significance of these factors in the development of trance and cure of psychoneurotic patients in context of our cultural background and faith healing practices has been discussed.

Social and diagnostic aspects of patients attending Mehandipur Balaji Temple (Satija et al., 1981) were studied in any earlier report. The study had revealed that neurotic patients out-numbered the other diagnostic groups at this temple and patients who develop "trance" or "Peshi", are more likely to benefit from 'temple healing'. The present work relates with detailed investigation of the factors responsible for the induction of "trance phenomenon" in neurotic patients at this place.

While reporting a series of studies, Sethi and his co-workers (1977, 1978, 1979, and Trivedi & Sethi 1977, 1979, 1980) expressed the view that the treatment methods of vedic period in terms of healing practices, may appear pseudo-scientific in light of modern knowledge. However, in terms of modern psychology-guilt, suggestion, projection and rituals among others seem to underlie the magico-religious or the traditional healing. Further, they added that ceremonial rituals, mantras, bali (oblation) etc. bring about favourable results in psychological problems. These views are not new but widely held by several researchers and they have documented various types of healing practices in different parts of the world in the treatment of psychiatric disorders (Sergant, 1959; Rose, 1968; and Nolen, 1974).

Another Indian researcher, Neki (1973) held that an overwhelming majority of Indian population, particularly rural prefers to be cured by healing practices. Of the several healing practices, temple healing has yet not received adequate scientific attention in this country. However, some preliminary reports are available (Somasundaram, 1973).

Supernatural phenomena as factors for

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causation of mental illness are still widely held in our culture. This belief is in line with Indian philosophy that 'spirits' of dead persons wander in search of possessing the living human beings to fulfil their desires and these spirits are believed to cause various types of manifestations, particularly, in females with attractive features. The deity of Hanumana or Bajaj is believed to drive out these evil spirits. This belief attracts large number of patients with various problems, especially psychiatric ones, to the famous Bajaj Temple. Here some patients with supposedly evil spirits present themselves in a form of trance before the idol of Bajaj, Mahakal Bhairav or Pratraj Maharaj. The moment these evil spirits are driven out by the power of Bajaj, patient finds himself/herself completely relieved. We got interested in underlying mechanisms and psychological explanations of this phenomenon of 'Peshi' or 'Trance'. The present study was, therefore, designed to fulfil the following aims and objectives:

1. To find out the occurrence of "trance" (peshi), in patients with neuroses.
2. To investigate the role of suggestion, intelligence, guilt, hostility and neuroticism in the induction of "trance" in these patients.
3. To study differences, if any, in terms of above variables in patients with early trance and of delayed trance.
4. To bring out the role of these variables in hysterical patients with trance and non-hysterical patients with trance.

MATERIAL AND METHOD

Sample: A sample of 100 psychiatric patients was randomly selected from 10 dharamshalas situated around the temple who qualified for the diagnosis of neuroses by independent psychiatrists. Socio-demographic characteristics of the sample revealed that mean age of the sample was 26.4 years. Females outnumbered the males (58% Vs. 42%). Only 5% patients were illiterates. Among the literates, primary (20%), middle (8%), high school (22%), intermediate (23%), B.A. (25%) and post graduate (5%) formed the group. 97% were Hindus and 3% were Sikhs. 65% were married. Most patients were Vaishyas (38%), and Brahmans (30%) by caste. An overwhelming majority of the patients were businessman (47%), housewives (20%) and students (16%). Majority of these patients hailed from urban areas (80%). Most of these patients were drawn from three states, i.e. U. P. (33%), Delhi (23%) and Haryana (12%).

Each patient was subjected to following psychological tools:

1. Test of suggestibility (APRG, 1977).
2. Bhatia Battery of performance tests of intelligence—Short scale (Passalong & Koh's block).
3. Thematic Apperception Test (Murray): Seven TAT cards, i.e., 1, 2, 3 BM, 4, 6, BM, 8 BM and 13 MF were used to measure hostility and guilt according to the procedure given by Saltz and Epstein (1963).
4. Punitive Scale—Guilty scale only (Foulds, 1965).
5. Middlesex Hospital Questionnaire (MHQ) (Crown and Crisp, 1966). Hindi adaptation by Srivastava and Bhatt (1974) was used in this study.

These tests were administered by a psychologist who stayed there for a period of one month.

CRITERIA OF CONCEPTS USED IN THE STUDY

Trance (PESHII): When patient spontaneously performs various physical activities, during which he/she strikes hard against the wall, iron bars, floor, swings in air, makes hissing sounds, and sometimes keeps heavy stones on the body and occasionally assumes an upside-down position.
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with head pushed in a small hole and the legs swinging in the air. These activities are performed for hours.

**Early Trance**: If "trance" (peshi) occurred within a week's time, it was labelled as "early trance".

**Delayed Trance**: If "trance" (peshi) occurred in more than a week but within a month.

**No Trance**: If "trance" (peshi) was not achieved during a month's time.

Results were compared for the variables of suggestion, intelligence, guilt, hostility and neuroticism level for the following three groups:

(a) Patients with "trance" and "non-trance".

(b) Patients with early trance and delayed trance.

Table 1. Means and S.D.s. on psychological variables of patients with "trance" and "non-trance"

| Tests            | Measures    | Trance (N=66) | NonTrance (N=34) | P     |
|------------------|-------------|---------------|------------------|-------|
|                  |             | Mean          | S.D.             | Mean  | S.D.   |       |
| Suggestibility   | Suggestibility | 70.38         | 9.28             | 46.97 | 11.37  | <0.1  |
| Bhatia Battery   | I.Q.        | 79.00         | 6.90             | 89.88 | 11.23  | <0.01 |
| TAT              | Hostility   | 4.50          | 3.11             | 3.10  | 2.42   | <.05  |
|                  | Guilt       | 4.00          | 3.03             | 2.80  | 1.94   | <.05  |
| Punitive Scale   | Guilt       | 3.50          | 2.37             | 2.70  | 2.11   | n.s.  |
| M.H.Q.           | Neuroticism | 69.86         | 10.49            | 42.82 | 11.18  | <0.01 |

Table 2. Mean & S.D. on psychological variable in patients with early "trance" and "delayed-trance"

| Tests            | Measures    | Early Trance (N=20) | Delayed trance (N=64) | P   |
|------------------|-------------|---------------------|-----------------------|-----|
|                  |             | Mean                | S.D.                  | Mean  | S.D.   | P     |
| Suggestibility   | Suggestibility | 76.00           | 6.96                  | 72.00 | 9.26   | n.s.  |
| Bhatia Battery   | I.Q.        | 76.50              | 6.86                  | 80.00 | 8.86   | n.s.  |
| TAT              | Hostility   | 4.00               | 2.79                  | 3.50  | 2.85   | n.s.  |
|                  | Guilt       | 4.20               | 2.15                  | 2.90  | 2.21   | n.s.  |
| Punitive Scale   | Guilt       | 4.50               | 1.86                  | 3.60  | 2.10   | n.s.  |
| M.H.Q.           | Neuroticism | 73.00              | 12.86                 | 68.62 | 9.45   | n.s.  |
TABLE-3. Mean & S.D.s on psychological variables in hysterical patients with “trance” and “non-hysterical” patients with trance.

| Tests            | Measures      | Hysterical (N=27) | Non-Hysterical (N=39) |
|------------------|---------------|-------------------|-----------------------|
|                  | Mean | S.D. | Mean | S.D. |
| Suggestibility   | 70.48 | 8.84 | 68.44 | 6.30 | N.S. |
| Bhatia Battery   | 82.59 | 10.82 | 87.48 | 9.04 | n.s. |
| TAT              |      |      | 4.62 | 1.89 | 4.46 | 2.27 | n.s. |
| Hostility        |      |      | 3.77 | 1.59 | 4.10 | 2.00 | n.s. |
| Guilt            |      |      | 2.62 | 1.86 | 4.15 | 2.10 | <.01 |
| Punitive scale   | Guilt | 31.81 | 12.13 | 63.39 | 22.23 | <.01 |
| M.H.Q.           | Neuroticism |            |              |              |              |

It is explicit from the Table No. 3 that the above two groups do not differ significantly with respect to suggestibility, I.Q., and projective measure of hostility and guilt. Hysterical patients with trance were found to have significantly lower level of neuroticism and confessed lesser degree of guilt as compared to other non-hysterical neurotics.

**DISCUSSION**

Findings of great importance have emerged, study revealed that patients, with trance (peshi) were found to be highly suggestible, less intelligent, express more hostility and guilt in TAT stories and show higher level of neuroticism as compared to those who did not display trance. These observations are expected and in line with the contention that suggestion and faith may serve as major factors in the induc­tions of “trance” in neurotic patients.

Psychodynamically it is commonly understood that persons with insecurity, more repressed and unfulfilled desires and traumatic experiences deeply rooted in pathological familial interactions with repressed hostility and feeling of sin or guilt, are more vulnerable for suggestive practices. More so, when such suggestions come from those who have benefitted at such religious places and have accepted authority figures with no undue hesitations. As to the question that why other neurotic patients, did not develop this phenomenon in spite of the fact that they might have had similar tensions and traumatic experiences and other common pathology with their counterparts, little can be offered as explanation, except a specific vulnerability may occur in the former.

Patients with “early trance” and “delayed trance” could not be differentiated in terms of suggestibility, intelligence, hostility, guilt and level of neuroticism. On the basis of these observations, it can be inferred that these variables have no association in differentiating early and delayed trance or it may be that our criterion for early and delayed trance is not an adequate one. Furthermore, it could be that demarcation line in some cases of early and delayed “trance” would have been very thin.

As regards to the hypothesis that hysterical neurotics would, as compared to other neurotics, differ on measures of suggestibility, hostility etc., it got ten partially substantiated revealing that hysterics had shown significantly less guilt and level of neuroticism as compared to non-hysterics. It is conceivable that symptomatology of
hysterics get somatised and they present low level of manifest symptoms of neuroticism.

Thus, mechanisms of role playing, imitation, identification, spontaneity and catharsis are all evidenced in such religious treatment. Modern psychological concepts such as psychodrama, therapeutic community, social modelling etc. are also evident in such a religious set-up. If that is so, we as behavioural scientists should make every possible effort to incorporate such indigenous, faith healing practices prevalent in our culture as part of modern psychotherapy.

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