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Divine trauma: Schizophrenia and unresolved realities in South India

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Abstract

This article explores the relationship between schizophrenia, divine encounters, and therapeutics based on ethnographic research in Chennai, Tamil Nadu, India. Contributing to a long history of single-subject ethnographies in psychological anthropology, this article narrates the events leading up to the diagnosis and the emerging life worlds post-diagnosis of an interlocutor I call Dhruv. I depart from symbolic constructions of the divine to an affective divine, a kind of force that enters and alters embodied existence. Following scholars who call for theories that move beyond Western metropolitan epistemologies, I draw upon the *Bhagavad Gita*, a poetic scripture from the Hindu tradition, as a form of psychological theory to contend how an encounter with the divine might be too much to bear, even traumatic. In doing so, the article offers an alternative entry point to the commonly held assumption of the therapeutic efficacy of divine encounters and religious sites in India.

KEYWORDS
affect, ambivalence, religion, schizophrenia, trauma

INTRODUCTION

Dhruv and I spent a long afternoon together at a cafe in central Chennai. After a few brief exchanges about his symptoms, Dhruv and I started to speak about the stars and planetary alignment. Dhruv was deeply engaged in the study of Hindu astrology, psychology, and spirituality. "Divine timing is timing of its own," he shared. "You can't ever know; in fact, you are not meant to." He paused for a while, acknowledging the fading shapes of the sky. "Maybe I'll go by the position of the sun rather than the time of clock to see when my body comes back. You see, my moon is in the house of the disease. That is one explanation for why this could have happened," he explained. Dhruv and I were both interested in cycles—Dhruv in

the rotations of the cosmos, me in the cyclical patterns of our encounters. Our interactions were often marked by non-linearity: silences, pauses, narratives with multiple starting points, bodily interruptions, and different registers of thought punctuated our dialogue.

We had met several months prior through a mutual friend, one who had also been reconciling a psychiatric diagnosis with alternative frameworks. Dhruv was in his early thirties, born and brought up in a middle class, upper-caste family in Chennai. His religious beliefs came from a lineage of familial traditions centered on non-duality, a sub-school of Hindu philosophy, closely equated to monism. Dhruv was also influenced by a variety of Hindu gurus and mystics, including Ramakrishna and Sri Aurobindo, and developed a set of personal spiritual practices that reflected this patchwork of beliefs.

Dhruv had a robust social network of friends and family, many of whom who had ardently supported him during his diagnosis, but also perhaps missed early signs. "My parents are bit liberal, they always let me free. So, I think they didn't feel anything was going on. Not only are they liberal, they never heard of psychological issues," he once shared humorously. Dhruv's parents were supportive, but did not intervene much in his life, including in the events leading up to his diagnosis. Outside of his meaningful social life, Dhruv was also educated at some of the best universities in India and worked at various finance firms and start-ups. However, Dhruv's main interest was Hindu astrology and how planetary alignment could shed light onto psychological processes. "I'm most interested in what astrology can do to help us with our psychological tendencies," he shared. Dhruv often offered me sound advice on my own anxieties based on the movements of my birth planets and stars.

Although his interest in astrology was kept at bay when we met, there were times when this interest submerged him completely. In 2015, Dhruv read his astrological chart and concluded that he was in a mystical period of his life. To understand this further, he decided to embark on a religious pilgrimage across various holy spaces in South India. However, upon returning from his trip, he started experiencing severe forms of bodily distress and having what he calls "amplified body thoughts." "After I came back from the trip, I wasn't even able to pick up the phone. When I could, I started typing something random because my hand wasn't in my control," he shared. Dhruv often describes the distress as if something else is in control of his limbs, a kind of body paralysis. Some days, he could do what he wanted to do. Other days, he could not. He felt the effects of this paralysis while performing simple tasks, such as making a phone call. He also felt it during more arduous tasks, like filling out a job application. When he pushes himself, a voice emerges.

"Something comes over me. When I force myself, a voice comes. '*Boodhoo* (idiot), I control you,'" he shared with a sense of urgency.

I had once witnessed this body paralysis. He first hesitated, closed his eyes, and then attempted the action. Then came the refusal. His body was enveloped by a deep physical and mental strain, his breathing intensified, and his eyes started to flash. Time stood still, both of us uncertain what might emerge until Dhruv returned to stasis. For the past several years, these "amplified body thoughts" controlled Dhruv, mostly affecting his corporeal capacities.

"It [the religious pilgrimage] was triggered, I guess, by what I wanted to do with my life, actually, what I'm *meant* to be doing. I was deeply uncertain, and I knew that I could only get these answers from divine sources. You could say I was compelled toward it." During his trip, Dhruv traveled from temple to temple, got *darshan* (seeing and to be seen by god) from various deities, and started creating energy networks, a kind of link between his home and these religious sites. "There was one link between the temple and my home, and another link between the temple and my sister's house." He could feel the energy networks inside his hands, along the back of his neck, at the top of his head. Energy flowed from his solar plexus at the center of his body to his exterior limbs.

His religious pilgrimage lasted a few months. Dhruv traveled in vans and buses through Karnaktaka, Tamil Nadu, and Andra Pradesh. He vaguely remembers a variety of characters in his story: a girl with long eyelashes, a beggar with holy ash, and a man with a snake-like head. He conversed with gurus, mystics, plants, and flowers. The details of what went on, where he was, how he got from place to place, remain fuzzy. However, in between one of the last legs of his journey, a member of his family decided that something was wrong with his speech and sleeping patterns and took him to the hospital. "Within two minutes, my energy networks suddenly became paranoid schizophrenia."

Taking Dhruv's narrative as the starting point, this article explores the relationship between schizophrenia, divine encounter, and therapeutics based off ethnographic research in Chennai, Tamil Nadu, India. Contributing to a long history of single subject ethnographies in psychological anthropology (Biehl, 2013; Crapanzano, 1980; Pandolfo, 2018; Pinto, 2014) and the potential of multiplicity in singularity within ethnographic description (Das et al., 2014), this article narrates the events leading up to diagnosis and the emerging life worlds post-diagnosis of an interlocutor I call Dhruv. In this article, I depart from symbolic constructions of the divine to an affective divine, a kind of force that enters and alters embodied existence. Building on the work of scholars who advocate for theories that move beyond dominant Western metropolitan epistemologies (Harrison, 2016; Jurist, 2007), and inspired by Dhruv's religious praxis, I turn to the *Bhagavad Gita* – a poetic scripture from the Hindu tradition. I use it as a form of psychological theory to argue that an encounter with the divine might be too much to bear, what a psychoanalytic or social science hermeneutic might describe as traumatic. I engage with scholars who think about the divine as ambivalent, uncertain, and agents in their own right (Beliso-De Jesús, 2014; Lambek, 2003; Mines, 2005; Scherz, 2018; Orsi, 2018; Whitmarsh [forthcoming]).

I then ask what it would mean for this conception of divine encounters to enter clinical, urban spaces. The numerous psychiatrists I interviewed in Chennai, Tamil Nadu often drew on religion and spirituality when they felt that psychiatry could not explain the entire prognosis of disorder or provide comprehensive therapy, reflecting an already well-documented anthropological engagement of the therapeutic potentiality of religious sites, practicing, and narrativizing in South Asia (Bharadwaj, 2016; Corin et. al., 2003; Corin, 2007; Luhrmann & Marrow, 2016; Obeyesekere, 1990, Singh & Sharan, 2022, Vora, 2015). I argue that ignoring the possibility of psychiatric distress being triggered within religious sites can result in debilitating consequences, such as a diagnosis of schizophrenia. An encounter with the divine, far from being only therapeutic, may result in a kind of subjectivity that undoes itself and a prolonged state of disintegration.

My ethnographic fieldwork spanned 18 months over the course of 3 years (2016–2020) in Chennai, Tamil Nadu. I interviewed individuals living with various forms of psychiatric distress, therapists, activists, and clinicians. My fieldwork sites in Chennai were diverse, including in-patient clinics, outpatient clinics, rehabilitation homes, beaches, religious healing sites, art therapy sessions, cafes, and home spaces. Moving through these different sites was integral to understanding how distinctions between various categories of experience—medicalized, pathologized, artistic, religious—are often slippery in India (McDaniel, 1989; Ram, 2013; Smith, 2006). Scholars have explored how the illness experience in India does not sit systematically on biomedical, Ayurvedic, and localized diagnostic grids (Luhrmann & Marrow, 2016; Lang, 2018; Pinto, 2014; Ram, 2013); McDaniel (1989) has argued that those experiencing different religious states do not always map neatly onto ritual or theological grids, offering a model of subjectivity that evades standardized, functional logics. I will demonstrate how distinctions between various categories—psychiatric, religious, experiential, ontological—move beyond slipperiness in Dhruv's case: they are sometimes commensurate and at other moments, entirely incompatible.

UNRESOLVED REALITIES

Dhruv and I would often discuss how he made sense of his diagnosis through competing and overlapping frameworks. For Dhruv, this has meant he partially accepts his diagnosis of schizophrenia while also holding onto the spiritual insights generated during his journey, despite being skeptical about the validity of either model. Dhruv's narratives were always rooted in a sense of detachment and carried a kind of analytical weight. He was consistently pensive and introspective and rarely let out any obvious emotion, though at times was gently humored by his own narrations. Once, reflecting on his astrological fate, Dhruv observes,

> I didn't realize these were signs of schizophrenia. I might have actually *taken myself* to the hospital if I knew. But what was occurring was what had been fated. According to the

> planets, I was supposed to be in a mystical period. These energy networks I was creating, these sensations in my body matched what one is supposed to feel.

Dhruv continues,

> I was definitely doing some strange things during the pilgrimage, but I was reading into my mystical process. I would do things like, pace around the room, do strange gestures with my body. I would feel a sensation pulsing at the top of my head, a force moving through my body. I was often overwhelmed by these sensations. I would have a dream about a particular space, and the next day I would end up at that same temple. These might have been symptoms back then that I missed, but nothing *felt* symptomatic. I was running in a mystical astrological time period according to my chart. So, I thought these were all mystical experiences. So, I continued to validate them.

During his trip, his conversations with gods and planets gave him some of the answers he was looking for, much like Pandolfo's (2018) interlocutors who find social, cultural, and divine insight in and through their madness. Dhruv told me on several occasions that he figured out what he is meant to be doing in life.

> I know I have to pursue this astrology and psychology connection through counseling services. All of my resonances within and outside of schizophrenia have led me to that. It has given me empathy and understanding of mental illnesses. And it has helped me understand how all these things work. It has given me and taken me in a direction that I ultimately wanted to go to. But yes, it has been a very unusual direction.

Since these revelations, Dhruv has been training to develop his own model of therapy based on a combination of Cognitive Behavioral Therapy training from the University of Madras and Hindu psychology training from the Aurobindo Ashram in Pondicherry.

However, despite these insights, Dhruv is also quite certain that he had a psychotic breakdown.

> It must have been that [schizophrenia], because the medications helped to some degree. In terms of lowering some of the symptoms. And there was a time when I stopped the medication, and all the symptoms came back. It's not necessarily that I agree with it fully, but it is just that I don't know what other model to adopt, what else would give me this rather linear, constant, slow and steady recovery. I use words like schizophrenia, psychosis, hallucination, but I just don't attach too much value to it.

Despite using biomedical terms, Dhruv also had a critique of "universal" models like the DSM-5 and ICD-10. "Diagnosis can be imprecise because the collective unconscious or the collective imagination of the individuals in each country is different. I mean the religious, social, cultural psyche could be different from place to place," Dhruv shared, referencing his readings of Freud and Jung.

In Dhruv's case, several types of diagnostic models—spiritual, astrological, psychoanalytic, psychiatric—co-exist, illuminating how an individual can feel that their own experience validates a biomedical model of diagnosis alongside several other subjective or ontologically situated modes of analysis. Dhruv lives quite extensively in ambivalence and is often his own biggest skeptic. As Pelkmans (2013) writes, there is a kind of certainty in some forms of skepticism, whereby Dhruv is certain about his skepticism as a form of psychic survival.

> It is possible I had an actual religious encounter. It is entirely possible, because some things with divinity you can understand, but some things you just simply can't know. That is certain. It's also possible that I have schizophrenia. We all try to make sense of the world in some way. Skepticism has served me well. Skepticism has kept me grounded.

While Dhruv doesn't necessarily take biomedicine, psychoanalysis, and even astrology as frameworks that certainly encapsulate his entire experience, he doesn't reject these theories either. However, where his mystical experiences ended and where schizophrenia started (or the reverse) has remained unclear for the past several years. The point is not that a border exists between these types of classifications, but rather, one model does negate or render the other false. Dhruv's experiences with schizophrenia and mysticism are equally real. As one of my other interlocutors, also based in Chennai and diagnosed with bipolar disorder, told me about her mental health and religious encounters,

> Spirituality is beyond human cognition because we are used to connecting to a narrow spectrum. I've never had the time to share all this with my psychiatrists in Chennai. I just talk about trauma and all the happenings of the human brain, like the biological consequences in terms of my lack of sleep. Nothing about what god makes me feel, because they won't take it seriously. But for me, both exist, both are real, and both have distressed and affected me deeply. It is not a question of either/or.

Dhruv's experience of psychosis and divinity co-existing mirrors this claim—"it is not a question of either/or." Although anthropology has long engaged with the relationship between supposedly universal signification (biomedical) and culturally specific idioms/expressions (Halliburton, 2005; Lang, 2018; Obeyesekere, 1990; Simpson, 2023), my classification of disorder in this paper follows Dhruv's own delineation, at times referring to his symptoms through the biomedical model (mental health) and at other times referring to it as a form of distress or affect. As Pinto (2014) describes, psychiatry has existed in India as long as it has anywhere else, enabling a re-thinking of the boundaries between global biomedical classifications and locally specific idioms.

However, due to Dhruv's multiple unresolved explanatory models, prayer has now become a complex experience, and engagement with the divine is a trigger for his symptoms, particularly impacting his motor capacities. Dhruv is not able to stare at any picture of a Hindu deity, visit temples, or engage in religious practices for too long. If he pushes himself, he becomes immobilized and overwhelmed; his eyes flash rapidly, and a voice emerges. However, reminding himself that his diagnosis does not negate his mystical experiences—to know that the fruits of his spiritual journey have not been rendered false by psychiatric discourse—has been necessary for psychic survival.

KNOWING THE DIVINE THROUGH SCHIZOPHRENIA

Schizophrenia is considered a severe, complex psychiatric disorder characterized by an array of symptoms. Typical symptoms include what psychiatry systemizes as delusions, hallucinations, disorganized speech or behavior, and diminished emotional expression (Patel et. al., 2014). However, there is a lack of consensus among clinicians and anthropologists alike regarding diagnostic criteria, the role of culture in its presentation, etiology, and pathophysiology (Luhrmann & Marrow, 2016; Patel et.al., 2014). Anthropologists have often approached studying schizophrenia through a phenomenological understanding of disorder that prioritizes life history and narrative (Biehl, 2013; Desjarlais, 1997; Hopper, 2014; Jenkins & Barrett, 2004; Luhrmann & Marrow, 2016) and/or through symbolic or semiotic analysis (Corin et al., 2003) by which individuals, much like Dhruv, often are involved in meaning-making of their disorder, using a variety of culturally specific myth models to understand their experience. The turn to narrative is partially a corrective measure in response to an increasingly biomedicalized psychiatry that deprioritizes subjectivity and life histories as meaningful modes of knowledge production (Owen & Harland, 2006).

Despite its varied approaches (Ram & Houston, 2015), phenomenological interpretations are rooted in understanding experience and perception as intraworldly phenomena, focusing on how things appear to a subject from a first-person perspective (Ram & Houston, 2015; Stewart, 2010). For those diagnosed with reality and perception-distorting disorders, such as schizophrenia, the legitimacy of a first-person perspective can become compromised under certain conditions.

In Dhruv's case, and more broadly as I will demonstrate in the second half of this paper, an ambivalent encounter with the divine gets subsumed into the totalizing effects of the disorder by his clinician. While this is not surprising given biomedicine's hierarchy of classification, and perhaps makes a compelling argument for reprioritizing subjectivity, it can invariably reiterate Dhruv's narrative as an intraworldly experience and negates any possible truth in supposed delusion. "This is Dhruv's interpretation of what is happening to him," his current psychiatrist once told me when I asked her about Dhruv's experiences at religious sites and his triggers. "I mean that is just a typical symptom of schizophrenia. It is just stress," she stated, rather dismissively. Dhruv's first psychiatrist listened carefully to Dhruv's entire narrative, but "within two minutes, [his] energy networks became paranoid schizophrenia." In these spaces, the divine and religious sites are typically understood as therapeutic. An ambivalent divine, therefore, is the subject's experience and/or an extension of the symptom. Turning to a set of analytics that move beyond an intraworldly experience might offer more legitimacy to Dhruv's narrative. Although Dhruv partially accepts his diagnosis, it has also been crucial for him to validate his divine encounters. "When you are first diagnosed, being told something isn't real is often more scary than the hallucination itself," he stated, one of the few moments his utterances carried heaviness, suggesting the need for recognition, despite his skepticism.

Divine, divinity, god are words rooted in the anthropology of religion, treated as emic concepts that are typically anthropological objects of inquiry (see Willerslev & Suhr, 2018). Anthropological engagement on this topic has focused on the existence of god (see Scherz, 2018), questions of methodological atheism (Berger, 1967), the ability to take the divine "seriously" without reducing it to a sociological, psychological or economic phenomenon (Orsi, 2018, Whitmarsh (forthcoming)), and locally specific understandings of divinity (Mines, 2005). In contemporary India, gods find their homes as signs and symbols in shop names, mobile stores, restaurants, and bronze idols inside a sanctorum (Chakrabarty, 2002; Mines, 2005; Orsi, 2018). As others have explored (Gell, 1999; Orsi, 2018; Porpora, 2006; Scherz, 2018; Willerslev & Suhr, 2018), interpretations of the divine that are mediated symbolically can sometimes serve as indirect ways to understand social or economic life. They can also be reduced to an exercise of thought or represent something other than what they are to practitioners, such as ignorance, false consciousness, or hysteria. Furthermore, despite the symbolically rich Hindu cosmology that Dhruv considers himself a part of, Dhruv never mentioned that his encounters and felt sensations with the divine were from a *specific* divine, and this article follows his usage of rather vague signifiers, where the divine itself becomes an unstable concept. While there are many rich accounts of how locally specific divinities in India might be dark, hopeful, chaotic, dangerous, ambivalent, or even madness-inducing (DeNapoli, 2017, Doniger O'Flaherty, 1980, Hawley, 2015; McDaniel, 2019; Obeyesekere, 1990; Ram, 2013; Smith, 2006), such accounts do not typically enter the urban, upper-caste spaces in India, such as the ones that Dhruv, his friends, family, and psychiatrists in Chennai operate within.

Several anthropologists (Luhrmann, 2016; Robbins, 2013; Willerslev & Suhr, 2018) have argued that taking divinity as real in its own right—without necessarily reducing it to psychological, cultural, or social experiences—returns us to a core tenet of the anthropological project. A symbolic construction of the divine does not account for how, once these gods appear and make their presences known, individuals may react—or how this coincides with designations of pathology. This article specifically draws upon three conceptions of the divine: one, it follows scholars who move away from a symbolic construction of the divine and explore the ways in which the divine cannot be fully known (Mittermaier, 2011; Suhr, 2015) and is an unpredictable agent, which can result in ambivalent encounters (Beliso-De Jesús, 2014; Lambek, 2003; Orsi, 2018; Scherz, 2018; Scherz & Mpanga, 2019; Smith, 2006; Suhr, 2015; Pandolfo, 2018; Whitmarsh [forthcoming]). For example, Scherz (2018), working in a Ugandan convent, explores how the uncertainty of the will of a divine entity that both harms and heals impacts human agency, constituting an ambivalent encounter. As Whitmarsh (forthcoming), working among Trinidadians who encounter divinities, writes, "to believe in a being, to affirm its existence, is to risk giving oneself over to it," and all the possible perils that come with such a surrender.

Two, I adopt an ontological agnostic position on the 'reality' of the divine (Holbraad &Viveiros de Castro, 2016; Scherz, 2018). It is not about whether god does or does not exist (for me, the ethnographer)

or that Dhruv and I necessarily participate in the same ontology—a complicated methodological and ethical question, further heightened due to the complexities of schizophrenia—but just that I cannot know for certain whether we do or do not. After many months of engaged fieldwork, listening to vivid descriptions of beings I cannot hear, smell, or see, and finding personal truth and revelation in my interlocutors' supposed "delusions," the lines between what is and what is not became hazy, resulting in sleepless nights and dream encounters. Although I cannot be certain which ontologies do or do not overlap, I attempt to take Dhruv's encounters with the divine as real, not reducing them to something other than what they are to him.

Finally, I also draw inspiration from Dhruv's felt sensation of the divine: a force, pulsation, shock, or 'something' that entered his body. These sensations include what he describes as resonances, an amplified body of thoughts, and feelings of immobilization. A social science hermeneutic might label this as an affect of trauma, or as this article terms it, divine trauma. Dhruv often describes his encounters with the divine through a sense of overstimulation, unable to place the sensation within contained signification, despite the ubiquitous cultural myth models in India that might allow him to contain the "other" of psychosis (see Corin, 2007). "This whole thing is an experience I cannot explain. And mostly I do not like to explain it often. Yes, there is the divine, but it could be mental illness, or both, but it could also literally be a cloud," Dhruv shared.

While there has been much debate on and critique of affect and its various genealogies (Gregg & Seigworth, 2010; Leys, 2011; Martin, 2013), affect offers a set of conceptual apparatuses to think about moving things and felt presences that evade signification (Stewart, 2007), presences that reach and alter embodied existence, a kind of other-than-human "something-something that catches you" (Collu, 2019, 296), and a felt reality of a relation (Massumi, 2002 in Collu, 2019). Affect theory decenters subjectivity, offering a mode of analysis that moves exclusively away from a subject's motivation to a felt sensation moving between entities. An effect of trauma can be conceptualized as the enigmatic qualities of trauma: trauma cannot be fully comprehended or grasped but is felt through fragments, repetitions, and forces (Caruth, 1996). Trauma has also been defined as a force of external and internal excitations potent enough to breach a protective shield (Freud, 1920). Trauma eludes signification, being "what remains unknown in our very actions and our language" (Caruth, 1996, 4), similar to Dhruv's inability to process the events surrounding him. Caruth (1996) has emphasized the importance of understanding trauma through a phenomenological lens as opposed to a consequence of external stressors. For Freud (1920), trauma is an intrapsychic process rather than an exclusively inter-psychic process. However, considering divine encounters as a kind of in-between affectual force might provide a new perspective on the supposed totalizing effects of a disorder like schizophrenia.

As Collu (2019) and Schneider (2023) write, however, there is a tendency to take notions generated in the field as anthropological objects and equate them to Western metropolitan hermeneutics. Equating Dhruv's sensation of the divine to an effect of trauma may also be another reductive mechanism. Instead of fully situating my analysis in either trauma or affect theory, I turn instead to the *Bhagavad Gita* as a form of psychological theory to make sense of Dhruv's exclamations. The *Bhagavad Gita*, translated to "The Song of God," is poetic scripture from the Hindu tradition, a tradition that Dhruv himself draws upon in his religious practices. The *Bhagavad Gita* is not often employed in the contemplation of madness and ecstasy because it is considered an "intellectual" text, emphasizing obedience over passion and devotion (Kinsley, 1974; McDaniel, 1989). However, this makes it an even richer text to draw upon, for even those traditions that propagate intellectual and disciplining paths to divinity still illuminate maddening experiences. I cite the *Bhagavad Gita* inspired by Harrison's call (2016) for theory from "ex-centric" sites and how anthropology's future can be driven by other knowledges beyond dominant metropolitan Western epistemologies (Harrison, 2016; Jurist, 2007; Raghavan, 2019). Furthermore, I follow decolonial feminist scholars (see Raghavan, 2019) who take poems as living, palimpsestic interlocutors. However, theories from "ex-centric" sites do not come without their own epistemic violence. I use and cite the *Bhagavad Gita* cautiously, aware of the ways in which these texts, as Ashis Nandy (1988) has noted, have turned from the mode of faith to one of ideology in India's contemporary right-wing Hindutva moment.

DIVINE TRAUMA

In the *Bhagavad Gita*, Arjuna, a warrior king, is with his friend Krishna, who is really the divine, asking for guidance before he steps onto the battlefield. Arjuna is torn, for the enemy is no stranger: Arjuna is to fight and kill his loved ones (his cousins, his mentors, his gurus) for a cause that he himself is ambivalent about. Krishna, at first, is a benevolent, therapeutic divine; he shares his divine knowledge of the duty that one has in life and compels Arjuna to accept that it is his *dharma* to enter this battle. In the 11th verse, Krishna reveals to Arjuna that he is not just a friend, but the divine, becoming what is known as the "Vishvarupa," the divine in its full form, at first beautiful, effulgent, radiant, delightful, and uncontainable through human flesh. Upon seeing the truth of Krishna's being, Arjuna exclaims:

> Everywhere, I behold You [who are] of endless form, [with] many arms, bellies, mouths, [and] eyes. I see in You no end, no middle, and also no beginning, O All-Lord, All Form!
>
> (Feuerstein & Feuerstein, 2014, 225)

However, after the initial delight, the Vishvarupa becomes too much for Arjuna to handle, too penetrating and too terrible, and Arjuna begs Krishna to turn back into his human form. It is a moment where the subject is filled with sudden terror, surprise, and shock after an encounter with the divine, similar to what we might understand as trauma. Arjuna begs Krishna:

> Tell me who You are of dreadful form. May salutation be to You! O Best of gods, have mercy! I wish to know You [as You were in] the beginning. For I [do] not comprehend Your [divine] creativity.
>
> I am thrilled at having seen [what] has not been seen before. But my mind is distressed with fear. [Therefore], o God, show me that [human] form [of Yours again]. Be gracious, O Lord of the gods. O home of the universe!
>
> (Feuerstein & Feuerstein, 2014, 233)

Arjuna continues by exclaiming all the ways he cannot comprehend this vision, how divinity cannot be contained within a form or structure, and the intense distress and fear that accompanies such an engagement. Arjuna's experience of the Vishvarupa can be conceptualized as divine revelation, but a revelation that is too much to bear. Arjuna's exclamation that Krishna in his true form cannot be contained by human flesh mirrors a sense of overwhelming a structure, similar to Freud's (1920) understanding of trauma. It also reflects Caruth's (1996) impossibility of the signification of trauma. Arjuna exclaims, "I do not comprehend Your divine creativity," an utterance that echoes my other interlocutor who recognized that "spirituality is beyond human cognition."

However, where the *Bhagavad Gita* departs from psychoanalytic interpretations of trauma and offers additional insight is that Krishna is *first known* by Arjuna and *then becomes unknown*; this reversal of known to unknown is the impetus of Arjuna's traumatic encounter with the divine. In Freudian psychoanalysis, trauma is not locatable in the original event—it is *first unknown then known* through traumatic repetition. As Caruth (1996) writes, "trauma is not locatable in the simple violent or original event in an individual's past, but rather in the way that its very unassimilated nature—the way it was precisely not known in the first instance—returns to haunt the survivor later on" (Caruth, 1996, 4). For Arjuna, the trauma lies in the realization that Krishna is not who Arjuna originally thought he was. Although Dhruv had encountered the divine throughout his life, these encounters intensified suddenly during his religious pilgrimage and coincided with his psychiatric diagnosis.

Furthermore, divine trauma is ambivalent. For Arjuna, it represents both a sense of distress and divine knowledge, marking a departure from psychoanalytic interpretations of the haunting, continued presence of trauma. Although Arjuna is paralyzed after his vision, he is also granted revelation that he carries with

him for the rest of the battle, comparable to Dhruv's own insight about his life and career in and through his diagnosis. The *Bhagavad Gita* suggests that the revelation of Krishna's true form was the work of the *divine* rather than a consequence of Arjuna's devotion or intention. The *Bhagavad Gita* takes seriously the ways in which the sight of the divine is too terrible for anyone to receive and see, not just those with a preexisting disorder. At the end of the canto, Arjuna tells Krishna he is afraid and requests him to return to a form that is more manageable for him to process. While one might be able to "develop" certain inner muscles through meditation, prayer, and ritual to withstand divine encounters (McDaniel, 1989), the *Bhagavad Gita* suggests there are encounters with the divine in which one can never fully be prepared for. Individuals like Dhruv might not always know how to respond to the divine or understand the parameters of such an encounter; however, Dhruv was still able to gather self-knowledge through his encounters, much like Arjuna's vision.

Reading the *Bhagavad Gita* as a type of psychological theory offers an analysis of traumatic or ambivalent religious encounters not only because of subject/patient/devotee's practices, but because of divine consequence and intention. While scholars (Orsi 2018) have explored how encounters with the divine are misunderstood and possibly misdiagnosed as mental illness, this does not account for the ways in which divine encounters can produce distress, co-exist with it, or even resolve it the way the *Bhagavad Gita* suggests.

After his diagnosis, when Dhruv goes to a temple or looks at an idol of a god for too long, his symptoms return. Certain ritualistic moments, such as when the priest unveils the deity by drawing back the curtains, when the lamps are lit at a temple, staring at an image of a deity for an extended duration, or simply sitting in a religious space for a prolonged period, can trigger his symptoms. Dhruv noted,

> One of the reasons it took me a long time to accept that [what I had] was schizophrenia was because of whatever I had read about it before. I thought I would be visualizing things or hearing things that other people didn't hear. That didn't happen for me. Everything that was happening was related to my body states, my resonances, these feelings. These resonances were directly prompted by the specific temple sites I was in, by the seeing of the deity and things associated with the deity, when the priests would perform certain actions. Now when I look back, I can see that certain things may have been schizophrenia.

Initially, Dhruv denied the idea that these divine forces could lead to negative outcomes, including causing mental distress and impacting his motor abilities. During our first meeting, Dhruv blinked repetitively, a reaction he attributed to having read a book filled with numerous images of different deities. Much of his current condition centers on managing his body's response to these divine encounters.

"What I feel is often like a pressure at the back of my head," Dhruv stated, pointing to the top of his head, the locus point that controls his motor skills. This pressure causes his body to react in ways he cannot fully dictate. For instance, he often finds himself unable to execute an intended action, whether it's standing up, picking up a phone, texting, attending a job interview, or moving in a specific manner. At other times, the pressure triggers rapid blinking or results in him texting random notes on his phone. While doctors often link his paralysis to stress, Dhruv observes that neither talk therapy nor medication has alleviated this specific symptom. "You see, I know my body has its own intelligence. When you talk of *karma* (duty), even the body has a certain karma to it. Karma is not just an individual thing. When we talk of karma, it can be of a family, of a time period, of a history, even of a body. So maybe my body is working through its own karma," he stated, again with a sense of mild skepticism. Although these symptoms are manageable, he notes, his encounters with the divine need to be limited.

DIVINE RELATIONALITY

I now move on to explore what it would mean for this conception of divine encounters—one that is ambivalent, possibly traumatic—to enter urban, inical, and upper-caste spaces. Before turning to a

clinician's point of view, however, I begin by briefly situating Dhruv in his social context to understand how Dhruv's encounters with the divine were not necessarily experienced in isolation or driven only by the parameters of his individual subjectivity. On several occasions, Dhruv would meet his friends just after he had spent hours at a temple.

> See, once I went to this Kali temple in Chennai, and all day I was there, until about 9:15 PM at night. I stayed there because I was immobilized. I couldn't move. Around 9:30 PM or so, I was finally able to move, and I met with my friends. They were all sitting in a 5-star hotel. I was in a *horrible* state, seriously horrible. So they had to come outside of the hotel to meet me. I should have been hospitalized then, but no one thought anything was wrong.

While he was in the middle of his religious pilgrimage, his friends continued to give him different recommendations on places to visit. "I had a friend who first told me to go to Mantralayam, then to the Kanchi sages, and then to Bangalore. I mean, he was sharing what he knew and what resonances he felt with what I was going through." Once, referring to his family,

> I was in my sister's house with my niece, and there was a Shiva statue there, and I just felt a strong force from it, and then I just fell down. And I couldn't move from that place where I fell for several hours. My sister was there, she saw that. The thing is, my friends, and my family, we all have a high tolerance toward all these things, these kinds of mystical experiences. She thought it was something to do with yoga again, like I was in some yogic state.

Neither Dhruv nor any member of his family suspected anything was wrong as he hopped from temple to temple for months, sometimes going without food or sleep for weeks, often remaining rigid and immobilized at various temple sites. Among Dhruv, his friends, and his family, there existed a specific conception of divine encounters: such "disturbances" were not viewed as actual disturbances but rather parts of mystical experiences. As Dhruv told me on multiple occasions, "I was supposed to be in a mystical period of time. These sensations matched what one is *supposed* to feel. " But, as he has also reminded me, "[He is] quite sure [he] also had a psychotic break down."

I once shared this conception of divinity intersecting with mental distress with Dhruv and that perhaps these encounters could be dangerous for his mental health. He declared:

> I can see that *now* because of the diagnosis. But I would have not thought so initially. But how would this be evoked within a scientific community? Or the psychological community? Freud and Jung didn't believe in mystical experience. Freud characterizes Ramakrishna's *samadhi* experience as the same as that of a baby, a human without an evolved ego. Jung refused to meet Ramana Maharishi because he felt like it would be like meeting with someone with an innocent tribal experience.

While there is a rich academic tradition of engaging psychoanalysis with mysticism (Eigen, 1998; El Shakry, 2017; Mittermaier, 2011; Pandolfo, 2018; Sayers, 2003), Dhruv's statement points toward one of the ways in which our interlocutors in the field may talk back to certain (Western) epistemologies. More pressingly, however, Dhruv's own relegation of the divine to realms outside the psychiatric or psychological prevented him from sensing any danger initially, a sentiment he expressed to me multiple times. Dhruv, along with his friends and family, all assumed that his altered states were not true disturbances but rather fell within the realm of mystical experiences that didn't warrant bio-psychiatric intervention.

To think about an encounter with a divine as an affectual, traumatic force offers another entry point to exploring therapeutic efficacy in urban, upper-caste spaces. Anthropologists have explored how a secular public forms around a figure that is unmarked by religious tradition (Asad, 2003; Whitmarsh & Roberts, 2016). Secularizing processes in India have relegated the presence of the divine to very specific places, such as homes, temple life, village life, or ashrams (Chakrabarty, 2002; Mines, 2005). If certain

extreme experiences do occur within relegated spaces—such as the temples or ashrams—these are "permitted" (Obeyesekere, 1990) with the understanding that disturbed mystical experiences may occur in certain spaces and are transitory states that ultimately culminate into a union with god (Kakar, 1991, Obeyesekere, 1990). The relegation of divine presence to these spaces, "confining the gods to the inner life of individuals" (Orsi, 2018, 38) and away from the secular public does not account for the instigation of mental distress within these supposedly sanctioned sites. For example, in rural areas of Tamil Nadu, some agricultural castes publicly accept the darker and more dangerous nature of the divine, which includes the possibility of deities causing mental distress (Ram, 2013). However, this perspective is not typically shared in upper-caste, urban, or clinical understandings of the divine, the cosmology which Dhruv, his psychiatrists, his family and friends participate in. Certain types of divine encounters, therefore, are acceptable only in certain places and for certain kinds of subjects.

THE SACRED AND THE PSYCHIATRIC

Not accounting for the various affective encounters with the divine, including divine trauma, overlooks the potential for the emergence of psychiatric symptoms in religious spaces. It may also lead clinicians to view these spaces solely as therapeutic. Almost all the psychiatrists I interviewed in Chennai had a unified conception of the role of religion and spirituality. "The way I just see the difference is simple. Spirituality is supposed to make you feel good, uplift you. It's not supposed to make you depressed," one psychiatrist told me, rather optimistically. Another noted, "spirituality is supposed to calm your mind, it is not supposed to bring this level of anxiety and restlessness." For these psychiatrists, if one experienced distress in relation to the divine, it must stem from a psychiatric illness. Religion serves as an effective coping mechanism and is useful for instilling structure, habit, and discipline. Moreover, many psychiatrists and psychologists I interviewed often recommended and incorporated religious and spiritual practices to supplement their bio-psychological therapeutic approaches. This mirrors the well-documented anthropological scholarship wherein health practitioners in India draw upon religious healing when allopathic methods are insufficient to provide comprehensive care (Bharadwaj, 2016, Corin et al., 2003, Vora, 2015).

I now present excerpts from three different psychiatrists in Chennai to examine patterns in their thinking regarding religion and mental health.

Dr. G:

> Me: What do you think about your patients turning to spirituality to facilitate their healing? Is there any risk in this?
>
> Dr. G: There is no risk I would say. But you know with religious things, some people get confused very easily. You see, you have to think about whether something like a hallucination is *really* a hallucination. In the real sense of the word. You have to find out what the primary narrative is. The few, *true*, spiritual people I have interacted with, they don't have hallucinations. They are not mentally disturbed. They are distinctly different experiences.
>
> Me: How would you classify the difference?
>
> Dr: G: Hallucination… is… an experience without any sensory input. Most of these so called religious experiences are just dissociative states which have an objective behind them, somewhat in a fake sense.
>
> Me: I guess I'm still uncertain how you …know what is what?
>
> Dr. G: Real spiritual people don't report any hallucinations. They don't tell me, "god told me this. I hear the voice of god. He's telling me this, he's telling me that." They aren't in any kind

> of distress, hurt, pain, they are just saying. Maybe they go into a trance state, but they calmly talk and tell. They don't tell me, "god is telling me to do this." I mean have you heard of any religious figure that tells you, "god told me to do this!" No! They are calm, they are collected, and they are just simply sharing a set of their own ideas. They are not disturbed.

By the end of our conversation, Dr. G was exasperated due to my lack of understanding, as the difference between religious states and psychiatric states was clear to him. His analysis can be placed in productive dialogue with a larger body of literature (Bourguignon, 2004; Kakar, 1991; McDaniel, 1989, Obeysekere, 1981; Smith, 2006) that explores these differences through their distinct temporalities. More relevant to this article is Dr. G's emphasis on the effect of individuals he labels as "truly" spiritual: they exhibit calm and collected behaviors, devoid of distress or hallucinations. Dr. G also distinguishes "fake" religious experiences, which he categorizes as dissociative disorders, from "true" spirituality. In Dr. G's perspective, these two realms of experience—psychiatric states and "true" spirituality—do not intersect.

Dr. S:

> Dr. S: Coming from a culture where there is so much religious belief, the first thing people do when they are distressed is that they go to religious sites. Especially people in the villages, but I would also say here in Chennai too. The first thing they do is seek religious healing before even coming to a mental health practitioner. And then those religious healers at those sites will also say, "I hear god telling me this. So, you should do this and that for your healing." I mean, I don't know what to think of these people, maybe in these healers there is a mild psychosis element, I couldn't tell you, but I would not classify this as pathological. Also there is purpose in all this religious healing. And people have faith in these religious sites, and faith can be extremely powerful in the context of healing. I always recommend my patients to go and pray because belief is very powerful. And that could be restorative.
>
> Me: What would you consider pathological?
>
> Dr. S: Again, if you ask us [mental health practitioners], there were some attempts to collaborate with religious sites for healing. Because even though they are saying certain things, I don't consider people there as pathological because their actions don't cause them any impairment. If you are engaging spiritually, and there is no impairment or distress, then it is not pathology. It's just a spiritual experience.

Dr. S was somewhat uncertain about her own explanation and frequently paused between my questions. However, her comments echo a common ideology among the mental health practitioners I spoke with in Chennai: pathology is often deemed symptomatic and problematic when it interferes with a patient's functionality. While Dr. G and Dr. S hold somewhat divergent views on the nature of pathology, they concur in their perspective on mental disturbances: spirituality does not result in impairment or distress.

Dr. H:

> Dr H: I have some experiences which I can tell you from my personal experiences. See, I come from a community that has a lot of superstitions and beliefs. So, there are times when people in the community I am a part of - they say things like, they hear god, they see god. Or like they are about to fall and some force catches them, and it must be god. And you see, the family lets all this pass. They are fine with it because there is no disturbance to them. The family says, "okay god has entered this person," and then they just let it pass. The family will just let it happen because there is no harm to them. And what can I do? If it is accepted by the entire family or the entire community and there is no harm, then what is the point of intervention? It's only when there is harm that it becomes pathology. They are feeling good, they are having a safety net, because of the spirituality.

> Dr. H's interpretation of spirituality and distress also mirrors Dr. H and Dr. S's views, particularly around the issue of harm. For all three psychiatrists, what constitutes pathology, what constitutes harm, and what constitutes spirituality do not overlap immediately.

There were, however, a few clinicians who spoke about their clients' ambivalent encounters with the divine. One psychotherapist shared an experience of a young adult who hallucinated having sex with a goddess. When the client was a young boy, his parents made him stay at his neighbor's house while the parents were away at work. The neighbor was an elderly woman who would fry and sell groundnuts. To ensure the boy was well-behaved, the woman would exclaim: "If you do mischief, god will put you in this big vessel and fry you like a groundnut and eat you!" The boy, according to his psychotherapist, automatically associated divinity with fear, and when the child became sexually active, he started hallucinating that he was having sex with the goddess whenever he saw a photograph of the goddess. The therapist continued, "power, sex, and fear all go hand and hand. When the boy went to his engineering college, he put a photo of this goddess everywhere. He couldn't focus on anything because he was constantly having sex with her. He couldn't control it until he attempted suicide. He survived, but that is when he came to me."

This psychotherapist automatically attributed her patient's ailments to a painful childhood experience that was then transformed into having sex with a goddess, a case of the disintegration of the subject and a traumatic childhood experience being projected onto a sexual fantasy. While I do not have evidence to suggest that the boy separated out what was wrong with him from what was wrong with the goddess inviting him into constant sexual desires, there is nevertheless an immediate understanding from the psychotherapist that his reactions were an internal response to the subject's infantile terrors rather than an encounter with an ambivalent divine.

In drawing upon these ethnographic encounters, a psychologized perspective of divinity negates the intersection of spiritual encounters and mental distress by reducing it to a subject's pathology or an extended expression of the symptom. For all three psychiatrists, and others I also interviewed, these are separate modes of experience. Anthropological insights have documented both how clinicians often recommend spiritual care when biomedicine proves insufficient and the pervasiveness of healing at various religious sites. Dhruv's narrative complicates these insights: while his own psychiatrist did not recommend religious sites to supplement his healing, she did not see any harm in Dhruv visiting them. Neither did his friends and family. "He must have been showing signs well before he left [on the pilgrimage]," Dr. F, his first psychiatrist, shared. While Dhruv himself has accepted he must have had symptoms before he left, Dhruv's symptoms nevertheless heightened in these spaces and now any engagement with the divine is a trigger. As Singh and Sharan have recently (2022) written, it is a popular moment for shrine-based healing in India, contrary to modernizing assumptions that healing shrines are becoming less important. What would it mean to read Dhruv's case alongside such a claim?

Finally, this understanding of the divine, I argue, is also crucial for anthropologists. It returns and reminds us of the long-standing debate on the difference between "methodological atheism" and the ability to "take religion seriously" as a way of challenging our thinking. In "Is there a place for faith in anthropology?," Willerslev and Suhr (2018) write, "religious traditions offer a language through which to deal with shifts in perspectives," offering anthropologists ways to sit with the unknown, a way to reckon with existential resignation in ethnographic (or maybe life) pursuits. "Disruptive" moments can become "transformative," a "search for new wisdom that necessitates self-transformation," they write (73), reflecting scholarship (Kakar, 1991, Obeyesekere, 1990) that attends to disruption and the unknown as transitory states. If one can surrender and sit with the unknown, resignation becomes a potential precursor for insight. Divine encounters, however, as Dhruv and the *Bhagavad Gita* suggest, may offer openings of the unexpected that are traumatic and perilous, offering an alternative to clinical, secular understandings of religious experience.

CONCLUSION

This article has argued for an understanding of the divine that moves beyond symbolic or socio-cultural constructions to re-think the supposed totalizing effects of severe psychiatric distress. While affect and trauma offer conceptual apparatuses to think through an ambivalent encounter with the divine, I instead draw from the *Bhagavad Gita* as a form of psychological theory to contend how an encounter with the divine might be too much for an individual to bear. In doing so, the article offers an alternative entry point to the commonly held assumption of the therapeutic efficacy of divine encounters and religious sites in India. Dhruv's insight also sheds light onto the complex relations between ontology, epistemology, and phenomenology, drawing attention to the possibility of instability and unresolved contradictions within a single subject's reality.

CODA

Many months later, the COVID-19 pandemic has changed our social and moral ecosystem, and I am many miles away from India's vibrant and uneasy cosmological universe. Dhruv and I are on the phone talking about the year ending, and what changed for us both because of the pandemic.

"To be honest, I had a really good year. I'm in a better place. I'm a lot more at peace with myself," he tells me.

The next day, I shared this sentiment with my aunt, a psychotherapist in Chennai—that maybe those who have already had their realities shattered are better equipped to handle the changes of the pandemic. "Maybe," she replies. "I also just think some are at a higher level of being."

In the year of the pandemic, Dhruv has finally begun to come to terms with the encounters of his journey:

> During my schizophrenia time, I resonated with that sense of depth within me and I associated it with a higher power… I started seeing patterns all over the place… Which I was connecting with the divine. My sense of seeing patterns and the experience and sense of depth now has evolved. I am not craving this, nor am I attached to it. I am able to be more composed about it now.

For Dhruv, a revelation sprung from these divine encounters, prompted by the radical changes in our social climate: that there is a limit to his relationship to the divine and that he must not be too attached to it and the messages it delivers. For Dhruv, the divine might not be able to give him everything he is looking for. As Willerslev and Suhr (2018) write, "faith is not about certainty or the elimination of doubt… 'letting go' in faith involves embracing these tensions, which constitutes the absurdity of the paradox" (74). And yet, to take this argument one step further, letting go also means letting go of the form for Dhruv, of the object of one's faith. The ethic for Dhruv now is to let go, to no longer want to be attached to particular messages and that revelation can be found elsewhere, perhaps in a different space of alterity, or maybe just in this world itself.

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