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Chhopuwa, Distress, and Gender in a Hindu Village of Nepal

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ABSTRACT

In a village in the Kathmandu Valley women were the predominant sufferers of *chhopuwa*, a disorder of possession and fits of unconsciousness. They often considered their attacks of chhopuwa to be the result of witchcraft, which they related to distressful social circumstances. Male sufferers, in contrast, considered their episodes of chhopuwa to be either a calling to act as a divine medium or epilepsy. This paper explores these gender distinctions in the meanings and social distribution of chhopuwa. By building on John Hitchcock's writings concerning the objectification of disordered behavior and the experience of "otherness," the paper seeks to describe how chhopuwa was positioned within the everyday meanings and structures of the social relations of sufferers. It shows how the divergent social positions and identities of men and women led to differences in their perceptions and practices related to chhopuwa.

John Hitchcock's seminal work on shamanism and healing in Nepal demonstrated how shamanic practices ministrate to the ill and anxious, integrating features of the cosmos, everyday life and social tensions, while providing a means of controlling the terrors and confusions of affliction (1976a). Hitchcock eloquently demonstrated how ambiguous and uncontrolled behaviors were objectified and given form as culturally meaningful experiences through the complex of activities that make up shamanic practices (1974, 1976b). In particular, he described how the main symptoms of an incipient calling to be a shaman, in the form of shaking and "flinging oneself around," or falling into an unconscious fit, "as if dead," were channeled into a specialist role through cultural expectations and ritual practices (1976b). He also observed that these expectations and roles largely involved only men in the villages where he worked.

In a Jaisi Brahman village in the Kathmandu Valley, a disorder known as *chhopuwa* or *chhopne betha*, which derives from the Nepali verb *chhopnu* or "to cover," was also characterized as fits of unconsciousness or shaking and speaking, as if possessed. Similar to Hitchcock's observations, men who suffered chhopuwa were typically suspected to have a calling to act as a medium of a clan deity or lineage spirit, or (when chhopuwa took the form of an unconscious fit) to be suffering from a physical disorder such as epilepsy. However, women more commonly suffered chhopuwa and, whether shaking as if possessed or falling into an unconscious fit, their behavior was usually thought to be the result of witchcraft. Social aspects of female sufferers and the meaning of their symptoms reflected many of the vulnerabilities and tensions of life in their marital households.

This paper explores gender distinctions in the experiences and distribution of chhopuwa and related disorders, identified in survey data and case studies collected between 1982 and 1984. By building on Hitchcock's writings concerning the objectification of disordered behavior and the experience of "otherness," the paper seeks to describe how chhopuwa was positioned within the everyday meanings and structures of the social relations of sufferers. It explores the preponderance of female cases of chhopuwa, as related in part, to gender dynamics and vulnerabilities, and the interaction of distressful affective and physical states, and social circumstances, which gender-oriented dispositions and interpretive/curative practices associated with chhopuwa.

Identifying chhopuwa

In 1982, we conducted a psychiatric survey of 830 individuals, 10 years of age and older, in the Jaisi Brahman village of Degalgaon (a pseudonym) in the Kathmandu Valley. We tested and utilized a culturally sensitive screening instrument developed in India to identify potential psychiatric cases (Indian Psychiatric Survey Schedule; Carstairs & Kapur 1976). Cases with high rates of symptomatology were followed up with a clinical psychiatric interview (see Shrestha, Rimal & Pach 1983). Nearly 8percent (n=65) of

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the population reported ever experiencing an unsolicited attack by a witch, spirit, or deity. Among the 431 women in the study, 13 percent (n=58) reported chhopuwa at some time in their lives, with 8 percent (n=38) reporting that they were active cases at the time of the study. In comparison, 2 percent (n=7) of the 399 male respondents in the village reported a lifetime prevalence of chhopuwa, with 1 percent (n=4) identified as active sufferers. At 89 percent of all cases, women represented a preponderance of the cases of chhopuwa in the village.

We conducted follow-up interviews with the 65 lifetime cases of chhopuwa using a semi-structured interview guide that explored sufferers' symptoms, experiences, perceived causes, treatment, and general social circumstances. We also collected narratives of illness histories of chhopuwa. The range of behaviors and experiences associated with chhopuwa; their distribution by age, gender, and social factors; and the narratives in which individuals elaborated on the experience and meaning of chhopuwa, reflected gender differences in the social positioning and significance of this affliction (cf. Fabrega & Miller 1995). The following section describes the behaviors and experiences of chhopuwa.

The form of chhopuwa

Generally chhopuwa was manifested in two ways. One might gradually fall into an unconscious or semiconscious sleeplike fit with a stiff body and hands and teeth tightly clenched, or one might shake in a sitting posture, not unlike deity mediums and shamans in this area. This latter form often was accompanied by aggressive speech, as the possessing spirit or witch would speak through the afflicted. Of the 65 reported cases of those who ever had chhopuwa, 44 percent had fallen into a sleeplike fit; 32 percent shook and spoke as if possessed; and 18 percent exhibited a mixture of the two forms, with fits of possession often later changing into a seizure-like, unconscious state. Other forms of behavior such as running wildly about, rolling and writhing on the ground, or suffering a kind of faltering or incapacitating weakness were also called chhopuwa. These atypical forms were frequently associated with earlier occurrences of typical forms of chhopuwa, and sufferers were most often women who related these episodes to disturbed emotional and physical states and problematic social circumstances.

In most cases, attacks of chhopuwa lasted from 1 to 2 hours, although sufferers reported a range of between 10 minutes and 24 hours. Yet, even the slightest faltering in motor ability or performance of likely sufferers may have been perceived as indications of chhopuwa, especially if one had had a previous attack or was in a heightened state of emotional distress or social conflict.

Similarly, the frequency of the disorder ranged from one or two episodes in a lifetime to several times a day for 30 years. Most commonly, episodes occurred once or twice a week for a specific period of time, often from 2 to 5 years. However, at the time only seven sufferers (11 percent) experienced attacks of chhopuwa less than five times in their lifetime, and 42 cases (65 percent)—most still active—had experienced chhopuwa 10 or more times.

A large number of sufferers claimed that their initial symptoms of chhopuwa had changed, not occurred for some time, or had become more of a feeling state. For instance, one woman (40 years old) said that her symptoms had typically occurred twice a month, but she had been asymptomatic for the past 5 months and was therefore uncertain whether she was still afflicted. Another woman (74 years old) said that she had not "shaken and spoke" for more than 50 years; she felt as if her symptoms were now more "inside than outside," as if she were shaking inside her body. Another case of chhopuwa, a 24-year-old woman, said that her attacks took the form of falling into a fit of crying and seeing terrifying individuals. Her attacks had occurred twice a month, then dropped to once in 6 months, finally diminishing into a feeling of anxiety (*manma kura khelne*) and sleeplessness. Thus, many sufferers believed that they were still suffering from the disorder even without experiencing its characteristic symptoms for long periods of time.

These experiences raise the question of what constituted a current case or episode of chhopuwa. Most descriptions of chhopuwa indicated disturbed cognitive/affective perceptions and behavioral disturbances that were related to distressful situations and misfortune. Thus, episodes of chhopuwa both communicated and embodied varied forms of distress. In acting as an idiom of emotional distress and social adversity within individuals' lives (cf. Low 1994), chhopuwa encompassed diverse physiological and affective experiences that were often associated with its characteristic manifestations. Thus, there were both salient, recognized symptoms and more tacit and varied experiential features that were part of the significance and perception of chhopuwa for sufferers[2].

Important in the description of an attack of chhopuwa are initial signs that may be thought of as "pre-symptoms" or foreknowledge of an impending attack. These sensations or feeling states took various, usually consistent forms, and often occurred in clusters. Generally, sufferers mentioned that before an attack, they felt dizzy, saw colored lights, or had various pains in their body—such as in their head, ears, feet, or heart—that moved around, spread, and overcame them as an attack of chhopuwa began. Many also described feeling depressed and anxious. While headaches, weakness, or a pain in the back of the neck were typical sensations, others had more atypical cognitive and affective presymptoms such as seeing snakes or terrifying figures. For example, before an attack of chhopuwa, one woman (24 years old) reported having a heavy body, a sharp pain in her heart, irritation, and feeling depressed. Other women felt sad, felt like crying, or were fearful and anxious before

[2] Allan Young (1995) makes similar observations in his study of post-traumatic stress disorder.

an attack. Although seemingly marginal and auxiliary to the defining features of the disorder, pre-symptoms were a critical part of the feeling states that triggered or signaled an impending attack of chhopuwa. Over time these sensations were part of the "embodied memories" (Young 1995) of the troublesome affect, behavioral and cognitive symptoms, and distressing situations that were drawn together within the experiences and meanings of chhopuwa for sufferers.

When asked what caused chhopuwa, most sufferers indicated that it was sent by someone as witchcraft (*pesuwa*), and thus related to strained social relations. However, many sufferers also mentioned the loss of a child, spouse, or parent, or pointed to long-term physical illness. These explanations suggest that, as an idiom of distress, chhopuwa condensed various conditions of vulnerability and adversity, as important features of the disorder.

Social aspects of chhopuwa

As indicated, women comprised 89 percent of all cases of chhopuwa, with initial episodes often related to the pressures of their early years of marriage. For example, 91 percent of female sufferers were married at the time of their first episode. The average age during this initial episode was 21 years old, with 69 percent (n=45) of all women having had their first attack before the age of 25. A factor especially related to their early years of marriage was that in their first episodes of chhopuwa, more than one-fifth (n=14) of female sufferers were in the transitional ritual status of recent childbirth known as *sutkeri*—which was a significant time in their early years of marriage.[3]

However, narrative accounts of chhopuwa often reflected the difficulties women faced within agnatic relations of power and authority in which male agnates took precedence in property and ritual relationships, and had privileged access to educational and employment opportunities, to the near total exclusion of women. However, these social arrangements among men were paralleled by female relations which were similarly structured by an age-based hierarchy that intersected with equivalent rights and responsibilities among in-marrying women. These relations were more entertwined and affective, and generated ambiguities and tensions that often led to conflicts across generations and among affines (cf. Gray 1995).

In the domestic politics of household life, in-marrying women were in a vulnerable and ambivalent position. Though they contributed needed labor and offspring, they also provided the capacity and motivation to establish independent conjugal families that often led to problematic household partitionings (cf. Bennett 1983). In the affective reciprocities of household relations, they expected a degree of nurturance and acknowledgement from superiors in exchange for their deference and hard work. However, inequalities in disbursements of food, clothing, and workload, as well as subtle affective messages given disproportionately to women of roughly equivalent status, often created feelings of competition and frustration. These tensions and feelings often led to outbursts and rivalries among women.

Feelings of hurt and anger, or pain at the loss of a child or abandonment by a husband, led to a sense of helplessness and uncertainty among women within their domestic situations. It is not surprising, then, that 78 percent of female sufferers related their chhopuwa to distressful quarrels and beatings that most often were attributed to tensions and conflicts with a husband's mother or husband's brothers' wives.

These perceptions and interpretations of chhopuwa were reinforced by themes of ritual aggression and danger, which were key features of the ritual healing typically employed in cases of chhopuwa. Ritual specialists utilized mantra and offerings to gain protection from or to expel the troublesome powerful, ritual forces of spirits, witches, and deities.[4] In this social context and cultural universe, it is understandable that 91 percent of women described the cause of their chhopuwa to be pesuwa—something "sent" by a witch. Thus, chhopuwa was often perceived as emerging along lines of social tensions. Capturing the sometimes painful intimacy of household social relations, one woman (30 years old) indirectly referred to the cause of her chhopuwa in saying, "the tongue and the teeth are very close, and the teeth cut the tongue."

However, placing women and the interpretation of chhopuwa only in relation to their powerless and conflicted social position does not capture the multileveled and shifting sources of meaning that they employed in characterizing their affliction over time. Accounts of chhopuwa also do not illustrate the diversity of relationships among women in the village, where a sphere of intimacy and supportive relations was shared among women. These relations provided a source of sociality and reciprocity, for example, in forms of labor exchange and socio-ritual activities that linked women and households beyond their patrikin. Narratives of chhopuwa, however, also depict differences among sufferers with some women simply more prone to illness and incapacity than others. Narrative accounts of chhopuwa also

[3] Also in transitional ritual statuses were 12 percent (n=8) of women who were observing death pollution (*barakhi*) and 11 percent (n=7) of women who were menstruating (*nachhune*) during their first episodes of chhopuwa. Villagers believed that the "shadow" (*chanyan*) of women was especially weak after childbirth or while menstruating, and so susceptible to physical illnesses and evil encroachments (cf. Cameron 1998).

[4] There were a number of ritual processes and interpretations that indicated mechanisms underlying an attack of chhopuwa, and entailed parallel behavioral manifestations, such as *boksi charhne* (i.e. ridden by a witch), or *masan lageko* (i.e. hit by the spirit of the creamation ground). However, chhopuwa was a more inclusive and encompassing illness category that implicated symptoms, etiological agents, and distressful circumstances and experiences which subsumed other more specific processes and interpretations.

show women asserting themselves in numerous contexts and actively constructing interpretations of their experience.

Watkins (1996) observes that because of the contingent nature of an individual's social circumstances, motivations, levels of knowledge and capacities, it is difficult to draw determinant links between relational structures and forms of experience. Yet, she also contends that expectations are continually reinforced, structures embodied, and dispositions strengthened through socially constituted ritual actions—and, I would add, parallel material relations and reciprocities. Such redundant relations and discourses produce a "socially-informed body" which generates and unifies perceptions of, and orientations to, experience (Bourdieu 1979; Desjarlais 1993). Thus, narrative accounts of chhopuwa depicted embodied experiences that were embedded within ritual and social configurations and contexts of power that informed orientations to their experience. These configurations of meaning and social relations also involved gender distinctions in productive and symbolic relations.

Material and symbolic relations

In Degalgaon in the early 1980s, households functioned as the key units of production and consumption. They served as the matrix of social relations, tying individuals to one another and to other, often kin-related, households through the sharing of land, labor, and ritual responsibilities.[5] Furthermore, households related collectively to health care resources and market contexts. They were based on a mixed economy of rice, wheat, and maize cultivation, with one-half of households owning buffaloes and cows. At this time, half of the households in the village had at least one male wage earner working in an urban setting, although among men there was an increasing participation in the labor markets of urban centers.

The male and female division of labor, though complementary, entailed unequal opportunities and responsibilities. Men fixed terraces and irrigation works, prepared fields, managed major market transactions, and participated in nonagricultural labor, particularly urban employment. Women planted, weeded, harvested, threshed, and winnowed grain, and if poor, worked as seasonal, low status agricultural laborers. At home young women did the least valued work of carrying manure, scrubbing pots, and cleaning the house.

Women had a voice in the consumption and distribution of foodstuffs and other goods in their conjugal family, and depending on their position within the age-related female hierarchy, in the extended household. Nevertheless, male elders and their sons, who shared equal rights to the property, acted as the final authorities in decisions regarding household production and transactions. Unmarried daughters, sisters, and widows had rights to a share of household property (Gilbert 1992), but their claims were often met with argument and manipulation. Being a single, "unattached" woman was, then, an especially disadvantaged position. These conditions were reinforced by marital practices of exogamy, virilocal residence, and injunctions against divorcée and widow remarriage, which combined to further undermine female autonomy and mobility.

The symbolic power of the patrimony was further substantiated in the recognition and propitiation of ancestors and lineage deities. These activities and roles extended the dominant order of social relations in the spiritual realm (cf. Comaroff 1985). Agnatic precedence in mortuary and ritual responsibilities paralleled the control and inheritance of land by sons and brothers (cf. Bennett 1983). In agnatic ritual cults, the prosperity, health, and well-being of local kindred were ensured and reproduced in annual clan deity and ancestor ceremonies, which occurred before the planting and rainy season as offerings of first fruits. These deities were also invoked in divinations in times of misfortune and illness.

Married women were not allowed to attend annual lineage-deity propitiation ceremonies, officiate in transformative possession ceremonies for suffering lineage spirits, or act as mediums for the invocation of clan or lineage deities (Bista 1972; Gaborieau 1974).[6] Yet, in serious cases of illness and misfortune, such as intractable cases of chhopuwa, the afflictions of women were divined through seances of clan and lineage mediums (*dangre*).[7] The organization and dynamics of these reciprocal material and symbolic relations underlay gender distinctions in practices and perceptions related to chhopuwa.

Case histories of chhopuwa

Narrative histories of sufferers illustrate the constellation of emotions, stresses, memories, and forms of local knowledge and practice that were drawn together as accounts of chhopuwa developed over time. In the following case history of an older woman ("Mayan") who had been a long-time sufferer of chhopuwa, we see how conflicts over scarce resources, unmet conjugal expectations, and physiological illness created distressful conditions that were associated with episodes of chhopuwa. Mayan's case also illustrates how individuals in these social positions were able to re-

[5] John Gray (1995) has provided an important study of household relations among a similar social group in Nepal and describes comparable household structures and processes.

[6] Only the *pancha kanya*, the five auspicious virgins, that is unmarried women, were allowed to bring offerings to clan and lineage-deity shrines during the annual propitiation rites. This signifies their agnatic and pre-marital identity and purity. These ceremonies involved vertical agnatic relations, Brahmanical rites and ministrations, animal sacrifice, and possession.

[7] Clan and lineage cults were also tied to pragmatic interests, such as loans, land, and leadership roles, so that over time their composition varied according to their histories of cleavages and factionalism.

spond to situations with their own interpretations and assertions of their needs and perspectives. Following this case history is the account of a male sufferer of chhopuwa ("Ramesh") whose wider socio-ritual opportunities and expectations led to the construction and trajectory of his affliction that took a different direction from Mayan's.

Mayan (Female, 60 years old)

Mayan, a woman from a wealthy household, recalled that her affliction with chhopuwa started a number of years after she was married. At the age of 29 and without offspring, her husband brought home two other wives. Soon after this, she had her first attack. At the time, she was menstruating (*nachhune*) and in a state of funeral pollution (*barakhi*) for her husband's mother who had recently died. In addition, she reported feeling weak and had blood and mucous in her stool. Her social situation had also been stressful, as she had been continually quarreling with her husband's other wives, as well as her husband's brother's wife. These latter tensions were a continuation of jealousies and disagreements that had occurred some years before, when their husbands had separated their joint household property. When possessed, Mayan would shake and speak and say that it was her husband's brother's wife who had attacked her. These episodes continually reaffirmed long-standing hostilities.

Mayan recalled that her bouts of chhopuwa began not long after an argument with her husband's brother's wife, who had reprimanded her for letting her goat run loose and feed in her fields. One day, after returning from transplanting paddy, she felt weak and depressed, and began warming herself by the fire. Suddenly she fell down and began to shake; she recalled seeing others in room and said that they had put a shoe on her head to dispel the witch that had come into her body. However, she continued shaking vigorously and defiantly.

This type of possession continued episodically for 30 years. In the beginning, it occurred every day; she would sit and shake with hands and teeth tightly clenched, feeling something moving within her body. Whenever a shaman would come to treat her, she would yell at him and attack him vigorously. Only if a shaman was strong could he subdue her. She had had many treatments throughout her life, such as offerings to spirits at crossroads (*manchaune*) and to powerful deities (*akas devi*), as well as ritual expulsions through blowing mantras and sweeping (*jhar phuk*) and being sprayed with a shower of flames and hot water (*soda pani*). However, her chhopuwa did not subside until her husband's brother's wife died. Before she died, the sister-in-law had been living virtually abandoned and penniless; Mayan took pity on her and brought her food. Shortly before her death, she blessed Mayan for helping her. Mayan attributes this reversal in their relationship to her relief from her attacks of chhopuwa.

Though Mayan and others attributed this relationship as the source of her chhopuwa, she was also considered a witch by some, for she was a childless widow, lived alone, was assertive with her female relations, and had a history of powerful episodes of possession by a witch. As a woman in a high-caste Hindu household, her behavior ran counter to Brahmanical and village social ideals of female cooperation, deference, and procreation (cf. Skinner & Holland 1998). At the onset of Mayan's chhopuwa, an acute case of dysentery no doubt contributed to her physical and affective malaise. Her menstrual (*nachhune*) and funeral (*barakhi*) pollution also may have contributed to her feelings of vulnerability.

This case illustrates how social and economic relations and dynamics positioned women in potentially tenuous and conflictual circumstances. Men likewise experienced pressures to contribute to and cooperate with their kin and were also involved in or anticipated the throes of underlying competition for household resources. However, there were important differences in socio-economic and ritual opportunities for men. The following case history of a young man's chhopuwa indicates a number of these gender distinctions in response to his illness episodes.

Ramesh (male, 19 years old)

While eating dinner one day, 13-year-old Ramesh suddenly fell over and lay on the ground. His hands and teeth were tightly clenched, his body stiff and shaking. While in this state, his family called a healer who blew him with mantras and circled his head with red-and yellow-colored rice offerings, which were then thrown outside the house (*puchera phalne*) to lure away any evil influences that were bothering him. Ramesh then came back to consciousness. The next day he shook and screamed for an hour. When offered incense and a lamp to appease what was troubling him, he stopped shaking and screaming.

At this time, it had been a year since Ramesh's mother had died. When she was ill and failing, a healer had diagnosed her problems as the result of witchcraft. He said that a woman from a nearby household with whom she had quarreled had buried a piece of her hair and clothing at a crossroad to destroy her. Ramesh's sister believed that this woman was jealous of their household and her treacheries were affecting her brother.

The family sought the help of a powerful healer (*dhami*) to further diagnose his problem and prescribe a remedy. The healer said that the spirit of a dangerous suffering ghost (*pichas*) was responsible for Ramesh's affliction. The family suspected that it was the unappeased spirit (*kancho bayu*) of his younger brother, who had died in an accident at the age of five. The healer said that it was necessary to raise the deceased child's spirit (*bayu utarne*) and perform the fire-walking ceremony (*khalikane*) to release it from its suffering (cf. Hoefer & Shrestha 1973; Gaborieau 1974). The ceremony would have required a minimum of 3,000 rupees to purchase the necessary materials (wood, ritual offerings) and hire a ritual specialist—more than Ramesh's father could

afford. He could not ask his brother to contribute to the ceremonies because of long-standing quarrels over their partitioning of their parental household. Therefore, his father continued to make offerings to deities (*akas devi puja*) and ghosts (*manchaune*) to help Ramesh, but did organized the ceremonies to transform his deceased son's suffering spirit.

Four years after his initial attacks of chhopuwa, Ramesh suffered stomach pains, had blood in his stools, began to cry and twist his body, and saw frogs and snakes coming at him. His family thought this illness had etiological links to his earlier attacks of chhopuwa, although the symptoms differed from its characteristic symptoms. After a number of medical and ritual treatments, Ramesh and his family thought that his chhopuwa had subsided. Still, whenever he became ritually impure from tainted food (*jutho*) or from touching a menstruating woman (*nachhune*), his body would stiffen and he would shake. If offered incense, his symptoms would subside.

It was believed that this type of reaction to impurity and its ritual cure happened to men who served as vehicles for clan (*kul deota*) and lineage (*pakho bayu*) deities. In contrast, most cases among women (such as in Mayan's experience) were perceived to be the result of attacks by impersonal spirits usually sent by witches or sorcerers; such spirits were expelled, rather than worshipped. Thus, Ramesh's disturbed behavior, though remaining somewhat indeterminate, was largely suspected of being a calling to act as a medium of a lineage spirit, rather than the result of witchcraft. However, due to the pragmatics and politics of his domestic circumstances—his father's lack of finances and family discord—designations of Ramesh's maladies remained open-ended and contingent on his future behavior and family fortune.

Chhopuwa, divine possession, and gender

In the cases above, we see how domestic relations of power and authority, associated with the economic and ritual life of households, and gendered ideals of comportment and performance, employed a politics of representation and deployment of categories of experience. These orientations led to distinctions in the meaning of disturbed behavior. Of course, there were a host of etiological explanations for chhopuwa (e.g., astrological disjunctions, fate, and physiological disturbances) that were invoked when attempts to appease angered deities or troublesome spirits had not been successful. These explanations reflected existential vulnerabilities within individual lives. However, cultural perceptions of male and female possession and fits of unconsciousness separated along lines of the divine and demonic.

For the seven males who had suffered chhopuwa, two were thought to be afflicted by a lineage spirit (*kancho bayu*) seeking relief and one sufferer was convinced that the clan deity was seeking him to act as a medium (*dangri*). When falling unconscious or shaking, these men received incense or an offering lamp to appease the lineage spirit or deity. These responses contrasted with the beatings or the placing of a hot spoon on women who suffered chhopuwa to expel the effects of the purported witch or evil spirit that was afflicting them. As mentioned, at this time it was only men who received a calling to act as divine vehicles and who were able to participate in propitiation and divinatory seances for lineage deities. In contrast, all possession by women was seen as demonic and usually the result of *pesuwa*, or witchcraft.

Chhopuwa and epilepsy

Villagers also thought that people could faint from physical weakness and from overexposure to the hot sun (*murchha parnu*). They also had a concept of epilepsy known as *chhare rog*, which they claimed was the result of physiological causes. They described chhare rog as involving sufferers foaming at the mouth and see flashing lights before a seizure. However, at least a quarter of all chhopuwa sufferers also saw flashing lights before an attack of chhopuwa and, in village perceptions, similarly fell into unconscious fits. Distinctions in illness attributions of chhopuwa and chhare rog, again, separated along gender lines.

In our psychiatric survey, we identified 12 cases of epilepsy, of which 5 were female and 7 male (Shrestha et al. 1983). Of the five female sufferers, three believed they were suffering from chhopuwa. The other two cases were a young child, who was considered too young to suffer chhopuwa, and an older woman who thought her problems were from physical weakness. On the other hand, the four men who suffered chhopuwa and did not suspect their seizures to be the result of a deity seeking to possess them thought their malady was epilepsy. Nevertheless, they labeled their behavior at least initially as a form of chhopuwa in describing their symptoms. In this sense, the term chhopuwa served more as a descriptive than an explanatory illness category (cf. Good & Good 1982).

The designation of fits of unconsciousness as either chhare rog or chhopuwa was situated within village social and health contexts, and, for some men, within wider health care settings. While accounts of chhopuwa typically presented its etiology and experience as embedded in contexts of distressful circumstances and vulnerabilities, designations of chhopuwa were also related to differences in access to health care. The men who perceived their chhopuwa-like symptoms to be epilepsy had received the care of a biomedical physician, unlike female sufferers of chhopuwa, whose cases typically implicated a form of ritual aggression and involved the assistance of ritual healers.

Residents in Degalgaon followed a pluralistic pattern of health-seeking, which included the use of multiple ritual and Ayurvedic healers, pharmacies, and public health clinics and hospitals (Pach 1990). However, opportunities for various sources of care were not evenly distributed. Thus, when men in the military or government employment suffered fits of unconsciousness, they were taken to a hospital

and received a medical diagnosis and treatment for their condition. This was rarely the case for women, whose work and social lives, and much of their health-seeking, were almost exclusively located in the village. Thus, variations in illness trajectories and constructions of disordered experiences were also influenced by differences in male and female socio-economic positions, mobility, and patterns of health-seeking.

Conclusion

John Hitchcock (1974, 1976a, 1976b) demonstrated how illness and healing involve deep emotional meanings that are intricately enmeshed in the lives of sufferers and their social relations. This study similarly explored how cultural perceptions of disturbed experience in the form of chhopuwa were embedded within the structures and tensions of gender roles and expectations in everyday life, and the practices and discourses extant at an historical moment, in a Nepalese village in the early 1980s.

The symbolic and material relations that formed gender identities and social positions also led to definitions of the body, personhood, and productivity that influenced modes of apprehending and responding to disturbed experience and illness (cf. Comaroff 1985). Distinctions in these relations were perceived to be related to differences in vulnerabilities and forms of distress for men and women, which influenced their interpretations of episodes of chhopuwa.

Transformations in these social and material contexts in Degalgaon (such as movements out of kin-based contexts of agricultural production and socio-ritual authority), along with expanded educational and occupational opportunities for men and women, have altered the fields of social relations and forms of discursive production that underlay cultural perceptions and responses to chhopuwa at the time of the research (Pach 2001).[8] The extent to which these changes have transformed categories of experience, contexts of distress, and the prevalence of chhopuwa need to be explored.[9] This paper provides an initial ethnographic baseline for examining the influence of these social transformations on the meaning and distribution of chhopuwa.

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[8] Researchers have noted major transformations in female social relations and identities in both rural (Skinner & Holland 1998) and urban (Thompson 1998) settings in Nepal especially following the democracy movement of 1990.

[9] Ong (1987) similarly examines the impact of social transformations on the expression of distressful experience among women, although in a different socio-economic and cultural context.

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