The Wanniya-laeto, often referred to as Veddas, are the indigenous people of Sri Lanka. They live primarily in governmental designated areas in the forest with a few Vedda villages on the eastern coastal region.

In-depth, semi-structured interviews as well as participant observation were the methods used to access the perceptions of mental health and mental illness among the Wanniya-laeto population. Research was conducted over a two month period and focuses primarily on the Ratugala Veddas with additional interviews conducted with three other Vedda communities, including one coastal village, to use for comparison and support. Five itinerant psychiatrist who work in clinics and hospitals that serve Vedda communities were also interviewed.
Results show that the Veddas believe mental illness is the result of not being satisfied by with the basic gifts supplied by the spirits and refer to mental illness as a "city disease." There are no acknowledged cases of acute mental illness among the participant's communities. There are a small number of cases of depression in the Vedda's communities, but they do not associate depression with mental illness. The Veddas believe depression is due to external factors, such as government intervention in their lifestyle.

Like many indigenous populations throughout the world, the encroachment of external forces has led to the loss of their land rights as well as a slow decline of their culture. The Veddas feel that the prevalence of depression in their society is increasing as they are becoming more detached from the land and traditional way of life. They believe that gaining their hunting and agricultural land rights would help restore their balance and prevent depression. Additionally, they believe that financial and social support from the government for their cultural preservation would also keep depression and other mental illness out of their communities.
Perceptions of Mental Health and Mental Illness Among the Wanniya-laeto of Sri Lanka

By

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Redacted for privacy

Major Professor, representing Applied Anthropology

Redacted for privacy

Chair of Department of Anthropology

Redacted for privacy

Dean of the Graduate School

I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

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Jill Amy Priest, Author
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PERCEPTIONS OF MENTAL HEALTH AND MENTAL ILLNESS AMONG THE WANNIYA-LAETO OF SRI LANKA

CHAPTER 1

INTRODUCTION

According to the World Health Organization (2001) concepts of mental health include psychological well-being, "... perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one's intellectual and emotional potential, among others." This may sound simple enough and easy to gauge, but what happens when the definition of "psychological well-being" is called into question? How is "self-actualization" and "emotional potential" expressed and felt in other communities? These are the types of questions that must be asked when examining mental health and mental illness from a cross-cultural perspective.

The purpose of this thesis is to explore the conception of mental health and mental illness of the Wanniya-laeto in the context of their culture. The Wanniya-laeto, also referred to as Veddas, are the indigenous people of Sri Lanka.

There are several communities of Veddas throughout Sri Lanka, but they all share a common heritage. Legend states that when Prince Vijaya came to the island with seven followers from India, he married an aboriginal woman named
Kuweni. With her assistance, he began a massacre of her people. Many escaped to caves within the forests and became known as the Wanniya-laeto, which translates to "forest dwellers." As different groups dispersed through the forests during the time of Prince Vijaya, the Veddas developed different communities throughout the country. Vijaya eventually abandoned Kuweni, married the daughter of King Pandava of India, and established the early Singhalese population (Saligman & Saligman 1911).

The arrival of Vijaya is believed to have coincided with the death of the Buddha in 486 B.C.E. and was intended to propagate Buddhism in Sri Lanka (Eller 1999). The Singhalese adopted Buddhism and ruled the country for several centuries until the invasion of the Indian Tamils. An ongoing political and religious struggle commenced and remnants of the conflict can be seen in Sri Lanka today. As a result of Tamil conquests, Buddhist Singhalese receded to the southern and western parts of the island while the Tamils dominated the northern and eastern parts, especially the Jaffna peninsula (Eller 1999).

With the arrival of the Portuguese during the sixteenth century, colonialism gained power in Sri Lanka and united the island politically (Kloos 2001). However, tensions continued to grow not only between the Singhalese
and Tamil, but also intraethnically between Tamil castes. The upper-caste Tamils had earlier contact with the British and already had begun speaking English. This gave them an advantage over lower-caste Tamils and Singhalese people and created great resentment (Kloos 2001).

The rule of the colonial powers came to a close in the 1940s, and Sri Lanka developed its independence with no political or economic structure. National leaders included Singhalese as well as Tamil politicians; however, the Singhala-Buddhist platform eventually became the dominant power, and resentments further developed. A new constitution was adopted in the early 1970s that recognized the supremacy of the Singhalese language and Buddhism. Anti-government groups formed, predominantly in Jaffna, and began holding demonstrations and attacking Singhalese soldiers, and civil war commenced (Kloos 2001). The civil war continued until the beginning part of 21st century when Chandrika Bandaranaike Kumaratunga was elected president. With her election, peace was established in 2001. However, tension remains between the two groups at the time of this report (2004).

During the colonial rule, the Veddas remained living in the forests. The Danigala Veddas were one of the groups who escaped into the caves of the jungle during the time of
Prince Vijaya. When the Singhalese gained power in the 1940s, they wanted to homogenize the entire population on the island to create a wholly Singhalese and Buddhist nation (Kloos 2001). Thus, the government removed them from the Danigala caves and mandated that they live in homes in the forest made with mud walls and thatched roofs (map p.5). With little option, the Veddas complied and have lived in these designated areas for over fifty years. With their relocation, they separated into two communities. One group moved to the region known as Ratagala, and another group relocated to Pollebedda.

The data presented here focuses on the Ratugala Veddas. I examine their attitudes towards mental health and mental illness to learn how they perceive mental illness with regards to symptoms, causes and treatments. The purpose for this study is two-fold. First, the data will add to the general understanding of cross-cultural mental health. The second application of the research is to provide information that will help medical clinicians provide effective and culturally competent mental health services in the relatively isolated and little studied Vedda community.
Map of Vedda Hamlets in Sri Lanka
(Courtesy of Living Heritage)
CHAPTER 2

LITERATURE REVIEW

According to George Foster (1998), definitions of health and disease vary throughout the world. He argues that each society has a medical system with its own classifications and explanations of what is means to be healthy or ill. However, the biomedical model became a dominant force in health care throughout the world in the 20th and 21st centuries, and the ethnomedical perspectives of other cultures are often ignored. The discrepancies between the biomedical and ethnomedical models of health and disease becomes even more apparent when discussing psychiatry.

Culture affects psychiatry in three primary ways (Kirmayer 2000). First, culture involves a set of beliefs and values that a patient holds that may differ from the clinician. However, culture should not be seen as merely baggage that the patient has; culture also influences the clinician and can lead to stereotypes and expectations of the patient. The third way that culture reflects onto psychiatry is in the discipline of psychiatry itself, which is a product of cultural values and beliefs. The diagnostic categories in Diagnostic Statistical Manual-IV, the manual used by biomedical psychiatrists to diagnose
patients, have materialized from Western values and beliefs that are a result of cultural and historical principles. Critical analysis on all three levels is a necessary step in providing effective mental health services and opening clear lines of communication between the clinician and patient (Kirmayer 2000).

Arthur Kleinman (1998), a psychiatrist and medical anthropologist, maintains that mental disorders differ between cultures. Using the biomedical model of psychiatry, the epidemiology of psychiatric disorders is determined by the symptoms listed in the DSM-IV. Kleinman (1998) argues that this is neither an exhaustive nor completely accurate inventory of symptoms. There are symptoms listed in this psychiatric handbook that do not have the same implications in all societies. Additionally, there are symptoms that people in other cultures as well as our own consider problematic that are not listed in the DSM-IV. The issue as to how psychology and what types of psychology should or can be globalized remains unresolved (Sloan 1997). Rosenhan (1995:20) reasons that if psychiatrists in this country cannot even decide who is sane using the DSM-IV criteria, then they certainly do not have the ability to decide who is sane in another culture.
Indigenous people are particularly susceptible to the encroachment of Western views on health and disease, and their own values and beliefs are often ignored. The definition of indigenous peoples varies widely, and the indigenous peoples have the right to define themselves according to the International Labor Organization (Gray 1999: 61). However, Gray (1999:61) does provide a basic definition that states that "... indigenous peoples are distinct peoples, with their own languages, cultures and territories, who have lived in a country since times prior to the formation of the current nation state." Using this criterion, the Wanniya-laeto are the indigenous people of Sri Lanka as they have their own language (albeit not currently used), cultural practices, and traditional land, and they have lived on the island many centuries before the current government gained authority.

While the Wanniya-laeto have not been the specific subjects of mental health research, other indigenous people have participated in studies in the area of mental health, and the results of these studies can help provide insights to the indigenous population in Sri Lanka. For example, Wig's (1999) article "Mental Health and Spiritual Values: A View from the East" examines the value of spirituality of psychiatric patients in India. The article argues that
within India there is a variety of cultures and philosophical systems that need to be addressed in the Indian paradigm of mental health and illness. The dominant viewpoint is that life is a cyclic phenomenon and encompasses the mind and body as one rather than separate entities (Wig 1999). Similarly, the predominant perspective in Sri Lanka, including the Vedda population, is a holistic one based on the unity between mind and body (De Silva 2002). As Shouksmith (1996) points out, indigenous populations throughout the world see the mind and body as one and have their own philosophical traditions and beliefs in the realm of psychology. Thomas Maretzki and Noel Chrisman (1982) maintain that many studies that have been conducted are done with an ethnomedical perspective. This means that cross-cultural psychiatric research focuses on the cultural context of the patient and treats the physicians' culture as the norm.

The Wanniya-laeto have their own perceptions about mental health and mental illness that lie outside that of the Western medical model. Their views on mental health issues are reflections of their cultural beliefs and values that have been recorded by previous researchers.

Almost a century ago, Charles and Brenda Saligman (1911) took an excursion to Sri Lanka and produced the most
extensive Western study done on the Vedda people. They explored the history, geography, social organization, family links, religious beliefs, language, agriculture and current lifestyles of various Vedda communities throughout the jungle as well as the coastal areas.

The Saligmans (1911) explained that the Wanniya-laeto believe that illness is believed to be caused by spirits, or yakus, as well as cured by them. When an evil yaku enters a man, the man will become sick. The Wanniya-laeto call upon good yakus to help remove evil spirits from the sick person. The Saligmans (1911) identified some of the spirits that the Wanniya-laeto call upon to help cure individuals that are suffering from an ailment. One example they give is the Rahu Yaku who is called upon to avert sickness from a man (Saligman & Saligman 1911:254).

Since then, researchers have focused their attention primarily on the Dambana Veddas, their cultural beliefs and practices, and the survival of such practices. Wiveca Stegeborn (1997) spent time with the Dambana Veddas examining their family lineage, language and their relationship with the land. She observed that their religious beliefs, subsistence practices and cultural traditions are intertwined elements of their daily lives that have been severely altered by government intervention.
The government has made fanatical attempts to "rehabilitate" the Vedda people by relocating them into designated areas that are removed from their original lands, prohibiting them from hunting and collecting plants, and pressuring them to adopt Sinhalese language, religion, education and clothing (Stegeborn 1997). As indigenous people's sense of identity incorporates ancestral heritage, special relationships with the land and kinship ties, these transformations have no doubt affected their physical as well as mental health (Coombs 1994:3). Due to the encroachment of external influences, original inhabitants are slowly losing this shared experience. Consequently, this has led to depression in many indigenous communities. Coombs (1994) explains that due to modern social structures, people are separated from their natural environment and familial heritage; thus, individuals are feeling isolated and depressed.

Despite the literature that argues in favor of culturally dependent principles in psychiatry, there are still pockets of people who maintain that the purpose of applied psychiatry is to cultivate the "savage" by exposing common principles that is shared with the Western people and that underline all of human nature (Obeyesekere 1990:218). It is important to question this line of
reasoning as there is a lack of research that conclusively shows that there are universal principles within the human psyche. As Wig (1999:954) points out, "There is no perfect definition of mental health acceptable across all cultures. Definitions differ, according to the point of view of the one who is defining it."
CHAPTER 3

METHODOLOGY

I spent most of 2003 winter term exploring options for conducting research with a South Asian indigenous population. It was during this time that I found the LivingHeritage website and made the decision to travel to Sri Lanka and conduct research with the Wanniya-laeto. The LivingHeritage organization works with the indigenous population of Sri Lanka as a means to help preserve cultural practices and beliefs. I contacted the chair of the organization and asked if there were any opportunities for a student researcher interested in the perceptions of mental health and mental illness among the Wanniya-laeto. The reply I received stated that the organization did not have any specific positions for my area of interest, but they could arrange an interpreter and guide if I was interested in going into the jungle and conducting my own research. I immediately answered yes to this opportunity, and thus, I was introduced into the Danigala Vedda community.

Prior to my departure to Sri Lanka, I developed an open-ended questionnaire to use for interviews with the Wanniya-laeto (see Appendix A). The questionnaire was designed to assess the beliefs and ideas about mental
health and mental illness. The first part requests information about the interviewees' spiritual beliefs. It continues with questions about their beliefs and practices regarding health and healthcare. The central questions focus on eliciting information about the interviewees' perceptions of mental illness and its causes. Finally, the questionnaire concludes with questions about their desired treatment for mental illness and their perceptions of access to such treatment.

I conducted semi-structured, in-depth interviews using the questionnaire. The questionnaire was used as a basic guideline for each interview. Most interviews began as social engagements such as tea or food, and I began the interviews after some social interaction. Each interview involved three people: the researcher, the interpreter and the interviewee. I would ask the interviewee a question, and the interpreter would translate the question into Singhalese. He would then translate the subject's answer into English. I recorded the translated answers into my notebook.

Additionally, I conducted eight focus groups that consisted of four to six people. These took place in the households of participants, and each focus group consisted of relatives who may or may not have lived in the same
household. The people to whom I had access were members of that household or relatives of the people living in the house. As with the individual interviews, I would ask questions from the questionnaire and have my interpreter translate the questions. He would then translate the responses in English after each person spoke. The participants were patient and allowed the translations to occur before the next person responded. I labeled each participant with a number and recorded the responses in my notebook.

About three hundred people identify themselves as Danigala Veddas. Approximately one hundred people live in Ratugala while the remaining resides in Pollebedda. The two communities have a total of seventy-seven households. A household is defined as a house in which a family lives. It is usual to have a married man and woman in a household. The children and unmarried siblings of the man and woman may spend time in that house as well as the homes of other family members, such as an aunt and uncle or a grandparent’s house. It is difficult to say the average number of people per household as the number changes daily. The only relatively constant people in the household are the eldest married man and woman.
Most of my research was conducted with the Ratugala Veddas as they are the people with whom I had the most contact. My interpreter had previously lived with the Danigala Veddas and was friends with the chief and his family. They told my interpreter that they trusted him, so they trusted me. I was informed that this meant that I was accepted into the community, and the local people were willing to participate in my research.

My method for gathering informants was snowball sampling (Bernard 2002). The people I interviewed were chosen through personal connections, but I was able to include fifty-seven adults over the age of twenty in the Ratugala community in interviews and focus groups (Table 1). However, the people who participated in my research from other villages were chosen because they knew my interpreter, were friends with the Ratugala chief, or were at the home of his friends while we were visiting. This, of course, creates a slight bias. It should be noted that the data collected outside of Ratugala is from a small sample and may not be representative of the entire group of people. The information is used only as a comparison or as additional support for findings in my research. It is not meant to sum up the entire community’s views on mental health.
I lived in a tent next to the home of the Ratugala chief in the Danigala jungle. My interpreter made frequent trips to the Danigala jungle. During his visits, I conducted interviews with community members. I conducted 14 interviews and 6 focus groups with members of the Ratugala community. Additionally, we made overnight treks to neighboring communities so that I could obtain interviews with other Vedda communities. We went to Pollebedda, the other community that stemmed from the Danigala region. I conducted three individual interviews with this group. We also ventured to Dambana where I performed three more interviews.
### Table 1: Age and Sex of Participants

#### Ratugala

<table>
<thead>
<tr>
<th>Interview participants</th>
<th>17-23</th>
<th>24-34</th>
<th>35-45</th>
<th>45+ status</th>
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<tr>
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<th>45+ status</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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<td>9</td>
<td>8</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Female</td>
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<td>7</td>
<td>6</td>
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#### Pollebade

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<th>Individual interview participants:</th>
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<th>24-34</th>
<th>35-35</th>
<th>45+ status</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>0</td>
<td>0</td>
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<td>1</td>
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#### Dambana

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<th>35-35</th>
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<th>Total</th>
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<td>2</td>
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<tr>
<td>Female</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
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</table>

#### Coastal Veddas

<table>
<thead>
<tr>
<th>Individual interview participants:</th>
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<th>24-34</th>
<th>35-35</th>
<th>45+ status</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
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<tr>
<td>Female</td>
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<td>0</td>
<td>0</td>
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<td>2</td>
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<th>Focus group participants:</th>
<th>17-23</th>
<th>24-34</th>
<th>35-35</th>
<th>45+ status</th>
<th>Total</th>
</tr>
</thead>
<tbody>
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<td>1</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Female</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>
I also traveled to the east coast of Sri Lanka to interview coastal Veddas. The coastal Veddas speak do not speak Singhalese as the jungle Veddas; they speak Tamil. A friend of my interpreter was able to meet us to act as my translator with the coastal Veddas. I used the same questionnaire and method of transcribing the responses as I did with the jungle Vedda people. I conducted six individual interviews and two focus groups with them.

In addition to interviewing members of the Wanniya-laeto communities, I also conducted five interviews with psychiatrists throughout the island (see Appendix B). I visited five different are medical clinics and spoke with the psychiatric consultants at the Badula General Hospital, the base hospital in Mahiyangana, the dispensary center in Dambana, the Bible District Hospital and the Kandy General Hospital. As the physicians spoke English, I did not require an interpreter for these interviews.

I was able to transcribe and code my interviews while in the jungle as well. This was particularly beneficial because I was able to make clarifications and ask additional questions after the coding process. I conducted three follow-up interviews with the Ratugala subjects.

I used the grounded theory approach to analyze the interview data (Bernard 2002). First, I inductively coded
the transcribed responses from the interviews and focus groups. I identified concepts and themes that emerged from data gathered in the interviews (Table 2). Then I identified groups of underlying common themes to develop categories. I linked these categories together and related them in a cultural context.

The data are analyzed in an idealist paradigm (Bernard 2002). This means that I look at their belief and value systems through a cultural lens. I use the themes that emerge from the interviews to understand the cultural basis for their attitudes toward mental health and mental illness. According to Margaret Mead (1963), what one society deems abnormal may be what another culture holds in high esteem. The data are examined and presented with this cultural relativism approach. There is no one set path or set of beliefs that is universal for all societies. As pointed out in the literature review, this certainly applies to the realm of mental illness. I explain the Vedda's attitudes about mental health and mental illness within their own cultural context to the best of my ability.

In addition to the structured questionnaire, I used participant observation was used to acquire further insight into the Vedda community. During my time in the jungle, I
slept in a tent next to the home of the chief of Ratugala and his family. I ate my meals with his family and washed myself and my clothes in the local stream. While I was not conducting interviews, I spent my time with the local people and took copious notes about their lifestyles. Information that I recorded included the kinds of food they consumed, their agricultural practices, use of jungle plants and the type of activities that filled their daily lives. Much of the specific information I gathered is not revealed in this paper, but the general themes of their lifestyles are examined as they relate to their perceptions of mental health and mental illness.
Table 2: Interview Themes:
Forest Veddas: Ratugala, Pollebedda, and Dambana

<table>
<thead>
<tr>
<th>Buddhist</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Speak Sinhalese</td>
<td></td>
</tr>
<tr>
<td>Illness is caused by spirits</td>
<td></td>
</tr>
<tr>
<td>Community holds a puja and offers herbal remedies for sick person</td>
<td></td>
</tr>
<tr>
<td>Only use hospital in for severe injuries or illness</td>
<td></td>
</tr>
<tr>
<td>Go to an elderly member of the community for medical treatment</td>
<td></td>
</tr>
<tr>
<td>Female participants do not know what it meant to be mentally healthy</td>
<td></td>
</tr>
<tr>
<td>Male participants believe being mentally healthy means having basic human needs met</td>
<td></td>
</tr>
<tr>
<td>Pissu (madness) is considered a &quot;city disease&quot;</td>
<td></td>
</tr>
<tr>
<td>Do not know anyone in community who suffers from pissu</td>
<td></td>
</tr>
<tr>
<td>Would accept person with pissu in community</td>
<td></td>
</tr>
<tr>
<td>Do not understand the word stress but do not think it was a problem in the community</td>
<td></td>
</tr>
<tr>
<td>Do have depression in the community but do not associate it with mental illness</td>
<td></td>
</tr>
<tr>
<td>Depression believed to be caused by lack of access and rights to land</td>
<td></td>
</tr>
<tr>
<td>Hold pujas for depression, will not go to hospital</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Interview Themes:
Coastal Veddas

<table>
<thead>
<tr>
<th>Hindu</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Speak Tamil</td>
<td></td>
</tr>
<tr>
<td>Community would hold puja for sick person</td>
<td></td>
</tr>
<tr>
<td>Pray to Hindu god to help heal sick person</td>
<td></td>
</tr>
<tr>
<td>Herbal remedies</td>
<td></td>
</tr>
<tr>
<td>Only use hospital for severe injuries or illness</td>
<td></td>
</tr>
<tr>
<td>Many did not understand the term mental illness</td>
<td></td>
</tr>
<tr>
<td>Believe being satisfied with the gifts of the gods makes a person mentally healthy</td>
<td></td>
</tr>
<tr>
<td>Do not know anyone in the community who suffers from a mental illness</td>
<td></td>
</tr>
<tr>
<td>Would accept person in the community</td>
<td></td>
</tr>
<tr>
<td>Did not understand the term stress</td>
<td></td>
</tr>
<tr>
<td>Did have depression in community</td>
<td></td>
</tr>
<tr>
<td>Depression believed to be caused by lack of access and rights to land</td>
<td></td>
</tr>
<tr>
<td>Treat depression by making offerings to the gods, will not got hospital</td>
<td></td>
</tr>
</tbody>
</table>
Table 3: Interview Themes: Psychiatrists

<table>
<thead>
<tr>
<th>Work as itinerant psychiatric consultants</th>
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<tr>
<td>Few known cases of Veddas receiving psychiatric treatment</td>
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<tr>
<td>No definite way to tell if patient is Vedda, but feel they can determine a Vedda by clothes and communities in which they live</td>
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<tr>
<td>No known cases of Veddas receiving emergency psychiatric care</td>
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<tr>
<td>Rural clinics see Veddas for depression</td>
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<tr>
<td>City hospitals see Veddas for anxiety and manic problems</td>
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<tr>
<td>No known alcohol or drug abuse</td>
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<td>Veddas tend to have low blood pressure</td>
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3.1 Reflexivity

As an American anthropology student conducting her first real field research, I was filled with excitement as my rented van curved its way through the jungle in the road leading to Ratugala. Not only did we get to see poisonous snakes and giant spiders crossing our paths, we were actually halted by a majestic elephant standing in the middle of the road. There really is little one can do when an elephant blocks the road except wait until he decides he does not want to be there anymore, so that is what we did. It gave me an opportunity to take in all the beautiful scenery, the scenery that is the home to the Danigala Veddas.

While in Sri Lanka, I encountered a variety of experiences that have expanded my understanding of cultural variation more than I ever imagined possible. Upon my arrival in Colombo at one in the morning, I was met by the wife of my soon-to-be driver and interpreter. She had a van waiting for us to lead us to a hotel that had been arranged for us. Unfortunately, she was not familiar with the capital city, which led to multiple hours of driving around looking for this specific hotel. We weaved through the various parts of the city in hopes of stumbling upon the proposed place of rest.
This random wondering about was not without consequence. It gave me the opportunity to see the city at its darkest hours and make various observations. What was particularly striking was the number of people out on the street. They were not drunk people coming home from clubs or bars as you might witness in an American city. They were people, mostly men, standing about on their porches or sitting on the curb of the street. I wondered what these men were doing. My first thought was that it involved nefarious, after hours activities. But, as we stopped several times to ask for directions, I realized that these people simply had little else to do. Many of the families in poorer neighborhoods lacked electricity, so any activity that required light was not possible. Additionally, these people had little money to be able afford luxuries that we consider hobbies, such as books or a musical instrument.

The realization that hobbies are indeed a luxury remained a running theme in my adventures in Sri Lanka. I had brought my guitar as well my drawing pad. Both are hobbies that I wanted to pursue while in the depths of the jungle. Until living in the jungle of Sri Lanka, it had never occurred to me that such hobbies were not ubiquitous. But after seeing so many people in the Ratagula community laugh at or express little interest in my activities, I
realized that my hobbies were merely diversions that I admitted into my life as part of my culture. While I had plenty of time to enjoy these pastimes, I found that I actually got more entertainment from having the kids in the community play with my 'toys.'

The children in the Ratagula community were truly a delight. While I did not do any official interviews with them, they taught me a great deal about Vedda life. I was rarely without at least five little followers running up to touch my light colored skin or to play with my hair. I do not think they realized that I was as enchanted with them as much as they were with me. We taught each other songs and hand games. Most of my Singhalese vocabulary came from speaking with the children, and I don't think I would have ever gotten my clothes clean without their help.

The adults were delightful as well. They made me feel at home, offering me a place to sit, food or some highly sweetened tea, and they were always willing to speak with me when I initiated an interview. Being the inquisitive anthropologist, I was perpetually bombarding them with questions about their cooking practices, medicinal customs and other traditions, but they never seemed impatient with my endless stream of inquiries.
While I was immersed in the Vedda culture, I often forgot that I was an outsider. The community made me feel so welcomed and comfortable that I felt quite at home for long periods of time, but often something would happen that would remind me of my own cultural biases. One such incident occurred when I was out hiking with the Ratagula chief, his son, and my interpreter. We were crossing a stream when we heard a large thud. We looked over and saw about one hundred feet away from us a beautiful elephant. Now, I come from the world with Babar the elephant and petting zoos. I had never encountered an elephant that I felt I had to fear, so it did not enter my mind that I would need to escape from the perils that might occur if the large mammal were to see me. The chief and his son were much wiser, and pulled me behind a rock. My interpreter explained to me that elephants are known to trample people as they often become scared when approached by humans.

While I am not particularly scared of elephants, I do have a healthy fear of snakes. While I was laying outside preparing for my night’s slumber, a slithering creature came from the trees and appeared determined to reach the mat on which I was lying. Upon noticing the snake I jumped up with a small cry. One of the elder sons came over and
beat the snake with his shoe. A small audience had formed and was laughing at the situation. I asked if the snake was poisonous to which I was answered that it was, but no one seemed concerned. I was enthralled at the fact that the Veddas seemed to hold little fear for poisonous snakes but great concern for elephants. I, on the other hand, find elephants non-threatening while I find snakes to be quite menacing.

Most people who travel have a story that involves trying local food. While I was fortunate to enjoy the traditional cuisine, I did have one noteworthy experience. On the day after my arrival to the Danigala forest region, I was offered a small nut wrapped in a large green leaf. Curious about trying everything I had the opportunity to try, I threw the treat into my mouth and began chewing it and then tried to swallow it, but I just couldn’t. It was a difficult task to keep myself from gagging in front of all the people watching me, but I eventually had to spit it all out. My reaction gave my audience a good laugh for days. I later found out that this “treat” consisted of the beetle leaf that I had read about and an arica nut of which I had not previously heard. I was supposed to masticate the nut and leaf slowly, and spit bits out as they became too saturated with my saliva to continue chewing, in a
similar fashion as chewing tobacco. A few weeks later, I
tried the leaf/nut snack again, thinking I could do it now
that I had seen the process and understood it. I was wrong
and again had to resist the urge to gag. I was luckily
able to refrain, but I decided against trying it again.
The experience was good, however, as it reminded me that I
was there not just as a focused researcher but also as an
eager learner and participant in the cultural experiences
of the Veddas.
CHAPTER 4

RESULTS

4.1 Spiritual beliefs and health:

The first two questions on the questionnaire (Appendix A) were concerned with the interviewees' religious beliefs and how they affect their attitudes toward health and illness. Veddas that live inland in the forest include the Ratagala, Pollebedda and Dambana, and all of these replied that they were Buddhists. They answered that they believe that spirits are the cause of illnesses. They believe that the type of illness or injury reflects the type of spirit that has produced ill effects on a person's body. One example that was given was of a person in the Pollebedda community who was injured when he fell off a mountain. The Pollebedda people believe that the spirit in that mountain was the source of the accident.

Another example given by a Pollebedda Vedda was when a man developed a severe illness after emerging from a cold river. He suffered from "too much cold," "cold chills," "sneezing" and "head pain." These symptoms were believed to be the result of the river spirit who was angry at the village for not providing her with the appropriate offerings.
Forest Veddas that participated in the interviews and focus groups said that they would hold a *puja* when there was an ill person in the village. *Puja* was defined as, “a ceremony where offering and praise are given to the spirits and Buddhist god.” The types of items that were believed to be acceptable for offering to the gods included monetary resources, incense, flowers (especially the lotus flower) and *dana*, or food prepared with the specific intention to offer to a god. *Dana* could be any food but usually had jackfruit in it. Additionally, men and women would chant and dance as a way to praise the spirits. The purpose of the *pujas* is to please the spirits and Buddhist god so that the sick person can be healed.

The coastal Vedda people who I interviewed stated that they are Hindu. This is likely because they live on the northeast coast that has a large population of Tamil Hindus who have influenced the local Vedda communities. They said that they would hold a *puja* when there was a sick person in their community. During the ceremony they take a monetary collection and offer it to the Hindu god *Muragan*. The chief added that he would apply *veputhy*, or burnt ash, on the forehead of the sick person. He reported that this would cure any illness. When asked what he would do if it did not cure a sickness, he responded that, “It always
cures any illness." The female coastal Vedda I interviewed stated that she was Hindu but did not feel educated enough to answer how her religious beliefs affected her attitudes about health.

### 4.2 Treatments for illness:

The next two questions on the questionnaire were designed to gather information about what types of treatments the Veddas use when an individual is sick or injured. The forest Veddas responded that in addition to holding as many as three puja(s), they would use herbal remedies to help the sick person. One example given was gurunnase, a local plant that helps cure a person suffering from the poison from a snake bite. The Ratugala, Pollebedda and Dambana participants stated that they would only send a family member to the hospital to receive treatment if their home remedies or puja(s) did not help the person's health improve or for severe injuries such as a fall from a mountain. About half of the participants said that they would go to an elderly family member or the village chief to obtain an herbal remedy. Ratugala female interviewees said that they would visit the chief's wife to get an herbal remedy. Four of the eight male Ratugala
interviewees said that they would go to the chief to get an herbal remedy. No male said that he would go to his wife.

The coastal Veddas stated that they would give family members herbal remedies from medical plants while chanting mantras that are believed to help heal a person. One example of a medicinal plant was the ponthuvaki tree. The bark is mixed with water and put onto a wound. One coastal Vedda commented that is important for a sick person and his family members to wash and pray to the Hindu god at the river in the early morning. The coastal Vedda participants said that they would only go to a hospital for severe illness or injury.

4.3 Mental illness:

The remaining questions were designed to elicit the Vedda's attitudes about mental health specifically. First, I questioned what the participants thought it meant to be mentally healthy. Female interviewees responded that they did not know. About ninety percent of the Vedda males from the forest region said that as long as basic needs are met for a person and his family, then he will be mentally healthy. One Ratugala male participant said that he did not understand the term "mentally healthy." Another male
interviewee said that he did not know what it meant to be mentally healthy, but he was sure he did not have a mental illness.

During five of the six focus groups I held with the forest Veddas, the participants agreed that a person is mentally healthy if a person’s basic needs are taken care of. However, during the other focus group a man said that, “People have to keep a strong mind” and “keep faith in spiritual beliefs to be mentally healthy.” Other members of the focus group agreed with this statement.

The Pollebedda respondents replied that they did not understand the question. They did not know what it meant to be healthy in the head. One male respondent said, “Everyone I know is mentally healthy, so it must be the way we are supposed to be.”

The members of the two focus groups that I conducted with the costal Veddas said that they did not understand the question. Five of the individual interviewees also said that the question did not make sense. One female respondent stated that people have to satisfy their needs with the gifts from the gods and have no additional desires to be mentally healthy.

The following two questions were designed to develop an understanding of the Veddas think it means to have a
mental illness and what they perceive as symptoms of a mental illness. Individual interviewees and at least one member in each focus group from the forest used the word *pissu*, which translates to madness, to describe a mental illness. Women participants from the forest replied that they either had no opinion about mental illness or that they did not know what one was. They had heard about people with *pissu* but they did not know anyone who suffered from it. The majority of jungle male participants, approximately eighty percent, also said that they knew about *pissu* but knew no one who had it. Two interviewees gave additional thoughts on mental illness. One male from Pollebedda said that *pissu* means that people have an internal anger caused by angering the gods. Another Pollebedda male stated that *pissu* is a result of people thinking about "the good of the old days and the old ways and dwell." He continued on to say that it is best not to do this or you will get "*pissu*.

The coastal participants also responded by saying they did not know anyone who suffered from a mental illness, but the word *pissu* was not used. This is could be due to the fact that the coastal Veddas predominately speak Tamil and know little Singhalese. I was not given the Tamil word for *pissu*. One female added that she thought that mental
illness meant that people have no inner peace and that people need to have "enjoyment of the mind" to keep from getting a mental illness.

Next, I attempted to assess what behaviors are considered abnormal in the Vedda community and how they feel about people who engage in such behaviors. The forest participants said that people who act bizarre are believed to have pissu. They also stated that they did not know of anyone who acted out of the normal. Three-fourths of the individual interviewees and at least one member of each focus group said that pissu is a "city disease." When I asked for clarification, one male respondent described how people in the city who have no money and no place to live develop a loss of control of their lives and, thus, a loss of control of their minds. One interviewee, a male from Pollebedda, said that he believed that he and his community would express disapproval of abnormal behavior. The remaining forest participants stated that they would allow the person to feel welcome in the community.

The participants from the coast stated that they would not differentiate a person with mental health problems from the rest of the group. One male interviewee said that he would try to offer help in the form of chant and pujas. The female participants said that they would accept a
person who acted abnormally, and they would try to help them if they could. Types of help mentioned included talking to the chief, holding pujas and singing to the gods.

The following questions were designed to determine if Vedda people suffer from symptoms commonly associated with mental illness according to the DSM-IV (see Appendix B). First, I asked if people in the community suffered from stress. During the first interview, my interpreter informed me that he was not familiar with the word stress. I attempted to define the word by saying "pressure" from the external world that often leads to internal struggle. I did not realize it at the time, but the word "pressure" is associated with "blood pressure", so my first interviewee said that he and his people did not suffer from blood pressure problems. After this interview, my interpreter and I looked up the word stress in a Singhalese-English dictionary. He informed me of the error and used the appropriate Singhalese translation for the remaining interviews and focus groups. There is no single word translation of stress in Singhalese, but the concept was translated using a phrase in Singhalese. The subsequent interviewees were not familiar with the
translated definition of stress, but they said that they
did not think that people had "stress" in their community.

My Tamil interpreter was also not familiar with the
word stress. The coastal Veddas did not understand my_attempts to define stress using English words with which my_Tamil interpreter was familiar. We did not have access to
a Tamil-English dictionary during these interviews, so I_was unable to receive answers to this question.

The next question asked about depression in the Vedda_community. Interviewees said that depression was rare but_could be found among the Veddas. The Veddas do not_associate depression with mental illness. The participants_stated that they while they knew someone with depression,_they did not know anyone who suffered from a mental_illness. However, no participant gave more than one example_of a depressed person in the community. Many of the_examples given in the interviews overlapped. I was able to_discern a total of three people with acknowledged_depression among the forest Veddas and one person with_known depression among the coastal Veddas.

Treatment for depression included pujas and herbal_medicine. Interviewees said that they would not consider-taking a person to the hospital for depression. The_hospital was only for severe physical damage that could not
be treated by local remedies. The Veddas stated that people with depression usually "get rid" of it after a puja is held. If he does not, the village just accepts the person's depression. A depressed person is not ostracized from the community. There were no known cases of suicide among the participants.

The subsequent question asked to what types of mental health services the Veddas felt that they currently have access and what types of services to which they would like to have access. The Veddas from both the forest and coastal areas said that they do not need mental health services because they do not have mental illness in their communities. Two male participants said that if a person in their community did have pissu, they would chant to the gods. No participants said that they would go see a doctor or send a family member to see a doctor if he were suffering from pissu.

I then asked to what types of services for depression they would like to have access. The forest Veddas said that they would not need services if everyone had the resources to take care of their basic needs. They said that if they had their land rights back and the government allowed them to live in their traditional style, there would be no need for such services. One woman added that
if a person were to go to the hospital for depression, the chief would have to go with him.

The coastal Veddas said that no mental health services were necessary because they did not have mental illnesses. One coastal participant said that the only service that they need is the "belief in God"; he is what keeps a person mentally healthy. They also said that there was no need for hospital services for depression. Depression is treated by making offerings to God such as incense, flowers and money.

I concluded the interviews by asking if the interviewees had any final comments that they would like to add. Two-thirds of the participants said that they had nothing more to input. The remaining third of participants added that they needed more concrete items for health, including clean water, better transportation to the hospitals. One forest Vedda and one coastal Vedda said that they needed to stay in small villages to stay mentally healthy because mental illness is only found in large cities. If they lived in large cities, they would probably get mental illness, too.
4.4 Psychiatric consultants:

There are few physicians in Sri Lanka who specialize in psychiatry. Many who do not work in large cities such as Colombo or Kandy work as visiting psychiatric consultants. This means they travel to several health clinics to provide psychiatric services.

When asked how often Veddas received psychiatric treatment, all psychiatric consultants said that it was a rare case. However, it is important to note that all five psychiatric consultants acknowledged that there is no definite way to tell if a patient is a Vedda. Clinic admission forms require patients to state whether they are Singhalese or Tamil, but this only represents the ethnicity and language they speak and not their tribal heritage. Given this, however, four of the consultants felt that they could determine a Vedda from their clothes and the communities in which they live. Veddas are believed to be easily identified in other parts of the hospital, so the psychiatric consultants believed the same would be true in the psychiatric ward. The psychiatric consultant from the Bible District Hospital said that he did not feel confident saying whether or not a patient was a Vedda unless the patient specifically said that he was. However, he believed that it was rare for Veddas to come for mental health
services because it was rare for them to come for other health services.

None of the psychiatric consultants knew of a Vedda patient needing emergency psychiatric services. While the consultant from Mahiyangana said that he had heard of Veddas coming into the clinic a few times a year for depression, he did not believe he had ever treated a Vedda for a mental illness. The psychiatric consultant from Dambana said that he had treated about five Veddas for depression in his three years as consultant, and he believed the depression was due to economic and family problems. The cases were all temporary situations, and he said he was not aware of any chronic problems with depression among the Vedda community. He prescribes Imipramine for depression.

The psychiatric consultants from Bibile and Badula said that they only treated Veddas with severe anxiety or manic problems. The consultants said they believed that they only saw the extreme cases because the Veddas only receive outside medical care for severe health problems, but even these cases were rare. Neither could give more than two examples of treating Veddas for psychiatric illness. One example that the consultant from the Badula General Hospital provided was of a Vedda man who was sent
to the hospital by the state for a psychiatric evaluation because he had sold meat from a dog claiming it was venison. While this behavior may have seemed like the actions of a man with *pissu*, the consultant believed that the man was not suffering from a mental illness but rather was just trying to make some money to support his family. The remaining examples were of acute psychiatric problems that lasted for no more than a few months.

All of the consultants said that they were not aware of any drug or alcohol abuse in the Vedda community. Three of the consultants said that the Vedda people tend to have low blood pressure and rarely suffer from hypertension. The Dambana consultant added that the Vedda were healthier than most people. He attributed this to their diet and leading "simple lives."
As the Saligmans (1911) observed almost a century ago, I also found that the Veddas are highly spiritual people. Participants claimed to hold beliefs of a macro-organized religion as well as their own religious system. The product of the integration of multiple religious principles into a culture’s world view shapes the way the people in that culture feel about the human mind, body and disease. Their perceptions of health and illness incorporate Buddhism or Hinduism with their traditional spiritual beliefs. The Veddas use both systems as models for causes and treatments for illnesses. Additionally, they incorporate ancestral heritage in the system of health and healing.

According to a Sumatran Rejang folk healer, “... mental health or ill health are a function of an individual’s reciprocal acceptance by kin, neighbors and the village community generally” (Jaspan 1976: 230). This means that medicine embodies certain cultural identities. For example, ayurvedic medicine entails Hindu values and act as not only medicine for physical ailments, but also as empowering remedies that facilitate connection with
ancestors who have used the same system of medicine (Nichter 1989:213).

The Vedda participants share the belief that health and healing encompasses a relationship with their ancestors. They believe that treatment for illness should come from ancestral spirits. They believe that the spirits of their ancestors provide everything necessary to stay healthy. They believe they will come to rid a person of evil sprits when called upon as well as supply them with appropriate plants with which to make healing concoctions. One participant stated that it is when one becomes greedy and desires more than what the ancestors provide that an individual experiences pissu.

Many of the participants stated that they did not know what it means to be mentally ill or mentally healthy. Those who had heard of diseases of the mind could not give examples of symptoms or behaviors of specific mental illnesses. Although no definite descriptions of mental illness were given, many of the participants said that neither they nor anyone they know suffers from mental illness. They had heard of people losing the ability to think “right” and called this pissu. They perceived pissu as a disease that develops from the stresses of living in large city.
The Wanniya-laeto believe in concrete external causes of mental illness rather than an internal or spiritual basis for diseases of the mind. One member of a Ratagula focus group stated that it is when one loses faith in the spirits and Buddha that the individual develops *pissu*. The other members agreed and added that it is demands from the outside world that causes people to lose faith.

Many of the participants claimed that mental illness occurs because of the stresses of living in a city, but they do not acknowledge mental illness in their own society. They also do not acknowledge stress from the need for material wealth in their community. They believe both can be found in cities, so it seems plausible to them that there is a correlation between the two.

The participants said that they do not consider depression a mental illness. They ascribe external causes to depression rather than an internal biological explanation. Socio-economic disadvantages as well as lack of access to or control over land has inhibited cultural development among the indigenous population (Young 1995:262). The lack of monetary and land resources and the ability to acquire them is believed to be the cause of depression among the Vedda community.
The children who attend school with non-Vedda children confided to me that they wish that they were not Veddas and are embarrassed of their heritage because of the disdainful way of which the Vedda people are spoken by the other pupils and teachers. This saddens the elders, and the chief said that it angered him that the Veddas are considered "dirty" and "uncivilized." He believes that they should be envied rather than scorned for living in a small hut, bathing in the river and living in harmony with the forest. He said that he is worried about the Vedda youth and believes that the poor attitude that others have about the Veddas will result in even more depression in the upcoming generations. Studies have supported the chief's fears. Walters & Simoni (2002:522) reinforce the chief's fears as they maintain that psychological distress, depression, and anxiety are all correlated with social oppression that occurs among indigenous populations.

5.1 Cultural Identity:

The attitude a native group holds about its own identity is a major determining factor of that group's psychological well-being (Walters & Simoni 2002). Walters and Simoni (2002:223) argue that immersion of traditional
health and healing practices in native societies has positive benefits to the health of the native people.

In Canada and Australia many citizens as well as government officials believe their aboriginals should join the mainstream society and condemn any support they receive for cultural development or special concessions they receive for cultural preservation (Young 1995:89). I found that similar sentiments exist in Sri Lanka. When I was asked by Tamil and Singhalese Sri Lanka citizens about my research, the most common response expressed the idea that the Veddas needed to conform and do not need special considerations in medicine or any other area. This mentality is detrimental to the Vedda cultural survival.

One measure that has been employed to address cultural identity issues is the attempt to incorporate them into mainstream society. In the late 1970s, the Prime Minister of Sri Lanka initiated the Model Village program, or Village Awakening. The primary goals of the program were the development of "backward" villages and moral "regeneration" by bringing the Veddas out of the jungle to live in a new settlement (Brow 1990). There was a ceremony where government officials came to the new village for the opening of a new post office, cooperative store and community hall and to hand out keys to concrete houses to
the Veddas. The local Member of Parliament claimed that the new settlement that was developed gave the Veddas "...the opportunity to regain self-respect and independence" (Brow 1990:9).

While the government may have felt its actions were "helping" the Vedda people, they were really hindering the Veddas recovery of their self-respect and independence. As Brow (1990:11) writes, the settlement program placed the Veddas into a community that is fixed within the confines of the Sinhalese Buddhist nation. It did not occur to the policy makers that the Veddas may not wish for such a settlement; thus, the Veddas were not consulted, and their needs and desires were not incorporated into the program.

The lack of consideration for the needs of the Veddas and the absence of a way for their needs to be met are key components that lead to depression. As I discussed in the previous chapter, the Veddas believe that depression and mental illness are the result of such external coercion. They feel that by being forced to be part of a city that they lose their sense of home. Furthermore, the Veddas feel that they can receive all their needs from nature and her spirits, and it is the desire and consumption of excess material gains that leads to depression and pissu.
Like the Wanniya-laeto, the Orang Asli of Maylasia is an indigenous population who has been displaced. Efforts have been made to integrate them into the mainstream Malaysian, but they have fought to retain their own identity and autonomy (Tachimoto 2001). Additionally, the Orang Asli have not been receptive to the attempts to convert them to Muslim, and therefore, are considered inferior people. Similar to the Wanniya-laeto, the Orang Asli have been placed in hamlets in regions where the resources have already been diminished due to prior human exploitation of the land (Tachimoto 2001).

In his article "Indigenous Knowledge and Biodiversity," Cunningham (1991) discusses how the vast knowledge of indigenous people about their local botanical environment is often neglected by governmental policy makers. While many indigenous groups hold special wisdom about plants and their uses, the urban-industrial society does not always value such input. Thus, land rights are revoked and native people are displaced from their traditional environment. While Cunningham (1991) was referring to societies in Latin America, the same phenomenon is occurring in Sri Lanka.

As the larger mainstream society loses interest in traditional knowledge, the newer generations of indigenous
populations abandon their interest as well in hopes of joining the larger society. And with the loss of interest comes the loss of knowledge (Plotkins 1990). This is debilitating for the continuation of their native culture and heartbreaking for the elders in the community.

A more effective model for improving the lives and decreasing the prevalence of depression among the Vedda people is one that facilitates the continuation of their traditions. Allowing them rights and guardianship of their ancestral land is beneficial in two ways. First, by giving respect to their knowledge, the Wannya-laeto can develop pride in their heritage, encouraging the newer generations to want to learn their heritage and cultural customs. Additionally, there is hope that giving native people "... the respect and recognition of the integrity of the land of their territory, of their organization, customs and traditions, they will be able to enjoy a peaceful and prosperous existence" (Bunyard 1989:256). This means that their mental well-being would be preserved by reducing pressures that alter their traditional ways of being.

Solutions are often difficult and are rarely definite, yet there are steps that can be made to improve the lives of the Wanniya-laeto. The government needs to recognize the importance and value of local knowledge about the
Danigala land by allowing them to act as guardians of the forests. This means that they are given rights to practice traditional customs, including hunting and traditional agricultural techniques (Living Heritage 1989).

5.2 Psychological Services:

The principles behind Western biomedical psychiatry are based on standardized assumptions about human interests and the belief that all humans have the same desires in the areas of living style, work pursuits, leisure and self-development (Patrick 1920:199). However, no standardized belief system accurately defines what all humans need or desire, yet there remains a set of symptoms and treatments that are being applied in mental healthcare in societies all over the world. Western values about mental illness are often assumed to be the same in other societies as if they regard the same self-interests, goals and behaviors in the same fashion that the Western world does (Patrick 1920).

Research has shown that the Veddas do not share the same value system that is common in Western society. As Richard Dana (1993:9) points out, the world view a person holds reflects the individual’s cultural background and
affects the way that individual perceives and experiences reality. The value and perception of illness and medicine are attached to the cultural beliefs surrounding them. In general, Western medicine remains detached from religious and spiritual traditions that would interfere with medical investigation. Western models of medicine treat religious values and physical ailments as separate spheres that have little connection (Fox 1976). Additionally, the importance of social support is often overlooked in the biomedical model (Baer 1999:82). The Veddas incorporate their spiritual beliefs and practices with their health and healing system. Charles Leslie (1976:270) maintains a need for a "terminological bridge" between modern and traditional medicine. This is a possible way to incorporate the inclusion of Vedda health concepts within the mainstream medical practices within Sri Lanka.

Examining previous research on cross-cultural psychiatry is a helpful tool that can be used to understand the negative consequences that can occur when cultural factors are not included in the research. For example arctic hysteria was a label given to Inuit women during the 19th century. As Lyle Dick (1995) points out, this notion of a culture-bound syndrome was a description of the reaction of Inuit women being exploited by European explorers and
other outsiders, a response that is not unique to Inuit women. A lack of context and understanding of the ramifications of external influences led to distortions and false literature on the psychology of the Inuit people (Dick 1995).

While Western thought allows for some external explanation for mental illness, there is also a heavy focus on brain chemistry and biology that does not exist in Vedda etiology. The Veddas believe that mental illness is caused by strains of the material world. They believe that treatment for mental illness needs to include their ancestral spirits.

Low-income nations, such as Sri Lanka, suffer a particularly daunting challenge in the psychiatric arena. The primary health care system used by the indigenous population consists of the most basic health services, usually with no specific staff or clinical units dedicated to mental health treatment (Kirmayer 2000). The lack of focus on psychiatric services is due not so much to a lack of funding but rather due to the fact that psychiatry is a relatively new field in Sri Lanka, and no university in Sri Lanka offers a post-graduate clinical training in psychology. Thus, there are few psychiatrists in Sri Lanka, and the few itinerant psychiatric consultants found
on the island are trained overseas where Western medicine is taught (Kirmayer 2000).

The psychiatrists bring the Western practices into Sri Lanka without proper resources to develop and incorporate the discipline with attention to cultural context. Clinical psychiatrists received their training abroad and return to Sri Lanka to practice a system of psychiatry that is culturally inappropriate (De Zoysa 2001 & De Silva 2002). Western psychology is characterized as "... distorting interpretations of behavior, diverting attention from key social variables and resulting in applied research orientations that do not match national social problems." (Adair & Kagitcibasi 1995:634). Psychiatry should orient itself in a way that incorporates indigenous reality. Physicians who intend to work in their native country need to be educated in that country to learn and incorporate medical practices of their indigenous population (Leslie 1976:1). If it is not possible to be trained solely in a physician's native country, I recommend that there is a supplemental training program that educates medical professionals about the medical beliefs and treatments of the diverse cultural groups that that physician will treat.
CHAPTER 6

CONCLUSION

With the increasing globalization of economic and political ideologies, indigenous populations and their cultures are being increasingly marginalized (Findlay 2000). Research has shown that the absence of attention given to the cultural factors and the deficiency of ethnographic research on the social realities of diverse populations leaves psychiatry bereft of adequate data that reflects the true realities of these populations (Kirmayer 2000). By investigating how the Waniya-laeto perceive mental illness with regards to symptoms, perceptions of those who have the symptoms, etiologies and treatments, the gap of missing data is narrowed.

Research on the cultural influences of perceptions, explanations and treatments of mental illness is beneficial as it helps provide mental health policy makers with concrete data on which they can make decisions that will provide the most effective mental health services. While the Wanniya-laeto do not feel that they have mental health problems because they do not feel the stress that they associate with the need of material gains, many do feel that depression is becoming more of a problem in the Vedda community because of their loss of land resources.
Additionally, there is a developing trend for the younger generation to be moving to larger cities. As more Veddas move to cities, the elders fear that depression and other mental illness may eventually become an issue.

In addition to mental health policy, the needs of the Veddas also need to be incorporated into government policy concerning land rights. By allowing the Veddas to have access to land resources, they are able to retain their cultural ties, pride of their heritage and autonomy as well as reduce the rates of depression that has developed from the loss of such things.
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World Health Organization  
APPENDIX A

Interview Questions Wanniya-laeto: Perceptions of Mental Health and Mental Illness

1) Do you hold any religious or spiritual beliefs?
2) How do these beliefs affect your attitudes towards health and illness?
3) When you are sick, what do you usually do first?
4) Which of the following do you use for illness?
   a. home remedies
   b. help from a friend or family member
   c. medical practitioner
   d. community healer
   e. other

5) What does it mean to be mentally healthy?
6) Can you think of some mental illness and describe their symptoms?
   6a. In your opinion, what does it mean to have a mental illness?
   6b. Do you have a term for depression or general sadness? What are the symptoms?
   6c. What do you call people who talk to themselves?
7) What do you call people who behave in ways that are outside the norm?
   7a. Can you describe examples of abnormal behavior and explain why it is abnormal?
   7b. How do you perceive these people?
   7c. How do you think the community perceives these people?
8) Have you or a family member had mental health problems?
   8a. If yes, what did you do?
   8b. What types of services did you receive?
   8c. Did these services fit your needs? Why or why not?
9) What types of mental health services would you like to have access to?
10) Do you feel you have access to these services?
   10a. If no, what do you think are the barriers that prevent you from receiving such services?
11) Is there anything else you would like to add about mental health or mental illness?
APPENDIX B

Interview questions for doctors about mental health services for the Wanniya-laeto

1) How often do you treat Veddas for psychiatric illness?
2) What types of services do they most often receive?
   2a. From what illness do they most often suffer?
   2b. What are the most common symptoms for which they require services?
3) Do the Veddas come to receive mental health services on their own accord?
4) Do the Veddas receive mental health services due to an emergency crisis?
Added after the first interview:
5) Why do you believe the Veddas do not come in for psychiatric services?