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Some Thoughts and Reflections on Therapy and Healing Across Cultures

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Nearly all my experience as a psychiatrist (before I became an academic) had been in or around UK's capital city, London. I trained as a psychiatrist in the 1960s while working in asylums (called by then 'mental hospitals') located just outside London and later worked at a teaching hospital in London itself; and finally, as deinstitutionalisation took hold, I worked in a multi-disciplinary team running a community-based service linked to a district hospital serving a multicultural part of London. The change from asylum-care to community-care that happened in the 1970s occurred soon after the 'medication revolution'—the advent of neuroleptic drugs when hopes were raised that mental illness would be cured by drug therapies. These changes led to the current mental health system in the UK where specific diagnosis and packages of treatment mostly centred around medication—a technological approach—take precedence over caring and human relationships as the bedrock of what people with mental turmoil and in extreme states of social suffering need.

I have no doubt that closing the asylums was a good thing—many had become corrupt and places of oppression and always worsened the stigma that many people in the throes of mental distress suffered from. Yet, there were several asylums that helped some people quite a lot by simply providing a safe place where they could develop, free from the stresses and indignities they often faced in the world outside. I remember working at one where the admission wards were run on therapeutic community lines (see Shoenberg, 1972) where some people really got much better (although admittedly others just became institutionalised) because they were able to work through their problems at their own pace and in their own ways with just occasional medication—we now call this the 'recovery approach' as if it's a new invention. Unfortunately, when the ethos of this

'recovery approach' is taken on, our current system all too often seems to lose the plot by turning it into a technological treatment process that is doled out in the form of courses run by specialists in 'recovery.' Looking back on the asylum era, I think we have lost something very important by forgetting that many people suffering distress or confusion, apparently mentally disturbed and disorganised, need time for reflection in a safe environment and the support of caring human beings—something that good asylums provided—and by looking instead to drugs targeted at symptoms and to packages of social support provided by various specialists.

In my studies after training as a psychiatrist, I found it illuminating to read about the history of East-West interactions in the field of what we call 'mental health' and 'mental illness'; and to get a grasp of differences between various cultures in the ways in which they approach matters to do with 'mind.' In the West, the disciplines we now call psychology and psychiatry developed through the study (during the eighteenth and nineteenth centuries) of 'madness' as identified in the West and within a cultural context of post-Enlightenment thinking where individuality (rather than communality) and a mind-body duality devoid of spirituality were emphasised. Doctors in charge of asylums theorised about (what they thought were) abnormalities of the 'mind' in people trapped in institutions, although many were there because of various social and relationship problems. These so-called mental abnormalities (psychopathologies) were attributed to biological, inherited causes; and clinical psychology took on this 'medical' approach by biologizing (philosophical) ideas about the mind, seeing the mind as something concrete like organs of the body. Yet, well before this sort of clinical psychiatry and psychology developed, a very different approach to mental problems, conceptualised as illness in Greek medicine, had thrived in Islamic mental hospitals (mãristãns) in North Africa of the middle ages where (for example) "a sort of spiritual therapy was carried out, involving music, dance, and theatrical spectacles and readings of marvellous stories" (Foucault, 2006, p. 117)—but Western scholars apparently ignored this knowledge.

In the 1970s, I became a consultant in a multi-ethnic area of greater London. I saw then how people from Asia, Africa, and the Caribbean who had migrated to the UK seemed to get a poor deal

from the mental health services provided there. I realised that racism was involved but also that cultural differences played a part—both race and culture were involved. So, in an attempt to find out why this was happening I looked at cross-cultural and cross-national studies. Unfortunately, much of the research published in psychiatric and psychological journals seemed problematic when looked at critically, mainly because they failed to deal with 'category fallacy'—the disadvantage of applying culturally inappropriate categories (Kleinman, 1977). Cross-cultural studies carried out in the traditional style of medical epidemiology did not seem to offer much that was useful. But more recently, I have been impressed by some work done in India.

Raguram et al. (2002), writing in the *British Medical Journal*, reported that the outcomes of people attending a Hindu temple in Tamil Nadu—a place known for helping people with mental health problems—matched the sort of result one would expect from good psychiatric treatment. A paper in the journal *Transcultural Psychiatry* (Halliburton, 2004) documented the experiences of 100 people who had accessed treatment in three forms of therapy in Kerala, namely Ayurvedic medicine, bio-medical psychiatry, and religious healing at one or other of three locations, namely a Hindu temple, a Muslim mosque, and a Christian church—all of which had reputations for healing people who suffer from mental illness. All the people studied in this piece of research were people who had sought help because they were in distress; and when their stories were looked at through the lens of psychiatry, they had mixtures of symptoms that amounted to the diagnosis 'schizophrenia' or similar severe mental disorder. Similar proportions of these people benefited from each form of therapy, and several had changed from one location to another until they found one that they benefited from. This shopping around had resulted in a very high overall improvement rate.

All through my life as a psychiatrist in the UK, I kept recollecting what I remembered of my life in Sri Lanka where I had spent my formative years—how differently people in non-Western settings conceptualised (what I had been trained in the UK to call) 'mental illness / disorders,' 'mental health problems' and such like. So, I was delighted when I was invited by colleagues in the section of transcultural psychiatry at McGill University in Canada to participate in a research program in Sri Lanka between 2007 and 2012. This was

led by a Sri Lankan sociologist and aimed at examining how local people had coped with distress and suffering that had come about as a result of conflict and natural disasters—and there were many since Sri Lanka was experiencing a civil war at the time and had been struck by several natural disasters including a tsunami—and at helping in local capacity building in the field of mental health (see Fernando, 2014).

I had been away from Sri Lanka since 1961 except for short visits to see family and it was only in 2007 that I got to know Sri Lankan people very closely again. As I talked to them, it struck me that, although (in 2007) the words and concepts (about mental health and illness) formulated in the West were being used—something that was not the case in the 1950s for example—many people still saw the problems they called 'mental' or 'psychological' (often using the English words) in terms of spirituality and healing, rather than illnesses requiring interventions directed at brain functions—the theories promoted by psychiatrists and psychologists. For many local people, notions of what is 'mental' seemed to fuse together Eastern and Western ideas and concepts. Yet, the services that were being built up to provide a proper mental health service were being led by psychiatrists and psychologists who had been trained in the Western systems of psychiatry and psychology that I had experienced in the UK—and I knew these were proving to be inadequate in the UK for people from non-Western cultural backgrounds.

I discovered during my work in Sri Lanka between 2007 and 2012 that most people who experienced social suffering and distress were willing to reach out for any sort of help that was offered, from indigenous healers, psychiatric clinics and hospitals, religious bodies and so on, but only felt fully 'recovered' when they felt connected to their families and communities. As for treatment, there was a plurality of systems available for (what they called) 'mental' or 'psychological' problems. An example of the systems in one particular district is given in Table 1 based on research done by a Dutch psychotherapist Beatrice Vogt (1999). The main problem was one of access—the poor and those without caring families missed out.

I visited the mental hospital just outside Colombo at Angoda, one that I had known in 1960, to find it virtually unchanged. However, I saw distinct changes take place for the better while there, and was delighted to be able to help the process as part of the

capacity building program of work I was involved in. I recalled that a centre for healing people deemed to suffer from 'mental' problems had been popular in the forties and fifties in preference to the mental hospital—even among relatively wealthy middle-classes in Colombo (the capital city of Sri Lanka). This was located at a Buddhist temple at Nilammahara, not far from Angoda, but alas was no longer operational (in 2007). But I read that the principles of treatment established there had been taken up by indigenous practitioners in several parts of Sri Lanka and were far from forgotten. According to anthropologist Gananath Obeyesekere (1997) the Nilammahara system recognised 22 types of psychopathology; and no doubt treatments would have consisted of physical interventions (like decoctions and head packs) combined with herbal remedies and life-style advice including Buddhist values. In 2007, I heard of many indigenous practitioners who claimed to treat 'mental illness'—using a literal translation of the English word 'mental illness' into Tamil and Sinhala (the two main local languages)—and it seemed that, although there was no recognisable *standard* Ayurvedic treatment for mental illness in Sri Lanka, a lot of it was going on (often at a price). I heard that exorcism was still practiced widely often with *kattadiyas* (the specialists who arrange exorcism ceremonies practiced in the community) working in partnership with indigenous doctors. A book by a local sociologist (Kusumaratne, 2005) about current indigenous medical practice in Sri Lanka notes that one such practice in a small hamlet in the south had overseen 50-60 exorcisms (presumably for 'psychosis') and 25-30 snakebite cases in just one month. Yet in another area we heard that exorcism had become very expensive, partly because the drummers and dancers necessary for the full rituals earned more by performing for tourists—and so exorcism was only accessed by the fairly well off.

Today, we live in a globalising world with cultural mixing and easy communication—and even more importantly, we live in a *post-colonial* world. During colonial times, colonialists built asylums like those in Western countries for people diagnosed as 'mentally ill' in some parts of (colonised) Asia and Africa, disregarding the fact that health and illness, and the notion of what is 'mental,' were all seen very differently in Asian and African cultures to those in the West. More recently, powerful forces, especially those allied to the pharmaceutical industry, are promoting a view that Western

biomedical therapies and psychological interventions are superior to indigenous forms of help (for example local healing systems) for people deemed to be suffering from mental and psychological problems (for examples of how this is being done, see Fernando, 2014). Drug-based biomedical treatments are being popularized through various social and political forces, and indigenous ways for alleviating mental distress, social suffering, and 'madness' are being pushed out (see Watters, 2010). What I have learned from my own studies and experience in British mental health services—and from what I experienced during my work in Sri Lanka between 2007 and 2012—is that, in developing mental health services anywhere, it is very important to focus on *local* needs and *local* cultures while taking on board knowledge drawn from East and West, North and South, on how best people with mental / psychological problems can be helped, and to keep in mind the benefits of the people that the services are meant for.

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