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Editorial Note

Beyond the Clinic: Coexistence and Collaboration

Modern healthcare understands illness or disease as derangements in biological functioning, inborn or acquired, that leads to diminished health, vitality and longevity. This cartesan dualistic point of view has led to the separation of physical healing process from the spiritual or religious ones (Steinhorn, Din & Johnson, 2017).

However, in recent times, there is increasing recognition that our model of health and wellness should go beyond the biological symptoms to include the psychological and social aspects of health. And there is further acknowledgement that this model of psychological and social aspects of wellness should focus on the spiritual health of individuals in order to maximize the healing process.

There is strong research evidence that suggests that health, medicine, spirituality and religion have a close interplay (Curlin & Moschovis, 2004, Sulmasy, 2006; Larimore, Parker, Crowther, 2002, Yawar, 2001, Sloan, Bagiella, VandeCreek, Hover, Casalone, Jinpu Hirsch, et al 2000, Barnes, Plotnikoff, Fox, Pendelton 2000, Chatters, 2000, Mills, 2002, Lawrence, 2002, Fortin & Barnett, 2004).

For example, in India, *Ayurveda*, the ancient Indian system of medicine has its roots in the ancient religious text of the *Atharvaveda*, which gives elaborate explanation of combining medicinal products, mainly derived from plants (leaf, root and seed) with magical spells, hymns or rituals (Griffith, Sehgal & Varma, 1985).

Similarly, Buddhism has a long history of healing that extends over two thousand years and embraces developments across the whole of Asia. This has been noticed by commentators. For instance the ***Dictionary of Medical Ethics*** under its entry on 'Buddhism' states "The principles governing Buddhism and the practice of medicine have much in common" (Duncan, Dunstan, & Welboum, 1981). The Buddha, drawing on his knowledge of contemporary Indian medical practice makes use of medical analogy when stating the 'Four Noble Truths' – 1) life involves suffering; 2) suffering has a definite cause; 3) an end to suffering can be found; 4) there is a path that leads to end of suffering. The medical analogy he is applying is – 1) a diagnosis is made; 2) the cause of the disease is established; 3) a prognosis is arrived at; 4) a plan of treatment is devised (Keown, 2012). The Sutta Nipāta states as follows:

> What, O Monks, is the Noble Truth of Suffering? Birth is suffering, sickness is suffering, old age is suffering, death is suffering. Pain, grief, sorrow, lamentation, and despair are suffering. Association with what is unpleasant is suffering, disassociation from what is pleasant is suffering. Not to get what one wants is suffering. In short, the five factors of individuality are suffering. (*Sutta Nipāta 56.11*)

The relationship between medicine and religion is not very surprising. Primitive man had primitive religion and worshipped the elements of nature – sun, earth, air, water, fire and other powerful symbols of nature. Advances in civilization led to institutionalized religion. And through all these changes from primitive to institutionalized religion, the human conceptual framework of a close relationship between humans, nature and god has remained unchanged. However, the centuries old close relationship between religion, spirituality and medicine was interrupted somewhere around the 17th Century, when there was increasing use of scientific methods for understanding nature and disease (Koenig, 2001; Sulmasy 2006). Since then the spectacular advance in application of scientific methods has led to widening of gap between modern medicine and healing methods grounded in traditional religion and spirituality (Koenig, McCullough & Larson, 2004).

Religion and spirituality may mean different things to different people. The word ***'religion'*** refers to the search for transcendent meaning by a community through a set of beliefs, practices and associated language used by the community. These beliefs, practices and language are generally based on belief in a particular deity (Sulmasy, 2002; Astrow, Puchalski, & Sulmasy, 2001).

The word ***'spirituality'*** refers to a person's or a group's search for meaning and purpose with the transcendent. It is often characterized as an experiential process whose features include - belief that a human being is more than simple material manifestation, connectedness with others and the divine, and values such as love, compassion and justice (Mueller, Plevak, Rummans, 2001; Emblen, 1992).

Though distinct in some regards, religion and spirituality share many common characteristics and tend to be used interchangeably. A sense of sacred is core to the experience of both religion and spirituality. And in both, the sacred is not automatically known, and it involves a search process. Thus at the heart of both religion and spirituality is primarily a way of thinking or reflecting about issues such as the nature of reality or one's purpose of existence (Hill, Pargament, Hood, McCullough Jr, Swyers, Larson, & Zinnbauer, 2000).

An ever increasing body of scientific research shows that religious belief and practices have a salutary effect on the physical and mental well being (Larson, Sherrill, Lyons, Craigie, Thielman, Greenwold & Larson, 1992,

Shahabi, Powell, Musick, Pargament, Thoresen, Williams, Underwood, Ory, 2002). Religious people tend to have better mental health and greater adaptability to stress (Koenig, 2000). Religious beliefs are associated with significantly lower anxiety, lesser degree and frequency of depression, lower suicide rates, less substance abuse, greater well being, hope and optimism, more purpose in life, greater marital satisfactions and higher social support (Koenig, 2012, Strawbridge, Shema, Cohen, & Kaplan, 2001).). Further, studies show that religious involvement is associated with lower death rates from cancer, lower rates of heart disease, lower blood pressure and increased longevity (Koenig, et al 2001, Koenig, 2000, Koneig, 2004, Craigie Jr, Larson, & Liu, 1990; Matthews, McCullough, Larson, Koenig, Swyers, & Milano, 1998; Thoresen, & Harris, 2002).

Kleinman (1988) points out that religion and traditional healing practices are part of Asian culture. People in Asia are largely accustomed to relying on distinct healthcare or treatment practices that are closely aligned with their religion. This is significantly different from the approach in the West, where the focus is on physical healing of illnesses and diseases, which is well separated from religion and spiritual practices. Further, as can be expected, each country or each community has its own legend about religious practices. India is a country with a rich heritage of religious and spiritual practice over centuries. It has been home to some of the greatest religions in the world – *Hinduism, Jainism, Buddhism, Christianity, Islam, Zoroastrianism* and *Sikhism*. Religion and spirituality are a way of life in India. Religious practices, religious rituals and spirituality have been an integral part of health interventions in the country. The diversity of religions and the resulting diversity in religious practices across India are reflected in the bewildering array of religion based healing practices in different parts of the country.

In the discussions that follow, we explore the prevalent practice in Tamilnadu (a state in South India), of combining traditional religious or spiritual healing with modern scientific medical health services to people visiting specific shrines for psychological and behavioral problems.

The traditional healing practices in Tamilnadu vary considerably – people avail the help of a '*shaman*' or an '*astrologer*' or a '*black magician*' or '*poojari*' (a temple priest). As Kleinman (1988) states, in all Asian cultures body-self is not a secularized private domain of the individual person, but an organic part of the sacred, socio-centric world, a communication system involving exchange with others, including the divine. The person in these therapies is seen as embedded in a social hierarchy and in a network of relationships. Families and other community members also actively engage in the treatment process. The healer and his or her healing practices are integral to the beliefs and practices of the local communities.

We discuss the cases of two well known places of worship in Tamilnadu - **Gunaseelam Temple** in Triuchirapalli District and **Erwadi Dargah** at Ramanathapuram District, to make a case for exploring disease treatment and rehabilitation models that support collaborative endeavor between religious healing methods and modern scientific treatment methods, which could lead to superior and culturally relevant models of healing that meet local needs.

The Gunaseelam Temple in the South Indian state of Tamilnadu is an example of best practices of indigenous practices in community based rehabilitation in India. It is a Hindu temple dedicated to lord *Vishnu* in the form of '*Venkatachalapathi*'. The temple offers a model of healing that combines 'medicine and prayer'. The temple has a longstanding – over two centuries – reputation, for healing devotees who suffer from mental illness. It is believed that a visit to the temple is curative to mentally challenged people. Over the past 15 years, the temple has integrated modern psychiatric treatment and rehabilitation with its traditional healing practices. The idea is to create a culturally relevant mental healthcare system. The Sowmanasya Hospitals Institute of Psychiatry based out of Tiruchirappalli District in Tamilnadu, has set up a treatment and rehabilitation centre which provides interventions such as psycho therapy, vocational training and education to the family members (Stanley S. & Shwetha, S. 2006). The rehabilitation centre accepts patients with chronic schizophrenia. The treatment process is overseen by a priest and a psychiatrist. The patient stays with his or her family members, to create an ecosystem where the patient's family shares the burden of caring for the patient. The patient and the family stay at the centre for a ritually significant period of 48 days, during which time they attend five prayer rituals each day which start as early as 5AM. During two of these prayer rituals, the faces of the devotees are splashed with holy water or 'tirtham', which they believe drives out evil spirits (Saglio-Yatzimirsky & Sébastia, 2015). The patient, families and priests believe this to be a more efficacious method than just using one aspect of either faith or modern scientific treatment methods.

Erwadi Dargah in Southern part of Tamilnadu is the tomb of Qutbus Sultan Syed Ibrahim Badusha, located in Erwadi village of Ramanathapuram district. Qutbus Sultan Syed Ibrahim Badusha was a Moroccan, who came to the place to propogate Islam. The tomb has turned into a holy Islamic shrine or a Dargah and is well known for healing mentally challenged people since the past 200 years. It is believed that the water and oil from a lamp in the dargah has spiritual healing powers and is administered to sick people Since 2012, the dargah has been following a blended approach of traditional healing with modern day treatment. The government of Tamilnadu has established an outpatient clinic at the Erwadi Dargah and has initiated an aptly titled program called 'Dawa and Dua' (medicine

and prayer), which has gained significant momentum since its launch. The District Mental Health Program DMHP of Tamil Nadu offers psychiatric care and counselling to patients. The 'spiritual healers' at the Dargah have undergone an awareness program and have joined hands with psychiatrists to treat mentally ill patients. Individuals with mental illness continue their prayers and rituals at the Dargah along with modern medical treatment. The treatment is given free of cost and is given without upsetting the patients' religious belief and faith. The success of the program at the Erwadi Dargah has resulted in other dargahs and temples in Ramanathapuram District of Tamilnadu adopting the same principle of incorporating spiritual practices along with medical treatment.

The 'success story' of Gunaseelam and Erwadi lies in the fact that they are able to sustain the model of combining modern medicine with religion. The dialogue between faith healing and scientific medical treatment has been a long and uneasy one. It's a dialogue in which the relative credibility of the scientific method is pitted against the notion of a 'higher power' held by the patients, their families and priests. But realisation is dawning that the dialogue need not necessarily be whether it should be 'faith OR medicine'. The priest and the physician don't necessarily need to agree with each other's methods. It is sufficient if the benefits of co-treating the patients is appreciated. From a treatment perspective, this framework is cheaper, rooted in the culture and is far more community based than treatment in a hospital. From a religious perspective, the patient recovery reinforces the reputation of the temple as a 'healing site' and the belief that 'religion' has the power to heal.

The success of Gunaseelam and Erwadi Dargah proves that it is possible to sustain a harmonious interface between medicine and religion. The World Health Organization (WHO) has accepted spirituality as an important aspect of quality of life. As Koenig (2012) in his study states, there is growing realization that it is important to provide a whole person care instead of just treating the disease. Patients are not just individuals but have emotions, social and family relationships that affect and are affected by illnesses. They have to confront potentially dramatic changes in quality of and well-being. And these issues are mixed with existential and religious or spiritual concerns. This understanding has renewed the interest in creating a framework in which religion and medicine can be harmoniously combined to create a contextually relevant health care model.

However, it should be noted that a composite model of healthcare that seeks to combine tradition religious or spiritual healing with modern medical treatment is not without challenges. While it is understood that spirituality and religion can provide intrinsic benefits, critics of these approach tend to be skeptic about the efficacy of these methods that are rooted in mysticism

and metaphysics. Thus there is a challenge with regard to the legitimacy and authenticity of these methods which are not rooted in scientific rigor.

Also, Koenig (2007) points out that there are certain negative outcomes associated with inclusion of religion in health interventions. For instance, patients are likely to develop feelings of guilt and distress, if the feel that they do not meet god's standards of virtuousness. And anxiety about being judged for sins can trouble patients (Ellison, Burdette, & Hill, 2009). Intense religious experiences have potential to lead to transient psychotic episodes. Bar-El, Durst, Katz, Zislin, Strauss & Knobler (2000) describe about psychotic breakdown linked to religious experience (sometimes referred to as the '*Jerusalem syndrome*'). In some cases, religious ideas appear to fuel delusions. This is not to say the delusions are caused by religion, but it serves as the basis for the content of the delusion (Mohr, Borras, Beitsey, Pierre-Yves, Gilliéron & Huguelet, 2010).

In line with the themes presented above, this issue of *International Journal of Traditional Healing and Critical Mental Health,* presents the following articles. The issue opens with Dr. Barbara Miller's study titled, "*Cultural Contexts of Healing - An Anthropological Perspective on Indigenous Mental Health Practice, with case study on Sámi Healers in Porsanger, Norway*", draws on interviews, participant observation, and historical analysis to provide rich narratives on Sámi healing. It takes the reader through Nanna and Sigvald's experiences as healers and posits the application of Sámi healing in contemporary times at the juncture of C.G. Jung's Analytical Psychology and William James's Pragmatist Philosophy of Religion. Furthermore, Dr. Mami Yanai's article titled, "*Delicious Moments (DLM): An Integrative Aesthetic Framework Bridging Japanese Culture, Healing, and Human Flourishing*" embraces savouring life in all its complexity and vulnerability. This paper introduces Delicious Moments (DLM) as an integrative aesthetic orientation and meta-framework for healing and human flourishing, The paper draws from the Japanese concepts: amae (relational belonging), daigomi (the essential flavour of experience), kintsugi (beauty through repair), and ba (relational field) to define healing from a holistic perspective.

Sraddha Kausthub and Khushi Shah's study titled "*Enhancing Client Agency: Bridging Yoga Therapy and Freire's Pedagogy*" study proposes integration of Freire's Pedagogy with psychotherapy to enhance client autonomy, enhance quality of life for individuals with mental illness and improve mental health literacy. It draws on classical yoga texts and Yoga therapy practices that enhance client agency that support a more balanced distribution of power between the therapist and client, thus setting the stage for culturally appropriate mental health care. Further, Alexandra Mounague's study titled "*West meets East: A Travelogue on Traditional Healing and Rethinking Mental Health*" is a travelogue the explores the intersection of

Western psychology and Indian traditional healing through the Fulbright scholar's journey. The study highlights significant contrasts in mental health conceptualization in Western models that rely on brain centric pathologies and Eastern models that rely on energy states, thereby bridging these two worlds to create a holistic methodology for mental health. The Issue concludes with an article from Miriam Priti Mohan and Dr. Baiju Gopal titled, "*Representations of Volunteerism among Young Indian Adults: An Indian Philosophical Perspective*" which explores Volunteerism as a key part of community healing. The study uses quantitative content analysis to the various youth representations of volunteerism. Concepts like 'Seva' and 'Dharma' and 'Śramadāna' are used to contextualise reciprocal giving and the act of volunteerism.

It is clear that integrated models of healing are the way forward. As Koenig (2007) puts it, religion may be incorporated into healthcare and treatment in circumstances that are appropriate and avoided where they may produce adverse effects. And the success of models at Gunaseelam Temple and Erwadi Dargah gives hope for innovative models of healing and healthcare that are strongly rooted in local cultures and sensitive to local contexts. The success of these models hopefully will spur more collaborative efforts in which the paradigm of medicine and religion combine harmoniously to create culturally relevant models of healing.

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Editor

References

Astrow, A. B., Puchalski, C. M., & Sulmasy, D. P. (2001). Religion, spirituality, and health care: social, ethical, and practical considerations. *The American journal of medicine, 110*(4), 283-287.

Bar-El, Y., Durst, R., Katz, G., Zislin, J., Strauss, Z., & Knobler, H. Y. (2000). Jerusalem syndrome. *The British Journal of Psychiatry, 176*(1), 86-90.

Barnes, L. L., Plotnikoff, G. A., Fox, K., & Pendleton, S. (2000). Spirituality, religion, and pediatrics: Intersecting worlds of healing. *Pediatrics, 106*(Supplement 3), 899-908.

Chatters, L. M. (2000). Religion and health: Public health research and practice. *Annual review of public health, 21*(1), 335-367.

Craigie Jr, F. C., Larson, D. B., & Liu, I. Y. (1990). References to religion in The Journal of Family Practice. Dimensions and valence of spirituality. *The Journal of Family Practice, 30*(4), 477-8.

Curlin, F. A., & Moschovis, P. P. (2004). Is religious devotion relevant to the doctor-patient relationship?. *Journal of family practice, 53*(8), 632-640.

Duncan A, S., Dunstan, G. R., & WelboumR, B. (1981). *Dictionary of Medical Ethics*. London: Darton.

Ellison, C. G., Burdette, A. M., & Hill, T. D. (2009). Blessed assurance: Religion, anxiety, and tranquility among US adults. *Social Science Research, 38*(3), 656-667.

Emblen, J. D. (1992). Religion and spirituality defined according to current use in nursing literature. *Journal of professional nursing, 8*(1), 41-47.

Fortin, A. H. 6th, & Barnett, K. G. (2004). *Medical school curricula in spirituality and medicine. Jama, 291*(23), 2883-2883.

Griffith, R. T., Sehgal, S. R., & Varma, S. (1985). *The Hymns of the Atharva-Veda: Translated with a Popular Commentary* (Vol. 1). Munshiram Manoharlal.

Hill, P. C., Pargament, K. I., Hood, R. W., McCullough Jr, M. E., Swyers, J. P., Larson, D. B., & Zinnbauer, B. J. (2000). Conceptualizing religion and spirituality: Points of commonality, points of departure. *Journal for the theory of social behaviour, 30*(1), 51-77.

Keown, D. (2012). Buddhism and Healthcare. *Japanese Religions, 37*(1/2), 143-56.

Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. Basic books.

Koenig, H. G. (2001, December). Religion, spirituality, and medicine: how are they related and what does it mean?. *Mayo Clinic Proceedings* (Vol. 76, No. 12, pp. 1189-1191). Elsevier.

Koenig, H. G. (2012). *Religion, spirituality, and health: the research and clinical implications.* ISRN psychiatry, 2012.

Koenig, H. G., McCullough, M. E., & Larson, D. B. (2004). *Handbook of religion and health*.

Koenig, H.G. (2007). *Spirituality in patient care: Why, how, when, and what* (2nd ed.). Philadelphia: Templeton Foundation.

Koenig, H.G. (2009). Research on religion, spirituality, and mental health: A review. *Canadian Journal of Psychiatry, 54*, 283–291.

Larimore, W. L., Parker, M., & Crowther, M. (2002). Should clinicians incorporate positive spirituality into their practices? What does the evidence say?. *Annals of Behavioral Medicine, 24*(1), 69-73.

Larson, D. B., Sherrill, K. A., Lyons, J. S., Craigie, F. C., Thielman, S. B., Greenwold, M. A., & Larson, S. S. (1992). Associations between dimensions of religious commitment and mental health reported in the American Journal of Psychiatry and Archives of General Psychiatry: 1978–1989. *American Journal of psychiatry, 149*(4), 557-559.

Lawrence, R. J. (2002). The witches' brew of spirituality and medicine. *Annals of Behavioral Medicine, 24*(1), 74-76.

Matthews, D. A., McCullough, M. E., Larson, D. B., Koenig, H. G., Swyers, J. P., & Milano, M. G. (1998). Religious commitment and health status: a review of the

research and implications for family medicine. *Archives of Family Medicine, 7*(2), 118.

Mills, P. J. (2002). Spirituality, religiousness, and health: From research to clinical practice. *Annals of Behavioral Medicine, 24*(1), 1-2.

Mohr, S., Brandt, P. Y., Borras, L., Gilliéron, C., & Huguelet, P. (2006). Toward an integration of spirituality and religiousness into the psychosocial dimension of schizophrenia. *American Journal of Psychiatry, 163*(11), 1952-1959.

Mueller, P. S., Plevak, D. J., & Rummans, T. A. (2001, December). Religious involvement, spirituality, and medicine: implications for clinical practice. *Mayo clinic proceedings* (Vol. 76, No. 12, pp. 1225-1235). Elsevier.

Norman, K. R. (Ed.). (1992). *Sutta-Nipāta* (Vol. 2). Wisdom Publications (MA).

Saglio-Yatzimirsky, M. C., & Sébastia, B. (2015). Mixing tīrttam and tablets. A healing proposal for mentally ill patients in Gunaseelam (South India). *Anthropology & medicine, 22*(2), 127-137.

Seybold, Kevin S.; Hill, Peter C. (February 2001). "The Role of Religion and Spirituality in Mental and Physical Health". *Current Directions in Psychological Science*. 10 (1): 21–24. doi:10.1111/1467-8721.00106.

Shahabi, L., Powell, L. H., Musick, M. A., Pargament, K. I., Thoresen, C. E., Williams, D., ... & Ory, M. A. (2002). Correlates of self-perceptions of spirituality in American adults. *Annals of Behavioral Medicine, 24*(1), 59-68.

Sloan, R. P., Bagiella, E., VandeCreek, L., Hover, M., Casalone, C., Hirsch, T. J., ... & Poulos, P. (2000). Should physicians prescribe religious activities?. *New England Journal of Medicine, 342*(25), 1913-1916.

Steinhorn, D. M., Din, J., & Johnson, A. (2017). Healing, spirituality and integrative medicine. *Annals of Palliative Medicine*.

Strawbridge, W. J., Shema, S. J., Cohen, R. D., & Kaplan, G. A. (2001). Religious attendance increases survival by improving and maintaining good health behaviors, mental health, and social relationships. *Annals of Behavioral Medicine, 23*(1), 68-74.

Sulmasy, D. P. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *The Gerontologist, 42*(suppl_3), 24-33.

Sulmasy, D. P. (2006). Spiritual issues in the care of dying patients:"... it's okay between me and God". *Jama, 296*(11), 1385-1392.

Thoresen, C. E., & Harris, A. H. (2002). Spirituality and health: What's the evidence and what's needed?. *Annals of behavioral medicine, 24*(1), 3-13.

Yawar, A. (2001). Spirituality in medicine: what is to be done?. *Journal of the Royal Society of Medicine, 94*(10), 529-533.