From Cure Back to Care in Biomedical Psychiatry: Learning from Psychiatric Pluralism in South India

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This paper examines an unacknowledged crisis in biomedical psychiatry, one that was discovered by biomedical psychiatrists and epidemiologists but has since been carefully sidestepped and underplayed in terms of international public health policies and interventions. A major untapped opportunity for medical anthropology to contribute to the improvement of mental health care has arisen from this crisis. The "crisis" I refer to is the repeatedly reaffirmed findings by the World Health Organization that so-called "developing" country research sites show better outcomes for serious mental illness compared to locations that were studied in developed countries. The implication of these large-scale epidemiological studies that now span four decades is that places with *less* biomedical psychiatry have been doing *better* in recovery from serious mental illness. This is not the claim of some overly interpretive, qualitative social anthropologist that might be dismissed by more quantitatively oriented epidemiologists. This is the finding, reconfirmed by multiple follow-up studies, by teams of WHO-sponsored researchers in psychiatry, psychology and other mental health disciplines. What has been the reaction of medical anthropologists? Some have explored the meanings of this finding asking what we can learn from these other places and writing primarily for an audience in the mental health professions (Hopper and Wanderling 2000, Halliburton 2004), but the research that has received the most attention within medical anthropology has assumed that we in the West and the cosmopolitan centers of the South, we custodians of biomedical psychiatry and progressive views of mental illness need to

help others solve mental health problems with our interventions (Desjarlais et al. 1995; Kleinman 2009). This work does point out important problems in the treatment of psychopathology around the globe (for example, highlighting abuses of the mentally ill and stigmatization), yet doesn't take to heart the fundamental challenge presented by the findings of the WHO studies.

This paper proposes that medical anthropologists take seriously and centrally the findings of the WHO and assume the responsibility of exploring their significance. We need to lead the effort to ask what we can learn from the "developing" countries to improve the treatment of mental health in the "developed" world and question international public health interventions that propose to treat mental illness problems in the developing world by exporting more psychiatric interventions. After highlighting analyses of the WHO studies and their implications, I will present insights from research conducted in Kerala in south India on patient experiences in three different forms of treatment for psychopathology: biomedical psychiatry, ayurvedic psychiatry (treatment centers and healers that treat mental illness using India's ayurvedic medical system) and religious forms of healing. One size does not fit all in this therapeutic environment. Each of these therapies benefits some patients but not others, including in all cases, patients suffering serious psychoses. I suggest that having the ability to try out different therapies in this highly pluralistic medical environment allows the person suffering illness and their family/caregivers to find a therapy that fits their own personalities, desires and dispositions and that is, therefore, more likely to be beneficial.

Further, I found that ayurvedic and religious treatments offer therapeutic measures that are more aesthetically or viscerally pleasant--or sometimes simply less unpleasant--to undergo than the interventions offered by biomedical psychiatry. The more aesthetically pleasant treatment process may enhance the possibilities of improvement or recovery especially for those who found

biomedical treatments more aesthetically abrasive. I am thus combining insights I have offered in other writings in an effort to explain the WHO findings—recalling that India, though not specifically Kerala, was one of the major research sites for the WHO studies (Halliburton 2004, Halliburton 2009) and that Indian sites were found to show better outcomes for serious mental disorders than other low income country locations in a study that shows significant differentiation in outcome among developing countries (Cohen et al. 2008).

The WHO's international studies of serious mental disorder were initiated in the 1960s and 70s and resulted in the publication of the *International Pilot Study of Schizophrenia* (IPSS) in 1973. Although the WHO research is often referred to as studies of "schizophrenia," researchers after this pilot study cast a broader diagnostic net than the strict ICD definitions of schizophrenia. The standard definitions of schizophrenia did not fit the symptomotology that was being found in diverse cultural settings. Rather than leading researchers to question the culture boundedness of this diagnostic category, researchers adjusted the criteria to include a greater variety of schizophreniform disorders and related psychoses (Kleinman 1988, Sartorius et al. 1986). The IPSS and the subsequent Determinants of Outcome of Severe Mental Disorder (DOSMeD) found greater improvement in the developing country sites upon two and five year follow-ups, and this finding was reconfirmed in 13, 17 and 25 year follow-ups of the original study (Sartorius et al., 1996; Hopper and Wanderling, 2000, Harrison et al. 2001).

Despite these results, the WHO's report on global mental health in 2001, the most recent such report, asserts that biomedical psychiatric research and interventions need to be intensified in developing countries in order to improve mental health. We are alerted that "In developing countries, most individuals with severe mental disorders are left to cope as best they can with their private burdens such as depression, dementia, schizophrenia, and substance dependence" (3) while

leaving unmentioned the WHO's own findings of a better outcome for these individuals and much research that reveals the availability of multiple forms of healing for mental suffering in developing countries. "Traditional healers" are only brought up in the context of offering suggestions of how to engage these individuals in helping implement biomedical psychiatric interventions and, very appropriately, to help root out abuse of the mentally ill. But the report does not suggest learning from such healers given that the places where they practice are doing better in treating serious psychopathology.

Researchers have looked for explanations of the developing country advantage in the prognosis of serious mental disorders by examining the practices of families in "traditional rural societies" versus "industrial urban societies" (Leff et al., 1990) and the labor markets in developed and developed locations (see Kleinman, 1988; Hopper, 1991 and Hopper and Wanderling, 2000 for reviews of attempts to explain this difference). Such factors may well be important, but one feature that has been overlooked in the attempts to explain this difference is that the so-called "developing" sites (Agra, India; Chandigarh, India; Madras, India; Cali, Colombia; Ibadan, Nigeria; Taipei, Taiwan and Hong Kong) are more medically pluralistic than the "developed" sites (Aarhus, Denmark; Dublin, Ireland; Honolulu, USA; Rochester, USA; Moscow; Nagasaki; Nottingham, UK and Prague, Czech Republic). That is, in these "developing" sites, multiple medical systems are broadly available and people often "shop around" between various therapeutic options while in the "developed" sites western biomedical care dominates (though not equally so in every case) and there is lesser use of nonbiomedical therapies. I would add that the questionable inclusion of Hong Kong and Taipei as "developing" sites helps make the case that degree of medical pluralism is a more stable basis of categorization for these research centers than the criteria of socioeconomic development.

Based on research I conducted in Kerala, I believe that because people living in a more medically pluralistic environment are more able to shop around and try out different therapies, they are more likely to find a therapy that fits their personality, beliefs and desires (and/or those of their therapy-seeking community) and is therefore more effective.

During fieldwork in Kerala in the late 1990's, my assistants and I were able to conduct follow-up interviews with 24 patients out of 69 originally interviewed early enough to qualify for at least 6 month follow-ups. Each of the three therapies I examined—biomedical psychiatry, ayurvedic psychiatry and religious healing--proved to be roughly equally effective, at least for this small group of patients over this relatively short period of time (Halliburton 2004). What was equally illuminating was the retrospective accounts of specific patients recalling their therapy over longer periods.

While I won't have space to explain the workings of ayurvedic medicine, I should mention that my term "ayurvedic psychiatry" refers to physicians who specialize in the treatment of psychopathology using South Asia's ayurvedic medical system. This treatment involves the administration of medications and talk therapy along with other interventions, some of which I mention later in describing their aesthetically "pleasant" characteristics. Medications and interventions are developed based on ayurvedic theories of physiology and substance.[1]

A 66 year-old Hindu man I'll call Kuttappan was being treated at the Government Ayurveda Mental Hospital (GAMH) in northern Kerala for problems that included talking too much, speaking nonsensically and having angry and violent outbursts when my assistant Benny and I met him. In an interview with Kuttappan and his wife, we learned that Kuttappan had been taken to several allopathic hospitals in the past and had switched to the GAMH partly due to the

recommendation of a friend and partly out of concern about the effect of abrasive allopathic therapies on this aging man:

> Kuttappan's Wife: One of my brothers is in M. [a town in Kerala]. His son also had a problem like this, and now he is in treatment in Trivandrum. They told us that he had gotten some relief from here.
> Benny: So you took him here.
> Kuttappan's Wife: They told us we should take him to K. Hospital [allopathic]. He is old now. If we take him there, they'll give him a shock [ECT] or something. He is 64 years old. Here they give only native medicine, and he will get improvement. They told us there was change with this medicine for their son so we took him here. He has cough and asthma now, but he will get over it. This treatment can do all this.

Kuttappan's wife reveals here that it is not only feelings about effectiveness that motivate a change in therapy. Concerns about the pleasantness or dangerousness of different therapies can also lead to such a move.

While several patients say they experienced greater benefit from ayurvedic treatment than they did from allopathic therapy, others felt they did not improve at all from ayurveda. We spoke with George Joseph, a 43 year-old church pastor who was an inpatient at an allopathic mental hospital because of his emotional problems, anger, family troubles, talking nonsensically and a suicide attempt. He had earlier tried ayurvedic treatment to no avail:

> Biju: Then why did you change from ayurveda to here?
> George Joseph: I changed from ayurvedic treatment. There was a lot to that. But I went to the hospital at Vellore, CMC [an allopathic hospital]. I was taken there and given treatment. They gave me "ECT." I stayed there three days and took "ECT" and all.
> Biju: You were not completely recovered after taking ayurvedic treatment?
> George Joseph: My illness did not change after taking ayurvedic treatment.
> Biju: That's why you...?
> George Joseph: I did "English" [allopathic] treatment. [2]

People who had found relief using religious therapies were usually the most enthusiastic about their healing experience. The brother of Mustapha, a 44 year-old Muslim fisherman who was seeking relief at Beemapalli mosque for violent behavior toward family members and others,

speaking nonsensically and spirit possession, recalled to us the various attempts to find a solution to Mustapha's problems, which had persisted for more than 20 years.

> Brother of Mustapha: When he first got this mental illness, he was taken to O. Hospital [allopathic] and was admitted there for two months. But he did not get any relief. No improvement at all. [...] We did not have faith here [Beemapalli], so we went there. He was admitted there for two months and they gave him "shock" treatment, but he did not get any better. So we took him back here. He was here for 20 to 22 days in treatment.
> [...]
> Brother of Mustapha: No this is the fifth time, the fifth time it has come. The problem has been coming and going for the past eight to ten years. We don't go anywhere else now. We took him everywhere and lost a lot of money and won't get any relief. When we take him here, he gets relief.
> [...]
> Kavitha: When he is sick, how long do you have to stay here?
> Brother of Mustapha: Until he gets relief. Now it won't take more than two months.
> Kavitha: Two months.
> Brother of Mustapha: Yes, two months. If we take him to the hospital, he won't get relief even if he is admitted for five months. Here it won't take more than two months.
> [...]
> Now we have faith in nothing other than this place. Only the mosque.

Mustapha and his family now swear by the treatment at Beemapalli mosque, which involves mostly prayer and ritual performances and a space where the afflicted can act out their behaviors without judgment or scorn. Similar endorsements were heard from patients regarding Chottanikkara Hindu temple and Vettucaud Catholic church.

Some Hindu patients also reported improvements from therapeutic-devotional practices at Beemapalli mosque, but as with ayurveda and allopathy, this therapy did not work for everyone. We interviewed a 31 year-old Muslim woman, Fatima, while she was in outpatient treatment at an allopathic psychiatric facility in Trivandrum recovering from an illness for which she was earlier admitted as an inpatient. Fatima is a housewife whose husband works as an army nurse. She developed a feeling of shock on seeing someone (a common description of the onset of spirit possession) and then developed somatic pains and a sense of disconnection from reality. Before seeking allopathic treatment, she went to Beemapalli mosque, but felt she got no benefit there. She

explicitly told us that she had no belief in faith healing. Later, she sought allopathic treatment which she said improved her condition. Fatima recalled she originally went to Beemapalli not because of her faith but simply because people in her community said she should.

We see in the cases of Mustapha and Fatima that there are different "fits" between individuals and therapies among people of the same religious background. Being Muslim does not necessarily lead a person to prefer a Muslim religious therapy. In fact, it may well be Fatima's husband's work in the army medical service that leads her to have faith in allopathic medical care. This suggests that different therapies can fulfill distinct preferences based on particular life histories, tastes and desires. Other concerns, of course, enter therapeutic preferences, but, overall, people's discussions of their healing choices were less laden with moral implications compared to what Paul Brodwin observed in a medically pluralistic setting in Haiti (1996). I would be interested in hearing from Paul, who is one of our discussants, whether he thinks that in Jeanty, Haiti as well this ability to shop around might help families find a more fitting and thus more effective therapy for psychopathology or whether that different social context might show the limitations of the claims I am making about the power of medical pluralism.

Another factor affecting a patient's fit to a particular medical system is the nature of the patient's visceral, aesthetic experience of undergoing therapy. Put more bluntly, some therapies feel better, or are less unpleasant than others to undergo, which may make some therapies more attractive. It is possible that a positive aesthetic experience in therapy helps people find some "improvement" or "change" to translate terms used in Malayalam (*bhedam, maruka/mattam*) to describe a fortuitous outcome from therapy. Patients I interviewed in Kerala generally found allopathic psychiatry more abrasive, primarily due to the side effects of medications and the use of electroconvulsive therapy (ECT), which is employed with relative frequency and less anesthetic

preparation than when it is used in the U.S. and Europe. Ayurvedic treatment, with its medicated mudpack and oil applications and gentler or, as patients would say, less heating medications, was characterized by the more aesthetically positive label "cooling" (*tannuppu*).

A review of interviews with current and former ayurvedic and allopathic patients for aesthetic evaluations of treatment revealed the following: *95 of the patients my assistants and I interviewed were currently using or had previously tried allopathy. A total of 14 of these informants offered, without our asking, some complaint about the effect of psychiatric medications or ECT during their allopathic treatment.* This group includes 35 patients currently using allopathy (3 complaints), 30 patients of ayurveda who had formerly used allopathy (9 complaints), and 30 patients of religious therapies who had formerly used allopathy (2 complaints). *Forty two patients interviewed were currently using or had previously tried ayurveda, and none of these informants complained of abrasive effects of ayurvedic therapy.* This group includes 32 informants who were currently using ayurveda, 4 who were currently using allopathy and had previously used ayurveda, and 6 who were currently using religious therapies having previously tried ayurveda.

A statement by Ajit, a young man who was seeing an ayurvedic psychiatrist and had formerly been treated by allopathic psychiatrists, embodied the most common adverse reactions to allopathic psychiatric treatments. Ajit's problems started four years before my assistant Biju and I interviewed him. He was aggressive, he hit his father and he was accused of burning down the family business (which he said he did not do). Like all inpatients of ayurvedic psychiatry we interviewed, Ajit was first taken to an allopathic hospital, the medicine of first resort in Kerala[3], but his reactions to the process of allopathic treatment were not positive:

> I came to [name of allopathic hospital], took "injection"s and was given a new medicine. Later I was forced to stop it. The reason was that I had started shivering. [...] In the case of allopathic doctors, after asking two or three questions, they will know which medicine to prescribe. But ayurvedic doctors, they want to take the patient to another level. At that

> level, things are very different. Right now I am taking treatment for mental illness. For this illness, there is a painful method. It is giving electric “shock”s. After going there [allopathy] and coming here [ayurveda], I feel this is better.

One sees in this excerpt frequently-heard complaints about unpleasant effects of medications and electroconvulsive therapy in allopathic psychiatry. Ajit says injections of medications caused him to start shivering, and he describes “electric shocks” as a “painful method” of treatment. This passage also contains a positive evaluation of ayurvedic care. Some patients undergoing treatment that involved what I call a pleasant process also enthusiastically described their treatment, not only as a way of getting rid of a problem but also as a means of transformation. This is one example of how orientations in this medical setting challenge the concept of "cure" inherent in biomedical approaches to treatment, as will be seen later.

Varghese, an 18 year-old Christian, was receiving treatment at an allopathic facility because of eccentric behavior at school as well as anxiety and depression around exam time. During our interview, he recalled the treatment he received at another allopathic facility:

> I was taken to [name of hospital]. There I was given three shocks. I felt numbness in my head when I got the first shock. [...] There I completed six months of treatment, I broke my lips [he later explained that this was due to ECT], was totally tired mentally, and came home. I could not write my examination in maths. [...] I was given an injection. Terrible pain. When I requested to do counseling, I was called in and examined for swelling.

Varghese’s way of avoiding these uncomfortable effects of therapy was to seek treatment at the allopathic facility he was currently utilizing but from a clinical psychologist who relied on fewer medications.

The wife of Hanifa, a 30 year-old Muslim man who was seeking relief for his tension, agitation and sleeplessness at Beemapalli mosque, was concerned about problems her husband experienced when taking allopathic psychiatric medications:

> Kavitha: Are you taking allopathic medicine now?
> Wife of Hanifa: No, no.

> Kavitha: Now he is not taking any medicine.
> Murphy: Now it is finished.
> Wife of Hanifa: Now that he is not taking medicine, there is a lot of improvement. When he was taking medicine, he had memory problems. [...]
> Kavitha: Was it because of memory problems that you stopped, or...?
> Wife of Hanifa: Yeah, because of memory problems and a lot of "tension," too much thinking–he was like this. So we changed. Now there is relief after coming here [Beemapalli mosque]. After he came here, he sleeps without taking medicine.

Recall also the comments of the wife of Kuttappan, whose explanation of why her family selected ayurveda for treating her 64 year-old husband was presented earlier. She explained that fear of ECT motivated her choice of therapy:

> If we take him there [the allopathic hospital], they'll give him a shock or something. He is 64 years old. Here they give only native medicine and will get change [*māṯṯaṃ*]. They [some relatives] told us there was improvement [*bhēdaṃ*] with this medicine for their son so we took him here.

Thus, the "pleasantness" of therapy is a feature that may have its own therapeutic effects while also affecting patients' and caretakers' decisions in shopping around for an appropriate form of treatment. Note that in the quotation just presented Kuttappan's wife uses the term *māṯṯaṃ*, which is best translated as "change," and *bhēdaṃ* which is "improvement," to describe what is sought when one goes for treatment. No Malayalam term for the dispensation of an illness has the same meaning as "cure."[4]

I do not have time to go into detail about this distinction in this short paper, but I believe the more abrasive treatments used in biomedicine stem from a more aggressive pursuit of the ideal goal of *curing*. Curing involves an, often heroic, eradication of a problem, sometimes by violent means both in the sense that violence is enacted upon the pathogen and in the sense that the powerful therapy that enables this healing violence can also adversely affect the body of the patient. The patient tolerates and is even reassured and healed by this violence in many more somatically-grounded illnesses (such as HIV/AIDS and cancer), but in the case of mental illness

(which does have somatic aspects but is more strongly connected to patients' sense of personhood) I propose that efforts to attack a pathogen are more problematic.

Historians of medicine point to the emergence of a distinction between care and cure that developed with the increasing professionalization of biomedicine, competition with other healers and the use of invasive procedures (Kothari and Metha 1988, Jecker and Self 1991). They claim this distanced doctors from developing empathy with patients, allowing "care" to be seen as the less prestigious work of nurses and women. Local ways of talking about healing in Kerala, and to some degree the methods of healing in ayurveda, don't invoke this ideal of curing. Complete remission of symptoms is a possibility and a higher level of enhanced health is an ideal, but more commonly healing is spoken of as seeking change and improvement. It is worth considering whether a renewed emphasis on care—that is, attention to the process of healing and not overly focusing on end results—in biomedical psychiatry may make this treatment more aesthetically agreeable and whether this may, in turn, improve its healing capabilities—or perhaps allow patients, some of whom are distracted by or feel punished by ECT or the use of strong psychoactive medications, to focus on other aspects of treatment such as talk therapy.

In reporting on an analysis of 15 and 25 year follow-ups to the original WHO studies in the *British Journal of Psychiatry*, Harrison and co-authors continue to find that sociocultural context significantly affects the course of schizophrenia while lamenting that "Our data underscore but fail to elucidate the contribution of sociocultural factors to the longer-term course and outcome of psychosis" (515). They then add, "The dual challenge is first to open up the 'black box' of culture subsumed under centre effects [i.e., sociocultural contexts of the research sites] and then to find ways of translating customary practices into interventions by design" (515). In response to this powerful enticement for assistance from people who study culture, I am offering two insights that

biomedical psychiatry and public health researchers can gain from one of the WHO research areas that seems to be doing a better job of treating serious mental illness: 1) the assumption that more biomedical psychiatry is needed in low-income countries should be challenged, 2) since no one therapy is effective for all patients and places with more pluralistic health care systems are doing better in recovery from serious mental illness, pluralistic health systems should be maintained in developing countries and further "developed" in developed countries and 3) psychiatric treatment may be improved by further attending to the degree of aesthetic pleasantness/unpleasantness experienced in undergoing treatment for psychopathology. Other medical anthropologists should also answer this call to "open up the 'black box' of culture"

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Notes

[1] See Pleiderer (1983) and Obeyesekere (1992) for further explanation.

[2] This and all other quotations from patient-informants are translated from Malayalam, although words in quotations marks occurred in English in the original.

[3] The vast majority of informants I interviewed consulted allopathic doctors for their first treatment. This pattern of selecting therapy is not characteristic of other societies where medical choice has been studied (e.g., Janzen 1978; Young 1981). The difference may relate to high literacy, widespread immersion in secular education, and the relatively widespread availability of allopathic health care, which have been projects of the Communist government of Kerala. The highly literate population of Kerala (around 90%) also has opportunities to read about allopathic medicine which receives a lot of coverage in the press. Although some informants first visited astrologers or *mantravādans* (sorcerers), these often simply made some prediction about the cause and chances of curing the problem and referred the client to a "doctor" or the "hospital."

[4] English-Malayalam dictionaries offer a variety of terms for the English "cure." However, these entries are usually long, Sanskritic neologisms, which translate into something like "to cause peace to come to an illness," and I did not observe these terms being used by any informants (Mekkolla Parameswaran Pillai 1995; T. Ramalingam Pillai 1996)