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MENTAL
HEALTH
SERVICES

The Cross-Cultural Context

7

TRADITIONAL ASIAN MEDICINE
Applications to Psychiatric Services
in Developing Nations

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WESTERN RATIONALISM AND MENTAL HEALTH

The concept of "mental health" is not unique to the Western world. It has long been a part of the cultural traditions of many Asian cultures under the rubric of religious and healing systems that emphasize harmonious relations among body, mind, and spirit. However, it has been mainly within the Western cultural traditions that these three levels of functioning have been separated and individually institutionalized via distinct professional roles, knowledge systems, and physical facilities (see Figure 7.1). To a large extent, this separation has been part of the legacy of Western scientific and technological ideologies that began in the eighteenth century to secularize a heretofore religiously inspired discourse about madness (see Foucault, 1971).

We, the inheritors of Western scientific rationalism, are today faced with a rather interesting dilemma. Clearly, the concept of "mental health" has become a valued goal. We frequently find ourselves speaking of "healthy values," "healthy relationships," and "healthy behavior." Yet, we seem to be somewhat confused about what these things actually mean. There seems to be an awareness that somehow mental health involves harmonious relationships among all levels of our functioning, and certainly between the individual and the world about him or her. Yet we seem unable to attain this harmony. To a certain extent, this appears to be due to the tremendous discontinuities fostered by our continually changing technological developments, which outpace our capacity to establish meaningful linkages

Institutional Representations

		Roles	Facilities	Knowledge
Levels of Human Functioning	Body	Physicians Physical and Biological Scientists Nurses	Hospitals Clinics Laboratories	Medicine Physiology Anatomy Chemistry
	Mind	Mental Health Professionals	Hospitals Clinics Rest Homes Laboratories	Psychology Theology Psychiatry
	Spirit	Priests Ministers Psychics	Churches Temples Shrines	Philosophy Theology Mysticism

Figure 7.1   Institutionalizing the Separation of Body, Mind and Spirit: The Legacy of Western Science and Philosophy

between our world and our experience. We are, in the industrialized West, forced to deal with life in small pieces without access to the beliefs and philosophies that permit some semblance of a holistic perspective to emerge and thrive.

This dilemma is particularly cogent to those of us whose notions of personhood derive from the "disenchanted" or empiricist world view associated with the Protestant Reformation in Europe (Gaines, 1982). The second great tradition in the West, that of Mediterranean Europe and Catholicism, in contrast, permits the intersection of spiritual and mundane realms. Gaines (1982, p. 180) found that the latter Western tradition embraced the "belief in a magical, enchanted world wherein threads of this world and those of the world beyond are woven together in a single fabric of perception and experience as in the medieval (e.g., Latin) world view."

But, in spite of the many limitations and inadequacies that characterize Western empiricist approaches to mental health, we have not been hesitant to import it to non-Western cultural milieus. Every day, Western mental health concepts, methods, facility designs, and professional training techniques are being fostered, encouraged, and promoted as the answer to the non-Western world's mental health

problems, regardless of the many pernicious effects[1] (see Higginbotham, in press).

The purpose of this chapter is to discuss the possibility of applying traditional Asian healing systems to the mental health problems of developing Asian nations. Our major argument is that psychiatric services in developing Asian nations could greatly benefit from the integration of traditional Asian healing systems with the existing Western systems that have been established in recent years. Further, we argue that this integration can and should occur at all levels, including basic philosophy, problem conceptualization, treatment, prevention, and facility design. The chapter is divided into three sections: The first concerns problems in establishing Western mental health services in Asian nations; the second addresses applications of traditional Asian healing systems; and the third discusses the implementation of traditional Asian healing systems.

PROBLEMS IN ESTABLISHING MENTAL HEALTH SERVICES IN ASIA

Administrative Problems

A number of people have written about the many administrative problems in establishing mental health care in Asian nations (for example, see Carstairs, 1973; Giel & Harding, 1976; Higginbotham, in press; Neki, 1973a, 1973b; Sartorius, 1977; World Health Organization, 1975a, 1975b). These sources have pointed out that there are many problems confronting the development of modernized psychiatric services in developing countries, including the following: (1) low national priorities for health and particularly for mental health; (2) limited institutional and organizational support networks; and (3) trained human resource shortages and difficulties. Let us examine these problems more closely.

Clearly, in nations with low capital resources, the priorities for health are often placed behind those for defense and agricultural and industrial development (see Harding, 1975; Neki, 1973a, 1973b; World Health Organization, 1978). Further, when health is able to receive a portion of a nation's resources, those resources usually must be directed toward infectious diseases, nutritional programs, sanitation, and other more publicly focused problems. Mental health

funds are almost always limited to maintenance of custodial-care institutions (Higginbotham, in press).

Health planning bodies are often more responsive to political pressures than to health needs. This means that mental health planning and legislation are often ignored or relegated to low-priority positions within the total political process. Further, within this context, Higginbotham (in press) has pointed out that psychiatric health care services become eliminated from the entire network of governmental and social processes that are needed to initiate and sustain a mental health care system. For example, Higginbotham has noted that weak national health leadership hinders (1) the creation of legislation for strengthening and regulating psychiatric services; (2) the recruitment and effective use of qualified health human resources; (3) the coordination of educational efforts with community and governmental health needs; (4) the establishment of national and regional health service systems; (5) the development of health insurance plans incorporating mental health care; (6) the absence of need assessment and program evaluation mechanisms; and (7) the biased distribution of the minimal mental health resources that are available in favor of urban-educated elite. Kiernan (1976) points out that the majority of mental health services in developing countries are directed toward the urban residents, who constitute only a small portion of the populations of those countries.

Another problem in the development of mental health services is the lack of human resources (Higginbotham, in press; Sartorius, 1977; World Health Organization, 1975a, 1975b). Few individuals enter the mental health professions largely because mental health training programs for psychiatry, social work, psychology, and psychiatric nursing are neither prestigious nor well developed. Further, there is a growing awareness among interested individuals that working conditions are poor and that status and pay are low. Carstairs (1975) points out that there is also a tendency for other medical specialties to look down on the psychiatric professions. The shortage of human resources is also compounded by the fact that individuals interested in pursuing mental health careers often travel abroad for their education and then return with technical competencies that are not applicable to the local situations (that is, if they choose to return at all).

In addition to the many public administrative problems that curtail the establishment of mental health services in developing Asian

nations, there are also a number of problems related to the cultural relevance of the services that are provided.

Cultural-Relevance Problems

For those mental health professionals who are dedicated to the development of "modernized"[2] psychiatric services, there is yet another set of problems that they must encounter, stemming from the cultural relevance of the services they seek to provide. Though one cannot question the commitment and sense of mission that characterize these leaders, there is a substantive basis for questioning the particular choice of service delivery models they seek to implement, specifically psychiatric models embodying assumptions, concepts, and methods that have little meaning for cultures with profoundly different traditions.

In the last half century, as part of the continuing effect of the colonial and neocolonial heritage, it has become the accepted practice for mental health professionals in developing countries to model their services after those in the West. In the immediacy of their desire to adapt Western technology, they have come to ignore the fact that large buildings, sizable staffs, and extensive treatment alternatives do not make a meaningful or effective mental health service system. What many of these pioneers have forgotten is that for a healing system to be effective, it must be acceptable; and acceptability is a function of the attributes that users assign to the system. What has been ignored is the rather simple fact that the introduction of a mental health delivery system based on alien cultural premises and traditions represents a major social change process that is subject to the same resistances that are true of other social changes. It is obvious to every religious missionary that religious conversion takes a great deal of time and requires a systematic penetration of the culture of the future converts. Further, it is clear that the final form the religion will assume in the activities of the convert is often a synthesis of new and old, rather than an unconditional acceptance of the new. This is because many aspects of the cultural milieu in which the convert lives have no continuity with the new religion. This rather simple example of the acceptability of a social change highlights the problems faced by the introduction of a Westernized psychiatric

service to non-Western people. Let us examine these problems more closely.

Physical Locations

The actual physical locations of the mental health services for either acute or chronic care are most often centered in urban settings that are inaccessible to the majority of a country's population, especially the rural poor. Thus, even though people may be aware of institutional care, they are unlikely to use it because of the travel cost and time required to reach urban destinations.

Lack of Support Networks

Because the mental health service network is poorly developed and frequently not integrated with primary care or primary prevention services, those problems for which patients desire professional consultation may become quite chronic and debilitating. This makes treatment difficult and increases the chance of failure.

Diagnostic Bias

When patients do come for care, their problems are often classified in Western diagnostic terms. Most often, biomedical nosologies have little relevance for the patient and his or her immediate kin group, who typically assume responsibility for managing illness episodes (Kleinman, 1980). Further, the conceptualization of the problem in terms of Western biologic and psychologic assumptions of causality is largely discordant with popularly held folk theories based upon such notions as supernatural intervention, fate, and cosmological harmony (see Marsella & White, 1982).

Communication Problems

The mental health professionals involved with the patient may be either Western or ruling-class nationals who have been trained in the West, and thus are unable to communicate effectively with the patient on either a verbal or a nonverbal level. In addition, in some Asian countries, there is distinct social stratification according to economic

position, geography, and subcultural membership. These groups are often in conflict with one another, yet it is possible that the mental health system may force one group to be treated by another. In other words, there is often a failure to have cultural, social class, and regional group representation in the administration of a mental health system.

Treatment Bias

Treatment in many mental health centers has become almost exclusively based on medications. These medications may be useful in either lowering or raising a level of arousal, but they fail to address the full spectrum of causes that may be implicated in the etiology, maintenance, and enhancement of the problem. In addition, the reliance solely on medication ignores the healing potential that is present in a closer, more ritualized healer-patient relationship in which there is extensive involvement with the patient, the patient's family, and the patient's environment. Even such potentially powerful sources of placebo effects as touching, holding, chanting, and specific behavioral commands are ignored. As Kleinman and Sung (1976, pp. 55-56) have pointed out, under the above circumstances disease may be dealt with, but healing does not necessarily occur:

> Healing is not so much a result of the healer's efforts [as it is] a condition of experiencing illness and care within the cultural context of the health care system. Healing is a necessary activity that occurs to the patient, and his family and social nexus, regardless of whether the patient's disorder is affected or not. The health care system provides psychosocial and cultural treatment . . . for the illness by naming and ordering the experience of illness, providing meaning for that experience, and treating the personal, family, and social problems which comprise the illness, and thus it heals, even if it is unable to effectively treat the disease.

Treatment Errors

Mental health professionals working in Asia will make mistakes in diagnosis if they lack familiarity with the cultural setting in which the patient's problems develop and remain ignorant of the discourse strategies underpinning effective communication in the indigenous

language environment (Gumprez, 1982). This can result in faulty, ineffectual, or even harmful treatment. For example, the first author's extensive research program on ethnocentric aspects of depressive experience and disorder (see Marsella, 1980) has revealed numerous ethnocultural variations in the manifestation (Marsella, Kinzie, & Gordon, 1973), experience (Tanaka-Matsumi & Marsella, 1976), measurement (Marsella, Sanborn, Kameoka, Brennan, & Shizuru, 1975), and personality correlates (Yanagida & Marsella, 1978) of depression.

Although there may be cultural invariances in certain patterns of disorder, there is a growing body of research that is pointing out the critical role of cultural factors across all clinical parameters, including etiology, expression, disability, course, and outcome (for example, see Draguns, 1980; Marsella, 1979, 1980; Fabrega, 1972; Waxler, 1974; Sartorius, Jablensky, & Shapiro, 1978). Indeed, it is our opinion that all mental disorders are "culture-specific" disorders and that this term should not be reserved for the so-called exotic syndromes, such as *latah, koro, imu, susto, mali-mali,* and so forth (see Marsella & White, 1982).

Iatrogenic Problems

Mental health professionals frequently produce many iatrogenic effects in the course of their treatments. These iatrogenic problems are related to both the medications and the difficulties created by giving advice or counseling that is at variance with the patient's cultural milieu (Higginbotham, 1979a). Without being aware of it, deviance may be fostered or stress added to the patient's life by encouraging behavior patterns that are at odds with the social nexus in which the patient resides. There is also an increased chance of iatrogenic problems developing because of the absence of extensive follow-up care networks in which the patient's progress and response to medication can be monitored effectively.

Stigma

Psychiatric care is highly stigmatized. To admit that a problem of madness exists evokes the possibility of witchcraft, evil, family curses, sorcery, and other supernatural explanations (see Asuni, 1975; Connor, 1982; Higginbotham, in press; Lieban, 1967). This

problem is faced in dealing with indigenous healers as well; however, the risks of institutionalization and the permanent loss of a family member are minimized. In our experience in Sarawak, the Philippines, and Thailand, once patients came to the hospital, they were at risk of being abandoned by their families and never returning home. This obviously makes for a great deal of resistance to seeking psychiatric care from Western-trained mental health professionals.

These eight problems regarding the cultural relevancy of developing Westernized psychiatric systems to serve non-Western populations are only a few of the many problems that must be dealt with by mental health professionals. Good psychiatric care requires extensive sensitivity to the cultural traditions of the people who are served.

Clearly, it would be unfair and inaccurate to state that indigenous healers do not have problems treating patients. They also have their share of failures and for many of the same reasons. But the notion that indigenous healers are "quacks" and "frauds" and that only Western ("modern") approaches to mental health care are valid is the greater inaccuracy. The argument that Western approaches are scientifically based while indigenous or traditional approaches are based on magic and superstition is invalid because it mistakes technology for science and because it assumes that only "rational" thinking guides Western assumptions and techniques. Further, it ignores centuries of effective healing knowledge.

In brief, the major point of this section has been to discuss both the administrative and the cultural-relevance problems that confront efforts to establish a Western-based psychiatric service in developing Asian nations. As should be clear, the problems are numerous and the solutions may reside in our ability to bring about a synthesis between Asian and Western philosophies and treatment approaches within the context of the same mental health system. This alternative offers a number of valuable options for strengthening and expanding existing services and for increasing the "acceptability" of the current psychiatric services.

SOME APPLICATIONS OF TRADITIONAL ASIAN HEALING SYSTEMS

The scope of traditional Asian healing systems is quite broad and encompasses everything from naturalistic to supernaturalistic

assumptions and therapeutic methods. A review of these systems is beyond the scope of this chapter and the interested reader is encouraged to pursue the topic in greater depth through publications in medical anthropology, Asian philosophy, and ethnomedicine (for example, see Fabrega, 1971, 1972; Kao & Kao, 1979; Kleinman, Kunstader, Alexander, & Gale, 1975; Lieban, 1973; Lock, 1980; Mulholland, 1979; Nakamura, 1964; Reid, 1979). However, it is important for us to acknowledge that traditional Asian healing systems are very sophisticated with regard to their assumptions about the nature of health and disorder and the treatments necessary for cure and prevention.

It is unfortunate that Western biomedical systems, especially those related to mental health, have tended to ignore traditional Asian healing approaches or to limit their interest to purely academic levels of inquiry and debate. Fortunately, the dissatisfaction with Western medicine in both the East and the West and the growing consumer demand for a more meaningful medical care system may force Western medical professionals to implement alternative healing philosophies and methods. Today, consumers of medical services are calling for greater accountability from professionals. They are seeking more than technical care and expertise—they are asking for a quality of care that encompasses all levels of functioning: holistic care (see La Patra, 1978). Many traditional Asian healing systems have long been based on philosophies and methods that emphasize "holistic" care.

Philosophical Applications

Contemporary Western medical systems are evidencing a growing disenchantment with the older "germ" and "mechanistic" models of health and disease. An outcome of this disenchantment has been the emergence of a number of alternative medical systems, including stress theory, general systems theory, holistic medicine, behavioral medicine, and various public health approaches. Further, another sign of this discontent is the growing attraction of various "Eastern" approaches to health care, including acupuncture, massage therapies, meditation, holistic diet/exercise activities, and herbal medicines. Thus it may be an opportune time for Western medical systems to shed their unwarranted sense of superiority and apply some traditional Asian philosophies that are very congruent with the new Western approaches.

For example, many traditional Asian healing systems are based on the ancient Chinese world view of "man as a microcosm," a reflection of the entire cosmic process and structure (Lock, 1980). Needham (1962, p. 281) writes:

> Things behaved in particular ways not necessarily because of prior actions or impulsations or other things, but because their position in the ever-moving cyclical universe was such that they were endowed intrinsic natures which made that behavior inevitable for them. If they did not behave in those particular ways they would lose their relational position in the whole (which made them what they were), and turn into something other than themselves. They were thus parts in existential dependence upon the whole world organism. And they reacted upon one another.

These thoughts are part of ancient Chinese philosophy, but they sound amazingly similar to contemporary Western notions in field theory physics, theoretical biology, and organismic psychology.

Within the context of such a philosophy, disorder, whether physical or mental, is viewed as a dysfunction in relationship. As Lock (1976, pp. 15-17) observes:

> Sickness . . . is not seen so much in terms of an intruding agent, although this aspect of disease causation is acknowledged, but rather due to a pattern of causes leading to disharmony. These causes can be environmental, social, psychological, or physiological level. . . . The function of diagnosis is not to categorize a patient as having a specific disease, but to record the total body state and its relationship to the macrocosm of both society and nature as fully as possible. . . . the model allows explanations for the benefit of the patient to be in broad psycho/social and environmental terms which are readily understandable and cognitively acceptable. These explanations can be used by the patient to account for the occurrence of suffering in the context of his or her own life history at that moment. . . . Therapy is designed to act on the whole body—removal of the main symptoms is not considered adequate as all parts of the body are thought to be interdependent—in this sense the model is holistic. . . . It is believed that the functioning of man's mind and body is inseparable.

A similar philosophy is found in the ancient Indian traditions. Kitaeff (1976, pp. 2-8), in a paper on the healing traditions of India, Nepal, and Tibet, noted the individual, social, and spiritual focus of the Indian tradition:

This total cultural continuity of individual, community, and god, and of sickness, health, and ultimate liberation involves the whole spectrum of the healing process—the purification of body, speech, and mind. Precise correspondence exists among all these elements, so that the elementary substances in the body are considered a microcosm of divine forces in the universe and the yogic or tantric ceremonies of healing may simultaneously act upon the physical and subtle bodies to achieve spiritual wholeness as well as physical and mental well-being. . . . Like Greek and Egyptian medicine, Indian and Tibetan medicine had a divine origin: as part of the universal creation of Brahma, the science of Ayurveda was handed down through the god Indra for the relief of suffering mankind. Since then, religious elements have been inseparable from all aspects of study and practice. . . . Not only the study of a new medical test, but also the giving and taking of medicine are accompanied by prayers. . . . Methods of treatment are different for the systems of Ayurvedic, yogic, and ceremonial or tantric medicine, but all share the common object of achieving universal wholeness and harmony through natural principles.

It is readily apparent that whether one is speaking of ancient Chinese or ancient Indian healing traditions, the emphasis is on the treatment of the whole person—holistic care. This approach may well be the most valuable for defining true mental health, a point that more and more Western approaches are beginning to recognize. The holistic nature of the Asian healing philosophies may be the most meaningful direction for the Western approaches to follow.

Many Western psychiatric approaches seem either unwilling or unable to offer the patient the hope of a new lifestyle or a new behavior pattern. They are content with symptom control at the expense of stupor and side effects. They are oriented toward the molecular at the expense of the molar, toward the part at the expense of the whole, toward the "disease" at the expense of the "illness."

Kleinman and Sung (1976, p. 4) state:

> Let us call *disease* any primary malfunctioning in biological and psychological processes. And, let us call *illness* the secondary psychosocial and cultural responses to disease, e.g., how the patient, his family, and social network react to his disease. Ideally, clinical care should treat both disease and illness. Up until several decades ago, when their ability to control sickness began to increase dramatically, physicians were interested in treating both disease and illness. At present, however, modern professional health care tends to treat

disease but not illness; whereas, in general, indigenous systems of healing tend to treat illness, but not disease.

Thus what we are advocating is that Western psychiatric healing systems begin actively to integrate Asian healing philosophies into their approaches. This practice would have beneficial effects for everyone and especially for Asian patients, because the healing services would be more continuous with their cultural traditions.

Now let us turn to possible Asian healing methods that might be effectively implemented by Western psychiatric healing systems.

Healing Method Applications

The spectrum of methods used in traditional Asian healing procedures is far beyond the scope of the present chapter. Thus we will only offer general comments. As is true of Western medicine, Asian healing systems make use of drugs from natural sources, diet, exercises, various forms of meditation and body control, counseling and advice, massages, and spiritual practices. There are numerous sources that provide overviews of these methods (see Jaggi, 1973; Jocano, 1973; Kiev, 1964; La Patra, 1978; Lebra, 1976; Leslie, 1976; Lieban, 1973; Marsella & White, 1982; Rechung, 1973; Reynolds, 1976; Wallnofer & von Rottauscher, 1974).

The study of ethnobotany has revealed that many traditional cultures have made sophisticated use of various plants and herbs for healing. A well-known example of this is the famed "snakesroot" of ancient India, which contains rauwolfia alkaloids that have powerful tranquilizing effects. This is only one example of hundreds of substances that have been used with success in traditional Asian healing. Kitaeff (1976, pp. 8-9) states that Indian physicians use a number of substances:

> Traditional Indian physicians have used medicines derived from vegetables, animals, and earth. Almost every part of plants can be used as drugs, but the time and method of collecting the plant products for medicinal purposes is an art that requires training and experience to know the proper seasons, places, and signs of full growth. . . . Medicines can be administered in many different forms—as decoctions, powders, pills, syrups, medicinal wine, oily or ash-like medicine. They act on the

body through the influence of their *rasa* (taste), *vipaka* (post-digestive content), *virya* (potency), and *prabhava* (special action).

There is certainly every reason to believe that traditional medicines may have a meaningful role in dealing with various psychiatric problems, especially when considered against the numerous side effects and iatrogenic effects that are part of the use of Western medicines.

In addition to plant and herbal medicines, the use of diet therapies is something that could be assiduously applied by traditional healers working in Western psychiatric settings. The use of various physical therapies, such as massages, saunas, Tai Chi Chuan, Aikido, yoga, polarity therapy, and acupuncture, is also something that should be explored. At the present time, Western psychiatric approaches are devoid of touch, manipulation, and patient activity. For the most part, drugs are prescribed and the patient is simply left alone to let the drugs do their work. It is exciting to envision a psychiatric setting where many of the previously cited Asian healing methods would be available for the patient.

Although counseling and psychotherapy assume many different forms in both the East and the West, it is clear that more could be done with various forms of hypnosis, meditation, palmistry, astrology, and general advice and counseling. Japanese culture has two culturally derived systems of psychotherapy (Morita therapy and Naikan therapy) that might be valuably adapted for other Asian cultural settings.

Closely allied to the various psychotherapy approaches are the numerous traditional Asian healers who emphasize spiritual approaches, including mediums, shamans, mystics, and masseurs. One wonders what improvements might occur in Western psychiatric settings if such practitioners were to establish true healing centers, offering their patients a spectrum of healing methods in which the patient could find knowledge, health, and enlightenment. How sterile our current hospitals and clinics are by comparison. We offer many drugs, a few words, and an occasional pat on the back. Can we really expect mental health to develop in such a situation? There is no vitality, no energy, no hope! Is it any wonder that non-Western patients tend to avoid these places except as a last resort? And often, when patients do come, they fail to return. There is no meaning in the treatment they receive and, without meaning, the source of healing is often lost.

Thus what we are advocating is a healing community, where the emphasis is on providing the patient accessibility to a spectrum of healing method directed not toward control, or even toward mental health—the harmonious relationship of body, mind, and spirit. Such centers could be termed "holistic healing centers" or "omnibus healing centers" rather than "hospitals" or "clinics." They could be centers for prevention as well as acute care; centers for learning, not solely for treatment. The only places we know of that even come close to such facilities are the "Esalen"-type programs, Hindu-inspired ashrams or residential-spiritual centers now present in several Western cities, and Lambo's treatment center in Nigeria, in which traditional healers and psychiatric professionals work in a residential treatment center surrounded by a patient community (Lambo, 1966). As is well known, Lambo's center provides for care of the patient by relatives living in a village close to the hospital. Treatment includes traditional methods such as confession, dances, rituals, and herbs; the indigenous healer is an active part of the treatment strategy. All of this has produced less stigma for the patient and more effective care.

Although the specific procedures that would be necessary for effective patient care in such a setting are more complex, they are not beyond possibility. It is true that there would be risks of conflicts between competing systems and personnel, but these could be worked out, especially in an atmosphere of mutual respect. We predict that many of the administrative problems that would inevitably arise would come from the chauvinistic attitudes of the Western-trained personnel rather than from the traditional healers. But it would be possible to alter these attitudes through effective training and administrative procedures. Some of the steps in establishing such a system are described in the next section.

TOWARD A SYNTHESIS OF TRADITIONAL ASIAN MEDICINE AND CONTEMPORARY WESTERN PSYCHIATRIC CARE SYSTEMS

Recently the senior author codirected a government-funded training program to develop effective cross-cultural counselors and

psychotherapists (see Marsella & Pedersen, 1981). What became quite clear in the course of this program was that teaching therapists to work with patients from different cultural traditions is a Brobdingnagian task that goes far beyond the mere exchange of academic knowledge about cultural differences. There is a need for information about specific cultural practices and forms, but there is also a more important need to sensitize trainees to both their own cultural assumptions and the cultural phenomenology of the patients with whom they will be dealing. We would suggest the following steps toward a synthesis of the different healing traditions.

Cultural Awareness

Perhaps the most important step in the successful synthesis of the diverse healing traditions is an awareness of the role of culture in human behavior. Though everyone acknowledges cultural differences, a true awareness and grasp of the enormous role that culture plays in our lives eludes most people's understanding. This is especially true of health care professionals, who are socialized to look on all patients as the same because of obvious physical similarities or diagnostic grouping. But few people are actually sensitive to the fact that culture guides and channels our basic epsitemology, our sense of time, space, and causality. Indeed, all of our notions about health and disorder are culturally and linguistically determined (see Good & Good, 1982). Yet we continue to train therapists who are oblivious to the phenomenological perspectives of the patients they treat and to their own cultural biases. Professionalism diminishes the therapist's capacity to respond emphatically to culturally divergent clients and replaces experiential awareness with stereotypic judgments. Therefore, we suggest that the first step be extensive training in culture awareness. We should train healers, Eastern and Western, to be aware of culture—their own as well as that of others. As part of this training, it would be very useful to encourage an awareness of the different healing systems as cultures in and of themselves. This might reduce chauvinism.

In addition to teaching about the culture of medicine, efforts should also be made to teach healers about the culture of *being* a patient. They should learn about "sick roles," "healing roles," and "medical

sociology." This learning should occur at an *experiential* level through the many culture-learning exercises that have been developed. Following training in culture awareness, training can then be focused on an awareness of the ethnocultural traditions of the patients the healers will treat.

Awareness of Patient's Cultural Traditions

Culture influences all aspects of functioning, from the physiological to the spiritual. This influence is extended not solely through basic values and beliefs, but also through the food people eat and the environments in which they live. If we are truly to understand behavior, whether it be adaptive or dysfunctional, we must understand its cultural foundations. Thus a second step in the synthesis is to teach an awareness of the patient's culture.

Our personal experience in "culture learning" has led us to believe that a number of instructional methods must be used in teaching about a cultural tradition. These methods involve experiential, didactic, and analogue approaches. There are facts to be learned, but there are also feelings to be experienced. Brislin (1979) provides a good overview of these alternative culture orientation approaches.

Assessment of the Cultural Accommodation of the Service Delivery System

A third step toward successful synthesis of the different healing traditions is an assessment of the Western psychiatric system's willingness to adjust to and be sensitive to the patient's cultural traditions. Perhaps the most extensive work in this area has been conducted by Higginbotham (1979b, in press). He investigated the mental health delivery system of seven Asian countries with regard to their "accommodation" to patient cultural traditions via an elaborate scale. This scale permitted him to assess the different points of bias, including conceptions of disorder, treatment preferences, staff attitudes toward patients, and so forth. Higginbotham's Ethnotherapy and Culture Accommodation Methodology is useful in appraising a system's cultural biases.

NOTES

1. Western approaches to mental health care should not be considered totally useless and destructive. The major problem appears to be the fact that our philosophies and methods have become disengaged from a meaningful perspective. We speak of mental health, but give people pills. When we provide psychological therapies, we do so in isolation from the everyday life of the person, ignoring the many social and community influences that help maintain behavior. We have confused cure with control and, in the process, our patients continue to feel isolated and estranged from their own experience.

2. It is unfortunate that many people have confused modernization with Westernization. The two are very different. It is clear that our contemporary world, our "modern" world, have not necessarily progressed through adoption of Western cultural traditions. Progress may well require that the Western world reconsider many aspects of its functioning, especially with regard to humanistic concerns. Western cultural traditions and economic practices are rapidly producing a broad array of social problems that may now be beyond solution. A more thorough discussion of this point is available in Marsella (1978a).

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