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UNDERSTANDING AND TREATMENT OF DEPRESSION WITH BIOMEDICINE AND AYURVEDIC MEDICINE: PATIENT EXPERIENCES IN SLOVENIA

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ABSTRACT

Research problem of the study is "major depression", which falls in a psychiatric categorization of mental disorders in the spectrum of mood disorders, and its incidence is greatly on the rise. First focus was a (de)construction of scientific knowledge of depression in terms of Ayurveda medicine and biomedicine, psychiatry. The second focus was the advantages / disadvantages of compared practices as experienced by patients diagnosed with major depression in Slovenia. The purpose of research was to examine the differences and similarities between the two approaches of treatment arising from different concepts of understanding depression - its causes, its course and therapeutic interventions. This paper presents the results of participant observation and interviews with 10 psychiatrists, 11 Ayurvedic practitioners, 10 psychiatric patients and 10 Ayurvedic users. The analysis revealed eight meta-themes.

Keywords: *major depression*, psychiatry, Ayurvedic medicine

INTRODUCTION

The article explores conceptualization of depression in Ayurveda medicine and biomedicine /psychiatry, and from the perspectives of their practitioners and patients diagnosed with major depression in Slovenia.

According to the American classification of mental disorders (DSM-IV), major depressive episodes occur when symptoms persist for at least 14 days, with an individual experiencing sadness all or at least most of the day.[1] In addition, the person must have at least five or more of the following symptoms: appetite disturbance, sleep disturbance, reduced physical activity or restlessness, fatigue or lack of energy, feelings of guilt and worthlessness, difficulty concentrating, and/or suicidal thoughts.

Although depression is the most biologized and medicalized mental disorder in the West,[2,3,4] today depression is understood and treated within the biopsychosocial model.[5,6] The socio-cultural factors became very important in the formation and devel-

opment of depression, so that current psychiatric studies are increasingly locating the causes of depression beside biological perspective also within the psychological and social perspectives.[7] In any health intervention all three levels should be taken into account, as any disease, condition or patient cannot be reduced to a single aspect.

Similarly, Ayurveda emphasize connectedness and holism in conceptualizing depression, meaning everything people think, experience and feel have effects on the mind and the body. According to Lang and Jansen[8] drawing on ethnographic fieldwork, Ayurvedic conceptualization of depression is relatively compatible with the biomedical concept of depression.

Ayurveda has developed comprehensive theory and well-structured mechanisms against psychological distress. The notion of *unmada* (insanity) is a general term for all mental disorders where doshas (three bioenergetic principles that govern psychosomatic functioning *Vatta, Pitta, Kapha*) and gunas (three energies of the brain *Sattva, Rajas, Tamas*) are out of balance and an individual loses the power to control his actions and perform social norms. *Charaka Samhita*, the oldest and the fundamental work of Indian medicine, provides a clear definition of *unmada,* describes the etiologic factors and the pathologic process, and defines clear diagnostic procedures that are oriented toward the individual and not to the disease.[9] Ayurveda configures illness as a disruption in delicate somatic, climatic, and social systems of balance[10,11,12,13] and offers a range of treatment models (Divine Therapy, Biological Therapy, Psychotherapy, and Yoga)..

Firstly, Charaka states that mental distress occurs when a person does not get what is wanted (frustration) and gets what is not wanted. Even getting what is wanted should be known as a cause (of mental illness). Secondly, Charaka states that emergence of mental diseases is linked to the *gunas* – the attainment of what is unwanted through an increase of *rajas* and the attainment of what is unwanted through an increase of *tamas*. Both experiences aggravate people's ability to think clearly and produce "a violation of knowledge". Thirdly, Charaka states that mental diseases are a matter of self-knowledge. Extreme feelings, such as grief, envy, and lust, as well as euphoria and jubilation, have the power to disconnect people's perceptions of themselves from reality.[14]

The effects of Ayurvedic practice as treatment of mental disorders are still relatively poorly examined, as well as the transfer of Ayurvedic medicine into a different cultural environment. Studies on the treatment of mental disorders with Ayurvedic medicine from the perspective of a European patient experience are few and there is a major gap in this research field.

Objectives

1. A comparison of participant's understandings of depression from the psychiatric and the Ayurvedic aspects using narrative approach.
2. An identification of key factors that prompt patients to undergo Ayurvedic or psychiatric practice.
3. An analysis and a comparison of the course and the outcome of the treatment using both approaches.
4. An examination of Ayurveda practice transferred to a different cultural environment, i.e. in Slovenia, in comparison with the environment from which it comes, i.e. in India.

Methods

For verification of research questions, the qualitative anthropological research techniques were used:

Participant observation in two settings, which provided data for the comparison between Ayurvedic practices in Slovenia and India. The fieldwork in Slovenia was conducted at one Ayurvedic practice between December 2010 and May 2011; the fieldwork in India at two institutions in the state of Kerala, i.e. at an Ayurvedic psychiatric hospital in

Kottakkal, and at the Cherian Ashram in Kottayam, between December 2011 and January 2012.

Autobiography or reflexivity describes my motivation to undertake this study and presents my personal contribution to the research.

Auto-ethnography uses tenets of autobiography and ethnography for doing and writing. By this the consistency between patients' narratives and observed were identified.

Semi-structured interviews with psychiatrists and Ayurvedic therapists in Slovenia and India;

Narrative interviews or illness biography with people who had needed help in both the psychiatric and the Ayurvedic practices.

A comprehensive data material from different participants' perspectives was used:

1. Psychiatric patient - 8 women and 2 men, from 26 to 64 years of age.
2. Ayurvedic patients - 6 women and 4 men, from 29 to 64 years of age.
3. Psychiatrists - 4 women and 6 men, from 38 to 66 years of age.
4. Ayurvedic doctors and therapists in Slovenia - 1 woman and 4 men, from 34 to 55 years of age.
5. Ayurvedic doctors and therapists in India - 3 women and 4 men, from 25 to 61 years of age.

The entry criterion for all patients' interviewees was biomedical diagnosis of major depression. The Beck questionnaire was used as a tool for the identification of depression symptoms which formed inclusion criteria for the selection of informants; the desire was to include persons with depression in remission and possibly exhibiting mild symptoms during the interviews.

Analysis and key results

Thematic analysis approach was conducted as the main method of analysis of the interviews, field notes and written texts. With this approach semantically similar parts were coded and organized into similar themes where eight meta-themes were identified.

Ayurvedic conceptualization of depression corresponds to biomedical concepts, but Ayurveda goes wider.

Both medical systems understand the etiology of depression within the bio-psychosocial model. A man is determined by biology in terms of genetics or karma and by biological constitution or *doshic* constitution. Besides that biomedical understanding of depression as a neurochemical imbalance corresponds to Ayurvedic concepts of *doshic* imbalance. Within Ayurveda, depression is also a disorder of the brain, but unlike in biomedicine, it is always associated with at least one fluid or *dosha*, i.e. *kapha*, *vata* and *pitta*.

Ayurveda emphasizes that everything we think, experience and feel affects the chemistry of our cells and vice versa. Within this tradition, fluid imbalance in the brain is therefore the result of biological, psychological, social, cultural and spiritual influence.

However, the Ayurvedic understanding of depression is wider because of the inclusion of spiritual aspect. Depression occurs because the energy of an individual soul is not streaming through the channels of the body - such as the brain chamber, nerves, blood stream, lymph etc. Due to the blocked channels, *doshas* and *gunas* cannot flow. This illustration also presents the psychopathological mechanism of depression, which is still unclear in biomedicine/psychiatry.

Bio-psychosocial model is insufficient - depression is a multi-faced disease.

Psychiatrists are well aware that bio-psychosocial model is insufficient. The same as Ayurvedic practitioners, they frequently discuss broader socio-cultural causes of depression - the growing loneliness, work environment, uncertainty, technological development, political and economic conditions, destigmatization, poverty, living environment, longer lifetime and transition from the traditional to post-modern/(post)socialist society.

Depression is a multi-faced disease what supported patients pre-histories where four types of depression were found that are intertwined - majority of informants reported at least two types.

- Traumatic experiences in childhood and adolescence (physical and psychological violence, father's alcoholism, parents' divorce, over-protectiveness or a lack thereof and depression in the family) – 13 informants (65%);
- Long-standing, unresolved and inappropriate relationships (with parents, partner, child) – 14 informants (70%);
- Working environment (transfer to another job, dissatisfaction with working environment, overload and burnout, poor conditions and unpleasant incidents) – 8 informants (40%);
- Negative life events (death of a close friend or relative, separation from a partner, moving to another social and cultural environment, moving for study purposes and disease) – 7 informants (35%).

The ethnographies revealed six "cultural" features of depression in Slovenia.

1. Burnt out individuals, who are excessively exhausted due to their work.
2. Lack of individualization, where many (especially women) live and often work with a narrow range of family members with frequent conflicts and constant interference in their lives.
3. Great fear of failure (especially men) - it is still not acceptable for a man to cry, to be hurt or express his feelings; they suffer in silence.
4. Alcohol abuse reflects another Slovenian problem since 100.000 to 200.000 people suffer from alcohol addiction.
5. Long-term unemployment (around 13%) which creates uncertainty and fear.
6. Lack of warm and supportive relations within families. In Slovenia no family members were involved in therapies.

Individual is co-responsible for depression.

More than half of psychiatrists and Ayurvedic doctors/therapists had identical opinions regarding the co-responsibility of the individual in the development of depression. Both medical systems stressed that while the onset of depression is not the individual's fault, he is co-responsible for something that is inside his range of influence.

Co-responsibility was also recognized by most of the patients who have attributed it to their temperament, unawareness, late help-seeking and the lack of experience and knowledge about depression. The informants talked about co-responsibility in their past from today's perspective, after analyzing the causes or factors of the individual's problems. Back then, when informants were looking for help, they were not aware of this.

Pure bio-psychosocial model is rarely used in the treatment of depression.

Although psychiatry uses the bio-psychosocial model in understanding of depression, it is not implemented in the treatment practice like it is in the Ayurvedic medicine. Most informants were not offered psychotherapy or other supportive methods in addition to antidepressant treatment. Current psychiatric treatment focuses largely on the biological and psychological components of depression and often the socio-cultural component is not considered enough in practice. This is actually the main criticism of the psychiatric treatment of depression.

The difference is that the role of psychiatric patients was much less oriented toward individual problem solving. Ayurveda recommends the use of certain guidelines and techniques (meditation, yoga, physical activity, dietary guidelines, communication, etc.) to all patients, while it highlights the individual guidelines in accordance with the patient's specific problem.

However, both groups of patients reported improvements after the treatment. Ayurvedic treatment can bring positive changes to several aspects of a person's life in three to five weeks, while psychiatric

patients have to wait at least three weeks before antidepressants start working.

Therapeutic relationship – crucial difference between both treatment approaches.
Although psychiatrist uses comprehensive interview similar to Ayurvedic to reveal the reasons for depression, Ayurvedic approach is more holistic. Ayurveda dedicates more time for each individual patient and includes much more contextual information (for example about the world, the person, health, illness, treatment method, nutrition, life-style, spirituality etc.).

Psychiatric patients were generally satisfied with psychiatrists, although they missed some more discussion during the follow-up control visits, a more active patient's role and a control test that would monitor the patient's progress. Ayurvedic patients, who were less satisfied with psychiatrists, pointed out the key differences between both therapeutic relationships:

- lower level of formality;
- a more personal and active dialog;
- therapist's willingness to listen and understand;
- mindfulness;
- directive therapy and
- time component and pragmatic guidelines.

People choose Ayurveda based on experience of other people.
People did not seek help in Ayurveda due to certain believes or premises as only one informant had prior knowledge of Ayurveda. Because there is no verifiable register of complementary practitioners in Slovenia, people made the decision based on the experience of others – friends, acquaintances or family member. Most patients were treated with Ayurveda exclusively, only one was using it complimentary to psychiatry.

However, patients themselves stressed the following reasons for turning to Ayurveda: depression itself, dissatisfaction with the psychiatric care, fear of medication's side effects and dependency, somatic and psychological complaints, failed attempts of biomedicine, searching for natural, safer methods, searching for a different interpretations of their problems and curiosity and because the psychiatric treatment might be more stigmatizing.

Ayurveda offers two complementary processes – individualization and connectedness.
Ayurveda corresponds to modern psychological directions, because it emphasizes the psycho-social-(spiritual) causes of mental illness. It fills up the gap caused by the lack of professional psychological practice in Slovenia. Ayurveda helps patients who lack personal individualization (people who are too much involved in family relationships and without self-reflexivity) to become more individualized by thinking about them, to learn who they are and what they want.

However, due to the emphasis on interconnectedness of all living beings within Ayurveda, these same patients feel connected, especially with others. Psychiatrists and representatives of Ayurveda (as well as several studies) emphasized on how important social relations are and how they can affect the individual's physical and psychological well-being.

In Slovenia, basic elements of Ayurvedic practice are missing.
In Slovenia Ayurveda is facing many obstacles and limitations and cannot be recognized as medical system. There is a lack of institutional Ayurvedic treatment, where patients could go through main detoxification *panchakarma* process and receive Ayurvedic medicines, which are impossible to obtain in Slovenia. Some herbal formulas can be found as food supplements.

CONCLUSION

Even though in the recent years psychiatry has progressed in the treatment of a man more holistically, this research has demonstrated two particular advantages of Ayurvedic treatment. One is directed-

ness (given direct advice); the other is daily support during treatment period via social networks or telephone. As participants' narratives suggested, both are effective in practice yet both are not allowed in psychiatry. The important contribution of this research is therefore trying to create an environment in which different views and different paradigms come into contact with each other, for the good of the people and their health. The study also broadens our understanding of practice in relation to the treatment of patients with depression and the analysis has drawn out the findings, which might inform the practice of psychiatrist and Ayurvedic practitioners in Slovenia and in the world.

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