

# Cultural U-Turns in Mental Well-Being: Acknowledging the Dilemma

Journal of Humanistic Psychology

1–10

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DOI: 10.1177/0022167818762916

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## **Abstract**

Today on social media I see an uprising of anger against Western psychiatry and its 19th- and 20th-century practices used to address mental distress and extreme experiences. I notice movements in social media groups that support people in new frameworks of understanding. At the same time, many practitioners realize that their biomedical training does not fit the spirit of our times: there are psychiatrists and psychologists who question the original diagnoses of their professions. Across Europe, America, and Australia, there are new practices set up by mental health service providers who want to see the status quo changed. Colleagues are reevaluating the nature of human consciousness and subtle energy, and they want to end stigma and the myth of labels. They are listening more closely to ancient wisdoms of indigenous people. I wrote this article to acknowledge our dilemma between challenging frameworks of knowledge, to explore the gap between different perspectives, and to suggest that we need a cultural U-turn toward more sensitive training in our educational institutions.

## **Keywords**

medical anthropology, human consciousness, spiritual, truth and reconciliation, academic collaboration, cultural humility

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## Disaffected and Dissatisfied?

I am a medical anthropologist and observe that in the West, several groups express dissatisfaction with current models of mental health diagnosis and treatment. These include culturally new migrants, refugees and asylum seekers, patients and carers with experience of mental health system, psychiatrists who know that their training does not fit the spirit of our times, and psychologists who are aware of the importance of personal history. Also affected are psychiatrists who have already shifted their models of understanding, based on the evidence available.

However, because of my background in ethnography, I am deeply aware of original indigenous inhabitants of Australia, Africa, Canada, and the United States who do not want their narratives about altered states of consciousness pathologized and prefer their ancient practices to be acknowledged. Indigenous communities had a greater awareness of subtle states of consciousness. In the old days, scholars in the West perhaps considered other's beliefs to be "superstitious," but today, others are seen as having deep insight into consciousness<sup>1</sup> and subtle states of being.

## New Course on Cultural Equalities

Aware of the need for educational change inside institutions, I developed a medical anthropology course and started teaching cultural equalities in medical schools, hospitals, and universities. This was one way to act as a bridge and bring cultural material into mainstream organizations. I wrote the book *Cultural Perspectives on Mental Wellbeing* (Tobert, 2017) based on these medical anthropology training seminars. I hoped that it would be used as a resource for "anomalous experiences" both by those who have experiences and by those who want to offer ethnographic data as evidence of a contemporary view to their practitioners.

## What Do We Mean by Anomalous Experiences?

Anomalous or extreme experiences are also called "spiritual crisis," "spiritual awakening," or "spiritual emergency," to name a few. In their seminal work (*Varieties of Anomalous Experiences*), Cardeña, Lynn, and Krippner (2013) review scientific evidence on a whole range of human experiences that support a profound understanding of psychology. Importantly, it is our beliefs around the phenomenology of experiences that influence how we interpret and engage with mental distress.

Paranormal experiences, religious experiences, spiritual awakening, and the symptoms of psychosis appear to lie at the ends of a continuum (Clarke,

2010). Some sensitive people access visionary experiences without taking any substances, while those who have spontaneous experiences that stop may have received a psychiatric label by people around them, if they were not familiar with spiritual frameworks of understanding.

It was obvious that my colleagues and peers meant different things by anomalous experiences. For some, it was the seeing of ghosts, spirits of the dead, ancestors or apparitions, or the hearing of voices, whereas for others, it was memories from past lives like the holocaust (Yehuda, 2015), or extreme sensitivity as they tuned into another time/space continuum. Some accepted their experiences only within a specific religious framework.

Deliberately sought experiences of shamans, mystics, mediums, and clairvoyants occurred not only in “other societies” but also in the Western world. Then there was the deliberate practice of remote viewing (in nonlocal realms). Those people who spontaneously accessed it might become confused when it was outside their frameworks of belief.

Experiences accepted by my academic colleagues are beliefs about survival beyond death, or reincarnation beliefs; end-of-life experiences (Fenwick & Brayne, 2011); and bereavement visions (Rees, 1971), or memories of patients with organ transplants (Pearsall, 1998). There were “acceptable” anomalous experiences, which people spontaneously had (e.g., religious experience; near-death, out-of-body, or end-of-life experiences). These started and stopped, and they were often transformational. They became acceptable topics for study. However, any one of them may have attracted psychiatric attention but only if they occurred with anxiety or distress.

## **Paranormal Interpretation**

Alongside mundane influences on mental health, there are a variety of interpretations for visions and hearing voices. The Hearing Voices Network explored problems with psychiatric diagnosis, and it discussed alternative ways of responding to emotional crises.<sup>2</sup> There are other interpretations of visionary experiences, which include some “paranormal” explanations. People may spontaneously shift into different dimensions of time and space. People who undertake the contested practice of remote viewing intentionally make such shifts. Remote viewing is a deliberate practice to shift consciousness through time and space according to a set of coordinates. However, might it be possible that some people with ‘delusions’ shift time and space spontaneously, and are disturbed by their unsolicited experiences?” Targ is well-known for his work on remote viewing and Larry Dossey comments, “For decades, physicist Russell Targ has produced some of the most significant scientific research ever conducted on the nature of consciousness. He

has demonstrated beyond reasonable doubt that the mind can function without limitation in space and time” (Targ 2012).

Myself, I had “memories” from Nazi holocaust times, and although I could witness what was here and what was there, that didn’t stop my on/off profound depression. The theory of epigenetic inheritance suggested that Nazi holocaust trauma in one generation passed on to the next generation, through the genes (Thomson, 2015; Yehuda, 2015). I wondered whether such apparent “memories” were also had by those with extreme experiences. Was it possible that people with mental distress or extreme experiences were triggered not only by trauma from their current human existence but also from one or more remote incarnations?

There are multiple explanatory models for those who have extreme experiences, where triggers can be mundane, spiritual, or “supernatural.” Today, more people accept deeper realities about human existence and altered states of consciousness. Alongside the evidence (Davies, 2014; Whitaker, 2010; Whitaker & Cosgrove, 2015), there is so much material on nonlocal experiences and “memories” that invites us to further question “diseases of the brain” and “chemical imbalance” models of mental ill-health. Many others who question this include ISEN (International Spiritual Emergence Network)<sup>3</sup> and private social media groups such as Shades of Awakening and Drop the Disorder.

## Practitioners Within a New Paradigm

Change has been manifesting for many years. Social discontent was brewing both on social media and in mainstream press. I was pleased to see the *Evidence-Based Mental Health* (a BMJ journal) reprint an article titled “Drop the Language of Disorder” (Kinderman, Read, Moncrieff, & Bentall, 2013), and the Council for Evidence-Based Psychiatry earlier published a report (2014) on “Unrecognised Facts about Modern Psychiatric Practice.” However, there is still dissonance between information presented on social media and the mainstream press. But the gap is closing. Alongside the thousands of people like us in social media groups demanding change in mental health practice are psychiatrists, psychologists, and other frontline practitioners. If peer-reviewed journals avoid certain research topics, then social media publishes it: Mainstream media sometimes appeared to be playing “catch-up.”

Today, there is a greater understanding of a spiritual dimension, which some people access deliberately, some by chance, while others may become distressed, particularly if they have no conceptual framework for understanding

the experience. In addition, there is a greater understanding of the trauma triggers of distress, plus the role of social, political, and economic inequalities. However, in the United Kingdom, Australia, and the United States, the dominant model for extreme experiences was assumed to be biomedical, and we mistakenly assumed that it was transferable throughout the world. But we were wrong (Fernando, 2014; Mills, 2014; Watters, 2010). Many practitioners are already aware of a need for a change in the paradigm around mental health (Bracken et al., 2012).

Various ways of interpreting human experiences, when taken together, provide evidence of the myth of old-fashioned psychiatric labels, and suggest that the tipping point of change of attitude has already manifested. Many practitioners in medicine and health are profoundly aware that their training does not fit the spirit of our times, nor with the current zeitgeist. These include psychiatrists like Breggin (2010), Moncrieff (2009, 2013), Razaque (2014), Stockmann (2015), Thomas (2014), and Timimi (2013); physicians such as Gøtzsche (2015); and psychologists such as Kinderman (2014) and Read, Runciman, and Dillon (2016).

In the United Kingdom, many psychiatrists and other National Health Service (NHS) staff remain silent about their beliefs and views about health, perhaps because they fear appearing before the General Medical Council if they express their views during consultation. While some psychiatrists in practice cling to a “disease model,” others acknowledge inequalities and trauma. In 2013, the British Psychological Society launched an attack on psychiatry, casting doubt on biomedical model of diagnosis of mental illness. They claimed that there was no scientific evidence that schizophrenia or bipolar disorder was valid (Doward, 2013).

After U.K.’s Prince Harry disclosed how he suffered grief some years after his mother’s death, others questioned whether bereavement and grief should be considered as a mental illness requiring medical treatment. Professor Read (2017) suggested that medical services still tell people that they have illnesses, caused by chemical imbalances, and inferior genes, which make them more vulnerable. He wrote, “Mental health services are dominated by an outdated, simplistic medical model of distress that is rather at odds with the prince’s views.”

For some years, there was a deepening awareness about a psychiatry that existed beyond any biomedical paradigm. The authors of an article in the *British Journal of Psychiatry* argue that psychiatry needs to acknowledge the evidence, then move toward a “more meaningful collaboration with the growing service user movement” (Bracken et al., 2012, p. 430). They continue, “All forms of suffering involve layers of personal history, embedded in

a nexus of meaningful relationships that are, in turn, embedded in cultural and political systems” (p. 433). They acknowledge that psychiatry is confronting a crisis.

## Mainstreaming

The esteemed U.K. psychiatrist Murray (professor of research, knighted for his services to medicine) claimed in an article in the *Schizophrenia Bulletin* (2017) that research had both ignored social factors that influenced schizophrenia and neglected the negative effects of medication.

In the United States, Berezin (2017) had opposed psychiatric drugs his entire career and noticed the arrival of a new paradigm for psychiatry. He suggests that beliefs about the effectiveness of pharmacology are “harmful, corrupt, and scientifically bankrupt.” His colleague Breggin (2017) also criticizes “biological psychiatry for covering up the real sources of human suffering.”

Changes are ongoing: In Europe, Norway created a medication-free psychiatric ward as part of their mental health care system (Håkansson, 2017). In the United Kingdom, the community mental health service Dialogue First was opened, which used a collaborative approach to care.<sup>4</sup> It was generated as part of an Open Dialogue approach, which offers compassionate, person-centered care to those in crisis, with its accredited course, and a research grant into effectiveness.<sup>5</sup>

In Geneva, for World Mental Health Day 2017, psychiatrist Pūras (2017) wrote that we must reconsider biomedical approaches to depression, shift away from medicalized intervention and “chemical imbalance,” and address power imbalance and inequality. He acknowledged evidence of a link between depression, childhood adversity, inequality, poverty, and social exclusion. I would like to see these views as part of every medical school education program.

The authors in a new book on “Sedated Society” suggest that our society is becoming sedated, as more than 15% of the U.K. population and 20% of the U.S. population takes psychiatric medication each day (Davies, 2017). They reveal the ways in which pharmaceutical marketing and the hiding of negative clinical trials result in commercial success (but not therapeutic efficacy). However, there is some movement on recognizing the problems of medication. In the United Kingdom, an All-Party Parliamentary Group lobbied Public Health England for a 24-hour helpline to help people withdraw from prescribed painkillers, tranquilizers, and antidepressants (Council for Evidence-Based Psychiatry, 2017). This was supported by the Royal College of General Practitioners, the Royal College of Physicians, and the Royal College of Psychiatrists.

## Ways Forward With Academic Collaboration

My invitation to academia:

Is there anyone out there creating bridges between the academic disciplines of Religious Studies, Psychiatry, Transpersonal Psychology, Paranormal Psychology, and Medical Anthropology, using research to compare and contrast the lived phenomena of human experience? I feel it is difficult to progress social and individual healing until these academic boxes are opened simultaneously for discussion. (Tobert, 2015).

Let us talk to one another.

Let us sit around the same table to discuss this. We would benefit from a Truth and Reconciliation Action Group, to acknowledge the dilemmas, so we don't remain in our private silos with consenting colleagues. We also need to be aware of the peer review system in academia, where a researcher's work is accepted, as long as it adheres to strong academic or scientific criteria, but not if it challenges a reviewer's paradigm.

Today, the way forward is to be present with suffering, rather than avoid it. Radical changes are happening within some parts of the NHS in the United Kingdom with the Dialogue First community mental health service for people with "first onset psychosis."<sup>6</sup> *Open Dialogue* and *Peer-Supported Open Dialogue* are new ways of working in the NHS. Using group discussion with consent, the open dialogue practice has taken off throughout Western countries (Seikkula et al., 2006), although for millennia, it was a normal practice for addressing distress by a council of elders in Africa and Australia,<sup>7</sup> and in the United States, New Mexico elders had sacred spaces (*kiva*) where they performed ceremony and held discussions.

My question is, "How do we work together?" "How do we acknowledge the anger and frustration of those with lived experience?" "How do we work with those psychiatrists, counsellors, and frontline service providers who were trained in one belief system about the cause, effect, and treatment?" "How do we support them and their peers in acknowledging the dilemma within practice, so people with lived extreme experiences receive appropriate, compassionate, and mindful support?" For these changes to be sustainable, we need to ensure that our education system in medical and health care establishments is up-to-date with our new understandings on culture and subtle states of consciousness. Cultural Equalities training<sup>8</sup> is a safe way to introduce humility into the education syllabus of older establishments and to negotiate with and bridge different frameworks of knowledge. Let us collaborate.

## Declaration of Conflicting Interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## Funding

The author received no financial support for the research, authorship, and/or publication of this article.

## Notes

1. <http://www.sriarobindoashram.org/ashram/yoga/index.php>
2. <http://www.hearing-voices.org/events/beyond-diagnosis/>
3. Spiritual Emergence Network. <http://www.spiritualemergencenetwork.org/history-of-isen/>
4. <http://www.nelft.nhs.uk/aboutus-initiatives-dialoguefirst>
5. <http://www.nelft.nhs.uk/aboutus-initiatives-opendialogue>
6. Dialogue First can be accessed via general practitioner referral. <http://www.nelft.nhs.uk/aboutus-initiatives-dialoguefirst>
7. <http://www.caesa.org/>
8. <http://aethos.org.uk/training/> (Cultural Equalities training)

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## Author Biography



**Natalie Tobert**, PhD, is a medical anthropologist who facilitates educational training events in the United Kingdom, Sweden, Switzerland, India, Spain, and the United States. Her latest book *Cultural Perspectives on Mental Wellbeing* (2017) was written as a resource for us, and for medical and therapeutic practitioners to raise awareness of cultural and spiritual ways of interpreting “symptoms.” The book acts as a bridge, acknowledging the cultural dissonance between different frameworks of knowledge and paradigms.